Category:

VIOLENCE

The strategies presented in this category can be used to help achieve the following public health improvement goal from Healthy Minnesotans: Public Health Improvement Goals 2004:

GOAL 6: Promote a violence-free society.
Violence can be defined as words and actions that hurt people. Acts of violence include suicide, child maltreatment, domestic and intimate partner violence, sexual violence, and youth violence. While overall crime rates remain fairly constant, the impact of interpersonal violence and suicide extends its reach across multiple generations of families, communities, and systems.

While violence cannot be attributed to any one cause, many social and economic factors may contribute to violence. For example, poor and overcrowded living conditions, low wage jobs over which people have little control of their time and responsibilities, and competition for limited resources within a community, can exacerbate feelings of powerlessness or anger that cause people to act out in violent ways. Because these underlying causes are complex, they cannot often be prevented through a single approach. Prevention is ideally suited to a community-based, public health approach.

This approach includes:

- Collecting and analyzing violence data.
- Designing multidisciplinary interventions based on scientific evidence, violence prevention theory, and input from those community members most affected by violence.
- Developing community-wide, multiple source monitoring systems to track the effects of interventions.
- Utilizing a population focus to maximize reach and to include service providers, policy makers, and marginalized populations.
- Examining individual behaviors and environments as well as social behaviors and environments.

As a Minnesota health issue, violence affects all aspects of life. Physical and mental health are nurtured and allowed to flourish in families and communities that are violence-free.

For information on prevention of other kinds of unintentional and violent injuries, see the web-based MDH publication, *Click Your Way to the Best Practices in Injury Prevention*. *Click Your Way* can be found, along with current data and other information, at the Injury and Violence Prevention website. For more information see the website for strategies resources at: [www.health.state.mn.us/strategies/](http://www.health.state.mn.us/strategies/). Click on “Violence Prevention”.

This information is current as of Fall 2002
**CATEGORY: Violence**

**TOPIC: CHILD MALTREATMENT, INCLUDING CHILDREN WITH SPECIAL HEALTH NEEDS**

The strategies below can be used to work on this topic. Organizations that may play a role in implementing each strategy are indicated.

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<thead>
<tr>
<th>Governmental Public Health Agencies</th>
<th>Health Plans</th>
<th>Hospitals &amp; Clinics</th>
<th>Educational Systems</th>
<th>Community-based Organizations</th>
<th>Businesses/Work Sites</th>
<th>Other</th>
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<tbody>
<tr>
<td>Promote culturally specific relational models of attachment, self-efficacy, community connectedness, and coping skills.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Community Coalitions</td>
<td>Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment</td>
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<tr>
<td>Promote healthy child development through early intervention.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>Policy Makers, Social Services</td>
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<tr>
<td>Facilitate access to family home visiting.</td>
<td>✓</td>
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<td>Policy Makers, Social Services</td>
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<tr>
<td>Facilitate access to child development and disability information.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Community Coalitions</td>
<td>Policy Makers, Social Services Mental Health Services</td>
</tr>
<tr>
<td>Facilitate access to culturally- and disability-specific parenting information and support.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Community Coalitions</td>
<td>Policy Makers, Social Services Mental Health Services, Corrections, Law Enforcement, Courts</td>
</tr>
<tr>
<td>Facilitate referrals to mental and chemical health programs.</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Community Coalitions, Counseling Centers</td>
<td>Policy Makers, Faith Communities, Social Services, Mental Health</td>
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<tr>
<td>Collect and analyze data to inform interventions, policies, and the community.</td>
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<td>✓</td>
<td>Community Coalitions</td>
<td>✓</td>
<td>Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts</td>
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<tr>
<td>Assess (including self-assessments) the strengths of individuals, families, communities, and systems and build upon those strengths to address risks for child maltreatment.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Community Coalitions</td>
<td>✓</td>
<td>Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts</td>
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<td>Educate the community to recognize and refer victims of child maltreatment to child protection, law enforcement, and supportive services.</td>
<td>✓</td>
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<td>✓</td>
<td>Community Coalitions</td>
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<td>Policy Makers, Faith Communities, Social Services, Mental Health Services</td>
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<td>Conduct child mortality reviews.</td>
<td>✓</td>
<td>✓</td>
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<td>Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts</td>
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<tr>
<td>Educate parents about Shaken Baby Syndrome.</td>
<td>✓</td>
<td>✓</td>
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<td>Policy Makers</td>
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This information is current as of Fall 2002
Page 4
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<tr>
<th>Incorporate information on the maltreatment of children with special needs into mainstream child abuse prevention programs.</th>
<th>✔</th>
<th>✔</th>
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<th>Faith Communities, Social Services, Advocacy Organizations</th>
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Child maltreatment is among the most prevalent and far-reaching forms of violence in Minnesota. It includes physical, sexual, and emotional maltreatment and physical and emotional neglect. It contributes to fatal and nonfatal injuries, disabilities, and mental health disorders and is associated with a range of social and intergenerational issues, including substance abuse and youth violence. The impact of child maltreatment on society at large includes national and state legislation, physical and mental health care, rehabilitative services, foster care, residential treatment, special education services, social services, law enforcement, adjudication and incarceration of juvenile and adult criminals, family stress, and the loss of earnings or poverty resulting from disability or other incapacity to secure or maintain employment (or both), and of the capacity to parent.

Reported and substantiated child maltreatment data reflect an over-representation of both black children and children with disabilities. Maltreatment can result in disabilities, while disabilities increase the risk of maltreatment. Fifty percent of typical children with severe neglect sustain permanent disabilities, including mental retardation and other forms of learning and cognitive disabilities. The maltreatment of black children is substantiated at a rate that is nearly nine times greater than that of Asian and white children (whose rates are lowest); the maltreatment of children with disabilities is substantiated at a rate that is nearly twice that of their peers without disabilities.

Effective child maltreatment prevention strategies focus on reducing risks and promoting strengths in ways that are culturally relevant and address the unique aspects of children with disabilities and special health needs. Central to these efforts is the promotion of healthy, relational models at all levels (individual, family, community, and systems) with the secure care giver-child attachment as the primary model.

Strategy: Promote culturally specific relational models of attachment, self-efficacy, community connectedness, and coping skills.

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Background:
Child maltreatment prevention literature and research indicate that the experience of healthy, nurturing relationships beginning in infancy has a profound impact upon individuals’ capacity to sustain healthy nurturing relationships throughout the life cycle. Within relationships, individuals begin to establish “working models” of self and others, of how to view themselves and others in the context of relationships. The primary “working model” is that of the primary caretaker and infant. Secure attachment between caretaker and infant depends upon the sensitivity and consistency of a caregiver’s response to an infant’s cues, including verbalizations, gestures, and facial expressions.
Caregivers’ capacities to provide for infants’ needs depends upon their own “working models,” as well as upon the unique mix of strengths and risks they face in their lives. Prevention theory and research also demonstrate the many opportunities to reduce risks and build strengths in people’s lives to ensure their resiliency to overcome negative influences. These opportunities exist at the individual, family, community, and systems levels, where healthy relational models can be encouraged and supported. A key question that drives effective approaches at all levels is: How does this intervention (program, policy, practice) promote resiliency?

Effective strategies include those that ensure individuals have the opportunity to direct their own lives in healthy and satisfying ways (self-efficacy), to build and sustain mutually beneficial relationships with their communities (community connectedness), and to be supported in learning and practicing healthy life skills (coping). Effective strategies must also accommodate and promote the unique aspects of different cultural groups, their histories, beliefs, and practices, as well as the unique aspects of people with disabilities. This includes:

< Teaching caregivers about child development, child behaviors, and the child’s disability.
< Promoting natural supports (i.e., parent-to-parent) and community connections.
< Facilitating healing and resolution of a victim’s experiences of maltreatment.
< Teaching and modeling healthy relationships (parenting, mentoring, partnering, and working relationships, as well as friendships), including how to manage challenges and conflicts.

Additional resources:
Bibliographic resources:
< Egeland, B., and Erickson, MF. 1986. Project STEEP: A prevention intervention with high-risk parents and infants [Proposal submitted to NIMH, Infancy Prevention Research Branch]. [For contact information, see the reference on the Children, Youth and Family Consortium below.]
< Resnick, MD., et al. 1997. Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. JAMA, 278(10): 823-832. This is a national study that used a cohort of Minnesota adolescents. It provides an excellent overview of the connections between family, child, school, and community that protect youth from risk behaviors.
Evidence for strategy:
It is well documented that if people have meaningful relationships with another person, their families, their communities, or all three, and if they have positive views of themselves and others, they are less likely to engage in violent behaviors toward themselves or others. Multiple tools have been designed to measure capacities, life skills, risks, strengths (assets or protective factors), mental health, and they may be implemented within programs.

Has this strategy been implemented in Minnesota?
Yes, in addition to ongoing Minnesota-based research at multiple sites (Project STEEP, University of Minnesota; see the Additional Resources section above), many organizations and disciplines are implementing aspects of this strategy. These include home visiting, mentoring, community coalitions, and early childhood family education programs. The Nurturing Parenting Program (see the Additional Resources section above), which includes aspects of this strategy and an additional focus on building parenting skills was field tested in Minnesota. The Nurturing Parenting Program has programs designed and tested with Hmong families, Hispanic families, African American families, and families in treatment and recovery.

Indicators for this strategy:
< Number and type of teaching opportunities for caregivers about child development, behaviors, and disabilities.
< Number of opportunities for and ways of building, parent-to-parent supports and community connections.
< Number and type of community resources available and accessible to victims and perpetrators of child maltreatment.
< Number of adolescents who self-report assets (feeling of belonging, intention of staying in school, presence of an important adult in their lives, feeling that their parents love them, etc.).
< Number of violent incidents toward children in a community.
< Number and type of injuries reported as a result of child maltreatment incidents.

For more information contact:
< Maureen Fuchs, at (651-281-9959), maureen.fuchs@health.state.mn.us, MDH Family Home Visiting Program.
< Junie Svenson, at (651) 281-9891, junie.svenson@health.state.mn.us, MDH Minnesota Healthy Beginnings Program.
Strategy: Promote healthy child development through early intervention.

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Background:
Effective preventive outcomes are maximized when begun early, whether it be screening and intervention for disabilities, caregiver-child interactions, injuries, physical and behavioral developmental milestones, or mental health problems. Opportunities and places for early intervention include assessments done prenatally and at the time of birth; postnatal, infant, toddler, and early childhood health check-ups and immunizations; preschool screening; home visiting; intakes for services; day care; and early childhood family education.

Additional resources:
Bibliographic resources:
For copies, contact: Sue Strohschein, at (320) 650-1078, sue.strohschein@health.state.mn.us
Contact: PACER Center, Minneapolis, Minnesota, at (612) 827-2966 (Voice) or (612) 827-7770 (TTY), http://www.pacer.org.

Organizational resources:
< Minnesota Department of Children, Families and Learning, Nancy Riestenberg, at (651) 282-6734.
< PAVE: Partnerships to Address Violence through Education, Center for Early Education and Development, University of Minnesota, Christopher Watson, at (612) 625-2898.

Evidence for strategy:
Studies document that early identification and intervention of physical, emotional, and health problems and other developmental delays increase the chances of minimizing lifelong complications from problems.

Home visitation programs are strongly recommended by the Centers for Disease Control and Prevention’s Task Force on Community Preventive Services (see Community Guide at http://www.thecommunityguide.org).

Has this strategy been implemented in Minnesota?
Yes, early intervention and screening services have been implemented in Minnesota for years, due to the Individuals with Disabilities Education Act (IDEA) and Minnesota’s birth-to-five and child maltreatment laws. IDEA is the 20-year-old
federal law that guarantees the rights of children with disabilities to a free appropriate public education.

**Indicators for this strategy:**

- Number and type of places and opportunities where screening for child development issues occurs.
- Number of children or families screened.
- Number of children identified with developmental issues that need to be addressed.
- Number of caregivers, parents, or families identified with child development issues that need to be addressed.
- Existence in the community of a seamless system of referral and follow-up for these issues.
- Awareness by community members that these screening opportunities exist.

**For more information contact:**

- Maureen Fuchs, at (651) 281-9959, maureen.fuchs@health.state.mn.us, MDH Family Home Visiting Program.
- Nancy Reed, at (651) 282-2953, nancy.reed@health.state.mn.us, MDH Family Home Visiting Program.
- Junie Svenson, at (651) 281-9891, junie.svenson@health.state.mn.us, MDH Minnesota Healthy Beginnings Program.

**Strategy: Facilitate access to family home visiting.**

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**Background:**

Successful home visiting programs offer an array of services and link families with other programs and community resources. They work primarily through the establishment of collaborative relationships with other community providers and organizations serving families. Partners may include, but are not limited to, health care providers, hospitals, schools, human services, community corrections, minority organizations, and businesses. Some home visiting programs are targeted at families with multiple challenges and some are offered universally to all families. Increasing the availability and accessibility of home visiting programs to all in a community who can benefit is an important community-wide effort.

**Additional resources:**

**Bibliographic resources:**

Evidence for strategy:
The research literature over the last 20 years indicates that home visiting is a successful strategy for improving child and family health outcomes and preventing child maltreatment. Prenatal home visits by nurses have been linked with increased birth weight, decreased smoking and substance use during pregnancy, improved dietary intake, increased use of prenatal care and community services, and fewer perinatal complications. Extended postpartum home visits by nurses have resulted in lower levels of maternal depression, greater social support, improved caregiver-infant attachment, fewer emergency room visits, less child maltreatment, improved high school completion rates among adolescent parents, reduced welfare use, and reduced subsequent pregnancies.

Home visitation programs are strongly recommended by the Centers for Disease Control and Prevention’s Task Force on Community Preventive Services (see Community Guide at [http://www.thecommunityguide.org](http://www.thecommunityguide.org)). Comprehensive training for all home visiting staff and ongoing supervision and support for the staff are critical elements of successful programs. Coordination with other home visiting programs, including Early Childhood Family Education (ECFE) and Head Start, is another important criteria for program success.

Has this strategy been implemented in Minnesota?
Yes, 19 MDH-funded home visiting projects to prevent child abuse and neglect have been implemented in Minnesota from 1992 through 2001. Minnesota Healthy Beginnings universal home visiting program is also implemented through the MDH. The Family Home Visiting Program, with TANF funds, is available to 87 counties and 11 tribes. In addition, there are multiple home visiting programs implemented through ECFE, Head Start, and other agencies.

Indicators for this strategy:
- Improvement of parenting skills.
- Increase in knowledge of child development.
- Increase in safe home environments.
- Increase in positive parent-child
interactions.
< Increase in the use of community resources.
< Reduction in the incidence of child maltreatment.

For more information contact:
< Maureen Fuchs, at (651) 281-9959, maureen.fuchs@health.state.mn.us, MDH Family Home Visiting Program.
< Nancy Reed, at (651) 282-2953, nancy.reed@health.state.mn.us, MDH Family Home Visiting Program.
< Junie Svenson, at (651) 281-9891, junie.svenson@health.state.mn.us, MDH Minnesota Healthy Beginnings Program.

Strategy: Facilitate access to child development and disability information.

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Background:
In order for individuals, families, communities, and systems (including policy makers) to be able to understand, support, and respond effectively to children’s strengths and needs, people at all levels need to share an understanding of child development and disability information. Without this information, children’s behaviors and other characteristics may be misinterpreted by caregivers, teachers, service providers, and others and result in inappropriate and potentially harmful responses. This information includes typical physical and behavioral developmental milestones, the unique developmental timelines and characteristics of children with disabilities and special health needs the unique vulnerabilities of children with disabilities for maltreatment, and the diverse meanings of language and behaviors across cultures and disabilities.

Systems and communities need to reach, include, be sensitive to, and become competent with families of multiple cultures, families who have children with disabilities, and children who have disabilities. Parental, professional, community training, education, and support are key components of this strategy.

Additional resources:
Bibliographic resource:
Organizational resources:
< Center for Early Education and Development, University of Minnesota. Contact: Christopher Watson, at (612) 625-2898.
< Local ECFE and Head Start programs. Contact your local school district for more information.
< PACER Center, Minneapolis, Minnesota, at (612) 827-2966 (Voice) or (612) 827-7770 (TTY), http://www.pacer.org.

Evidence for strategy:
Project STEEP (see the Erickson and Egeland article above) demonstrated the need for parents to learn about child development.
development in order to meet the needs of their children and to form healthy attachments.

Has this strategy been implemented in Minnesota?
Yes, many programs and resources throughout the state provide access to child development and disability information. These programs and resources include ECFE programs offered in all Minnesota school districts, county extension agents and programs, and disability advocacy organizations such as PACER or ARC.

Indicators for this strategy:
- Number of community programs that offer information on child development and disabilities.
- Accessibility of those programs to community members who need them.
- Number of community members who use these community resources.
- Level of satisfaction among community members with these resources.
- Increase in knowledge among community members of child development and disabilities.
- Number of parental self-reports of child maltreatment.
- Number of child maltreatment incidents in the community.
- Type of injuries reported as a result of child maltreatment incidents.

For more information contact:
- Mary York, at (651) 281-9958, mary.york@health.state.mn.us, MDH Child Health Consultant, MCH Section.
- MDH Minnesota Children with Special Health Needs Program (MCSHN), at (800) 728-5420, or (651) 215-8956 (metro).

Strategy: Facilitate access to culturally- and disability-specific parenting information and support.

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Background:
A key component in child maltreatment prevention strategies is ensuring that caregivers are equipped with the information they need to nurture healthy attachments with their children. Furthermore, the parenting capacities of families facing multiple challenges are stretched without necessary assistance, guidance, encouragement, and support. Parenting information and support are generally available through early childhood family education, libraries, and community programs. These resources may not be accessible to some parents due to differing cultural norms and values, isolation, or language differences. Also, some parenting issues may remain unaddressed because they are common only among certain cultures or to parents of children with specific disabilities. Furthermore, effective parenting approaches that have been generated from European cultures may not translate effectively across all cultures and may not always bring about the desired outcomes for children with disabilities.

Parenting information needs to be adapted to multiple cultures and to meet the needs of families who have children with disabilities and special health needs. Not only does the
information need to be adapted, but approaches to disseminate it may also need to be expanded, including community-based and family-to-family approaches. For example, many Hmong families have traditionally learned orally, rather than through writing. Also, many families of children with special needs are challenged to find competent childcare, so they can attend parenting classes or support groups. Systems and communities need to assess their efforts toward meeting these needs, identify the unique strengths and needs of all families, and include them when designing educational and supportive approaches.

Additional resources:
Bibliographic resources:
< Resnick, MD., et al. 1997. Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. JAMA 278(10): 823-832. This is a national study that used a cohort of Minnesota adolescents. It provides an excellent overview of the connections between family, child, school, and community that protect youth from risk behaviors.
Organizational resources:
< Center for Early Education and Development, University of Minnesota.

Evidence for strategy:
Project STEEP (see the Egeland and Erickson article above) demonstrated the need for parents to learn about child development in order to meet the needs of their children and form healthy attachments. It is also well known that providing information that is culturally and disability-specific will increase the likelihood of it being used appropriately.

Has this strategy been implemented in Minnesota?
Yes, parenting information and support that is culturally and disability-specific is generally available through local ECFE, Head Start, libraries, and ethnic and minority community-based organizations. Most of these agencies and organizations work collaboratively with cultural groups and families of people with disabilities to assure that the provision of parenting information and support is culturally- and disability-specific.
Indicators for this strategy:
< Number of community programs that offer culturally and disability-specific parenting information and support.
< Accessibility of those programs to community members who need them.
< Number of community members who use these community resources.
< Level of satisfaction among community members with these resources.
< Increase in knowledge among community members of parenting and parental support.
< Number of parental self-reports of child maltreatment.
< Number of child maltreatment incidents in the community.
< Type of injury reported as a result of child maltreatment incidents.

For more information contact:
< Maureen Fuchs, at (651) 281-9959, maureen.fuchs@health.state.mn.us, MDH Family Home Visiting Program.
< MDH Minnesota Children with Special Health Needs Program, at (800) 728-5420, or (651) 215-8956 (metro).
< Nancy Reed, at (651) 282-2953, nancy.reed@health.state.mn.us, MDH Family Home Visiting Program.
< Junie Svenson, at (651) 281-9891, junie.svenson@health.state.mn.us, MDH Minnesota Healthy Beginnings Program.

Strategy: Facilitate referrals to mental and chemical health programs.

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Background:
Child maltreatment prevention efforts may be hindered by the unresolved or unmanaged mental or chemical health needs (or both) of families. These issues may go unaddressed for a variety of reasons. Systems, including policy makers, communities, and service providers can ensure access to these health services by promoting:
< Healthy youth development and chemical health promotional efforts in communities.
< Adequate health care coverage, including coverage for mental and chemical health services.
< Availability and accessibility of providers and programs.
< Culturally specific programs and services.
< Programs that address a range of associated issues (i.e., chemical health norms and attitudes in the community, history of victimization, etc.).
< Policies and community norms that support recovery.
< Education and training of community members and professionals on identification of mental illness and substance abuse and referral making to appropriate interventions.
For related information, see the strategies in the *Alcohol, Tobacco, and Other Drugs* category and the section on Mental Health in the *Mental Health* category.

**Additional resources:**

**Bibliographic resources:**


**Organizational resources:**

< County social services agencies in Minnesota. They are very involved in the assessment, referral, and provision of and payment for, services in Minnesota counties.

< Mental Health Association of Minnesota, Minneapolis, Minnesota, at (612) 331-6840.


< Minnesota Department of Human Services, Chemical Dependency Program Division. For information about Rule 25 chemical dependency assessments and for information about chemical dependency treatment and aftercare programs in Minnesota, at (651) 582-1832.

< Minnesota Prevention Resource Center. This clearinghouse for information on a variety of chemical health issues has materials for use in classrooms, community-based programs, public information campaigns, etc. Contact: (800) 247-1303 or (612) 427-5310 (metro), [http://www.emprc.org/index.html](http://www.emprc.org/index.html).

**Evidence for strategy:**
Families and individuals who could benefit from and do not have access to necessary mental and chemical health services are at greater risk for child maltreatment. Providing timely referrals for those who need them has been found to decrease the incidence of child maltreatment.

**Has this strategy been implemented in Minnesota?**
Yes, many programs and resources across the state facilitate access to mental and chemical health services. These resources include schools, counseling centers, county social service agencies, faith communities, and health care providers.

**Indicators for this strategy:**

< Availability and accessibility of mental health and chemical health programs.

< Existence of a seamless web of assessment, referral, and aftercare mechanisms in the community for mental and chemical health problems.

< Number of community members who use resources and use them appropriately.

< Satisfaction of community members with the services and programs.

**For more information contact:**

< Maureen Fuchs, at (651) 281-9959, maureen.fuchs@health.state.mn.us, MDH Family Home Visiting Program.
Strategy: Collect and analyze data to inform interventions, policies, and the community.

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Background:
A common measurement of child maltreatment is its reported and substantiated incidence. Although this measure can be useful, it also presents some distinct limitations.

For example, the available data do not reflect those incidents that are not reported or those that are reported but not assessed or investigated. Similarly, the data do not indicate why some populations have a higher incidence of child maltreatment than others. Child protection data include cases where maltreatment has not been determined but services are needed. The state’s maltreatment data include cases in which:

- Maltreatment has been determined and child protection services needed.
- Maltreatment has been determined and no child protection services are needed.
- Maltreatment has not been determined and child protection services are needed.
- Maltreatment has not been determined and no child program services are needed.

By promoting a comprehensive, integrated data collection system, including monitoring of indicators from multiple sources, we can design and evaluate prevention interventions. Furthermore, as we track and analyze indicators, we must reflect both the strengths and risks of individuals, families, communities, and systems. This will ensure that subsequent interventions build upon existing strengths and successes. A comprehensive data collection system includes:

- Selection of data sets that are driven by prevention research and theory.
- Involvement of partners that represent multiple systems and community stakeholders.
- Shared data standards, categorizations, and technologies.

Additional resources:
Bibliographic resources:

- Reiss, AJ., Jr., Roth, JA. (Eds.). 1993. *Understanding and Preventing Violence*. 

< Resnick, MD., et al. 1997. Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. *JAMA* 278(10): 823-832. This is a national study that used a cohort of Minnesota adolescents. It provides an excellent overview of the connections between family, child, school, and community that protect youth from risk behaviors.

**Evidence for strategy:**
Data collection and analyses are fundamental public health tasks that create the foundation for solid public health planning, decision-making, and resource allocation.

**Has this strategy been implemented in Minnesota?**
Yes, some statewide data collection efforts have begun, are ongoing, and are being newly developed, including the collection of child maltreatment injury data. Also, some communities have initiated risk and strength assessments and tracking of other health indicators related to child maltreatment.

**Indicators for this strategy:**
< Increase in the number of stakeholders designing, evaluating, and utilizing data collection systems and the resulting data.
< Increase in the number and variety of indicators being collected and analyzed.
< Decrease in incidence and risk indicators for child maltreatment.
< Increase in protective factors in individuals, families, communities, and systems.

**For more information contact:**
< Judy Kuck, at (651) 296-5416, Department of Human Services, Family and Children’s Services Division.
< Jon Roesler, at (651) 281-9841, jon.roesler@health.state.mn.us, MDH Injury and Violence Prevention Unit.

**Strategy:** Assess (including self-assessment) the strengths of individuals, families, communities, and systems and build upon those strengths to address risks for child maltreatment.

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**Background:**
Prevention theory underscores the importance of influencing the balance between risks and protective factors (strengths or assets), building protective factors to increase resilience across the life span. Resilience, in turn, serves to overcome the potential negative impact of risks and life’s adversities. Systematic and sensitive assessments, including self-assessments, of the strengths of individuals, families, communities, and systems will indicate where to begin building and promoting those assets necessary to prevent child maltreatment. Through the purposeful, integrated promotion of asset-building in individuals, families, communities, and systems, communities can come together to prevent violence in multiple, tangible ways. Strength-based strategies include:
< Facilitating individuals, families, communities, and systems to identify...
and prioritize their own strengths and needs. This can be done one-on-one, through community partnerships, or within individual systems.

< Involving all community stakeholders in designing preventive approaches.
< Approaches that are person-, family-, or community-centered, as opposed to an array of fragmented services and programs, focusing on the development of natural supports within families and communities.

Additional resources:
Bibliographic resources:
< Resnick, MD., et al. 1997. Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. JAMA, 278(10): 823-832. This is a national study using a cohort of Minnesota adolescents. It provides an excellent overview of the connections between family, child, school, and community that protect youth from risk behaviors.

Organizational resources:

< PACER Center, Minneapolis, Minnesota, at (612) 827-2966 (Voice) or (612) 827-7770 (TTY), [http://www.pacer.org](http://www.pacer.org).

Evidence for strategy:
There is extensive research to show that people who are supported by an array of strengths, assets, or protective factors (such as connection to caring adults, positive connection to school, opportunities and recognition for meaningful activities in the community, etc.) are less likely to engage in risky or violent behaviors or both. Rigorous program evaluation on the outcome of child maltreatment based on a strength-based framework has shown a positive impact. It is presumed, therefore, that use of a strength-based framework in policy, professional training, and funding will make a difference in the prevention of child maltreatment.

Has this strategy been implemented in Minnesota?
Yes, strengths-based approaches and asset building are being implemented through a variety of disciplines and community-based efforts. These approaches are the bases for most of the current youth development and healthy community initiatives in communities.

Indicators for this strategy:
< Resources are available and accessible for individuals, families, communities, and systems to use to assess their strengths.
< Increased participation in assessment and goal setting by individuals, families, communities, and systems.
Strategy: Educate the community to recognize and refer victims of child maltreatment to child protection, law enforcement, and supportive services.

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Background:
All community members can become informed about child maltreatment indicators as well as how, and to whom, to report their reasons to believe maltreatment may have occurred. Also, through community-wide training and education, community members can become knowledgeable about preventive resources to which families can be referred. This includes self-protection and reporting skills training for children, including information that is adapted for children with disabilities. Essential topics for this education include:
- How to build and maintain community partnerships and collaborations.
- How state and federal child maltreatment statutes and their implementation and enforcement work.
- How local child protection and law enforcement practices and procedures work with regard to child maltreatment.
- How local child protection and law enforcement can best manage their child maltreatment caseloads.
- How to conduct surveys and assessments of existing community supports for families.
- What are the roles and responsibilities of mandated reporters, especially teachers and day care providers.
- What are the unique risks for maltreatment among children with disabilities, including out-of-home care, cognitive and communication challenges, increased dependency, lack of credibility as self-reporters, isolation, and painful intrusive medical care and therapies that may be confused with maltreatment.
- What are the behavioral and physical indicators of child maltreatment that may resemble disability or medical characteristics or reflect cultural practices or behaviors.

See the additional resources section below for educational programs and materials that are available for use by communities.

Additional resources:
- Beach Center on Families and Disabilities. *Abuse and Neglect of Children with Disabilities: A
Has this strategy been implemented in Minnesota?
Yes, training and education for mandated reporters is available through the Minnesota Department of Human Services (see below for contact information) and local county child protection services throughout Minnesota. However, this audience can be expanded to include all community members.

Indicators for this strategy:
< Number (or existence) of community partnerships and collaborations that focus on child maltreatment.
< Number of educational sessions for community members on the state and federal child maltreatment statutes.
< Number of training sessions for local child protection and law enforcement personnel.
< Number of educational sessions on ways to survey for and assess for community resources for child maltreatment.
< Number and type of surveys and assessments of community resources conducted.
< Increase in knowledge and understanding of the roles and responsibilities of teachers and day care providers with regard to child maltreatment.
< Increase in understanding of the unique issues with regard to children with disabilities in relation to child maltreatment.

For more information contact:
< Deb Jones, at (612) 827-2966 (Voice) or (612) 827-7770 (TTY), PACER Center, Minneapolis, Minnesota: http://www.pacer.org.
Strategy: Conduct child mortality reviews.

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Background:
Systematic child mortality reviews provide critical information about individual, family, community, and system risks for fatal child maltreatment. The purpose of reviewing child mortality cases, is to make recommendations to state and local agencies to improve the child protection system, including modifications in statute, rule, policy and procedure. The child mortality review panel studies specific cases with the intent to develop better policy and thereby reduce the number of children who sustain fatal or near fatal injuries as a result of child maltreatment. Multidisciplinary participation on review panels reflects a variety of professional viewpoints, which enhance the policy and practice recommendations. Child mortality reviews are conducted by county agencies and in addition, select cases are also reviewed by the Minnesota Department of Human Services.

Additional resources:
Bibliographic resources:

Organizational resources:
< Child Mortality Review Panel, Minnesota Department of Human Services, Fran Felix, at (651) 297-3834.

Evidence for strategy:
Child mortality reviews are required by state statute. Each case review is based on the information contained in the case file and other documents obtained from government agencies and medical facilities as well as the experience of those reviewing the case. To date, the panels are not able to document a connection between the work of the panels and a reduction in the rate of child mortality in Minnesota. However, some of the identified issues have been ameliorated. In 1998, a database was established by the Minnesota Department of Human Services, which will help to document progress on issues identified through the mortality review process.
Has this strategy been implemented in Minnesota?
Yes, the Child Mortality Review Panel was instituted in Minnesota in 1987. Local counties review every child death or near fatality, which meets the review criteria. The criteria include every child who died whose family received social services in the 12 months preceding the death of the child AND the manner of death was determined to be by suicide, homicide, Sudden Infant Death Syndrome, accident or could not be determined. Upon completion of the local mortality review, a written report of the review is sent to the Minnesota Department of Human Services. Cases selected for the State mortality review are cases where there appears to be broad policy or practice issues, which have an implication for broader policy changes or issues of the delivery of child protection services throughout the state.

Indicators for this strategy:
- Existence of mechanisms to conduct systematic child mortality reviews.
- Type of multidisciplinary professionals involved in the reviews.
- Number of reviews conducted.
- Increase in numbers of policy and practice recommendations implemented based on the results of the reviews.
- Results of evaluations conducted on those policies and practices.
- Decrease in number of child maltreatment fatalities.

For more information contact:
- Fran Felix, at (651) 297-3834, Fran.Felix@dhhs.state.mn.us; Minnesota Department of Human Services, Child Mortality Review Coordinator.
- Cheryl Fogarty, at (651) 281-9947, Cheryl.Fogarty@health.state.mn.us; MDH Infant Mortality Consultant.
- Maureen Fuchs, at (651) 281-9959, maureen.fuchs@health.state.mn.us; MDH Family Home Visiting Program.

Strategy: Educate parents about Shaken Baby Syndrome.

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Background:
Shaken Baby Syndrome is the term used to describe the brain injuries that result when children birth to three years are violently shaken with or without physical impact. The results of Shaken Baby Syndrome are devastating; most victims will either die or suffer permanent disability.

Prevention of Shaken Baby Syndrome is based on the premise that most caregivers do not intend to injure or kill the child, but simply do not recognize the danger of shaking a young child.

An effective program to prevent Shaken Baby Syndrome was developed and tested in Western New York and has been replicated in several sites around the country. The program involves educating both parents of a newborn while they are still in the hospital about the dangers of shaking a baby. Parents are asked to sign an affidavit confirming that they have received this information. Other sites have used minor variations on this format.
Additional resource:
Organizational resource:
< Midwest Children’s Resource Center, Minnesota, at (800) 422-0879.

Evidence for strategy:
In western New York, the results were dramatic: a more than 50 percent decrease in the incidence of Shaken Baby Syndrome. Results from other sites should be available shortly.

Has this strategy been implemented in Minnesota?
The Midwest Children’s Resource Center is working with Twin Cities hospitals and the MDH to implement this strategy in Minnesota.

Indicators for this strategy:
< Number of parents receiving education.
< Incidence of Shaken Baby Syndrome.

For more information contact:
Sara Seifert, at (651) 282-2968, sara.seifert@health.state.mn.us, MDH Injury and Violence Prevention Unit.

Strategy: Incorporate information on the maltreatment of children with special needs into mainstream child abuse prevention programs.

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Background:
Children with special needs and their families may face unique risks for maltreatment. These include increased demands on caregivers; inability to distinguish between abuse and physical therapies; increased dependency on others; inability to self-defend, ask for help, or report maltreatment; decreased credibility as a self-reporter of maltreatment; social isolation; caregivers misinterpreting behaviors characteristic of a disability; and societal attitudes that devalue people with disabilities.

Children, families, health care providers, teachers, paraprofessionals, and other providers of services can help prevent maltreatment with an increased awareness and understanding of these unique risks. Approaches include:
< Adapt ing typical prevention strategies to each child’s disability.
< Helping children learn about body parts, personal body space, and boundaries.
< Teaching children about abuse, e.g., how and whom to ask for help and when and how to report it.
< Teaching children, early on, about healthy sexuality.
< Providing opportunities for children to practice decision making, as well as social and assertiveness skills.
< Adding personal safety goals to each child’s Individualized Education Program (IEP) and family’s Individualized Family Service Plan (IFSP).
< Educating everyone who comes in contact with a child about that child’s unique vulnerabilities.
< Assuring coordination between public health and child protection workers when child protection assesses a report of a child with medical issues or
disabilities that involve multiple therapies.

Providing education or training for child protection workers to learn about children with developmental disabilities or high medical needs to better understand the issues that families struggle to overcome, and some of the resources available to assist the children and families.

It is important to implement these strategies as early and as often as possible, to coach the child in practicing help-seeking behaviors in multiple environments, and to work with a child’s and family’s strengths to foster life skills and resiliency. Communities and systems can also become more aware, responsive, and supportive of children with special needs and their families by including them in all aspects of community life, as well as in program and policy making.

Additional Resources:

* Beach Center on Families and Disabilities. *Abuse and Neglect of Children With Disabilities: A Compilation of Legal and Social Readings.* Lawrence, KS: University of Kansas. Contact: The Beach Center on Families and Disabilities, University of Kansas, 3111 Haworth Hall, Lawrence, KS 66045-7516, Phone: (913) 864-7605.


Evidence for the strategies:

Project STEEP (see the Egeland and Erickson article above) demonstrated the need for parents to learn about child development in order to meet the needs of their children and to form healthy attachments. It is also well known that providing information that is culturally- and disability-specific will increase the...
Has this strategy been implemented in Minnesota?
Yes, parenting information and support that is culturally and disability-specific is generally available through local ECFE, Head Start, libraries, and ethnic and minority advocacy groups. In addition, a number of Minnesota agencies work with cultural groups and families of people with disabilities to provide access to parenting information and support.

Indicators for this strategy:
< Substantiated rates of maltreatment of children with disabilities will be no higher than those for children without disabilities.
< Increased knowledge among children with disabilities, their families, and their service providers about the unique risks for maltreatment among children with special needs.
< Prevention strategies are integrated throughout mainstream prevention education, as well as within the child’s environments.
< Presence of personal safety goals in children’s IEPs and families’ IFSPs.
< Involvement of children with special needs and their families in community programs, policy making, and community life.

For More Information contact:
MDH Minnesota Children With Special Needs Program, at (800) 728-5420, or (651) 215-8956 (metro).
The strategies below can be used to work on this topic. Organizations that may play a role in implementing each strategy are indicated.

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<th>Increase availability, accessibility, and utilization of services for victims, perpetrators, and affected family members involved in domestic violence.</th>
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<td>Educate the community about the prevention, forms, and effects of domestic violence.</td>
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<td>Identify and promote community norms that discourage domestic violence, including norms from a diversity of cultures.</td>
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Domestic violence is experienced among people who know and live with each other, including children in the home who witness violence. It includes actual or threatened physical, sexual, psychological, and economic abuse among married, divorced, separated, dating heterosexual, or same-sex adult and adolescent partners (current or former).

Domestic violence is associated with a wide range of physical and mental health problems, including injuries, depression, substance abuse, and child maltreatment. The consequences of domestic violence extend beyond the immediate family into subsequent generations and the extended family and into the health care systems, the workplace, schools, faith communities, and service systems, and throughout the community as a whole. For related information see also Click Your Way to the Best Practices for Injury Prevention, a part of the MDH’s Injury and Violence Prevention Unit website, at: www.health.state.mn.us/strategies/. Click on “Violence Prevention”.

See also the other public health strategies on violence in this category; and related strategies in the Mental Health; Alcohol, Tobacco and Other Drug Use; Children and Adolescent Growth and Development; and Service Delivery Systems categories.

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**Background:**
In domestic and intimate partner violence prevention, it is essential to ensure that victims, perpetrators, children who witness battering, and other affected family members have access to the information and support they need to heal, be safe, and sustain healthy relationships. Many communities do not have fully accessible services or programs, including ones that are culturally and linguistically appropriate. Systems, communities, and service providers can ensure access to these important services by:

- Advocating for local and state support of services.
- Advocating for enforcement of laws that address domestic violence.
- Forming collaboratives to develop a coordinated community response across systems.
- Conducting local assessments to understand and address barriers to accessing services, including physical, social, cultural and language barriers.
- Advocating for adequate health care and mental health coverage, including reimbursement for violence-related treatment and services.
- Ensuring availability of providers and programs that are geographically and culturally accessible.
Strengthening policies and community norms that promote help seeking and recovery.

- Educating and training community members and professionals to identify domestic violence and refer to appropriate interventions.
- Publicizing available services for victims and those perpetrating domestic abuse.

**Additional resources:**

**Bibliographic resources:**
- St. Louis County Health Department. *Responding to Domestic Violence.* Duluth, MN: St. Louis County. For more information, contact: Jean Larson, at (218) 725-5236.

**Organizational resources:**
- The Alliance. A group of major shelters for domestic violence victims in Minnesota. Contact: (651) 646-9622.
- Day One domestic violence crisis line. Links caller immediately to shelter services nearest them. Crisis line: (866) 223-1111. Shelters also can make recommendations and referrals to local batterers’ treatment programs.
- Family Violence Prevention Fund. Provides information and professional training resources in areas such as health care and public policy. Go to [http://endabuse.org](http://endabuse.org)
- The Men’s Line. Counseling and referral service for men, currently serving the Twin Cities metro area. Contact: (612) 379-6367.
- Minnesota Center for Crime Victim Services. Contact Paula Weber, at (651) 282-4826. For a directory of domestic violence programs in Minnesota, go to [www.dps.state.mn.us/mccvs/](http://www.dps.state.mn.us/mccvs/)
- Minnesota Coalition for Battered Women (MCBW). The state coalition of battered women’s programs. Contact: (651) 646-6177.

**Evidence for strategy:**
Studies have shown positive outcomes over time when battered women receive shelter/advocacy services. Treatment programs for perpetrators of domestic violence have also demonstrated effectiveness in stopping domestic abuse, particularly when the treatment is based on professionally accepted standards. Quality
services for victims and perpetrators share the common goals of promoting safety, healing, and prevention of further abuse.

Children witnessing domestic violence are at high risk for mental health problems and involvement in future abuse. Also, the association between domestic violence and child maltreatment is very high. An effective intervention to interrupt this cycle of violence is to refer both victims and perpetrators to services and programs as early as possible.

**Has this strategy been implemented in Minnesota?**
Yes, a number of Minnesota communities have programs and services for victims, perpetrators, and their children. Some also have systematically assessed community strengths, including domestic violence resources. A regional collaboration in southeastern Minnesota has conducted an assessment to identify resources and to survey community members about gaps.

**Indicators for this strategy:**
- Number of programs, resources, and services available to victims and perpetrators of domestic violence.
- Number of ways that information about resources and services is available to those who need them.
- Number of health care professionals and paraprofessionals who receive training on domestic violence.
- Number of victims and perpetrators referred for services.
- Number of victims and perpetrators served.

**For more information contact:**
Amy Okaya, at (651) 281-9874, amy.okaya@health.state.mn.us
Program Administrator, MDH Injury and Violence Prevention Unit.

**Strategy: Promote relational models that focus on community connectedness, intimacy, and coping skills.**

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**Background:**
Research indicates that an infant’s experience of healthy, nurturing relationships has a profound impact on his or her capacity to sustain healthy, nurturing relationships throughout life. As a person develops relationships, he or she begins to establish working models of self and others, of how to view relationships. Because many perpetrators of domestic violence were themselves victims or witnesses of domestic violence as children, prevention strategies should seek to resolve these past relational models, in part, by promoting healthy relationships and life skills.

Effective strategies should ensure that individuals have the opportunity to build and sustain mutually beneficial relationships with their families and communities, and to learn and practice healthy relationship-building and life skills. Effective strategies must also accommodate and promote the unique aspects of all cultural groups, as well as their histories, beliefs, and practices.
This includes:

- Promoting natural supports (i.e., parent-to-parent) within families and communities.
- Facilitating healing and resolution of a victim's experiences of maltreatment.
- Teaching and modeling healthy relationships (parenting, mentoring, partnering, and working relationships, as well as friendships), including how to manage challenges and conflicts.

Additional resources:

Bibliographic resources:


Organizational resources:


Evidence for strategy:

It is well-documented that if people have meaningful relationships with another person, their families, their communities, or all three, and if they have positive views of themselves and others, they are less likely to engage in violent behaviors toward themselves or others. Many tools have been designed to measure capacities, life skills, risks, strengths (assets or protective factors), and mental health, and they may be implemented within programs.

Has this strategy been implemented in Minnesota?

Yes, many social programs implement and promote strategies such as home visiting, mentoring, community coalitions, and early childhood family education programs. In addition, faith communities and other formal and informal social organizations often are
highly effective in implementing this strategy.

**Indicators for this strategy:**
- Number of opportunities for, and ways of building, parent-to-parent supports and community connections.
- Number of adolescents who self-report assets (e.g., feeling of belonging, intention of staying in school, presence of an important adult in their lives, belief their parents love them, etc.).

**For more information contact:**
Amy Okaya, at (651) 281-9874, amy.okaya@health.state.mn.us
Program Administrator, MDH Injury and Violence Prevention Unit.

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**Strategy:** Assess (including self-assessment), the strengths of individuals, families, communities, and systems, and build upon those strengths to address risks for domestic and partner violence.

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**Background:**
Prevention theory underscores the importance of influencing the balance between risks and protective factors (strengths or assets), building protective factors to increase resilience across the lifespan. Resilience, in turn, serves to overcome the potential negative impact of risks and life adversities. Systematic and sensitive assessments (including self-assessments) of the strengths of individuals, families, communities, and systems, will indicate where to begin building and promoting those assets that can help prevent domestic violence.

Opportunities exist at the individual, family, community, and systems levels, to encourage and support healthy relational models. A key question that drives effective approaches at all levels is: How does this intervention (program, policy, practice) promote resiliency? Through the purposeful, integrated promotion of asset-building in individuals, families, communities, and systems, communities can come together to prevent domestic and intimate partner violence in multiple, tangible ways.

Strength-based strategies include:
- Helping individuals, families, communities, and systems to identify and prioritize their own strengths and needs. This can be done one-on-one, through community partnerships, or within individual systems.
- Involving all community stakeholders in designing preventive approaches.
- Creating approaches that are person-, family-, or community-centered, as opposed to an array of fragmented services and programs. Approaches should focus on developing natural supports within families and communities.

**Additional resources:**
Bibliographic resources:
Evidence for strategy:
There is extensive research to show that people who are supported by an array of strengths, assets, or protective factors (such as connection to caring adults, positive connection to school, opportunities and recognition for meaningful activities in the community, etc.) are less likely to engage in risky or violent behaviors or both. In addition, strength-based intervention approaches are more likely to be effective in interrupting the cycle of violence.

Has this strategy been implemented in Minnesota?
Yes, a large number of Minnesota communities and systems have initiated self-assessments, including formal assessments conducted with the Search Institute. Strengths-based approaches and asset-building are being implemented through a variety of disciplines and community-based efforts, such as the Initiative for Violence Free Families and Communities in Ramsey and Hennepin Counties, and efforts facilitated by the Center for Reducing Rural Violence. In addition, many schools and community organizations incorporate asset building into their youth development; ATOD (alcohol, tobacco, and other drug) prevention; adolescent pregnancy prevention; and crime prevention initiatives.

Indicators for this strategy:
- Resources are available and accessible for individuals, families, communities, and systems to use to assess their strengths.
- Policies are adopted that promote individual and family strengths, and that reduce barriers – including economic, cultural and language barriers – to community connectedness.
- Resources to assess and enhance their strengths are available and accessible for individuals, families, communities, and systems.
Additional individuals, families, communities, and systems participate in assessment and goal setting.
Number and type of efforts in the community that individuals, families, communities, and systems use to build upon their strengths.
Number and type of activities implemented by individuals, families, communities, and systems to strengthen and build on assets.

For more information contact:
Amy Okaya, at (651) 281-9874, amy.okaya@health.state.mn.us, Sexual Violence Prevention Program Coordinator, MDH Injury and Violence Prevention Unit.

Strategy: Collect and analyze data to inform interventions, policies, and the community.

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Background:
A comprehensive, integrated data collection system, including monitoring of indicators from multiple sources, is integral to designing and evaluating prevention interventions. A comprehensive data collection system includes:
- Selection of data sets driven by prevention research and theory.
- Partners representing multiple systems and community stakeholders.
- Shared data standards, categorizations, and technologies.

Additional resources:
Bibliographic resources:
- National Center for Injury Prevention and Control, National Centers for Disease Control and Prevention (CDC). To view publications and resources related to domestic and intimate partner violence data and research, go to http://www.cdc.gov/ncipc/dvp/fivp/fivp.htm

Organizational resources:
- Minnesota Center for Crime Victim services, at (651) 282-6256.
- Minnesota Coalition for Battered Women, at (651) 646-6177.
- Minnesota Department of Health, Injury and Violence Prevention Unit. Contact Jon Roesler, at (651) 281-9841.

Evidence for strategy:
The promotion of a comprehensive, integrated data collection system, including monitoring of indicators from multiple sources, is a basic public health strategy that informs the design and evaluation of prevention interventions. Tracking and analyzing indicators must reflect both the
strengths and risks of individuals, families, communities, and systems to ensure that subsequent interventions build upon existing strengths and successes.

Has this strategy been implemented in Minnesota?
Yes, a range of state and local systems and organizations collect data related to domestic violence. State hospitals, emergency departments, and other organizations and agencies are currently contributing to the development of an integrated statewide intimate partner violence injury surveillance system, coordinated through the Minnesota Department of Health. Several statewide community surveys provide information on the prevalence of domestic and intimate partner violence.

Many organizations and systems recognize the need to collect data on domestic violence, but may lack the commitment, resources, or ongoing support for collecting and/or integrating data into planning and operations. There are ample opportunities for further data collection efforts and coordination through agencies as well as community-based services, including health care and public health.

Indicators for this strategy:
- Increase in the number of stakeholders designing, evaluating, and utilizing data collection systems and the resulting data.
- Increase in the number and variety of indicators being collected and analyzed.
- Increase in technical capacity and resources for data collection and evaluation among programs designed to prevent abuse.

For more information contact:
Jon Roesler, at (651) 281-9841, jon.roesler@health.state.mn.us, MDH Injury and Violence Prevention Unit.

Strategy: Educate the community about the prevalence, forms, and effects of domestic violence.

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Background:
Education can occur in schools and colleges, within community organizations and collaboratives, in the workplace, among religious congregations, through web sites, through family and client education, and as part of community violence-prevention efforts. Education should include:
- Information to dispel myths about domestic violence.
- Identification of cultural norms that perpetuate domestic violence.
- Discussion of characteristics of healthy, nonviolent relationships.
- Information on risk factors and treatment for perpetration of domestic violence.
- Information on local services for victims, perpetrators, and those at risk.

Additional resources:
For referrals to local battered women’s program prevention services, contact:
- Minnesota Coalition for Battered Women, at (651) 646-6177.
- Central Minnesota Task Force on Battered Women, at (320) 253-6900
Bibliographic resources:


- *Domestic Violence Report*. A useful digest of current research and practice related to domestic violence. For copies, contact: (609) 683-4450.


Organizational resources:

- Center for the Prevention of Sexual and Domestic Violence. An educational resource on abuse and religion, [http://www.cpsdv.org](http://www.cpsdv.org/)

- Center for Reducing Rural Violence. Provides rural communities with technical assistance, research and evaluation, and education and advocacy to prevent violence and promote peace. Contact: Steve Hirsch, at (218) 751-1585.

- The Initiative for Violence Free Families and Communities in Ramsey and Hennepin Counties. Action teams focus on preventing family violence by focusing on different sectors of the community. Contact: Shirley Pierce, at (651) 266-8020 (Ramsey County) or Lois Gunderson, at (612) 728-2094 (Hennepin County).

- VAWnet Library. An online resource for advocates working to end domestic violence, sexual assault, and other violence in the lives of women and their children. [http://www.vawnet.org/VNL/library/](http://www.vawnet.org/VNL/library/)


Evidence for strategy:

Experts agree that societal attitudes, beliefs, and practices serve to perpetuate domestic violence. As with other forms of health...
promotion, perceptions and behaviors about domestic violence may be changed with accurate information and education at all levels of society. In the case of violence, experts believe that increased awareness and knowledge of the issues must exist in order for change to occur.

Has this strategy been implemented in Minnesota?
Yes, domestic abuse programs, community collaboratives, health care organizations and other professionals have been active in community education about domestic violence.

Indicators for this strategy:
- Number of community requests for information and presentations on domestic violence.
- Newspaper articles that include information addressing education topics listed in this strategy.
- Community observance of Domestic Violence Awareness Month (October).
- Formation of a multidisciplinary collaborative to provide comprehensive education about domestic violence (i.e., domestic abuse programs, perpetrator treatment, law enforcement, education, health care, public health).
- Number of schools working with sexual assault program staff to educate about sexual violence.

For more information contact:
Amy Okaya, at (651) 281-9874, amy.okaya@health.state.mn.us, Program Administrator, MDH Injury and Violence Prevention Unit.

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Strategy: Identify and promote community norms that discourage domestic violence, including norms from a diversity of cultures.

Background:
Public discussion should occur about community norms and values that discourage domestic violence. Such norms can be discussed in the context of distinct cultural and religious community values. Healthy norms can be promoted by:
- Ensuring that students, employees, and members of institutions and organizations are covered by, aware of, and in compliance with their organizations’ policies on sexual harassment and violence.
- Articulating community norms at community and organizational gatherings, such as community events, sports and recreational activities, civic and volunteer organization meetings, religious services, and gatherings at workplaces and schools.
- Building the capacity of parents and caregivers to foster empathy, a healthy sense of responsibility, and self-esteem in children through economic and social support, community programs, and home visiting.
- Developing and promulgating policies in the public and private sector that deter abuse and promote recovery from domestic violence.
Additional resources:

Bibliographic resources:

Organizational resources:
- Center for Reducing Rural Violence. Provides rural communities with technical assistance, research and evaluation, and education and advocacy to prevent violence and promote peace. Contact: Steve Hirsch, at (218) 751-1585.
- Children, Youth and Families Consortium, University of Minnesota, at (612) 626-1212, [http://www.cyfc.umn.edu](http://www.cyfc.umn.edu)
- Dads and Daughters, Duluth, MN. [http://www.dadsanddaughters.org/](http://www.dadsanddaughters.org/)
- Institute on Domestic Violence in the African American Community. [http://www.dvinstitute.org/](http://www.dvinstitute.org/)
- The Initiative for Violence Free Families and Communities in Ramsey and Hennepin Counties. Action teams focus on preventing family violence by focusing on different sectors of the community. Contact: Shirley Pierce, at (651) 266-8020 (Ramsey County) or Lois Gunderson, at (612) 728-2094 (Hennepin County).
- Men As Peacemakers, Duluth, at (218) 727-1939.
- Minnesota Coalition for Battered Women, at (651) 646-6177.

Evidence for strategy:
In recent years, people have recognized that problem-focused strategies are only part of resolving large societal issues such as violence. Asset- or strength-based approaches are increasingly articulated and practiced in Minnesota and across the U.S. These approaches emphasize the positive values and behaviors that exist in a community and show how, by honoring and cultivating them, communities can move toward their own positive visions of health. Efforts stimulated by the Search Institute, John Kretzman and John McKnight, Michael Resnick, and others are demonstrating how communities can promote health by examining and exercising their own strengths.
Has this strategy been implemented in Minnesota?
Yes, numerous community collaboratives and coalitions in Minnesota have been formed based on approaches that build on community strengths. Organizations that routinely talk about values, such as businesses and religious congregations, can and sometimes do take advantage of natural opportunities to promote values that discourage domestic violence.

Indicators for this strategy:
- Development and review of organizational policies relating to domestic violence.
- Proportion of males included in domestic violence prevention efforts.
- Number and type of educational programs and opportunities for children, youth, and adults to learn about and discuss healthy relationships.
- Range of collaborators involved in domestic violence prevention.
- Number of parents receiving parenting education, support, mentoring, or all three.
- Number of news articles and editorials that speak out against domestic violence and affirm nonviolence.
- Community preferences for media and entertainment that do not glorify abuse or degrade women.
- Increased knowledge among community members about domestic and intimate partner violence.

For more information contact:
Amy Okaya, at (651) 281-9874, amy.okaya@health.state.mn.us
Program Administrator, MDH Injury and Violence Prevention Unit.
**CATEGORY: Violence**

**TOPIC: VIOLENCE - SEXUAL VIOLENCE**

The strategies below can be used to work on this topic. Organizations that may play a role in implementing each strategy are indicated.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Governmental Public Health Agencies</th>
<th>Health Plans</th>
<th>Hospitals &amp; Clinics</th>
<th>Educational Systems</th>
<th>Community-based Organizations</th>
<th>Businesses/Work Sites</th>
<th>Other</th>
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<tr>
<td>Increase availability, accessibility, and utilization of services for victims and perpetrators of sexual violence.</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Community Coalitions</td>
<td>✓</td>
<td>Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts</td>
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<td>Collect and analyze data to inform interventions, policies, and the community.</td>
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<td>Community Coalitions</td>
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<td>Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts</td>
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<td>Educate the community about the prevalence, forms, and effects of sexual violence.</td>
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<td>Community Coalitions</td>
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<td>Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts</td>
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<tr>
<td>Reduce risks and increase protective factors at the individual, family, community, and societal levels that discourage sexual abuse.</td>
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<td>Community Coalitions</td>
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<td>Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts</td>
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This information is current as of Fall 2002
Page 43
Sexual violence causes physical and emotional injuries which severely affect victims, families, and communities. Forms of sexual violence include sexual assault by a stranger, acquaintance, or partner; incest and other types of child sexual abuse; commercial sexual exploitation, such as prostitution; and sexual harassment. Experiences of sexual assault are associated with alcohol and other drug use, mental health problems, suicide attempts, early pregnancies, and other health problems.

To prevent sexual violence, all sectors of the community need to be actively involved in community-wide efforts. For related information see also “Click Your Way to the Best Practices for Injury Prevention,” a part of the MDH’s Injury and Violence Prevention Unit website. For more information see the website for strategies resources at: www.health.state.mn.us стратегий/ Click on “Violence Prevention”.

See also public health strategies on violence; mental health; Alcohol, Tobacco and Other Drug Use; Adolescent Health; and Service Delivery Systems.

Strategy: Increase availability, accessibility, and utilization of services for victims and perpetrators of sexual violence.

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Background:
Sexual violence is a form of abuse that has historically been under-addressed by communities, particularly when the victim knows the perpetrator. Victim-blaming and community disbelief are two of the many disincentives often faced by victims coming forward to report sexual abuse and seek help. When services specifically designed for victims of sexual violence are available, victims are assured greater safety in disclosing their abuse. Disclosure can have several health-positive effects (e.g., the victim receives important information and support for healing), and increases the likelihood that perpetrators will be identified, held accountable, and offered appropriate treatment.

Accessibility of treatment for perpetrators is also important in preventing sexual violence. Perpetrators may be discouraged from seeking help on their own, when community norms about sexual violence are ambivalent and when there is social stigma associated with perpetration. Counseling and treatment can be especially helpful to young people who exhibit sexually inappropriate or abusive behavior, and to those who recognize they are involved in sexually abusive or exploitative behavior and wish to change.

Because sexual violence involves particular laws, health effects, and social issues, people who are victims or perpetrators typically require specialized services such as counseling, treatment, legal services, advocacy, and medical services. Help is also often available for family members and others immediately affected by the abuse. Use of these services helps ensure that the abuse does not continue, and that the
individual has the opportunity and support for recovery. To be useful and accessible, services need to be appropriate in terms of culture, language, and age. Examples of specific activities include:

- Training public health staff, health care workers, counselors, clergy, those who work with children, and the community-at-large to identify and appropriately refer victims, perpetrators, and those at risk of perpetrating sexual abuse.
- Forming collaboratives to develop a coordinated community response to sexual violence cases across systems.
- Conducting local assessments to understand and address barriers to accessing services, including physical, social, and language barriers.
- Ensuring that treatment for perpetrators and services for victims are readily available, and that barriers to accessing help are minimized.
- Strengthening policies and community norms that support help seeking and recovery.
- Advocating for local and state support of services.
- Publicizing available services for victims and those at risk of perpetration.
- Advocating for adequate health care and mental health coverage, including reimbursement for violence-related treatment and services.

Additional resources:

Bibliographic resources:


Organizational resources:

- The Men’s Line. Counseling and referral service for men, currently serving the Twin Cities metro area. Contact: (612) 379-6367.
- Minnesota Association for the Treatment of Sexual Abusers (MNATSA), Minnesota Chapter of the National Association for the Treatment of Sexual Abusers. Contact: Steven Huot, at (651) 642-0279.
- Minnesota Center for Crime Victim Services (MCCVS) of the Minnesota Department of Public Safety. To locate local sexual assault victim services, contact: (651) 282-6256, [http://www.dps.state.mn.us/mccvs/](http://www.dps.state.mn.us/mccvs/)
- Minnesota Coalition Against Sexual Assault (MCASA). Represents sexual assault programs from across Minnesota. Operates the Sexual Violence Justice Institute which promotes a victim-centered community response to sexual violence through “Sexual Assault Multidisciplinary Response Teams” (SMART) Contact: Tammie Larsen, at (612) 313-2797, [http://www.mncasa.org/](http://www.mncasa.org/)
- The Network. Informal statewide organization of professionals who work with perpetrators of sexual violence. Contact: Tom Thompson, at (651) 643-2584.
- STOP IT NOW! Minnesota. Provides public education about child sexual
abuse and promotes self-identification and treatment for perpetrators. Contact: Project Pathfinder, at (651) 644-8515.

**Evidence for strategy:**
Services for victims, perpetrators, and their family members represent important efforts to reduce the likelihood that sexual violence will continue. Studies show that individuals who complete treatment are much less likely to re-offend, whether they were incarcerated or were only placed on probation.

When victims do not receive relevant information and services, there is increased risk that their legal rights, health and well-being will be further compromised.

**Has this strategy been implemented in Minnesota?**
Yes, currently there are approximately 90 programs in Minnesota providing services to victims of sexual violence. For perpetrators, there are about 50 treatment providers associated with the major professional organizations in this field. A significant number of counties and populations remain unserved by one or both types of provider.

Through the development of SMART in Minnesota, increasing numbers of organizations and systems have worked to provide a more sensitive and effective response to victims of sexual assault.

**Indicators for this strategy:**
- Utilization of sexual assault victim service programs.
- Utilization of sexual abuse treatment services.
- Degree of local funding for sexual assault and perpetrator treatment services.
- Creation of services in areas where currently there are none.
- Existence of services to meet needs of under-served populations, such as non-English-speaking clients.
- Visibility and collaboration surrounding outreach efforts in the community.
- Number of referrals from health care, public health, schools, community-based organizations, and worksites to appropriate services and treatment.
- Number of self-referrals to services and treatment for sexual violence.
- Extent of coverage by health plans and/or counties for sexual violence-related treatment and services.
- Number of professionals trained to identify and refer individuals experiencing sexual violence.
- Degree of stigma associated with seeking help for sexually abusive behavior.
- Identification and reduction of barriers to accessing services for different populations in the community.

**For more information contact:**
Amy Okaya, at (651) 281-9874, amy.okaya@health.state.mn.us, Program Administrator, MDH Injury and Violence Prevention Unit.

**Strategy: Collect and analyze data to inform interventions, policies, and the community.**

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This information is current as of Fall 2002
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Background:
Current systems data on sexual violence are incomplete and do not reflect the actual number of incidents. The promotion of a comprehensive, integrated data collection system is an integral strategy to inform the design and evaluation of prevention interventions. Indicators from multiple sources should be monitored. A comprehensive data collection system includes:
- Selection of data sets driven by prevention research and theory.
- Partners representing multiple systems and community stakeholders.
- Shared data standards, categorizations, and technologies.

Evaluation of prevention efforts is also critical to advance the understanding of effective interventions.

Additional resources:
Bibliographic resources:
- National Center for Injury Prevention and Control, National Centers for Disease Control and Prevention (CDC). To view publications and resources related to domestic and intimate partner violence data and research, go to [http://www.cdc.gov/ncipc/dvp/fivp/fivp.htm](http://www.cdc.gov/ncipc/dvp/fivp/fivp.htm)

Organizational resources:
- Minnesota Coalition Against Sexual Assault, at (612) 313-2797.
- Minnesota Department of Health, Injury and Violence Prevention Unit. Contact: Jon Roesler, at (651) 281-9841.

Evidence for strategy:
State and national surveys have consistently found that the vast majority of sexual violence incidents are unreported. By promoting a comprehensive, integrated data collection system; working to better identify sexual violence cases; and monitoring indicators from multiple sources, we can better inform the design and evaluation of prevention interventions. It is important to reflect both the strengths and risks of individuals, families, communities, and systems, to ensure that interventions build on existing strengths and successes.

Has this strategy been implemented in Minnesota?
Hospitals, emergency departments, and agencies that collect data on sexual violence are currently helping to develop an integrated statewide sexual violence injury surveillance system, coordinated through the Minnesota Department of Health. Several statewide community surveys provide information on the prevalence of sexual violence.

Many organizations and systems recognize the need to collect data related to sexual violence, but sometimes lack the
commitment, resources or ongoing support for collecting and/or integrating data into planning and operations. There are ample opportunities for further data collection efforts and coordination through agencies and community-based services, including health care and public health.

**Indicators for this strategy:**
- Increase in the number of stakeholders who are designing, evaluating, and utilizing data collection systems and the resulting data.
- Increase in the number and variety of indicators being collected and analyzed.
- Increase in technical capacity and resources for data collection and evaluation among programs designed to prevent abuse.

**For more information contact:**
- Amy Okaya, at (651) 281-9874, amy.okaya@health.state.mn.us, MDH Injury and Violence Prevention Unit.
- Jon Roesler, at (651) 281-9841, jon.roesler@health.state.mn.us, MDH Injury and Violence Prevention Unit.

**Strategy: Educate the community about the prevalence, forms, and effects of sexual violence.**

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**Background:**
Such education can occur in schools and colleges, community organizations and collaboratives, the workplace, religious congregations, web sites, sex offender community notification meetings, family and client education, and community violence-prevention efforts. Education should include:
- Information to dispel myths about rape and sexual assault.
- Identification of cultural norms that perpetuate sexual violence.
- Discussion of healthy sexuality and sexual behaviors in the context of child and youth development.
- Information on risk factors and treatment for perpetration of sexual violence.
- Information on local services for victims, perpetrators, and those at risk.

**Additional resources:**
- Minnesota Department of Health materials (to order, contact the MDH Sexual Violence Prevention. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Sexual Violence”, or contact the MDH Library, at (612) 676-5090.
- *A Place to Start: A Resource Kit for Preventing Sexual Violence.* [Developed for communities by the Minnesota Department of Health.]
- *Town Meeting: A Community Response to Sexual Violence.* [Videotapes of the 1998 Town Meeting broadcast on Minnesota public television stations. Educational and presentation versions are available for stimulating discussion in your community.]

For referrals to local sexual assault program prevention services, contact:
- Minnesota Center for Crime Victim Services (MCCVS), Sexual Assault Program, at (651) 282-6256, http://www.dps.state.mn.us/mccvs/

This information is current as of Fall 2002
- Minnesota Coalition Against Sexual Assault (MCASA), at (612) 313-2797, [http://www.mncasa.org/](http://www.mncasa.org/)
- Bibliographic resources:
  - Arizona Rape Prevention Education Project. Providing sexual assault statistics, research and evaluation online at [http://www.u.arizona.edu/~sexasslt/arpep/index.html](http://www.u.arizona.edu/~sexasslt/arpep/index.html)
  - *Sexual Assault Report*. A useful digest of current research and practice related to sexual assault and sexual violence. For copies, contact: (609) 683-4450.

This information is current as of Fall 2002
Page 50
Evidence for strategy:
Experts agree that societal attitudes, beliefs, and practices serve to perpetuate sexual violence. As with other forms of health promotion, perceptions and behaviors about sexual violence may be changed through information and education at all levels of society. In the case of violence, there is consensus among experts that increased awareness and knowledge of the issues must exist in order for change to occur.

Has this strategy been implemented in Minnesota?
Yes, sexual assault programs, community collaboratives, and other professionals have been active in community education about sexual violence. See A Place to Start: A Resource Kit for Preventing Sexual Violence in the above list of references for other examples of how this strategy has been implemented.

Indicators for this strategy:
- Number of community requests for information and presentations on sexual violence.
- Number of prevention-related follow-up activities to sex offender community notification meetings.
Newspaper articles that include information on the topics listed in this strategy.

Community observance of Sexual Assault Awareness Month (April).

Formation of a multidisciplinary collaborative to provide comprehensive education about sexual violence (e.g., sexual assault programs, perpetrator treatment, law enforcement, education, sexuality educators, public health, etc.).

Evidence that sexual violence is addressed specifically by local violence-prevention collaboratives.

Number of schools working with sexual assault program staff to educate about sexual violence.

For more information contact:
Amy Okaya, at (651) 281-9874, amy.okaya@health.state.mn.us, Program Administrator, MDH Injury and Violence Prevention Unit.

Strategy: Reduce risks and increase protective factors at the individual, family, community and societal levels that discourage sexual abuse.

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Background:
Research and clinical experience with sex offenders has revealed certain risks and protective factors associated with the perpetration of sexual violence. Risks are related to: socialization of males that affirms violence and dominance; lack of means to express or receive appropriate emotional responses from others; family turmoil and violence; neglect of child development, including sexual development; and in some cases biological and neurological conditions.

Key protective factors that make sexual violence less likely to occur include: the existence of warm, secure family relationships; emotional awareness and management skills (including those related to sexual feelings); and connectedness to friends, family and adults in the community.

Effective strategies, therefore, ensure that individuals build and sustain mutually beneficial relationships with their families and communities, and are supported in learning and practicing healthy relationship-building and life skills. Addressing social conditions that increase stress - such as poverty, lack of access to appropriate health care, and social isolation or discrimination - is also important as part of a comprehensive, ecological approach to prevention.

Public discussion can be convened to deal with community norms and values that discourage sexual violence. Such norms can be discussed in the context of distinct cultural and religious community values. Healthy norms and protective factors can be promoted by:

- Building the capacity of parents and caregivers to foster empathy, a healthy sense of responsibility, and self-esteem in children through economic and social support, community programs, and home visiting.
Dispelling myths and messages that equate masculinity with dominance and violence.

Ensuring that students, employees, and members of institutions that have policies on sexual harassment and violence are covered by, aware of, and in compliance with those policies.

Recognition and support for healthy child and adolescent sexual development.

Articulation of community norms at community and organizational gatherings, such as community events, sports and recreational activities, civic and volunteer organization meetings, religious services, and gatherings at workplaces and schools.

Additional resources:

- Minnesota Department of Health materials (to order, contact the MDH Sexual Violence Prevention. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Sexual Violence Prevention”, or the MDH Library, at (612) 676-5090.

- A Place to Start: A Resource Kit for Preventing Sexual Violence. Developed for communities by the Minnesota Department of Health.


Bibliographic resources:


- Toolkit to End Violence Against Women. Provides concrete guidance to communities, policy leaders, and individuals engaged in activities to end violence against women. Go to http://toolkit.ncjrs.org/

Organizational resources:

- Center for Reducing Rural Violence. Provides rural communities with technical assistance, research and evaluation, and education and advocacy to prevent violence and promote peace. Contact: Steve Hirsch, at (218) 751-1585.


- Men Can Stop Rape. Promotes gender equity and men's capacity to be strong without being violent. Go to http://www.mencanstoprape.org/

The Search Institute. Promotes positive youth development through community asset-building. Contact: (612) 376-8955, or go to http://www.search-institute.org.

The Sexual Violence Prevention Action Team of the Initiative for Violence Free Families and Communities in Ramsey County. Contact: Grit Youngquist, at (651) 266-2407.


Evidence for strategy:
Many social programs implement and promote these strategies. These include home visiting, mentoring, community coalitions, and early childhood family education programs. In addition, faith communities and other formal and informal social organizations often are highly effective in implementing this strategy.

Community-based projects and many schools and community organizations incorporate asset building and risk reduction into their youth development and youth risk behavior prevention, adolescent pregnancy prevention, and crime prevention initiatives.

Has this strategy been implemented in Minnesota?
Yes, numerous community collaboratives and coalitions in Minnesota have been formed based on approaches that build on community strengths. Organizations that routinely talk about values, such as businesses and religious congregations often take advantage of natural opportunities to promote values that discourage sexual violence.

Indicators for this strategy:
- Development and review of organizational policies relating to sexual violence.
- Number of businesses that sell sexually exploitative media and services.
- Proportion of males included in sexual violence prevention efforts.
- Number of hours of school sex education at each grade level.
- Range of collaborators involved in sexual violence prevention.
- Surveillance of community events and media for use of key words, such as respect and sexuality.
- Percentage of children living at or below the poverty level.
- Number of parents receiving parenting education, support, mentoring, or all three.
- Number of community organizations working to strengthen families at risk of child abuse and neglect.
- Number of adolescents who self-report assets (e.g., feeling of belonging, intention of staying in school, presence of an important adult in their lives, belief their parents love them, etc.).
- Adoption and maintenance of state and local policies that promote individual and family strengths, and that reduce barriers - including economic, cultural and language barriers - to community connectedness.
Availability and accessibility of resources for individuals, families, communities, and systems to use to assess and enhance their strengths.

For more information contact:
Amy Okaya, at (651) 281-9874, amy.okaya@health.state.mn.us, Program Administrator, MDH Injury and Violence Prevention Unit.
The strategies below can be used to work on this topic. Organizations that may play a role in implementing each strategy are indicated.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Governmental Public Health Agencies</th>
<th>Health Plans</th>
<th>Hospitals &amp; Clinics</th>
<th>Educational Systems</th>
<th>Community-based Organizations</th>
<th>Businesses/Work Sites</th>
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<tbody>
<tr>
<td>Promote a safe and supportive home environment.</td>
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<td>Policy Makers, Faith Communities, Social Services, Sports &amp; Recreation, Victim Services, Mental Health Services, Law Enforcement, Courts, Child Care Providers.</td>
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<td>Work with schools to proactively prevent violence.</td>
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<td>Policy Makers, Social Services, Mental Health Services, Law Enforcement, Seniors.</td>
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<td>Organize the community to reduce risks and increase protective factors.</td>
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<td>Faith Communities, Political Parties, Neighborhoods, Policy Makers, Social Services, Opinion Leaders, Professional Organizations.</td>
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</table>
Youth are disproportionately affected by violence. Between the ages of 12 and 17, they are twice as likely as adults to be victims of serious violent crimes and three times as likely to be victims of simple assault. In 2001, 38% of 9th grade girls and 59% of 9th grade boys in Minnesota reported that they had been pushed, shoved, or grabbed at school during the past year.

Violence takes many forms, and includes verbal, emotional, sexual and physical abuse. In all its forms, violence is most often perpetrated by someone known to the victim, including family members and peers. While society often draws distinctions between different violent behaviors and levels of severity, it is important to recognize that the degree and nature of harm can vary, based on individual characteristics and on the response of other individuals, the community, and systems.

Experiences of victimization are associated with many other health problems, including tobacco, alcohol and other substance use, injuries, early pregnancy, and psychological effects such as Post Traumatic Stress Disorder and depression.

In recent years, youth violence has increasingly been identified as a public health issue. This perspective has brought new opportunities for the synthesis of existing information and ongoing attempts to determine best and promising practices for prevention. At present, prevention approaches and data from many fields, such as education, criminal justice, psychology and public health, are beginning to reflect a growing consensus around key areas for prevention.

The strategies below are organized according to an ecological framework, indicating that prevention can and must occur at different levels of social organization. Prevention is most likely to be successful when work occurs at multiple levels simultaneously and when these efforts are connected and integrated. Public health is in a unique position to facilitate and advocate for prevention across these multiple levels.

The following are central approaches that apply to all strategies:

- Strengthen social ties with pro-social individuals and groups (connectedness).
- Collect data and conduct assessments that identify strengths as well as problems.
- Build on individual, community, and system strengths.

The following bibliographic and organizational resources provide information relevant to all four strategies below:

Bibliographic resources:

- Mann, RP., Borowsky, I., Stolz, A., Latts, E., Cart, CU., and Brindis, CD. 1998. Youth Violence: Lessons from the Experts. Department of Pediatrics, University of Minnesota, and...
Department of Pediatrics and the Institute for Health Policy Studies, University of California, San Francisco. [http://allaboutkids.umn.edu/konopka/](http://allaboutkids.umn.edu/konopka/).


Organizational resources:


- Partnerships Against Violence Network (PAVNET). A “virtual library” of information about violence and youth-at-risk, representing data from seven different federal agencies. The database is organized into three main search categories: research, promising programs, funding. Available at: [http://www.pavnet.org](http://www.pavnet.org).

See also the other public health strategies on violence (e.g., domestic, sexual, child maltreatment) in this category; and related strategies in the Mental Health; Alcohol, Tobacco and Other Drug Use; Children and Adolescent Growth and Development; and Service Delivery Systems categories.

### Strategy: Promote a safe and supportive home environment.

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**Background:**
The home environment can be a place to build a sense of security and peace for children and youth. Warm, caring relationships with caregivers and family members have been shown to reduce the risks for violent behavior as well as many other risk behaviors. In order to promote
freedom from violence at home, it is important that caregivers have the support and tools they need to parent effectively and model nonviolent behavior. Parent education and support can be very effective in building the capacity of parents. In addition, it is important that when violence exists in the home, family members are connected with appropriate services that can help end the abuse. Whether youth experience violence at home directly, or witness it, violence in the home is harmful.

Exposure to violence in the home can also occur through exposure to violent media. Studies indicate that such exposure can increase aggression, and in the case of the Internet, can also increase risk of victimization.

Strategies to promote nonviolence in the home include:

- Increasing the capacity of parents and/or caregivers to raise nonviolent youth.
- Assuring and promoting alcohol and chemical dependency treatment for parents.
- Supporting and facilitating help seeking where family violence occurs.
- Educating about the benefits and ways of restricting exposure to violent media.
- Promoting connectedness between family members and the community.

Additional Resources:

Bibliographic resources:

- Initiative for Violence Free Families and Communities. Thriving With Your Teen, a booklet designed to promote positive parenting of adolescents, at (651) 266-2404.

Organizational resources:

- Adults and Children Together against violence (ACT), a violence prevention campaign composed of a national multimedia campaign and community-based training programs. The campaign focuses on adults who raise, care for and teach children ages 0 to 8 years, at www.actagainstviolence.org.
• Dads and Daughters, Duluth, MN. A resource and advocacy group to help fathers inspire, understand, and support their daughters, at http://www.dadsanddaughters.org.
• First Call Minnesota. Regionally based information and referral to services such as individual and family counseling, domestic violence advocacy, perpetrator treatment, chemical dependency treatment, and other community support. Phone: (800) 543-7709, http://www.firstcall-mn.org.
• Minnesota Center for Crime Victim Services. Offers information on local victim service organizations and other resources for victims of crime, at http://www.dps.state.mn.us/mccvs.
• Minnesota Department of Health Family Home Visiting Program, Maureen Fuchs, at (651) 281-9959, Maureen.fuchs@health.state.mn.us, Nancy Reed, (651) 282-2953, nancy.reed@health.state.mn.us, or Junie Svenson (tribal liaison), at (651) 281-9891, junie.svenson@health.state.mn.us. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Home Visit”.
• PACER Center, Minneapolis, at (612) 827-2966 (Voice) Phone: or (612) 827-7770 (TTY), at http://www.pacer.org. Exists to expand opportunities and enhance the quality of life of children and young adults with disabilities and their families, based on the concept of parents helping parents.

Evidence for this strategy:
The Surgeon General has identified parent-child development center programs, home visitation by public health nurses to new parents and other parenting education programs to demonstrate results in building parenting skills that reduce risk for future violence. Secure parent-child attachment and homes free of violence are consistently identified as protective factors against violent behavior. The Commission for the Panel on Youth Violence has identified exposure to violent media as a significant contributing factor to youth violence and has recommended increased restrictions and controls in this area.

Has this strategy been implemented in Minnesota?
Yes, home visiting is offered throughout the state through local public health agencies. Additionally, parent-child development education is offered through Early Childhood Family Education programs statewide. A wide variety of services exist through health plans and local agencies to address violence issues within the home. In Ramsey County, efforts have taken place through the Initiative for Violence Free Families and Communities to promote successful parenting of teens. The Jacob Wetterling Foundation offers resources and a speakers’ bureau to educate parents and their children about online safety.

Indicators for this strategy:
• Percentage of parents who have received parenting education.
- Percentage of youth who report experiencing violence at home.
- Percentage of youth who report witnessing violence at home.
- Percentage of youth reporting having been solicited online.
- Number of runaway youth.
- Numbers of local sales of violent video games.

**For further information, contact:**
Deborah Trombley, at (651) 281-9815, deborah.trombley@health.state.mn.us, MDH Alcohol and Violence Prevention Specialist.

**Strategy: Work with schools to proactively prevent violence.**

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**Background:**
As another environment central to the lives of youth, schools offer further opportunities to promote nonviolence and safety, and to intervene where risk or violence occurs. As a social environment, schools have the capacity to set standards of respect, and to promote warm and supportive relationships within the school community. Schools can promote recognition and awareness of less visible forms of violence, such as sexual and intimate partner violence. They can also offer guidance and connect youth with supportive services.

Many programs exist to help students build skills that may help prevent nonviolence, however not all programs have been found to be effective (see “Additional resources” below). Research on school-based violence prevention indicates that comprehensive, school-wide approaches that involve not only students but also staff, administrators, parents, and the surrounding community, and that strengthen school policies and practices, are most likely to be effective.

One example of a comprehensive approach to youth violence prevention is bullying prevention, based on the model developed by Dan Olweus. Designed to target elementary, middle and junior high school students, these efforts seek to create a social climate with supportive adult involvement and positive adult role models, firm limits on behavior, and consistent noncorporal sanctions when bullying behavior is exhibited. Program components include school-wide and classroom strategies as well as strategies outside the school. These are examples:
- Fully implement evidence-based youth violence prevention programs.
- Promote on-site screening and intervention, including mental health services for trauma, loss, use of alcohol and other drugs, and abuse.
- Intervene early with students with multiple risk factors for violence.
- Create school climates that foster a sense of inclusivity and belonging among students.

**Additional Resources:**
Bibliographic resources:
- Committee for Children. *Second Step: A Violence Prevention Curriculum*, and


Minnesota Department of Children, Families and Learning, Nancy Riestenberg, at (651) 582-8433, Prevention Specialist, for information about School, Drug and Violence Prevention Coordinators.

Evidence for Strategy:
Numerous research reviews exist that assess the effectiveness of different school-based violence prevention programs (see “Additional resources” above). Recommended programs vary somewhat according to the review criteria used. As mentioned earlier, efforts that do not comprehensively address violence school-wide and at multiple levels are less likely to be effective. Strategies should also be a permanent component of school environments, rather than temporary programs.

The Olweus Bullying Prevention Program is one program that has been evaluated by the Study of Violence Prevention at the University of Colorado Center, and it has been included in Youth Violence: A Report of the Surgeon General (see the resources listed in the introduction to this Youth Violence section). Full implementation of the program has been found to reduce frequency of bullying reports by up to 50
percent. This program also found a reduction in vandalism, fighting, theft, and truancy. The social climate of classrooms improved, consistent discipline was established, and students reported positive social relationships and positive attitudes toward schoolwork and school itself. Bullying programs that concentrate on the high school level are less effective and programs that address only the students exhibiting bullying behavior without a school-wide approach are less likely to show results.

Has this strategy been implemented in Minnesota?
The extent of use of these programs in Minnesota schools is unclear, but all school districts that receive state violence prevention education funds can include community involvement components. Elements of Olweus’ bullying prevention strategy are included in prevention programs throughout Minnesota. The program has been replicated in its entirety in North and South Dakota, with similar positive results as previous implementations of the strategy. Among schools participating in the 1995 Minnesota Sexuality and Family Life Education Survey, instruction on date rape, sexual abuse, and/or sexual harassment varied significantly from year to year between 7th and 12th grade.

Indicators for this strategy:
› Improved data on bullying via increase in bullying reports.
› Improved peer relationships.
› Improved school climate.
› Increased percent of students reporting they feel safe at school.
› Percent of school staff involved in a comprehensive school violence prevention strategy.
› Percent of parents involved in a comprehensive school violence prevention strategy.

For more information contact:
› Nancy Rietsenberg, at (651) 582-8433, Prevention Specialist, Minnesota Department of Children, Families and Learning.
› Deborah Trombley, at (651) 281-9815, deborah.trombley@health.state.mn.us, MDH Alcohol and Violence Prevention Specialist.

Strategy: Organize the community to reduce risks and increase protective factors.

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Background:
Prevention at the community level seeks to involve community members, businesses, and organizations to help create a safer, healthier environment for youth. By working collectively to reduce risks and increase protective factors among youth and by modeling nonviolent behavior, communities can help prevent violence, along with many other risk behaviors.

Minnesota has several excellent resource organizations that can provide tools and guidance in effective youth development (see “Organizational resources” below). An understanding of youth development can be especially important in understanding risks and protective factors at each developmental stage.
Communities also play a crucial role in limiting drugs and weapons directly related to violence. Alcohol use is associated with both victimization and perpetration for many forms of violence, including physical and sexual assaults and homicide. In the seven-county metro area and for some racial/ethnic communities, the risk of assaultive injuries due to firearms is especially high. In particular, African American youth aged 15 – 24 have firearm injury mortality rates eight times greater than for all males 15 – 24 in Minnesota, and 15 times greater than the rates for all ages, races, and genders combined. In general, youth and young people are disproportionately both victims and perpetrators of firearm injuries and death. Community efforts to reduce youth access to alcohol and firearms are important strategies to reduce risk for violence. Ways to accomplish this include:

- Strategically engage in youth development approaches.
- Provide youth with opportunities to discuss and develop healthy intimate relationships.
- Reduce access to alcohol (See Alcohol and Other Drugs category).
- Reduce the proportion of persons living in homes with firearms that are loaded and unlocked. (Healthy People 2010 Objective #15-4).
- Strengthen community standards against violence, harassment, aggression, racism, sexism, heterosexism and bullying.

**Additional Resources:**

**Bibliographic resources:**


**Organizational resources:**

- Center for Reducing Rural Violence. Provides rural communities with technical assistance, research, evaluation, education and advocacy to prevent violence and promote peace. Steve Hirsch, at (218) 751-1585.

Initiative for Violence Free Families and Communities in Ramsey and Hennepin Counties. Citizen action teams are organized to prevent violence by focusing on different sectors of the community. Contact: Shirley Pierce, at (651) 266-8020 (Ramsey County), or Lois Gunderson (Hennepin County), at (612) 728-2094.


Minnesota Department of Health. 1998. A Place to Start: A Resource Kit for Preventing Sexual Violence and Promoting Sexual Health. A tool kit that contains a wealth of information and tools for sexual and youth violence prevention. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Sexual Violence”.

Minnesota Department of Health. For statewide data on child maltreatment, intimate partner and sexual violence injury data, contact Jon Roesler, at (651) 281-9841, jon.roesler@health.state.mn.us, MDH Injury and Violence Prevention Unit.


Search Institute, Minneapolis, Minnesota. Community-based tools and resources to build youth assets. Phone: (612) 376-8955, at http://www.search-institute.org.

University of Colorado at Boulder, Center for the Study of Violence Prevention, at http://www.colorado.edu/cspv/blueprints

Evidence for Strategy:
Community involvement in action to prevent youth violence has been included in virtually all major state and national recommendations. Youth development research indicates that youth who have fewer risks and more key protective factors are less likely to engage in violent behavior. The national Commission to Prevent Youth Violence, the National Youth Violence Prevention Resource Center, and others have identified that access to drugs and firearms predicts a greater likelihood of injury-causing violence.

Has this strategy been implemented in Minnesota?
Youth development approaches are being implemented in many communities in Minnesota, through specific and community-wide programs. Organizations, including those listed below, are providing coordination and technical assistance. Many communities are involved in reducing youth access to alcohol and there are numerous community projects seeking to limit the availability of firearms to youth. Community health service agencies often play an instrumental role in education and other approaches.

Indicators for this strategy:
- Percentage of youth that say they have a relationship with at least one caring adult.
- Breadth and accessibility of community opportunities for youth to develop their interests and skills.
Strategy: Advocate with systems to address social conditions and improve system practices related to violence.

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<th>Systems</th>
<th>Community</th>
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Background:
Social conditions such as poverty, homelessness, and inadequate responsiveness of systems can significantly contribute to family stress and risks to health and safety, and have been consistently associated with risks for violence. Typically, children and youth experience these conditions in numbers disproportionate to the general population. In 1997, families with children were three times more likely to live in poverty than were others. The lack of public willingness to overcome these conditions may be understood as another way that youth are victimized in our society. Persons working in health and other social systems are increasingly aware of the risks and impact of violence on youth. They have many opportunities to improve practices related to youth experiencing violence and to provide leadership in creating a social climate of compassion and regard for human worth. Here are some strategies:

- Advocate for policy initiatives to meet basic family support needs, including income, housing, food and nutrition, prenatal and childcare.
- Train professionals to recognize and respond to violence, and to refer individuals for support.
- Decrease institutional racism and heterosexism, and promote cultural respect, inclusivity, and competency.
- Endorse and promote a comprehensive package of preventive health services for youth ages 11-21 years. This could include screening, guidance and health counseling for violence victimization or perpetration, history of abuse and/or neglect, and information on mental health disorders and alcohol and other drug abuse.
- Advocate for funding to expand financing and reimbursement for preventive and primary adolescent health services.
- Ensure safe housing and neighborhoods.
- Provide housing and care for all youth who cannot live at home.

Additional Resources:
Bibliographic resources:
This information is current as of Fall 2002
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Use of data on social conditions to communicate about youth violence prevention.

Use of data on social conditions to communicate about youth violence prevention.

Degree of organizational interaction between local public health agencies and state policy advocacy organizations.

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