Taking the Next Step to Stop Woman Abuse: From Violence Prevention to Individual, Family, Community and Societal Health

A Practical Vision of Collaboration and Change

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Health Canada

Prepared by:Linda MacLeod and Dianne Kinnon

Linda MacLeod and Associates

150 Carleton Street

Ottawa, Ontario

KIM 0G7

For the: Family Violence Prevention Division

Health Canada

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For further information on family violence issues, please contact:

National Clearinghouse on Family Violence

Health Promotion and Programs Branch Health Canada Address Location: #0201Al Ottawa, Canada K1A 1B4 (613) 957-2938

Fax: (613) 941-8930 Fax Link: (613) 941-7285 or toll-free: 1-888-267-1233 or call toll-free: **1-800-267-1291**

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Executive Summary

Introduction

The need to find effective, appropriate and inexpensive ways to respond to woman abuse has never been greater. While the concern and commitment of people across Canada to stop violence against women has been a powerful force for almost 20 years, the growth in unemployment and poverty in the 1990s, coupled with reductions in health, social and legal services, have increased both the threat of escalating violence and the pressure to improve and expand the ways governments and communities respond. Policymakers, community workers and individuals are all searching for ways to make better use of existing services, resources and knowledge. They are looking for ways to respond effectively without creating new programs and without depending on diminishing government funding. People concerned about stopping the violence want reassurance that it will be possible to sustain these efforts without the same level of government support. People are looking for tools and information to achieve this goal. And people are looking for a vision of change that reflects the reality of individual's lives, that uses existing knowledge and that builds on the strengths and diversity of the many different communities across Canada.

Overview of Findings

This report suggests that recognition of violence as a health issue, as well as the central involvement and contribution of the health sector, is critical to bringing about this change. The authors provide evidence that women who are abused turn to health services for help more often than to any

other type of service. They cite studies which show that women want services that can respond to their full range of needs, not just those directly related to abuse. Perhaps most importantly, women who are abused do not want services that emphasize only the pain and suffering they have experienced. They want a positive vision to help them build toward a healthy life where violence cannot thrive.

Through a brief historical overview, the authors suggest that this quest for a positive, health-centred

vision is mirrored in the evolution of responses to woman abuse across Canada, from primary emphasis on treatment and intervention in the 1970s and early 1980s, to a stronger prevention focus in the late 1980s and early 1990s and, finally, to a health promotion emphasis in recent years. But has this evolution resulted in knowledge and tools to enable Canada as a society to respond effectively to the needs of women who are abused, even in a time of government restraint? How can a health promotion perspective help guide future action?

Review of Projects Funded under the Family Violence initiative

To address some of the present paradoxes in response to woman abuse, 30 projects funded by Health Canada in the most recent federal government Family Violence Initiative were analyzed using a Population Health Promotion Model, developed by Health Canada, to explore what learnings and tools are available to meet the current challenges.

Many projects analyzed allude to income, employment, class and other social status issues as root factors encouraging and perpetuating woman abuse. Nine major categories of health determinants were used in the analysis: income and social status; social support systems; education; employment and working conditions; physical environments; biology and genetics; personal health practices and coping skills; healthy child development; and health services.

Chronology of Canadian Responses to Woman Abuse

Stages	Characterized by
Disempowering Treatment Approaches and Women Helping Women in the Community (Mainly before 1980)	• Emphasis on treatment of violence as an individual aberration • Little public or professional awareness of the issue and its magnitude
Safety First, Then Education... the Importance of Crisis Intervention and the Beginning of Prevention through Public Education	• Crisis intervention • Emphasis on safety of individual women and on physical and sexual violence • Greater awareness of the extent of abuse; grass-roots activists begin to speak of the structural roots of violence
Challenging the Accepted Responses through Collaboration and Communication about Diverse Needs (1987-1994)	• Growing emphasis on prevention • Greater mainstream involvement in the issue, and recognition of the needs of diverse communities that may not be served in existing services • Issue of woman abuse accepted as a legitimate and important social issue

A Time of Paradox: Healing or Risk Assessment? (1995...)	• Impatience for solutions and for predictability of risk • Growing concern about how to bring about structural change to address violence • A quest for new directions and deeper analysis based on a positive vision of health and healing and moving toward a violence-free society

Approaches and Activities

- Professionals treat symptoms of abuse in the context of "family problems" or a woman's mental illness.
- Knowledge of the realities of abuse and its effects is very limited.
- The issue is cloaked in silence and disbelief.
- Survivors of abuse, their family and friends, and women's advocates begin to mobilize.

- The first major national report on woman abuse is released by the Canadian Advisory Committee on the Status of Women.
- Shelters for battered women and their children begin to open and, by 1986, there are more than 400 in operation.
- Federal, provincial and territorial governments and service agencies begin to respond to woman abuse with justice -oriented policies, legislative change, changes in policies and procedures, and education and awareness.
- The National Clearinghouse on Family Violence and the first Family Violence Initiative are established.

- Mass media coverage of the Montreal massacre of 14 young women, supported by an increasingly well -articulated feminist analysis, brings out the importance of looking beyond the individual victims and perpetrators for the causes of violence.
- There is a greater involvement of the health sector to improve awareness and understanding and to make health services and interventions more sensitive and appropriate.
- Prevention of women abuse begins to be built into more health programs and services and initiatives become more coordinated and integrated.
- The federal government announces an expanded and renewed Family Violence Initiative, in which violence against women is a priority concern. This initiative provides support for numerous projects and programs, and contributes to a great leap forward in knowledge.
- Provincial, territorial and local governments also are active in the areas of crisis services, treatment, prevention and public education.

- A time of paradox and consolidation of knowledge: There is impatience for solutions and predictability of risk, as well as a greater understanding of the complexity of the issue and the need to delve into new areas of inquiry.
- There are heightened expectations for action in a time of fiscal restraint and cutbacks.
- There is a desire for more harmonious living and individual, family, community and societal health in a time of great stress and uncertainty.
- There is a desire for continued government involvement in the issue, as well as a need for solutions that are not dependent on government support.

A common theme in many of the projects funded by Health Canada is the constellation of challenges that women who are abused face. This constellation often revolves around poverty and unemployment, but is compounded for many women by histories of child abuse, low self-esteem and health problems caused by the abuse. Clearly, the **low incomes and low social status** of women make them more vulnerable to abuse and, in turn, acts as a barrier to escape.

Front-line workers have always emphasized the importance of ensuring that women have information to help them know that the violence, threats and/or put-downs they are experiencing are in fact abuse, to help them understand their rights and to assist them in finding help. The projects funded by Health Canada reiterate the necessity of good **public education** as a tool for women who are abused, for their children and for their abusive partners. They also stress the importance of public education as a way to communicate values of equality and respect. The projects assert that value and attitude change is essential to reduce violent behaviour and to create healthier families and communities. The additional learnings summarized below provide information about the most effective approaches to public education.

The importance of informal as well as **formal social support networks** to reduce the isolation that contributes to violence was found to be an essential part of creating healthy individuals, families and communities by most project teams. Since many women who are abused do not seek the help of formal services, it is essential to encourage the development of informal peer and friendship networks in the community, instead of relying purely on support groups and outreach from services for women who are abused and their children.

Health Canada funded the first projects to help people see that they could do something to prevent violence and to create **healthier workplaces** and communities in their roles as employers and employees.

Biology and genetics was not dealt with extensively through the projects funded. Several projects explored the links between disability and violence, but no reference was made to genetics for any group and no study explored biological issues for women who are not disabled, for their children or for partners who are abusive.

The projects funded tended to deal with **physical environment** primarily in terms of the ways that geographic isolation and physical barriers contribute to violence by cutting women off from the social supports that they could use to help stop the violence and create a healthier life. Geographic isolation was referred to in all the resources that speak of the situation of rural and isolated women. However, the major reference to physical environments concerned lack of access to buildings and communication for women with disabilities.

Health Canada, through the recent Family Violence Initiative, has broken new ground in areas related to personal **health practices and coping skills** through its work on the links between substance abuse and violence, the overmedication of psychiatrized women, and in work with DAWN Canada on suicide attempts and thoughts about suicide among women who are disabled and who have also been abused.

Health Canada, through projects focused on child abuse funded by the Family Violence Initiative, has supported numerous projects related to **healthy child development.** In addition, the projects supported which concentrated on woman abuse also contribute learnings about healthy child

development as a determinant in violence prevention and individual, family and community health. They substantiate the generational links in violent behaviour and the efforts of women who are abused to make choices which will provide a healthy, non-violent environment for their children.

Improvement to **health services** represents the greatest achievement in addressing health determinants and creating new knowledge. The projects supported by Health Canada provide invaluable information to guide the process of re-creation, reduction and amalgamation currently affecting services across Canada. As the learnings listed below reveal, the knowledge gained includes knowledge about unfair, inequitable, ineffective or violating approaches used by services, as well as knowledge about effective service approaches. Tools include excellent training and evaluation tools to promote the health of services. Model programs are listed in the next major section of this report.

In fact, there is a wealth of resources and learnings available to help Canadians take the next step from a focus on violence prevention to a more positive and holistic vision of individual, family, community, institutional and societal health.

Conclusion

The authors conclude that through the most recent federal government Family Violence Initiative, knowledge about woman abuse and how to respond appropriately, sensitively and effectively has increased dramatically. A significant collection of tools and resources has been created to provide the energy to fuel change. While there is the need for some further research, particularly on genetic and physical determinants as well as the links across different forms of violence, overall there are ample tools and information for individuals, families, community groups, institutions, services and businesses, with governments acting as catalysts primarily through continuing funding, information exchange and policy reform, to take the next step.

Given the magnitude of the problem and work yet to be done, there is a strong need for continued government commitment to this issue. In addition to government involvement, however, many of the projects reviewed support the conclusion that individuals, families and communities can make a difference with more information concerning what they can do in their daily lives to prevent violence and promote health. The projects analyzed reveal that individuals, families and communities can benefit from peer support programs and from the increased involvement of existing health services, churches, schools, businesses and other community services.

Many of the tools which have been created to make these sectors part of the solution require no funding specifically dedicated to woman abuse or very limited special funds, for they require not new programs specifically for women who are abused and their families, but instead a change in attitude, a change in employment, income, health, education and social service policies, a change in the ways service providers work with one another, a change in our ways of living and working together.

This analytical paper suggests that if the promotion and understanding of health, not the absence of violence alone, becomes the overriding goal of people across Canada, this goal can be used to 'provide the foundation for informed public participation in the setting of priorities that will have the most positive effects on the health of all Canadians." (Strategies for Population Health, 1994) As a society, Canada has the tools and the knowledge to build on the past toward this new vision. Now all that is needed is the courage and the will to change.

Introduction: The Growing Importance of Approaching

Violence as a Health Issue

The Challenge of Change

If anything has been constant in attempts across Canada to prevent woman abuse, it has been the challenge of change. The need and desire to bring about change in order to eliminate violence against women has faced individuals, families, communities, institutions and our society as a whole. Many individual women living with the violence of woman abuse, search every day for ways to change themselves, their partners, their lives. Families struggle to change the patterns that perpetuate violence and to create healthy, respectful relationships. Communities living with the personal, social and economic costs created by violence have discovered that to stop the violence, they must embrace changes in attitudes, in values, in the way we treat others, in the ways we see the world. In fact, as a society, the search for an end to woman abuse has been an ongoing "challenge to our ways of living." 1

Never has this challenge seemed so necessary and so urgent. While the concern and commitment of people across Canada to stop the violence has been a powerful force for almost 20 years, the growth in unemployment and poverty, the growth in Canada's cultural and linguistic diversity, and reductions in health, social and legal services in the 1990s have increased both the threat of escalating violence and the pressure to improve and expand the ways governments and communities respond to this violence. Policy makers, community workers and individuals are all searching for ways to make better use of existing services, resources and knowledge. They are looking for ways to respond effectively without creating new programs or depending on diminishing government funding. People working to stop violence against women are also looking for a vision of change that reflects the reality of people's lives and builds on the strengths and diversity of the many different communities across Canada.

Violence as a Critical Health Issue

Recognition of violence as a health issue and the involvement and contribution of the health sector are critical to bringing about this change. Increasingly, at the international, national, provincial /territorial and community levels, violence is being recognized as an individual, community and societal health issue.

The Ottawa Charter for Health Promotion, a pivotal statement for a health promotion approach, highlights peace, and therefore freedom from violence and fear, in the following statement:

> "...the fundamental conditions and resources for health are **peace, shelter, education,** food, stable ecosystems, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic conditions."2

In commenting on these prerequisites of health, Joan Feather, Coordinator of the Prairie Region Health Promotion Research Centre, said:

> "Where people experience violence in their neighbourhoods and in their homes, they lack one of the prerequisites for health. War and social instability, domination and exploitation, can happen anywhere, if we consent to policies that produce those results. The effects are not limited to injury and violent death. Families are disrupted by loss and

> grief; minds and hearts are broken by fear and horror."3

The B.C. Ministry of Health's Health Impact Assessment Guidelines include safety and control over our lives as two of the factors that affect the health of individuals and communities.

1 . Church Council on Justice and Corrections, *The Fire in the Rose: Churches Exploring Abuse and Healing,* a kit funded by Health Canada and the Donner Canadian Foundation, Ottawa, Ontario, 1995.

2. World Health Organization, Health and Welfare Canada and *Ottawa Charter of Health Promotion,* Canadian Public Health Association, Ottawa, Ontario, 1986, p. 1.

3. Feather, Joan, *The Determinants of Health: implications for Social Policy,* Prairie Region Health Promotion Research Centre, University of Saskatchewan, Saskatoon, Saskatchewan, 1995, p. 4.

Growing knowledge of the experiences of women who are abused makes the link between violence and health appear self-evident.

As a recent paper written for the National Clearinghouse on Family Violence asks:

> "Is it conceivable to think that a woman who lives with a partner who on a daily basis criticises her, tells her she is worthless, hits her with little warning or beats her in a blind rage, restricts her access to money and to her friends and may also abuse their children, is 'healthy'? By most of our definitions, a woman cannot enjoy any measure of physical or mental well-being if she lives in a state of terror and uncertainty and suffers repeated physical injuries. "4

The growing emphasis on violence as a health issue has also emerged through recognition of the significant effects of violence on health, through increased knowledge of the extent to which women who are abused use the health system, and through new information about the costs of violence to the health system.

The Effects of Violence on Health

The impact of violence on women's health is increasingly being documented to include:

- physical trauma, including brain and reproductive damage;
- long-term disabilities;
- alcohol and drug dependence, including tobacco use and the use/abuse of prescription drugs;
- depression;
- high-risk and self-destructive behaviours such as promiscuity and slashing;
- suicidal thoughts and attempts;
- other mental health problems;
- low self-esteem leading to weight gain, unhealthy eating and lack of activity;
- eating and sleeping disorders;
- miscarriage;
- low birth weight babies and premature births; and
- lack of mobility and frailty among older women.5

Violence also has less direct but equally significant effects on health, such as:

- impeding girls' and women's ability to learn and interact with others which often influences them to drop out of school resulting in low levels of education;
- creating barriers to employment and difficulties keeping a job;
- contributing to low income through the barriers to employment that violence creates; and
- marginalizing and isolating women through shame and silence which prevent them from drawing on social supports, participating fully in society and reaching their potential.

Women Who Are Abused Are More Likely to Use Health Services Than Any Other Service or Program

Statistics Canada's National Survey on Violence Against Women, funded by Health Canada, revealed that approximately four in ten women injured by a marital partner saw a doctor or a nurse for medical attention.6

By comparison, only eight percent of women abused by their partner contacted a transition house. Only six percent actually stayed at a transition house.7 In addition to going to health professionals for injuries, women who are abused, like all women, also seek out health professionals on a more routine basis for check-ups and general ailments suffered by themselves and/or their children. Tanis Day, in a study on the healthrelated costs of violence, found that women who are abused use health professionals much more than women who have not been abused. She estimates that women who have lived with violence, on average, seek out over six **more** consultations with health professionals over a one-year period than do women who have not been abused.8

4. Hanvey, Louise and Kinnon, Dianne, *The Health Sector's Response to Woman Abuse: A Discussion Paper for the Family Violence Prevention Division,* National Clearinghouse on Family Violence, Ottawa, Ontario, 1993, p. 1.

5.Many of these findings are reported on p. 9, Canadian Public Health Association, *Violence in Society: A Public Health Perspective,* Ottawa, Ontario, 1994.

6. Rodgers, Karen, "Wife Assault: The Findings of a National Survey," *Juristat,* March 1994, 14(9): p. 9.

7. lbid, p. 18.

The Health Costs of Abuse Are Significant

Tanis Day, in the same study cited above, estimates that "The total of the measurable costs related to health and well-being alone amounts to $1,539,650,387 per year." And she adds "This is just the tip of the iceberg." For example, she has not included the costs of hospital admissions in this figure since it is not known what proportion of women injured through abuse were admitted for stays in hospitals.9

The World Bank, in its *World Development Report* of 1993 estimated that "in industrialized countries, rape and domestic violence take away almost one in every five healthy years of life of women aged 15 to 44." They suggested as well that 'On a per capita basis, the health burden of

domestic violence is about the same for reproductive -age women in both developed and developing countries."10

The Purpose and Approach of This Report: Using a Population Health Promotion Model to Take the Next Step

The Purpose of This Report

This report begins by gathering the threads of change, knowledge and experience which connect our efforts to prevent violence and promote social harmony today. By looking at past and present directions, at accomplishments and learnings, the authors have attempted to display an unfinished tapestry of the efforts of people across Canada to prevent woman abuse. The authors have then tried to identify the holes in the tapestry as well as the economic, political and social challenges of the time. The report concludes with practical suggestions for action that can help fill these gaps and join the threads from the past to our future visions and efforts.

Who Is This Report For?

This report was written for policy makers, community leaders and people working at the community level who are concerned about violence and its relation to health. It is intended for anyone looking for a new vision, a new approach which will help us all work together to create healthy ways of living where social harmony, peace, safety and respect will thrive.

How Does This Report Help Clarify our Knowledge?

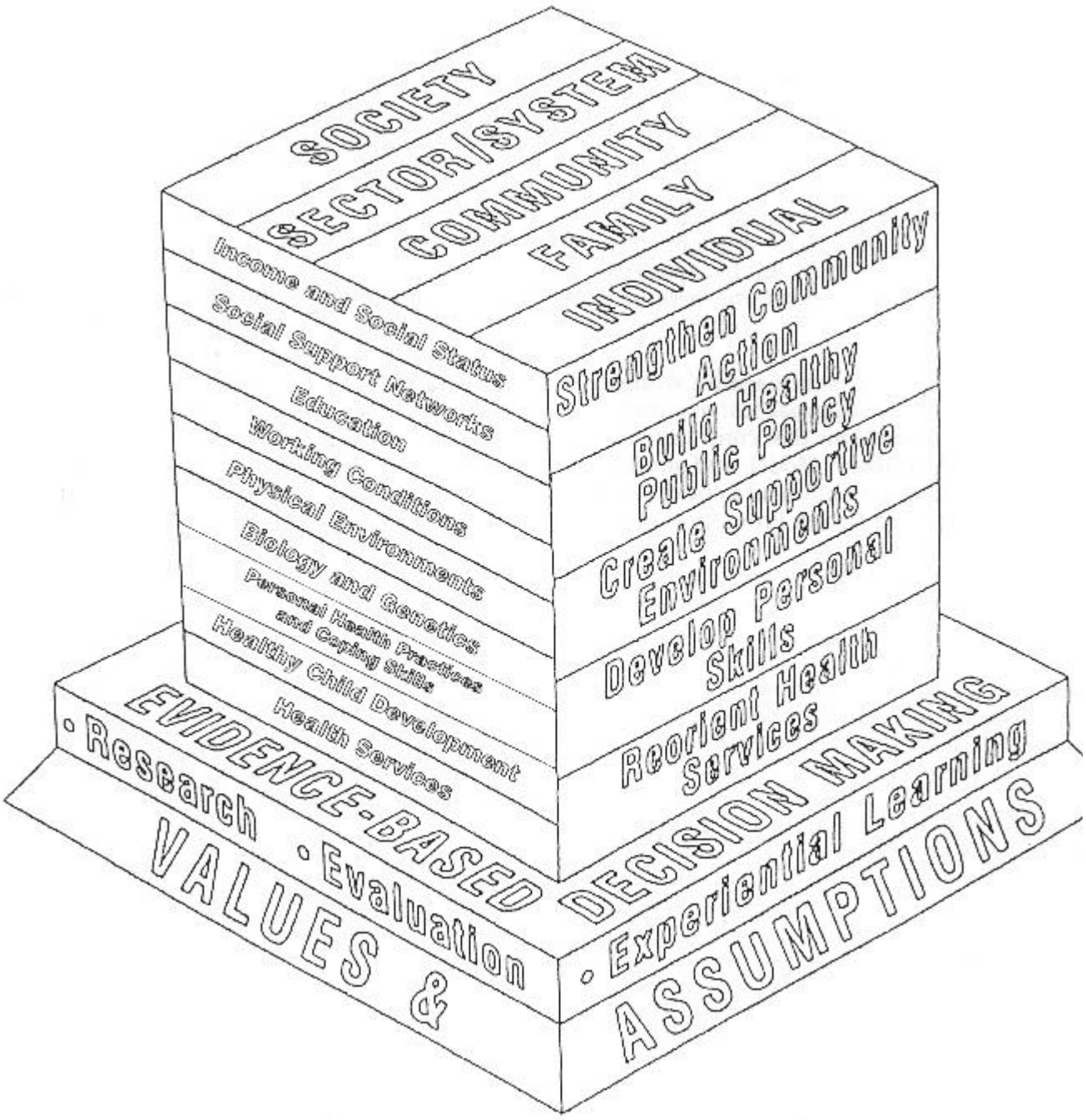
To help individuals, families, communities and society as a whole take the next steps toward a violence-free society, the authors looked for a new way to present and make sense of the many different ideas and learnings that have come out of efforts to stop the violence. Many people feel that, as a society, we have been working for so long to stop the violence, and yet we have barely made a dent in the problem. Could our apparently limited progress be the product of narrow perspective? As a society, are we so entrenched in looking at the problem of preventing woman abuse in one way that we have lost the ability to problem solve effectively?

8. Day, Tanis, *The Health-Related Costs of Violence Against Women in Canada,* Centre for Research on Violence Against Women, London, Ontario, 1995, p. 9. This figure was calculated by comparing the number of consultations with health professionals reported by women who stayed at a shelter for women who have been abused, with the number of consultations with health professionals reported by women who had not been abused but who were matched to the first group in terms of socioeconomic characteristics.

9. p. 18, Day, Tanis, op. cit.

10. United Nations, Focus *on Women, p.* 4, Violence Against Women, Fourth World Conference on Women, 4-15 September 1995, Beijing, China, Action for Equality, Development and Peace.

Population Health Promotion Model



Nancy Hamilton & Tariq Bhatti

Health Promotion Development Division 1996

To challenge current ways of thinking, the authors of this report explored new ways to frame our thinking and present our learnings. After examining many programs and directions emerging from diverse communities across Canada, the authors concluded that one thread connecting more and more efforts to stop the violence might be the key. That key is the desire to move from a negative... violence against women, to a positive... a way of living defined not only by the absence of violence, but by a positive state of individual, family, community, institutional and societal health.

but by a positive state of individual, family, community, institutional and societal health.

This report will examine violence against women within the context of two approaches: one that considers all of the conditions that contribute to health... a Population Health Model, and another that looks at violence prevention as a critical issue for promoting health... a Health Promotion Model.

While some may say that models are often used to confuse an issue, it is the hope of the authors that this approach may help people question the ways we look at violence prevention. Perhaps through this questioning process, we can see the next steps toward healing for individuals, families and communities which make the most sense for them and their communities.

Using a Health Framework to Clarify Needed Change

The health framework chosen adopts the positive definition of health adopted by the World Health Organization, namely that:

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." I I

The framework merges health promotion strategies with knowledge of health determinants into a dynamic model known as the "Population Health Promotion Model" developed by

Nancy Hamilton and Tariq Bhatti for the Health Promotion Development Division of Health Canada. A schema of this model, reproduced from a recent paper, appears on page 13.12

The Population Health Promotion Model has some useful applications to violence against women. Like the holistic, ecological and feminist approaches now commonly used to explain violence, Population Health proposes that a number of interconnected factors, operating at the individual, community and societal levels, contribute to violence against women.

A Population Health framework 13 states that the following groups of factors contribute to health (and, we propose, to the elimination of violence, which in turn is a prerequisite to health):

- income and social status;
- social support networks;
- education;
- employment and working conditions;
- physical environments;
- biology and genetic endowment;
- personal health practices and coping skills;
- healthy child development; and
- healthy services.

This model was chosen because it embraces a number of principles of change which have characterized much of the past work on woman abuse and most of the current work on violence prevention. These principles are listed and briefly discussed beginning on the page immediately after presentation of the overall schema.

11. World Health Organization. *Ottawa Charter for Health Promotion*. Copenhagen. World Health

11. World Health Organization, *Ottawa Charter for Health Promotion*, Copenhagen, World Health Organization Regional Office for Europe, 1986.

12. Hamilton, Nancy and Bhatti, Tariq, *Population Health Promotion: An Integrated Model of Population Health and Health Promotion*, Health Promotion Development Division, Health Canada, Ottawa, Ontario, 1996.

13. Federal, Provincial and Territorial Advisory Committee on Population Health, *Strategies for Population Health: Investing in the Health of Canadians*, prepared for the Meeting of the Ministers of Health, 14 September 1994, Minister of Supply and Services Canada, Ottawa, Ontario, 1994.

Principles of Change implicit in a Population Health Promotion Framework

1 **. Change must occur on many dimensions**

This model is built on the premise that change must not be focused only on individuals or families or communities, but must involve individuals, families, communities, systems (such as the health, social service, educational or justice system or sectors such as government and voluntary sectors) and the society as a whole.

2. **Prevention must include systemic change** This model explores health determinants that look at major systems in our society, including service systems, income and status systems, social support systems, education and employment systems, and family systems. The action dimensions it embraces for health promotion include policy, service and community change, not just individual change. As such, it responds centrally to the concern expressed by many groups that systemic change must be addressed if violence against women is to be reduced.

3. **Change must address the many factors that contribute to the risk and perpetuation of violence against women and are woven throughout our society** This model, in its grouping of health determinants, recognizes the importance of both internal and external factors in health and in freedom from violence. As the analysis of existing knowledge which follows will reveal, the absence of these health factors contributes to violence against women: power differentials resulting from gender, income and status inequities; lack of social support networks; inadequate or incomplete information about equality rights, violence-free living, protection or prevention; non-supportive working environments; isolation; alcohol and drug dependency and/or overmedication; witnessing abuse as a child; and services that respond in ways that disempower women.

4. **Prevention Approaches Must Be Cross-Culturally Relevant** Because the health promotion perspective is well accepted across Canada and internationally, it provides a source of unity from which to build creative solutions. In Canada, it is a perspective that extends across cultures. The Aboriginal vision of violence prevention has always emphasized a holistic healing model. While immigrant and refugee women and other women from minority cultures may not express the need for a health model as overtly, many women from other cultures are distrustful of a legalistic approach to violence prevention and express their need for a more community-based and culturally relevant approach to prevention. The approach they prefer is consistent with a population health promotion model. 14

5. **Community-based Perspectives Are Often Most Effective in Violence Prevention**

A perspective which values community-based approaches is essential in these times when fiscal and program responsibility is devolving to the local level. Such an approach also builds on Canada's diversity, as noted in the previous point.

6. **Effective Prevention Depends on Multifaceted Solutions**

Anecdotal evidence collected by the authors for this report reveals a growing frustration among people working to prevent violence with current approaches, and particularly with ‚single-issue" approaches. They point out that single-issue services focused *only* on woman abuse or *only* on substance abuse can make people feel like failures because the expecta tions and goals that service providers attach to the single issue cannot be met without ignoring or even increasing other problems. For example, teaching a person who is abusive to recognize the emotional, physical and situational cues that trigger violence and to develop a plan to take responsibility at these times will be ineffective for a person who abuses drugs or alcohol and who is abusive primarily when high or intoxicated.

14. For an example of this perspective, see MacLeod, Linda and Shin, Maria, *Like a Wingless* Bird.... Department of Canadian Heritage, Ottawa, Ontario, 1993.

7. **True Change Reaches for a New Vision, Not the Absence of an Old Problem** Finally, this model explores how health is created, not how disease is prevented. Similarly, as a society we are at a turning point, attempting to move from how to prevent violence toward a vision of healthy communities in which there are real alternatives to violence, and healthier ways of interacting so that violence will not thrive.

It is the hope of the authors that by reframing our knowledge within this model, the keys to creating a positive vision of healthy individuals, families and communities will emerge.

Source of the Knowledge and Achievements Highlighted in This Report

So much has been done to help reduce the impact and incidence of woman abuse over the past 20 years in Canada that it is daunting, if not almost impossible, to synthesize these achievements in a short and digestible form. To acknowledge this work within a manageable number of pages, the authors have attempted to provide an overview of knowledge, accomplishments and directions up to 1991 through a brief history presented in the next section.

To highlight knowledge from recent and current initiatives and to identify directions for future work, the authors have focused primarily on a sample of the projects funded by Health Canada, the department which led the most recent federal government initiative on family violence, as well as the former initiative spanning the years from 1988 to 1991. A brief summary of each of these projects, summarized from a health perspective, is included as Appendix I to this report.

Why Were These Particular Projects Chosen for Special Emphasis?

Health Canada has sponsored more projects on woman abuse than any other organization across Canada over the past decade. Accordingly, the full range of projects funded by Health Canada reflects a rich collection of many recent learnings and accomplishments. The projects chosen from the 96 on the issue of violence against women that were funded over the past five years were selected by Health Canada employees as strong examples of the many types of projects funded. They also represent the different regions of Canada, and reflect the emphasis of Health Canada in this current initiative on

different regions of Canada, and reflect the emphasis of Health Canada in this current initiative on various groups of women at high risk of victimization through woman abuse.

Even though only 30 projects are highlighted in this report, the authors have attempted as well to refer to some examples of the work that has grown through voluntary community efforts, through provincial/ territorial government or municipal government support and at the international level. The authors encourage readers to use their knowledge of additional initiatives to reflect on the conclusions and recommendations made in this report. It is only by tracing how the many ways of intervening and preventing the violence are woven together that we can create a collaborative vision fashioned from shared wisdom.

A Brief Summary of the Past: A Journey from Crisis Intervention to Health

In order to change paths, it is important to understand where previous paths have led. The challenge to prevent woman abuse has taken individuals, families, communities and governments within Canada on a difficult but enlightening journey. This journey cannot be reduced to one simple pattern or to a one dimensional line of progress since all elements of the journey are found to some extent at each stage of that journey.

A Shift in Emphasis from Crisis Intervention to Health Promotion

This journey has also resulted in a shift of emphasis from the individual victim/survivor to a focus on community and social change. Through a brief historical overview, the authors suggest that this quest for a positive, health-centred vision is mirrored in the evolution of responses to woman abuse across Canada from primary emphasis on treatment and intervention in the 1970s and early 1980s, to a stronger prevention focus in the late 1980s and early 1990s and, finally, to a health promotion emphasis in recent years. Please see the chart on page 6 for a summary of this history. A more detailed description can be found in Appendix H.

What Has All This Work and Investment Accomplished?

A Brief Overview of Projects and Initiatives Funded by Health Canada through the Most Recent Family Violence Initiative

This brief over-view presents an overwhelming amount of work, commitment and investment. But now that all this effort, all these resources have been expended, the question begs to be answered: Was it all worth it? What was accomplished? Do individuals, families and communities now have the knowledge and the tools to take the next steps toward health and harmony? Will it be possible to sustain our effort as a society to prevent violence without the same level of government support?

The range of knowledge and resources now available as a result of resources and support provided by Health Canada in this most recent initiative has touched every region and many sectors across Canada. A brief overview of these accomplishments follow.

- In all, 96 projects were funded on the issue of violence against women in this initiative by Health Canada.

- In total, since the 1980s, the federal government has funded more than 1500 projects related to woman abuse.
- The National Clearinghouse on Family Violence has been a major player in terms of increasing public awareness of woman abuse and other forms of violence in the family and in intimate relationships. In just one year (1994-95), the Clearinghouse responded to over 58 000 requests for information, of which 21 percent were requests for information on violence against women.
- The Clearinghouse also assumed a leadership role in developing and implementing a three-year action plan on media and violence. For example, the Clearinghouse supported the

Association of Television Educators of Canada to develop a series for broadcast and use in secondary schools that examines the portrayal of women and violence against women in the media.

- Health Canada, in collaboration with the Social Sciences and Humanities Research Council, established five Research Centres on violence against women and family violence. These Centres are promoting collaboration between the academic community and front-line community workers /advocates to develop strategies for change that are community-centred and based on solid research.
- A policy circle on woman abuse, made up of women who have worked to prevent violence in different ways for many years, was organized as part of a broad approach to evaluation and healthy policy development. This was one of five policy circles organized by Health Canada on different forms of violence in the family.
- Collaboration has been emphasized in the projects funded. This emphasis has gone beyond collaboration at the local level. It has also taken the form of collaborative funding support for projects, across federal government departments and between federal and provincial /territorial governments. Similar collaboration has occurred between the federal government and private foundations. For example, the Canadian Association of Broadcasters' Public Awareness Campaign on violence in society represents the combined efforts of the federal departments of Justice, Solicitor General, Human Resources Development, Defence, Canadian Heritage, Status of Women, the RCMP and Health. The Interdisciplinary Project on Domestic Violence (one of the projects highlighted later in this paper) was jointly funded by the federal departments of Health, Justice, Solicitor General and the Donner Canadian Foundation. The public education program organized through the YWCA and sponsored by Health Canada included partnerships with the Body Shop and Avon Canada.

In the remainder of this section of the report, the impact of these accomplishments will be elaborated. Thirty projects related to violence against women, sponsored by the Family Violence Prevention Division of Health Canada in the most recent federal government initiative on family violence, will be analyzed using a Population Health Promotion framework for their specific contributions to the knowledge and resources needed to take the next step toward health and harmony. A brief summary of each of these projects is included in Appendix I to this report. While the authors, within the constraints of creating a report of readable length, could not include a complete list of all the learnings produced by even the 30 projects analyzed, much less all the learnings gained through all the projects funded by Health Canada and by other federal departments, every attempt has been made to include learnings that will help guide healthy policy development and community change over the years ahead.

What Have We Learned about the Determinants of Health That We Did Not Know Before? What Tools and Resources Have We Gained?

A. **Income and Social Status**

Learnings:

Many projects analyzed allude to income, employment, class and other social status issues as root factors encouraging and perpetuating woman abuse. The projects referred to below have contributed new knowledge about income and social status as determinants of either violence or health.

i) Income and Employment

A common theme in many of the projects funded by Health Canada is the constellation of challenges women who are abused face. This constellation revolves around poverty and unemployment but is compounded for many women by histories of child abuse, low self-esteem and health problems caused by the abuse. Clearly, the low incomes and low social status of women make them more vulnerable to abuse and, in turn, act as a barrier to escape.

- The project Family Violence in Rural, Farm and Remote Canada tells us that farm women believe the three realities that contribute to violence are:

- poor economic conditions;

- long hours of labour on and off the farm, both paid and unpaid; and

- high debt loads and few solutions.

It explains that "one of the reasons women do not leave abusive situations is because of economic security. " 15 This study points out that feelings of economic disempowerment and inequality can fuel inequality in relationships which contribute to violence. Further, the study points out that assets and farm equity are major problems when women leave abusive situations. The women are in danger of losing custody of their farms if they separate from their husbands and many farm women have not only invested years of unpaid labour in the farm, they have also invested personal inheritances.

- The same project revealed that many family farms are facing economic crisis, and that the fear of further destabilizing the farm is a strong motivation for many farm women to stay in abusive situations. "In many cases there is no cash accessible to take the initial step. Fear of poverty without a home is greater than poverty at home."16
- The National Survey on Violence Against Women found that women in families with household incomes below $15,000 were twice as likely as women with higher family incomes to have been physically or sexually assaulted by their spouses. 17
- The evaluation of the Bridges Employability Project reveals that women who have been abused and who have been dependent on government financial assistance "require a longer period of time to attain financial independence than is allowed under the Canada Employment funding guidelines." These guidelines suggest that people who graduate from programs designed to increase employability must attain successful placements within six months of program graduation. This project discovered that women who have been abused and who have been on government assistance can attain financial independence but it will take longer than this, anywhere from six months to three years. Further, this project shows that, if women who have been abused are to achieve "lasting independence from government financial assistance, their

needs must be met through intensive one-to-one support, counselling and follow-up."18

- The profile of the women who used the Bridges program also suggests that women who have been abused, are on government financial assistance and must utilize employability programs are more likely than other women on financial assistance to have a wide range of problems which contribute to their employment difficulties. These women are more likely to:

- have survived childhood abuse;
- be single parents of young children needing child care;
- have less than Grade 12 education;
- have had no previous job-related training;
- have lived away from their parents from a younger age;
- have been employed in the past for a short period of time;
- have an unstable employment history;
- be in poor health; and
- have a current or past substance abuse problem.

The coordinators of this project stress that the full range of problems which create barriers to the employability of women who are abused must be addressed if these women are to become financially independent over the long term.

- The Roeher Institute project on Violence and Disability shows that more disabled, poor, vulnerable women live in rural areas and have low knowledge of rights. This project connects poverty and low social status with limited access to information which could help women take action to stop the violence.
- The DAWN Canada project *Don't Tell Me to Take a Hot Bath* concurs that women with disabilities are more likely to be poor and argues that this fact limits their ability to escape or avoid abuse.

Toward Empathy, the Second Opinion Society project, points out that poverty, economic uncertainty, childhood abuse, woman abuse and responsibility for children are common features in the lives of most psychiatrized women.

15. Canadian Farm Women's Network, *Family Violence in Rural, Farm and Remote Canada,* Fredericton, New Brunswick, 1995, p. 71.

16.lbid, p. 72.

17. Statistics Canada, *Canadian Social Trends,* Autumn 1994 no. 34, p. 4.

18. Feuz, Karen, *The Bridges Project: An Employability Program for Women Abuse Survivors: A Comparative Program Evaluation,* British Columbia, 1995, pp. i-4.

ii) Social Class

- The project undertaken by the National Organization of Immigrant and Visible Minority Women of Canada, *Violence Against Immigrant, Refugee and Racial Minority Women,* emphasizes the influence that class can have on the attitudes, needs and preferences of minority women. For example, the community coordinator in one of the sites in which consultations were organized for this project reported that: "Women from upper class backgrounds, with

were organized for this project reported that "women from upper class backgrounds, with good English capabilities, either deny the existence of the problem or show complete apathy. Women at the grassroots level often lack the English language capability and other means to articulate their needs."19 While the importance of class was not overtly addressed in any of the other projects, it is likely that this relationship exists regardless of ethnicity or race.

iii) Marital Status

- The National Survey on Violence Against Women also found that marital status and length of marriage are factors influencing the risk and severity of violence. The survey revealed that violence may increase following separation. Approximately one fifth of the women who experienced violence by a previous partner reported that the abuse occurred following or during separation, and in 35 percent of these cases, the violence increased in severity at the time of separation.20 Further, young women who are in common-law unions or marriages of two years or less were more likely than others to report that their spouses had abused them in the year before the survey.21

iv) Race, Culture and Language

- Racism, cultural and language barriers are presented as central barriers to positive social status and as factors that exclude people from good jobs and high income in several reports but no new learnings were presented about this relationship in the documents reviewed.

Tools:

1. Building Bridges: A Guide for Setting Up an Employability Project for Women Abuse Survivors in Your Community provides community workers with a tool to help women who have been abused gain employment and thus the economic independence they may need to make decisions to live healthy lives without violence.

B. **Social Support Networks**

The importance of **informal** as well **as formal** social support networks to reduce the isolation that contributes to violence was found to be an essential part of creating healthy individuals, families and communities by most project teams. Since many women who are abused do not seek the help of formal services, it is essential to encourage the development of informal peer and friendship networks in the community, instead of relying purely on support groups and outreach from services for women who are abused and their children.

Learnings:

- An exception to the point made above is psychiatrized women. *Toward Empathy* points out that women who have been labelled, mentally ill" are unlikely to have community and family supports because they have been considered "crazy." Therefore, psychiatrized women must be assisted to develop other forms of social support to reduce their isolation.
- The Mid-Island Tribal Council Family Development project points out the importance of developing and implementing a process which will create broad-based community ownership of a problem so that the community will proactively provide a variety of social support networks throughout the community. They suggested that this can be promoted by involving the community from the outset in the discovery process of identifying the problem and in

the community from the outset in the discovery process of identifying the problem and in designing the program. This project points out as well that community ownership can also be encouraged by rediscovering the past the community has shared.

19. National Organization of Immigrant and Visible Minority Women of Canada, *Violence Against Immigrant, Refugee and Racial Minority Women, Phases II and III,* 1995, p. 11.

20. Rodgers, Karen, Wife Assault: "The Findings of a National Survey," *Juristat,* March 1994, 14(9): p. 12.

21. lbid, p. 5.

- The YWCA public education project, through its working group on rural women, learned that to create an effective project or program team, this team must become a type of support group for its members. This is achieved when there is:

- a shared understanding of what is needed to promote action on violence against women;
- clarity of group parameters and operating principles;
- clear terms of reference and a set of guiding principles about inclusion and diversity, as well as a respect for specificity and difference;
- team-building activities in the early meetings;
- clear incentives that make sense to the participants as individuals as well as representatives from their organizations and their communities; and
- staff support and expertise.
- The *Fire in the Rose* project also emphasized the importance of support groups for people working to prevent violence. Each of the six community facilitators was encouraged to build a small network of care locally. In addition, through project meetings and mailouts, the facilitators and project coordinators became a support group for one another.
- The Klinic Study, *Women Who Experienced Woman Abuse and Child Sexual Abuse: Deaf, Hard of Hearing, Deaf-Blind, Late-Deafened and Oral Deaf,* emphasizes that "the isolation of the deaf community from the rest of the society creates a greater dependence upon the husband, the family and the community. A hearing - impaired woman is likely to be even more afraid of threatening this support system than a hearing woman who has more alternatives for establishing a new one."22
- According to the National Survey on Violence Against Women, 22 percent of women assaulted by their spouse never told family or friends, the police, a support agency or anyone else about the abuse they had suffered... Women have a variety of reasons for not telling people about their abuse, including a feeling of shame or embarrassment, being too afraid of their spouse or *not having anyone to turn* to.23

Tools:

1. The *Mid-Island Tribal Council Family Development* report includes a description of how they built community commitment and ownership (pp. 1-6). This description can help other communities develop their own community -building process.
2. The *Fire in the Rose* kit includes a booklet "Getting Started" which includes many ideas for building community and social support.
3. The report *Violence Against Immigrant, Refugee and Racial Minority Women* includes a section on how to build a culturally diverse mutual help group (pp. 16-23).
4. The Goulbourn Peer Support Program provides modules for community building and for the

actual creation of a peer support program.

C. **Education**

Front-line workers have always emphasized the importance of ensuring that women have information to help them know that the violence, threats and/or put-downs they are experiencing is in fact abuse, to help them understand their rights and to assist them in finding help. The projects funded by Health Canada reiterate the necessity of good public education as a tool for women who are abused, for their children and for their abusive partners. They also stress the importance of public education as a way to communicate values of equality and respect. The projects assert that value and attitude change is essential to reduce violent behaviour and to create healthier families and communities. The additional learnings summarized below provide information about the most effective approaches to public education.

22.Weaver, Amethya, *Women Who Experienced Woman Abuse and Child Sexual Abuse: Deaf Hard* of *Hearing, Deaf-Blind, Late-Deafened and Oral Deaf.- A Resource Manual for Service Providers,* Klinic Community Health Centre, Winnipeg, Manitoba, 1995, p. 4.

23.Statistics Canada, op. cit., p. 7.

Learnings:

- Videos and fact sheets are the most flexible tools and the resources used most often by professionals according to the evaluation for the Interdisciplinary Project on Domestic Violence (IPDV).
- The IPDV Project also found that having a facilitator to present a kit increased its impact significantly.
- Tools are only as good as their distribution and use. The evaluation for the IPDV found that distribution through a facilitator will enhance use. The same evaluation also found that lending resources is not a particularly efficient or effective way of maximizing distribution even though it can make a resource available to an organization that could not afford to purchase it. Subsidies or sliding charges for groups depending on their ability to pay could be more effective.
- It also found that community groups and professional organizations need and want practical and very specific information, more skill development material and information on how to deal with difficult situations.
- The Mid-Island Tribal Council Family Development project emphasizes that if a program, community developer or public educator is dealing with a culture in which oral skills are predominant, it may not be advisable to use written education methods, even if the participants are literate.
- The simultaneous use of male and female coaches or facilitators in awareness or training workshops helps model appropriate behaviours from two different perspectives. This is an excellent way of breaking down gender-based stereotypes.
- People with disabilities cite limited education about abuse as a factor in their ability to identify abuse, know their rights or know what to do in the event of harm.24

Tools:

1. The Mountain and Beyond: Collaborative Approaches to Domestic Violence, the kit produced by

the IPDV, provides flexible educational tools for a variety of individuals and groups working to stop violence in the family. The evaluation for the IPDV found that approximately *15 000* people were reached through the kit, and 73 percent of those who used the kit said that they promoted collaboration within their profession as a result of using the kit. One-third formed or became involved in a multidisciplinary group.

2. The *Fire in the Rose* kit includes many educational resources including an "Individual Workbook," a booklet of "Facts and Stories," "Resources for Children and Youth" and another booklet with many innovative ideas for stimulating education and action called "Resources for Education and Action."

3. The *There's No Excuse for Abuse* kit, developed through the YWCA, is a good educational and community action kit designed particularly for rural areas.

4. *Taking Action on Violence in the Lives of Young Women: A Youth Leader's Kit* developed by the YWCA provides educational and action material for awareness sessions organized for young women.

5. *Making Communities Safer for Women* and *Stop Violence Against Women* are two brochures created through the partnership between Avon Canada and the YWCA, made possible through funding and support provided by Health Canada. These brochures were initially handed out by Avon representatives along with their catalogues.

6. Body Shop bookmarks and T-shirts were excellent educational tools distributed very widely through the YWCA project (one million bookmarks were distributed). These educational tools were developed through the partnership between the YWCA and the Body Shop, made possible through funding provided by Health Canada. The first T-shirt had the slogan "In the Name of Love-STOP the Violence Against Women." It sold for *$9.95,* with $2 from each shirt going to a fund to support shelters, women's centres and various programs and services working to end violence against women. Thirty thousand T-shirts were sold by May *1994.* This was the Body Shop's biggest selling T-shirt ever. The second T-shirt used the slogan "You've Got the Power!" Thousands of these were sold as well.

7. The YWCA project also resulted in a kit called *Getting Our Message Out,* which provides ideas to help community groups work with the media and find other ways to raise public awareness.

8. The resource, *Violence Against Immigrants Refugee and Racial Minority Women,* produced by the National Organization of Immigrant and Visible Minority Women of Canada includes a sheet on systemic oppression through racism and sexism including tactics for power and control. This sheet is an excellent tool to explain how policy decisions and systemic conditions contribute to racism and sexism.

9. The same resource includes an anti-racism training model.

10. The *Goulbourn Peer Support Program Manual* includes a handbook for ongoing training activities.

11. The Bingo Game, produced by the Bay St. George Coalition to End Violence in Newfoundland, is a tool developed especially for women who are low literate and those who are unlikely to access the information they need to change their lives because they are isolated in smaller communities and/or

information they need to change their lives because they are isolated in smaller communities and by the controlling behaviour of their partners.

12. *La violence enfante la violence/Violence Breeds Violence,* produced by La Fédération des Ressources d'Hébergement pour Femmes Violentées et en Difficulté du Québec, includes an effective poster and other public education tools. The kit is available in French and English.

24. The Roeher Institute, Harm's Way, North York, Ontario, 1995, p. 35.

D. **Working Conditions**

Health Canada funded the first projects to help people see that they could do something to prevent violence and to create healthier workplaces and communities in their roles as employers and employees.

Learnings:

- The report, *Wife Abuse: A Workplace Issue,* by the Canadian Council on Social Development showed while women who are abused will, often for years, continue to come to work and get on with the job despite their pain and suffering while their "lowered self-esteem, isolation and self-blame, a result of the violence in their lives, make them particularly vulnerable to other forms of abuse and harassment in the workplace."25
- The same project found that, even though not all women wanted to talk at work about the abuse in their lives, "they all agreed that the workplace had an important role to play in providing a supportive environment and offering them information on the resources available, both at work and in the community, where they could get help."26

Tools:

1. The awareness and training guide, *Wife Abuse: A Workplace Issue,* provides outlines, training notes, handouts and activities for use in the development and facilitation of workplace workshops on woman abuse. it also provides women's stories and ideas for action "which reinforce the urgency and necessity for making workplaces more supportive for abused women."27

2. Handbook 2 of the *Goulbourn Peer Support Program Manual* includes excellent ideas and checklists to improve working conditions. It deals with staffing, decision making, confidentiality issues, decisions around the structure of meetings, etc., which can help make a workplace healthier.

3. The *Fire in the Rose* kit also includes in the "Getting Started" booklet ideas about working together in healthy, affirming, non-violent ways.

E. **Physical Environments**

The projects funded tended to deal with physical environments primarily in terms of the ways that geographic isolation and physical barriers contribute to violence by cutting women off from the social supports that they could use to help stop the violence and create a healthier life. Geographic isolation was referred to in all the resources which speak of the situation of rural and isolated women. However, the major reference to physical environments concerned lack of access to buildings and communication for women with disabilities.

communication for women with disabilities.

Learnings:

The Roeher Institute and the DAWN Canada reports summarized in Appendix I stress that despite advances in physical accessibility in mainstream services, many community-based services are not accessible to all people with disabilities. They point out that accessibility should extend beyond wheelchair accessibility to include TTY/TDD phone lines for people who are deaf or hard of hearing. Changes could also include wider use of personal safety technologies that link people with disabilities electronically to service providers.

- The 1992-93 Statistics Canada Transition Home Survey indicated that 44 percent of shelters across Canada have access for wheelchairs, 16 percent have audiotapes and braille material and 11 percent have telephone devices (TTY/TDD) for people with hearing disabilities.28
- As of March 31, 1995, there were 405 shelters for abused women across Canada. The most frequently cited physical security measures used to ensure the safety of women and children who come to them included intercom systems, alarm systems, steel doors and security fencing.29

25. Denham, Donna and Gillespie, Joan, *Wife Abuse: A Workplace Issue.- A Guide for Change,* Canadian Council on Social Development, Ottawa, Ontario, 1992, *p. 1.*

26. lbid, p. 3.

27. lbid, p. 3.

Tools:

1. The Roeher Institute's book, *Harm's Way,* provides a number of suggestions for improving accessibility of services through change in the physical environment.
2. The *Fire in the Rose* kit emphasizes that congregational involvement should extend to the Property Committee. The kit includes the suggestion that the Property Committee conduct a Safety Audit to help identify physical conditions that could be changed to make the church and its surrounding property more secure.

F. **Biology and Genetics**

This determinant was not dealt with extensively through the projects funded. Several projects explored the links between disability and violence, but no reference was made to genetics for any group and no study explored biological issues for women who are not disabled, for their children or for partners who are abusive.

Learnings:

Women who have lost their hearing as a result of abuse trauma, both physical and psychological trauma, must be treated differently from those who became deaf by other causes (birth, illness, etc.). For these women, deafness may be a reminder of violence and so they may not feel comfortable with the pride that Deaf culture takes in being deaf. Similarly, some deaf community members may feel quite threatened and may not be able to listen to those whose deafness was due to abuse trauma.30

quite threatened and may not be able to listen to those whose deafness was due to abuse trauma.30

The Roeher Institute report, *Harm's Way,* underscores the way disabilities combine with other risk factors to dramatically increase the potential for victimization. Thus, the authors point out that individuals with disabilities from ethnocultural minority groups are more likely than others to be very vulnerable to victimization. They link this vulnerability to:

- not knowing where to get information about human rights or how to make a complaint;

- being reliant on others;
- living in poverty so that they are less able than others to pay for alternative care choices that deliver them from dangerous situations; and
- being seen as less valuable because of their disability.31

The same report speaks of the apprehension of the children of women with psychiatric disabilities since the women had been deemed "unfit" as parents because of stereotypes and attitudes around their disabilities, even when there was no evidence of their lack of fitness as parents.

The National Survey on Violence Against Women revealed that 39 percent of evermarried women with a disability or a disabling health problem reported physical or sexual assault by a partner over the course of their married lives, compared with 27 percent of other women.32

Tools:

1. Women Who Experienced Woman Abuse and Child Sexual Abuse: Deaf Hard of Hearing, Deaf-Blind, Late-Deafened and Oral Deaf.- A Resource Manual for Service Providers was prepared by Amethya Weaver, Klinic Community Health Centre, Winnipeg, Manitoba, 1995. This resource provides practical information about the different cultures and communication approaches used by women with these different disabilities.

28. Statistics Canada, op. cit., p. 11.

29. lbid, p. 11.

30. Weaver, Amethya, op. cit., p. 2 1.

31. The Roeher Institute, op. cit., p. 2 3.

32. Statistics Canada, op. cit., p. 4.

G. **Personal Health Practices and Coping Skills**

Health Canada, through the recent Family Violence Initiative, has broken new ground in its work on the links between substance abuse and violence, the overmedication of psychiatrized women, and in work with DAWN Canada on suicide attempts and thoughts about suicide among women who are disabled and who have also been abused.

Learnings:

- *Toward Empathy* points out that for the same symptoms, women are prescribed twice as many

- *Toward Empathy* points out that for the same symptoms, women are prescribed twice as many drugs as men.
- The Vancouver General Hospital Emergency Department project found that quite a few of the patients seen in the department for domestic violence do not have permanent addresses and are difficult to reach by telephone.
- *Link: Violence Against Women and Children in Relationships and the Use of Alcohol or Drugs* by the Addiction Research Foundation (Ontario) found through literature reviews that problem drinkers (i.e., those who drink excessively) are far more likely to abuse their partners than abstainers. Problem drinkers who abuse their partners also are more likely than other abusers to abuse when they are intoxicated. One study found that almost one half of abusers who were problem drinkers were drinking when they assaulted their partners, compared to only one in five abusers who were moderate drinkers.
- *Don't Tell Me to Take a Hot Bath* reveals that 60.6 percent of the 225 women with disabilities who had also been abused, who were surveyed, thought about suicide and 45 percent of those women attempted suicide, even though none of the women wanted to die.
- The National Survey on Violence Against Women found that "approximately one quarter of ever-married women who have lived with violence reported using alcohol, drugs or medication to help them cope with the situation. This included 12 percent who used alcohol, nine percent who used drugs or medication and five percent who used both alcohol and drugs or medication. Women who suffered emotional abuse as well as physical assault more frequently reported the use of alcohol or drugs to cope (31 %). In addition, women who sustained an injury were more likely to use alcohol or drugs (41 %). Alcohol use by women previously with a violent partner was almost twice the rate (15 %) of those currently living with violence (8%). Also, women previously with a violent partner were three times (12 %) more likely to have used drugs or medication than those currently with a violent partner (4%).-33
- The National Survey on Violence Against Women also found that "in one half of all violent partnerships, the husband was drinking at the time of the assault. The rate of wife assault for women currently living with men who drank regularly in the year before the survey (at least four times per week) was triple the rate of those whose partners never drank. Women whose partners drank heavily (five or more drinks at a time) were six times (I I%) as likely to be abused than those whose partners never drank."34

Tools:

1. *Link: Violence Against Women and Children in Relationships and the Use of Alcohol and Drugs,* produced by the Addiction Research Foundation (Ontario), provides an informative and flexible training resource to help service providers and individuals understand better the links between alcohol/drug use and abuse of women and children.

2. *Don't Tell Me to Take a Hot Bath,* produced by DAWN Canada, provides real insight into the experiences and feelings of women who are disabled and have been abused. It helps clarify the links between isolation caused by social attitudes to disability combined with isolation created by the disability itself and the risk of choosing suicide as the only way of coping with the enormous pain with which so many women live.

33. lbid, p. 8.

34. ibid.

H. **Healthy Child Development**

Health Canada, through projects focused on child abuse funded by the Family Violence Initiative and through its Child Development Initiative projects, has supported numerous activities related to healthy child development. In addition, the projects supported which concentrated on woman abuse also contribute learnings about healthy child development as a determinant in violence prevention and individual, family and community health. They substantiate the generational links in violent behaviour and the efforts of women who are abused to make choices which will provide a healthy, non-violent environment for their children.

Learnings:

- The Bridges Employability Project points out that low self-esteem and isolation leading to low levels of engagement in the world by mothers can increase the risk of child abuse or neglect.
- *A Cappella* identified a potential link between pressure put on girls to succeed (which can be experienced as a form of psychological abuse), the emotional abuse of benign neglect (simply assuming a young girl can make decisions and cope with the world without parental guidance) and vulnerability to dating violence.
- The *Link* educational resource states: "studies have reported that from 25-57 per cent of men who beat their partners also abuse their children."35
- The *Link* resource also reports that young people who have been abused start to use drugs earlier and become multi-drug users more often than their peers. Their early start relates to the need to medicate their pain, while multi-drug use relates to their need to experience various emotional states safely.36
- The National Survey on Violence Against Women found that children from abusive homes are at greater risk of abusing or being abused. "Women with a violent father-in-law were three times (36%) more likely to have been abused by a current partner than women whose father-in-law was not violent (12%). Women whose father-in-law abused his wife also were more likely than other women to endure repeated and more violent spousal assault. Fifty-five percent of women whose partner had witnessed violence when growing up reported being abused by that partner on more than one occasion, compared with 3 5 % of women whose partners had not witnessed violence. Women with a violent father-in-law were more likely to be injured (37%) than those whose father-in-law was not abusive (21 %). In addition, women with a violent father-in-law were more frequently beaten, choked or hit than other victims of wife assault."37
- The survey also indicated that women frequently make the choice to seek help in order to spare their children from witnessing or experiencing abuse. "Of abused women with children, those whose children witnessed violence against them were almost three times as likely (43%) as others (16%) to report their partner to the police."38

Tools:

- The *Fire in the Rose* kit includes a booklet with exercises and action ideas specifically for children and youth to help young people understand and identify violence, and to give them ideas for how to deal with problems, conflicts and anger in non-violent ways. The booklet on "Skills for Support and Prevention" in the kit includes a module on parenting to promote healthier families and healthier child development.
- *A Cappella* includes a booklet on violence for adolescent girls.

I. **Health Services**

Improvement to health services represents the greatest achievement in addressing health determinants and creating new knowledge. The projects supported by Health Canada provide invaluable information to guide the process of re-creation, reduction and amalgamation currently affecting services across Canada. As the learnings listed below reveal, the knowledge gained includes that of unfair, inequitable, ineffective or violating approaches used by services, as well as learnings about effective service approaches. Tools include excellent training and evaluation tools to promote appropriate, effective services. Model programs are described in Appendix I of this report.

35.Addiction Research Foundation, *LINK...*, Toronto, Ontario, 1995, p. 7.

36.lbid, p. 11.

37. Statistics Canada, op. cit., p. 7.

38. Ibid.

Learnings:

i) Learnings about Inequitable, Unfair, Ineffective or Violating Service Approaches

- in *Toward Empathy,* the point is made that the children of psychiatrized women are more likely to be labelled in need of psychiatric treatment themselves.
- The same report points out that women who have had psychiatric treatment during their lives and who are abused are more likely than other women who have been abused to seek help from community-based services but are most likely to be turned away on the basis of their past treatment.
- Evaluation processes for support or awareness groups which involve completing evaluation forms during or after each session when women are attending more than one session are unrealistic. Group leaders are unlikely to find the time during each session for women to complete the forms.
- Women surveyed for the DAWN Canada study, on which *Don't Tell Me to Take a Hot Bath* is based, said that the main problems with existing crisis centres were: - the inaccessibility of follow-up services; and - the discomfort of the counsellors with the woman's disability.

ii) Effective Service Approaches

The positive, health-creating goals shared by most wife assault education or support groups are: accessibility (physical, communication, culture), empowerment, support (social, emotional, connection), self-protection, healing and education/ information/ resources. 3 9

- The Vancouver General Hospital Emergency Department project points out that women who are abused are more likely to want to use hospital-based support services than services specifically identified as services for women who are abused. Half of the women treated in the emergency department of the Vancouver Hospital for a documented incident of domestic violence accepted hospital-based support services. This contrasts with the finding that in only 24 percent of wife assault incidents reported in the Statistics Canada National Survey on Violence Against Women did the woman use a social service.40 While some of this hospital-based support was brief, serving as a bridge to existing community services and/or services

- [illegible] available at the hospital, some patients maintained contact with the program for more than a year.
- The same project also found that for many individuals who will refuse follow-up support, "if there is to be any attempt at supporting and educating the patient concerning domestic violence, it needs to be immediate, while she is in the emergency department. To this end, emergency department nurses and physicians should be trained and comfortable at addressing domestic violence as a health issue and supporting and validating the patient's experience."41
- The same resource pointed out that what women who are disabled and have been abused and have attempted suicide need the most, is a safe place to work through their crisis, that is: "a place to be protected without getting medicated and psychiatrized."42

39. Morton, Mavis, *Wife Assault Support Group Evaluation Pilot Project Report,* Catholic Family Services of Peel-Dufferin, Brampton, Ontario, 1994, *p. 8.*

40. Hotch, Grunfeld, Mackay and Cowan, *An Emergency Department-Based Domestic Violence Intervention Program: Findings After One Year,* Vancouver Hospital and Health Sciences Centre, Vancouver, British Columbia, 1996, *p. 11.*

41. lbid, p. 15

42. DAWN Canada, *Don't Tell Me to Take a Hot Bath,* Vancouver, British Columbia, 1995, p. 51.

Tools:

1. *Toward Empathy,* a training manual for shelter workers to help workers respond more caringly and appropriately to psychiatrized women, includes information on:

- how to deal with specific manifestations of ‚mental illness";
- the uses, common dosages and side effects of drugs prescribed for psychiatric conditions;
- relaxation techniques;
- herbal remedies; and
- peer counselling.

2. The Wife Assault Support Group Evaluation Project developed a series of evaluation tools for wife assault education and support groups.

3. *Understanding and Charting Our Progress Toward the Prevention of Woman Abuse is* another evaluation tool, most useful for longer-term evaluations of programs with a prevention focus. This framework starts from the assumption that it is virtually impossible to measure prevention, so it is necessary to attempt to assess success in addressing factors that contribute to violence (e.g., isolation and inequality).

4. The training course developed for health care professionals in the Vancouver General Hospital Emergency Department project is an interdisciplinary and practical course which can help raise the awareness and involvement of health care professionals in hospitals and health clinics across Canada.

5. *Women Who Experienced Woman Abuse and Child Sexual Abuse: Deaf Hard of Hearing, Deaf-Blind, Late-Deafened and Oral Deaf.- A Resource Manual for Service Providers* includes excellent information on the characteristics of a supportive service provider (p. 6), on the responsibilities of

information on the characteristics of a supportive service provider (p. 6), on the responsibilities of visual language interpreters and intervenors for deaf -blind women (p. 7), and on the etiquette of using telecommunications devices for the deaf.

What Have We Learned about Health Promotion Approaches That We Did Not Know Before? What Tools and Models or Best Practices Have We Gained?

The Family Violence Initiative supported the production of numerous model programs and valuable tools to promote individual, family, community, institutional and societal health.

A. **Strengthen Community Action**

The most recent Family Violence Initiative emphasized the need to develop collaborative, community -building approaches which emphasized that violence prevention is everyone's responsibility in order to build a healthier, lessviolent society.

Learnings:

- Several of the projects funded show that community mobilization is most effective when community members work together on practical projects that are action- oriented.
- Three elements are essential to a healthy community process, according to the Violence Prevention Council (Durham Region), which created a process for stimulating a comprehensive community response and an interdisciplinary protocol. These elements are:

- making the needs of abused women the priority;

- being accountable to the abused women we serve; and

- sharing power in an equal, inclusive and accountable way.

- To successfully reach members of a community and help give them a sense of ease and ownership with a program, it is essential to use a traditional communication channel, such as "kitchen table" talks, when the program is still in the planning stages. These informal communications can give people information about the proposed program, and gather information on how supportive the community would be as well as about the kinds of activities the community would like to see included in the program.43
- People living with abuse need responses which "wrap around the family rather than slotting the family into pre-existing categories of service."44
- The Goulbourn Peer Support Program found that the existence of a peer support program in their community led to an increase in the number of prevention activities taking place in the community, and a decrease in calls by peers to their counsellors.

43. Two projects highlighted emphasized this approach: the *Mid-Island Tribal Council Family Development Program* and the *Fire in the Rose* kit.

44. Burford, Gale and Pennell, Joan, Family Group Decision-Making Project: Manual for Coordinators and Communities: The Organization and Practice of Family Group Decision Making, Memorial University of Newfoundland, 1995, p. 45.

Tools:

tools.

Many tools have been produced through the Family Violence Prevention Division, over the past few years, to strengthen community action.

1. *From Dark to Light: Regaining a Caring Community* is a tool created for Northern people who would like to deliver workshops on family violence and healthy family issues in Northern and Aboriginal communities.

2. The training resource produced by the Canadian Association of Independent Living Centres, *Responding to Family Violence and Abuse,* includes a section on peer support as one way to respond to abuse and provides a step-by-step approach to set up a peer support program.

3. *Responding to Family Violence and Abuse* also presents an interesting process to help communities involve their members in research and create training or awareness tools that will be relevant to the community. This process could be adapted by other communities attempting to create community-relevant material.

4. The community-building process described in *Creating a Community Response to Abused Women and Their Families: The Durham Region Experience is* an excellent tool for any community attempting to create a collaborative, interdisciplinary approach to appropriate intervention and prevention of violence.

5. The Mid-Island Tribal Council Family Development Program provides an outline of a program which includes life skills including family therapy, community activities and a community development component. During initial planning of the program, the decision was made to include a separate family, individual and group therapy section. Ultimately, this section was built into life skills and community development as a way of asserting that healthy individuals and healthy communities together promote healthy families.

6. The Goulbourn *Peer Support Program Manual is* an excellent tool in its entirety to help community groups create a peer support program in their communities. However, it also includes several tools which could be used separately. For example, Handbook I includes a checklist of indicators to assess whether or not a community needs a peer support program. It includes ideas for writing a funding proposal, tips on staffing which could be useful for any program, a checklist to decide if a group is healthy, etc. Handbook 4 contains a confidentiality policy and ideas for social action.

7. *The Bingo Game* developed by the Bay St. George Coalition to End Violence is an excellent tool to build community awareness and to stimulate community action in communities which do not have any or many official services.

Best Practices/Models:

- A Process to Build Awareness, Commitment and Involvement to a Product in a Northern Region Made Up of Isolated Communities

The broad community-based approach to the needs assessment, development of the kit content, promotion and distribution, used in the production of *From Dark to Light, is* an innovative approach to achieving community buy-in to a product even in a geographically large area made up of isolated

communities. The evaluation of this process has not yet been completed, but the large number of requests for facilitation training from across the Northwest Territories which resulted from advertisement of the training- evaluating workshop indicates that this process, as well as the kit itself, have successfully responded to the needs of Northern communities.

- Family Group Decision-Making Model

This model provides a way to build connections among community services and between them and government agencies and individual families. Participation in the conferencing process educates community members about the abuse and builds awareness of ways for identifying and stopping family violence, as it contributes to healing and practical problem solving.

- The Goulbourn Peer Support Model

This model provides a way for users of a service to become active participants in working for social change. Its organizers believe that it may be adapted to other social service programs. Unlike many peer support programs which tend to be short-lived, this model has been designed to be ongoing. It provides ideas for organizational and funding support that contribute to continuity.

B. **Build Healthy Public Policy**

Projects funded by Health Canada and highlighted in this report alert policy makers to the many unanticipated consequences of policies which can create barriers for women who are abused and who try to seek help. Several of the projects also suggest that many women want multipurpose programs to meet their full range of needs, and that many women would prefer to use programs not designed specifically for women who are abused, but instead programs focused on the creation of healthy families and communities. These findings would support the development of policies which would encourage existing institutions, such as health clinics, community health centres and hospitals, to create more appropriate responses to women who are abused.

The findings also encourage the consideration of policies which create coordinated intervention and prevention responses among a variety of existing services, including services concerned with child health, parenting skills, employability, literacy and education, substance abuse treatment, housing, as well as shelters and support services specifically for women who are abused. Further, while the projects funded by Health Canada indicate that a significant number of women who are abused use and need effective justice system responses, projects revealed that women are more likely to use health services than legal services to deal with their abuse. Therefore, policy makers might want to consider putting more emphasis on the development of health-sector responses than on justice-sector responses.

Learnings:

The *Bridges Employability Project* report concluded that the experience of abuse during childhood "interferes with women's readiness for (employability) programs and with the pursuit of their employability goals. This finding suggests that the provision of services to help women deal with the issues of child abuse should be given priority if the government hopes to help income assistance recipients to achieve social, emotional and financial independence. It should also be considered as a priority in terms of preventing the reliance of future generations on government assistance."45

Family Violence in Rural, Farm and Remote Canada points out that woman abuse among farm women will not be reduced without increased economic security for rural and farm women, as well as the re-instatement and/or development of essential health and social services for families in rural, farm and remote regions, including flexible rural child care.

Systemic change including program cuts can increase abusive or degrading treatment, particularly among people who are disabled or who are especially vulnerable because they are poor, do not speak English or French or are from a minority culture. For example, the Canadian Association of Independent Living Centres training resource entitled *Responding to Family Violence and Abuse: An Independent Living Approach* points out that cuts to hospitals and residential health facilities have resulted in more people with disabilities being forced to wear diapers because there are not enough staff members to help them to the bathroom.

The project by the National Organization of Immigrant and Visible Minority Women of Canada suggests that power tactics of labelling, divide -and- rule, fragmentation, creating the fear of unemployment and crime can all be used to disempower women and men. Policy makers therefore must consciously check that policies do not inadvertently contribute to these tactics.

This same project found that in some provinces, ethno-specific groups have difficulty getting a charitable number since one of the conditions for acquiring a number is that the group must serve the public at large. Without a charitable number, it is difficult to fund raise from donations.

45. Feuz, op. cit., p. 94.

The Family Group Decision-Making Project found that ongoing success of this model requires that family group conferences be acknowledged in legislation.

This same project also learned that this model, when used in situations of woman abuse, child abuse or other forms of violence in the family, requires a partnership between mandated authorities, families, communities and agencies in a position to help. It also works best when it is administered by a well- established community organization that can adapt the model to the local culture and conditions. These findings have been highlighted in many other reports referred to in this document.

DAWN Canada and The Roeher Institute pointed out that there are no clear operational definitions of acts and omissions that constitute abuse and violence against persons with disabilities. These definitions are needed to help service providers, policy makers and people with disabilities understand what constitutes abusive behaviour.46

The National Survey on Violence Against Women revealed many findings which could help direct policy. For example:

- Young women (under 24) are most likely to be the victims of abuse, particularly if they are in marriages or common-law unions of less than two years, and yet (according to the Statistics Canada Transition House Survey) women under 25 were not the most likely to use shelters. This would indicate that different types of policy responses may be needed for younger women.
- Few women use support agencies specifically for women who are abused. Only eight percent contacted and six percent of women who reported abuse stayed in a shelter for women who are abused. Women in many of the studies highlighted in this report indicated that they were more likely to use programs for abused women housed in multipurpose institutions (e.g., hospitals)

so that they could avoid stigmatization and could access a variety of services to meet their needs.
- Only 26 percent of women in abusive marriages reported the violence to the police, even though one half of women who contacted the police said that they were satisfied with the way the police handled the case.47

Tools:

1. The *Building Bridges* kit provides a tool to demonstrate to policy makers that there is a way to help women who have been abused, who may have many barriers to employment, to become employable and thereby gain choices which allow them to find ways to stop the violence in their lives.
2. *Harm's Way* provides a comprehensive discussion of policy barriers and suggestions for policy change concerning the response to abuse against persons with disabilities.

Best Practices/Models:

1. The evaluation of the Bridges Employability Project reveals that it is a successful approach to increase the employability of women who have been abused and who have been dependent on government financial assistance. After comparing this program with another one designed to enhance employability (Access Program funded by Canada Employment, and intended for a more general population), the evaluators concluded that "Women abuse survivors served by the Bridges program are not likely to be as effectively served by the Access program. The Bridges core program elements, including intensive one-to-one support from program staff and ancillary services (professional counselling and follow-up support services), play a major role in the success of the Bridges program.
2. *Understanding and Charting Our Progress Toward the Prevention of Woman Abuse* provides an evaluation framework for front-line programs but also for policy initiatives concerned with the prevention of violence.

46. The Roeher Institute, op. cit., pp. 44-45.

47. Statistics Canada, op. cit., p. 7.

C. **Create Supportive Environments**

Many of the projects funded emphasize that to create supportive environments, it is not enough to build sensitive specialized programs specifically for people living with violence. instead, the challenge of building healthy communities, families and individuals is to change existing institutions, values and behaviour across the society so that people will feel and be safe if they decide to look for help to stop the abuse.

Learnings:

- Wife Abuse: A Workplace Issue project, through interviews with women who have been abused, confirmed that the response of the workplace can make a significant difference in the lives of women living with abuse.
- The companion document to *Wife Abuse: A Workplace Issue*, entitled *A Guide for Change*, points out that if a woman is living in an abusive relationship, although she will miss very few

days often for years regardless of the extent of her physical and emotional pain, "it has an impact on her work performance **over time.** For a man who is an abuser, the impact on work performance is often similar: absenteeism, loss of concentration, fatigue and emotional instability all contribute to decreased productivity. The cost to the organization is real and substantial."48

- Women need practical support (e.g., a drive to the supermarket or to the lawyer, child care) at least as much as they need verbal support, according to the Goulburn Peer Support Program.
- Congregations involved in the Fire in the Rose project emphasized the importance of creating a safe and trusting community environment before attitude and behavioural change can take place.
- The Vancouver General Hospital Emergency Department project found that even the people most apparently resistant to becoming part of the solution to violence against women could be open to change and preventive action if the ideas and objectives were presented to them in practical ways.
- The Dating Violence Survey sponsored by Carleton University stressed that it is important to change attitudes not just of men who are abusive but of their friends as well so that these friends will not provide positive reinforcement for abusive behaviour toward women.
- The A Cappella project of the Canadian Teacher's Federation reveals that adolescent girls will share their concerns in ways that can break their isolation, if they are given the opportunity to define their issues in their own ways.
- To provide a supportive environment for survivors in any intervention or prevention efforts, it is important that the person has a support "advocate"- someone who will accompany them to programs, who will explain what to expect, who will help them understand what is happening during the process and who will listen to their concerns as well as respond to their needs as they arise. it can be helpful for some survivors to write down their thoughts and feelings before they attend a family group conference, a court date, etc.49

Tools:

1. The Fire in the Rose project is an excellent example of an intense and comprehensive community-building and change process centred around church congregations. It challenges churches to look at their ways of living, worshipping and caring for one another so that they can help create supportive and healthy communities.

2. *Workplace Learnings About Woman Abuse: A Guide for Change 11 is* a compilation of practical ideas, strategies and activities that have been implemented by varied organizations across the country.

Best Practices/Models:

1. The *Fire in the Rose* kit, even though focused on churches, provides a model for building healthy communities through a major institution not specifically focused on violence in the family. This kit explores ways to promote healthy individuals, families, institutions and communities in its effort to help congregations respond to and prevent violence.

48. Denham, Donna, Gillespie, Joan and Barbara Cottrell, *Workplace Learnings about Woman Abuse: A Guide for Change* II, Ottawa, Ontario: National Clearinghouse on Family Violence and Halifax, Nova Scotia, 1994, p. 2 1.

49. Burford and Pennell, op. cit., p. 46.

D. **Develop Personal Skills**

Anecdotal information collected by the authors of this report revealed that people involved in many of the projects funded by Health Canada want and need tools and programs to help them develop personal skills to identify and respond appropriately to woman abuse. They also want tools to help them build healthy self-esteem, healthy families (primarily through parenting information and support) and healthy communities.

Learnings:

- The Canadian Farm Women's Network points out that individuals need to be made aware of the signs of fear as well as the signs of abuse.
- It also found that people living on farms and in isolated areas need to learn basic medical procedures because nurses and doctors are often not readily available to them in emergencies.
- As well, people caring for elder relatives need information on how to communicate with the elderly, on the process of aging and on how to access services in their communities.
- The Dating Violence Survey showed that psychological and verbal abuse are good predictors of physical violence.
- The Defensive Themes project demonstrated how power can hide behind depression, compliance, guilt or even good communication. This insight can help women who are abused understand that abusers can in fact appear depressed, compliant, guilty or communicative to manipulate and control both them and service providers.
- The ASAP program teaches us that "the creation of and use of a Control Plan by the man is a necessary step towards changing his violent abusive behaviour. He must recognize the fact that he alone is responsible for his violent actions, and for the need to change his attitude against his partner and/or children and others."50 In the development of this plan, the man is taught to identify:

- physical cues that occur when he is escalating toward violence;
- self-talk of the internal dialogue that takes place within the man immediately before being violent;
- emotional cues; and
- red flag words, situations and locations.

Tools:

1. The *Fire in the Rose* kit includes a variety of tools to help develop individual skills. it includes an "Individual Workbook" to allow people to learn about abuse and what they can do to reduce abuse and build healthier ways of living at their own pace and in their own ways. The kit also includes a booklet on "Skills for Support and Prevention" which includes modules on peer support, conflict resolution and parenting.
2. The *Links* kit on the links between alcohol/drug use and the abuse of women and children provides some excellent tools to develop personal skills, such as how to talk about alcohol and drug use, how to talk about abuse in the family with women or children who have been abused, with the person who is abusive and with the extended family.
3. The resource *Violence Against Immigrant, Refugee and Racial Minority Women* includes a section on Proposal Writing which will be useful for many individuals working in front-line groups.

50. Helping Spirit Lodge Society, Aboriginal Spousal Assault Program, To *Heal Is to Know Where You Have Been,* Vancouver, British Columbia, 1995, pp. 1, 2-15,

Best Practices/Models:

1. To Heal Is To Know Where You Have Been is a healing program for Aboriginal men who are abusive. It is based on learning personal skills to control the violence by taking responsibility for one's own actions, and connecting with a Native way of life.

E. **Reorient Services**

The projects funded by Health Canada through the Family Violence Initiative underline the need for multifaceted services which respond to women who are abused not as **abused women,** but as individuals who need social support systems, information and healthy services related to their full range of needs, so that they can make choices that lead to a healthier life free from violence. Many of the projects point out that too many existing services are unwilling, unequipped or unable to respond to the woman as a whole person for whom abuse is just one part of her life.

Learnings:

- Gisela Sartori, the author of *Toward Empathy,* writes that women who have had psychiatric treatment at some point in their lives are more likely to have suffered abuse in their lives, are more likely than other women who are abused to seek help, particularly from shelters, and are the most likely to be turned away on the basis of their disability.
- This same study pointed out that psychiatrized women, like all women who have been abused, need understanding and support in dealing with their lives as a whole.
- Organizers for the Goulburn Peer Support Program learned that some women find "timelimited" support programs ultimately isolating because they feel rejected when the time is up.
- The Durham Region experience, Creating a Community Response to Abused Women and Their Families, teaches that effective implementation and accountability to protocols regarding woman abuse will not happen unless process is addressed, and this process must involve:

- rethinking of the issue, of attitudes, beliefs and current practices by those who will develop and use the protocols; and

- stimulating "buy-in" to the protocols.

- *Understanding Abuse in Lesbian Relationships* indicates that lesbian women feel that shelters and other services specifically for women who are abused are not accessible to them, particularly in times of crisis, because such services assume heterosexuality.
- None of the shelters and second-stage houses surveyed in the project Understanding Abuse in Lesbian Relationships specifically names lesbians as being welcome in their brochures, through public education or outreach of any kind.
- The *Link* kit stresses that it is essential to treat alcohol or drug abuse along with woman or child abuse. Alayne Hamilton from the Victoria Family Violence Project is quoted as saying "When a man has both problems, both must be addressed. Attempting to teach self-control

strategies to prevent abuse to a man who is incapacitating himself with alcohol or other drugs is futile. it would be like trying to teach impaired drivers such good driving skills that they would be able to drive safely when drunk." (p. 18, Module 3)

- The authors of *A Study to Examine Dual Relation ships: When the Wife Abuse Victim and Offender Are Patients of the Same Primary Care Physician* found that if the physician is the primary care physician for both a woman who is abused by her partner and for her partner, this dual relationship does influence a physician's choice of responses. In fact, the study found that such a dual relationship is a stronger predictor of the physician's response than physical or emotional signs of abuse. If the physician is treating both partners, the physician was most likely to endorse bringing in the partner for a talk, with the woman's permission. This course of action was particularly favoured by older male physicians. Other studies have shown that this type of approach can put women in danger.

Tools:

1. The Canadian Association of Independent Living Centres' resource, *Responding to Family Violence and Abuse: An independent Living Approach,* can help service providers and community organizers learn how to respond more effectively to people with disabilities.

2. *Toward Empathy,* although a training manual for shelter workers, could assist other service providers who try to help women who are abused to respond more appropriately to women who have been abused and who also have been labelled "mentally ill."

3. The manual *Toward Empathy* includes a detailed section on psychiatric drugs, usual dosages, side effects and warnings which can be useful for a variety of community services.

4. The resource *Violence against Immigrant, Refugee and Racial Minority Women* includes an anti-racism training model for agencies or organizations. (pp. 36-40)

5. The Interdisciplinary Project on Domestic Violence kit, *The Mountain and Beyond,* provides simple and usable tools to "improve the capacity of professionals to respond to the real needs of domestic violence survivors and perpetrators and to effectively address the whole issue of violence within families, using a collaborative approach."51

6. The entire *Interdisciplinary Curriculum Guide for Health Professionals* created by Lee Ann Hoff is an excellent tool. It is oriented to health professionals but contains many sections that would be of use to anyone training or educating a wide variety of professionals around woman abuse. The stories of abuse situations are a particularly good learning tool, for Dr. Hoff has included with each story, key issues /concepts, related situations, the attitudes and values that are implicit in the situation, and the clinical skills which are highlighted in the case. The guide also includes an excellent bibliography which could be used by any trainer/educator.

7. Pages 31-37 and Appendix HI to *Understanding Abuse in Lesbian Relationships* provides an outline for a three-day training workshop for service providers.

8. *Women Who Experienced Woman Abuse and Child Sexual Abuse: Deaf, Hard of Hearing, Deaf-Blind, Late-Deafened and Oral Deaf.- A Resource Manual for Service Providers,* prepared by Amethya Weaver for the Klinic Community Health Centre, provides practical information about the different cultures and communication approaches used by women with these different disabilities.

different cultures and communication approaches used by women with these different disabilities.

Best Practices/Models:

1. The Wife Assault Support Group Evaluation Project provides a range of evaluation tools for wife assault support and education groups. The tools have been evaluated and found to be useful in rural as well as urban locations in ethno-specific groups and culturally diverse groups.
2. The Vancouver General Hospital Emergency Department interdisciplinary model for responding to woman abuse, according to the evaluation done of the program, is an excellent model for emergency departments. It could probably be adapted for use in health clinics across Canada as well.
3. *Violence Issues: An Interdisciplinary Curriculum Guide for Health Professionals,* by Lee Ann Hoff, could be used by a variety of community and institutional health facilities and organizations across Canada to increase the awareness of health professionals and to stimulate the creation of more appropriate health sector responses.
4. The Violence Prevention Council's (Durham Region) *Interdisciplinary Protocols* could provide a starting point for other communities interested in developing protocols. While evidence suggests that each community must create its own protocols, for it is the process that nurtures the commitment and insight needed for the protocols to work, this excellent document also provides a story of the challenges and successes this community had in creating the protocols. Therefore, the protocols plus the information about "how to" create protocols in other communities provide an invaluable model for developing protocols.
5. The *Link* kit provides a user-friendly training resource to help people working to prevent woman and child abuse and alcohol/drug abuse to understand the links across these various forms of abuse, and deal with these problems together.

51. Kinnon, Dianne, *The Mountain and Beyond: Resources for a Collaborative Approach to Domestic Violence, An Evaluation Report,* Family Violence Prevention Division, Health Canada, Ottawa, Ontario, 1995, p. i.

Conclusion

As a society, Canada is currently faced with an important opportunity to take the next step toward long-term violence prevention through the promotion of healthy individuals, families, institutions and communities. But this opportunity comes at a time when there is a very real danger that reductions in funding support will lead to a reduction in concern, understanding and programs to protect and support victims/ survivors and to prevent violence.

It is a time when the importance of collaboration across federal, provincial/territorial and local levels is paramount. It is more important than ever to share information, to share experience, to avoid duplication and to stimulate courage for change. It is a time when it is essential not to succumb to the fear of the unknown but to see the potential in change.

This report reveals that, through the most recent federal Fan-lily Violence Initiative, knowledge about woman abuse and how to respond appropriately, sensitively and effectively has increased dramatically. It is also obvious that a significant collection of tools and resources has been created to provide the energy to fuel change.

While there is the need for some further research and the creation of some additional resources, overall there are ample tools and information for individuals, families, community groups

overall there are ample tools and information for individuals, families, community groups, institutions, services and businesses, with government acting as a catalyst primarily through information exchange and policy reform, to take the next step. This is not to say that government funding is no longer necessary. However, the findings from many of these projects do support the conclusion that individuals, families and communities could benefit from more peer support programs, from the increased involvement of existing health services, churches, schools, businesses and other community services. Many of the tools which have been created to make these sectors part of the solution require no funding or limited funds, for they require not new programs specifically for women who are abused and their families, but a change in attitude, a change in policy, a change in the way one service works with another, a change in our ways of living and working together.

If the promotion and understanding of health, not the absence of violence alone becomes our overriding goal, we can use this goal to "provide the foundation for informed public participation in the setting of priorities that will have the most positive effects on the health of all Canadians.52

We have the tools and the knowledge to build on the past toward this new vision. Now all that is needed is the courage and the will to change.

52. Federal, Provincial and Territorial Advisory Committee on Population Health, *Strategies* for *Population Health, Investing in the Health of Canadians, Supply* and Services Canada, Ottawa, Ontario, 1994.

Appendix I

Projects Funded by Health Canada Which Were Analyzed for This Report

1. Koski, Katharine and Mahoney, Diane, *From Dark to Light: Regaining a Caring Community,* Advisory Council on the Status of Women, Northwest Territories, Yellowknife, NWT, 1995.

This kit is a tool to help people in the North return to healthy communities and gain the knowledge, insight and well-being necessary to ensure the continuation and healthy development of such communities. It includes an extensive collection of activities to help people heal from the effects of abuse on individuals, families and communities through individual and group activities focused on spousal assault, child sexual abuse, sexual assault, healthy relationships, parenting skills and abusive men's support groups. This resource emphasizes the caring aspects of community work, is sensitive to a Northern point of view and is available in plain English, plain Inuktitut and plain French.

2. Wells, Arlene, *Building Bridges: A Guide for Setting Up an Employability Project for Women Abuse Survivors in Your Community,* by Bridges for Women Society, Victoria, B.C., 1994.

This kit is unique in that it is one of the few resources available which moves beyond increasing awareness about abuse to assisting women in their quest for healing through personal and financial independence. The Bridges program works with women who have been abused to enhance their employability and thereby to overcome their barriers to employment and independence and move toward a more healthy way of living, free from violence.

3. Scott, Wendy, *Family Violence in Rural, Farm and Remote Canada,* The Canadian Farm Women's Network, Fredericton, New Brunswick, 1995.

This research project explores the experiences and needs of farm women who have been abused, the realities that farm women believe contribute to violence and helps work for a change in the attitude of rural Canadians, as well as urban Canadians in order to create healthy communities and help families function in a more healthy environment.

4. Canadian Association of Independent Living Centres, *Responding to Family Violence and Abuse: An Independent Living Approach,* Ottawa, Ontario, 1995.

This is a training resource intended to help people gain an understanding of violence and abuse as they relate to people with disabilities and to introduce the basic skills required to respond to abuse survivors with disabilities. While it is intended primarily for use by Independent Living Centres, it can be used by other service providers and community developers wanting more information about how to respond more effectively to people with disabilities who have been abused.

5. Ferris, Lorraine E. et al., *A Study to Examine Dual Relationships: When the Wife Abuse Victim and Offender Are Patients of the Same Primary Care Physician,* Sunnybrook Health Science Centre, North York, Ontario, 1995.

This study includes some of the first information available about attitudes and decisions of physicians who are the primary care physician for both the woman who is abused by her partner and the partner who is abusive.

6. Sartori, Gisela, *Toward Empathy: Access to Transition Houses for Psychiatrized Women,* Second Opinion Society, Whitehorse, Yukon, 1995.

This training manual is designed to promote equal access to transition houses for "psychiatrized women," that is, for women who have had psychiatric treatment at some point in their lives. It is an attempt to encourage workers in transition houses to put aside the labels that isolate women and give these women the empathy and support they need and that "are true to their own lives and perceptions." (p. viii)

7. Morton, Mavis, *Wife Assault Support Group Evaluation Project Report:* Catholic Family Services of Peel-Dufferin, Brampton, Ontario, *1994.*

This project contributes to healthy front-line services. The project team developed a range of measures which assess or monitor some of the most common outcome goals of wife assault support/ education groups to help different support and education groups:

- assess the extent to which wife assault support/ education groups meet the needs of assaulted women;
- collect information useful to front-line agencies, groups, leaders and funding bodies; and
- capture the social and psychological focus of the groups.

Every attempt has been made to design a tool which is flexible, portable and useful for a variety of groups for assaulted women. These tools have been piloted in four sites which provide some comparison between rural/urban locations, and some feedback on the usefulness of the tools with ethno-specific groups as well as culturally diverse groups. The evaluation found that the tools were useful and suggested some revisions which were made to the evaluation forms.

8. MacLeod, Linda, *Understanding and Charting Our Progress Toward the Prevention of Woman Abuse,* Health Canada, Ottawa, Ontario, *1994.*

This evaluation framework paper was the result of an agreement reached at a Policy Circle on Woman Abuse that the concept of prevention is so amorphous and changeable that any direct attempt to measure prevention is virtually impossible. This paper provides a framework for assessing how successful a program or initiative has been at preventing woman abuse, using indicators of health determinants and factors which research and experience have shown contribute to violence prevention. This report also provides a brief history of the responses to woman abuse in Canada since *1975.* Finally, using the framework developed, it includes an overview assessment of the success of projects funded by Health Canada through the most recent Family Violence Initiative in preventing woman abuse.

9. Grunfeld, Anton, Hotch, Deborah and Mackay, Kathleen, *Identification, Assessment, Care, Referral and Follow- Up of Women Experiencing Domestic Violence Who Come to the Emergency Department for Treatment,* The Vancouver Hospital and Health Sciences Center Project, *1995.*

This project developed an interdisciplinary program with procedures and protocols to meet the needs of women who are abused and who are seen in the Vancouver Hospital emergency department. The project also developed an educational program on woman abuse for health care workers and a registry to assist in research on woman abuse. it has been evaluated and could serve as a model approach for other emergency departments to adapt to their realities.

10. The Interdisciplinary Project on Domestic Violence, a project coordinated by Dianne Kinnon on behalf of eight national organizations: Canadian Association of Chiefs of Police; Canadian Association of Social Workers, Canadian Medical Association, Canadian Nurses Association, Canadian Psychological Association, Canadian Teachers' Federation, the Canadian Bar Association and the Canadian Council of Churches.

This project is an inspirational story of how eight large national professional organizations came together to learn more about violence in the family, collaborated on the development of a kit, *The Mountain and Beyond,* to raise awareness among professionals about violence in the family and to promote a collaborative, interdisciplinary approach to violence prevention, and participated in the distribution of the kit. Rather than focus primarily on the issue of violence itself, this project chose to concentrate on changing the way in which domestic violence is addressed. Accordingly, it encouraged professionals to consider the role of interdisciplinary cooperation as a means of reducing violence in the home. It encouraged the development of strategies and models to stimulate interdisciplinary cooperation. It developed interdisciplinary principles and guidelines and developed and implemented a process to promote discussion and action on interdisciplinary work at the service level.

11. Hoff, Lee Ann, *Violence Issues: An Interdisciplinary Curriculum Guide for Health Professionals,* Health Canada, Ottawa, Ontario, August 1994.

This curriculum guide was created to increase the sensitivity and awareness of health professionals to family violence issues through the development of health sector-focused educational material. It was commissioned by the Mental Health Division of Health Canada in response to a series of consultations with health sciences faculties across Canada, from March 1993 to June 1994. These consultations highlighted the need of every health practitioner to have a core understanding of

violence issues, to develop basic skills to deal with violence in everyday practice settings and to understand interdisciplinary approaches as well as the importance of collaboration.

After providing a conceptual framework, definitions of violence and linking this information to the essential knowledge, attitudes and skills required by health professionals, the curriculum moves to a number of stories of abuse and translates the more abstract material of the previous chapters into concrete illustrations for educators and clinicians. It then discusses personal/ professional victimization in the health sector and ends with curriculum design ideas.

12. The Violence Prevention Council (Durham Region), *Creating a Community Response to Abused Women and Their Families: The Durham Region Experience*, Whitby, Ontario, 1995.

This document includes valuable information on how to build community action and the kind of supportive environment necessary to create a healthy community. It describes the "pitfalls and successes of taking a community through the process of developing new understandings as well as new policies and approaches to woman abuse."53 It then includes the protocol guidelines developed for Durham Region for police, Crown attorneys, probation and parole services, linking police, Crown and probation, shelters, hospitals and health services, distress centres, children's aid society, income support, counselling services, linking probation and counselling services and churches.

13. Mid-Island Tribal Council, *Family Development Program: Project Manual*, Chemainus, B.C., 1995.

This is a program which provides victims/ survivors of family violence with a community-oriented and community-owned treatment program designed to reduce and prevent the frequency and intensity of family violence. This program encourages and assists the community to not only accept responsibility for family violence as a community problem, but also to participate actively in the recovery process. Thus, it is a process which promotes not only individual and family health, but community health as well. This approach was developed consciously to be portable to other communities.

14. Burford, Sale and Pennell, Joan, *Family Group Decision-Making Project*, Memorial University of Newfoundland, 1995.

"The Family Group Decision-Making Project started from the premise that to stop family violence, partnerships need to be created in which families regain a constructive voice over their own affairs."54 It is an excellent example of a project which looks to the positive goals of healthy individuals, families and communities to respond to the harm caused by woman and child abuse. "This approach offers a way for the family and friends of people who have lived with family violence to help stop the violence and to address the problems that contributed to the violence. The immediate family, including the person or people who have been victimized, as well as the person or people who have abused them, meet with extended-family members and friends, to tell the story of the abuse, of the needs and hopes from all sides, and then together to plan ways to prevent future violence and to resolve the wrong that has been done. Throughout the process, the family receives the support and protection of the referring agencies (e.g., child welfare, youth corrections, parole) and these agencies must approve the family's plan for it to go into effect and be resourced. A local coordinator organizes the conferences and is also responsible for ensuring that the plan includes specific protective and care measures as well as monitoring and evaluation of the plan. Where necessary, the family group is brought back together to review and reformulate the plan."55

53. The Violence Prevention Council (Durham region), *Creating a Community Response to Abused Women and their Families,* op. cit., p. 1.

54. Burford and Pennell, op. cit., p. 1.

15. The Community Action on Violence Against Women Project, undertaken through the YWCA of Canada, Toronto, Ontario, 1995.

This project was established to produce resources to communicate the messages that violence against women is unacceptable and that everyone has a role to play in ending the violence. The goal was to convey ownership of the issue to communities across Canada and thus to promote community and societal health as well as individual and family health through freedom from violence. The project promoted both education on the issues and action responses to violence. It provided examples of sectoral and community-based partnership models for delivery of the messages. An Advisory Task Force made up of national and local agencies provided direction and support to three working groups on:

- rural and remote communities;
- community pilots; and
- young women.

One of the unique outcomes of this project has been a partnership between the YWCA and the Body Shop and a partnership between the YWCA and Avon Canada. A number of excellent resources were produced through the project. They are referred to in the body of this report.

16. Denham, Donna and Gillespie, Joan, *Wife Abuse: A Workplace issue: A Guide for Change,* Ottawa, Ontario, 1992.

This guide provides information and ideas to encourage employers and employees to see what can be done through workplace settings to support women who are abused in their homes, and who are our colleagues, our bosses and our employees. This guide is another important tool to build the kind of healthy and supportive communities that ensure that we are all part of the solution to abuse. The guide points out the enormous personal pain to individuals living with violence as well as the costs to employers and other employees created through woman abuse.

17. Balan, Angie, Chorney, Rhonda and Riscock, Janice, *Understanding Abuse in Lesbian Relationships,* Coalition of Lesbians on Support and Education and Klinic Community Health Centre, Winnipeg, Manitoba, 1995.

This project put together a training program that would help educate shelter workers about lesbians and lesbian abuse. The program focuses on exploring homophobia and heterosexism and the connections between these forms of oppression with sexism, racism, classism and ableism.

18. Addiction Research Foundation, *Link: Violence Against Women and Children in Relationships and the Use of Alcohol and Drugs: Searching for Solutions,* Addiction Research Foundation, Toronto, Ontario, 1995.

This educational resource includes a trainer's guidebook, information resource materials in five

modules, training support materials such as overhead masters and case studies and a video called "Nola's Story." It explores the links between the use of alcohol as well as other drugs and violence against women and children in relationships. While it acknowledges that drug and alcohol use do not cause violence against women and children in relationships, and that everyone who has been abused or is abusive does not abuse drugs or alcohol, it stresses the need to explore these links since services which help women recover from drug and alcohol dependency report that at least 70 percent of their clients have a history of sexual or physical abuse.

The resource attempts to:

- raise understanding and awareness of the links between violence against women and children and the use of alcohol or other drugs;
- familiarize service providers working in the addictions field with physical and sexual abuse issues, and familiarize service providers working to prevent woman or child abuse with addictions knowledge;

55. National Crime Prevention Council, *Mobilizing Political Will and Community Responsibility to Prevent Youth Crime*, Ottawa, Ontario, December 1995, pp. 38-39.

- provide tools that will help service providers identify the co-existence of the two problems; and
- emphasize the importance of collaborative approaches.

19. Weaver, Amythya, *Women Who Experienced Woman Abuse and Child Sexual Abuse: Deaf, Hard of Hearing, Deaf-Blind, Late-Deafened and Oral Deaf.. a Resource Manual for Service Providers,* Klinic Community Health Centre, Winnipeg, Manitoba, *1995.*

This resource is a manual for service providers on working with women who are deaf, hard of hearing, deaf-blind, late-deafened, oral deaf and deaf as a result of abuse trauma. It provides practical information and tools to help service providers communicate appropriately and effectively with women who have these different disabilities. It emphasizes the cultural as well as communication differences across these groups. The resource also provides information about technical devices available to facilitate communication.

20. Maharaj, Indra, *Violence Against Immigrant, Refugee and Racial Minority Women, Phases 11 and III: A Manual for Promoting Awareness and Understanding, Networking and Linking, Organizing Activities for Breaking Down Barriers,* National Organization of Immigrant and Visible Minority Women of Canada, Ottawa, Ontario, *1995.*

This manual was created through extensive consultation by community workers with mainstream organizations, women's agencies, immigrant, refugee and racial minority women from Afro-Canadian, Nigerian, Chinese, South Asian, Latin American, Haitian, South African, Sri Lankan, Filipino and Vietnamese ethnic-minority groups. it provides information on:

- how to build a culturally diverse support group;
- how non-profit organizations can write funding proposals;
- how service providers can better understand the causes, effects and extent by which a racist system can oppress non-white people; and
- how to develop culturally responsive counselling.

21. The Roeher Institute, *Harm's Way: The Many Faces of Violence and Abuse Against Persons with Disabilities,* North York, Ontario, *1995.*

This book "Provides insight into the way our systemic practices, prejudices and ignorance combine to encourage or support the abuse of our most vulnerable citizens."56 it is based on a review of literature, federal /provincial/territorial legislation, case law, policy and program arrangements that place individuals with disabilities at risk, Statistics Canada data, and interviews with self-selected individuals with disabilities.

22. Masuda, Shirley, *Don't Tell Me to Take a Hot Bath,* DAWN Canada: DisAbled Women's Network Canada, Vancouver, *B.C., 1995.*

This is a resource manual written for suicide crisis workers. it is intended to help workers understand what it is like to have a disability to help them focus their energies and build support in the community for women with disabilities. it attempts to help crisis workers understand why responses appropriate for women without disabilities are often inappropriate for women with disabilities.

23. Community Resource Centre, *Peer Support Handbooks,* Goulbourn, Kanata, West Carleton, Ontario, *1995.*

This is a comprehensive kit explaining the peer support approach and how to create and maintain a peer support program. It includes a wealth of practical information, including how to get funding, how to staff the program, how to evaluate the program. It speaks to an approach which is based on the experience and knowledge of survivors, the skill of front-line women counsellors and the energies of the community to work collectively against the abuse of women. It is designed to:

- provide a local opportunity for women, especially survivors, to work toward the elimination of abuse;
- mobilize individual and community action to work toward the prevention of abuse;

56. Back cover comments by Frederick Mathews, Community Psychologist, Central Toronto Youth Services.

- provide a model for community-based participation that reaches out to rural, immigrant and visible minority women; and
- improve and complement existing services available to abused women.57

24. Helping Spirit Lodge Society, *Aboriginal Spousal Assault Program, To Heal is to Know Where You Have Been,* Vancouver, British Columbia, 1995.

This is an Instructor's Manual for a 17-session Aboriginal Spousal Assault Program for Native men who voluntarily recognize and want to stop their abuse and violence against their partners and children. However, men mandated by the courts and men referred by various community organizations are also included in the program. The manual is designed to address the issues of violence against women and children within the Native community. It challenges and examines men's attitudes, beliefs and values toward women and themselves. "ASAP embraces a variety of First Nations ceremonies, rituals and practices to aid participants in finding themselves, their people and

Native ceremonies, rituals and practices to aid participants in finding themselves, their people and their traditional ways; a journey which leads to understanding self (mental, physical, emotional, spiritual) and balance within the family unit and becoming whole from a sense of fragmentation." (pp. i-4)

25. The National Survey on Violence Against Women, Statistics Canada with funding from Health Canada, Ottawa, Ontario, 1993.

Under the federal government's Family Violence Initiative, Health Canada funded Statistics Canada's first National Survey on Violence Against Women. The primary objective of the survey was to provide reliable estimates of the nature and extent of male violence against women in Canada. The development of this survey was based on extensive consultations with women's groups across Canada. These consultations were used not only to create the survey instrument, but to guide staffing, staff training and the development of interview methods which were sensitive to safety and support needs of women. The survey and its methodology have received high praise internationally. A number of countries are considering replicating the survey.

26. Bay St. George Coalition to End Violence, *An Educational Tool on Violence Against Women,* Stephenville, Newfoundland, 1995.

This educational tool, in the form of a bingo game, was created out of a community needs assessment. It provides a way to reach women with limited literacy skills and those who are isolated in smaller communities or by the controlling behaviour of their spouses. It is an excellent example of a tool which builds on existing community activities that reduce isolation and provide opportunities for women who are abused to gain support.

27. Canadian Teachers' Federation, *A Cappella: Phase II,* Ottawa, Ontario, 1993.

This project followed an earlier project which built understanding of the challenges and concerns facing adolescent women. The purpose of Phase 11 was to stimulate change in schools to better respond to the needs of adolescent women and to mobilize coalitions of education leaders, women's organizations and community groups in responding to the expressed concerns of adolescent women. A series of discussion papers were prepared to facilitate this process, including one entitled "Ending the Violence in Adolescent Girls' Lives: A Challenge for Schools and Communities."

28. Fédération des ressources d'hébergement pour femmes violentées et en difficulté du Québec, La violence enfante la violence : une campagne de sensibilisation pour contrer la violence conjugale, Longueuil, Québec, 1992.

This public education campaign was intended to reach the largest number of individuals and organizations possible to increase commitment to the idea that we must all be part of the solution to violence prevention. The poster and pamphlets created through this project became well known, not only in Quebec, but across Canada.

57. Goulbourn, Kanata and West Carleton, Community Resource Centre, *Peer Support Handbooks,* Ottawa, Ontario, 1995, p. 1.

29. Comité d'aide aux femmes sourdes de Québec, Outils d'intervention adaptés à la culture des femmes sourdes du Québec, Lévis, Québec, 1995.

This study, which is complementary to the Klinic study in Winnipeg on deaf and hard-of-hearing women who are abused, was funded:

- to raise awareness about the needs of women who are hearing disabled;
- to develop a model of intervention adapted to the culture of deaf women who are also victims of violence;
- to promote the accessibility of shelters to deaf women; and
- to develop a training program for women who are deaf to inform them about the problem of violence and the resources they can use.

30. Carleton University, Woman Abuse in University Dating Relationships, Ottawa, Ontario, 1994.

This survey examined the incidence and prevalence of woman abuse in Canadian university and college relationships. As such, it is complementary to the National Survey on Violence Against Women. However, it differs from the National Survey in that it surveyed women and men. The sample for this survey included 1 835 women and 1 307 men from universities in Atlantic Canada, Quebec, Ontario, the Prairies and British Columbia.

Appendix II

A Chronology of Canadian Responses to Woman Abuse

There has been a change in emphasis and direction over time in our responses to woman abuse. This change moves along the health continuum from treatment and intervention to prevention to health promotion, as responses to violence against women changed, from:

- a very early emphasis on treatment of violence as a symptom of a deeper illness or aberration, usually attributed to the woman; to
- a major emphasis on crisis intervention; to
- an ever-stronger emphasis on prevention through public education; to
- an increasing concern with the need for social and structural change and the ultimate goal of promoting non-violent, healthy individuals, families, institutions and communities.

Reflecting on past efforts in Canada to prevent violence against women by their husbands and partners reveals movement across four intertwined stages. While approximate dates have been attributed to each stage, none of the stages has ever completely ended. It is this overlap and continued influence of different approaches and visions that have contributed to the paradoxes and challenges experienced today.

Stage I: Disempowering Treatment Approaches and Women Helping Women in the Community (mainly before 1980)

In the mid- 1970s, when people in Canada first began to respond to violence against women in their homes, those responses were focused on treatment and intervention.

Health professionals who acknowledged violence against women by their husbands or partners at this time, and in the decades before the 1970s, were most likely to interpret woman abuse as an outcome

of a psychiatric condition. It was common among professionals in the health, social services and legal professions to interpret woman abuse as one symptom of more generalized "family problems" or as a reaction by the man to the woman's mental illness. Symptoms were treated, but the full impact of abuse on health was not recognized.

Knowledge of woman abuse as a social phenomenon was very limited in these early days and the issue was still cloaked in silence and disbelief. The prevalence of the violence was not known. The violence was rarely addressed in its own right by these professionals. Instead, the woman was frequently blamed, her complaints ignored and her danger minimized.

On the other hand, this was also the time when survivors, friends and relatives of survivors, and women's advocates began to mobilize to start neighbourhood shelters and support services for women. In these early days, the needs of the women directly determined the responses, and the need for safety came first. There was little or no funding available for services.

Stage II: Safety First, Then Education... The Importance of Crisis Intervention and the Beginning of Prevention through Public Education (1980-1990)

The second stage began with an explosion of awareness about woman abuse. A report on wife battering released by the National Advisory Council on the Status of Women in 1980 received extensive national press.58 The number of women's shelters had reached about 80 by this time and the staff in these shelters were educating people in their communities. Interest in the issue was also growing in the United States and in Great Britain. Some of the results of research done in these countries were reaching Canada. At first, the general public, professionals and policy makers in Canada were incredulous. But soon the disbelief of most was replaced with outrage at the suffering going on behind closed doors. This anger fuelled demands to governments to do something about this violence.

Federal, provincial/territorial and municipal governments across Canada responded dramatically to these demands both through policy decisions which increased the scope of crisis intervention and through efforts to educate the public. One of the most visible and enduring public education initiatives was announced in 1982, in the federal Department of National Health and Welfare (now known as Health Canada). The National Clearinghouse on Family Violence was established with its own newsletter Vis-à-Vis. Two years later, the National Victims Resource Centre was also opened by the federal Ministry of the Solicitor General to provide information services on victims of crime, including female victims of violent crime. The federal government also promoted public dialogue concerning violence against women and demonstrated political will to address such violence through the creation of a Parliamentary Committee. In 1982, the House of Commons Standing Committee on Health, Welfare and Social Affairs tabled the results of five months of hearings and study on violence against women in a document entitled *Report on Violence in the Family: Wife Battering.* In the mid-1980s, Ontario, Alberta and other provinces began to launch public education campaigns. These early campaigns put a strong emphasis on the criminal nature of wife assault.

During this stage, most shelters began or continued to receive government funding. The number of shelters grew dramatically during this time, increasing from 78 in 1978 to about 400 in 1986, about the same number that exists today. The face of most shelters over this stage changed as dramatically as their numbers. Most shelters became more "professionalized" (procedures and standards were introduced, and formal education was demanded of staff) in response to funding conditions and

introduced, and formal education was demanded of staff, in response to funding conditions and growing public and professional interest in preventing woman abuse. These changes contributed to divisions within the shelter movement that have continued to the present, as many shelter workers and boards agonized over the pros and cons of professionalization and the effects of funding on the organization and institutionalization of shelters.

58. This report was called *Wife Battering in Canada: The Vicious Circle.* It was written by Linda MacLeod and published by Supply and Services Canada in 1980 in Ottawa, Ontario.

The justice system adopted a leadership role in terms of crisis intervention when the federal Solicitor General wrote to all Chiefs of Police across Canada, in 1983, urging them to direct their officers to lay charges in cases of wife assault when they had reasonable and probable grounds to believe that an assault had taken place. In 1983 as well, broad amendments made to Canadian sexual assault legislation included an amendment making sexual assault in marriage a crime.

During the 1980s, the health sector became more involved with the issue of violence against women. Physicians, nurses and hospitals began to realize the extent to which the problem existed, and how often it went undetected and untreated by health professionals. Provincial and national associations undertook professional education and awareness initiatives, and local service providers developed screening tools and service protocols. Public health personnel began to look at abuse as a health issue.

During the first two stages, the main emphasis was on physical and sexual violence and on the safety of individual women. While many grass-roots workers and some publications spoke of the structural roots of violence against women, the time was not yet right to act on this knowledge.

Stage III: Challenging the Accepted Responses through Collaboration and Communication about Diverse Needs (1987-1994)

The third stage was a time of expansion of programs, options and questioning. In this stage, justice system and shelter responses began to be scrutinized more closely. Much of this scrutiny was the result of greater mainstream involvement in the issue and different perspectives introduced by immigrant and refugee women, women who speak neither English nor French, Aboriginal women, lesbian women and women with disabilities. Many of these women found both institutional and general community responses inappropriate for their needs. New information about the prevalence and incidence of woman abuse and the use of services by women who are abused also helped to fuel the questioning. in this stage, spiritual abuse, at least in Aboriginal communities, and psychological abuse became recognized widely as important components of woman abuse.

In this stage, the interest and involvement of health, social service and education professionals increased. Mental health professionals and services began to recognize abuse as a factor in many mental health problems, not the result of these problems. Other health service providers worked to improve responses to victims and to undertake primary and secondary prevention efforts with women considered to be at risk of being abused. Interdisciplinary responses to woman abuse grew and coordinating committees appeared across the country. While health sector organizations were rarely the initiators of these committees, they were willing participants.

Recognition of the need for systemic change also began to appear consistently in most reports and statements. The Montreal Massacre of 1989, supported by an increasingly well -articulated feminist analysis, brought to the forefront the importance of looking beyond the individual 'perpetrator" and

analysis, brought to the forefront the importance of looking beyond the individual "perpetrator" and "victim" toward social values, attitudes and structures that create and perpetuate women's inequality, that fuel hatred and disdain for women, and that portray women as appropriate victims.

But perhaps the most significant influence during this stage was the legitimation of violence against women as an important social issue, demonstrated in part by massive increases in government funding for projects and programs concerning woman abuse. During this stage, governments across Canada actively supported research, demonstration projects, conferences, workshops and programs concerned about reducing the impact and incidence of woman abuse. Whereas the first programs for women who were abused were run by volunteers, community programs in this stage began to compete for government funding. The burst of funding support meant that activity and awareness around the country grew by leaps and bounds. To communicate the extent of the effect of government commitment to and funding for this issue, a few highlights of government activity are listed below.

Federal Government Initiatives

1988:

The federal government, under the leadership of Health and Welfare Canada, committed $40 million to a four-year federal government family violence initiative with a priority on wife assault. This initiative stressed the need for emergency shelters for battered women and their children as well as public education and coordination. More than half of this money ($22 million) was earmarked for the creation of new shelter spaces through the Central Mortgage and Housing Corporation.

1988-89

The federal government undertook extensive consultations with provincial/territorial governments and with voluntary sector agencies to determine what was most needed to help prevent violence against women and children in the home and to ensure the sensitivity and relevance of federal government initiatives. A National Forum on Family Violence was held as a culmination of this consultative process.

1991:

The federal government announced a renewed four-year family violence initiative, again under the leadership of Health and Welfare Canada. Under this initiative, the government committed $136 million to the prevention of family violence and the improvement of community responses. Once again, violence against women in the family was the priority concern.

1992:

The National Panel on Violence Against Women was created and mandated to report back to the government and the people by December 1992. This arms-length panel contributed an invaluable synthesis of knowledge on violence against women, and a clear gender analysis of the social and structural roots of the problem in women's inequality.

Collaboration between Different Levels of Government

1991:

The Federal/Provincial/Territorial Ministers Responsible for the Status of Women, at their Tenth Annual Conference, outlined a coordinated, multifaceted framework for a national strategy on violence against women.

A Brief Overview of Provincial/ Territorial Government Initiatives

During this stage, all provincial and territorial governments began to provide funding for emergency shelters for victims/ survivors of wife assault. In some provinces and territories, these included not only transition houses or crisis shelters but "second stage" shelters for longer term accommodation and a few "safe homes," that is, accommodation in private homes in areas without shelters.

Most provinces and territories created interdepartmental government committees that included representatives from the departments of health, social services, justice, women's equality, education and other relevant departments, to plan coordinated strategies for dealing with family violence. Many provincial /territorial governments, like the federal government, put a priority on wife assault.

A few specific provincial/ territorial government initiatives follow.

- New Brunswick developed an interdisciplinary protocol for dealing with wife assault in the justice system. Regional training sessions were held with criminal justice personnel, transition house workers and others who work with women who are assaulted and/or their partners.
- Nova Scotia opened a family violence office to coordinate both government and community programs by providing a clearinghouse function, research and training programs for professionals.
- Newfoundland addressed the need for better coordination among service providers by forming a province-wide committee.
- Prince Edward island, through the Interministerial Committee on Family Violence, held community consultations on family violence across the island. These consultations emphasized wife assault, raised awareness about violence in families and invited dialogue and action on prevention strategies.
- Quebec created ongoing Tables de Concertation, or coordinating bodies, across the province to sensitize and educate the public and service providers, to publish resource inventories and to avoid duplication and contradictory services.
- Ontario undertook a major public education campaign around the theme: "Wife Assault... It is a Crime," and adopted an integrated policy approach merging wife assault and sexual assault prevention initiatives into a combined violence against women strategy.
- Manitoba started the first Family Violence Court in Canada.
- Saskatchewan also has created a multisector Partnerships initiative to devise and implement new ways of working collaboratively.
- In Alberta, the Office for the Prevention of Family Violence provided a focus for prevention work and provided small grants to community organizations for prevention activities. It also produced a kit for teens to increase their knowledge about dating violence and woman abuse, to increase self-esteem and to promote positive preventive action.
- In British Columbia, a Task Force on Family Violence was created in 1991. It emphasized the need for more effective and culturally appropriate service delivery. The Ministry of Women's Equality placed a priority on violence against women and allocated funds to the training of service providers and support of community services across the province.
- In the Northwest Territories, a certificate training program for shelter workers was developed in collaboration with shelter workers.

- In the Yukon Territory, the Safer Places Initiative provided funding and developmental support to assist communities to open shelters or provide non-residential support to battered women and their children.

Municipal Government Commitment to the Issue

A number of municipal governments created violence against women committees following the Montreal Massacre. The Federation of Canadian Municipalities supported their work. Municipal governments contributed to the funding of shelters in most provinces /territories.

Community Initiatives

Government funding has helped many communities to become active in the attempt to stop the violence. Some of these efforts are highlighted in Appendix I. Funding dramatically increased the range and number of programs and research projects across the country. While this funding contributed significantly to knowledge about woman abuse and its prevention, in some locations it also created pressures and expectations of continued funding.

Stage IV: A Time of Paradox: Healing or Risk Assessment? (1995...)

The fourth and current stage is a time of paradox. It is a stage characterized by a quest for new directions and deeper analysis based on a positive vision of health and healing. But it is also a stage of impatience in which people are looking for certainty through the prediction of risk, the compartmentalization of the problem and simple directives for action. The questions from Stage III have continued into this present stage but are framed within a recognition that the step beyond violence prevention - the promotion of social harmony, individual, family, institutional and community health - requires the courage to change the ways we live, work and interact with one another. To add to the challenge, we are in fact living in increasingly stressful times, in which values of mutual responsibility, community and compassion are competing with those of survival, individualism and competition.

This time is paradoxical in large part because it is a time of heightened expectations in a time of limited resources. Many people concerned about preventing violence are struggling with the desire to continue to receive government funding for initiatives funded on a pilot basis, along with the reality that such funding will not be as plentiful or

may disappear altogether. The federal, provincial/ territorial and municipal governments are reducing expenditures for social programs, and the new Canada Health and Social Transfer will continue the trend toward smaller transfers to provincial governments for social programs.

in this paradoxical time, the desire is growing to expand the search for knowledge in order to expand the flexibility and responsiveness of services and programs. in particular, there is a growing energy to explore areas previously avoided because such knowledge could promote victim blaming and divert attention from the central question of women's inequality as the cause of violence against women. For example, current interest in lesbian abuse and other forms of violence by women is increasing, as is interest in how existing services such as shelters can respond to psychiatrized women and women with other disabilities.

At the same time, increasing poverty is creating barriers for more and more women who want to access services and escape abuse. Even maintaining presently inadequate services and programs will be a challenge, much less improving them. In a time of reduced resources, there is a tendency to focus on immediate needs and those in greatest need, eliminating a longer-term strategy that is truly prevention- oriented.

The challenge facing Canada as a society, and the many women and men in communities across Canada actively working to prevent violence against women, will be to find ways to fuel this questioning spirit and continue the awareness and community programs which have sprung up over the past decade without reliance on government funding. It is the contention of the authors of this report that a shift to a health perspective will help governments, businesses and existing community groups see that violence prevention is really part of making all our institutions, programs and services more healthy. The learnings which have emerged through work on the prevention of violence against women can help direct the change we are now experiencing as a society toward more costeffective, but also more healthy, ways of living and working together. These learnings also show

clearly that the promotion of healthy individuals, families, communities and institutions cannot be the responsibility of governments alone, but must be shared by all sectors of society.

Canada's Contribution to International Work around Woman Abuse and the International Movement from Violence Prevention to a Vision of Health

The importance of Canada's continued involvement in this area extends beyond national boundaries. Over the last 20 years, Canada has become internationally recognized for the courage and decisiveness with which it has worked to reduce the prevalence and impact of woman abuse. Canada has helped lead international policy and action to prevent woman abuse. The international response to woman abuse has mirrored the journey in Canada from an emphasis on justice system solutions to a broader preventive vision of healthy and non-violent families, communities and societies which embraces justice, economic, education, social, health and other community approaches.

In 1985, Canada contributed to the drafting of a statement for the Nairobi Forward-Looking Strategy which affirmed that violence against women is a serious human rights violation and urged governments to take action to:

- establish or strengthen forms of assistance to victims of such violence through provision of shelter, support, legal and other services."59

In 1990, at the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, Canada took leadership in the drafting and adoption of a resolution which "urged Member States to develop and implement policies, measures and strategies, within and outside the criminal justice system, to respond to the problem of domestic violence. The policies were to include appropriate preventive measures as well as fair treatment and effective assistance for victims of domestic violence. in the same resolution, the Assembly requested the Secretary- General to

59. United Nations, *The Nairobi Forward-Looking Strategies for the Advancement of Women,* Nairobi, Kenya, July 15 -26, 1985, excerpted and reprinted by Status of Women Canada, Ottawa, Ontario, p. 70.

convene a working group of experts to ... produce a manual for practitioners on the subject of

convene a working group of experts to... produce a manual for practitioners on the subject of domestic violence." The first version of this manual was written with the support of the Canadian Department of Health and Welfare.60 The purpose of this manual was "to give everyone with a responsibility for, or an interest in, ending the violence that women experience in their own homes, ideas on actions that they can take and strategies that they can promote to solve the problem."61 The manual stresses that the most important strategy of all is to work together effectively.

More recently, at the Ninth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held in Cairo, Egypt, in 1995, Canada took the lead in drafting and negotiating the passage of a far-reaching resolution which highlighted not only the need for legislation and justice system intervention to prohibit and respond to acts of violence against women, but also emphasized the high social, health and economic costs of violence against women and urged multidisciplinary responses to such violence.

At the Fourth World Conference on Women at Beijing, in 1995, the emphasis on collaborative and preventive approaches as well as the perspective of violence as a human rights violation were repeated in the resolutions on violence against women. The emphasis on health, social service and community responses to woman abuse was also strengthened.

60. The quoted sections of this paragraph are taken from p. 3 of this report, entitled *Strategies for Confronting Domestic Violence: A Resource Manual,* published by the United Nations Office in New York, in 1993. The first draft was prepared by the Canadian Department of Justice in cooperation with the Crime Prevention and Criminal Justice Branch of the Centre for Social Development and Humanitarian Affairs and with the Helsinki Institute for Crime Prevention and Control affiliated with the U.N. The draft was reviewed at an expert group meeting hosted by the International Centre for Criminal Law Reform and Criminal Justice Policy.

61. lbid, Preface.