Ontario Public Health Association
l'Association pour la santé publique de l'Ontario
Established/Établi 1949

POSITION PAPER #1
VIOLENCE PREVENTION: CONTINUED CALL TO ACTION FOR ONTARIO

CONTENTS

A Position Paper and Resolution adopted by the
Ontario Public Health Association
Code: 2008-01 **(PP)** ; 2008-01 **(RES)**

Status Active

POSITION PAPER

Violence Prevention: Continued Call to Action for Ontario

EXECUTIVE SUMMARY:

Violence Prevention: Continued Call to Action for Ontario (2007) is intended to provide the Ontario Public Health Association (OPHA) directional focus through continued leadership and advocacy efforts in sustaining working relationships with multi sectoral partners to advance efforts to prevent violence. The paper outlines accomplishments to-date from a national, provincial/territorial and local perspective including the specific achievements undertaken through the OPHA Violence Prevention Workgroup. The paper also provides a snapshot on the impact and cost of violence across the lifespan . Current information contained in this document a) support a public health approach utilizing an ecological model as advanced by the World Health Organization (WHO, 2004) with a focus on evidence based, collaborative approaches; and b) suggests that OPHA continue advocacy efforts within these key areas:

1) improved data collection and research;
2) emphasize primary prevention;
3) promoting social and gender equality and equity;
4) strengthening support and care services for victims.

The paper concludes with recommendations and resolutions.

INTRODUCTION:

Much has been accomplished since 1997 when the Ontario Public Health Association (OPHA) passed a Resolution formally recognizing violence as a public health issue. The OPHA position papers, *A Public Health Approach to Violence Prevention* (1999) and *Public Health and Violence Prevention- Maintaining the Momentum* (2003) along with the Resolutions passed in 2003, 2004 and 2007 have provided OPHA a directional focus in working with multi sectoral partners in the area of violence prevention. This paper illustrates the ongoing need for OPHA and its multi sectoral partners to continue providing leadership and advocacy efforts to prevent violence.

Definition

The World Health Organization (WHO) defines violence as:

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

Since 2003 the Ontario Public Health Association (OPHA) Violence Prevention workgroup has worked collaboratively with the OPHA Executive Board, Executive Director, staff and other OPHA workgroups and a number of partners from across Ontario, Canada and Internationally in a number of violence prevention initiatives.

ACHIEVEMENTS:

- Initiated and provides ongoing leadership, co-ordination and administrative support to Prevention of Violence Canada- Prévention de la violence Canada to develop a national violence prevention strategy (2003 –ongoing).

- Member of the Neighbours, Friends and Families campaign which is a partnership between the Ontario government, Ontario Women's Directorate and Expert Panel on Neighbours, Friends and Families, through the Centre for Research and Education on Violence Against women and Children to develop a provincial campaign to raise awareness of woman abuse (2005 - ongoing).

- OPHA violence prevention data base is established (2007-ongoing).

- Representation on the writing team reviewing the 1997 Mandatory Health and Services Guidelines (2003, 2006).

- Advisory Committee member on the Ontario Injury Prevention Resource Centre (2005-ongoing).

- Representation on the development of the Ontario's Injury Prevention Strategy (2007).

- Advisory Committee member Injury Prevention Research Office, St. Michael's Hospital – Geographical Information System research on intentional and unintentional injuries. (2005 – ongoing)

- McMaster University Woman Abuse Screening Research Project.

Advocacy activities

- OPHA advocates locally, provincially, and federally to support the repeal of Section 43 of the Criminal Code and endorsed *Joint Statement on Physical Punishment of Children and Youth[2004] (2003 – ongoing)*

- Co-ordinate and disseminate comprehensive packages of violence prevention programs and initiatives across the province. Ongoing collaboration and sharing of initiatives and research. (2003 – ongoing)

- "*Reaffirming the importance of strict firearm regulation in preventing firearm deaths and injuries" Resolution* (2007)

- Submission to the Roots of Youth Violence Secretariat appointed by the Premier of the Ontario Government (2008).

OVERALL CONTEXT:

International:
Great strides are being made throughout the world, in Canada, provinces and territories and local areas to prevent violence. The World Health Organization (WHO) and the United Nations continue to provide leadership to countries on violence prevention. The WHO's *World Report on Violence and Health* (2002) and the subsequent document, *Preventing violence: A guide to implementing the recommendations of the World report on violence and health* (2004) is providing the framework for the development of a national violence prevention strategy in Canada. The WHO Violence Prevention Alliance provides an international forum for sharing of expertise and experience. The United Nations *Declaration on the Rights of Children* (adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989) which Canada is a signatory provides clear direction on improving child wellbeing and the prevention of child maltreatment.

National:
Her Excellency, The Right Honourable Michaëlle Jean, the Governor General of Canada is a national leader and a champion for violence prevention. Prevention of Violence Canada-Prévention de la violence Canada is developing a national violence prevention strategy. This movement was initiated by OPHA in conjunction with the Canadian Public Health Association (CPHA) and involves partnerships with Public Health Associations from across Canada, the Public Health Agency of Canada, national, provincial and territorial organizations and government departments as well as researchers and practioners. The Institute for the Prevention of Crime, University of Ottawa is providing leadership, research and dissemination of knowledge in collaboration with many sectors including public health. They have released *Making Cities Safer Canadian Strategies and Practices (2008), Homelessness, Victimization and Crime: Knowledge and Actionable Recommendations (2008),*and *Building a Safer Canada First Report of The National working Group on Crime Prevention* (2007).

Various national strategies and research have been developed in Canada on issues which are interconnected to violence such as the *Blueprint for a Canadian National Suicide Prevention Strategy* (October, 2004), *National Alcohol Strategy: towards a culture of moderation* (2007); *National Strategy To Prevent Abuse in Inuit communities and Sharing Knowledge, Sharing Wisdom A Guide to The National Strategy* (2006). *Ending Canada's Invisible Epidemic – A National Injury Prevention Strategy* (2005) and a recent report by Dr. K. K. Leitch special advisor for Honourable Tony Clement, *Reaching for the Top A Report by the Advisor on Healthy Children & Youth* (2007). The Mental Health Commission of Canada (2007) was created with three priority key initiatives which include an anti-stigma campaign, the promotion of the development of a national strategy, and the creation of a Knowledge Exchange Centre. The Public Health Agency of Canada's Family Violence Prevention Unit provides leadership throughout Canada. Promoting Relationships and Eliminating Violence – La promotion des relations et l'elimnation de la violence (PREVNet) a national coalition to prevent bullying and improve healthy relationships is providing the research, knowledge and application to prevent violence in relationships. The Coalition for Gun Control a non partisan, nonprofit organization is supported by over 300 organizations inclusive of national, provincial and local organizations. The Coalition's position includes licensing all gun owners, registering all firearms, a ban on military assault weapons, strict control on handguns, safe storage, and measures to reduce the illicit trade in firearms and community based implementation. There are many national organizations such as Roots of Empathy, Red Cross, Centre for Addictions and Mental Health, SMARTRISK and the Canadian Mental Health Association who are involved in violence prevention initiatives. The Centres for Research and Education on Violence Against Women and Children provide a host of experts who provide research and application to practice. Canada has academics, researchers and practioners who are leaders in the area of violence prevention.

Provincial and Territorial:

Much has been done provincially, territorially and locally in regards to violence prevention. Provincial examples include work done by the Government of Newfoundland and Labrador in the creation of a *Provincial Strategy Against Violence - a five year plan* (2007) which involves the coordination of service delivery to women, children, the elderly and other vulnerable adults who have experienced violence. Alberta has a Safe Community Secretariat and a plan to reduce crime with a huge focus on prevention. In Ontario, *Ontario's Injury Prevention Strategy Working Together for a Safer, Healthier Ontario* (2007); *Poverty Reduction Strategy* (2008); the *Domestic Violence Action Plan (2004*) including *Neighbours, Friends and Families* (2006) Bill 212 – the Education Amendment Act which dealt with progressive discipline and school safety (2007) are all initiatives to reduce and prevent violence. Steps have been initiated for a provincial alcohol strategy and violence is a part of this. Soon to be published report from the Roots of Youth Violence Secretariat.

Local:
The Early Child Development funding (ECD) for Family Abuse Prevention; Childhood Injury Prevention; Healthy Pregnancy and Child Development; Support for At Risk Pregnant and Parenting Women (2003-2006) provided all Health Units across Ontario the funding to implement or augment violence prevention initiatives. A variety of important family violence initiatives were undertaken such as the prevention of "Shaken Baby Syndrome", campaigns to prevent physical punishment of children, programs which focus on building healthy relationships and initiatives for the prevention of violence in intimate relationships.

Some communities have a Crime Prevention Councils or coalitions of community partners to address specific areas of importance in their communities. Others have youth engagement inclusion activities that emphasize recreational and educational opportunities; while other communities have adopted community safety initiatives i.e. physical and built environmental safety features.

PREVALENCE AND IMPACT OF VIOLENCE

There is no single research study that describes the entire spectrum of violence. Research studies often examine one aspect of this diverse problem. Violence is an area that is often unreported and it's difficult to capture the full extent of the issue. It is important to note that prevalence data regarding violence should be interpreted with caution due to the complex nature of violence. This data reflects numerically the pervasiveness of violence in our society yet it falls short in describing the effects of violence from a human perspective. The limited research available regarding the cost of violence to our society indicate the staggering effects financially, yet again do not reflect the personal cost and pain to the individual or society which cannot be calculated. Some of these costs or impacts are described along with the prevalence data below.

Children and Youth

Prevalence:

- Every four hours in Ontario, one child visits an emergency department and every four days, one child is hospitalized due to a violence-related injury. Injuries to the head are most common (Ontario Injury Prevention Resource Centre, 2008).
- According to police data in Canada, the majority of physical assaults against children were perpetrated by someone the child knew, most commonly a parent (AuCoin 2005; Canadian Centre for Justice Statistics, 2007). In the 10-year period from 1996 to 2005, over one-quarter of children and youth killed by a family member were infants (Canadian Centre for Justice Statistics, 2007). Baby boys were at greater risk than baby girls.
- In national sample of Canadian students, over 20 percent of students reported that they were both bullies and victims of bullying, although more students reported being bullied compared with those who reported bullying others. In this same survey, sexual harassment reported by girls increased with age and peaked in Grade 9. Harassment because of race, ethnicity, and religion is a form of bullying that was reported by more boys than girls. Also, boys reported more physical fighting, and frequent fighting, than did girls, and this peaked in Grade 7. Boys most often fought with friends or acquaintances, while girls were equally likely to fight with their siblings (Public Health

Agency of Canada, Young people in Canada: their health and well-being, http://www.phac-aspc.gc.ca/dca-dea/publications/hbsc-2004/hbsc_summary_e.html).

- Among a sample of Ontario students in grades 7 to 12, 10% reported that in the past 12 months they had seriously considered suicide; 3% of students reported that they attempted suicide; 11% of students assaulted someone; 5% were involved in gang fighting at least once in 12 months; 16% of students reported fighting on school property; 9% of students reported having been threatened or injured with a weapon on school property; 30% of students reported being bullied at school (Adlaf et al, 2007).
- In Canada in 1997, there were 58 homicidal deaths among young men aged 15–24 years, making homicide the fourth leading cause of death (after unintentional injuries, suicide and cancer) in this age group (Weir, 2005).

Impact: Abusive situations in early life may result in children becoming perpetrators and victims of interpersonal and self-directed violence. Children who have experienced abuse are more likely to suffer from mental health problems both as children and as adults. That is, neglected infants and toddlers experience greater deficits in coping skills, more frustration, anger, and non-compliance, low self-esteem, poor impulse control etc.

Children who witness violence at home are at increased risk for developing serious emotional, behavioural, and health problems. Child behaviours that have been associated with witnessing violence include: aggression, negative effects on social and academic development, low self-esteem and lack of confidence. Witnessing or being a victim of violence has an enormous impact on the neurological development of the child's brain. (Moukas, 2004 p 12) Further, research has demonstrated a link between children's exposure to images of violence through television and film and aggressive behaviour in adulthood (Huesmann et al, 2003).

Youth that have experienced violence are at an increased risk for post traumatic stress disorder. (Fein, et al, 2002 cited Moukas, 2004 p.34) Youth victims of violence who are also exposed to interparental violence are at greater risk for psychiatric disorders. Youth who fail to learn alternatives to their aggressive behaviour are "among the most delinquent from pre-adolescence onward, are the first to initiate substance use and sexual intercourse, are most at risk of dropping out of school, being charged under the Young Offenders' Act, and being diagnosed with a psychiatric disorder (Temblay, 2000, p.23 cited Moukas 2004 p. 34)

Women

Prevalence:

- An estimated 227,000 women in Ontario experienced spousal violence in 2004 (Statistics Canada, 2006). Women were more likely than men to experience spousal assault. For example, in Ontario, from 1975 to 2004, there were an average of 25 spousal homicides each year among women compared to 6 each year for men.
- Spousal violence has an impact not only on the couple but also on children. Almost 40% of women assaulted by their spouse reported that their children witnessed the violence (Statistics Canada, 2006).

- Violence also occurs during pregnancy with numerous adverse outcomes for the mothers and their children. For example, abuse during pregnancy can also impact the longer term psychological outcome of children born. In a 2006 study in Northwestern Ontario reported even after key confounding variables were controlled in the study, the results still showed that children born to women abused during pregnancy had greater behavioral problems (Tan and Gregor, 2006).

Immigrants and Refugees Women:

- Violence has been associated with immigrant status. For example in one Canadian study, the crude prevalence of intimate partner violence was similar among recent (0-9 years) and non-recent (>= 10 years) immigrant women (Hyman et al., 2006). However, after adjusting for other factors, the risk was significantly lower among recent immigrants compared with non-recent immigrants. Other factors also played a role. Country of origin, age, marital status, and having an activity limitation were also associated with a higher risk for intimate partner violence.

Impact: Women in abusive relationships experience higher levels of anxiety, chronic stress, somatic complaints, eating disorders, suicide and depression. Abused women are also more likely to rely on drugs, sedatives, alcohol and sleeping pills in order to deal with their mental illness, behavioural disorders, and reproductive and sexual health problems. Victims of physical abuse are at greater risk for complications during pregnancy or childbirth, STIs, HIV, PTSD, OCD, adjustment disorders, decreased self-esteem, and gynecologic problems. The physical and psychological implications of emotional abuse include depression, anxiety, stomach problems, chronic headaches, back and limb problems. (Moukas, 2004 p.11)

Older and Vulnerable Adults

Prevalence:

- Police-reported data found that violence incidents among seniors were more likely to be perpetrated by a family member. The most common perpetrators of family violence against seniors were adult children and current or previous spouses. (Ogrodnik, 2007)
- Senior males were more likely than senior females to experience violent crime. In 2005, rates of police-reported violent crime were 1.5 times higher among senior men compared to senior women (Ogrodnik, 2007).

Impact: Older adults whom are dependent upon their children or other caregiver may be at greater risk for physical, emotional, and financial abuse. Disability, illness, and mental incapacitation may place a vulnerable adult at risk for abuse by a caregiver who lacks understanding concerning the person's condition or a caregiver who is overwhelmed. Older women are particularly vulnerable to abuse (Hightower, 2004). Further, emotional maltreatment of older adults may result in feelings of inadequacy, guilt, depression, low self-esteem, hopelessness or powerlessness. (Moukas, 2004 p.14)

Men

- Every week, two Ontarians are killed by violence and every day 6 Ontarians are hospitalized with violence-related injuries (Ontario Injury Prevention Resource Centre, 2005). Males accounted for about 66% of these deaths and 81% of hospitalizations. Cutting or piercing was the most common type of violence-related injury death followed by assault with a firearm or explosives. In contrast, the most frequent type of violence-related injury hospitalization was a fight, brawl, or sexual assault followed by cutting or piercing and being struck by a blunt or thrown object.

Impact: Often ignored are the male victims of spousal abuse who suffer from some of the same types of consequences as female victims who are or who have experienced abuse in that, abused husbands tend to suffer from low self-esteem, fear or paranoia, and shame. (Moukas, 2004 p. 25)

Marginalized and discriminated against groups

People belonging to groups that have traditionally been subjected to discrimination based on race/ethnicity, religion, gender, and sexual orientation are more likely to experience hate crimes than others. Hate crimes are committed against individuals and organizations representing marginalized populations based on ethnicity, religion, gender and sexual identity. They involve, acts of violence**,** literature/hate mail; verbal slurs, vandalism of religious, ethnic, lesbian or gay, or minority sites, intimidation or harassment as means of reinforcing marginalization and stigmatization of people and institutions that are considered non-normative.

Prevalence:

- In 2006, police services reported 892 hate motivated crimes of which 6 in 10 were motivated by race/ethnicity, one-quarter were motivated by religion, 1 in 10 were motivated by sexual orientation and one-third of all hate crimes involved assault (Statistics Canada, 2008)
- Self-report data shows that race/ethnicity was the most common motivation for hate crimes
- In 4 out of 10 hate crime incidents, victims found it difficult or impossible to carry out their daily activities versus 23% of incidents involving victims of non-hate crimes.
- In 502 hate crimes motivated by race/ethnicity in 2006, 50% Blacks, 13% South Asians, and 12% Arabs or West Asians
- Among 220 religion motivated hate crimes, 63% were against Jews, 21% were against Muslims, and 6% were against Catholics
- Eighty percent of the hate crimes motivated by sexual orientation were against homosexuals and were more likely to result in physical injury to victims.

Impact: The impact on victims of hate crimes mimics the symptoms of post traumatic stress disorder. Symptoms associated with post traumatic stress disorder include general anxiety, negative self-image, self-doubt, fear, re-victimization, self-hatred, self-blame, inferiority, feeling of worthlessness. (Moukas, 2002 p.24)

Lesbian, gay, bisexual, transgender and Two-spirit, queer and questioning (LGBTQ)

Violence targeting LGBTQ people may include threats, physical or sexual assault, rape, attempted murder. These actions can be attributed to cultural, religious, or political mores and biases. LGBTQ people also suffer through intimate partner violence at the same rate as heterosexual women. The abuse also looks similar to that of heterosexual women i.e., emotional bullying, social isolation, control of finances, extreme jealousy. However, the additional feature which impacts on LGBTQ is the close knit dynamic of LGBTQ community along with the threat of disclosure to family and friends if they are not "out" about their sexuality. For children and youth "homophobia and transphobia is often linked to poor performance in school, drop-out rates and teen suicides." (©365Gay.com2008 Newscenter Staff)

Prevalence:

Statistics Canada 2004 General Social Survey on Victimization for spousal abuse among same-sex partners found:

- That while the overall proportion of those who experienced spousal violence and who indicated that they were gay or lesbian was low, the rate of spousal violence reported between same-sex couples was twice the rate of violence between heterosexual couples (15% versus 7%).
- Analysis of a 10-year police-reported linked file, showed that 2.5% of police-reported incidents of spousal violence occurred between same-sex couples. The proportion of these incidents in which the couples were gay males was two-and-a-half times that of lesbian couples (72% versus 28%).

The first national study – phase one survey results of students from grades 8 through 12 based only on those who self identified as LGBTQ undertaken by Egale Canada a national LGBTQ rights organization found:

- Over two-thirds of LGBTQ participants reported that they felt unsafe at school, compared to 1 in 5 straight participants.
- Over half of LGBTQ participants reported that they have been verbally harassed because of their sexual orientation.
- Almost half (49%) have had mean rumours spread about them at school.
- Almost a third (31%) have had mean rumours spread on the internet or through text messages because they are LGBTQ.
- Over a quarter have been physically harassed because of their sexual orientation.
- 41% had been sexually harassed compared to 19% of straight kids.
- LGBTQ participants who had been harassed or assaulted were much less likely than straight participants to report it to school staff members.
- Almost half (47.5%) agreed with the statement, "It is hard for me to feel accepted at my school" (compared to one fifth [19%] of straight participants).
- Almost two-thirds (62%) agreed with the statement, "Sometimes I feel very depressed about my school" (compared to just over one-third [36%] of straight participants).
- Almost 40% of straight participants reported that they made homophobic remark sometimes or frequently.
- 19% of LGBTQ participants made homophobic remarks sometimes or frequently, perhaps to fit in. (©365Gay.com Newscenter Staff, May 12, 2008)

People with disabilities

Prevalence:

- Higher risks for intimate partner violence were found across three large-scale Canadian surveys among women with disabilities. Women with disabilities reported a significantly higher prevalence of violence than those without disabilities (Brownridge et al., 2008).

Impact: The health effects of violence and abuse against people with disabilities are: post traumatic stress disorder, alienation from self and others, fear and nightmares, anger and guilt, re-victimization, difficulties in forming relationships with people, complications with sexual functioning, lower quality of life. (Moukas, 2004 p.15)

Homeless people

Prevalence:

- According to research findings at Wellesley Institute, homeless people in Toronto report a rate of physical assaults 35 times higher than the housed population; and a sexual assault rate that is also many times higher than those who are housed. In addition to physical and sexual violence, people who are homeless suffer serious illness and premature death at a rate many times higher than the housed population. Physical and sexual violence is a leading cause of homelessness, especially for women and youth. Women who are victims of violence are more likely to experience discrimination from landlords. The 2007 Street Health survey reports that 35% of homeless people reported being physically assaulted in the past year. (Wellesley Institute backgrounder, May 8, 2007 www.wellesleyinstitute.com)
- According to the 2003 Statistics Canada statistical profile of a snapshot on family violence on April 15, 2002, almost three-quarters (73%) of the women and more than four-fifths (84%) of the children admitted to family shelters across the country were fleeing abusive situations. (Canadian Centre for Justice Statistics 2003, cited Public Health Agency of Canada, 2006).

Impact: Family violence is a strong contributing factor for homelessness among children, youth and adults. Chronically homeless women, generally have histories of higher rates of physical and sexual abuse than other segments of the population. Homeless youth who flee abusive home environments face greater vulnerabilities in re-victimization while living on the street – especially for female homeless youth who were victims of sexual abuse in their families. A Canadian study conducted in 10 major cities across Canada cited family violence as one of the main causes of homelessness among families interviewed. Respondents noted that family violence leading to homelessness often co-occurred with other events such as marriage breakdown and eviction. (Social Planning and Research Council of B.C. 2003, cited Public Health Agency of Canada, 2006)

Street Youth

Prevalence:

- Abuse was common among various marginalized populations. For example, in a study of street youth in Vancouver, relationships between the level of childhood maltreatment and involvement in sex work were examined. The prevalence rates for abuse in the sample were 73% for physical abuse; 32% for sexual abuse; 87% for emotional abuse; 85% for physical neglect; and 93% for emotional neglect. The authors noted that not only was sexual abuse independently associated with sex work, but emotional abuse was as well (Stolz et al., 2007).

Mental Illness

Although the indicators for violence among persons with a mental illness is the same as for the general public, (e.g., male gender; childhood abuse, substance misuse, stressful and unpredictable environment, lack of social support etc.) a person suffering from mental illness is more likely to be a victim of violence than a member of the general public. The strongest predictor of violence is a history of violence rather than mental illness contributing to violence. At present, correlation between mental illness and substance use and violence continues to be examined, but it would seem that substance use among people with mental illness seems to increase the risk of violence significantly (i.e., in the general population substance use increases the rate of violence by two and a half times, conversely with mental illness substance use increases the rate of violence by seven time). [CMHA, BC Division, 2005]

Suicide:

As noted within their published blueprint, The Canadian Association for Suicide Prevention recognized the connections between mental health, mental illness and suicide in that "suicidal actions…should be viewed in the context of mental health issues and other conditions of risk" (CASP, 2004; p.17).

Suicide Risk Factors: (Moukas, 2002)

For children and youth, mood and conduct disorder, schizophrenia, gender identity, access to lethal means in the home and school environment (i.e., drugs, alcohol, firearms, and poisons) have been identified as potential risks. Within the school setting, harassment and victimizations – bullying, perfectionist tendencies, poor academic performance, rejection by peers or peer group pressure are also known risk factors. Within the family unit, experiencing intra-familial or extra-familial emotional, physical or sexual abuse as well as witnessing violence or abuse may increase a person's risk for suicide. Mothers of suicide victims are more likely to smoke cigarettes, drink alcohol.

The majority of adults who commit suicide have a diagnosable mental illness. The various diagnostic groups in descending order of risk are depression, personality disorder, alcoholism, schizophrenia, organic mental disorder, and other mental disorders. The presence of depression and alcoholism, family history of violence or assault, imprisonment, or antisocial behaviour, childhood physical and sexual abuse, recent interpersonal loss (e.g., divorce, separation or widowhood) also increases the risk of suicide. Some types of physical

and chronic conditions (i.e., neurological disorders, epilepsy, stroke, cancer, HIV/AIDS, diabetes, multiple sclerosis etc.) and socio-economic factors such as poverty, unemployment, poor education are also associated with an increased suicide risk.

For older adults, being male, Caucasian, single, divorced or widowed plays a contributory role to suicide. Generally, increasing age, loss of health, social roles, loss of significant relationships, having a fear of institutionalization and having access to lethal means such as alcohol, drugs, or firearms are associated with an increased suicide risk.

Firearms:

- Each year in Ontario, more than 600 people visit an emergency department with a firearm injury and more than 190 are hospitalized (Ontario Injury Prevention Resource Centre, 2006). About 24% of emergency department visits and 46% of hospitalizations for firearm injuries were classified as violence-related.
- In 2003, there were 183 deaths associated with firearms in the province of Ontario. Of these deaths, 27% were violence-related (Statistics Canada).

The Canadian Paediatric Society (CPS) has identified firearms as an important cause of injury among children and youth. Firearms are the third leading cause of death among Canadians from ages 15-24 following motor vehicle accidents and suicide by other means. Firearms kill more youth in this age group than cancer, drowning and falls combined (CPS, 2005). Statistics Canada study of family violence between 1991 and 1999 found that the majority of Canadian child and adolescent homicide victims are killed by family members. Young males between 17 and 24 years account for the majority of firearm related injuries seen in emergency departments (Smartrisk, 2006). Further, the problems of youth suicide are largely ignored and most parents are unaware of the risks associated of firearms in the home (taken from firearm resolution). Results from the Ontario Student Drug Use Survey in 2005, indicated that one in 50 Ontario high school students reported carrying a gun (CAMH, 2006).

Substance Abuse:

There is a greater risk for violence in households where one or both caregivers abuse substances. Victims of sexual or physical violence may abuse substances in order to deal with the traumatizing effects of the abuse. The trauma experienced by victims of sexual abuse manifests itself in many ways including depression, chronic sleeping problems and nightmares, eating disorders, anxiety or panic attacks, suicide attempts, lower self-esteem. (Moukas, 2004 p.11)

- The risk of being a victim of serious assault rises when alcohol sales are higher, and young urban males appear to be particularly vulnerable. The study, published on PLoS Medicine looked at sales by the Liquor Control Board of Ontario, as well as health-care data for people involved in assaults who admitted to hospital. For each of the 3,212 patients age 13 and older, the researchers at St. Michael's Hospital and the Institute for Clinical Evaluative Sciences (ICES) used postal codes to find the liquor store closest to an individual's home. The study covered the period between April 1, 2002, and December 1, 2004. During this 32-month period, the researchers found that 36 percent of the assaults involved the use of a sharp or blunt object, while 48 per cent occurred during

a flight or brawl without weapons. Sexual assaults accounted for 1.7 per cent of victims and maltreatment by a spouse or partner for 2.1 per cent. Eighty-three per cent of those admitted to hospital due to assault were male, with 25 per cent of cases aged 13 to 20. In all, 48 patients involved in the assaults died from their injuries. Overall, the risk was highest in three subgroups of people: men – 18% increased risk; youths aged 13 – 20 years -21% increased risk; and those living in urban areas – 19% increased risk.[Alcohol Policy Network, June 2008 issue]

SUMMARY

This section has provided a glimpse of some statistics of violence within various populations across the lifespan. Due to the complex nature of violence, it is difficult to truly capture the depth and scope of the problem. The section below contains an estimate of the economic cost of violence.

THE ECONOMIC COST OF VIOLENCE

The impact of violence on individuals, families and communities as discussed in the previous section outlines the emotional, psychological, and social costs. The prevalence of violence data may be under represented since many incidents are not reported to police services and screening tools in health services may not always capture the cause of injury. Yet, estimates have been calculated on the cost of injuries related to violence that highlight the magnitude and economic burden: For example, in a 2006 Ontario report, the economic burden of violence-related injury was estimated at $230 million. (SMARTRISK, 2006) Fight, brawls, and sexual assaults made up the largest portion of the costs at $88 million, followed by cutting or piercing injuries at $41 million, and child battering or other maltreatment at $16 million. Other Canadian studies have also examined violence specific types of violence, such as violence against women. For example, the financial cost to society of violence against women was conservatively estimated at approximately $1.2 billion annually in Canada (Day, 1995) and more recently direct medical costs of violence against women at $1.1 billion. (Waters et al., 2004). These estimates may reflect the cost across various sectors such as health, social services, and legal systems.

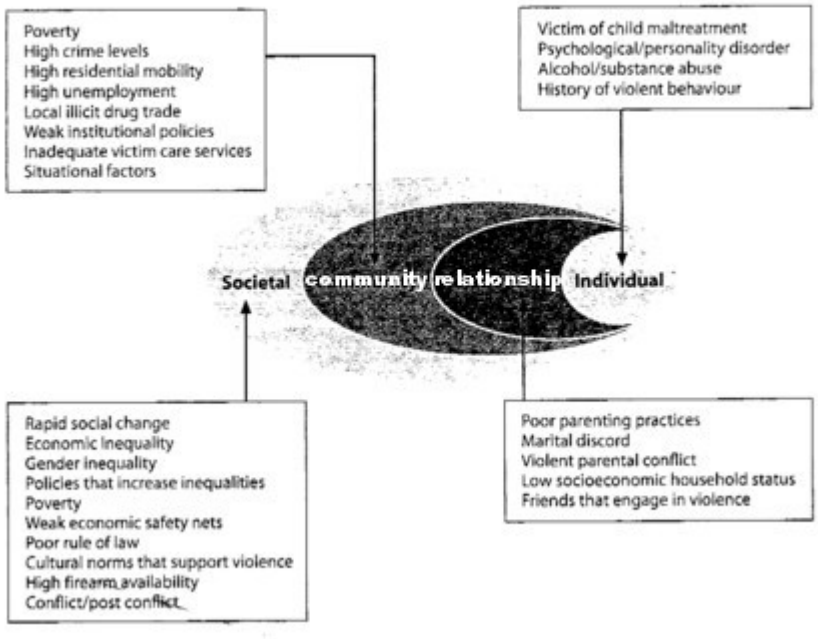
Since the economic burden of violence is absorbed at all levels of government and across various sectors, addressing violence requires an approach that is cross cutting with an emphasis on intersectoral collaboration. Collaboration and partnership are characteristic of a public health approach that has been applied to address violence and to reduce incidents in a variety of contexts. The public health approach to violence prevention is further examined in the section below.

A PUBLIC HEALTH APPROACH

Violence prevention is a complex issue which will take many different strategies and approaches from many sectors. The importance of considering a population health approach and the determinants of health and how they can contribute to risk factors and protective factors need to be addressed.

The WHO ecological model as noted below which purports that interpersonal violence is the outcome of interaction among many factors at the individual, relationship, community and societal captures the lens through operationalizing a public health approach to the prevention of interpersonal violence.

Ecological model showing shared risk factors for sub-types of interpersonal violence



A public health approach utilizes an ecological model which is evidenced based and is collaborative among many disciplines and has these four steps; 1) define the problem; 2) identify the risk and protective factors; 3) identify best practices; 4) implement and evaluate. (WHO 2004, p. 5)

Health has been identified as a leader in violence prevention as it has the capacity, knowledge and experience to bring together multiple sectors in major public health issues. Health Ministries and organizations have the ability to collect the data, provide treatment as well as information and resources to reduce violence.

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

OPPORTUNITIES:

- The WHO provides a solid framework for action. In Canada and Ontario we have leading experts in research, academia and front line workers who have the knowledge and expertise to lead the way.

- OPHA has an opportunity to continue to influence the development of the national violence prevention strategy through the participation of Prevention of Violence Canada/Prévention de la violence Canada

- The Ontario Injury Prevention Strategy (Ministry of Health Promotion, 2007) includes both unintentional and intentional injury. There is significant opportunity to assist in the development of the intentional injury component of this strategy. There is an opportunity for the Ministry of Health Promotion (MHP) to coordinate violence prevention initiatives across sectors through this strategy.

- Under the new "Prevention of Injury and Substance Misuse" program standard, Public Health Units have an opportunity to implement violence prevention initiatives under the "Other" category, based on local needs and available intervention to address said needs.

- Public Health along with its partners is developing promising violence prevention strategies. A Public Health approach that emphasizes a multi sectoral and collaborative approach which looks at the root causes of violence, the collection of data and solid evaluation are key.

- Public Health is significantly contributing to the identification and reduction of many identified public health problems through methods of surveillance and data analysis. Similar methods need to be developed specifically for violence issues, possibly through such methods as the Rapid Risk Factor Surveillance System which has been used to measure public awareness of various violence related issues and the use of Geographical Information Systems.

- Ontario Injury Prevention Resource Centre is seminal in providing information to Public Health Units regarding violence in Ontario.

- Promotion, dissemination, update and utilization of OPHA Violence Data Base.

- There are also opportunities to learn from other jurisdictions that have successfully implemented effective violence prevention strategies based on public health approaches.

CHALLENGES:

- Violence prevention continues to be an urgent public health issue and concerted action is needed at all levels of government (municipal, provincial/territorial, federal).

- There is a need for increased coordination of violence prevention initiatives between sectors in Ontario.

ACTION PLAN:
OPHA is well positioned to continue with advocacy efforts within these key areas as identified by the World Health Organization (2004).

IMPROVED DATA COLLECTION:
Despite the growing awareness of the reality, impact and costs of violence, we need to make a concerted effort to achieve more complete documentation to support the efforts of those working to prevent violence. All forms of violence need to be statistically described and targeted with appropriate prevention and intervention. The Provincial government needs to support the enhanced documentation of the effects of violence on the population of the province, as it has with respect to cancer, tobacco, heart disease and stroke.

RESEARCHING VIOLENCE:

It is important to research violence to understand the causes, consequences and prevention. Information obtained through research will lead to better understanding and the development of promising and best practices which will lead to the opportunity to advocate for increased investment (WHO, 2004, p.27).

EMPHASIZE PRIMARY PREVENTION:
There will a range of strategies that will act at different stages of development and across the different levels of the ecological model for effective intervention for prevention of violence (WHO, 2004 p. 35) Investing in early intervention from a young age is more effective than waiting for adulthood.

PROMOTING SOCIAL AND GENDER EQUALITY AND EQUITY:
Violence has widespread health consequences for individuals, relationships, communities and society. In analyzing violence, it is necessary to adopt an anti-oppression framework that includes gender-based lens that accounts for how men and women experience violence differently. This means looking at how the patterns of violence differ for men and women, and recognizing that violence represents a manifestation of gender inequality.

Overall, it is important to examine violence issues from a gender-based analysis, as "a gender-neutral has the effect of blinding us as we desperately search for clues about how to respond" (Katz, 1999). As Katz (1999) emphasizes, "the fact that violence – whether of the spectacular kind represented in the school shootings or the more routine murder, assault, and rape – is an overwhelmingly male phenomenon should indicate to us that gender is a vital factor, perhaps the vital factor."

Violence prevention can be achieved through the promotion of both social and gender equality and equity. It is a known fact that gender and social inequities are major risk factors which adversely impacts on interpersonal violence. Conversely, promoting and advocating for effective social and gender policies will enhance protective factors to reduce levels of violence. Anti-racism frameworks can be used to address hate related violence that are symptomatic of social, political, and economic inequality for people of various race/ethnic groups and new immigrants. Further, a public health approach not only addresses poverty and inequality but also places emphasis on integrating violence prevention into social and educational policies. An integrated violence prevention approach ensures:

- increased access to, and quality of, early childhood education and care;
- improved and equal access to primary and secondary education inclusive of adequate resource allocation
- reduced unemployment rates;
- stronger social-protection systems (i.e. protection and accessible universal health insurance, universal child care; social security safety net for the most vulnerable) (WHO p.50)

STRENGHTENING SUPPORT AND CARE SERVICES FOR VICTIMS:
Strengthening support and care services for victims goes hand in hand with advancing and promoting primary prevention approaches in response to interpersonal violence. The aim is to minimize harm to the victim by strengthening quality services to:

- "treat injuries and minimize harm and suffering in both the short and long term;
- reduce the likelihood of secondary victimization – both intentional and unintentional – by service providers;
- facilitate redress through the criminal justice system where possible;
- reduce the likelihood that individuals will suffer repeat victimization in the future and the likelihood that victims themselves will become perpetrators." WHO, 2004 p.61)

In addition, the following are still particular areas that require concerted attention towards collective and collaborative efforts in promoting a violent free society of which Public Health can take a leadership role.

Resiliency:
It is evident that individuals, faced with similar circumstances and challenges, respond differently and experience different health impacts depending on their resiliency. Public Health's role in building resiliency within individuals, families and communities needs to be implanted, evaluated and honoured. Public Health needs to work with other community partners to foster that resiliency and to establish best practices that can be seen to aid in preventing further violence and in dealing with the health effects of violence already experienced.

Build Protective Factors:
From a prevention perspective, building on protective factors is based on the notion of resiliency. Resiliency is attributed to the ability to bounce back from adversity in that resiliency if often used to "describe the individual's ability to manage or cope with significant adversity or stress in ways that are not only effective, but may result in an increased ability to respond to future adversity". (Health Canada, 2000, p. 8; cited Moukas, 2002).

The internal aspects of protective factors consist of a person's temperament and cognitive abilities. Externally, it's impacted by social, economic and environmental events. To this end, it is important for Public Health to continue partnering to advance preventive programming/interventions which promote creating and enhancing personal skills and healthy environments by increasing individual, familial and community protective factors and support systems which influence the effect of adverse conditions and strengthens resilience.

Conclusion:
The complexity of the issue of violence prevention can be overwhelming and effective interventions can only be achieved through collaborative interdisciplinary actions in which public health is a partner. Most importantly, change can only occur if action is taken at all levels of government and society, as well as with individuals, families and the community at large. Action to prevent violence requires a multi-faceted, multi-disciplinary approach, sustained and adequate funding, attention for resources, services and coordination. Public Health can play a key role, using evidence to inform practice, to deal with the extensive health effects of violence and to prevent future violence. Extensive community partnerships with other sectors and agencies are essential for effective delivery of programs and services by Ontario Public Health Units with a focus on promotion of optimum protective factors and the reduction of risk factors from a population health and social determinants of health approach.

RECOMMENDATIONS:

OPHA will continue to utilize the WHO (2004), *Preventing violence: A guide to implementing the recommendations of the World report on violence and health as the guiding framework for violence prevention activities and advocacy* as the basis for promoting a public health approach to violence prevention.

OPHA will work with local and provincial bodies (councillors, LHINs municipal sectors) to ensure the development and adoption of policies that prevent and reduce violence within their own communities and advocate for the coordination of initiatives locally, provincially and federally.

The Ontario Public Health Association (OPHA) will continue to advocate for adequate provisions and sustained funding for Violence Prevention in the Mandatory Health Program and Services Guidelines through the Ministry of Health Promotion (MHP) and affiliated bodies.

OPHA will work with its constituents, the Ministry of Health Promotion, other related ministry officials, public health units, provincial associations and other key partners to promote the development of a comprehensive and co-ordinated provincial interministerial strategy aimed specifically at the prevention of violence across sectors through the Injury Prevention Strategy.

OPHA will continue to advocate with multi sectoral partners for adequate and sustained funding for promising and best practices.

OPHA will continue to advocate with multi-sector partners for policies and practices which promote resiliency and well being throughout the lifespan utilizing an ecological framework OPHA will continue to support and advocate for the work of the coalition on Physical Punishment of Children and Youth and the Coalition for Gun Control.

OPHA will continue facilitating efforts towards developing a national violence prevention strategy by supporting the Prevention of Violence Canada-Prévention de la violence Canada related activities and workgroups.

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

OPHA will foster sharing of violence prevention initiatives through the OPHA violence prevention data base.

RESOLUTIONS:

WHEREAS violence is a pervasive problem impacting the health and well-being of individuals throughout the lifespan, families and communities;

WHEREAS it is important to address the root causes of violence with attention given to many variables such as mental health, alcohol and other substance use, homelessness and vulnerable populations;

WHEREAS a Public Health approach which is multi-sectoral, collaborative and utilizes an ecological framework with focus on research, data collection, promoting primary prevention, promoting social and gender equality and equity and strengthening victim support and care is recommended by the World Health Organization in preventing violence;

BE IT RESOLVED THAT OPHA continue to endorse and utilize the WHO (2004), *Preventing violence: A guide to implementing the recommendations of the World report on violence and health* as a framework for action;

BE IT FURTHER RESOLVED THAT OPHA continue to provide leadership and facilitation in Prevention of Violence Canada- Prévention de la violence Canada;

BE IT FURTHER RESOLVED THAT OPHA continue to work with our multi sector partners to augment the intentional injury prevention component of the Ontario Injury Prevention Strategy;

BE IT FURTHER RESOLVED THAT OPHA continue to support the Coalition on Physical Punishment of Children and Youth and the Coalition for Gun Control;

BE IT FURTHER RESOLVED THAT OPHA continue participating in activities and partnerships that enhance violence prevention surveillance, research, program implementation and evaluation;

BE IT FURTHER RESOLVED THAT OPHA continue to advocate for the social determinants of health to improve protective factors and decrease risk factors;

BE IT FURTHER RESOLVED THAT OPHA continue to advocate with the provincial government for effective primary prevention strategies which are adequately resourced and implemented.

BE IT FURTHER RESOLVED THAT OPHA continue to advocate with the provincial government for increased coordination of violence prevention initiatives between sectors.

References

Adlaf, E. M., Paglia-Boak, A., Beitchman, J. H., & Wolfe, D. (2007). The Mental Health and Well-Being of Ontario Students. *OSDUHS Highlights, CAMH Document Series, No. 23,* Toronto: Centre for Addiction and Mental Health

AuCoin K. *Children and Youth as Victims of Violent Crime.* Juristat. Ottawa: Statistics Canada; Canadian Centre for Justice Statistics, 2005. Catalogue no. 85-002-XIE, Vol. 25, no. 1.

Brownridge DA, Ristock J, Hiebert-Murphy D. The high risk of IPV against Canadian women with disabilities. Med Sci Monit 2008;14:PH27-32.

Butchart. A., Brown, D., Khanh-Huynh, A. Florquin, N. & Muggah, R. (2008). *Manual for estimating the economic costs of injuries due to interpersonal and self-directed violence.* Geneva: WHO & Atlanta: CDC.

Butchart, A., Phinney, A., Check, B., Villaveces, A. (2004). *Preventing violence: A guide to implementing the recommendations of the World report on violence and health*. Geneva: WHO.

Canada. National Clearinghouse on Family Violence. Family Violence and Homelessness: A Review of the Literature. Prepared by Sylvia Novac. Ottawa: Public Health Agency of Canada, 2006.

Canadian Association of Suicide Prevention. (2004). *CASP Blueprint for a Canadian National Suicide Prevention Strategy*. Edmonton: Author.

Canadian Centre for Justice Statistics. *Family Violence in Canada: A Statistical Profile.* Ottawa: Statistics Canada; Canadian Centre for Justice Statistics, 2007. Catalogue no. 85-224-XIE.

Canadian Mental Health Association, BC Division "Violence and Mental Illness: Unpacking the Myths" info@cmha-bc.org published March 2005.

Canadian Paediatric Society (CPS). (2005). Canadian Paediatric Society Position statement (AH 2005-2): Youth and firearms in Canada. *Paediatrics and Child Health, 10(8), 473-477.* Accessed on July 9, 2008 at http://www.cps.ca/English/statements/AM/AH05-02.pdf

Canadian Red Cross. *RespectED: Violence and Abuse Prevention* (www.redcross.ca)

Centre for Addiction and Mental Health. *Strategies for healthy youth relationships: Featuring the Fourth R.* (www.camh.net).

Centre for Suicide Prevention. Making the connection: mental Illness and Suicide. SIEC Alert #64, January 2007.

Day T. *The health related costs of violence against women: the tip of the iceberg.* London: Centre for Research on Violence Against Women and Children Publication Series, The University of Western Ontario, 1995.

Durrant, J., Ensom, R., & Coalition on Physical Punishment of Children and Youth. (2004). *Joint Statement on Physical Punishment of Children and Youth*. Ottawa: Coalition on Physical Punishment of Children and Youth.

Fisher, J., (2008) LGBT Domestic Violence Abuse in Lesbian, Gay, Bisexual, and Transgender Relationships. http://gaygenderissues.suite101.com/article.cfm/lgbt_domestic_violence downloaded 6/20/2008.

Hightower, J. (2004). Age, gender and violence: Abuse against older women. *Geriatrics & Aging, 7(3), 60-63.* Accessed June 26, 2008 from http://www.geriatricsandaging.com/pdf/pdfMarch2004/0703violence.pdf

Huesman, L. R., Moise-Titus, J., Podolski, C. L., & Eron, L. D. (2003). Longitudinal relations between children's exposure to TV violence and their aggressive and violent behaviour in young adulthood: 1977-1992. *Developmental Psychology, 39(2), 201-221.* Accessed June 26, 2008 from http://www.apa.org/journals/releases/dev392201.pdf

Hyman I, Forte T, Du Mont J, Romans S, Cohen MM. The association between length of stay in Canada and intimate partner violence among immigrant women. Am J Public Health 2006;96:654-9.

Institute for the Prevention of Crime (2008) *Making Cities Safer Canadian Strategies and Practices.*

Institute for the Prevention of Crime. (2008). *Homelessness, victimization and Crime: Knowledge and actionable recommendations.* Ottawa: Institute for the Prevention of Crime.

Institute for the Prevention of Crime. (2007). *Building a safer Canada: First Report of the National Working Group on Crime Prevention.* Ottawa: Institute for the Prevention of Crime.

Katz J., Jhally, S. (1999) "The National Conversation in the Wake of Littleton is Missing the Mark" http://www.jacksonkatz.com/missing.HTML

Krug, E., Dahlberg, L., Mercy, J., Zwi, A., & Lozano, R. (2002). *World report on violence and health.* Geneva: World Health Organization.

Leitch, K. (2007*). Reaching for the top: A report by the Advisor on Healthy Children & Youth.* Ottawa: Health Canada.

Ministry of Health Promotion. 2007. *Ontario's Injury Prevention Strategy: Working together for a safer, healthier Ontario*. Toronto: Queen's Printer for Ontario.

Moukas, E. (2002) "Preliminary Review of Selected Violence Prevention Literature" for Toronto Public Health Mental Health Services Redesign. Violence Prevention Compendium, 2004.

Moukas, E. (2002) "A Review of Selected Literature on Effective Best Practices in Suicide Prevention: for Toronto Public Health Mental Health Services Redesign. Suicide Prevention Compendium, 2004.

Ogrodnik, L. *Seniors as Victims of Crime 2004 and 2005.* Ottawa: Statistics Canada; Canadian Centre for Justice Statistics, 2007. Catalogue no. 85F0033MIE.

Ontario Government, Ontario Women's Directorate & the Expert Panel on Neighbours, Friends and Families through the Centre for Research and Education on Violence Against Women and Children. (2006). *Neighbours, Friends and Families*. Toronto: Queen's Printer for Ontario.

Ontario Injury Prevention Resource Centre. Ontario Injury Compass-Firearm Injuries. Toronto: Ontario Injury Prevention Resource Centre, 2006.

Ontario Injury Prevention Resource Centre. *Ontario Injury Compass-Violence.* Toronto: Ontario Injury Prevention Resource Centre, 2005.

Ontario Injury Prevention Resource Centre. *Ontario Injury Compass-Violence among Children.* Toronto: Ontario Injury Prevention Resource Centre, 2008.

Ontario. (2008). *Ontario Poverty Reduction Strategy*

Ontario. (2005) *A Domestic Violence Action Plan for Ontario.*

Pauktuutit Inuit Women of Canada. (2006). *National Strategy to Prevent Abuse in Inuit Communities and Sharing knowledge, Sharing wisdom: A Guide to the National Strategy.*Ottawa: Pauktuutit Inuit Women of Canada.

Roots of Empathy (www.roootsofempathy.org)

SMARTRISK. *The Economic Burden of Injury in Ontario.* Toronto: SMARTRISK, 2006.

Statistics Canada. (2008). Study: Hate-motivated crime 2006. *The Daily: Statistics Canada; Monday, June 9, 2008.* Catalogue 11-001-XIE (Français 11-001-XIF) ISSN 1205-9137. Accessed June 26, 2008 at http://www.statcan.ca/Daily/English/080609/d080609a.htm

Statistics Canada. *Measuring Violence Against Women. Statistical Trends 2006.* Ottawa: Statistics Canada, 2006. Catalogue no. 85-570-XIE.

Statistics Canada. Canadian Centre for Justice Statistics. Family Violence in Canada: A Statistical Profile 2005 and Family Violence in Canada: A statistical profile 2006 (Cat. No.85-224-XIE) as reported in National Clearinghouse on Family Violence - NCFC E-Bulletin – July 2008.

Statistics Canada. Mortality, *Summary List of Causes-2003*. Table 1-7 Deaths by selected grouped causes, sex and geography- Ontario. Cat. No.: 84F0209.

Stoltz JA, Shannon K, Kerr T, Zhang R, Montaner JS, Wood E. Associations between childhood maltreatment and sex work in a cohort of drug-using youth. Soc Sci Med 2007;65(6):1214-21.

Tan JC, Gregor KV. Violence against pregnant women in Northwestern Ontario. Ann N Y Acad Sci 2006;1087:320-38.

United Nations. (1989). *Convention on the Rights of the Child.* New York: Office of the High Commissioner for Human Rights.

Violence Reduction Unit.(2006). *Reducing violence: An Alliance for a safer future.* Scotland: Violence Reduction Unit.

Waterloo Region Community Safety and Crime Prevention Council. (2006). *Reducing violence by enhancing human and social development- A 40-year plan for Waterloo Region.* Waterloo: Waterloo Region Community Safety and Crime Prevention Council.

Waters H, Hyder A, Rajkotia Y, Basu S, Rehwinkel JA, Butchart A. *The economic dimensions of interpersonal violence.* Geneva: Department of Injuries and Violence Prevention, World Health Organization, 2004.

Weir, E., Preventing violence in youth. CMAJ 2005;172(10):1291-2.

World Health Organization. (2007). *Preventing injuries and violence: A guide for Ministries of Health.* Geneva: WHO.

Regarding Resolutions, Position Papers, and Motions:

Status: Policy statements (resolutions, position papers, and motions) are categorized as:

Active, if:
1. The activities outlined in the policy statement's implementation plan have not yet been completed,
2. The policy statement addresses an issue that is currently relevant to public health in Ontario.

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

Reproduction: This document is the property of the OPHA. It may be freely referenced with full acknowledgement of the OPHA, and may not be used for commercial purposes.