Research and Education for Solutions to Violence and Abuse

RESOLVE news

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"Building the smallest democracies at the heart of society."
The United Nations: The International Year of the Family, 1994

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Addressing Increasing Domestic Violence Rates in Alberta

by Linda McCracken RN, AHS Calgary Zone Domestic Violence Program Coordinator

Evidence suggests that it is good practice for health care providers to ask patients about domestic violence (DV) as part of a comprehensive health assessment. At the same time, research demonstrates that to be effective, screening programs require institutional support, training for providers, protocols, and access to appropriate external and internal services.

DV rates in Alberta are increasing, even more significantly this year (2016), due to the economic downturn and the Fort McMurray fires. As a result, many Alberta Health Services' (AHS) staff recognize that DV has become a public health emergency that needs evidence–based approaches to identify, intervene and prevent within acute care and community–based facilities. Universal education and direct questioning about DV is practiced in some health care environments but current practices are inconsistent across the province.

March 7, 2016, saw sixty–seven individuals, inclusive of AHS personnel, community service providers and academics from across Alberta gather in Calgary to spend a full day in collaborative and facilitated discussions to try and bridge this gap. The event was spearheaded by **Dr. Laura McLeod** (Medical Officer of Health), **Linda McCracken** (RN, Calgary Zone DV Program Coordinator), **Katrina Milaney** (Assistant Professor, Specialization Chair, Graduate Student Advisor Community Rehabilitation & Disability Studies Cumming School of Medicine, University of Calgary), **Sue Ramsden** (Site Manager, South Calgary Health Centre & East Calgary Health Centre) and **Penny Morelyle** (AHS Senior Policy Advisor). Funding for this 'DV Roundtable' was graciously received from Campus Alberta. Participants identified the following reasons for attending—'that they wanted to be part of a larger community addressing family violence'; 'that they wanted to facilitate change and social justice'; 'to address the gaps in community practice' and 'to explore a universal DV screening process within Alberta Health Services'.

The goal of the day was to share stories of what has worked well and to identify opportunities for joint learning and action. Key themes that emerged from discussions and proposed next steps and actions for follow-up included enhancement of front-line practices through training, education and support for staff to adequately respond and refer people to supports; prioritization of high level AHS policy development; enhanced government relations for advocacy efforts; and development of a research agenda and consistent data collection to develop best practice responses for DV interventions and prevention.

Positive responses from the roundtable included

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Female Genital – Mutilation/Circumcision/Surgery/Cutting?

A closer look... Part II

by Sally Ogoe

As researchers, the knowledge we share and communicate has the potential to invoke a sense of power and emotion in others and to challenge negative cultural practices which still persist. In my last article, I focused on the debate surrounding female genital mutilation (FGM), why this practice has been condemned globally and the need to look deeper into this cultural practice. I believe that including the perspectives of various informed stakeholders is vital because different groups have something valuable to add to what is already known as well as what is unknown. It is beneficial to address why there is support for this cultural practice despite global backlash.

Contrary to how 'outsiders' see FGM, within the African context many individuals argue that it is an initiation rite for females, which is to prepare them for womanhood and the duties associated with this role. For centuries, this practice has been passed down from one generation to the next such that the perceived benefits for practicing groups in African countries and abroad are deeply ingrained. The practice of FGM persists for a number of reasons. The practice is regarded as a religious obligation that serves as prevention against promiscuity and is part of cultural identity. FGM is supported by a strong patriarchal influence, as females who undergo this procedure are believed to be better sexual partners for men. The practice is perceived to have economic value for females by ensuring marriageability.

In addition, prominent myths include the myth that FGM improves women's health by making them fertile and ensures smooth child birth. The practice is thought to induce healing powers and is also thought to improve the appearance of female genitalia. According to supporters of this tradition, if left in its natural state, the female genitalia produces very unpleasant discharges, or the clitoris will grow to the size of a penis if not cut. The expectations that practicing communities attach to this practice go beyond keeping clean, community acceptance, or identity. There is high level of coercion among practicing groups. Without undergoing this practice, females would not get suitors to marry and would face public humiliation, social exclusion, and forced excisions.

Should society be concerned? Should this cultural practice be an issue of international concern? Or should only Africans and other cultures that participate in this practice have the opportunity to engage in discussions about it? If there is no single universal way of expressing body modifications, expressing morality and sexuality, or even of abiding by the beliefs of one's group, is cultural preservation the way forward regardless of its implications? As we ponder on these questions, let us consider the fact that research from WHO (2001, 2008), estimates that between 100 and 140 million females worldwide have experienced female genital mutilation.

While we approach cultural practices which are close to the hearts of practicing groups with sensitivity, thoughtfulness, and respect, we also need to be conscious of the fact that culture is dynamic. This means deconstructing existing barriers that serve to preserve female genital mutilation and realizing that females who come from communities where this procedure is required have few, if any, economic opportunities available to them, leading to their engagement in this tradition. There is a need for proper education of all members in practicing countries on what sexual and physical health entails, as well as community participation where affected females can have the platform to discuss this issue in a safe and free environment. Additionally, continually mobilizing resources from governments as well as NGOs can assist in transforming the challenges females face in their communities. Such action can be a step toward improving the independence and rights of females and fighting for these rights both privately and publicly. Most importantly, deconstructing existing barriers would allow women to break away from this cultural practice.

Manitoba Update

by Cheryl Fraehlich

RESOLVE Research Day, themed Indigenous Healing and Trauma: Intergenerational Solutions, was held in Calgary October 4 and 5. Once again this year, Research Day included presentation of the RESOLVE Award. This award is given to a member of the community in each province in recognition of their distinguished contribution to creating homes and communities safe from interpersonal violence and abuse. The recipient of the 2016 RESOLVE Award in Alberta was **Laura Ducharme**, Community Mobilization Officer with HomeFront. In Saskatchewan the award was presented to **Karen Wood**, Executive Director of Family Service Saskatoon. **Sharon Mason** was the Manitoba recipient of the award for 2016.

*Introducing Our Steering Committee Member **Sharon Mason***

Sharon Mason is an Ojibway–Cree woman from the Peguis First Nation in Manitoba. For over two decades, her passion has been in the area of family violence prevention/education as well as healing of First Nations people through therapy and counselling. Recognizing the importance of education in overcoming oppression and marginalization, Sharon has also developed a passion for assisting young people in achieving their educational goals.

From left: **Sharon Mason & Suhad Bisharat**

Sharon was the Executive Director of the First Nation Healing Centre, a women's shelter in Fisher River Cree Nation, from 1991 to 1997 and from 2007 to 2010. Within this position, she organized the first meeting of and served as the Coordinator for the Manitoba First Nations Shelter Networking Group; Sharon is still a member of this group and her current role is shelter advisor and liaison between the four First Nation shelters and Circling Buffalo. She has been a board member for Circling Buffalo (formerly Manitoba First Nations Regional Board for Family Violence Prevention) since its inception and is also a member of the National Aboriginal Circle Against Family Violence. During her career, Sharon has worked as the Coordinator for Aboriginal Services at Selkirk Mental Health Centre and as the Finance Manager for Peguis Healing Centre where she also coordinated the Residential School Project. Since 2013, she has been teaching at Red River College.

Sharon has been a committed member of the RESOLVE Manitoba Steering Committee for 22 years. During this period, she has played a key role as liaison and advisor to ensure that our research is sensitive to and informed of appropriate protocol in working with Indigenous agencies and communities. In addition, Sharon organized a panel on First Nations shelters for one of RESOLVE Manitoba's Research Days. She was a community partner on the tri-provincial SSHRC CURA project, "Rural and Northern Community Response to Intimate Partner Violence" and is currently working with and advising RESOLVE on a national SSHRC project, "Canadian Domestic Homicide Prevention Initiative for Vulnerable Populations". RESOLVE Manitoba is working on the Aboriginal Population Hub, along with Circling Buffalo, who is a partner on this project.

We thank Sharon for her remarkable work.

Saskatchewan Update

Introducing Our Steering Committee Member ***Darlene Juschka***

Shortly after I arrived in Regina, Saskatchewan in 2000, I met **Jane Ursel**, who was looking to establish a provincial RESOLVE office in Saskatchewan. Happily, RESOLVE Saskatchewan was established. Although initially at the University of Saskatchewan, the office was moved to the University of Regina. This was the point I joined the Steering Committee.

My area of study during my PhD had been feminisms in the study of religion. Focusing on myth, ritual, and representation, I charted their rereading, rethinking and reinterpretations of the Bible. It was my expertise in feminisms that came into focus when I interviewed for the position of coordinator for the recently created Women's Studies Programme at the University of Regina.

The work I took up as department head in 2000 brought me into contact with many people throughout Regina, along with various organizations, generations of students, and folks working at the university. It has been over sixteen years that I have taught at the university, served on committees in the university, and those related to my academic areas of study. As of June 30, 2017, I will have served as head for Women's and Gender Studies for thirteen years and it is at that time I will step down.

Over these years I have met hundreds of students who helped shape and reshape my pedagogy. Their youth and exuberance vibrates through the halls and classrooms as they develop their own skills to engage the worlds they inhabit.

I have also been involved in several research projects over the years. Recently I was the co–applicant for the ALL Rise Project *Community check-up: Identifying barriers to economic participation of Aboriginal Women in Urban Setting*. I am co–applicant and Saskatchewan lead on *Rural and Northern Community Response to Intimate Partner Violence* (2011–2016) headed up by **Dr. Mary Hampton**. I am currently working on a case study related to this project. Previously I was co–applicant on *The Healing Journey: A Longitudinal Study of Women Who Have Been Abused by Intimate Partners* (2004–2010), working as site coordinator for Regina.

I've had the great pleasure of working with community folks from a number of different services and organizations having served on the Regina sexual assault board, organized a couple of LEAF breakfasts, and developed more than a few IWD events. I have worked with ALL RISE, MATCH International, Saskatchewan Council for International Cooperation, Saskatchewan Human Rights, Daughters of Africa, Immigrant women, AMAKRON, Regina Transition House, Family Services Regina, among others on subjects related to social justice. My interactions with all these folks, as well as working on RESOLVE and in the University, have enriched my life and my work and for this I am truly grateful. ⌘

Alberta Update: *What it means to be a "Good Enough" Parent: Evaluating the Impact of Fetal Alcohol Spectrum Disorder (FASD)*

by Ann Marie Dewhurst, PhD, Registered Psychologist

Fetal alcohol spectrum disorder (FASD) is classified as a group of neurodevelopmental conditions stemming from preterm alcohol abuse that can affect normal physical, cognitive and behavioral development. Although some cases are quite severe, impacting the extent to which these individuals can form meaningful relationships, it is possible to assist individuals with FASD to learn how to form appropriate relationships with their children and become nurturing parents. To provide safe and ethical guidance in this feat, we have developed a parenting assessment tool specifically tailored for parents affected by FASD. Parenting assessments provide an understanding of a parent's behaviour and their ability to meet minimal parenting standards. A universal standard of parental capacity does not exist, however, it is important to consider what parent-based factors contribute to being "good enough."

The developed assessment considers many of the typical vulnerabilities that FASD presents including overall health conditions (e.g., physical health, conditions, limitations, sensitivities etc.); cognitive style (e.g., comprehension, learning style, judgment, etc.); executive functioning abilities (i.e., impulsivity, cognitive flexibility, self-awareness, social perceptiveness, organization & planning skills, working memory, initiation skills); adverse childhood experiences (i.e., physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, mother treated violently, household substance abuse, household mental illness, parental separation or divorce, incarcerated household member); and attachment issues or socio-economic issues (i.e., lack of education or employment). In order to help FASD impacted adults become nurturing parents, we also must consider secondary concerns including the potential for violent, abusive, additive or criminal behavior.

It is important to note that an FASD diagnosis alone provides little information about parenting ability/capacity. The parenting assessment devised is comprehensive, primarily considering whether the affected adult is capable to parent either independently, with specific supports and interventions, or embedded within an extended family/caregiver context. These questions are answered based on an evaluation of the constellations of skills, abilities, knowledge sets, attitudes and supports that are specific to the affected individual (including an evaluation of executive functioning skills, learning disabilities, physical limitations, emotional health, and the ability to connect with prosocial supports). Our risk assessment models include determining "Signs of Safety" for the child (i.e., what are the strengths and weaknesses of the parent in terms of providing appropriate safety for the child; are there existing safety issues to consider, etc.), and whether the child has any unique developmental needs that the parent must learn to attend to. Ideally, we seek to determine these factors in a minimally invasive form, conducting as little psychological testing as possible over successive short intervals of time that will still provide the appropriate data

Our approach is not solely based on articulated professional knowledge, it is also equally elicits and draws upon family knowledge and wisdom. It is designed to always undertake the risk assessment process with the full involvement of all stakeholders, both professional and family; from the judge to the child, from the child protection worker to the parents and grandparents. Thus, this assessment is naturally holistic in design, since it brings everyone (both professional and family member) to the assessment table. In addition, we also consider the parent's personal history and development from two perspectives: the parent's experience, and the experience of professionals/community supporting the parent. Such information may inform us about the parent's judgment, perceptiveness and responsiveness.

In summary, our parenting assessment is designed to provide a comprehensive understanding of the affected (FASD) adult's strengths and vulnerabilities as they relate to parenting, allowing assessors to provide very specific, clear and exclusive information pertaining to each individual parent's and child's strengths, weakness and needs.

Addressing increased DV rates‥ continued from Page 1

appreciation for new relationships/collaborations, recognition of the importance of shared work, a better understanding of the complexities of DV, and valuing the diversity of community and other stakeholders' perspectives. As well, participants reported feeling motivated and inspired that AHS cares about this topic and that they already have expert knowledge upon which to build. Participants thought the best way to build momentum and ensure that the work continues to move forward is to form an oversight committee and a steering committee. These committees are essential as they can identify key supporters and engage decision makers, build relationships with government officials, build from existing networks, enhance collaborations and continue conversations.

The end result was a thirty member DV Provincial Network created to continue work on intervention/prevention of DV within AHS. Key priority areas will include front–line practice (education supports, community resources and referral pathways); policy and government relations; compliance in screening initiatives and surveillance (data) and research (health outcomes, decrease in rates of violence, screening question, uptake, and education). Work has already begun to secure AHS Executive Leadership sponsorship. As the impacts of direct and indirect exposure to DV encompass the issue of health and safety, a logical partnership would be to collaborate with the AHS Provincial Injury Prevention Steering Committee. Historically, 'intentional injury' had been defined as that of suicide–inflicting injury on oneself. This definition has now been broadened to include trauma directed at a significant other. Addressing domestic violence has recently been identified as one of the initiatives the Provincial team has identified to focus on in their 2017–2020 Injury Prevention Action Plan, so the time was right to join forces.

Much research has examined the validity of universal 'screening' for DV within the health system. Numerous reviews come to the conclusion that this practice cannot be recommended. One of the goals of our DV Network is to redefine this intervention. A longstanding protocol within various regions within AHS, specifically in the Calgary Zone since 2003, is the provision of 'universal education and direct questioning' on the issue of exposure to domestic violence to all patients within the emergency/urgent care setting. "The question" is framed so as to educate patients that DV impacts health and comes in many forms. Our 'asking' is an

intervention. Positive disclosures illicit a current safety assessment and referral to the experts (on–site and community) for safety planning. Success of the initiative is measured by such efforts as reduction of isolation to improve safety options.

Validation of the above process is proposed as one of the potential research projects of our newly formed AHS DV Network Research Working Group. Working within the DV Network will afford us the opportunity to be part of a collaborative, interdisciplinary, multi–institutional and multi–zonal project with a focus on addressing the complexities of interpersonal violence and whether such a protocol is achievable and has an impact on better patient outcomes.

The chief goal of the DV Network's collaborative strategy is to support healthy relationships and families, thereby reducing the incidence of childhood adverse experiences. Meeting this goal will make for healthier, safer Albertans in the future. This work aligns with the core values defined within the AHS organizational structure—that of "compassion, accountability, respect, excellence and safety to achieve excellent patient– and family–centred healthcare". ⌘

Announcements, Conferences and Events

November 25–December 10 - *16 Days of Activism Against Gender Violence.* Gender–based violence affects us all. It destroys families, weakens the fabric of our society, and takes a heavy toll on our communities and our economy. Canadians are reminded during the 16 Days of Activism that they can take actions, now and throughout the year, to eliminate violence against women and girls in all its forms. Source: **www.swc-cfc.gc.ca/commemoration/vaw-vff/days-jours-en.html**.

February 15–17, 2017 - Canadian Conference on Promoting Healthy Relationships for Youth: *Breaking Down the Silos in Addressing Mental Health & Violence*, at the London, ON, Convention Centre. This conference will bring together researchers, policy makers and practitioners working with children and adolescents to prevent and address relationship violence and mental health challenges. These fields of practice have evolved through different disciplines and services systems and often exist in separate silos. The purpose of this conference is to break down the silos through a recognition that there are overlapping issues with common health promotion, prevention, early identification and intervention strategies. For more information refer to **www.learningtoendabuse.ca/canadian–conference–promoting–healthy–relationships–youth**.

Every Friday at 6PM - *Meet Me at the Bell Tower* at the North End Bell Tower on Selkirk and Powers in Winnipeg, MB. We are a community united to be the change and STOP THE VIOLENCE. Together we are ONE! For more information refer to **www.ayomovement.com/mmbt.html** or check our Facebook page at **www.facebook.com/northendbelltower**.

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Prairieaction FOUNDATION

We're finding solutions to protect women and children from violence and abuse!

Telephone: **1–877–926–8129**
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Prairie*action* Foundation to Launch Youth Leadership Award

Interpersonal violence continues to be a serious issue in our society. Prairie*action* Foundation (PAF) is a tri–provincial organization committed to finding solutions to violence and abuse. PAF believes that young people have the power to make their schools, neighbourhoods, and communities safe and respectful to everyone. The PAF Youth Leadership Award will recognize and reward groups of youth who demonstrate leadership by raising awareness about violence and abuse, promoting healthy relationships, or developing innovative approaches to violence prevention. In addition to public recognition, each group selected to receive the Award will be given the opportunity to access up to $3000 to continue, expand, or duplicate their award–winning project, or to initiate a new activity. Through the Youth Leadership Award, PAF hopes to encourage more young people to become involved in ending the cycle of violence. PAF will accept nominations for groups from Alberta, Saskatchewan, and Manitoba. For additional information and the nomination form go to **prairieaction.ca**.

Prairie*action* Foundation (PAF) Youth Leadership Award Contact:
Email: media@prairieaction.ca

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