doctors, nurses, social workers, teachers, court personnel, employee assistance counselors, psychiatrists, police, clergy, and all other health, social service, and criminal justice professionals. (E-42)

In the area of *Research* we recommend that . . .

. . . the factors that aid in the prevention of spouse abuse should be identified. (R-37)

. . . research and demonstration projects should be designed for the prevention of spouse abuse and woman battering. (R-38)

. . . existing intervention and treatment programs should be evaluated. (R-39)

. . . the different dynamics and consequences of abuse for men and for women — and the service implications of these differences — should be identified. (R-40)

In the area of *Services* we recommend that . . .

. . . health and social service personnel should uniformly define spouse abuse as any assault or threat of assault by a social partner, regardless of gender or marital status and whether or not they are present or former cohabitants. (S-60)

. . . the empowerment of women should be supported by expanding their social and economic options before and after the identification of abuse and by addressing such vital issues and services as pay equity, the enforcement of child support orders, adequate and low-cost housing, child care, and job training. (S-61)

. . . model protocols for spouse abuse and woman battering should be used in health settings for the early identification of such abuse and for aiding victims. (S-62)

. . . spouse abuse protocols need to be developed for secondary treatment sites primarily concerned with alcohol and drug abuse, suicide prevention, rape and sexual assault, emergency psychiatric problems, child abuse, and the homeless. (S-63)

. . . federal, state, and local initiatives to prevent child abuse should be mandated to directly address spouse abuse and woman battering as well. (S-64)

. . . the Regional Centers established under the 1984 reauthorization of the National Center for Child Abuse and Neglect should have spouse abuse and woman battering added to their charters and the National Advisory Board on Child Abuse and Neglect should be appropriately renamed (e.g., the National Advisory Board on Family Violence) and its membership expanded to represent these linked concerns. (S-65)

. . . shelters should be supported and encouraged to meet the emergency needs of all victims, including protection, housing, and violence. (S-66)
. . . each governor should designate a state office or agency as the focal point for programs and policies related to domestic violence. (S-67)
. . . the criminal justice system must acknowledge rape and sexual assault as crimes, regardless of the past or present marital relationship between victim and perpetrator. (S-68)
. . . battered women need to be assured that the violence against them will stop, and that they will receive equal protection under the law and a swift resolution of their cases. (S-69)
. . . Congress should make sure that the full protection of the law in matters involving domestic violence is provided for all families living within exclusive federal jurisdictions. (S-70)
. . . new programs in education, treatment, and counseling need to be developed to help stop abusive men from committing further acts of violence. (S-71)

Plenary Session V

Response to the Recommendations

Presented by C. Everett Koop, MD
Surgeon General, USPHS
Tuesday afternoon, October 29, 1985

This Workshop may be a new departure, but the sheer number of victims — some 4 million — who cry out for help each year demands a public health response. If prevention is the business of public health, where better to focus attention than on this scourge of violence that permeates every level of our society — where victims live not only in fear and dread, but they also desperately try to sort out the shame and the guilt and the fear that competes with their feelings of love and loyalty to their families. While our attention has been directed primarily at interpersonal violence within the family, we seek to address the causes and effects of such violence outside the family as well.

Because this is the first Surgeon General's meeting on the subject of violence, the scope may be more diffuse than some would have wished. We have focused on public health, with additional participants representing the law, the criminal justice system, and social services. I would want the next workshop to focus more directly on the partnership of health and justice.

Your recommendations are just what I had hoped for. It should be possible for individual health professionals as well as the leaders of major

health institutions and associations to understand and act on them. Several themes do recur in the recommendations from among the 11 work groups: education of the public on the causes and effects of violence, education of health professionals as to better care for victims and better approaches to violence prevention, improved reporting and data-gathering, some additional research, and increased cooperation and coordination — "networking," if you will — among health and health-related professions and institutions.

Senate Hearing

I will begin carrying out that first recommendation of public education tomorrow when I lead off the witnesses at a special public hearing before Senator Paula Hawkins' Subcommittee on Children, Families, Drugs, and Alcoholism. I will also send your recommendations to the Secretary of Education and will indicate your willingness to work with his Department to get something accomplished in our public and private schools, colleges, and universities.

As for professional education, in addition to a report in *Public Health Reports*, I will post your recommendations on the Surgeon General's electronic bulletin board as soon as possible. The bulletin board, which is part of the American Medical Association's computerized Medical Information Network, or MINET, reaches about 26,000 physician subscribers.

I will also convey your concerns to many other professional groups, such as the American Nurses Association, National Board of Medical Examiners, Association of State and Territorial Health Officers, American Academy of Pediatrics, and the National Association of Social Workers.

As for the recommendations for research, I will convey them to the Assistant Secretary for Health and to the heads of the five PHS agencies who have the legal authority and the funds to conduct research. Several work groups have suggested new prospective, longitudinal studies of victims and families. Such studies are complicated and costly to mount. I honestly do not know how my colleagues will react to that, but I will certainly give them the suggestions.

I would also like to respond to some specific recommendations.

- You asked that the Surgeon General undertake an informational campaign about spouse abuse — something that I can and will do. I will transmit to the American College of Obstetricians and Gynecologists the recommendation for more sensitive evaluation and care for battered spouses who are pregnant. That also has my strong support.
- Both work groups on rape were concerned about the need for additional

research and recommended that a conference be held specifically to sort out what needs to be done. I endorse that suggestion and convey it to the Alcohol, Drug Abuse, and Mental Health Administration. You also called for greater interdisciplinary cooperation in the field of rape, and I agree that it is absolutely essential.

• In reference to assault and homicide, I understand your emphasis on paying special attention to the impact upon minorities. Rather than responding now, I would first like to see how the recommendations dovetail with those recently made by the Secretary's Task Force on Black and Minority Health.

• A number of recommendations concerning child abuse and child sexual abuse might well receive a more appropriate response from the Department's Office of Human Development Services, a co-sponsor of this Workshop. I intend to stay in close touch with that Office, as you clearly imply I should. I can say, however, that I agree completely with the recommendation that the abused child be treated promptly according to an evolving plan. The victim should not be seen merely as a pawn in some legal chess game.

Meanwhile, the PHS Division of Maternal and Child Health is beginning an aggressive public education campaign on child abuse and child sexual abuse and in May 1986 will co-sponsor a conference on child sexual abuse. The Division will also be disseminating materials related to these problems; I will ask them to include the recommendations in their mailings.

I'd like to add that I will carry the recommendations to certain other groups, such as the American Red Cross, the Boy Scouts and Girl Scouts, and the 4-H Clubs of America.

• From the day I was appointed in 1981, I've chosen the role of advocate for vulnerable, threatened older people in our society. I assure you that I will speak to this issue of elder abuse as well. I will deliver the recommendations on elder abuse to the Administration on Aging in the Department of Health and Human Services. The AoA interacts with about 1,200 centers on aging, so it is an important ally for getting broad exposure to the recommendations in this area. I will also discuss research in elder abuse with Dr. T. Franklin Williams, Director of the National Institute on Aging.

One work group recommended, in effect, that the Federal Government practice what it preaches, and I agree completely. Hence, I'm pleased that we've had a strong delegation from the Department of Defense at the workshop. They represent not only the policy function but also the

line function, the people who actually deliver health care to servicemen and women and their dependents.

What PHS Can Do

Let me share what the Public Health Service itself can do, is doing, or will do in respect to interpersonal violence. The National Health Service Corps, for example, is a PHS organization of health care professionals working in medically underserved areas, most of them remote rural areas or distressed inner-city neighborhoods. The Corps will be absorbing as many of the recommendations as possible into its continuing medical education program for the 3,100 NHSC officers in the field. And we have agreement from the Indian Health Serivce that the same actions would be useful for their personnel, too.

The 60,000 PHS employees are a cross-section of American society; they also have their share of personal problems, for which we have an employee counseling service. I understand that domestic violence will be receiving more attention from that counseling service during the coming year, including the establishment of a support group for battered women within PHS.

I believe the recommendations will be especially significant for the National Institute of Mental Health, which supports research in violence and anti-social behavior. I'm sure your thoughts regarding trends and emphases will be carefully studied by NIMH personnel and by the PHS people who work with migrant health centers, community health and mental health centers, state and local health agencies, and so on. I'd like them to have a heightened awareness of interpersonal violence in the conduct of the important grass-roots programs in public health.

Regional Follow-Up

Some of the participants are thinking ahead to follow-up activities to this Workshop. Regional meetings and some educational programs are being discussed. I hope that you will drop me a note about subsequent developments in this campaign against interpersonal violence. For my part, I pledge that my Office will put that information together for a 6-month follow-up report and a 12-month report. I agree with the strong recommendation of greater coordination and information-sharing within — and among — the health professions.

A final word. The causes of interpersonal violence, especially family

violence, are complex, multi-faceted, and extend into the social and cultural fabric of society. Sometimes the etiologic agent may be far removed from the narrower realm of health care. However, any remedies undertaken by a health official, including — and especially — the Surgeon General, must be consistent with his actual sphere of responsibility and influence and moral persuasion. Several recommendations — thoughtfully conceived and vigorously presented — are nevertheless well outside that public health sphere. But I want to assure you that, when and where feasible, I will transmit those recommendations as the sincere concerns of participants of this Workshop, even though they address social and political problems well beyond the influence of our colleagues in medicine, nursing, public health, psychology, and health-related social services and of the Surgeon General and the Public Health Service.

As long as I am Surgeon General, those who are victims of violence in this country will have a strong advocate in my Office.

Thank you.

The "Delphi Survey"

In the spring of 1985, in anticipation of "The Surgeon General's Workshop on Violence and Public Health" scheduled for late October, the Public Health Service decided to incorporate a Delphi survey in its pre-Workshop planning. The contractor was Survey Research Corporation.

Delphi surveys are designed to measure the collective wisdom of a group of experts. The participants are asked a series of questions, or exposed to the group averages, and are then invited to reconsider their positions. The process continues until a consensus emerges.

PHS felt that a Delphi survey preceding the Workshop would be of value on three counts:

1. It would give a sense of shared purpose to participants who had no prior contact with each other.
2. It would serve to clarify positions in advance of the Workshop, thereby shortening the time needed to explore viewpoints. The Workshop could, therefore, go directly into action the moment it convened.
3. It would help sustain interest in the Workshop during the inactive summer months.

Everyone on the invitation list was invited to participate in the Delphi and virtually all agreed: an unusually generous response.

Delphi I (the first iteration) was launched in June. It contained three broad questions representing the Workshop's areas of interest.

Q1 What is the role of education?

Q2 What should be done in research?

Q3 What should be done about the delivery of medical, health, and social services?

Under each question, there were statements that asked for agreement or disagreement on an 11-point scale. There was also space to propose additional statements for evaluation by the group.

The substance of statements proposed twice or more were included in Delphi II and III (the next iterations). Neither the Public Health Service nor Survey Research Corporation proposed or vetoed statements. Delphi II and III were, therefore, the products of the participants.

With Delphi III in late August, the concentrations were well established and there were no additional statements proposed. The Delphi survey was, therefore, over.

Results

Response to the survey statements is measured by an 11-point scale used as a continuous variable from "1" signifying total agreement to "11" signifying total disagreement. The midpoint "6" is the neutral position.

Two statistics are used to describe the results.

The first is the *mean*, or arithmetic average. It is interpreted as follows:

1-2 : very close to complete agreement
3-4 : substantial or general agreement
5-7 : verging toward or in the neutral area
8-9 : substantial or general disagreement
10-11: very close to complete disagreement

The second is *support level*. This is the total number (of percent) on one side or the other of the neutral position. The following is an example:

Scale Value		Number of Respondents	
1		5	
2		9	
3	AGREEMENT	36	
4		25	
5		5	Total above 6 is 80
6	NEUTRAL	5	
7		2	Total below 6 is 15
8		3	
9	DISAGREEMENT	3	
10		4	
11		3	
	Total	100	

In the example, the positive (agreement) support level is 80, the negative (disagreement) support level is 15. The neutral position is 5. A positive support level of 80 is high, since a substantial majority shows some level of agreement with the position.

The *mean* and the *support level* taken together are usually an adequate

description of the results. In the few cases where they are not, the distribution of the data will be given in the text.

The following results of the survey are shown in question/statement order.

Q1 What is the Role of Education?

The set of 14 statements under this broad question focused mainly on action recommendations. In the few instances where theoretical positions were offered, such as "education can change the mores," there was a significant but relatively unenthusiastic response. On the other hand, positive support levels for training in recognition, reporting, and other situations calling for direct action were all extremely high.

Q1a POLICE SHOULD BE TRAINED IN EFFECTIVE METHODS OF INTERVENTION.

The mean is 1.8 and the positive support level is 99%: an extremely strong showing for this and the two related statements that follow.

Q1b HEALTH PROFESSIONALS SHOULD BE TRAINED TO RECOGNIZE DOMESTIC VIOLENCE.

The mean is 1.6 and the positive support level is 100%.

Q1c HEALTH PROFESSIONALS SHOULD BE TRAINED IN VIOLENCE-REPORTING PROCEDURES.

The mean is 1.8 and the positive support level is 99%.

Q1d HEALTH PROFESSIONALS SHOULD BE TRAINED IN VIOLENCE INTERVENTION PROCEDURES.

The mean is 2.9 and the positive support level is 95%: agreement with the position but with some reservations. We speculate that these may have to do with the practical consideration of danger to the intervening person.

Q1e INTRODUCE VIOLENCE PREVENTION IN FAMILY LIFE COURSES IN THE SCHOOLS.

The mean is 2.3 and the positive support level is 96%.

Q1f EDUCATION CAN CHANGE THE MORES (AND SOCIAL NORMS) THAT DICTATE VIOLENT BEHAVIOR.

The mean is 4.1 and the positive support level is 81%. But there is a substantial 38% cluster around the generally neutral 5-6-7 area.

Q1g EDUCATION CAN LEAD TO BETTER COMMUNICATION SKILLS AND THEREFORE LESS VIOLENT BEHAVIOR.

The mean is 4.0, with positive support at 83%: a slightly better showing than the preceding statement, but in the same area of general agreement.

Q1h IMPROVE PUBLIC AWARENESS OF LEGAL RIGHTS AND AVAILABLE SERVICES.

With a mean of 2.7 and a positive support level of 98%, agreement is unequivocal. The next statement, which proposes a method to achieve this, is even more acceptable.

Q1i USE THE MASS MEDIA IN A POSITIVE EDUCATION PROGRAM AGAINST VIOLENCE.

The mean is 2.0 and the positive support level is 96%.

Q1j TRAIN AND CERTIFY FORENSIC PSYCHIATRISTS AND PSYCHOLOGISTS.

The mean is 5.0 and the positive support level is 60%: a response that tends toward the neutral position. Response to the next, related statement is even more so. Several respondents wrote "why?" to both statements.

Q1k TRAIN AND CERTIFY FORENSIC SOCIAL WORKERS.

The mean is 5.3 and the positive support level is 52%.

Q1l HEALTH EDUCATION, COMBINED WITH POSITIVE MODELING AND SUPPORT FOR NON-VIOLENT RESPONSE, CAN LEAD TO LESS VIOLENT BEHAVIOR.

The mean is 3.9 and the positive support level is 85%: general but not enthusiastic agreement.

Q1m GIVE CHILDREN EXPLICIT EDUCATION IN NEGOTIATION TACTICS AND CONFLICT RESOLUTION.

The mean is 2.9 and the positive support level is 95%: a clear acceptance of the position.

Q1n PROVIDE PROFESSIONALS DEALING WITH VIOLENCE WITH SENSITIVITY TRAINING AND IN-DEPTH CASE CONSULTATION.

The mean is 3.5 and there is a positive support level of 83%; thus, there is general, but not total agreement.

Q2 What Should Be Done in Research?

The 16 statements under this question were a mix of specific projects and generalized approaches. In general, the group showed strong support for practical rather than theoretical projects and for the study of environmental rather than biological factors in violence. For example, statements that called for the development of intervention field models or for the evaluation of existing programs had mean values of 2.6 and 1.9, while those that dealt with verbal skills or the structure of genes had values of 5.0 and 7.7.

Q2a NEUROPSYCHOLOGICAL AND BIOMEDICAL AREAS HAVE BEEN NEGLECTED.

The response is neutral, with a mean of 5.8.

Q2b ANALYSIS OF STRUCTURAL (ENVIRONMENTAL) PROBLEMS IS THE KEY TO BETTER RESEARCH.

There is general support for the statement with a mean of 4.2.

Q2c RESEARCH SHOULD BE FOCUSED ON THE MORE VULNERABLE, HIGH-RISK POPULATION GROUPS.

The mean is 3.7 and the positive support level is 85%, which indicates a favorable position on the statement.

Q2d DETERMINE THE FUNCTION OF POOR VERBAL SKILLS IN RELATION TO VIOLENCE.

The mean is 5.0 and the positive support level is 58%, a marginally neutral response.

Q2e DETERMINE THE RELATIONSHIP BETWEEN VIOLENCE AND THE ABUSE OF DRUGS AND ALCOHOL.

The mean is 3.0 and the support level is 93%. Evidently there is considerable interest in exploring the drug-alcohol-violence hypothesis.

Q2f THOSE DOING RESEARCH ON VIOLENCE SEEM TO KNOW LITTLE ABOUT IT.

The mean is 6.3 and the negative support level is 31%. Most of the response—60%—is in the 5-6-7 neutral range. Clearly, the respondents were not able to express a clear judgment here.

Q2g PRIVACY LAWS HINDER RESEARCH ON VIOLENCE.

The mean is 5.6 and 52% are at the neutral (6) point. Some of the write-in comments indicate that the subject is a mystery to many of the participants.

Q2h MORE INTERDISCIPLINARY RESEARCH IS NEEDED.

With 95% positive support and a mean of 2.6, the response is unequivocal.

Q2i MORE RESEARCH ON INNATE CHARACTERISTICS, SUCH AS GENE STRUCTURE.

The position is generally rejected: a mean of 7.7 and a negative support level of 72%. (See also the related Q2a.)

Q2j CONCENTRATE ON APPLIED RATHER THAN PURE RESEARCH.

There is substantial agreement with the position at a mean of 4.1 and a positive support level of 67%.

Q2k DEVELOP FIELD MODELS OF EFFECTIVE INTERVENTION.

The positive support level is 97% and the mean is 2.6. There is no doubt that the group is strongly in favor of this kind of pragmatic research.

Q2l INVESTIGATE VIOLENCE AS NORMATIVE BEHAVIOR.

There is substantial agreement with a 3.8 mean and a support level of 84%.

Q2m INVESTIGATE THE RELATIONSHIP BETWEEN STRESS AND VIOLENCE.

92% agree, with a mean of 2.8.

Q2n INVESTIGATE THE ETIOLOGY OF COPING SKILLS.

There is substantial agreement with a mean of 3.6 and 84% support.

Q2o DETERMINE THE RELATIONSHIP BETWEEN ABUSE IN CHILDHOOD AND HIGH RISK IN ADULTHOOD.

Strong agreement at a mean of 2.8 and a support level of 93%. The importance of this research may be stronger than the statistics indicate, since some who disagreed did so on the grounds that the relationship had already been established.

Q2p EVALUATE EXISTING PREVENTION AND INTERVENTION PROGRAMS.

100% support and a mean of 1.9 for this pragmatic approach.

Q3 What Should Be Done About the Delivery of Medical, Health, and Social Services?

These 14 statements were extremely diverse, as they dealt with specific actions and procedures. All the proposals were given varying degrees of support, except for the location of shelters in or near hospitals, which was viewed neutrally. Real enthusiasm, however, was reserved for the expansion of shelter and crisis facilities, for bringing schools and the justice community into the violence prevention network, and for creating multidisciplinary teams at the local level.

Q3a CREATE A CENTRAL DATABANK FOR CHECKING AND SHARING HOSPITAL RECORDS.

There is substantial agreement at a mean of 4.3 and a support level of 78%.

Q3b DEVELOP MORE SHELTERS FOR VICTIMS OF DOMESTIC VIOLENCE, BOTH ADULTS AND CHILDREN.

There is strong agreement at a mean of 2.9 and a support level of 93%.

Q3c LOCATE SHELTERS FOR VICTIMS IN OR NEAR HOSPITALS.

The group is neutral at a mean of 5.5 and 58% in the 5-6-7 scale range.

Q3d IMPROVE MEDICAL-SOCIAL SERVICES COOPERATION BY DEFINING AREAS OF RESPONSIBILITY.

There is substantial agreement with the position at a 3.1 mean and a 93% support level.

Q3e IMPROVE THE QUALITY OF PERSONNEL ENGAGED IN EMERGENCY MEDICINE.

87% agree at a mean of 3.3.

Q3f DEFINE TYPES OF EMERGENCY ROOM PATIENTS WHO REQUIRE THE ASSISTANCE OF A SOCIAL WORKER.

The mean is 3.2 and the positive support level is 91%.

Q3g BRING SCHOOL HEALTH FACILITIES INTO THE VIOLENCE PREVENTION NETWORK.

Strong agreement at a mean of 2.2 and a 97% support level.

Q3h CREATE MULTIDISCIPLINARY TEAMS AT THE LOCAL LEVEL.
96% support the position at a mean of 2.5.

Q3i DEVELOP STANDARDS THAT DEFINE WHAT IS ABUSE OF OLD PEOPLE.
There is substantial agreement at a mean of 3.1 and a support level of 91%.

Q3j BRING THE JUSTICE COMMUNITY INTO THE VIOLENCE PREVENTION NETWORK.
100% agree, with a mean value of 2.0.

Q3k IMPROVE THE QUALITY AND AVAILABILITY OF SHORT-TERM CRISIS INTERVENTION FACILITIES.
99% agree. The mean is 2.0.

Q3l CREATE LOCAL COORDINATING BODIES TO PREVENT THE DUPLICATION OF SERVICES.
78% agree and the mean value is 3.7. Some write-in comment feared this would mean further regulation.

Q3m DEVELOP STANDARDS OF CARE FOR OFFENDERS.
With a mean value of 4.0 and a support level of 76%, agreement is unenthusiastic.

Q3n MAKE QUALITY DAY CARE AVAILABLE TO ALL.
74% agree and the mean value is 3.6.

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