



CORE

Public Health Functions for BC

**Model Core Program Paper:
Prevention of
Violence, Abuse &
Neglect**

This Model Core Program Paper was prepared by a working group consisting of representatives of the BC Ministry of Healthy Living and Sport and BC's health authorities.

This paper is based upon a review of evidence and best practice, and as such may include practices that are not currently implemented throughout the public health system in BC. This is to be expected, as the purpose of the Core Public Health Functions process—consistent with the quality improvement approach widely adopted in private and public sector organizations across Canada—is to put in place a performance improvement process to move the public health system in BC towards evidence-based best practice. Where warranted, health authorities will develop public performance improvement plans with feasible performance targets and will develop and implement performance improvement strategies that move them towards best practice in the program component areas identified in this Model Program Paper.

This Model Program Paper should be read in conjunction with the accompanying review of evidence and best practice.

Model Core Program Paper approved by:

Core Functions Steering Committee (March 2010)

Population and Public Health, BC Ministry of Healthy Living and Sport (March 2010)

© BC Ministry of Healthy Living and Sport, 2010

TABLE OF CONTENTS

1.0	Overview/Setting the Context.....	1
1.1	An Introduction to This Paper.....	2
1.2	Introduction to Prevention of Violence, Abuse and Neglect	3
1.2.1	Child Abuse	3
1.2.2	Intimate Partner Violence and Abuse	4
1.2.3	Youth Violence	4
1.2.4	Abuse of Older Adults	5
1.2.5	Other Vulnerable Groups.....	5
1.2.6	A Public Health Approach.....	7
2.0	Scope And Authority For Prevention of Violence, Abuse and Neglect	11
2.1	National/International Roles and Responsibilities.....	11
2.2	Provincial Roles and Responsibilities.....	12
2.2.1	Ministry of Healthy Living and Sport.....	12
2.2.2	Ministry of Health Services	13
2.2.3	Ministry of Education	13
2.2.4	Ministry of Children and Family Development.....	13
2.2.5	BC Housing Roles and Responsibilities	14
2.2.6	Ministry of Housing and Social Development.....	14
2.2.7	Ministry of Public Safety and Solicitor General.....	14
2.2.8	Ministry of Attorney General.....	15
2.2.9	Other Provincial Ministries.....	15
2.2.10	Provincial Health Services Authority Roles and Responsibilities.....	15
2.2.11	Other Provincial Organizations.....	16
2.3	Health Authorities Roles and Responsibilities	16
2.3.1	Leadership and Advocacy.....	17
2.3.2	Health Promotion	17
2.3.3	Early Identification, Prevention and Protection.....	17
2.3.4	Surveillance, Monitoring and Program Evaluation	18
2.4	Local Level	18
2.5	Aboriginal Communities.....	19
2.6	Legislation and Policy Direction	19
3.0	Goals and Objectives	20
4.0	Principles/Fundamental Concepts.....	21
4.1	A Primary Prevention/Determinants of Health Approach.....	21
4.2	Multi-Disciplinary/Multi-Sectoral Collaboration	22
4.3	Universal and Selected/Targeted Initiatives	23
4.4	Responsiveness to Vulnerable and At-risk Population Groups	24

Core Public Health Functions for BC: Model Core Program Paper
Prevention of Violence, Abuse & Neglect

5.0	Main Components and Supporting Evidence	25
5.1	Leadership and Advocacy	25
	Summary of Supporting Evidence	26
5.2	Health Promotion	26
5.2.1	Summary of Supporting Evidence	28
5.3	Early Identification, Prevention and Protection	29
5.3.1	Early Identification and Screening	29
5.3.2	Universal Initiatives	30
5.3.3	Targeted Interventions	31
5.3.4	Summary of Supporting Evidence	34
5.4	Surveillance, Monitoring and Program Evaluation	36
5.4.1	Summary of Supporting Evidence	37
6.0	Best Practices	38
7.0	Indicators, Benchmarks and Performance Targets	40
7.1	Introduction	40
7.2	Indicators for the Program on Prevention of Violence, Abuse and Neglect	41
8.0	External Capacity and Support Requirements	42
8.1	Key Success Factors/System Strategies	42
8.2	Intersectoral Collaboration and Integration/Coordination	42
References	43
Glossary	47

Figures

Figure 1: Types of Abuse and Corresponding Periods during the Life Course	3
Figure 2. The Ecologic Model	8

Appendices

Appendix 1: Summary of Statistics on Violence, Abuse and Neglect	56
Appendix 2: The Evidence Base for a Model Core Program for Prevention of Physical Violence and Abuse	60
Appendix 3: Supplementary Evidence	64
Appendix 4: Program Schematic – Model Core Program for Prevention of Violence, Abuse and Neglect	69

EXECUTIVE SUMMARY

This paper identifies the core elements that are provided by British Columbia health authorities to support prevention of violence, abuse and neglect. It is intended, as part of the BC Core Functions in Public Health, to reflect evidence-based practice and support continuous performance improvement.

A Working Group of representatives from the Ministry of Health, Provincial Health Services Authority and the health authorities worked together to develop this paper. They agreed that the goal of the program for prevention of violence, abuse and neglect is to prevent or reduce the incidence of violence, abuse and neglect experienced by children, youth, intimate partners and older adults across their lifespan. The specific objectives are to:

- Increase healthy interpersonal relationships in families, schools, workplaces and health care environments.
- Strengthen the healthy development, resiliency and self-esteem of children and youth.
- Strengthen cultural norms and attitudes that reflect social and gender equality and equity, to empower women and men of all ages, abilities, races, cultures and sexual orientation.
- Enhance community involvement in caring for, supporting and protecting seniors.
- Prevent or reduce vulnerabilities, risks and inequities that represent threats to the physical, emotional, sexual or mental health of children, youth, women and men, older persons, including those with disabilities and mental disorders, people from diverse cultural backgrounds, and people who are gay, lesbian, bisexual or transgendered.

A number of key principles and overarching strategies are necessary to achieve these objectives:

- Zero tolerance of violence, abuse and neglect.
- Respect for the human rights, dignity and well-being of all people.
- A public health primary prevention approach, which takes into account protective factors, risk factors and populations that are vulnerable to violence, abuse and neglect.
- Multidisciplinary and multi-sectoral collaboration through strengthened partnerships across sectors, issues and levels, including integrated planning and program delivery with other related model core programs as appropriate.
- A combination of universal interventions for the general public, as well as selective and targeted prevention interventions for at-risk populations, focusing on early identification and intervention.
- The use of equity lenses, including gender and diversity lenses, to identify the differential impact of the determinants of health on the lives of women and men and on vulnerable population groups across their lifespan, as well as to determine policies and programs

Core Public Health Functions for BC: Model Core Program Paper

Prevention of Violence, Abuse & Neglect

necessary for overcoming systemic barriers that are unique to their circumstances, experiences and needs.

- Presumption that every adult is capable of making decisions about their personal care, health care, legal matters, financial affairs, business or assets.
- Facilitation of community development and community capacity building to enhance prevention of violence, abuse and neglect.
- Involvement of the respective population groups in any planning and program development that will impact them.
- Advocacy for evidence-based practices and for a culture of continuous quality improvement.

Preventive measures are essential to counteract the high costs of violence, abuse and neglect in BC, both the costs of treatment and services for victims and perpetrators, as well as the costs of human suffering. In BC, an economic analysis in 1996¹ estimated the cost of violence against women to be \$385 million (taking into account policing, corrections, criminal injury compensation, victim assistance programs, counselling, mental health care, alcohol and drug treatment, income assistance, transition houses, sexual and women assault centres, women's loss of work time, and treatment for assaultive men). Considering the additional costs for treatment and services related to child abuse, youth violence and abuse of older persons, the total amount is significant.

The major program components for prevention of violence, abuse and neglect in regional health authorities are:

- Leadership and advocacy.
- Health promotion.
- Early identification, prevention and protection.
- Surveillance, monitoring and program evaluation.

Best practices and promising practices for each program component, based on the evidence and experience of experts in the field are:

Leadership and Advocacy

Health authorities should take a leadership role in developing a strategic approach to prevention of violence, abuse and neglect, including:

- Proactive collaborative planning with health partners, the school system and community stakeholders to identify regional priorities.

¹ Kerr, R. & Mclean, J. (1996). *Paying for violence: some of the costs of violence against women in BC*. Victoria, BC: Ministry of Women's Equality.

Core Public Health Functions for BC: Model Core Program Paper
Prevention of Violence, Abuse & Neglect

- Advocating for healthy public policies by working with municipal councils, local media, school boards, social services agencies, employers, community care facilities and other community organizations.
- Advising and supporting all public health programs in the integration of strengthened preventive measures to identify and reduce the incidence of violence, abuse and neglect experienced by clients.
- Leading the development and planning for safe, violence-free health authority workplaces.

Health Promotion

- Creating supportive environments through supporting the development and delivery of public education, awareness and social marketing, and through collaboration with health care, community, provincial and national partners.
- Strengthening community action:
 - Facilitate existing community development and community capacity building processes, to develop policies and programs across multiple sectors and multiple settings to reduce risk factors for violence, abuse and neglect of children, youth, women, men and elderly people, as well as specific vulnerable population groups.
 - Support and assist Aboriginal communities in their development of prevention plans and programs that address cultural norms and attitudes and respond to specific needs in communities.
 - Network with police, justice officials and victim's support groups to enhance community risk assessment and safety planning.
- Developing personal skills for health professionals:
 - Develop and implement a strategy for health authority workforce training and development, to enhance the knowledge and capacity of staff to understand, recognize and support victims of child abuse, youth violence, intimate partner violence, and abuse of older adults
 - Provide educational resources and training opportunities for physicians in the recognition and treatment of victims of interpersonal violence.

Early Identification, Prevention and Protection

Early identification and assessment/screening for at-risk children and youth, adults and older people, including:

Core Public Health Functions for BC: Model Core Program Paper
Prevention of Violence, Abuse & Neglect

- Undertaking early detection of at-risk children and youth through linkages and consultation with social workers, school systems, primary care providers and other community contacts.
- Integrating appropriate screening processes, through work with primary care providers, acute and emergency health care programs, for women (including perinatal women), for intimate partner violence and abuse, and/or sexual assault (considering the specific context, circumstances and risk factors).
- Integrating appropriate screening processes, through work with primary care providers, care facilities and other community contacts, for violence, abuse and neglect of older adults.

NOTE: The working group understands that development of a province-wide approach to screening of women for interpersonal violence requires discussion of the challenges, issues and evidence, and how these apply to the various contexts and circumstances related to women who are victims of violence and abuse. They recognize that a rigid approach, either for or against screening, needs to be tempered by a number of considerations. **Therefore, they recommend that a follow-up working group be established to enable the Ministry of Healthy Living and Sport and all health authorities together, to build a consensus on appropriate policies and practices that can be applied to decisions on screening women for violence and abuse.**

Furthermore, the working group recognizes that understanding and sensitivity by care providers towards violence, abuse and neglect of individuals of all ages and genders needs to be strengthened, and that screening policies and practices for these groups also need to be developed, clarified and supported. **Therefore, they further recommend that the follow-up committee or working group develop a consensus on policies and practices for identifying children, youth and older adults (women and men) who are victims of violence, abuse and neglect, taking into account the relevant issues, circumstances and evidence for each group.**

- *Universal Initiatives:*
 - Infants, children and youth: optimal perinatal care; parenting skills training for parents of infants and toddlers; educational interventions for new fathers, and work with school and community partners to implement proven programs for school-aged children and youth, including social development, physical exercise, dating violence prevention and academic enrichment programs.
 - Adults: collaborate with communities to deliver interventions to strengthen protective factors and community networks (e.g., healthy lifestyles, healthy workplaces, social connectedness, physical education, etc.)

Core Public Health Functions for BC: Model Core Program Paper **Prevention of Violence, Abuse & Neglect**

- Older adults: provide information on their rights; encourage and support local networks; and provide psychosocial educational interventions.
- *Targeted Initiatives*
 - At-risk infants, children and youth: prenatal and postpartum counselling for at-risk pregnant women and new mothers to address risk factors, including intimate partner violence, abuse and neglect, and psychosocial problems, with referral to specialized support and resources as necessary; parenting training including home visits; and work with partners to provide preschool enrichment combined with home visitation. For school-aged children and youth, promote and support resilience-focused programs, educational incentives, mentorship programs, brief family interventions, etc.
 - At-risk adults: comply with legislative requirements to respond to reports of adult abuse; work with partners to promote healthy workplaces, empowerment and life skills development for women, job skills programs that incorporates social support and coping skills, and family interventions as appropriate.
 - At-risk older adults: Build or strengthen information support networks for seniors among family members/community gatekeepers/neighbours and peers to enhance support, and provide proactive support and involvement in community response networks.

Surveillance, Monitoring and Program Evaluation

- Gather information on key indicators related to violence, abuse and neglect of children, youth, adults and older people.
- Analyze and interpret data to clarify local and regional trends, major issues, key risk factors, and vulnerable groups and populations.
- Report publicly on the level of violence, abuse and neglect, and its related impact, as an important public health issue (through the authority of medical health officers in collaboration with the Provincial Health Officer).
- Collaborate with partners in developing an information sharing system.
- Collaborate in developing program evaluation frameworks and evaluating new initiatives.

1.0 OVERVIEW/SETTING THE CONTEXT

As demonstrated in recent Canadian reports, public health needs to be better structured and resourced in order to improve the health of the population. The Framework for Core Functions in Public Health is a component of that renewal in British Columbia. It defines and describes the core public health activities of a comprehensive public health system. This policy framework was accepted in 2005 by the Ministry of Health and the health authorities.

Implementation of core functions will establish a performance improvement process for public health, developed in collaboration between the Ministry of Healthy Living and Sport, the health authorities and the public health field. This process will result in greater consistency of public health services across the province, increased capacity and quality of public health services and improved health of the population. To ensure collaboration and feasibility of implementation, the oversight of the development of the performance improvement process is managed by a Provincial Steering Committee, with membership representing all health authorities and the ministry.

What are core programs? They are long-term programs representing public health services that health authorities provide in a renewed and modern public health system. Core programs are organized to improve health; they can be assessed ultimately in terms of improved health and well-being and/or reductions in disease, disability and injury. In total, 21 programs have been identified as “core programs,” of which the program for prevention of violence, abuse and neglect is but one.

In a “model core program paper,” each program will have clear goals, measurable objectives and an evidentiary base that shows it can improve people’s health. Programs will be supported through the identification of best practices and national and international benchmarks (where such benchmarks exist). Each paper will be informed by an evidence paper, other key documents related to the program area and key expert input obtained through a working group with representatives from each health authority and the Ministry of Healthy Living and Sport.

The Provincial Steering Committee has indicated that an approved model core program paper constitutes a model of good practice, while recognizing it will need to be modified to meet local context and needs. In addition, over time, model core programs will need to be reviewed and updated, and a process of renewal is currently being developed by the Provincial Steering Committee. While health authorities must deliver all core programs, how each is provided is the responsibility of the health authority, as are the performance improvement targets they set for themselves.

It is envisioned that the performance improvement process will be implemented over several years. During that time the process will contribute to and benefit from related initiatives in public health infrastructure, health information and surveillance systems, workforce competence assessment and development, and research and evaluation at the regional, provincial and national levels.

1.1 An Introduction to This Paper

This model core program paper for prevention of violence, abuse and neglect is one element in an overall public health performance improvement strategy. It builds on previous work from a number of sources.

In March 2005, the then-Ministry of Health released a document entitled *A Framework for Core Functions in Public Health*. This document was prepared in consultation with representatives of health authorities and experts in the field of public health. It identifies the core programs that must be provided by health authorities, including prevention of violence, abuse and neglect, and the public health strategies that can be used to implement these core programs. It provides an overall framework for the development of this document.

Other documents that have informed this paper include:

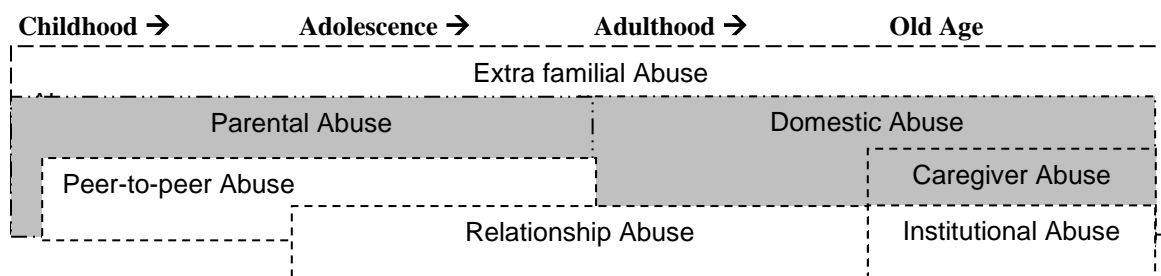
- *Primary Prevention of Physical Violence and Abuse in British Columbia* (2008), prepared by P. Joshi, L. Pllaveshi, P. Verma and I. Pike, BC Injury Research and Prevention Unit.
- *Strategies for Violence Prevention: Supplement to the Core Functions Evidence Review for the Prevention of Physical Harm* (2009), prepared by the Women's Healthy Living Secretariat, Ministry of Healthy Living and Sport.
- *Preventing Violence: A Guide to Implementing the Recommendations of the World Report on Violence and Health* (2004), by the World Health Organization. Available from:
http://www.who.int/violence_injury_prevention/media/news/08_09_2004/en/index.html.
- *Primary Prevention of Intimate-Partner Violence and Sexual Violence: Background Paper for WHO Expert Meeting, May 2-3, 2007*, by A. Harvey, C. Garcia-Moreno and A. Butchart, for the World Health Organization. Available from:
http://www.who.int/violence_injury_prevention/publications/violence/IPV-SV.pdf.
- *Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence* (2006), by the World Health Organization and the International Society for Prevention of Child Abuse and Neglect. Available from:
http://www.who.int/violence_injury_prevention/publications/violence/child_maltreatment/en/index.html.

A Working Group on Prevention of Violence, Abuse and Neglect, formed of experts from the Ministry of Healthy Living and Sport, the Provincial Health Services Authority, and the regional health authorities, was formed in Spring 2009. The group provided guidance and direction in the development of the model core program paper during meetings in spring and fall, 2009, as well as through regular telephone and e-mail discussions.

1.2 Introduction to Prevention of Violence, Abuse and Neglect

Violence, abuse and neglect are insidious and frequently deadly social problems. They include interpersonal violence such as child maltreatment, intimate partner violence and abuse of older adults, as well as community violence encompassing acquaintance and stranger violence, youth violence, and violence in the workplace and other institutions. Cross-cutting each of these categories is the four modes in which violence may be inflicted: physical, sexual and psychological attack, and deprivation.¹

Figure 1: Types of Abuse and Corresponding Periods during the Life Course



The experience of violence and abuse during the life course (as seen in Figure 1) has marked consequences on health in several domains. The impact on physical health includes mortality, injury and disability, worsened general health, chronic pain, substance abuse, dissociation and an overuse of health services.²⁻⁴ In addition it has a major psychological impact and related mental health and behavioural problems.⁵

1.2.1 Child Abuse

Child abuse has serious impact on the victims' physical and mental health, well-being and development throughout their lives, and by extension, on society in general.⁶ As well, experience of abuse as a child, either directly as a victim or indirectly as a witness, is a significant risk factor for further victimization or for perpetration of violence and abuse as an adult.

Individuals who have experienced childhood trauma are significantly more likely to experience a range of negative mental health outcomes including alcoholism, drug abuse, suicide/suicide attempts and depression. There are also multiple long-term effects on physical health: childhood trauma has been found to be a predictor for many of the leading causes of death in adulthood, including heart disease and cancer.⁷

Data is somewhat limited but statistics indicate (further data provided in Appendix 1):

- In 2008, the number of BC youth who experienced physical abuse increased from 15 percent in 2003 to 17 percent in 2008 (19 percent of females and 14 percent of males); 8 percent of youth reported sexual abuse (13 percent of females and 3 percent of males), and 5 percent reported both physical and sexual abuse (7 percent of females and 2 percent of males).

- Youth who are particularly vulnerable to relationship violence included those who had been sexually abused, had a disability or chronic illness, and gay, lesbian and bisexual youth.⁸
- Almost 40 percent of women assaulted by spouses said their children witnessed the violence against them (either directly or indirectly) and in many cases the violence was severe.⁹
- Children who had seen violent behaviour were more likely than those who had not, to be overtly aggressive. Level of physical aggression remained high 2 and 4 years later for both sexes.⁹

1.2.2 Intimate Partner Violence and Abuse

It is important to recognize, particularly with a public health holistic approach, gender as a basis for understanding intimate partner violence with respect to power imbalances in families, cultural and structural supports for gendered power relationships, and women as the primary victims of partner violence. Although abuse can be perpetrated by either men or women, experts note the major underlying causes include abuse of power, gender inequality and modeling of violence in the home.¹⁰

- In BC in 2004, the five-year prevalence rate of spousal violence against women was 9 percent;¹¹ in Canada the rate was 7 percent. Spousal violence against women by previous spouses compared to current spouses was 21 percent in 2004.¹¹ The rate of spousal violence against men was 6 percent in 2004.¹¹
- The United Nations estimate that the lifetime rate (compared to the five-year rate) of intimate partner violence against women is one in three worldwide, based on surveys from 71 countries.¹²
- Women victims of domestic violence are more than twice as likely as male victims to be physically injured by partners; six times more likely to receive medical attention; five times more likely to be hospitalized due to injuries; and twice as likely to report chronic ongoing assaults (10 or more).¹¹ Of women in Canada who report being abused by an intimate partner, 21 percent said they were abused during pregnancy.¹³

1.2.3 Youth Violence

- In BC, males accounted for a higher number of assault-related hospital separations when compared to females at an approximately 5:1 ratio, peaking among young males aged 15-24 years and declining among males aged 25-69 years.¹⁴
- A BC survey (2006) of marginalized and street-involved youth¹⁵ found:
 - Violence was a significant issue for most of the youth: 63 percent reported having witnessed family violence, and almost 60 percent reported being physically abused.

- Thirty percent of males and 23 percent of females had been sexually exploited. Youth who reported physical or sexual abuse were twice as likely to be sexually exploited as those who were not abused.
- In BC, lesbian, gay, bisexual and transgendered youth are two to three times more likely to have experienced physical and sexual abuse, bullying, harassment in school and discrimination compared to heterosexual teens, and rates seems to be rising.¹⁶

1.2.4 Abuse of Older Adults

Abuse of older adults, or elder abuse, is often hidden with little recognition by the public of its extent. Some experts believe that it is underreported by as much as 80 percent due to the isolation of older people, general resistance to reporting suspected cases,¹⁷ and dependence on caregivers who may be the perpetrators of abuse. They note that the impact of the trauma may be worsened by shame and fear resulting in a reluctance to seek help. The World Health Organization has called for changes in attitudes, policies and practices at all levels and in all sectors to ensure that people are able to age with security and dignity, as citizens with full rights.¹⁷

- Five percent of Canadian seniors surveyed in 2008, reported they had experienced abuse. Of these, the types of abuse experienced were lack of respect (23 percent), psychological/verbal/emotional abuse (19 percent) and financial abuse (17 percent). Fewer than half of these seniors (44 percent) sought help. Doctors/health professionals (39 percent), as well as seniors or community groups/organizations (30 percent), were the sources to which seniors turned for help.¹⁸
- Other family members (63 percent) are most likely to be seen as the main sources of elder abuse, followed by caregivers in institutions (50 percent).¹⁸

1.2.5 Other Vulnerable Groups

Aboriginal People

Colonization, shifts in diet, the impact of residential schools and reserves have all contributed to the disruption of Aboriginal cultures, communities and family structures.¹⁹ Residential schools in particular have resulted in a loss of family connectedness and attachment across generations, and a high incidence of child maltreatment and abuse, youth violence and intimate partner violence. For example, in 2004, the rate of domestic violence for Aboriginal women was more than three times higher than for non-Aboriginal women or men: 21 percent of Aboriginal women reported being victims of spousal violence (compared to 7 percent of non-Aboriginal women).¹¹ They were significantly more likely than non-Aboriginal women to report the most severe and potentially life-threatening forms of violence (i.e., being beaten or choked, having had a gun or knife used against them, or being sexually assaulted).¹¹

The larger pattern of intergenerational abuse is almost always linked to individual or collective trauma and the need for healing. All of these factors and the resulting behaviours have profound implications that must be considered when developing appropriate community responses.²⁰

People with Disabilitiesⁱⁱ

People with disabilities can be doubly disadvantaged through a combination of discrimination, social exclusion and “invisibility”, gender inequity, and limited access to health care and other services. Violence can take many forms, both individual and systemic: both men and women who are disabled experience a higher rate of violence and abuse (compared to the general population). Disabled women in particular experience a high rate of physical and sexual abuse:²¹ a 1989 survey in Canada found that 40 percent of women with disabilities had experienced abuse, while 12 percent had been raped.²¹

Those people with developmental disabilities are particularly at risk of abuse. Although data is sparse, a review of available literature from the United States, Canada, Australia and Great Britain concluded that the best conservative estimate is that people with developmental disabilities are 4 to 10 times more likely to be victims of crimes than are people without these disabilities: 2.9 times higher for crimes of assault; 10.7 times higher for sexual assault, and 12.7 times higher for robbery.²² Moreover, studies have shown that there is a high probability of repeat victimization: 83 percent of women with intellectual disabilities in one sample had been sexually assaulted and of those, nearly 50 percent had been sexually assaulted 10 or more times. Revictimization is frequent because a high percentage of perpetrators are care providers or family members and certain disabilities can prevent victims from defending themselves, or from reporting the attacker.²³

People with Mental Disorders

People with mental disorders are also linked to a high rate of abuse, more frequently as victims of violence than as perpetrators. The annual incidence of violence against people with severe mental illness is, on average, 4 times higher than in the general population, and the prevalence is 6 to 23 times greater.²⁴ People with mental illness perpetrate 3 to 5 percent of violence in the general population. Those with severe mental illness are 2 to 3 times as likely as people without such an illness to be assaultive; however, this violence tends to be associated with the presence of multiple risk factors such as substance use, homelessness, being a victim of violence and/or poor medical health²⁵ (e.g., people who abuse alcohol or drugs are nearly 7 times more likely to report violent behaviour.²⁵

People who are Gay, Lesbian, Bisexual or Transgendered

In BC, lesbian, gay and bisexual youth are two to three times more likely (than other youth) to have experienced physical and sexual abuse, harassment in school, and discrimination about race/ethnicity, sexual orientation and other issues in the community.¹⁶ Acts of psychological, physical abuse and sexual abuse can lead to reduced self-esteem, social withdrawal and isolation.²⁶

People in Care

ⁱⁱ According to the World Health Organization, disability is an umbrella term for impairments, activity limitations or participation restrictions that are measured through an individual functional assessment, and acknowledge that disability is also a product of culture and social institutions (See Glossary).

Children and adults in care are particularly vulnerable to abuse. Children in care (through the Ministry of Children and Family Development) face significant, often systemic, issues. For example, in comparison with the general population of children, children in care are 4 times more likely to be diagnosed with mental disorders; prescribed mental health-related drugs at a rate of 5.5 to 12 times more often; and admitted to hospital 2 to 3.5 times more frequently, and generally for longer periods.²⁷ Institutionalized dependant adults, including those with developmental disabilities and mental disorders, and elderly people in nursing homes, often have limited capacity and an associated heightened vulnerability to neglect and abuse.

Multicultural, Immigrant and Visible Minority Populations

In multicultural Canada, some persons or groups may face additional risks due to conditions such as marginalization, stigmatization, loss or devaluation of language and culture, experience with violence and trauma, and lack of access to culturally appropriate health care services. Appropriate support services are required to address a variety of differing cultural practices, risk factors and needs that are unique to the many immigrant and refugee populations in the province.

British Columbia is home to a significant number of people who have migrated from conflict zones. Conflict and war-linked experiences may influence attitudes and behaviours and/or cause mental health problems such as post-traumatic stress disorder, depression and anxiety.²⁸ War-related trauma can also have trans-generational impacts on family members. In addition, violent cultural traditions may also be transferred to an immigrant's new country. For example, honour killings and female circumcision are accepted in some countries but are against the law in Canada.ⁱⁱⁱ

1.2.6 A Public Health Approach

The relationship between the determinants of health, violence, abuse and neglect are complex and multi-layered. To address these, a public health approach has been recommended by the World Health Organization.²⁹ This response is partly due to the fact that violence has often been addressed in a context-specific manner, by issue-focused groups including women's health, domestic violence, sexual abuse and anti-bullying groups. By combining expertise, identifying risk patterns, and providing interventions that are equally broad in scope, it is expected that a public health approach will more effectively address violence at the community and population levels.

A number of

reviews of empirical research on what reduces crime and interpersonal violence have been completed by governments, intergovernmental agencies and university groups – the findings are highly convergent and agree that rates of interpersonal violence can be significantly reduced through well-planned and multi-sectoral strategies that tackle multiple causes, using frameworks such as the public health approach.²⁹

ⁱⁱⁱ Female genital mutilation/cutting is a crime under sec. 268 of the Criminal Code of Canada.

Core Public Health Functions for BC: Model Core Program Paper
Prevention of Violence, Abuse & Neglect

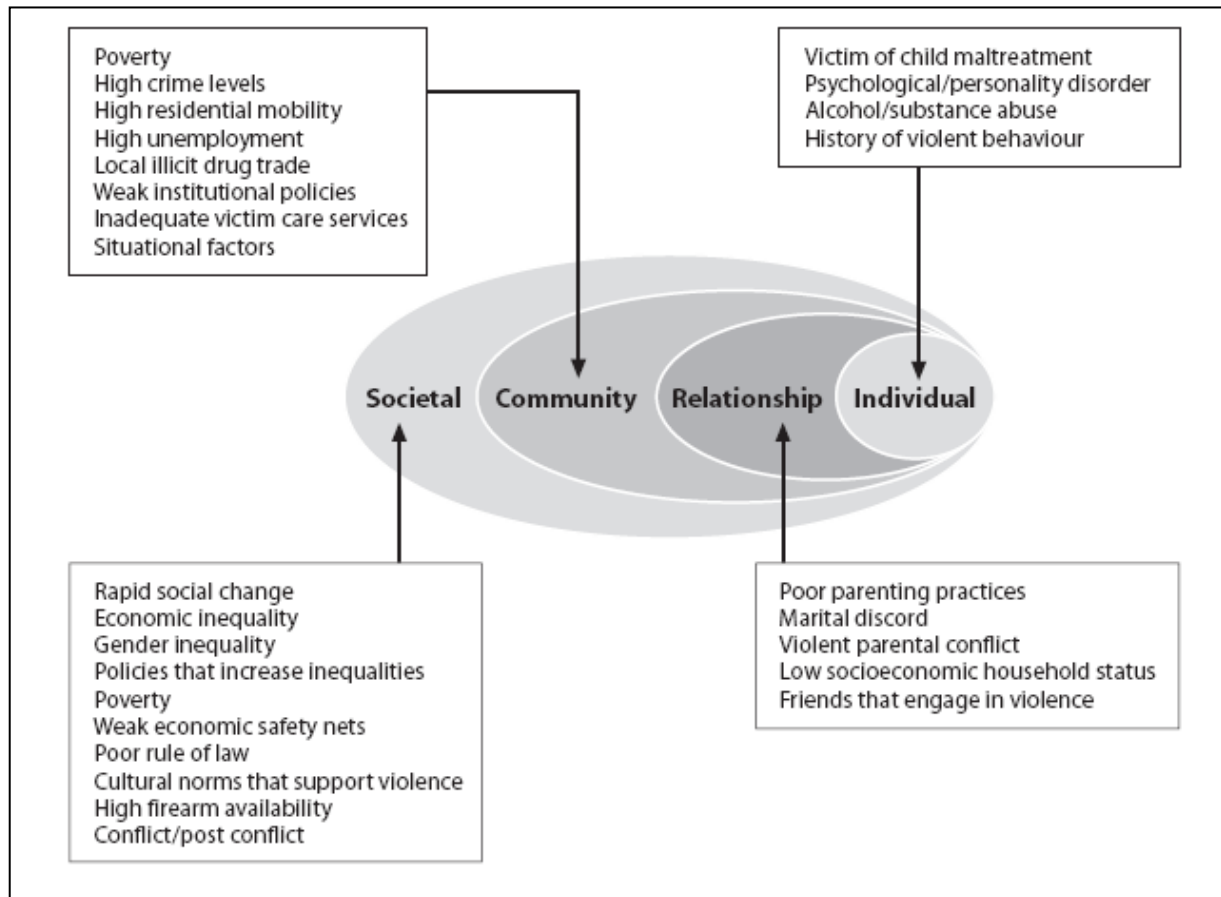
NOTE: It is recognized that prevention initiatives targeted to specific at-risk groups can be an effective supplement to a universal approach, and also, that treatment and support services for victims need to be targeted to address the different types of violence and the specific needs of each groups (i.e., child abuse, intimate partner abuse, youth violence, abuse of older adults, etc.).

Treatment by primary and acute health care providers is outside the scope of this paper; however it is recognized that the public health preventive functions may be provided by any sector of the health authority.

Risk Factors

The World Health Organization provides a conceptual overview of risk factors for violence, abuse and neglect in an ecologic model, which reflects different levels of influence. This provides a context for considering the wide range of factors that may be addressed within the public health or population health approach:

Figure 2. The Ecologic Model



Source: *World Report on Violence and Health*, by Krug et al. (2002).³⁰

Researchers are increasingly acknowledging the converging evidence from a number of sources, which indicate that exposure to violence in the media and in video games can be a risk factor for aggressive and violent behaviour.³¹ Also, additional risk factors known to contribute to abuse and neglect of elderly people include isolation, financial dependence and aggressive behaviour by those with dementia.

Protective Factors

In the same way that certain factors increase the susceptibility of child and families to violence and abuse, there are also factors that may offer a protective effect. Research to date has focused mainly on resiliency factors for children; i.e., the ability to thrive even in adverse circumstances. Research on resilient children has found that certain characteristics that promote or allow for healthy development include a relatively small set of global factors, including connections to competent and caring adults in the family and community, cognitive and self-regulation skills, positive views of self and motivation. Studies also note that the essential foundations of children's resiliency could be found in the taken-for-granted contexts provided by adequate housing, nutrition, education, parenting and health care.³² Researchers conclude that environmental circumstances and protective resources can offset risks and change children's developmental trajectories away from the mental, behavioural and health problems typically associated with adversity. Families and even communities that weather adverse circumstances with sustained positive growth can be considered to be resilient.³¹

Costs of Violence, Abuse and Neglect

- A researcher from the University of British Columbia found that among Canadian women who left abusive partners, health effects were significant, particularly disabling conditions such as chronic pain, depression and post-traumatic stress disorder. This study estimated the annual cost of state and private-sector expenditures attributable to violence as \$13,162 per women—this translated to a national cost of \$6.9 billion dollars for women who have left abusive partners (costs included medical costs, moving, legal costs, safety measures, etc.).³³
- In BC in 1996, costs of violence against women were estimated to be \$385 million, taking into account policing, corrections, criminal injury compensation, victim assistance programs, counselling, Aboriginal programs, mental health care, alcohol and drug treatment, income assistance, transition houses, sexual and women assault centres, women's loss of work time and treatment for assaultive men.³⁴
- Several studies have identified cost benefits of violence-related prevention programs:
 - The Prenatal/Early Infancy Project, a home-based visitation program for high-risk families in Elmira, New York, was found to have produced overall public-sector savings of US\$27,854 per child through reduced health and social service use and savings in the criminal justice system.¹

- A Rand Corporation study compared different types of interventions to reduce youth crime, including violent crime. They found that parent training, delinquent supervision programs and provision of incentives to high-school students to graduate, were all more cost-effective than California's "three strikes and you're out" law that incarcerates individuals.
- The financial costs of violence and abuse reviewed above overlook some significant issues that should also be taken into account, including the human costs of pain and suffering by victims and their families, which often extend across a lifetime and cause a "cycle of violence" across generations; the emotional suffering and poverty caused by financial abuse of the elderly, usually by close family members; the dysfunction experienced by perpetrators, many of whom experienced abuse as children; and the negative impact on productivity at the workplace and the strength of social capital at the community level.

Linkages for a Multi-sectoral Approach

There is recognition that violence is a public health problem that can be prevented by addressing underlying causes using the same public health tools as applied to other health problems: epidemiology, primary prevention and evaluation; at the same time, the involvement of many other sectors is essential in building a sustained multi-sectoral response. These sectors include partners within government, the private sector and groups and organizations at the local, regional and provincial levels.

2.0 SCOPE AND AUTHORITY FOR PREVENTION OF VIOLENCE, ABUSE AND NEGLECT

In order to implement the program for prevention of violence, abuse and neglect, there must be clarity on the roles of the Ministry of Healthy Living and Sport, the Ministry of Health Services, the Provincial Health Services Authority, the regional health authorities, and other ministries and levels of government.

2.1 National/International Roles and Responsibilities

The Public Health Agency of Canada (PHAC) focuses on policy development, research and strategic analysis of public health issues in Canada. With respect to violence, abuse and neglect it provides:

- The National Clearinghouse on Family Violence (NCFV), a national resource centre for information on family violence, collects, develops and disseminates resources on prevention, protection and treatment. By increasing awareness, the NCFV encourages Canadian communities to become involved in reducing the occurrence of family violence. The NCFV offers publications, videos, a library reference collection, and a bi-monthly E-Bulletin featuring new products and resources, funding opportunities, and key family research and events.
- A range of health promotion initiatives to protect children from violence, abuse, exploitation, injury and neglect, as well as promotion of safe, supportive environments including safe built environments, safe play spaces, safe transportation, water safety and a safe physical/natural environment.
- Promotion of, and reporting related to, the United Nations Convention on the Rights of the Child, the United Nations Convention on the Rights of Persons with Disabilities, and the World Health Organization International Plan of Action on Ageing.
- Studies and surveys including (with partners) the Canadian Incidence Study of Reported Child Abuse and Neglect.
- Federal leadership on health issues related to aging and seniors.

The Federal Minister Responsible for the Status of Women is responsible for coordinating Canada's reporting related to the United Nations Convention on the Elimination of All Forms of Discrimination Against Women. The Federal/Provincial/Territorial (F/P/T) Ministers and Officials for the Status of Women meet regularly to address key issues, including violence against women. They share information, develop collaborative action plans and strategies, and advocate with their colleagues to enhance awareness, support and interventions to reduce violence and abuse of women. Similarly, the F/P/T Ministers and Officials Responsible for Seniors meet regularly to take joint action that will strengthen public awareness and prevention initiatives that will reduce violence and abuse of older adults.

In addition, Health Canada, First Nation and Inuit Health, provides related health promotion and health care services for children and families on reserves.

2.2 Provincial Roles and Responsibilities

2.2.1 Ministry of Healthy Living and Sport

The mandate of the Ministry of Healthy Living and Sport is to:

- Promote health and prevent disease, disability and injury.
- Protect people from harm.
- Facilitate quality opportunities to increase physical activity, participation and excellence in sport.
- Support the health, independence and continuing contributions of women and older people.

In its stewardship role, the Ministry of Healthy Living and Sport provides leadership, strategic policy direction, legislation and monitoring for public health and sports programs to support the delivery of appropriate and effective public health services in the province. The Ministry has a role in addressing health inequalities, with a specific focus on the development of policies and programs to close the gap in Aboriginal health status. The Ministry works with the health authorities to provide accountability to government and the public for public health service outcomes.

Specifically in the area of prevention of violence, abuse and neglect, the Ministry of Healthy Living and Sport is responsible for:

- Advising the Minister on public health policies and programs to prevent violence, abuse and neglect towards children, youth, adults and elderly people.
- Collaborating, coordinating and advocating across government on policy development and long-term planning for the prevention of violence, abuse and neglect, and related health policies and programs.
- Facilitating collaborative partnerships with other provincial ministries and agencies, the federal government, and federal/provincial forums on initiatives to prevent child abuse, youth violence, intimate partner violence and elder abuse.
- Collaborating and consulting with health authorities, clinical and academic partners in the development of plans and strategies to establish provincial priorities and establish policy, best practices, and service frameworks to prevent violence, abuse and neglect on an individual, family, community and societal level and in health care facilities and workplaces.
- Supporting research on prevalence, effective strategies, and estimated costs and benefits on prevention of violence, abuse and neglect.

2.2.2 Ministry of Health Services

The Ministry of Healthy Living and Sport has a unique relationship with the Ministry of Health Services, which is the primary linkage to the regional health authorities, who have responsibility for actual service delivery of public health programs. The roles and functions of the Ministry of Health Services are predominately focused on:

- Leadership for the delivery of health care services and programs.
- Funding and accountability for regional health authorities.
- Ensuring the long-term sustainability of the health care system.
- Improved patient care.
- Leadership, direction and support to health care service delivery partners.
- Establishment of province-wide goals, standards and expectations for health care services delivery by health authorities.
- Management of the Medical Services Plan, Pharmacare, Ambulance Services and HealthLink BC self-care programs.

2.2.3 Ministry of Education

The Ministry of Education has a major role in supporting and facilitating violence prevention through its curriculum development and a range of related programs that support healthy emotional development and positive relationships. “Healthy Schools” recognize that health and learning are interdependent and encompass children’s physical, social and emotional well-being, including violence and abuse prevention and bullying. It addresses health in every aspect of the school environment, including teaching and learning, healthy social and physical environments, healthy school policy, services and community partnerships.

Action Schools BC, funded by the BC government, promotes healthy living in BC elementary and middle schools by offering teaching resources and equipment, as well as professional development to participating schools. It helps educators develop action plans to provide more opportunities for children to make healthy choices. Physical exercise is considered a preventive factor as it enhances well-being and self-esteem.

2.2.4 Ministry of Children and Family Development

The Ministry of Children and Family Development provides support to children and their families and has provincial legislative authority for the protection of children. Programs include:

- Child protection services for children who are abused, neglected or in need of protection for any reason (with authority under the *Child, Family and Community Service Act*), including support services for families or placement with relatives or foster families.
- Adoption services and foster homes for children who cannot live with their parents.

Core Public Health Functions for BC: Model Core Program Paper

Prevention of Violence, Abuse & Neglect

- Collaboration with, and support for Aboriginal people in delivering their own child and family services.
- Community youth justice services, and youth custody services for young people involved in the justice system.
- Community-based interventions and child care services for children with special needs, including Autism disorders, Fetal Alcohol Spectrum Disorder, developmental delays, mental health disorders, and Aboriginal children and youth.

2.2.5 BC Housing Roles and Responsibilities

BC Housing is responsible for increasing access to safe, affordable and stable housing for victims of violence and low-income families, through:

- Transition houses, safe homes and second stage housing for women and their dependent children who leave abusive relationships. These housing arrangements, located in 87 communities across the province, provide safe, supported temporary shelter, food, crisis intervention and referrals.
- Subsidized housing programs for low-income families and individuals including homelessness initiatives.

2.2.6 Ministry of Housing and Social Development

The Ministry of Housing and Social Development addresses some of the socio-economic factors that can influence protective and risk factors related to violence and abuse, by providing:

- Income assistance and employment programs for unemployed or underemployed people.
- A disability strategy and related support services for people with disabilities.

2.2.7 Ministry of Public Safety and Solicitor General

The Ministry of Public Safety and Solicitor General works to maintain and enhance public safety in communities across the province. With respect to violence, abuse and neglect, its role includes crime prevention, restorative justice, law enforcement, victim services, adult custody and community corrections. Specific services include:

- Community and police-based victim services programs, which provide emotional support, information referrals and practical assistance to people affected by crime and trauma, including victims of family and sexual violence (women, children, male survivors of sexual abuse, ethno-specific communities and Aboriginal peoples).
- Counselling programs for women who have experienced childhood abuse, sexual assault and violence in relationships, and counselling for children who have witnessed abuse.
- Police training on violence against women in relationships, and designated police officers to provide enhanced investigational support to all domestic violence cases.

Core Public Health Functions for BC: Model Core Program Paper **Prevention of Violence, Abuse & Neglect**

- A relationship violence prevention program for sentenced domestic violence offenders who are court-ordered to attend. Modified forms of the program are delivered by Aboriginal communities and multicultural groups.
- Proactive victim notification, contact and referral of victims who are the subject of protective conditions.

2.2.8 Ministry of Attorney General

The Ministry of Attorney General is responsible for legal services in two separate areas: the prosecution of criminal matters and the provision of legal services to the government. It prosecutes perpetrators of violence, abuse and neglect, based on definitions and requirements of the *Criminal Code of Canada* (see Glossary). Prosecutions are conducted by Crown counsel who, following a police investigation, independently consider whether there is substantial likelihood of conviction based on the available evidence, and if so, whether the public interest requires a prosecution. The ministry also provides family justice counselling services that enable disputes to be settled out of court; legal aid services through consultation with the Legal Services Society; the Family Maintenance Enforcement Program, which assists in the collection of child and spousal maintenance from spouses who have not honoured their support payment obligations; and funds the human rights system.

2.2.9 Other Provincial Ministries

Other key partners within the government include the Ministry of Attorney General, the Ministry of Aboriginal Relations and Reconciliation, and the Ministry of Advanced Education and Labour Market Development.

2.2.10 Provincial Health Services Authority Roles and Responsibilities

The Provincial Health Services Authority (PHSA) is responsible for ensuring that high-quality specialized services and programs are coordinated and delivered within the regional health authorities. PHSA operates eight provincial agencies: BC Mental Health and Addiction Services, BC Children's Hospital, BC Women's Hospital & Health Centre, BC Centre for Disease Control, BC Cancer Agency, BC Provincial Renal Agency, BC Transplant Society and Cardiac Services BC.

One of PHSA's four key strategic directions is population and public health. A steering committee consisting of representation from all PHSA agencies and programs oversees population and public health activity across PHSA. Due to the provincial scope of PHSA's mandate, a dual role for PHSA is emerging: improvements aimed at streamlining population and public health activities within PHSA agencies and programs, as well as potential provincial coordination in areas such as surveillance, consistent messaging, expert advice, and supporting development of healthy public policy.

With respect to the prevention of violence, abuse and neglect, PHSA encompasses a wide range of services:

- BC Children’s Hospital has implemented a prevention program on Shaken Baby Syndrome, or “period of purple crying”, involving the promotion of practical, evidence-based tools to help parents and caregivers manage inconsolable crying. These tools are distributed through regional health authorities.
- Child Health BC is a network that links PHSA, the regional health authorities, health professionals and care facilities through a collaborative approach to improve services and resources.
- BC Women’s Hospital & Health Centre has a Women Abuse Response Team, which offers training, resource development, consultation and clinical support to health care staff in communities across BC. The PHSA coordinates delivery of the Perinatal Services BC across the province, including an Obstetrical Guideline for BC health care providers on Intimate Partner Violence During the Perinatal Period.³⁵
- BC Mental Health and Addiction Services oversees the delivery of a number of mental health literacy programs, as well as specialized services. It has a comprehensive strategy for use as a resource for all organizations to support employee and organizational health, including activities to improve organizational culture and employee/manager understanding of mental health in the workplace; and reduce risk or increase protective factors among employees at risk for mental health problems.

2.2.11 Other Provincial Organizations

There are many other organizations at the provincial level that are active in supporting the prevention of violence, abuse and neglect, both directly and indirectly. These include the following: Developmental Neurosciences & Child Health in the University of British Columbia (UBC) Child & Family Research Institute; the UBC Centre for Community Child Health Research; the BC Association of Community Response Networks; Community Coordination for Women’s Safety Program; the Ending Relationship Abuse Society; BC Council for Families; BC Centre for Elder Advocacy & Support; the BC Healthy Childhood Development Alliance; Federation of Community Social Services of BC; BC Federation of Foster Parent Associations; and other groups such as the BC Association of Social Workers; BC Crime Prevention Association, UBC BC Injury Research and Prevention Unit, post-secondary institutions in the field of care and youth care, social work and nursing, the public health professional practice councils and other professional associations and professional regulatory bodies.

2.3 Health Authorities Roles and Responsibilities

The role of health authorities is to identify and assess the health needs in the region, to deliver health services (excluding physician services and BC Pharmacare) to British Columbians in an efficient, appropriate, equitable and effective manner, and to monitor and evaluate the services they provide.

Core Public Health Functions for BC: Model Core Program Paper

Prevention of Violence, Abuse & Neglect

In the area of prevention of violence, abuse and neglect, there are many factors outside the direct control of health authorities; as a result, they must work closely with partners and other sectors to influence them in building an effective prevention approach in this field. Key roles of the health authorities are summarized below (Section 5.0 provides more detailed descriptions).

2.3.1 Leadership and Advocacy

Health authorities have a leadership role in developing a strategic approach to prevent violence, abuse and neglect, including:

- Proactive collaborative planning with health partners, the school system, and community stakeholders to identify regional priorities and coordinate strategies.
- Advocating for healthy public policies by working with municipal councils, local media, school boards, social services agencies, employers, community care facilities and other community organizations to advise, encourage and support them in implementing “health-promoting” evidence-based policies.
- Advising and supporting all public health programs in the integration of strengthened preventive measures to identify and reduce the incidence of violence, abuse and neglect experienced by clients.
- Leading the development and planning for safe, violent-free health authority workplaces.

2.3.2 Health Promotion

- Creating supportive environments through public education, awareness and social marketing (by collaborating with partners).
- Strengthening community action:
 - Facilitate existing community development and community capacity building processes, policies and programs across multiple sectors and multiple settings to reduce risk factors for violence, abuse and neglect of children, youth, women and older adults including specific vulnerable population groups.
 - Develop personal skills through implementation of health authority workforce training and development to enhance understand, recognition and support for victims of violence, abuse and neglect, including specific vulnerable populations.

2.3.3 Early Identification, Prevention and Protection

- Early Identification and Screening:
 - Work with partners (primary care providers, etc.) to identify at-risk children and youth, and to assess / screen for intimate partner violence, and abuse of older adults as appropriate.

- Universal Initiatives:
 - Infants, children and youth: optimal prenatal care, parenting skills training for parents of infants and toddlers, and work with school and community partners to implement proven programs for school-aged child and youth.
 - Adults: collaborate with communities to deliver interventions to strengthen protective factors and community networks.
 - Older adults: provide information on their rights, encourage and support local networks, and provide psychosocial educational interventions.
- Targeted Initiatives
 - At-risk infants, children and youth: prenatal and postpartum counselling for mothers with risk factors and psychosocial problems (with referral to specialized support and resources as necessary); parenting training including home visits; and work with partners to provide preschool enrichment. For school-aged children and youth, promote and support resilience-focused programs, educational incentives, mentorship programs, brief family interventions, etc.
 - At-risk adults: comply with legislative requirements to respond to reports of adult abuse; work with partners to promote healthy workplaces, and encourage empowerment, skills development, and family/caregiver intervention programs as appropriate.
 - At-risk older adults: build or strengthen information support networks for seniors among family members/community gatekeepers/neighbours and peers to enhance support, and provide proactive support and involvement in community response networks.

2.3.4 Surveillance, Monitoring and Program Evaluation

- Gathering and analyzing information to identify trends, issues, and community risk factors for program planning and evaluation.
- Developing an information system to integrate data on child and youth development.
- Conducting program evaluation.

2.4 Local Level

Local governments can exert important influence on policy and bylaws for initiatives that support healthy cultural norms and attitudes that oppose violence and abuse, and that reflect fairness and equality for all residents regardless of age, gender, race, ethnicity or sexual orientation. Local initiatives include public and community health, housing, social services, community safety, recreational services and environmental health. Also, many community

organizations and service agencies provide important local support services for children, youth, families, women, the elderly, multicultural groups, etc.

2.5 Aboriginal Communities

Also on a community level, it is necessary for Aboriginal groups to have full involvement in the planning and delivery of violence and abuse prevention programs on First Nations reserves as well as for Aboriginal families in other communities. Capacity building and partnership with Aboriginal communities can strengthen and support the shift toward self-governance of the health care system and facilitate the management, planning and delivery of Aboriginal services.

On a provincial level, with the signing of the Transformative Change Accord, the Leadership Council representing the First Nations of British Columbia, the Province of British Columbia and the federal government have agreed to a shared commitment to action on closing health, social, and economic gaps between First Nations and other British Columbians. Further work has taken place to develop action plans to close health gaps by 2015. Also, the Ministry of Children and Family Development is working with Aboriginal communities to develop their capacity to carry out responsibilities for child and family support, including expanded delegation agreements for Aboriginal communities to manage these services. The success of these initiatives will require, in part, ongoing collaboration among the various levels of government.

2.6 Legislation and Policy Direction

The overall legislative and policy direction for prevention of violence, abuse and neglect is derived from:

- The following acts and regulations:
 - *Public Health Act; Health Act; Community Care and Assisted Living Act; Adult Guardianship Act; and Child, Family and Community Service Act.*
- *The Criminal Code of Canada.*
- The United Nations Convention on the Rights of the Child; the United Nations Convention on the Elimination of All Forms of Discrimination Against Women; the United Nations Convention on the Rights of Persons with Disabilities; and the World Health Organization International Plan of Action on Ageing.
- *A Framework for Core Functions in Public Health* (March 2005).
- *Transformative Change Accord: First Nations Health Plan.*
- Specific policies/priorities that may be established by the health authority, the Ministry of Healthy Living and Sport or the provincial government.

3.0 GOALS AND OBJECTIVES

The working group agreed that the goal of the program for prevention of violence, abuse and neglect is to prevent or reduce the incidence of violence, abuse and neglect experienced by children, youth, intimate partners, and older adults across their lifespan throughout the province. The specific objectives are to:

- Increase healthy interpersonal relationships in families, schools, workplaces and health care environments.
- Strengthen the healthy development, resiliency and self-esteem of children and youth.
- Strengthen cultural norms and attitudes that reflect social and gender equality and equity, to empower women and men of all ages, abilities, races, cultures and sexual orientation.
- Enhance community involvement in caring for, supporting and protecting seniors.
- Prevent or reduce vulnerabilities, risks and inequities that represent threats to the physical, emotional, sexual or mental health of children, youth, women and men, older persons, including those with disabilities and mental disorders, people from diverse cultural backgrounds, and people who are gay, lesbian, bisexual or transgendered.

4.0 PRINCIPLES/FUNDAMENTAL CONCEPTS

A number of key principles and overarching strategies are necessary to achieve these objectives:

- Zero tolerance of violence, abuse and neglect.
- Respect for the human rights, dignity and well-being of all people.
- A public health primary prevention approach, which takes into account protective factors, risk factors and populations that are vulnerable to violence, abuse and neglect.
- Multidisciplinary and multi-sectoral collaboration through strengthened partnerships across sectors, issues and levels, including integrated planning and program delivery with other related model core programs as appropriate.
- A combination of universal interventions for the general public, as well as selective and targeted prevention interventions for at-risk populations, focusing on early identification and intervention.
- The use of equity lenses, including gender and diversity lenses, to identify the differential impact of the determinants of health on the lives of women and men and on vulnerable population groups across their lifespan, as well as to determine policies and programs necessary for overcoming systemic barriers that are unique to their circumstances, experiences and needs.
- Presumption that every adult is capable of making decisions about their personal care, health care, legal matters, financial affairs, business or assets.
- Facilitation of community development and community capacity building to enhance prevention of violence, abuse and neglect.
- Involvement of the respective population groups in any planning and program development that will impact them.
- Advocacy for evidence-based practices and for a culture of continuous quality improvement.

Some of these principles or fundamental approaches, considered by experts in the field to be essential in achieving progress, are described more fully in the following section.

4.1 A Primary Prevention/Determinants of Health Approach

Primary prevention of violence, abuse and neglect requires a focus on multiple causal factors at the societal, community, relationship and individual levels. The determinants of health are critical factors in assessing those who are at risk of being victims, or perpetrators of violent and abusive acts (see Figure 2). Researchers have established that risk factors are often interrelated and that interventions may be required in multiple domains to influence a specific behaviour. Protective factors can influence and shift a variety of different risk behaviours.³⁶

Based upon the scientific literature relating to the epidemiology, aetiology and prevention of violence,¹ several overarching approaches to the primary prevention of violence have been identified, including:

- Investing in early interventions targeted at children.
- Increasing supportive adult involvement with children and youth.
- Strengthening community efforts in preventing violence and associated risk factors.
- Changing cultural norms that justify violence (gender inequities, harsh punishment of children, etc.).
- Reducing income inequality (especially where there is juxtaposition of extreme poverty with extreme wealth).
- Strengthening the criminal justice and social welfare systems.

Similarly, a 2007 World Health Organization expert meeting on intimate partner violence and sexual violence³⁷ proposed that primary prevention focus on

- Changing individual's knowledge, attitudes and behaviours.
- Promoting healthy and equal relationships.
- Creating enabling social environments, including gender-equitable and non-violence social norms, and responsive and protective community institutions.
- Promoting gender equality and strengthening protective factors at the societal level.

4.2 Multi-Disciplinary/Multi-Sectoral Collaboration

To strengthen the health authority role in this area, a proactive approach is necessary to build partnerships with other agencies and other community organizations (e.g., social services, recreational/sport programs, family and parent groups, etc.) to enhance, supplement, expand and strengthen initiatives, and to ensure consistent, seamless services. The interrelatedness of violence, abuse and neglect with physical, social and emotional problems, for both victims and perpetrators, requires a collaborative approach across disciplines to target common determinants, clusters of related problems and populations at risk. In fact, it is important that prevention measures are integrated into all public health programs and, indeed, into all health care services offered by the health authorities and by private health care professionals.

Key linkages for successful delivery of the program are:

- All public health model core programs, with a particular emphasis on:
 - Reproductive health and prevention of disabilities (teen pregnancy, healthy sexuality).

- Healthy infant and early childhood development (parent education, child care).
 - Healthy community care and assisted living residences.
 - Prevention of harm associated with substances (reduce problematic substance use).
 - Mental health promotion and mental disorder prevention (enhance protective factors, reduce risky behaviour).
 - Prevention and control of communicable diseases (control of sexually transmitted diseases, etc.).
 - Healthy communities (healthy municipalities, health care facilities, workplaces, and schools).
- Community partners – local governments, media outlets, housing services, employment programs, family support services, social services, Aboriginal Friendship Centres, child care agencies, women’s centres, transition houses, victim support services, mental health agencies, multicultural and immigrant agencies, Aboriginal groups, foster parent organizations, corporate workplaces, police and the justice system, universities and research institutes, and religious/faith organizations.
 - Multidisciplinary health care providers – health care partners, including primary care practitioners, acute care practitioners, emergency care providers, nurses, rehabilitation professionals and pharmacists.
 - Other provincial ministries and agencies – Ministry of Children and Family Development, Ministry of Education, BC Housing, Ministry of Housing and Social Development, Ministry of Attorney General, Ministry of Public Safety and Solicitor General, and Public Guardian and Trustee of BC.

In addition to collaborative and coordinated approaches, integrated program delivery with other core public health programs can enhance and strengthen prevention efforts and support a comprehensive approach to addressing the multiple causal factors (e.g., integration of physical and sexual violence prevention into existing programs such as those for reduction of HIV/AIDS, alcohol and substance use, adolescent sexual and reproductive health, etc.).

4.3 Universal and Selected/Targeted Initiatives

It is necessary to have a combination of universal initiatives, focused on all ages and the population as a whole (e.g., policies, public awareness, etc.) and selected initiatives targeted towards the needs and issues of specific populations. Targeted interventions are aimed at those who are vulnerable or at risk of violence, abuse and neglect.

4.4 Responsiveness to Vulnerable and At-risk Population Groups

The use of a range of population “lenses” is important to assist in identifying vulnerable groups: a gender equity lens can identify specific risks that are unique to the experiences of girls and boys, and a diversity equity lens can examine population groups that are at risk, or are more vulnerable to problems due to a range of biological, social, cultural and other factors. Other physical, emotional and social risk factors can be identified through assessments by partners including primary care providers, teachers, mental health professionals, victim support services, police, sports and recreational personnel, family support agencies and community service organizations. Tailored measures can thus address the specific barriers, inequities and vulnerabilities that are unique to each community population group.

5.0 MAIN COMPONENTS AND SUPPORTING EVIDENCE

The major program components for prevention of violence, abuse and neglect in regional health authorities are:

- Leadership and advocacy.
- Health promotion.
- Early identification, prevention and protection.
- Surveillance, monitoring and program evaluation.

5.1 Leadership and Advocacy

Health authorities should take a leadership role in developing a strategic approach to prevention of violence, abuse and neglect, including:

- Proactive collaborative planning:
 - Consult with health partners, the school system, care facilities and other community stakeholders to identify regional priorities in preventing violence, abuse and neglect.
 - Identify effective, evidence-based, “health-promoting” protective strategies related to the areas of priority.
 - Establish a joint plan for a comprehensive, multi-sectoral violence prevention strategy with public health programs, acute care and long-term care facilities, health professionals, school, community agencies and other partners.
- Advocating for healthy public policies – work with governments at all levels (federal, provincial and municipal) as well as media, school boards, social services agencies, employers, community care facilities and other community organizations to advise, encourage and support them in implementing “health-promoting” evidence-based policies that support “protective” factors in preventing violence, abuse and neglect, including:
 - Policies that address inequities in social, economic, cultural and environmental conditions (e.g., safe and stable housing and neighbourhoods, quality child care, anti-poverty measures, prevention of discrimination based on race, culture, ability, age, sexual orientation, etc.).
 - Policies that promote human rights and respect for all people and groups.
 - Policies that promote healthy, active and independent aging, and age-friendly communities.
 - Integration of gender equality/equity into mainstream planning, policy and program development in all areas, including elimination of sexist messages and media representations.

- Comprehensive school health policies, including programs that develop resiliency, self-esteem, social and emotional learning, positive communication, and skills in stress reduction and conflict resolution.
- Healthy workplace policies and practices.
- Policies and strategies for alcohol reduction (e.g., pricing mechanisms and regulations to reduce availability), reduction of substance use, as well as enhanced physical activity/recreational/sport programs.
- Advising and supporting all public health programs in the integration of strengthened preventive measures to identify and reduce the incidence of violence, abuse and neglect experienced by clients.
 - For example, encourage proactive measures by licensing programs to address issues of violence and abuse in licensed community care facilities, including child care services, long-term care for older adults, and community care for those with developmental disabilities and mental illness.
- Leading the development and planning for safe, violence-free health authority workplaces, including the effective implementation of Policy Communique (#2005-01) Prevention and Management of Aggression and Violence in the BC Health System.

Summary of Supporting Evidence

The advocacy role for public health is well-accepted and a central feature in seminal health promotion frameworks such as the World Health Organization’s Ottawa Charter. The Public Health Agency of Canada identifies advocacy as a core competency of public health and notes that it is important to “advocate for healthy public policies and services that promote the health and well-being of individuals and communities.”

5.2 Health Promotion

Health authorities should take a proactive role in promoting and facilitating public awareness and systemic support for the prevention of violence, abuse and neglect, including:

- Creating supportive environments
 - Support the development and delivery of public education, awareness and social marketing, through collaboration with health care, community, provincial and national partners, based on evidence-based strategies and priorities such as skills for healthy interpersonal relationships, education on human rights, positive communication and conflict resolution, censoring acts of violence, etc.
 - Network with police, justice officials and victim support groups to support coordinated approaches to risk and safety assessment and community safety planning.

- Strengthening community action
 - Facilitate and/or support existing community development and community capacity building processes with local organizations and stakeholders to develop community-based planning, prioritization and implementation of initiatives across multiple sectors and multiple settings to reduce risk factors for the population, as well as for specific vulnerable groups. Initiatives should:
 - Build knowledge, information and awareness related to risk factors and protective factors, the different types of violence, abuse and neglect, and ways of preventing, recognizing and responding to them.
 - Focus on evidence-based programs to enhance protective factors, such as resiliency and self-esteem for both the general population and vulnerable populations (e.g., quality child care programs, multifaceted skill-building programs for teachers, parents and students, empowerment programs for low-income women, victim support services, etc).
 - Enhance opportunities to influence risk factors by addressing low incomes, inadequate housing, unemployment issues, problematic substance use, needs of single parents, support for older adults, etc.
 - Support and assist Aboriginal communities and organizations in their development of prevention plans and programs that address cultural norms and attitudes and respond to the specific needs of individuals, families and communities.
 - Collaborate with other specific community populations that are vulnerable, based on analysis through gender and diversity lenses, to develop strategies on reducing discrimination, social and cultural pressures, systemic barriers, physical barriers for those with disabilities, language barriers and other vulnerabilities and risks for violence, abuse and neglect.
- Developing personal skills for health professionals
 - Develop and implement a strategy for health authority workforce training and development, to enhance the knowledge and capacity of staff to understand, recognize and support victims of child abuse, youth violence, intimate partner violence, and abuse of older adults.
 - Provide educational resources and organize professional training sessions for physicians in the recognition and treatment of victims of interpersonal violence.
 - Offer training and workshops to health care workers to increase knowledge, sensitivity, respect and cultural competency related to people with disabilities; older people; multicultural, immigrant and refugee groups; and other vulnerable population groups.

NOTE: These activities should be implemented in conjunction with local initiatives for core programs on preventing harm from substances, mental health promotion and mental disorder prevention, healthy communities, reproductive health and prevention of disabilities, healthy infant and early childhood development, healthy children and youth, healthy community care facilities, and other related core public health programs.

5.2.1 Summary of Supporting Evidence

The World Health Organization states that the

focus of health promotion should be on strategies focused on communities, groups and individuals which include: creating physical and social environments supportive of health, strengthening communities' capacity to address health issues of importance to them, and to mutually support their members in improving their health, helping people to develop the skills they need to make healthy life choices and to care for themselves and their families.³⁸

More specifically, the pillars of the Ottawa Charter for Health Promotion include healthy public policy, supportive environments, personal skills and strengthened community action.

The evidence suggests that community engagement through community capacity building and networking can prevent violence as it is identified and defined locally, and can link primary prevention across multiple forms of violence. Steps include creating safety, understanding violence, building community, promoting peace and building democracy and social justice.³⁹ The Communities That Care Program, implemented in several hundred communities in the United States, has been successful as a “whole community” approach to assess local needs, prioritize intervention goals and work toward reducing elevated risk factors and building low protective factors. It was originally intended to address violence and problematic substance use, but has been adopted as a crime prevention program.⁴⁰

A lack of social and gender equality and equity are related to many of the major risk factors common to multiple types of interpersonal violence, and act as risk factors themselves particularly at the societal level. They can exacerbate other risk factors to facilitate conditions in which violence can thrive. Conversely, increased equality and equity can multiply the effects of protective factors to reduce levels of violence.¹

The World Health Organization also identifies specific “promising practices” for reducing violence, or risk factors for violence, including reducing alcohol availability, establishing adult recreational programs, reducing media violence and public shaming of intimate partner violence offenders. The literature also suggests that the weight of evidence confirms that multi-component or comprehensive interventions have a higher effectiveness and cost-effectiveness compared to those programs that focus on a single component.⁴¹

5.3 Early Identification, Prevention and Protection

5.3.1 Early Identification and Screening

- Early detection of at-risk children and youth (i.e., those with risk factors for physical, emotional, mental or sexual abuse), through linkages and consultation with social workers, school systems, primary care providers, family support agencies and other community contacts. Referrals to specialized health professionals as necessary, as well as reports to the Ministry of Children and Family Development as necessary regarding child abuse (as required under provincial legislation).
- Work with primary care providers, acute and emergency health care programs, to integrate appropriate screening processes for women (including perinatal women) for intimate partner violence and abuse and/or sexual assault, using a validated risk assessment tool, and taking into account:
 - The specific context, circumstances, risk factors and potential for physical, emotional and mental harm.
 - The connection between mental health, substance use and experiences of violence, abuse and neglect, and the high rates of abuse experienced by other vulnerable population groups.
 - The need for provider knowledge of the dynamics and cycles of violence, the importance of trust building and other best practices in screening and brief intervention counselling, as well as knowledge of local supports and services for referral and follow-up.
- Ensure that primary care providers, acute and emergency health programs have:
 - Information on validated screening tools for abuse of older adults, noting the issues involved and sensitivities required for screening.
 - Information on the management of suspected cases of abuse and referral processes to other professionals such as social workers, counsellors in transition houses and other programs for women who are victims of abuse.

NOTE: The working group understands that development of a province-wide approach to screening of women for interpersonal violence requires discussion of the challenges, issues and evidence, and how these apply to the various contexts and circumstances related to women who are victims of violence and abuse. They recognize that a rigid approach, either for or against screening, needs to be tempered by a number of considerations. **Therefore, they recommend that a follow-up working group be established to enable the Ministry of Healthy Living and Sport and all health authorities together, to build a consensus on appropriate policies and practices that can be applied to decisions on screening women for violence and abuse.**

Furthermore, the working group recognizes that understanding and sensitivity by care providers towards violence, abuse and neglect of individuals of all ages and genders needs to be strengthened, and that screening policies and practices for these groups also need to be developed, clarified and supported. **Therefore, they further recommend that the follow-up committee or working group develop a consensus on policies and practices for identifying children, youth and older adults (women and men) who are victims of violence, abuse and neglect, taking into account the relevant issues, circumstances and evidence for each group.**

5.3.2 Universal Initiatives

Infants, Children and Youth

- * Optimal prenatal care, including individual or group education sessions for women to enhance psychosocial health, positive parent-infant attachment, infant care and parenting skills [Core Program on Reproductive Health, and Core Program on Mental Health].^{iv}
- * Parenting skills training for parents of infants and toddlers to enhance parenting abilities, parent-child interactions and improvements related to children’s behavioural problems [Core Program on Healthy Infant and Child Development].
- Educational interventions for new fathers to prevent shaken baby syndrome.
- Work with school and community partners to implement proven programs for school-aged children and youth as follows:
 - *School-based social development programs that teach children social and problem-solving skills.
 - *Physical exercise programs to enhance health benefits as well as self-esteem and well-being.
 - *School-based dating violence prevention programs.

^{iv} The asterisk (*) symbol is used to indicate specific initiatives that have been highlighted in the evidence review as “strongly supported practices” based on strong evidence of effectiveness in reducing violence or risk factors for violence. Initiatives without the symbol are “good” practices or “promising” practices based on the evidence.

Core Public Health Functions for BC: Model Core Program Paper
Prevention of Violence, Abuse & Neglect

- *Academic enrichment programs for adolescents.
- *Ecological approaches that promote school connectedness and social connectedness through school and school/community strategies, taking into account systemic barriers based on gender, ethnicity and culture, sexual orientation, and physical and mental disabilities [Core Program on Mental Health].
- School-based initiatives to build positive-images of aging and opportunities for intergenerational interaction.

Adults

- Collaborate with other core public health programs, the Ministry of Children and Family Development, and community support services to deliver interventions that function at multiple levels to strengthen protective factors and community networks (e.g., enhance healthy lifestyles, social connectedness, involvement in physical education and recreation, healthy nutrition, etc.).
- Promote and support employers and employee groups in the region to develop and implement workplace violence prevention programs, including risk assessments, incident reporting and regular assessment and review of program effectiveness (violence-free health authority workplaces are noted in section 5.1).

Older Adults

- Provide older people with information about their rights, particularly in relation to abuse, neglect and exploitation.
- Encourage and support local networks for education, awareness, prevention and development of protocols, including multidisciplinary approaches to care, information-sharing among caregivers, and social support.
- Provide psycho-educational interventions (i.e., lectures, group information sessions, written materials and training) for family caregivers of chronically ill or older adults, to reduce elevated levels of stress and depression [Core Program on Mental Health].

5.3.3 Targeted Interventions

At-risk Infants, Children and Youth

- Promote and support with health partners, the provision of prenatal and postpartum counselling for at-risk pregnant women and new mothers to address risk factors, including intimate partner violence, abuse and neglect, and psychosocial problems, with referral to specialized support and resources as necessary [Core Program on Healthy Infant and Early Childhood Development].

Core Public Health Functions for BC: Model Core Program Paper

Prevention of Violence, Abuse & Neglect

- * Parenting training, incorporating home visits, for parents of infants and toddlers [Core Program on Healthy Infant and Early Childhood Development, and Core Program on Mental Health].
- Work with health care, school and community partners to support and promote:
 - * Preschool enrichment (e.g., day care programs with language, cognitive, perceptual-motor and social development) supplemented with home-visitation programs administered by professionals (e.g., nurses, trained child care providers) [Core Program on Healthy Infant and Early Childhood Development].
 - Resilience-focused programs that combine child, family and school-based interventions (e.g., cognitive-behavioural therapy and social competence skills building sessions for children) [Core Program on Mental Health].
 - * One-to-one mentorship programs that match at-risk children and youth with caring adults to provide social support, role models and/or tutors [Core Program on Healthy Child and Youth Development].
 - * Brief family interventions to enhance parent-adolescent communication using multiple methods of interaction to reduce aggressive and hostile behaviour.
 - * Educational incentives for at-risk, disadvantaged high-school students.
 - School-based youth violence prevention, including bullying prevention, in at-risk communities, involving training for teachers and school counsellors on effective ways of dealing with student anger, hostility and aggression.

At-risk Adults

- Comply with legislative requirements^v to respond to reports of abuse or neglect of vulnerable adults including:
 - Investigation of all allegations of abuse or neglect to determine if there is evidence of a criminal offence.
 - Provision of a response to each allegation, based on the investigation, including the reporting of any criminal offences to the police.
 - Intervention in emergencies by working with the police to remove abused adults to a safe place and arrange for needed health care.
 - Liaison with the Provincial Guardian and Trustee if initial inquiries reveals an adult's assets are at risk.

^v Health authorities are Designated Agencies under the *Adult Guardianship Act* to provide support and assistance to abused and neglected adults.

Core Public Health Functions for BC: Model Core Program Paper
Prevention of Violence, Abuse & Neglect

- Utilization of relevant Orders (access orders, restraining order, support and assistance orders) as necessary from the Provincial Court, Family Division.
- Inform and support health care providers in implementing Perinatal Service BC's policy pertaining to intimate partner violence during the perinatal period, including building trust, empowering women, creating safe opportunities for discussion, evaluating clinical indicators, asking questions, developing safety plans and respecting choices.
- Work with health care partners, other ministries and community groups to promote and support delivery of:
 - * Empowerment and life skills development for women to modify their social and economic circumstances, enable them to become more independent and build self-esteem, skills and resources.
 - * Job skills programs that incorporate social support, job search skills, motivation and coping skills for those who become unemployed [Core Program on Mental Health].
 - Multi-level family intervention, with self materials, positive parent training, intensive training and support for high risk families, including *cognitive behaviour therapy for survivors of trauma and abuse [Core Program on Mental Health].
 - Coordinate linkages and referrals between prevention programs and treatment professionals to support self-care, access to family psycho-educational sessions and social support.
- Work with employers, unions and professional associations to promote comprehensive strategies and support systems for employees/families at risk to minimize both violence within the family and at the workplace.

At-risk Older Adults

- Build or strengthen informal support networks for seniors among family members, community gatekeepers, neighbours and peers to enhance support and reduce isolation.
- Comply with legislative requirements^{vi} (as noted earlier) to respond to reports of abuse or neglect of older adults.
- Encourage the use of advanced care planning by care providers to ensure clients have the opportunity to choose appropriate care and safety measures in advance of deteriorating health conditions.
- Facilitate intergenerational opportunities in order to build self-esteem and mutual respect.

^{vi} Health authorities are Designated Agencies under the *Adult Guardianship Act* to provide support and assistance to abused and neglected adults.

- Proactive support and involvement in community response networks to address the needs of older adults at risk of abuse, as well as with the BC Adult Abuse and Neglect Prevention Collaborative.

NOTE: Additional preventive initiatives for violence, abuse and neglect programs are included in other public health programs, such as healthy living; reproductive health and prevention of disabilities; prevention of violence, abuse and neglect (in progress); healthy communities; prevention of harm associated with substances; and prevention of communicable diseases.

5.3.4 Summary of Supporting Evidence

Infant and Early Childhood

The World Health Organization found strong evidence of effectiveness for violence prevention for programs targeted to children that involved preschool home visitation services, preschool enrichment, parenting training, and social-development training for at-risk children and families.¹ For example, the Prenatal/Early Infancy home visitation project targeted to low-income, first-time mothers was shown to have long-lasting positive outcomes for both mothers and their children including enhanced mother-child attachment, improved emotional and cognitive development, and subsequent healthy emotional development later in life (in comparison with a control group).⁴² Similarly, the Perry Preschool Program for low-income children, consisting of participation in preschool combined with home visits by trained workers, found that subsequent results during adolescence showed lower arrest rates and fewer rates of self-reported fighting, higher rates of secondary school completion, and higher grade point averages than their control group counterparts.⁴³

A literature review of efforts to prevent shaken baby syndrome resulted in recommendations for “promising practice” involving educational interventions for new fathers (either prenatally or in the hospital after the child was born). It was also recommended that this information be integrated into child and adolescent health curricula to develop realistic expectations for normal crying among infants and to provide advice on handling caregiver stress.⁴⁴

Children and Youth

Systematic reviews of mentorship programs provide strong evidence of their effectiveness in enhancing youth development. For example, an evaluation of Big Brothers Big Sisters found that participants reported improved attendance and performance in school, improved relationships with their family, improved peer relationships, and fewer had started using drugs or alcohol, in comparison with a control group.⁴⁵

Strong evidence for reducing family violence was found for brief family interventions to reduce aggressive and hostile behaviours among adolescents targeting parent-adolescent interactions, using strategies for good parental communications including: 1) active communication; 2) expanding vocabulary to include statements of feeling; 3) using win-win negotiation strategies; and 4) developing peaceable homes for the student.⁴⁶ The World Health Organization notes that for youth, the violence prevention programs with demonstrated effectiveness include

social-development training, educational incentives for at-risk, disadvantaged high school students; academic enrichment programs; and school-based dating violence prevention programs.¹ The most successful violence prevention programs engage youth throughout the school; have peer-led components; are culturally relevant; use standardized interventions with age-appropriate, interactive methods; provide training for school staff; and engage parents to reinforce newly acquired skills at home.⁴⁷

Adults

Parenting education and support programs are effective in creating positive changes in children's behaviour as well as changes in parents' behaviour and relationships with their children. The evidence also indicates that "intensity matters"; i.e., the more issues a family presents, the more a multi-modal program is required.⁴⁸ A systematic review found that group-based parenting programs are effective in improving the psychosocial health of mothers—results showed statistically significant improvements in depression, anxiety/stress, self-esteem and relationship with spouses.⁴⁹

Evidence on screening of women for intimate partner violence is not definitive and it is recognized that a number of factors need to be considered, such as health care provider knowledge and sensitivity, availability of follow-up interventions, and the potential for harm. While there is evidence that women are willing to be asked direct evidence about violence,^{50,51} and that they will use the information provided to them,⁵² there is limited evidence to demonstrate that screening and intervention can lead to improved outcomes for abused women.^{50,53} However, several studies and some anecdotal evidence of benefit are described in the literature.⁵⁴⁻⁵⁸ Some prominent organizations (e.g., Health Canada, the Society of Obstetricians and Gynaecologists of Canada, the College of Family Physicians of Canada), note that absence of proof of benefit is not proof of harm and, as a result, recommend routine screening by direct questions for intimate partner violence.³⁴

Empowerment and life skills training for women is strongly supported in the evidence for the primary prevention of domestic abuse (physical abuse and sexual abuse), including the use of concrete tools to modify their social and economic circumstances and enable them to become more independent.⁵⁹

The *BC Workers Compensation Act* requires that employers provide a workplace as safe from the threat of violence as possible, and that procedures be implemented to eliminate or minimize the risks to employees. WorkSafeBC provides advice and information to employers on conducting risk assessments, and developing policies, procedures, incident reports and other processes that can be effective in preventing violence in the workplace.⁶⁰

Systems approaches that target individual and organizational change hold the most benefit for healthy workplaces—there is strong evidence that comprehensive workplace interventions combining behavioural and structural components have higher clinical and cost-effectiveness compared to single components. For those people who experience job loss, programs that assist

with social support, motivation and coping skills and teach basic job search skills show improved rates of re-employment and reduction in depression and distress.^{61 vii}

Older People

In BC, there is a movement to empower communities to organize, coordinate and prevent abuse and neglect of vulnerable adults, led by the BC Association of Community Response Networks, based on evidence that education, awareness, prevention and development of protocols in local communities are pivotal in prevention of abuse and neglect.^{viii} The association is also involved in a broader initiative to address abuse of older people through the BC Adult Abuse and Neglect Prevention Collaborative. The informal networks (e.g., family members, neighbours, peers, etc.) can also provide help for older people as they are close by and trusted—informal support systems can be an important element in the detection, intervention and prevention of abuse and neglect of older adults, especially in communities where few, if any, formal services exist.⁶² Effective multidisciplinary caregiving is important as well as increased knowledge about issues related to ageism. It has also been suggested that primary care providers are best positioned to educate elderly patients on abuse prevention. Although assessment and screening tools are relatively new, a number of organizations have researched, standardized and validated tools for elder abuse screening (e.g., Elder Abuse Suspicion Index, funded by the Canadian Institute for Health Information, the WHO Suspicion Index, and many others noted in the World Health Organization document *Discussing Screening for Elder Abuse at Primary Health Care Level*. Research notes the importance of taking a humanistic view when dealing with abuse, as the harm-benefit paradigm needs to be considered along with the importance of managing the health effects and preventing further abuse.⁶³

5.4 Surveillance, Monitoring and Program Evaluation

Surveillance and monitoring assists in identifying regional trends and patterns in violence, abuse and neglect, and provides a basis for assessing needs, priorities and developing strategic plans. Initiatives include:

- Gather information on violence, abuse and neglect of infants, children, youth, adults and older people:
 - Collection of data on key health indicators based on agreed upon performance measures that enable consistent measurement among health authorities.
 - Data gathering through collaboration with hospitals, schools, victim support services, community response networks, police and the justice system, as well as through socio-economic surveys, national and provincial surveys, etc. to identify regional prevalence rates and issues.

^{vii} The safety and protection of health care staff from patient violence is included in the core program on adverse effects of the health care system.

^{viii} More information on the BC Association of Community Response Networks can be found at <http://www.bccrns.ca/resources/index.php>.

Core Public Health Functions for BC: Model Core Program Paper

Prevention of Violence, Abuse & Neglect

- Analyze and interpret data to clarify local and regional trends, major issues, key risk factors, vulnerable groups and populations, to support effective planning and decision-making.
- Report publically on the level of violence, abuse and neglect, and its related impact, as an important public health issue (through the authority of medical health officers in collaboration with the Provincial Health Officer).
- Collaborate in developing an information sharing system, by encouraging a joint approach with health care services and community partners to develop consistent data collection, data-sharing and data collection processes.
- Collaborate in developing program evaluation frameworks and evaluating new initiatives.

5.4.1 Summary of Supporting Evidence

Surveillance of violence, abuse and neglect is challenging, as abuse is frequently hidden and victims are often reluctant to seek help: it is widely acknowledged by researchers that many incidents are unreported. In addition, a wide range of agencies are involved in this field at national, provincial and community levels, including those dealing with perpetrators of violence, those that respond to the needs of victims, as well as multidisciplinary teams and coordinating agencies for the different types of abuse.

The World Health Organization suggests a number of action steps to increase data-collection capacity:

- Identify and review existing sources of information.
- Conduct an audit of policy and legal support for data collection.
- Develop an initial profile of the problem.
- Establish an information working group.
- Create a more accurate profile of the problem.
- Evaluate data-gathering processes, policies and interventions.
- Modify the data-collection system based on evaluation results.¹

It is recognized that although public health, and prevention programs in particular, are difficult to measure, it is nonetheless likely that “we will be able to manage, and improve, core functions in public health if we can measure performance.”⁶⁴ A prevention information system capable of measuring success is necessary for this purpose: the public has a right to expect that the public health sector, along with the rest of the health care system, is paying attention to the quality and effectiveness of the interventions it undertakes, and is working to improve that quality.⁶³

6.0 BEST PRACTICES

Often, there is no one “best practice” that is agreed upon; rather, there are practices that may have been successful in other settings and should be considered by health authorities. The terms “promising practices” or “better practices” are often preferred to reflect the evolving and developmental nature of performance improvement.

The evidence review prepared to support the development of this core program paper provides a detailed discussion of best practices in the field. As well, a number of other reviews noted below present a comprehensive set of health promotion and disease prevention strategies that support prevention of violence, abuse and neglect, and provide additional guidance and advice on effective practices.

- *Primary Prevention of Physical Violence and Abuse in British Columbia* (2008), prepared by P. Joshi, L. Pllaveshi, P. Verma and I. Pike, BC Injury Research and Prevention Unit.
- The 2009 World Health Organization meeting, 4th Milestones of a Global Campaign for Violence Prevention Meeting: Boosting Global Violence Prevention,^{ix} issued two documents:
 - *Report of the 4th Milestones of a Global Campaign for Violence Prevention Meeting: “Boosting Global Violence Prevention”* (2009).
 - *Violence Prevention: The Evidence* (2009). An 8-part series of background evidence reviews prepared to support the 2009 meeting.
- *Preventing Violence: A Guide to Implementing Recommendations of the World Report on Violence and Health* (2004), by the World Health Organization.
- *Strategies for Violence Prevention: Supplement to the Core Functions Evidence Review for the Prevention of Physical Harm* (2009), prepared by the Women’s Healthy Living Secretariat, Ministry of Healthy Living and Sport.
- *Primary Prevention of Intimate-Partner Violence and Sexual Violence: Background Paper for WHO Expert Meeting, May 2-3, 2007*, by A. Harvey, C. Garcia-Moreno and A. Butchart, for the World Health Organization.
- *Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence* (2006), by the World Health Organization and the International Society for Prevention of Child Abuse and Neglect.
- *Making the Links: Disabled Women and Domestic Violence, Final Report* (2007), by G. Hague, R. Thiara, P. Magowan and A. Mullender for Women’s Aid.

^{ix} More information on the meeting can be found at http://www.who.int/violence_injury_prevention/violence/4th_milestones_meeting/en/index.html.

Core Public Health Functions for BC: Model Core Program Paper
Prevention of Violence, Abuse & Neglect

- *Manual for Estimating the Economic Costs of Injuries Due to Interpersonal and Self-Directed Violence* (2008), by A. Butchart, D. Brown, A Khanh-Huynh, P. Corso, N. Florquin and R. Muggah, for the World Health Organization.

7.0 INDICATORS, BENCHMARKS AND PERFORMANCE TARGETS

7.1 Introduction

It is important to define what one means by the terms *indicators*, *benchmarks* and *performance targets*. An indicator is a summary measure (usually numerical) that denotes or reflects, directly or indirectly, variations and trends in, this case, violence, abuse and neglect. Indicators are more than outcome measures; they constitute an important reflection of some aspect of a given program or service, and their value is that they also drive decision and action. Indicators need to be standard so that they can be compared across different organizational entities such as health regions. Benchmarks are reflective of “best” practices. They represent performance that health authorities should strive to achieve. Benchmarks are determined by reviewing the literature, reviewing the best practice experience in other jurisdictions, or by determining “consensus” opinion of leading experts and practitioners in the field. Performance targets, on the other hand, are locally determined targets that represent a realistic and achievable improvement in performance for a local health authority.

This section presents a number of key indicators or performance measures for a program on prevention of violence, abuse and neglect. Suggested benchmarks can apply across the province, while other benchmarks may need to be modified to account for key variables such as geographic size or population density of the health authority.

One can develop indicators related to the inputs, activities, outputs and outcomes (immediate, intermediate or final) of each of the respective components of the program. Thus, it is not necessary to only have outcome related indicators and benchmarks. Furthermore, indicators need to be understood within a broader context. For example, a low per-capita cost for a specific program could reflect the efficiency and effectiveness of the program, or reflect a program that is under-resourced. It is recognized that prevention programs on violence, abuse and neglect are multi-faceted and that it may be difficult to link interventions with direct health outcomes, particularly as initiatives involve multiple factors and multiple sectors, which all play a role in determining outcomes. In general, it is best to consider a number of indicators, taken together, before formulating a view on the performance in this area. Indicators and benchmarks work best as flags to indicate a variance from accepted norms and standards. Further investigation is usually required to determine the causes of any given variance from such norms or standards.

A health authority could determine its performance targets by assessing its current (and perhaps historical) level of performance; then, based on consideration of local factors, it could establish a realistic performance target. This performance target would be consistent with the goal of performance improvement, but would be “doable” within a reasonable period of time. Initially, health authorities will set performance targets for a number of indicators. However, over time, and particularly if consistent data collection methods and definitions are applied, it would be realistic for health authorities to share information related to their targets and then develop a consensus approach to determine provincial benchmarks for these indicators. In other words, locally developed performance targets, over time, could lead to development of provincial benchmarks.

7.2 Indicators for the Program on Prevention of Violence, Abuse and Neglect

Indicators prepared by the working group are presented in Appendix 8. It is understood that some of the indicators may not be under the control or influence of health authorities; nevertheless, they can provide important information for the health authorities to collect. Those indicators and benchmarks that are under the control and influence of health authorities provide a basis for ongoing performance review and evaluation.

In many cases, baseline data will need to be established to provide a basis for comparative analysis in future years. Benchmarks will be determined over time between the Ministry of Healthy Living and Sport and the health authorities. In addition, health authorities may wish to establish local or regional benchmarks and performance targets.

8.0 EXTERNAL CAPACITY AND SUPPORT REQUIREMENTS

8.1 Key Success Factors/System Strategies

The previous sections outlined the main components and best practices that health authorities could include in strengthening prevention of violence, abuse and neglect. However, successful implementation of effective strategies will also depend on having in place key system strategies, including:

- Strong support from the Board and management of the health authorities, from the Ministry of Healthy Living and Sport, as well as strong support from the other key players in the region, such as women’s health groups, social service agencies, child care settings and local governments.
- Allocation, by the health authorities, of sufficient resources to meet the priority needs identified in their health improvement plan.
- Well-trained and competent staff with the necessary policies, information and equipment to carry out their work efficiently.
- An information system that provides staff with appropriate support, and provides management with the information it needs to drive good policy and practice decisions.
- High-quality and competent management of the violence and abuse prevention program, including monitoring of performance measures.
- Clear mechanisms of reporting and accountability to the health authority and external bodies.

8.2 Intersectoral Collaboration and Integration/Coordination

It will be important for health authorities to review their existing information and monitoring systems with respect to their ability to measure and monitor performance indicators. This should include:

- Where necessary, establishing new policies and procedures to ensure that necessary data is gathered.
- Facilitating the process of recording and monitoring data.
- Assisting in the development of electronic health records to support interdisciplinary and collaborative approaches among health care professions.
- Establishing baseline levels for new data sets as a foundation to compare and assess trends and differences over time.

Health authorities will also need to consider the impact of program monitoring and evaluation on their staffing resources. Expertise will be needed in the fields of program monitoring, program analysis and program evaluation to ensure effective implementation and assessment of the core functions improvement process.

REFERENCES

- ¹ World Health Organization. Preventing violence: a guide to implementing recommendations of the World Report on violence and health. Geneva: World Health Organization; 2004.
- ² Plitcha SB. Intimate partner violence and physical health consequences: policy and practice implications. *J of Interpersonal Violence*. 2004;19(11):1296-1323.
- ³ Moskowitz A. Dissociation and violence: a review of the literature. *Trauma, Violence and Abuse: A Review Journal*. 2004;5(1):21-46.
- ⁴ Brown EJ. Child physical abuse: risk of psychopathology and efficacy of interventions. *Current Psychological Reports*. 2003;5(2):87-94.
- ⁵ National Clearinghouse on Child Abuse and Neglect Information. What is child abuse and neglect? Washington, DC: US Department of Health and Human Services; 2004. Available from: <http://nccanch.acf.hhs.gov/pubs/factsheets.whatiscan.pdf>.
- ⁶ World Health Organization, International Society for Prevention of Child Abuse and Neglect. Preventing child maltreatment: a guide to taking action and generating evidence. Geneva: World Health Organization; 2006.
- ⁷ Harris WW, Lieberman AF, Marans S. In the best interests of society. *J of Child Psychology and Psychiatry*. 2007;48(3):392-411.
- ⁸ McCreary Centre Society. A picture of health: highlights from the 2008 BC Adolescent Health Survey. Vancouver, BC: McCreary Centre Society; 2008.
- ⁹ Statistics Canada. Family violence in Canada: a statistical profile 2001. Ottawa, ON: Statistics Canada; 2001.
- ¹⁰ Johnson H. Preventing violence against women: progress and challenges. *IPC Review*. 2007;1:69-88.
- ¹¹ Johnson H. Measuring violence against women: statistical trends 2006 [Catalogue #85-570-XIE]. Ottawa, ON: Statistics Canada; 2006.
- ¹² UN study of violence against women finds 50% of disabled women experience abuse. *Disability World*. 2007 Jan; 28. Available from: http://www.disabilityworld.org/01_07/abuse.shtml.
- ¹³ Johnson H. Dangerous domains: violence against women in Canada. Scarborough, ON: International Thomson Publishing; 1996.
- ¹⁴ Joshi P, Pallaveshi L, Verma P, Pike I. Primary prevention of physical violence and abuse in British Columbia. Vancouver, BC: BC Injury Research and Prevention Unit; 2008.
- ¹⁵ McCreary Centre Society. Moving upstream: Aboriginal marginalized and street involved youth in BC; Vancouver, BC: McCreary Centre Society; 2003.
- ¹⁶ Saewyc EM, Poon C, Wang N, Homma Y, Smith A, McCreary Centre Society. Not yet equal: The health of lesbian, gay and bisexual youth in BC. Vancouver, BC: McCreary Centre Society; 2007.
- ¹⁷ World Health Organization. A global response to elder abuse and neglect: building primary health care capacity to deal with the problem worldwide: main report. Geneva: World Health Organization; 2008.
- ¹⁸ Human Resources and Social Development Canada. Awareness and perceptions of Canadians toward elder abuse (prepared by Environics Research Group). Toronto: Human Resources and Social Development Canada; 2008.

- ¹⁹ Mussell B, Cardiff K, White J. The mental health and well-being of Aboriginal children and youth: guidance for new approaches and services. Vancouver, BC: Sal'i'shan Institute and the Children's Mental Health Policy Research Program; 2004.
- ²⁰ Bopp M, Bopp J, Lane P. Aboriginal domestic violence in Canada. Ottawa, ON: Aboriginal Healing Foundation; 2003.
- ²¹ Barile M. Individual-systemic violence; disabled women's standpoint. *J of Intern Women's Studies*. 2002;4(1).
- ²² Petersilia J. Invisible victims: violence against person with developmental disabilities. *Human Rights*. 2000 Winter; 27(1). Available from: <http://www.abanet.org/irr/hr/winter00humanrights/petersilia.html>.
- ²³ Sobsey D, Doe T. Patterns of sexual abuse and assault. *J of Sexuality and Disability*. 1991;9(3):243-59.
- ²⁴ Teplin LA, McClelland GM, Abram KM, Weiner DA. Crime victimization in adults with severe mental illness: comparison with the National Crime Victimization Survey. *Arch Gen Psychiatry*. 2005 Aug;62(8):911-21.
- ²⁵ Friedman RA. Violence and mental illness – how strong is the link? *New Engl J Med*. 2006;20:2064-66.
- ²⁶ Brown R, Perlisz A, Proctor K. Mental health issues for GLBTI Victorians. In: Leonard W, editor. What's the difference? Health issues of major concern to gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians. Melbourne: Rural and Regional Health and Aged Care Services Division, Victorian Government Department of Human Services; 2002. p. 29-36.
- ²⁷ Provincial Health Officer, Representative for Children and Youth. Health and well-being of children in care in British Columbia. Victoria, BC; 2006.
- ²⁸ Musisi S, Mollica R, Weiss M. Supporting refugees and victims of war. In: Hosman C, Jané-Llopis E, Saxena S, editors. Prevention of mental disorders: effective interventions and policy options. Oxford: Oxford University Press; 2005.
- ²⁹ Krug, EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World report on violence and health. Geneva: World Health Organization; 2002.
- ³⁰ Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World report on violence and health. Geneva: World Health Organization; 2002. pp. 3-21.
- ³¹ Anderson CA. Violent video games: myths, facts, and unanswered questions. *Psychological Science Agenda*. 2003 Oct; Available from: <http://www.apa.org/science/about/psa/2003/10/anderson.aspx>.
- ³² Masten AS. Ordinary magic: resilience processes in development. *American Psychologist*. 2001;56:227.
- ³³ Varcoe C. (nd). Violence against women - attributing selected costs to intimate partner violence in a sample of women who have left abusive partners: a social determinants of health approach. <http://mc.manuscriptcentral.com/vaw>
- ³⁴ Kerr R, McLean J. Paying for violence: some of the costs of violence against women in BC. Victoria, BC: Ministry of Women's Equality; 1996.
- ³⁵ BC Reproductive Care Program. Intimate partner violence during the perinatal period [Obstetrical Guideline 13]. Vancouver, BC: BC Perinatal Health Program; 2003.
- ³⁶ Komro KA, Sigler M. Growing absolutely fantastic youth: a review of the research on "best practices". Minnesota: School of Public Health, University of Minnesota; 2000.

- ³⁷ Harvey A, Garcia-Moreno C, Butchart A. Primary prevention of intimate-partner violence and sexual violence: background paper for WHO expert meeting. Geneva: World Health Organization; 2007.
- ³⁸ World Health Organization. The Ottawa Charter for Health Promotion. Copenhagen: World Health Organization; 1986.
- ³⁹ Bowen LK, Gwaisda V, Brown M. Engaging community residents to prevent violence. *J of Interpersonal Violence*. 2004;19(3):356-367.
- ⁴⁰ Hawkins JD, Catalano RF, Arthur MW. Promoting science-based prevention in communities. *Addictive Behavior*. 2002;27(6):951-976.
- ⁴¹ Ministry of Health, Population Health and Wellness. Evidence review: healthy communities (prepared by the Public Health Association of BC). Victoria, BC: Ministry of Health; 2006.
- ⁴² Canetti L, Bachar E, Galili-Weisstub E, De-Nour AK, Shalev AY. Parental bonding and mental health in adolescence. *Adolescence*. 1997;32(126):381-94.
- ⁴³ Schweinhart LJ, Weikart DP. The High/Scope preschool curriculum comparison study through age 23. *Early Childhood Research Quarterly*. 1997;12:117-143.
- ⁴⁴ Barr M, Barr RG, Taylor T. Shaken baby prevention efforts. In Rauth-Farley K, Fraiser L, Parris K, editors. *Abusive head trauma: a medical, legal and forensic reference*. Missouri: GW Medical Publishers; 2005.
- ⁴⁵ Tierney JP, Grossman JB, Resch NL. Making a difference: an impact study of Big Brothers Big Sisters. Philadelphia, PA: Public/Private Ventures; 1995.
- ⁴⁶ Spoth RL, Redmond C, Shin C. Reducing adolescents' aggressive and hostile behaviours. *Arch Pediatr Adolesc Med*. 2000;154(12):1248-1257.
- ⁴⁷ National Center for Mental Health Promotion and Youth Violence Prevention. Promotion and prevention. Strengthening capacity, promoting health. Available from: <http://www.promoteprevent.org>.
- ⁴⁸ Hume S, Hubberstey C, Rutman D. Parenting support and education: a literature review. BC Parenting Vision Task Group, BC Council for the Family; 2005.
- ⁴⁹ Barlow J, Coren E, Stewart-Brown S. Parent training programs for improving maternal psychosocial health. *Cochrane Database of Systematic Reviews*, 4; 2003.
- ⁵⁰ Hayden S, Barton E, Haden M. Domestic violence in the emergency department: how do women prefer to disclose and discuss the issue. *J Emerg Med*. 1997;15:447-451.
- ⁵¹ Ramsay K, Richardson J, Carter Y, Davidson L, Feder G. Should health professionals screen women for domestic violence? *BMJ*. 2002;325:314.
- ⁵² McFarlane J, Soeken K, Reel S, Parker B, Silva D. Resource use by abused women following an intervention programs: associated severity of abuse and reports of abuse ending. *Public Health Nurs*. 1997;14:244-250.
- ⁵³ MacMillan HL, Wathen CN, Jamieson E, Boyle MH, Shannon HS, Ford-Gilboe M, et al. Screening for intimate partner violence in health care settings; a randomized trial. *JAMA*. 2009;302(5):493-501.
- ⁵⁴ Randall T. Hospital-wide program identified battered women, offers assistance. *JAMA*. 1991;266:1177-1180.
- ⁵⁵ Herman J. *Trauma and recovery*. 2nd ed. New York: Basic Books; 1997.
- ⁵⁶ Kimberg L. Screening for domestic violence changed my practice. *Health Alert*. 1999 Summer.

⁵⁷ McFarlane J, Soeken K, Wiist W. An evaluation of interventions to decrease intimate partner violence to pregnant women. *Public Health Nurs.* 2000;17(6):443-451.

⁵⁸ Parker B, McFarlane J, Soeken K, Silma C, Reel S. Testing an intervention to prevent further abuse to pregnant women. *Res Nurs Health.* 1999;22:59-66.

⁵⁹ Hyman I, Guruge S, Stewart DE, Ahmed F. Primary prevention of violence against women. *Women's Health Issues.* 2000;10(6):288-293.

⁶⁰ WorkSafeBC (2006). Take care: how to develop and implement a workplace violence prevention program. British Columbia: Workers' Compensation Board of British Columbia; 2006. Available from:

http://www.worksafebc.com/publications/high_resolution_publications/assets/pdf/BK41.pdf.

⁶¹ Vinokur AD, Schul Y, Vuori J, Price RH. Two years after a job loss: long-term impact of the JOBS Program on reemployment and mental health. *J Occup Health Psychol.* 2000;5(1):32-47.

⁶² Kinnon D. Abuse and neglect of older adults: community awareness and response. Ottawa, ON: National Clearinghouse on Family Violence, Health Canada; 2001.

⁶³ Perel-Levin S. Discussing screening for elder abuse at primary care level. Geneva: World Health Organization; 2008.

⁶⁴ Ministry of Health. A framework for core functions in public health. Victoria, BC: Ministry of Health; 2005.

GLOSSARY

Abuse: the deliberate mistreatment of an adult that causes the adult (a) physical, mental or emotional harm, or (b) damage to or loss of assets, and includes intimidation, humiliation, physical assault, sexual assault, overmedication, withholding needed medication, censoring mail, invasion or denial of privacy or denial of access to visitors.¹ (Abuse of children is defined under child abuse).

In addition, the *Criminal Code of Canada* defines abuse of adults as:

- **Physical abuse** includes: simple assault (e.g., slapping, pushing, shoving, pinching or threats of harm); assault with a weapon or causing bodily harm; and aggravated assault (e.g., when injuries occur or the victim's life is endangered).
- **Sexual abuse** includes three offences: assault in circumstances of a sexual nature in a way that the sexual integrity of the victim is violated; sexual assault (a) with a weapon, or (b) while threatening to harm someone else, e.g., a child, (c) by causing bodily harm to the victim; and aggravated sexual assault when the attack wounds, maims, disfigures or endangers the life of the victim.
- **Psychological/emotional or verbal abuse** can include the following criminal offences: uttering threats; forced confinement; failure to provide the necessities of life; mischief; and cruelty to animals.

Adult: means anyone who has reached 19 years of age and, for all purposes incidental to an application under the *Adult Guardianship Act*, section 6 (2), includes a person who has reached 18 years of age.¹

Furthermore, the *Adult Guardianship Act* notes that:

- (a) all adults are entitled to live in the manner they wish and to accept or refuse support, assistance or protection as long as they do not harm others and they are capable of making decisions about those matters;
- (b) all adults should receive the most effective, but the least restrictive and intrusive, form of support, assistance or protection when they are unable to care for themselves or their assets;
- (c) the court should not be asked to appoint, and should not appoint, decision makers or guardians unless alternatives, such as the provision of support and assistance, have been tried or carefully considered.

3.(2) An adult's way of communicating with others is not grounds for deciding that he or she is incapable of making decisions about anything referred to in subsection (1).

Best Practices: These are activities based on sound scientific evidence, extensive community experience and/or cultural knowledge. Healthy living interventions will be more effective if they are based on established best practices.²

Care Facility:

- (a) a facility licensed under the BC Community Care and Assisted Living Act and regulated under the Adult Care Regulations, B.C. Reg. 536/80,
- (b) a private hospital licensed under Part 2 of the Hospital Act,
- (c) an institution designated as a hospital under the Hospital Act for the treatment of persons referred to in paragraph (b) or (c) of the definition of "hospital" in that Act, or
- (d) any other facility, or class of facility, designated by regulation as a care facility;

Child Abuse: All forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.³ In BC, the Ministry of Children and Family Development define child abuse and neglect (based on the *Child, Family and Community Services Act*) as follows:⁴

- **Physical abuse** is the deliberate physical assault or action by a person that results in, or is likely to result in, physical harm to a child. It includes the use of unreasonable force to discipline a child or prevent a child from harming him/herself or others. The injuries sustained by the child may vary in severity and range from minor bruising, burns, welts or bite marks to major fractures of the bones or skull to, in the most extreme situations, death.
- **Emotional abuse** is the most difficult type of abuse to define and recognize. It may range from ignoring to habitually humiliating the child to withholding life-sustaining nurturing. Generally, it involves acts or omissions by those in contact with the child that are likely to have serious, negative emotional impacts. Emotional abuse may occur separately from, or along with, other forms of abuse and neglect. It includes the emotional harm caused by witnessing domestic violence. Emotional abuse can include a pattern of: scapegoating; rejection; verbal attacks on the child; threats; insults; and humiliation.

When emotional abuse is chronic and persistent, it can result in emotional harm.

Emotional harm is defined under the *Child, Family and Community Services Act*, when a child demonstrates severe: anxiety; depression; withdrawal; or self-destructive or aggressive behaviour.

- **Sexual abuse** is when a child is used (or likely to be used) for the sexual gratification of another person. It includes: touching or invitation to touch for sexual purposes; intercourse (vaginal, oral or anal); menacing or threatening sexual acts, obscene gestures, obscene communications or stalking; sexual references to the child's body / behaviour by words/gestures; requests that the child expose their body for sexual purposes; deliberate exposure of the child to sexual activity or material; and sexual aspects of organized or ritual abuse.
- **Sexual exploitation** is a form of sexual abuse that occurs when a child engages in a sexual activity, usually through manipulation or coercion, in exchange for money, drugs, food, shelter or other consideration. Sexual activity includes: performing sexual acts; sexually explicit activity for entertainment; involvement with escort or massage parlour services; and appearing in pornographic images. Children living on the street are

particularly vulnerable to exploitation. Children in the sex trade are not prostitutes or criminals. They are victims of abuse.

- **Neglect** is failure to provide for a child's basic needs. It involves an act of omission by the parent or guardian, resulting in (or likely to result in) harm to the child. Neglect may include failure to provide food, shelter, basic health care, supervision or protection from risks, to the extent that the child's physical health, development or safety is, or is likely to be, harmed.

Children with Special Needs: Children and youth between birth and 19 years of age who require additional educational, medical/health and social/environmental support, beyond that required by children in general, to enhance or improve their health, development, quality of life and community integration.⁵

Culture: The understandings, patterns of behaviour, practices and values shared by a group of people. Children and families may identify as belonging to more than one culture.

Decision maker: means a person appointed under the *Adult Guardian Act* as an associate decision maker or substitute decision maker.

Designated agency: means, under the *Adult Guardianship Act*, an agency (ie., all health authorities, Community Living BC and Providence Health Care Society) who receive a report of abuse, neglect or self-neglect of an adult, or becomes aware of this through the course of its work, must;

- Look into the situation;
- Involve the adult as much as possible;
- Report criminal offences to the police.

Designated agencies may also:

- Intervene in emergencies by working with the police to remove the adult to a safe place and get needed health care;
- Liaise with the Provincial Guardian and Trustee if initial inquiry reveals adult's assets are at risk – overlapping role to investigate;
- Obtain orders from the Provincial Court, Family Division for: access orders; interim or longer term restraining orders; and support and assistance orders.

Determinants of health:⁶ The range of personal, social, economic and environmental factors which determine the health status of individuals or populations. (WHO, Health Promotion Glossary, 1998) These can include:

1. **Income and Social Status:** Health status improves at each step up the income and social hierarchy. In fact, these two factors seem to be the most important determinants of health.
2. **Social Support Networks:** Support from families, friends and communities is associated with better health.

3. **Education and Literacy:** Health status improves with level of education. Canadians with low literacy skills are more likely to be unemployed and poor, to suffer poorer health and to die earlier.
4. **Employment/Working Conditions:** Unemployment, underemployment and stressful work are associated with poorer health.
5. **Social Environments:** The importance of social support also extends to the broader community. Civic vitality is reflected in the institutions, organizations and informal giving practices that people create to share resources and build attachments with others.
6. **Physical Environments:** Physical factors in the natural environment (air, water quality) are key influences in health. At certain levels of exposure, contaminants in our air, water, food and soil can cause a variety of adverse health effects, including cancer, birth defects, respiratory illness and gastrointestinal ailments.
7. **Personal Health Practices and Coping Skills:** Those actions by which individuals can prevent diseases and promote self-care, cope with challenges, and develop self-reliance, solve problems and make choices that enhance health.
8. **Healthy Child Development:** New evidence on the effects of early experiences on brain development, school readiness and health in later life confirms early child development as a powerful determinant of health.
9. **Biology and Genetic Endowment:** The basic biology and organic make-up of the human body. In some circumstances genetic endowment appears to predispose certain individuals to particular diseases or health problems.
10. **Health Services:** Health services, particularly those designed to maintain and promote health, to prevent disease, and restore health and function contribute to population health.
11. **Gender:** Gender refers to the array of socially-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes.
12. **Culture:** Some persons or groups face additional health risks due to their socio-economic environment: marginalization, stigmatization, loss of language and culture, lack of access to culturally appropriate health care and services.

Developmental Disabilities: childhood conditions that require additional educational, medical/health and social/environmental support, beyond that required by children in general, to enhance or improve their health, development, quality of life, and community integration (MHLS definition).

Disability: The WHO states that disability is an umbrella term for impairments, activity limitations or participation restrictions which are measured through an individual functional assessment, and acknowledge that disability is also a product of culture and social institutions. The WHO has extended the scope of the international classification of functioning, disability and health into two lists, based on 1) body functions and structure, and 2) activities and participation. This approach describes health and health-related domains from the perspective of the body, the individual and society and allows for positive experiences to be described.⁷

Diversity: Differences and unique attributes within each child based on values and beliefs, culture and ethnicity, language, ability, education, life experiences, socio-economic status, spirituality, gender, age and sexual orientation.

Elder abuse: Elder abuse is a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person.⁸ The abuse causes the elderly person physical, emotional, or mental harm and/or damage to, or loss of, assets or property. Many of these abuses are criminal offences under the *Criminal Code of Canada*, including Theft, Forgery, Extortion, Assault, Intimidation, Threats and Failure to Provide the Necessities of Life.⁹ More specifically, the abuse may involve:

- **Physical abuse** is the non-accidental use of physical force for coercion, or to influence bodily harm including unreasonable confinement or punishment, hitting, slapping, pinching, pushing, shaking, physical restraint, physical coercion, forced feeding, withholding physical necessities.¹⁰
- **Psychological abuse** is the willful infliction of mental anguish or the provocation of fear of violence or isolation. It diminishes the identify, dignity and self-worth of the senior and includes behaviours such as name-calling, yelling, ignoring the person, scolding or shouting, insults, threats, etc.¹⁰
- **Financial abuse** is the most common form of elder abuse – it is damage to, or loss of assets or property. The abuser is usually a spouse or partner, family member (often adults child), caregiver, friend, or a trusted person in the senior’s life.⁹
- **Sexual abuse** in any kind of sexual interaction without a senior’s full knowledge and consent. It includes assault, rape, sexual harassment, fondling, inappropriate sexual comments, etc.¹⁰
- **Neglect** refers to the intentional withholding by a person who has care or custody of dependent senior of basic necessities or care (active neglect), or not providing basic necessities or care (passive neglect).¹⁰

It should be noted that the term “abuse of older adults” is the term generally preferred by Aboriginal people, and it is thus used frequently throughout this paper. However, since the term ‘elder abuse’ is commonly used in the literature, it is also used in this paper.

Equality/equity: Equality is the “outcome” reached through equity measures. Equity is the “process” of being fair to women and men or to other groups in order to compensate for historical and social disadvantages that prevent them from otherwise operating on a level play field. Equity leads to equality.¹¹

Guardian: means a person appointed as

- (a) a guardian under the *Adult Guardianship Act*, or
- (b) a committee of a person who is declared under the *Patients Property Act* to be
 - (i) incapable of managing himself or herself, or
 - (ii) incapable of managing himself or herself and his or her affairs.¹²

Health care: defined in the *Health Care (Consent) and Care Facility (Admission) Act* and *Adult Guardianship Act* is anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health, and includes

- (a) a series or sequence of similar treatments or care administered to an adult over a period of time for a particular health problem,
- (b) a plan for minor health care that
 - (i) is developed by one or more health care providers,
 - (ii) deals with one or more of the health problems that an adult has and may, in addition, deal with one or more of the health problems that an adult is likely to have in the future given the adult's current health condition, and
 - (iii) expires no later than 12 months from the date consent for the plan was given, and
- (c) participation in a medical research program approved by an ethics committee designated by regulation.

Major health care: means (a) major surgery (b) any treatment involving a general anesthetic (c) major diagnostic or investigative procedures, or (d) any health care designated by regulation as major health care.

Minor health care: means any health care that is not major health care, and includes (a) routine tests to determine if health care is necessary, and (b) routine dental treatment that prevents or treats a condition or injury caused by disease or trauma, for example (i) cavity fillings and extractions done with or without a local anesthetic, and (ii) oral hygiene inspections.

Health Promotion: Any planned combination of educational, political, regulatory and organizational supports for actions and conditions of living conducive to the health of individuals, groups or communities (L. Green). Health promotion is also the process of enabling people to increase their control over, and to improve their health. In health promotion, therefore, health is seen as a resource for everyday living, not the objective of living. Health is a positive concept, emphasizing social and personal resources, as well as physical capacities. (Ottawa Charter for Health Promotion, 1986).¹³

High Risk: term used in early identification and intervention programs to describe a situation where, based on the results of a complete assessment and professional judgment, there is a serious risk that a child may not reach his/her potential and that the family may benefit from more intensive supports.

Intimate-partner Violence: any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.¹⁴

Integration: Service integration and collaboration are related but distinct methods of services delivery. Integration is characterized by features such as common intake and 'seamless' service delivery, where the client receives a range of services from different programs without repeated registration procedures, waiting periods, or other administrative barriers. In contrast, coordinated systems generally involve multiple agencies providing services, but in different locations and with separate program registration processes.¹⁵

Neglect: means any failure to provide necessary care, assistance, guidance or attention to an adult that causes, or is reasonably likely to cause within a short period of time, serious physical, mental or emotional harm or substantial damage to or loss of assets, and includes self neglect.¹

Population Health: focuses on the underlying and interrelated conditions that influence the health of populations over the life course. These include factors such as education, income, early childhood experiences and the social and physical environments that surround individuals and groups. By addressing these factors, a population health approach aims to reach beyond the limited effectiveness of lifestyle-based interventions and reduce disparities in health outcomes.²

Prevention: approaches and activities to reduce the likelihood of a disease or disorder affecting an individual, to interrupt or slow the progress of the disorder, or to reduce disability.²

- **Primordial:** prevention of risk factors, beginning with a change in social or environment conditions.
- **Primary prevention** reduces the likelihood of a disease or disorder developing in an individual.
- **Secondary prevention** interrupts, prevents or minimizes the progress of a disease or disorder at an early stage.
- **Tertiary prevention** focuses on preventing the damage that has already occurred from becoming worse.

Representation Agreement: means an agreement made under the *Representation Agreement Act* - representative means a person authorized by a representation agreement to make decisions on behalf of another

Self-neglect: any failure of an adult to take care of himself or herself that causes, or is reasonably likely to cause within a short period of time, serious physical or mental harm or substantial damage to or loss of assets, and includes:

- (a) living in grossly unsanitary conditions,
- (b) suffering from an untreated illness, disease or injury,
- (c) suffering from malnutrition to such an extent that, without intervention, the adult's physical or mental health is likely to be severely impaired,
- (d) creating a hazardous situation that will likely cause serious physical harm to the adult or others or cause substantial damage to or loss of assets, and
- (e) suffering from an illness, disease or injury that results in the adult dealing with his or her assets in a manner that is likely to cause substantial damage to or loss of the assets.¹

Resilience: an ability to recover from or adjust easily to misfortune or change e.g. recovering from traumatic events, overcoming disadvantages to succeed in life, and withstanding stress to function well in the tasks of life.

Risk Factors: Social, economic or biological status, behaviours or environments which are associated with or cause increased susceptibility to a specific disease, ill health or injury.¹

Sexual Violence: any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality, using coercion,

Core Public Health Functions for BC: Model Core Program Paper **Prevention of Violence, Abuse & Neglect**

threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work.¹⁴ (see also definition under “Abuse”)

Targeted Interventions: The predominant characteristic of these interventions are that children and their families do not seek help, and certain children or families are singled out for the intervention, not necessarily because they already have a disorder but because they are at greater risk for developing one. Children can be targeted in two ways: the identifying characteristic can lie outside the child (e.g., family in poverty), or the children themselves can have the distinguishing characteristics (e.g., behaviour issue).¹⁶

Universal Interventions: Characteristics of this type of intervention are that individual families (and their children) do not seek help and children are not singled out for the intervention. All children in a geographical areas or setting (e.g., school) receive the intervention. Two types of universal programs can be: those that focus on particular communities or settings (e.g., a public housing complex) or those that are province-wide or countrywide, for example.¹⁶

Violence: 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, mal-development or deprivation.¹⁷

Workplace Violence: As defined by Worksafe BC, violence is the attempted or actual exercise by a person, other than a worker, of any physical force so as to cause injury to a worker, and includes any threatening statement or behaviour which gives a worker reasonable cause to believe that he or she is at risk of injury.¹⁸

REFERENCES

¹ *Adult Guardianship Act*.

² Public Health Agency of Canada. Glossary. Available from: <http://www.phac-aspc.gc.ca/hl-vs-strat/hl-vs/glossary-eng.php>.

³ World Health Organization & International Society for Prevention of Child Abuse and Neglect. Preventing child maltreatment: a guide to taking action and generating evidence. Geneva: World Health Organization; 2006. Available from: http://whqlibdoc.who.int/publications/2006/9241594365_eng.pdf. [Accessed 2009 Mar 20].

⁴ Ministry of Children and Family Development. *BC handbook for action on child abuse and neglect*. Victoria, BC: Ministry of Children and Family Development. Available from: http://www.mcf.gov.bc.ca/child_protection/pdf/handbook_action_child_abuse.pdf.

⁵ Ministry of Children and Family Development. Children and Youth with Special Needs. Available from: www.mcf.gov.bc.ca/spec_needs/index.htm.

⁶ Public Health Agency of Canada. What determines health? Available from: <http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php>.

⁷ World Health Organization. (2001). International classification of functioning, disability and health. Geneva: World Health Organization.

⁸ World Health Organization. A global response to elder abuse and neglect: building primary health care capacity to deal with the problem worldwide: main report. Geneva: World Health Organization; 2008.

⁹ BC Centre for Elder Advocacy and Support. What is elder abuse? Vancouver, BC: BC Centre for Elder Advocacy and Support; 2009. Available from: <http://bcceas.ca/faq/elder-abuse/what-is-elder-abuse>.

¹⁰ Ontario Network for Prevention of Elder Abuse. About elder abuse. Toronto: Ontario Network for Prevention of Elder Abuse. Available from: <http://www.onpea.org/english/elderabuse/formsofelderabuse.html>.

Core Public Health Functions for BC: Model Core Program Paper
Prevention of Violence, Abuse & Neglect

¹¹ World Health Organization. Gender analysis in health. Geneva: World Health Organization. Available from: <http://www.who.int/gender/documents/en/Gender.analysis.pdf>.

¹² *Health Care (Consent) and Care Facility (Admission) Act*.

¹³ Repository of International Non-Communicable Disease (NCD) Prevention Interventions. Available from: <http://www.med.mun.ca/rinpi/>.

¹⁴ Harvey A, Garcia-Moreno C, Butchart A. Primary prevention of intimate-partner violence and sexual violence: background paper for WHO expert meeting. Geneva: World Health Organization; 2007.

¹⁵ Pindus N, Koralek R, Martinson K, Trutko J. Coordination and integration of welfare and workforce development systems. Washington, DC: Urban Institute; 2000.

¹⁶ Offord D, Kraemer HC, Kazdin AE, Jensen PS, Harrington R, Gardner JS. Lowering the burden of suffering: monitoring the benefits of clinical, targeted and universal approaches. In Keating D, Hertzman C, editors. *Developmental health and the wealth of nations: social, biological and educational dynamics*. New York: Guilford Press; 1999. p. 293-311.

¹⁷ Krug, EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. *World report on violence and health*. Geneva: World Health Organization; 2002.

¹⁸ Workers' Compensation Board Health and Safety Reg. 4.27.

APPENDIX 1: SUMMARY OF STATISTICS ON VIOLENCE, ABUSE AND NEGLECT

Child Abuse and Neglect

Child abuse has serious impact on the victims' physical and mental health, well-being and development throughout their lives, and by extension, on society in general.¹ As well, experience of abuse as a child is an indicator for violence in adulthood, as either a victim or perpetrator.

- In BC, the number of youth who experienced physical abuse increased from 15% in 2003 to 17% in 2008. Eight percent of youth reported sexual abuse, and 5% reported both physical and sexual abuse (2008). Youth who were particularly vulnerable to relationship violence included those who had been sexually abused, had a disability or chronic illness, and gay, lesbian and bisexual youth.²
- The Canadian Incidence Study of Reported Child Abuse and Neglect (2003)³ indicate a rate of 21.7 cases of maltreatment per 1,000 children, based on substantiated child maltreatment investigations by child welfare services across Canada (data does not include suspected cases or those reported to other authorities). Of these cases, 30% involved neglect as the primary category of maltreatment; 28% exposure to domestic violence; 24% direct physical abuse; 15% emotional abuse; and 3% sexual abuse.
- In comparison with the 1998 study, the rate of substantiated maltreatment in the 2003 study increased 125% (due in part to more systematic identification and greater awareness of the impact of emotional maltreatment and exposure to domestic violence).³
- Almost 40% of women assaulted by spouses said their children witnessed the violence against them (either directly or indirectly) and in many cases the violence was severe. In half of cases of domestic violence witnessed by children, the woman feared for her life.⁴
- There is a 30 to 40% overlap between children who witness violence in relationships and children who experience direct physical abuse themselves.⁵
- Children who had seen violence behaviour were more likely than those who had not to be overtly aggressive. Level of physical aggression remained high two and four years later for both sexes.⁵

Intimate Partner Violence

- In Canada in 2004, the five-year prevalence rate of spousal violence against women was 7% (based on Statistics Canada, General Social Survey);⁶ in BC, the rate was 9% of women. Spousal violence against women by previous spouses compared to current spouses was 21% in 2004.⁶ The rate of spousal violence against men was 6% in 2004.⁶
- Women who are victims of domestic violence are three times more likely than male victims of domestic violence to be physically injured, five times more likely to require medical attention, five times more likely to report being choked, much more likely to fear for their lives, and twice as likely to have suffered more than ten violence episodes.⁴

- The United Nations estimate that the lifetime rate (compared to above 5-year rate) of intimate partner violence against women is one in three worldwide, based on surveys from 71 countries.⁷
- In BC, during the 2005/06 fiscal year, 21,390 people reported to a funded victim service program being victims of spousal assault. In 2005, 10,273 incidents of spousal assault were reported to police—of these, 74% involved a male offender, 16% involved a female offender and 10% involved both spouses.⁸
- Between 1997 and 2006 in BC, there were 124 female victims in spousal and intimate relationships, who were murdered.⁹
- Twenty-one percent of women in Canada who reported being abused by an intimate partner said they were abused during pregnancy.¹⁰ This rate of abuse is similar to that reported in other studies.^{11,12}
- An American study found that women with disabilities are significantly more likely to experience violence compared with those without disabilities (33.2%).¹³
- In 2004, the rate of domestic violence for Aboriginal women remained more than three times higher than for non-Aboriginal women or men—21% of Aboriginal women reported being victims of spousal violence, compared to 7% of non-Aboriginal women.⁶ They were significantly more likely than non-Aboriginal women to report the most severe and potentially life-threatening forms of violence (i.e., being beaten or choked, having had a gun or knife used against them, or being sexually assaulted).⁶

Abuse of Older Adults

Elder abuse is any action by someone in a relationship of trust that results in harm or distress to an older person. Neglect is a lack of action by a person in a relationship of trust with the same result. Commonly recognized types of elder abuse include physical, psychological and financial. Often, more than one type of abuse occurs at the same time.¹⁴

- Five percent of Canadian seniors surveyed in 2008, reported they had experienced abuse. Of these responses, the types of abuse experienced were lack of respect (23%), psychological/verbal/emotional abuse (19%) and financial abuse (17%). Fewer than half of these seniors (44%) sought help. Doctors/health professionals (39%), as well as seniors or community groups/organizations (30%), were the sources to which seniors turned for help.¹⁵
- Ninety-five percent of Canadians think most of the abuse experienced by older adults is hidden or goes undetected. Ninety percent think the abuse often gets worse over time.¹⁵
- Other family members (63%) are most likely to be seen as the main sources of elder abuse, followed by caregivers in institutions (50%).¹⁵

Other Interpersonal Violence

- In BC, males accounted for a higher number of assault-related hospital separations when compared to females at an approximately 5:1 ratio, peaking among males aged 15-24 and declining among males aged 25-69 years.¹⁶ The leading cause of injury for assault-related hospital separations among both males and females was bodily force (60.7%) among persons aged 15-75 years.¹⁶
- In a BC survey (2006) of marginalized and street-involved youth:¹⁷
 - Violence was a significant issue for most of the youth - 63% reported having witnessed family violence, and almost 60% reported being physically abused.
 - Thirty percent of males and 23% of females had been sexually exploited. Youth who reported physical or sexual abuse were twice as likely to be sexually exploited as those who were not abused.
- In BC, lesbian, gay and bisexual youth are two to three times more likely to have experienced physical and sexual abuse, harassment in school and discrimination compared to heterosexual teens, and rates seems to be rising.¹⁸
- People with disabilities are particularly at risk of violence and abuse:
 - The United Nations estimated that in Europe, North America and Australia, more than half of women with disabilities have experienced physical abuse.⁷
 - A 1989 survey in Canada found that 40% of women with disabilities had experienced abuse, while 12% had been raped.¹⁹
 - A University of Alberta study found 44% of the perpetrators of abused persons with intellectual impairments were service providers.²⁰
- The International Labour Office estimated that in Canada, 3.9% of men and 5% of women have experienced violence at their workplace.²¹ (Violence at work includes physical violence, sexual assault and psychological abuse, e.g., bullying, sexual harassment, threats and intimidation).

References

- ¹ World Health Organization & International Society for Prevention of Child Abuse and Neglect. Preventing child maltreatment: a guide to taking action and generating evidence. Geneva: World Health Organization; 2006. Available from: http://whqlibdoc.who.int/publications/2006/9241594365_eng.pdf. [Accessed 2009 Mar 20].
- ² McCreary Centre Society. A picture of health: highlights from the 2008 BC Adolescent Health Survey. Vancouver, BC: McCreary Centre Society; 2008.
- ³ Public Health Agency of Canada. Canadian Incidence Study of Reported Child Abuse and Neglect. Ottawa, ON: Public Health Agency of Canada; 2003.
- ⁴ Statistics Canada. Family violence in Canada: a statistical profile 2001. Ottawa, ON: Statistics Canada; 2001.
- ⁵ Sudermann M, Jaffe P, Watson L. Wife abuse – the impact on children. Ottawa, ON: National Clearinghouse on Family Violence; 1996.
- ⁶ Johnson H. Measuring violence against women: statistical trends 2006 [Catalogue #85-570-XIE]. Ottawa, ON: Statistics Canada; 2006.

Core Public Health Functions for BC: Model Core Program Paper **Prevention of Violence, Abuse & Neglect**

⁷ UN study of violence against women finds 50% of disabled women experience abuse. Disability World. 2007 Jan; 28. Available from: http://www.disabilityworld.org/01_07/abuse.shtml.

⁸ Ministry of Public Safety and Solicitor General. Victim Service Program Data, 2005/06. Vancouver, BC: Ministry of Public Safety and Solicitor General.

⁹ Communication with Ministry of Attorney General, Police Services Division, February 2008 (as reported in Keeping Women Safe: Eight Critical Components of an Effective Justice Response to Domestic Violence, by the Critical Components Project Team, BC).

¹⁰ Johnson H. Dangerous domains: violence against women in Canada. Scarborough, ON: International Thomson Publishing; 1996.

¹¹ Stewart D, Cecutti A. Physical abuse in pregnancy. Can Medical Assoc Journal. 1993;149(9):1257-1263.

¹² Rodgers K. Wife assault: the findings of a national survey. Juristat: Service Bulletin. 1994;14(9):1-22.

¹³ Barrett KA, O'Day B, Roche A, Lepidus Carlson B. Intimate partner violence, health status, and health care access among women with disabilities. Women's Health Issues. 2009;19(2):94-100.

¹⁴ Government of Canada. Elder abuse: it's time to face the reality [CA-542-05-09]. Ottawa, ON: Government of Canada; 2009.

¹⁵ Human Resources and Social Development Canada. Awareness and perceptions of Canadians toward elder abuse (prepared by Environics Research Group). Toronto: Human Resources and Social Development Canada; 2008.

¹⁶ Joshi P, Pallaveshi L, Verma P, Pike I. Primary prevention of physical violence and abuse in British Columbia. Vancouver, BC: BC Injury Research and Prevention Unit; 2008.

¹⁷ McCreary Centre Society. Moving upstream: Aboriginal marginalized and street involved youth in BC; Vancouver, BC: McCreary Centre Society; 2003

¹⁸ Saewyc EM, Poon C, Wang N, Homma Y, Smith A, McCreary Centre Society. Not yet equal: The health of lesbian, gay and bisexual youth in BC. Vancouver, BC: McCreary Centre Society; 2007.

¹⁹ Barile M. Individual-systemic violence; disabled women's standpoint. J of Intern Women's Studies. 2002;4(1).

²⁰ Sobsey D, Doe T. Patterns of sexual abuse and assault. J of Sexuality and Disability. 1991;9(3):243-59.

²¹ Canadian Initiative on Workplace Violence. Working together. Available from: <http://www.emirrorsolutions.ca/workplaceviolence/org/together.html>. [Accessed 2010 May 6].

APPENDIX 2: THE EVIDENCE BASE FOR A MODEL CORE PROGRAM FOR PREVENTION OF PHYSICAL VIOLENCE AND ABUSE

Taken from: *Primary Prevention of Physical Violence and Abuse in British Columbia* (2008), prepared by P. Joshi, L. Pillaveshi, P. Verma and I. Pike, BC Injury Research and Prevention Unit.

EXECUTIVE SUMMARY

Background

Physical violence and abuse related injuries are a significant public health concern. The burden of injury from physical violence and abuse is difficult to ascertain, however morbidity and mortality data from BC have assisted in elucidating the prevalence of assault-related deaths and injuries in the province.

Assault-related mortalities in BC demonstrated the following trends:

- Males presented higher assault-related deaths when compared to females at a ratio of 3:1 with assault-related deaths peaking among those aged 20-24 years.
- Between 1990 and 2003, assault-related mortality rates in BC declined among both males and females, which is consistent with national declines in assault-related mortality rates attributed to demographic, social and economic factors.
- The leading method of injury for assault-related deaths among males was firearms and explosives (37 percent), predominantly among males aged 15-64 years. Among females, cutting and stabbing (27 percent) was the leading cause among females aged 15-75+ years.
- Assault related deaths occurred primarily at home (53 percent), suggesting that domestic or intimate partner violence should be evaluated as a potential precipitating factor for assault-related deaths.

Assault-related hospital separations in BC demonstrated the following trends:

- Males accounted for a higher number of assault-related hospital separations when compared to females at an approximately 5:1 ratio, peaking among males aged 15-24 and declining among males aged 25-69 years.
- Between 1990-2003, there was a similar pattern of decline for assault-related hospital separation rates among both males and females in BC.
- The leading cause of injury for assault-related hospital separations among both males and females was bodily force (60.7 percent) among persons aged 15-75 years.
- Forty-five percent of assault-related hospital separations occurred in an unspecified place, indicating that additional surveillance may be required to determine the location of injury occurrence.

Core Public Health Functions for BC: Model Core Program Paper **Prevention of Violence, Abuse & Neglect**

To address physical violence and abuse, the BC Ministry of Health commissioned this systematic review to determine how physical violence and abuse injuries may be reduced by utilizing primary prevention initiatives, within a public health model. The review focuses on the strength of evidence supporting which interventions have demonstrated effectiveness in the primary prevention of physical violence and abuse. The results of this review will be used to inform programming and planning for the primary prevention of physical violence and abuse by health authorities in BC.

To ensure that evidence-based practices were ecologically valid, the Spectrum of Injury Prevention Model¹ was used. The Spectrum of Prevention Tool is a multifaceted systems approach to injury prevention targeting the individual, family, community and policymakers.¹ The Spectrum of Prevention Tool consists of six levels of increasing scope, and encourages an overall strategy to injury prevention.

The Spectrum of Prevention Tool

Level of Spectrum	Definition of Level
1. Strengthening individual knowledge and skills	Enhancing an individual's capacity to prevent illness and injury, and to promote safety
2. Promoting Community Education	Reaching groups of people with information and resources to promote health and safety
3. Educating Providers	Informing providers who transmit skills and knowledge to others
4. Fostering Coalitions and Networks	Bringing together groups and individuals for broader goals and greater impact
5. Changing Organizational Practices	Adopting regulations and shaping norms to improve health and safety
6. Influencing Policy and Legislation	Developing strategies to change laws and policies and influence outcomes

Project Objectives

The systematic review of primary prevention of physical violence and abuse was conducted by reviewing formal academic literature and grey-area literature. This combined approach in searching the formal and grey-area literature ensured the capture of best practices in an emerging area where there is likely to be a lack of formal scientific literature. To manage the volume of evidence, primary prevention interventions were divided by the life course period (childhood, adolescent, adulthood and older adult) of the general population.

The objectives of the review were to:

- To identify current evidence-based practices for the primary prevention of physical violence and abuse through a formal literature review and grey-area literature search.
- To assess the scope and quality of interventions for the primary prevention of physical violence and abuse.
- To identify systematic reviews that evaluate the effectiveness of primary prevention interventions of physical violence and abuse.
- To determine which primary prevention interventions are responsible for catalyzing change in community norms to prevent physical violence and abuse.

Determining the Effectiveness of a Primary Prevention Intervention

Effective primary prevention interventions were considered to be: a) those that were evaluated and found to be effective using empirical analyses (or through a systematic review) or b) those strongly supported by expert opinion through formal or non-formal consensus.

The level of evidence was determined by using the Scottish Intercollegiate Guideline Network (SIGN)² taxonomy. Rankings of the evidence were based on the SIGN ratings. Based on the results of evidence appraisals, studies with rigorous methodological design were ranked as strongly supported practices. Studies with moderately rigorous methodological designs were ranked as promising practices. Studies with less rigorous methodological designs or based on expert consensus (either formal or non formal) or individual level expert opinion were ranked as practices requiring further investigation.

Effective Practices for Physical Violence and Abuse Prevention and Relevance to Regional Health Authorities

The following table provides an overview of the primary prevention interventions supported by evidence. Investments in practices classified as strongly supported, good or promising are more likely to yield reductions in physical violence and abuse related injuries. Relevance to health authorities has been summarized.

Summary of Practices and Level of Support

Life Course Period: Childhood	
Home visitation programs administered by professionals (e.g. nurses, trained child care providers) are strongly supported, especially among single parent, impoverished, teenage parents and mothers with mental health risk factors	Strongly Supported Practice
Parent skills training on anger management and developmental expectations for children	Good Practice
Educational training programs to prevent shaken baby syndrome	Promising Practice
Elementary school-based programming activities designed to enforce a non-violent and non-aggressive school climate	
Parental counselling on violence prevention by primary care providers and counselling on reducing the impact of exposure to media violence	Practice Requiring Further Support
Research on the effectiveness of multidisciplinary teams on abuse prevention	
Relevance to Health Authorities: Activities that health authorities could facilitate or lead at the childhood level are focused on parental education including the development of home visitation programs in conjunction with parenting skills training programs, Under this context, educating new parents on developmental expectations and infant care would likely lead to gains in preventing physical violence and abuse in childhood. For example, promoting parental understanding of normal infant crying behaviour and the relationship to the prevention of shaken baby syndrome. Activities for children taking place in the school setting that are likely to be promising are the implementation of strategies to promote mental health and non-violent, non-aggressive school environments.	
Life Course Period: Adolescence	
Interventions targeting parent-adolescent interactions demonstrated effectiveness at decreasing aggression. Active communication strategies among parents would also be effective as a primary prevention strategy	Strongly Supported Practice
Use of intervention materials that are culturally and developmentally sensitive including integration and social inclusion of marginalized youth by educating school and government officials to their needs	Good Practice
A participatory action approach where students engage in developing, implementing, and assessing programs or strategies based on their identification and perspectives on school problems including psychoeducational or social-skills training programming	

Core Public Health Functions for BC: Model Core Program Paper

Prevention of Violence, Abuse & Neglect

Investigation on dating violence and interpersonal relationships curriculum efficacy From the included studies, none were found to lead to significant differences between intervention and control groups	Promising Practice
Programs building teacher efficacy and school counsellor efficacy at administration of primary prevention curriculum	Practice Requiring Further Support
Counselling on primary prevention of physical abuse by primary care providers for adolescents and parents of adolescents	
Firearm restriction strategies (including product orientation approaches) were also recommended for adolescents	
Relevance to Health Authorities: At the adolescent level, health authorities can facilitate or lead programs targeting parents to reduce aggressive communication with adolescents. Health authorities can push for school based prevention programming that is developmentally and culturally sensitive and conducted only with rigorously tested materials and rigorous evaluation. In addition, violence prevention programming materials should address gender assumptions that perpetuate physical violence and abuse of women, and the rise in female to male dating violence.	
Life Course Period: Adulthood	
Empowerment and life skills development for women with concrete tools to modify their social or economic circumstances and enable women to become more independent by building self-esteem and increasing skills and resources	Strongly Supported Practice
Primary care service providers being provided with information regarding the alternatives to screening for domestic violence against women such as the Safety and Health Enhancement Toolkit.	Good Practice
Community capacity building for primary prevention including building bridges to organizations to promote shared resource, creating and nurturing learning communities and coordinate community responses to the prevention of physical abuse and violence	Promising Practice
Inter-agency coordination of uniform policies and procedures demonstrated increased rates of identification and intervention. Development of primary prevention coordinating councils promoting the broad inclusion of participants	
Trans-national and cross cultural agenda in abuse prevention	
Approaches suggesting firearm restriction control and storage practices including physician counselling on the dangers of owning firearms	Practice Requiring Further Support
Relevance to Health Authorities: At the adulthood level, Health authorities could lead or facilitate activities supporting empowerment and life skills for women to prevent violence against women. In addition, capacity building activities designed to enhance the safety of women among health care service providers are also suggested.	
Life Course Period: Older Adult	
Studies of ageism and its contributions to the physical abuse of elderly	Promising Practice
Strengthening collaboration and care-giver support networks including multidisciplinary collaborations	
Strengthening and building informal support networks including family, community gatekeepers, neighbours and peer supports	
Primary prevention approach to physical abuse especially among elderly in long term care facilities Including sensitizing elders to the problem of abuse	
Relevance to Health Authorities: Among the elderly, strengthening multi-disciplinary collaborations and care-giver support networks are among areas where health authorities can engage to prevent elder abuse.	Practice Requiring Further Support

References

- ¹ Cohen L, Swift S. The spectrum of prevention: developing a comprehensive approach to injury prevention. *Injury Prevention*. 1999;5:203-207.
- ² Scottish Intercollegiate Guidelines Network. Available from: <http://www.sign.ac.uk/>.

APPENDIX 3: SUPPLEMENTARY EVIDENCE

This appendix supplements the information in the evidence review entitled *Primary Prevention of Physical Violence and Abuse in British Columbia* (2008), prepared by Joshi, Pllaveshi, Verma and Pike, BC Injury Research and Prevention Unit. The original evidence review was examined by staff from the Ministry of Healthy Living and Sport and the health authorities, and preliminary feedback suggested that the issues of violence against women and child maltreatment prevention, including neglect, exposure to domestic violence, physical abuse, emotional maltreatment and sexual abuse, could be strengthened.

STRATEGIES FOR VIOLENCE PREVENTION

The ministry reviewed other major documents and research to be used as additional supplemental resources regarding strategies for violence prevention. The Women's Healthy Living Secretariat recommends the use of the World Health Organization's (WHO) document entitled *Primary Prevention of Intimate-Partner Violence and Sexual Violence: Background Paper for WHO Expert Meeting, May 2-3, 2007*, as the most comprehensive document and highly useful for supplemental material.

Summary of *Primary Prevention of Intimate-Partner Violence and Sexual Violence*

Population-based studies have proven that the effects of intimate partner and sexual violence critically influence long-term health and well-being of members in society, specifically women and girls. However, population-based studies (such as mortality and hospitalization data) fall short of providing an analysis of the context of the abuse or situation surrounding physical violence. These forms of violence impact physical, mental, reproductive and sexual health and have consequences such as physical injuries, post-traumatic stress disorder, depression, suicide attempts, substance abuse, unwanted pregnancy, gynaecological disorders, sexually transmitted infections, increased HIV/AIDS risk, and others health risks. As a result, a gender-based analysis provides methods to adequately address the complicated nature of intimate partner violence and sexual violence.

Primary Prevention Framework

The WHO document explains that a primary prevention framework is highly beneficial for addressing physical violence in BC. The public health approach to the primary prevention of intimate partner violence and sexual violence is grounded in four stages:

1. Define intimate partner violence and sexual violence and document their scope and magnitude.
2. Identify factors that increase risk of intimate partner violence and sexual violence, or have a protective effect.
3. Design prevention strategies using knowledge of risk and protective factors and grounded in social science theory for modification of those factors. Evaluate the impact of any strategy.
4. Implement proven and promising strategies on a larger scale in various settings and continue to monitor their impact.

Primary Prevention Approaches

The WHO recommends the use of seven broad categories of approaches when addressing intimate-partner violence and sexual violence:

1. Early-childhood and family-based approaches.
2. School-based approaches.
3. Interventions to reduce alcohol and substance misuse.
4. Public information and awareness campaigns.
5. Community-based approaches.
6. Structural and policy approaches:
 - Fostering gender equality and women’s empowerment.
 - Legal reform and strengthening criminal justice responses.
 - Integrating intimate-partner and sexual violence prevention into other program areas.
 - Improving the safety of physical environments.
7. Working with men and boys.

Conclusion

The WHO encourages broader research and strategies for measurable results in addressing violence against women. By critically understanding the health impacts on women, including planning services that are trauma-informed, and working towards violence prevention, communities will see a change in sexual violence and intimate-partner violence. The implementation of evidence-based and evidence-generating approaches will be most successful through a strong gender-based analysis and the use of primary prevention approaches. The other suggested approaches will need further analysis and strategies for policy and practice in order for successful results to be met. In addition, a broader analysis focusing on marginalized populations requires further attention such as Aboriginal populations, Lesbian/Gay/Bisexual/Transgender/Transsexual communities, and immigrant and refugee populations.

PREVENTING CHILD MALTREATMENT AND ABUSE

The ministry reviewed the literature for supplemental best practice evidence regarding strategies for preventing child maltreatment and abuse. The ministry recommends the use of the 2006 publication by the World Health Organization, entitled *Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence*, to supplement the existing violence prevention evidence paper.

Summary of Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence

Child maltreatment causes a broad range of adverse physical and mental health outcomes with costs to both the child and society, over the course of a victim’s life.

To prevent child maltreatment, the following strategies are recommended:

1. Address the underlying causes and risk factors and strengthen protective factors.
2. Link prevention programs with other community programs that reach out to “high-risk” or marginalized groups.
3. Address and reduce poverty and economic inequalities.
4. Provide programs that encourage women to seek proper prenatal and postnatal care.
5. Promote early and secure infant-parent attachment.

The report states that if interventions are “targeted to at-risk individuals and groups, then rigorous criteria and screening procedures to identify those at risk must be developed.”

Strategies

Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence indicates that there is strong evidence that programs focusing on parenting improvement and support are effective in preventing child maltreatment. The WHO report indicates that successful home visitation and parent education programs include the following elements:

1. Focus on families in greater need of services including families with:
 - low-birth-weight and preterm infants;
 - children with chronic illness and disabilities;
 - low-income, unmarried teenage mothers;
 - a history of substance misuse;
2. Begin interventions in pregnancy and continue to at least the second year, or as long as the fifth year, of the child’s life;
3. Be flexible, so that the duration and frequency of visits and the types of services provided can be adjusted to a family’s need and level of risk;
4. Actively promote positive physical and mental health-related behaviours and specific qualities of infant care-giving;
5. Address a range of issues specific to the needs of the family - as opposed to focusing on a single issue;
6. Include measures to reduce stress within the family, by improving the social and physical environments;
7. Use nurses or trained semi-professionals.^{cvi}

The WHO supports the use of parent training programmes to educate parents about child development and to improve parenting skills to manage their children’s behaviour.

Successful training programmes for parents should contain the following elements:

1. Focus on the parents of pre-adolescent children aged 3–12 years.
2. Test parent recall and comprehension of the components of training materials.
3. Include step-by-step teaching of child management skills, where each newly learned skill forms the basis for the next skill.

Additional Evidence on Strategies to Prevent Child Maltreatment

To the degree possible, evidence in support of a particular strategy has been assigned according to the following:

<p><i>Type 1</i> – at least one good systematic review (including at least one randomized controlled trial) <i>Type 2</i> – at least one good randomized controlled trial <i>Type 3</i> – an interventional study without randomization <i>Type 4</i> – an observational study <i>Type 5</i> – expert opinion: influential reports and studies, national guidelines/policies</p>
--

Home Visitation

- “Home visitation programs are of proven effectiveness in preventing child maltreatment. A recent systematic review of mainly American outcome evaluation studies showed, on average, a 40% reduction in child maltreatment by parents and other family members participating in home visitation programs.” (Type 1).^{cvii}
- “Home visitation programs also appeared promising in preventing youth violence.” (Type 1).²
- “On the basis of strong evidence of effectiveness, early childhood home visitation is recommended for prevention of child abuse and neglect in families at risk for maltreatment, including disadvantaged populations and families with low-birth weight infants.” (Type 1).²
- Compared with controls, the median effect size of home visitation programs was a reduction of approximately 40% in child abuse or neglect. (Type 1).²
- Programs delivered by professional visitors (nurses or mental health workers [with either post-high school education or experience in child development]) yielded more beneficial effects than did those delivered by paraprofessionals. Programs delivered by nurses demonstrated a median reduction in child abuse of 48.7%; programs delivered by mental health workers demonstrated a median reduction in child abuse of 44.5%.²
- Evidence from the single study of the effects of home visitation on partner violence indicated that home visitation might not prevent child maltreatment in the presence of ongoing partner violence”.²
- “Home visitation is most likely to succeed when combined with a range of prevention and intervention services in communities, such as high-quality child care.”^{cviii}

Training Programs for Parents

- Parenting support programs and parenting skills programs are both recommended for at risk families by the BC Family Violence Prevention Working Group.^{cix} Recommended programs include Success by Six, Children First, Roots of Empathy, the Family Resources Program, Nurse Family Partnership, FRIENDS for Life program (BC), ASAP

Core Public Health Functions for BC: Model Core Program Paper

Prevention of Violence, Abuse & Neglect

- A School-based Anti-Violence Prevention Program (Ontario), Incredible Years: Parent, Teacher and Child Training Series (US), Promoting Alternative Thinking Strategies (US).
- The Triple P Parenting Program has also been shown as effective.¹

Training Health Care Professionals

- “Health professionals providing direct service to children and families can play several important roles in the prevention of child abuse and neglect. Two primary prevention roles (vs. medical management of the consequences of maltreatment or secondary prevention) for primary-care health-providers are (1) careful assessment of the home environment to identify modifiable and non-modifiable risk factors for maltreatment, and (2) health professionals’ awareness of triggering situations that can contribute to maltreatment incidents, such as crying and toilet-training. In paediatric settings, supplemental services can be delivered by child-development and parent-support specialists.” This is the approach taken by the Healthy Steps for Young Children program, supported in part by the American Academy of Pediatrics. (Type 5).³

Screening for Risk of Child Maltreatment

- A Manitoba provincial program called Families First (previously called BabyFirst) screens all newborns and their families, to identify those babies at greatest risk of being maltreated.^{cx}
- Public Health Nurses in Manitoba interview all families of newborns using Families First screening form. If families score above a threshold on an initial “screening” and a second, more detailed screening, they are then offered a home visitor.^{cx}

References

- ^{cvi} World Health Organization & International Society for Prevention of Child Abuse and Neglect. Preventing child maltreatment: a guide to taking action and generating evidence. Geneva: World Health Organization; 2006. Available from: http://whqlibdoc.who.int/publications/2006/9241594365_eng.pdf. [Accessed 2009 Mar 20].
- ^{cvi} Centers for Disease Control and Prevention. First reports evaluating the effectiveness of strategies for preventing violence: early childhood home visitation. Findings from the Task Force on Community Preventive Services. Morbidity and Mortality Weekly Report. 2003;52, 1-9.
- ^{cvi} Eckenrode J. The prevention of child abuse and neglect. Encyclopedia on Early Childhood Development; 2004. Available from: http://www.child-encyclopedia.com/pages/PDF/Prevention_Maltreatment.pdf. [Accessed 2009 Mar 20].
- ^{cix} BC Family Violence Prevention Working Group. Developing a family violence prevention action plan for BC: a literature review; unpublished.
- ^{cx} Manitoba Centre for Health Policy. Manitoba’s BabyFirst Program: a way to reduce child maltreatment? Winnipeg, MB: Manitoba Centre for Health Policy; 2007. Available from: <http://mchp-appserv.cpe.umanitoba.ca/reference/BFsumm.pdf>. [Accessed 2009 Apr 3].
- ^{cx} Manitoba Centre for Health Policy. Next steps in the provincial evaluation of the BabyFirst Program: measuring early impacts on outcomes associated with child maltreatment. Winnipeg, MB: Manitoba Centre for Health Policy; 2007. Available from: http://mchp-appserv.cpe.umanitoba.ca/reference/BF_web.pdf. [Accessed 2009 Apr 3].

APPENDIX 4: PROGRAM SCHEMATIC – MODEL CORE PROGRAM FOR PREVENTION OF VIOLENCE, ABUSE AND NEGLECT

Goal: To prevent or reduce the incidence of violence, abuse and neglect experienced by children, youth, intimate partners, and older adults across their lifespan.

Components	Activities	Outputs	Short and Intermediate Outcomes	Long-Term Outcomes	Ultimate Outcomes
Leadership and Advocacy	<ul style="list-style-type: none"> • Proactive collaborative planning <ul style="list-style-type: none"> ○ Consult with health partners, schools and communities to identify regional priorities; ○ Establish a joint plan, based on evidence-based strategies for a multi-sectoral violence prevention regional plan. • Advocate for healthy public policies <ul style="list-style-type: none"> ○ Consult with community partners (service agencies, health care organizations, workplaces, etc) to identify priorities ○ Advise and support partners in implementing evidence-based policies that prevent violence • Advise and support all public health programs to integrate strengthened preventive measures, including proactive measures by licensing programs • Lead the development and planning for safe, violence-free health authority workplaces 	<ul style="list-style-type: none"> • Priorities • Evidence-based policies and best practices • Community partnerships • Multi-sectoral plans • Health authority violence prevention plans <p><u>Proposed Indicators:</u></p> <ul style="list-style-type: none"> • Number of violence prevention plans by partner organization. (Settings/Organizations/Governance) • List of public health programs with violence prevention plans (Roles) 	<ul style="list-style-type: none"> • Community priorities identified • Increased community capacity and multi-sectoral prevention strategies implemented • Health-promoting ‘protective’ policies implemented by community partners • Enhanced safety of health authority workplaces <p><u>Proposed Indicators:</u></p> <ul style="list-style-type: none"> • Lists of priorities by community. (Settings/Organizations/Governance) • Lists of “protective” policies by community and partners. (Settings/Organizations/Governance) • Restorative justice • Access to legal services • Region wide response team - aligned with a Regional Aboriginal Mental Health and Addictions Team 	<ul style="list-style-type: none"> • Enhanced community commitment and involvement in prevention of violence • Reduced level of risk and inequities which contribute to violence and abuse <p><u>Proposed Indicators:</u></p> <ul style="list-style-type: none"> • Children in Care (per 1000 pop aged 0 to 18) (Cost/Investment) 	Improved health and wellness for British Columbia
Health Promotion	<ul style="list-style-type: none"> • Create supportive environments <ul style="list-style-type: none"> ○ Collaborate in developing and delivering public education, awareness and social marketing strategies • Strengthen community action <ul style="list-style-type: none"> ○ Work with partners to plan / implement strategies to build knowledge, awareness and programs to decrease risk factors and enhance protective factors ○ Support Aboriginal communities to develop plans / programs • Develop personal skills <ul style="list-style-type: none"> ○ Implement health authority workforce training to enhance capacity to deal with violence and abuse ○ Provide educational resources and training in the recognition and treatment of victims of interpersonal violence 	<ul style="list-style-type: none"> • Public education strategies and materials • Background information • Educational resources and educational training opportunities for health authority staff <p><u>Proposed Indicators:</u></p> <ul style="list-style-type: none"> • Descriptive updates on collaborative activities (Settings/Organizations/Governance) • Cultural Competency training for health care staff responding to Aboriginal family violence - number of trained health care staff. 	<ul style="list-style-type: none"> • Enhanced public awareness and skills associated with healthy interpersonal relationships • Cultural norms shifted to decrease inequities, discrimination, and abusive behaviours • Enhanced expertise of health authority staff <p><u>Proposed Indicators:</u></p> <ul style="list-style-type: none"> • Description of processes in place to enhance expertise of health authority staff: percent completing training. • Access to culturally inclusive education/prevention tools and services/programs 	<ul style="list-style-type: none"> • Reduced incidence and prevalence of violence abuse and neglect in families, schools, workplaces and health care settings • Enhanced community involvement in caring for, supporting and protecting seniors <p><u>Proposed Indicators:</u></p> <ul style="list-style-type: none"> • See list below (in Long Term Outcomes for Early Identification, Prevention & Protection). 	Reduced premature mortality and morbidity Reduced burden on the health care system

Core Public Health Functions for BC: Model Core Program Paper
Prevention of Violence, Abuse & Neglect

Components	Activities	Outputs	Short and Intermediate Outcomes	Long-Term Outcomes	Ultimate Outcomes
Early Identification, Prevention and Promotion	<ul style="list-style-type: none"> • Early Identification and Screening <ul style="list-style-type: none"> ○ Detection of at-risk children and youth through linkages with schools and other partners ○ Work with health care providers and partners to integrate appropriate screening processes for women • Universal Initiatives <ul style="list-style-type: none"> ○ Infants, children and youth: optimal prenatal care, parenting skills training for parents, educational interventions for new fathers, and work with school and community partners to implement proven programs for school-aged child and youth, including social development, physical exercise, dating violence prevention, and academic enrichment programs ○ Adults: collaborate with communities to deliver interventions to strengthen protective factors and community networks (e.g., healthy lifestyles, social connectedness, physical education) ○ Older adults: provide information on their rights, encourage and support local networks, and provide psychosocial educational interventions • Targeted Initiatives <ul style="list-style-type: none"> ○ At-risk infants, children and youth: prenatal and postpartum counselling, parenting training including home visits, and work with local partners to provide preschool enrichment combined with home visits. For school-aged children and youth, promote and support resilience-focused programs, educational incentives, mentorship programs, brief family interventions, etc. ○ At-risk adults: comply with legislative requirements to respond to reports of adult abuse and provide follow-up assistance, support and referral as necessary. Also, work with partners to promote healthy workplaces, empowerment and life skills for women, job skill programs that incorporate social support and coping skills, and family interventions as appropriate. • At-risk older adults: Build or strengthen information support networks for seniors among family members / community gatekeepers / neighbours / peers to enhance support, and provide proactive support and involvement in Community Response Networks 	<ul style="list-style-type: none"> • Parenting education sessions for new mothers and fathers • School-based programs on social and physical development • School-based dating violence prevention • Healthy lifestyle and social connection programs for adults • Educational resources and social networks for seniors Individual parent training by nurses at home for at-risk pregnant women and new mothers • Multi-component home and preschool programs for at-risk children • School districts offering resiliency focused programs for at-risk children • Investigative reports on adult abuse • Healthy workplace strategies • Lifeskills training for women • Job skills and employment support <p><u>Proposed Indicators:</u></p> <ul style="list-style-type: none"> • Presence of healthy public policy related to prevention efforts. (Systems, Settings) • Number of schools with anti-bullying programs. • The percentage of students, 19 years of age and under, attending schools that have adopted an anti-violence/anti-bullying policy. Where data exists, this indicator will also capture the percentage of children in licensed childcare settings with an anti-violence/anti-bullying policy. • The percentage of workers attending workplaces that have adopted an anti-violence/anti-bullying policy. • Number of Community Support Networks in communities to coordinate prevention and response protocols for vulnerable adults. • Regional inventory of Emergency and shelter services for Aboriginal Women/Children • Rehabilitation programs for the batterer • Services for children who witness abuse and/or are victims of violence, sexual abuse. • Access to matrimonial property in situations of family violence (on Reserves) • Prevention/Education programs in schools (on and off Reserve) 	<ul style="list-style-type: none"> • Violence prevention integrated in multiple health programs • Enhanced parenting skills among new parents • Decreased shaken baby syndrome • Enhanced social skills and self-esteem for children • Improved emotional and cognitive development for infants • Enhanced resiliency and self-esteem among children and youth • Healthy adult lifestyles and social functioning • Increased communication and networking with, and among seniors • Reduced social and gender inequities experienced by at-risk children and adults • Increased empowerment for women • Reduced isolation of at-risk seniors • Increased identification of abuse by primary health care providers • Improved recognition and reporting of adult abuse <p><u>Proposed Indicators:</u></p> <ul style="list-style-type: none"> • Descriptions of strategies/policies for identification of abuse by primary health care providers. • Six Year Completion Rate • Feel safe at school all or most of the time (Cost/Investment) • Percent of Children Vulnerable On At Least One EDI Scale (Cost/Investment) • Number of At Risk Adults identified and supported using lesser intrusive measures. • The percentage of children and youth (6-19 years of age) attending schools where suicide prevention programs are in place. 	<ul style="list-style-type: none"> • Strengthened resiliency and self-esteem among children and youth • Improved social skills and positive interpersonal relationships for children and youth, adults and seniors • Improved social and gender equality • Reduced incidence and prevalence of violence abuse and neglect in families, schools, workplaces and health care settings <p><u>Proposed Indicators:</u></p> <ul style="list-style-type: none"> • Child Abuse Rate (per 1000 pop aged 0 to 18) (Cost/Investment) • Physical Abuse Reported by Female Adolescents (per 1000 pop female aged 12 to 18) (Cost/Investment) • Sexual Abuse Reported by Female (per 1000 pop female broken out by age) (Cost/Investment) • Adolescent Binge Drinking 3 + days in past month (Cost/Investment) • Non-Cannabis Drug Offences (per 100,000 Population; Juvenile- per 100,000 12-17) (Cost/Investment) • Admission Rates for Mental Disorders (Cost/Investment) 	<p>Improved health and wellness for British Columbia</p> <p>Reduce premature mortality and morbidity</p> <p>Reduced burden on the health care system</p>

Core Public Health Functions for BC: Model Core Program Paper
Prevention of Violence, Abuse & Neglect

Components	Activities	Outputs	Short and Intermediate Outcomes	Long-Term Outcomes	Ultimate Outcomes
<p>Surveillance, Monitoring and Program Evaluation</p>	<ul style="list-style-type: none"> Gather information on key indicators related to violence, abuse and neglect of children, youth, adults and older people Analyze and interpret data to clarify local and regional trends, major issues, key risk factors, vulnerable groups and populations Report publically on the level of violence, abuse and neglect, and it's related impact; Collaborate with partners in developing an information sharing system Collaborate in developing program evaluation frameworks and evaluation of new initiatives. 	<ul style="list-style-type: none"> Statistical reports and trends analysis Baseline data Evaluation frameworks Program evaluation reports <p><u>Proposed Indicators:</u></p> <ul style="list-style-type: none"> Establish partnerships with appropriate research agencies and organizations to jointly undertake research; Support evaluation studies and monitoring of programming at the local, regional and national levels. Enhance the surveillance capacity of VCH AHSI for the Region. Develop an Aboriginal Health Surveillance Strategy (inclusive of a prevention of violence/abuse/neglect component). Ensure ownership, control, access, and possession (OCAP) principles are respected. 	<ul style="list-style-type: none"> Improved decision-making to enhance program effectiveness 	<p>As above</p> <p><u>Proposed Indicators:</u></p> <ul style="list-style-type: none"> Spousal Assault Rate (offences per 1,000 population) Physical Abuse Reported by Female Adolescents (per 1000 pop female aged 12 to 18) Sexual Abuse Reported by Female Adolescents (per 1000 pop female aged 12 to 18) (Systems) Increased average age of seniors living independently in community Crime rates (violent* crime, sexual offences, adult serious crime) (Systems) Juvenile Serious Crime Rate (Systems) Alcohol-related Mortality SMI (Systems) Alcohol-related PYLLSR (Systems) Illicit Drug Death Rate (Systems) Potential Years of Life Lost Due to Suicide (Systems) Number of adults protected using legislative & legal mechanisms. The cause-specific mortality rate per 100,000 population. Where data exists, rate can be stratified by specific cause, sex, age, socio-economic status and geographic place. 	<p>As above</p>

Core Public Health Functions for BC: Model Core Program Paper
Prevention of Violence, Abuse & Neglect

Components	Activities	Outputs	Short and Intermediate Outcomes	Long-Term Outcomes	Ultimate Outcomes
Surveillance, Monitoring and Program Evaluation (continued)				<ul style="list-style-type: none"> • The number of hospital separations per 100,000 population for all violence and abuse related injuries. Where data exists, rate can be stratified by sex, age, socio-economic status and geographic place. • The average number of days spent in hospital following violence and abuse related injury. Where data exists, stratified by sex, age, socio-economic status and geographic place. • The calculation of the annual direct and indirect costs related to violence and abuse related injury in BC. • The number of inflicted head and brain injuries among children four years of age and under, per 100,000 population. • * Violent- Homicide, attempted murder, sexual and non-sexual assault resulting in bodily harm, robbery and abduction; Property – B&E. 	

Suggested Indicators from Aboriginal Health Strategic Initiatives

- Number of Aboriginal communities with a Plan or Program (Health Promotion).
- Training program for Aboriginal people on preventing and responding to family violence (# of programs and # of participants).
- Number of households that are alcohol and drug free.
- Number of households that are engaged in a healing journey.
- Number of adults of 21 years of age involved in healing and willing to identify themselves with community efforts for change.
- Number of youth involved in healing and change efforts.
- Number and range of healing activities co-organized by community members.
- Degree of support for healing from community leaders.
- Presence of effective public policy and programs aimed at supporting and promoting wellness.
- Degree to which the community’s cultural and spiritual traditions are involved in healing and community development efforts.
- Incidence of family violence in Aboriginal communities.