Preventing Family Violence

A Multidisciplinary Approach

Edited by
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Contents

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1
The Public Health Approach to the Prevention of Family Violence in Hong Kong

Ko-Ling Chan

Chapter summary

1. The public health approach has been adopted by the World Health Organization as a conceptual framework for the prevention of family violence.
2. The public health approach has four key steps: (a) problem description/public health surveillance; (b) risk and protective factor research; (c) preventive intervention development and evaluation; and (d) broad implementation of effective prevention programmes.
3. Public health intervention can be categorized into three levels of prevention: primary, secondary, and tertiary prevention.
4. Preventive strategies can be classified as universal, selective, or indicated.
5. The social ecological model of family violence conceptualizes the risk factors at four levels: the individual, relationship, community, and societal levels.

Prevention is the key to combating family violence. The World Health Organization has adopted the public health approach as a conceptual framework in order to identify the essential elements that would contribute to the prevention and intervention of family violence (Krug, Dahlberg, Mercy, Zwi, & Lozaro, 2002). The approach also provides a common framework for professionals from various disciplines—including social scientists, health and legal professionals, psychologists, and social workers—with which to work

collaboratively. This chapter introduces the framework and discusses how it can inform a multidisciplinary approach to the prevention of family violence.

The approach

Public health relates to individuals as well as populations. The public health approach, with the building of healthy communities as an end goal, posits that the health of individuals and groups depends upon social policies and programmes, as well as coordinated national, regional, and community services. Historically, the public health approach has attempted to control morbidity and mortality through targeted measures against infectious diseases. The approaches identify and control factors that affect the two rates among men and women across the life span (Arias & Ikeda, 2006). It has been found that behavioural, psychosocial, and sociocultural factors associated with lifestyle choices are major contributors to the leading causes of chronic diseases or death (Schneiderman & Speers, 2001).

Many public health researchers have begun to adopt the public health approach in examining the roots of family violence. In the context of such an approach, family violence is not conceived of as an individual problem; rather, its appearance is seen to reflect a deeper-rooted problem within the society where the violence occurs. The public health approach therefore attempts to promote collaboration between various sectors—legal, health, and social—and diverse disciplines in carrying out preventive actions against violence.

The public health perspective has broadened from one emphasizing the role of government policy to one which includes the "development and dissemination of interventions at the community level" (Arias & Ikeda, 2006, p. 175). Traditionally, the government took the lead in implementing public health interventions, as many such interventions required decision making and the exercise of leadership at the higher level. But the public health model has since expanded and moved beyond its earlier practice to a new and more comprehensive approach. The new approach draws upon knowledge from multiple disciplines including medicine, epidemiology, sociology, psychology, criminology, education, and economics, and involves a greater role of the community (Arias & Ikeda, 2006). This creates greater innovation and versatility in the field of public health, and widens the applicability of the approach to a range of problems around the world.

The four steps

The public health approach to violence adheres to the rigorous process of the scientific method. It comprises four key steps in the progression from problem to solution: (a) surveillance, (b) risk and protective factor research, (c) preventive intervention development and evaluation, and (d) broad implementation of effective prevention programmes (Mercy, Rosenberg, Powell, Broome, & Roper, 1993). Although the model suggests a linear progression from the first to the fourth step, with data obtained from earlier on used to guide and inform the subsequent steps, it should be noted that actions at different stages may occur concurrently.

The first step—problem description—includes those activities that help to define and to delineate the public health problem. This goes beyond simply counting cases or tracking, but also includes monitoring the problem over time. Public health surveillance, which can be defined as the "ongoing systematic collection, analysis, and interpretation of outcome-specific data for use in the planning, implementation, and evaluation of public health practice" (Thacker & Berkelman, 1988, p. 164), falls into this category. Public health surveillance systems are designed to provide data regarding the incidence and prevalence of health problems, the general demographic characteristics of the persons involved, and temporal and geographic characteristics such as regarding the incidence of violence.

The second step involves identifying risk and protective factors associated with the public health problem. This is done through etiologic and epidemiologic research. Factors that might be modifiable via interventions are also examined in this step.

In the third step, interventions and preventions are identified and developed based on the information obtained from the previous steps. The interventions may include treatment programmes, policies, and any other efforts adopted to prevent violence (Hammond, Haegerich, & Saul, 2009). This step also includes evaluating the interventions for both efficiency and effectiveness. Methods for evaluation include prospective randomized controlled trials, controlled comparisons of populations for the occurrence of health outcomes, time-series analyses of trends in multiple areas, and observational studies such as case-control studies.

In the fourth step, effective preventions are advocated on a wide scale. Broad application of effective strategies against violence would decrease its

incidence at the population level. Another important component of this step is to determine the cost effectiveness of such programmes: evaluating the cost and benefit can be useful for policymakers in determining optimal public health practices.

Prevention strategies

The first two steps of the public health model provide important information about populations requiring preventive interventions, as well as the risk and protective factors that need to be addressed. A foremost goal of public health is to formulate this knowledge into actionable solutions, in the form of interventions characterized into three levels of prevention: primary, secondary, and tertiary prevention (Krug et al., 2002).

Primary prevention aims to prevent the very occurrence of such health problems as intimate partner violence. Unlike earlier prevention efforts primarily concentrated on victims of abuse, this level of prevention also attempts to address directly the risk and protective factors associated with the perpetration of violence.

Secondary prevention focuses on more immediate responses to public health problems that have already manifested. In the case of violence prevention, for example, secondary prevention may include hospital care, emergency services, and treatment for sexually transmitted diseases following a rape.

Tertiary prevention addresses the long-term impacts of public health problems. It may include rehabilitation and reintegration to lower the likelihood of recurrent violence, therapy to lessen trauma, and attempts to mitigate long-term health effects caused by violence.

The three levels of prevention, forming a critical strategy of the public health approach, are defined by their temporal aspect—whether preventive measures take place prior to an incident, immediately afterwards, or over a period of time in the aftermath. On the other hand, researchers have increasingly characterized preventive strategies in terms of the target group of interest (Tolan & Guerra, 1994). According to the targeted intervention approach, preventive strategies can be universal, selective or indicated (Gordon, 1987).

Universal strategies, which usually aim to function as primary prevention, are targeted at the entire population (i.e., without regard to individual risk). Prevention is implemented on a general, indiscriminate basis through reducing risk and enhancing health. One example would be launching public education campaigns in schools about violence prevention.

Selective strategies, usually aiming to function as primary or secondary prevention, target heightened risk groups and individuals. Prevention is implemented through the reduction of risks. One example would be providing support through home visitation to families dealing with issues related to substance abuse, or to families headed by low-income single parents, and offering them training in parenting skills.

Indicated strategies, usually aiming to function as secondary or tertiary prevention, target symptomatic and high-risk individuals. This may include administering interventions such as targeted treatment and rehabilitation for perpetrators of domestic violence, in order to prevent relapse into undesirable behaviour or reoccurrence of risk factors.

Comprehensive prevention therefore not only protects and supports victims as has been traditionally the case, but also ensures immediate and long-term services are in place in the unfortunate event of an incidence, in addition to guiding persons with violent and abusive behaviour towards healthy ways of interaction, especially within the family.

Study of risk factors using the ecological model

The study of risk factors or markers associated with family violence is one which demands to be grounded on rigorous research. Risk markers of violence are defined as antecedent variables that are significantly correlated with consequent variables, either increasing risk (in which case they are known as risk factors), or decreasing risk of the latter (i.e., protective factors; Barnett, Miller-Perrin, & Perrin, 2005).

Past research has identified potential risk markers for family violence at all levels of the environment in which individuals and families live. The risk markers could be better understood using the ecological model proposed by Bronfenbrenner (1977). The ecological model was initially applied to child abuse (Belsky, 1980, 1993) and subsequently, to youth violence (Garbarino, 1985). More recently over the past decade, researchers have applied it to understanding intimate partner violence (Dutton, 1995; Heise, 1998) and elderly abuse (Carp, 2000; Schiamberg & Gans, 1999). In the respective applications, Bronfenbrenner's framework was modified to suit the subjects of different studies. As Heise (1998) notes, "considerable room exists for interpretation as to exactly where a particular factor most appropriately fits into the framework" (p. 266), so both the nomenclature and the indicators of the systems in the

framework vary across these applications (Brownridge, 2006). The strength of the ecological model is that at the same time of distinguishing between the myriad influences leading to violence, it provides a framework for understanding the interactive dynamics between such influences (Bronfenbrenner, 1977). The application of the nested ecological framework to family violence conceptualizes the environment into four contexts: the individual, relationship, community, and societal levels; and explores the linkage between each risk factor and its influence on violence (Krug et al., 2002).

Individual level. The first level of the ecological model seeks to identify the demographic characteristics that influence an individual's behaviour. These characteristics include an individual's personal history, biological factors, and personality traits. With regard to violence prevention, this level of the ecological model examines how these characteristics may increase the likelihood of an individual's being a victim or a perpetrator of violence.

Relationship level. The second level of the model explores how proximal social relationships (e.g., relations with peers, intimate partners, and family members) have an effect on one's risk of being a perpetrator or victim of violence. In the case of intimate partner violence, risk factors at the relationship level are significantly correlated with partner violence (K. L. Chan, 2004; Hicks, 2006; Lau, 2005; Parish, Luo, Laumann, Kew, & Yu, 2007). Daily interactions with perpetrators of violence also increase the risk of repeated victimization among children (Stith et al., 2009). Thus, social relationships are likely to shape an individual's behaviour and experience.

Community level. The third level examines the formal and informal social networks/structures, such as schools, workplaces and the community, in which the family is involved. These networks may influence what takes place in the family setting, and hence, the incidence of violent behaviours. In cases of intimate partner violence, many women who were abused reported that their partners had attempted to socially isolate them from family, friends, and other social support systems (Taillieu & Brownridge, 2010). In addition, poverty is an important variable in predicting family violence in a community (Y. C. Chan, Lam, & Cheng, 2009). The importance of focusing on the community as a primary site of prevention against family violence is also suggested in recent research (Arias & Ikeda, 2006; Slep & Heyman, 2008).

Societal level. The fourth level includes societal factors that foster or perpetuate family violence. These factors include:

1. cultural norms that support violence as an acceptable way to resolve conflicts;
2. attitudes that regard suicide as a matter of individual choice instead of a preventable act of violence;
3. norms that give priority to parental rights over child welfare;
4. norms that entrench male dominance over women and children;
5. norms that support the use of excessive force by police against citizens;
6. norms that support political conflict;
7. health, educational, economic, and social policies that maintain high levels of economic or social inequality between groups in society.

These factors are conducive to creating a climate in which violence is more likely to be seen as acceptable, and are also likely to reduce inhibitions against perpetration of violence.

The ecological model highlights the multifaceted nature of violence and the different risk factors operating on the individual, family, and broader community and social levels, as well as the entangled interactions between them. Indeed, Bronfenbrenner (1977) emphasizes that "in ecological research, the principal main effects are likely to be interactions" (p. 518). Child abuse and intimate partner violence, for example, are often found within the same nuclear family (Appel & Holden, 1998; Edleson, 1999). Violent home settings resulting in intimate partner violence have also been shown to pose a risk for elderly abuse (Aronson, Thornewell, & Williams, 1995; Deitch, 1997). The links between different types of family violence suggest that addressing risk factors across the various levels of the ecological model may contribute to decreases in more than one type of violence.

Application of the public health approach to the prevention of child abuse and partner violence in Hong Kong

A social ecological model has been applied to categorize the risk factors of child abuse and partner violence in Hong Kong. Based on the household survey commissioned by the Social Welfare Department in 2005 (K. L. Chan, 2005), a number of risk factors were identified, as summarized in Table 1.1.

Table 1.1 Risk factors associated with child abuse and spouse battering in Hong Kong

Individual factors	Relationship factors	Family factors	Societal factors
• Pregnancy • Young age • Exhibiting stalking behaviour • Experienced or witnessed parental violence in childhood • Criminal history • Face need • Low self-esteem • Suicidal ideation • Violence approval • Lack of support • Stressful conditions • Alcohol and drug abuse • Depression • Poor anger management • Low social desirability	• Spousal age difference • Male domination • Jealousy • Relationship distress • Negative attribution • In-law conflict • Influence of extended family	• Unemployment • Disability • New immigrants • Chronic illness • Low income/ poverty (receiving social security) • Indebtedness	• Violence approval (social norms supportive of violence) • Gender inequality (male domination) • Lack of social resources to render support

I have modified the ecological model adopted in the household survey (K. L. Chan, 2005) to categorize risk factors at the individual, relationship, family, and societal levels. Family risk factors are highlighted because family constitutes an important basis for understanding social problems in Chinese culture. Based on the identified risk factors, strategies for violence prevention have been developed following the public health approach (see Table 1.2).

Universal strategies

Several universal strategies of violence prevention have been proposed. These include introducing anti-domestic violence policy, anti-violence education/campaigns, anti-poverty policy, and campaigns for global health and psychological health awareness; building enhanced and coordinated community and legal responses; promoting legal remedies and judicial reforms; and

Table 1.2 Summary table of preventive strategies for domestic violence in Hong Kong

Intervention Approach	Target Populations	Scope	Objectives	Risk Factors	Preventive Strategies	
					Child Abuse	Spousal Abuse
Universal Preventive Intervention	General populations or groups regardless of individual risk	Society	Prevent violence through reducing risk and enhancing protective or mitigating factors across broad groups of people	• Violence approval (i.e., social norms supportive of violence) • Gender inequality	• Anti-domestic violence policy and policy in tackling poverty • Global health and psychological health awareness • Enhancing coordinated community and legal responses • Anti-violence education/campaign • Legal remedies and judicial reforms • Research on domestic violence	
		Community		• Pregnancy • Mental illness • Child abuse and neglect	• School programmes on reduction of delinquency, substance and alcohol abuse • Training programmes for healthcare professionals and other related parties to facilitate detection and reporting of abuse • Universal screening for people at risk	
					• Training in parenting • Resources for child care • Encourage reporting of child abuse	• Encourage help-seeking
Selective Preventive Intervention	Identified individuals or subgroups bearing a significantly higher-than-average risk	Community	Prevent violence through addressing population-specific characteristics that place individuals at a higher-than-average risk	• Low income/ poverty • Lack of social resources	• Outreach work • Coordinated community response • Multidisciplinary collaboration in conducting standardized risk assessments	
		Families or individuals at risk		• Receiving social security • Chronic illness • Mental illness • New immigrants • Disability • Spousal age difference • Separation • Indebtedness	• Screening for potential risk and risk assessment • Programmes to contact isolated individuals/families • Home visitation • Family support programmes	
					• Training and support in parenting • Training in child protection procedures	• Referral for drug and alcohol treatment, and gambling, debt, or suicide crisis counselling • Community “gatekeepers” to detect changes in lives of people

(continued on page 10)

Table 1.2 *(continued)*

Intervention Approach	Target Populations	Scope	Objectives	Risk Factors	Preventive Strategies	
					Child Abuse	Spousal Abuse
Indicated Preventive Intervention	Identify high-risk individuals with detectable symptoms	Problematic families/ victims	Treat individuals with symptoms and risk factors to prevent emergence of full-blown disorder and reoffending violence	• Familial conflict • Male dominance • Economic stress	• Family approach of risk assessment • Family support services • Home visitation and referral • Court-mandated batterers intervention programme	
		Perpetrators		• Mental disorders • Criminal and antisocial behaviours • Addiction problems	• Treatment and supervision of mentally ill perpetrators • Treatment for drug and alcohol abuse, gambling, debt, suicidal ideation or suicide attempt	
		Victims	Protect, support, and treat victims of spousal battering, child abuse, and children who have witnessed domestic violence		• Therapy for victims and survivors of domestic violence • Helplines and other resources for victim support • Legal and health support services for victims of domestic violence	
					• Child protective services • Surrogate parents for children being abused	• Women's shelter for the victims

supporting research on domestic violence (K. L. Chan, 2005). Each of these universal strategies aims to reduce risk factors at the societal level (e.g., violence approval, gender inequality). Other universal strategies such as offering school programmes and universal screening in school or health settings, encouraging the reporting of violence, and training professionals in different intervention skills are also directed toward this end.

Selective strategies

Findings from the household survey (K. L. Chan, 2005) showed that families receiving social security and those headed by young couples may have an increased likelihood of using violence as a means of handling conflict. Without the proper conflict resolution skills, these families are more susceptible to intense conflict, which may in turn result in severe violence. Regular monitoring of families in this category can aid early identification of high-risk cases. Several preventive strategies that focus on helping families at risk are recommended; these include outreach work, initiating neighbourhood watch, engaging the public to serve as community "gatekeepers", developing coordinated community response as well as multidisciplinary collaboration in conducting standardized risk assessment. In particular, protocols and tools for screening for potential risk and risk assessment should be promoted to professionals who specialize in family violence. Special preventive strategies for child abuse should include training and support in parenting, as well as training for teachers, health professionals, and social workers on child protection procedures. These selective strategies target at-risk individuals and families to reduce risk factors at family and individual levels (e.g., low income, mental illness).

Indicated strategies

Among high-risk individuals who have demonstrated violent behaviour in the past, it is recommended that a family approach of risk assessment be adopted, in view of the close association of various types of violence, e.g., that between spousal battering and child abuse. The family approach has the merit of extending its investigation into other types of violence (e.g., physical, psychological, and sexual) once incidence of a certain type of family violence is identified. Family support services should encompass counselling, health services, and support for victims and perpetrators. Home visitation and referral of social

services, as well as treatment for perpetrators are crucial in reducing recurrent violence and promoting change and rehabilitation. Launching court-mandated batterer intervention programmes can also serve protective and rehabilitative functions through a legal framework.

Multidisciplinary collaboration in violence prevention

The ecological model views violence as the product of a complex interplay of individual, relational, social, cultural, and environmental factors. In light of the multifaceted nature of family violence, we must conceive of prevention strategies not in the form of piecemeal solutions, but under the purview of comprehensive and integrative violence prevention programmes—capable of addressing risk factors at multiple levels—if the strategies are to be at all effective. Multidisciplinary collaboration is thus emphasized as a way to allow social scientists across disciplines (e.g., psychologists, sociologists, anthropologists) and professionals working in health, the judiciary, and social services to pool together their information and expertise. Collaboration with stakeholders representing different sectors in the society (e.g., education, labour, public housing, media, business, hospital, criminal justice) is also warranted. The public health approach also emphasizes the involvement of local communities in policy and programme development, and encourages communities to assume ownership and responsibility in countering problems whose impact have important ramifications for all (Slep & Heyman, 2008).

Multidisciplinary collaboration is to be championed for three reasons. First, it allows us to take advantage of the synergistic benefits of cooperation. Resources can be combined and allocated more effectively and efficiently based on the information obtained from multiple disciplines. Second, we can learn from different prevention efforts and share experiences and lessons. As Mercy et al. (1993) emphasizes, “the more coordinated these disparate initiatives and programmes are, the easier it will be to ensure adequate evaluation and to derive and share prevention knowledge from those activities” (p. 25). Third, since different organizations have their own methods of identifying, preventing, and intervening in cases involving family violence, there is a possibility for confusion and redundancy of services. Thus, there is a need to establish a consistent mechanism (e.g., a centrally-coordinated government committee) to take on the tasks of supervision and regulation. The prevention of violence requires the collaborative work of a broad spectrum of community

leaders and organizations, including governmental, business, and grassroots organizations. Each sector has an important role to play in addressing the problem, and collectively, the approaches taken by each have the potential to effect important reductions in violence rates.

The government has now set up two committees, the Committee on Child Abuse (CCA) and the Working Group on Combating Violence (WGCV), to serve facilitating roles within Hong Kong. Both CCA and WGCV are convened by the director of Social Welfare, and are made up of representatives from different policy bureaus, departments, and nongovernmental organizations (NGOs). The two committees are tasked with mapping out strategies and approaches at the government level for the prevention and handling of spouse battering and sexual violence. Procedural guides for handling child abuse and battered spouse cases have since been developed and revised to promote multidisciplinary collaboration, so as to serve the best interests of the victims. More generally, since suspected cases and victims of family violence may come to the attention of different organizations at the same time, be it schools, the police, medical social services, hospitals, clinics, or child centres, it has been recommended that all parties concerned should maintain communication regarding case progress, as they act as advocates on behalf of victims, survivors and other vulnerable individuals.

Conclusion

This review describes the framework of the public health approach, and explores its application to family violence prevention through collaboration across disciplines, organizations and communities. In doing so, it attempts to address the various associated risk factors at different levels. The public health approach and framework can serve as the underpinning framework informing the discussion of violence prevention in this book.

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Index