

## OPHA Violence Prevention Work Group Briefing Note

Date: 08/27/99

To: Member of the OPHA Violence Prevention Work Group

Cc: Violence and Health Research Initiative, Centre for Research in Women's Health

From: Rajwant Mangat, CRWH

Re: Spring 1999, OPHA Violence Prevention Survey

This briefing note has been prepared for the Ontario Public Health Association's Violence Prevention Work Group to bring the work group up to date on the results of the OPHA Violence Prevention Survey, collated and analyzed by the Centre for Research in Women's Health.<sup>1</sup> The survey was prepared and disseminated by mid-February 1999<sup>2</sup> and 97% of the surveys have been returned (35/36 units). Based on these data, the following aspects of violence prevention work are addressed in this note: need for violence prevention work, mandatory guidelines, role of public health, community collaboration, evaluation, youth, policies and more general work in violence prevention, woman abuse, health promotion, and personnel/training resources, along with more general comments provided by the various Public Health Units.

### IDENTIFIED NEED

Approximately 69% of the respondents (24/35) state that their units have identified violence prevention as a need. An analysis of the accompanying comments illustrates that in at least five cases, there is no formal identification of this need. A number of other units state that violence prevention has been identified as a need through community consultation and strategic directions. Apart from two units, that have articulated that their actions were in response to external events, the remaining units cite examples of their work in violence prevention, as indicators of need assessment. This work ranges from education/awareness raising, counselling and referral, to community development. In cases where violence prevention is not articulated as a need per se (in 11/24 units), violence prevention work is integrated into other programs, occurring on an "as-needed" basis.

20% of the units (7/35) state that their Boards of Health have adopted a policy/definition related to violence prevention. Of nine units with further comments, three cite "Employee (Sexual) harassment" and "Violence in the Workplace" policies and five identify more specific goals/guidelines for violence prevention. These comments are,

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<sup>1</sup> Members of the OPHA Violence Prevention Work Group who participated in the development and discussion of the Violence Prevention Survey were: Daina Mueller, Chair (Hamilton-Wentworth); Mary Chipman (University of Toronto); Lynn Gates (Halton); Susan Harrison (Peel); Angela Loconte (Toronto); Donna Lunn (); Josie Paul-Miles (York); Karen Quigley (Waterloo); and Kristine Sisson ().

<sup>2</sup> The staff of the Centre for Research in Women's Health involved in the drafting, carrying out and analysis of the Violence Prevention Survey were: Sandra Rum, MHS candidate (University of Toronto) and a practicum assignment who co-ordinated the survey's development, and data collection, and who subsequently prepared an initial overview; Rajwant Mangat, M.A. candidate (Carleton University) who completed the analysis of survey findings and prepared this summary report; Dr. Marie Boutilier and Dr. Robin Mason, Research Associates, CRWH Violence and Health Research Initiative; and Robin Badgley, Senior Research Scientist.

however, on the whole sufficiently vague to be inclusive of violence prevention work generally, without articulating specific criteria, goals or objectives.

28/35 units responded to the question, "How important is work on prevention of violence compared to other priority issues in your department?" An overwhelming 86% of the respondents (24/28) state that violence prevention is a low priority, most often due to the issue not having been prioritized under the Mandatory Guidelines. As a result, violence prevention has become a "second tier" issue, having to be woven into the Mandatory Programs whenever possible, addressed as a secondary consideration once Mandatory Program Guidelines have been met. Consequently, for some units, violence prevention is "not on the work plan" or not a priority except as a "potential outcome of other supports." A few units state that violence prevention does have some visibility through Healthy Child Development, Parenting Skills Development, Injury Prevention/Safety or Sexual Health Programs.

While a majority of units (69%) state that violence prevention has been identified as a need in their communities, the issue is admittedly a low priority for an equal number of units. This is also reflected by the lack of clear policies/definitions for violence prevention work. Consequently, the prevailing approach is that violence prevention is addressed as a "secondary issue."

## MANDATORY GUIDELINES

In responding to the question specifically referring to Mandatory Guidelines, "Do the Mandatory Guidelines influence your unit's activity in the prevention of violence?" 57% of the units (20/35) answered affirmatively. However, 63% of the units (22/35) believe the Guidelines to be non-supportive in terms of influencing violence prevention work. Of these, 36% (8/22) believe the Guidelines to be completely non-supportive. While 30% of the units (10/35) state that the Guidelines are supportive (with none of the units stating that they are highly supportive), the corresponding comments are lukewarm. The Guidelines are considered in this group of "supportive" respondents to be: "supportive, but limiting"; "somewhat supportive"; "supportive depending on interpretations." The set of "non-supportive" comments state further that violence prevention is: "not specifically addressed, therefore as an issue does not get staffing or resources"; "not identified as a Mandatory Program"; and must be "teased out" and violence prevention initiatives "made to fit the Guidelines."

This negative perception of the Mandatory Guidelines is consistent throughout the survey. As stated earlier, the exclusion of violence prevention in explicit form from the Guidelines is seen as an impediment to prioritizing the issue. Along the same lines, the Guidelines are identified as the number one barrier to public health working in the area of violence prevention. When asked to give suggestions for further collaboration with the community, a majority of units state that a clearer mandate and more direction is needed with respect to violence prevention work. Finally, a majority of units with further general comments cite the inclusion of violence prevention in the Mandatory Guidelines as most useful to support further work in this area.

## ROLE OF PUBLIC HEALTH UNITS

With respect to the question, "What strengths/capacities do public health units have for working in the area of violence prevention?" All 35 units offer responses. The listings have been coded as follows (in descending order): 25 listings for staff (well trained/able to teach/expertise/commitment); 24 for Community Collaboration; 15 for Access to Community and People; 11 for Expertise in Health Promotion/Determinants of Health; 8 for Acceptance by the Community (credibility/respect); 7 for Resources; 4 for Research Abilities; 4 for Prevention Abilities; 4 for Policy Work; 3 for Expertise in Population Health; 3 for Leadership; 2 for Vision; 2 for "Neutrality"; 2 for Holistic Approach; 3 for Work Across Life-span; 1 for Political Power; 1 for Advocacy; 1 for Social Marketing Skills; 1 for Nursing Perspective; and 1 for Intervention.

When asked to comment on barriers faced by Health Units working in the area of violence prevention, all 35 units offered response. The listings have been coded as following (in descending order): 17 for Mandatory Guidelines; 14 for Poor/lack of Funding; 11 for Limited Staff Resources; 7 for Limited Staff Education; 6 for Acceptance by community as Public Health Issue; 4 for Poor/Lack of Research on Effective Outcomes; 3 for No Direct Support (from government); 3 for Isolation of Community/Poor Transportation; 2 for "Vagueness of the Issue"; 1 for Resources; 1 for (Political) Climate; 1 for Lack of Systemic Overview of the Issue; 1 for Concerns re: Female Staff's Personal Reality with Violence; 1 for Concerns re: Few Male Role Models; and 1 for lack of Time (as a resource).

With respect to the appropriate role(s) for public health in the area of violence prevention, the following responses were offered. These listings have been coded as follows (in descending order); 21 for Education/Increase Awareness; 19 for Community collaboration; 12 for Prevention; 9 for Advocacy; 4 for Health Promotion/Peace Promotion; 4 for Program Development; 4 for Research; 3 for Intervention; 2 for Intersectoral Work; 2 for Policy Work; 1 for Leadership; 1 for Vision; 1 for Evaluation Skills, and 1 "Unclear at this time."

From the responses above, it is noted that few units see violence prevention as a lead issue for public health. Leadership, Vision and Intervention are seen as strengths/capacities for public health by very few units. Further, these roles are identified as appropriate for public health by only a few respondents. The Mandatory Guidelines, Lack of Funding and Insufficient Staff Resources are seen as the primary barriers to violence prevention work.

## COMMUNITY COLLABORATION

80% of the units (28/35) state that they have developed partnerships with community groups on violence prevention. Many units identify working relationships with local agencies around specific issues of sexual abuse counselling, elder abuse, child abuse prevention and woman abuse. However, it is difficult to ascertain the exact nature of

this collaboration (i.e., whether it is transitory and ad-hoc, or well-established and regular; and whether it has been a public health lead activity or not). While a majority of units seem to have developed partnerships, only two explicitly state examples of their collaboration that have been initiated and led by public health. Both of these initiatives target teen violence, specifically date rape. The remaining responses are divided between membership on committees and coalitions as partnering activities and activities/programs carried out on behalf of the community cited as evidence of partnership.

82% of the units (29/35) responded when asked, "On what projects does your health unit collaborate with the community?" the breakdown of projects (based on either primary target group or program content) are as follows: 13 units for Youth (education/awareness raising); 11 for Community Development; 9 for Child Abuse; 9 for woman Abuse ("Family" Violence); 8 for Sexual Abuse/Assault; 5 for Elder Abuse/Caregiver Support); 3 for Suicide Prevention; 2 for Gay/Lesbian/Bisexual Youth Support; and 1 for Care for Kids Program.

74% of the units (26/35) state that there are 'violence prevention' coalitions in their communities. Of these 26 units, 21 (80%) have worked with these coalitions. Such collaboration has occurred in the areas of: 5 units for Sexual Abuse/Sexual Health/Sexual Assault; 4 in Violence Prevention (general); 3 in Woman Abuse; 2 in Elder Abuse; 2 in Child Abuse; 1 in Gay/Lesbian/Bisexual Youth Support; and 1 Community Development. Two units answered this question by citing examples of the sorts of sharing activities they engage in with 'violence prevention' coalitions in the communities. The responses are as follows: shared cost of literature and support for development of promotional materials; and the development of a protocol regarding a coordinated community response, program development, resource development, advocacy and political action. The remaining 4 units affirm membership on/commitment to various coalitions and committees.

Just over half of the units, 54% (19/35), provided suggestions for more effective collaboration with community partners. Most prominent among these is a need for more direction (clearer mandate) and resources (both time and staffing) in order to establish and develop entrenched and equal partnering relationships.

While a majority of units have developed partnerships within the community for violence prevention work, the survey indicates that much of this work is not public health-led or initiated. Further, the overwhelming majority of this collaboration occurs with youth populations, through school-based programming and outreach. Most units believe that by having a clearer mandate and more direction for violence prevention work, along with increased resources, collaboration with the community would become more effective.

## EVALUATION

When asked about written goals and objectives for direct activities/programs on violence prevention, only 30% of the units (9/35) answered affirmatively. Of the 6 units

which provided copies of these goals and objectives, the programs ranged from woman abuse, youth (healthy relationships), bullying prevention, violence prevention (general), sexual assault, Care for Kids Program, child abuse, and suicide prevention.

30% of the units (9/35) state that their Health Unit has specific indicators to assess program initiatives. Of these nine, six units offer further information. Only one unit has provided a specific listing of general indicators that may be applicable to assess all program initiatives: effectiveness, efficiency, reach, cost, political support, community need/want, and community partnerships. The remaining units responded with the following: 1 unit provided indicators specific to two youth education projects (assessing knowledge levels of peer educators and targeted youth post-project); 1 unit provided Ministry Indicators for child health; 1 unit offered a listing of media resources and estimated reach; and the remaining two units cited operational plans and policy and coalition work supporting injury prevention initiatives.

The remaining questions in this section address process and outcome evaluation for violence prevention work in a) direct and b) indirect activities/programs on violence prevention. The vast majority of units did not respond to these questions. 5/35 units (14%) responded when asked to describe any evaluation component examining process evaluation for direct activities/programs on violence prevention. Again, only 5 units (14%) responded when asked the same question with respect to indirect activities/programs. 3 units (9%) responded when asked to describe any evaluation component examining outcome evaluation for direct violence prevention activities. 4 units (11%) responded to this question for indirect activities/programs.

The general impression gleaned from these data is that evaluation plays a very minimal role in violence prevention programming, outside of what is provincially mandated. Where units did respond with further information about process or outcome evaluation, their responses reflected traditional volume outcome measures on public exposure – numbers of messages aired, newsletter/pamphlets delivered, articles published, interviews given, calls for resources – or more vaguely "participant feedback."

#### YOUTH:

When asked whether their Health Unit does any specific work in the area of violence prevention in the target population of youth, 71% of the units (23/35) answered in affirmative. The range of responses are as follows: 25 listings for Date Rape/Sexual Health Education; 15 for Bullying/Gang Violence; 14 for Personal Development (self-esteem, anger-management, risky behaviours); 11 for School-Based Programming (education/awareness raising in schools); 10 for Healthy Relationships; 8 for Healthy Babies, Healthy Children; 8 for Community Development/Community Education; 7 for counselling/Referral; 6 for Child Abuse/Child witnessing; 6 for Alcohol and Drug Abuse; 4 for Care for Kids; 4 for Day/Lesbian/Bisexual Youth Support; and 2 for Suicide Prevention.

The composite picture, drawing upon the results of the entire survey, indicates that the majority of violence prevention work is done with the target population of youth. It is in this area, also, that the work is most widely distributed, among specific violence prevention programs/activities to initiatives promoting healthy relationships and personal and community development to indirectly impact upon violence prevention in youth populations. As such, many of the activities listed above serve to create an "enabling environment" in preventing further violence.

## POLICY & ACTIVITIES/PROGRAMS RELATED TO VIOLENCE PREVENTION

Approximately 17% of the units (6/35) state that they have developed policies that are specifically on, or related to, violence prevention in the community. Of these six units, five submitted copies of their policies. Two additional units submitted employee harassment policies, but answered no to the question. Another unit did not respond to the question, but provided a framework for addressing violence prevention. In general, the policies submitted address: procedure for reporting child abuse, safe working conditions for employees, and in four cases, strategies or frameworks for violence prevention work. The nature of the policies in the first two cases (reporting child abuse and employee harassment) is interventionist and curative, making little or no mention of preventive measures. Of the four units that have provided policies for violence prevention in the community, these have tended either to target a particular group of potential victims (in both cases, the elderly), or offered more general frameworks and strategies for violence prevention work (in two cases). The nature of these four policies/strategies is more holistic, with features of both prevention and cure.

In the second part of this question, respondents were asked to list and describe programs focused on preventing violence both directly and indirectly. With respect to direct violence prevention programming, approximately 63% units (22/35) responded by listing their programs. The range of responses is as follows (in descending order): 58 listings for youth initiated/targeted programming; 27 for healthy relationships/dating violence/sexual health; 25 for violence prevention/community development; 22 for bullying/anger management/conflict resolution/gangs/race and violence; 20 for family violence/woman abuse; 15 for sexual harassment/sexual assault/sexual abuse; 12 for child abuse/parenting; 7 for high risk behaviours/alcohol and drug abuse; 7 for 1:1 counseling; 6 for sexual orientation/gay, lesbian and bisexual; 6 for elder abuse/caregiver support; 5 for mental health (self-image)/suicide; 4 for Healthy Babies, Healthy Children; 4 for Care for Kids; 2 for Train the Trainer; and 1 for violence in the media.

The results for indirect violence prevention activities and programs are as follows (in descending order): 18 for mental health (self image/suicide); 17 for community development (food security, homelessness, poverty among others); 16 for listings for parenting programs/courses; 14 for Youth initiated/targeted; 14 for high risk behaviours/alcohol and drug abuse; 14 for sexual harassment/assault/abuse; 11 for healthy relationships/dating violence/sexual health; 9 for bullying/anger management/gangs; 7 for Healthy Babies, healthy Children; 5 for elder abuse/caregiver

support; 5 for child abuse/protection; 4 for Care for Kids; 3 for 1.1 counseling; 2 for crisis intervention; and 1 for sexual orientation/gay, lesbian and bisexual.

Sections three and four of this question ask as to whether violence prevention activities/programs are shared with other health units and/or the community at large and how. Approximately 29% of the units (10/35) state that they share violence prevention initiatives with other public health units through the following means: 3 listings for informal networks; 3 for formal networks; 2 for shared resources; 2 for documents made public; 2 for conferences/teleconferences/workshops/meetings; 2 for newsletters; 1 apiece for operational plans; provincial initiatives; television programming; videos and journal articles. With respect to sharing such initiatives with the larger community, 57% of the units (20/35) responded. The range of responses is as follows: 9 listings for media (displays, newsletters, television, videos, newspapers, pamphlets, etc.); 6 for "community collaboration"; 6 for conferences, meetings, committees, workshops; 5 for teaching/public education sessions; 4 for integrated partnerships; 4 for networking/disseminating information at the community level; 3 for direct service component; 3 for school boards; 2 for inter-agency planning; 1 for dissemination of strategy documents; and 1 for ongoing implementation of established programs.

The results of general violence prevention programming, both direct and indirect, highlight the overwhelming preference for targeting youth populations. A vast proportion of responses not slotted directly into the youth category (such as high-risk behaviours, healthy relationships, and anger resolution) also target youth. Category (such as high-risk behaviours, healthy relationships, and anger resolution) also target youth. It is interesting to note the diversity of "direct" and "indirect" activities in violence prevention, as many of these are embedded in a broader social context. Clearly the social context of the community (i.e. levels of poverty, rate of homelessness, etc.) is seen to be an influence in the prevention of violence. Violence prevention activities are only marginally shared with other healthy units, mostly on an ad-hoc basis. Similarly, just over half of the respondents offered methods for sharing these activities with the community, while from the section on community collaboration, it is shown that 80% of the units have developed partnerships with community groups. It seems from the data, then, that public health units, on the whole, have not formalized methods for sharing information with other units, or within their communities.

#### WOMAN ABUSE:

When asked whether their health units did any specific work in the area of woman abuse, approximately 46% of the units (16/35) responded in the affirmative. 3 units left this question unanswered. Of the 16 units which answered yes to the first question, 7 went on to provide their unit's definition of woman abuse. These responses fall into the following categories: 6 definitions included listings of types of abuse experienced by women (i.e. during pregnancy, physical, verbal, emotional, etc.), 2 definitions spoke to the issue of "power and control" in violence against women, and 1 definition stated that woman abuse is intentional violence. The third section of this question asked respondents to describe their work in the area of woman abuse. Of the 35 units

responding to the survey, 19 (52%) responded to this question, with a response rate of 93% from those units which identified themselves as doing work in the area of woman abuse. Additionally, a few units which did not identify themselves as doing work in this area provided responses to this question. Work in woman abuse is done through the following strategies: community development (identified by 10 units); education/awareness raising (8 units); counselling/assessment (5 units); advocacy (1 unit); and social supports (1 unit). The remaining units provided examples of the areas/issues covered by programming in woman abuse: family violence (3 listings); anger management (2 listings); drug-related rape (1 listing); sexual assault (1 listing); high risk behaviours (1 listing); caregiver support (1 listing); extension of mandated programs (1 listing); parenting (1 listing); and life skills development (1 listing).

The results of the survey indicate that just below half of the respondents cite specific programs for work in the area of woman abuse. Further, only 20% of these state that their health unit has a definition of woman abuse. Descriptions of work in the area of woman abuse fall into two categories: strategies and issue-areas covered. The greatest number of units state that their work in woman abuse is done through community development, education/awareness raising and counselling/assessment. For units responding with issue-areas, family violence (spousal abuse) is the greatest priority. Advocacy is again shown to be a low priority, and the role of public health as a whole with respect to woman abuse is not one of leadership.

## HEALTH PROMOTION

Approximately 51% of the units (18/35) responded to the question, "What health promotion strategies are you using in your violence prevention activities/programs?" This question was applicable to another 11 units who left it unanswered. The following health promotion strategies were identified by the respondents (in descending order): Education/Awareness Raising (17 units); Community Development (8 units); Communication (5 units); Policy (5 units); Social Supports (5 units); Counseling (5 units); Advocacy (2 units); Safety and Violence Prevention /Consultation (1 unit); Environmental Supports (1 unit).

94% (all but one of 18 respondents) identified education/awareness raising as a health promotion strategy for violence prevention work. Almost half (44% identified community development) and just over one-quarter (28%) of the respondents identified both communication and policy as strategies. Only 11% of the respondents (2/18) identified advocacy as a strategy for health promotion in violence prevention work.

## PERSONNEL AND TRAINING RESOURCES

In the first question of this section, respondents were asked to identify the numbers of staff working in the health unit. 86% of the units (30/35) responded and responses have been sub-divided into three categories: 8 units with 0-50 employees: 11 units with 51-100; and 11 units with 101+. Units were then asked to state whether their staff has received any training/education on the issue of violence prevention? 28/35 units

(80%) responded affirmatively. 54% (19/35 units) identified how many staff were involved with such training. Less than 50% of staff for the majority of these 19 units have undergone training/education on the issue of violence prevention.

27/35 units (77%) responded when asked to describe what type of training/education in violence prevention staff have received. These responses have been tabulated as identifying either form/structure of training or content/subject of training. Many responses fall into both categories. With respect to form/structure of training, the responses are as follows: 12 listings for workshop; 6 for inservice; 4 for conference; 2 for Train the Trainer; 2 for seminar; 2 for formal education session; 1 for peer consultation; 1 for police updates; and 1 for referral. With respect to content/subject of training the results are: 8 listings for child abuse; 4 for sexual assault/abuse; 2 for dealing with difficult people; 2 for gender role issues/consent; 2 for Care for Kids; 2 for orientation of staff (general); 1 for conflict resolution; 1 for counselling, 1 for crisis intervention; 1 for family violence/woman abuse; 1 for strategizing different violence prevention issues; 1 for homophobia; and 1 for personal development.

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When asked to identify training needs in the area of violence prevention, 66% of the units (23/35) replied. Responses have been broadly grouped into training needs based on approach to training and training needs based on content of training although there is some overlap. With respect to approach to training, the following has been suggested: 7 listings for general education/awareness of issue; 6 for consistent approach to the issue; 2 for policy development; 3 for full training; 3 for more sharing with other health professionals/helping staff; and 1 for evaluation methods. With respect to content of training, the following has been suggested: 5 listings for cultural sensitivity; 3 for increased attention to spousal abuse/woman abuse and elder abuse; 2 for current information; 2 dynamics of violence/prevention; 2 for intervention; and 1 for violence to boys and men not related to sexual health.

The remaining two sections of this question ask about staff mandated to work directly on violence prevention, and staff hours directly related to violence prevention respectively. 30/35 units (86%) responded to the former question. Over half the respondents, 57% (17/30), state that they have zero staff mandated to work directly on

violence prevention. Another 4 units have minimal staff resources mandated for violence prevention. Among the remaining 7 units, the responses range from 10 to 16 staff members. 21/35 (60%) units responded to the latter question. 57% (12/21) of the respondents state that they have either zero or very minimal staff hours directly related to violence prevention. The remaining 9 units have a wide range of staff hours directly related to violence prevention, from 96 to 2 994 hours/year.

The results of these data point to deficiencies in violence prevention training. The percentage of staff and hours mandated for direct violence prevention work is minimal or non-existent given the high proportion of health units which have identified this as a need. Staff training is shown to be inconsistent across regions as well as within units. The lack in current training is seen in the training needs identified by health units. They want training which provides a greater awareness of the issue and a consistent approach.

## COMMENTS AND ISSUES FOR OPHA WORK GROUP

Respondents were given an opportunity at the end of the questionnaire to make comments about issues not covered in the survey and other useful initiatives that might be taken up by the OPHA Violence Prevention Work Group. 12 units responded with further comments. These fall into four categories. 7/12 respondents to this question (58%) cite inclusion of the issue in the Mandatory Guidelines as being most useful to support further violence prevention work in their Health Units. 3/12 respondents believe that the OPHA Work Group should play a stronger role in advocating for violence prevention to be included as such in the Mandatory Guidelines. Three units believe that more research needs to be done and current research needs to be better disseminated to support the need for violence prevention programming in terms of establishing "best practices", promoting non-violent behaviour, and policy development. Two units offered suggestions directly relating to youth. One unit would like to see youth representation on the Work Group, while another unit believes there ought to be a programming bias in favour of looking at child and youth resiliency to violence. One unit believes that there needs to be a gender-balance in violence prevention work.

The survey comments specifically highlight the need to make changes to the Mandatory Guidelines to be inclusive of violence prevention work in explicit form. It is believed that the OPHA Work Group should be a strong advocate for such change.