Plenary Session I

Welcome and "Charge" to the Participants

Presented by C. Everett Koop, MD
Surgeon General of the U.S. Public Health Service
Sunday evening, October 27, 1985

Let me personally thank you all for accepting my invitation and coming to this workshop. Before we end our work on Tuesday, I hope I will have been able to thank each of you in person.

I will be here throughout the workshop, and I hope to visit each work group once to catch at least the sense of your deliberations.

I have also assigned each member of my "Ad Hoc Planning and Advisory Committee" to a specific work group. I have asked each one to be helpful to the chair when needed and in other ways carry my personal interest to — and from — those important work sessions.

I will also rely on them to help me frame my response to the recommendations that are to be presented in the fourth plenary session on Tuesday afternoon.

Because they've been so important to the planning of this workshop over the past 13 months — and because they continue to be important to the way we proceed — I'd like to take a moment to introduce them to you in

alphabetical order: Ann Burgess, Ted Cron, Margo Gordon, Dave Heppel, Tom Lalley, Bob McGovern, Nikki Millor, David Nee, Eli Newberger, Delores Parron, Mark Rosenberg, Saleem Shah, and Alan Wurtzel.

If you're still wondering by what magic your name came to my attention, please be assured that it wasn't through magic at all but rather through the diligence of this committee reaching out into the larger community. They spent almost five months searching out the best possible people to come together to share what they know and what they see as the things still to be done.

Let me hasten to add that many excellent people are not here and their absence may be noted. First, it is possible that we *did* invite them, but they either had to decline or, after accepting, found they could not make it after all. Others did not receive an invitation for the time-worn but unsatisfactory reason of space: We asked Xerox for just so many spaces . . . 150 of them . . . a number we felt was the maximum for a workshop in which we hope everyone will contribute.

But I would be very disappointed if this were both the first and the last workshop on this subject. I am hoping that our experience here will be repeated in the coming months in every region of our country and that, as a result, many of the people who are missing from this workshop will have a chance to contribute in the future through those follow-up events.

I understand that such may well be possible in the southwest, thanks to the people here from Texas. And later this week, my staff will be talking with some people from the midwest about a follow-up meeting there.

But the prize for immediate follow-up ought to go to the nurses who are here. A contingent of the "Leesburg Nurses" will form a panel and present the recommendations of this workshop on Friday evening, at the opening session of the "First National Nursing Conference on Violence Against Women," being held November 1 through 3 at the University of Massachusetts at Amherst.

Congratulations . . . good for you.

For most of you, I'm sure this will not be your only conference on violence this year. Some of you will have attended several before the year has ended.

But I hope the Leesburg Workshop will be different in one major respect: Our focus will be squarely on how the health professions might provide better care for victims of violence and also how they might contribute to the prevention of violence.

It is clear that the medicine, nursing, psychology, and social service professions have been slow in developing a response to violence that is

integral to their daily professional life. As a result, we are not sure if the estimated 4 million victims of violence this year will receive the very best care possible.

Nor can we be sure that enough will be done to prevent violence from claiming 4 million or more victims again *next* year.

I think we all share these nagging suspicions. Fortunately, we also seem to share the same notions about what can be done about them and how we can do it.

That is one of the interesting outcomes of the "Delphi" survey that so many of you took part in over the summer. According to the final report, we generally agree on many ideas that lead directly to action.

Multidisciplinary Approach

One such idea is that the best approach the health professions can make to interpersonal violence is a multidisciplinary approach.

We know we have not been as successful as we would like to be in the care and treatment of victims of violence because of the way our health professionals continue to indulge in compartmentalization . . . the vertical separation of one life-saving service or discipline from all others.

It's a frustrating habit we've developed, but one which we agree should be ended as soon as possible and as effectively as possible.

For just that reason, we have a range of disciplines, skills, and experience represented at this workshop. Through our own multidisciplinary deliberations, we might produce recommendations for the profession of medicine, for example, that not only reflect actual and potential medical practice, but also reflect the contributions of social services, nursing, and law enforcement, as appropriate.

Ideally, the multidisciplinary approach we're taking here in Leesburg ought to be replicated in every community in the Nation. I say "ought to," but I know it can't be accomplished in most of the country. Therefore, reality dictates that we produce here the kinds of recommendations that reflect the thinking of many disciplines, yet recommendations that can be — themselves — the stimuli of change and progress everywhere.

Here, again, through the "Delphi" technique, we seem to have reached general agreement on another idea, and that is the fact that we've had ample time to develop our theories and concepts. What we need now — and what the *country* needs now — is action.

Our recommendations, then, ought to be framed in such clear, direct language that our colleagues in medicine, nursing, psychology, and social

service anywhere in the country can absorb them, understand them, and put them into practice.

- We need to make such recommendations for all the health services . . . how they might be organized, how they should interact, how they ought to respond to the needs of victims of violence, and how they should contribute to the prevention of violence. To say we're in favor of a multidisciplinary approach is obviously not enough. We need to focus in on those current multidisciplinary programs that seem to work . . . to isolate and describe their elements . . . and then indicate how they can be replicated in any community or institution.

- We also need to be just as pragmatic in the area of education and information. How can we get certain life-protective messages across to young people? . . . to our elderly? . . . and to our colleagues in the health professions? And what role could our public schools, our professional schools, and our professional associations play in this educational effort? And what ought to be the role of the media . . . television, radio, newspapers, magazines?

- While we might feel we have learned enough from research and experience to move forward into action, there are still many areas — especially in the field of human behavior — where we could use more specific information based on good research and demonstrations. I hope these will be discussed here and later put forward among your recommendations, also.

From these two days of hard work should come a document that can be read in two ways. One way would be to read the recommendations, one by one, for the evaluation and treatment of victims and for the prevention of violence. These recommendations could apply to the various professions, to local and state governments, to voluntary organizations, and to academia according to a cross-grid of the different kinds of interpersonal violence: child abuse, spouse abuse, rape, and so on.

The second way to read the document would be not as specifics but as an overall strategic design.

One of the great deficits of our health delivery system generally has been its stubborn resistance to the development of any overall strategy of care. I will not concede that there's a good reason for this because there isn't.

But there is a bad reason. And that reason is our own unwillingness to

really try. We have become so used to a health system that grows and changes incremently that we think that's the way things ought to be.

But that's not so.

And so I would hope that here at Leesburg we would not fall into the same particularistic trap that we bemoan as existing everywhere else.

Let's not do that. Let us instead arrive at a set of recommendations that make sense by themselves . . . but make even *more* sense when they are perceived together, sewn throughout a seamless fabric of lifesaving, dignity-preserving, quality health care.

I want that to happen here at Leesburg. I believe it's an assignment that is worthy of the knowledge, experience, and reputations assembled in this room.

And now a closing word.

It had been our intention to take the recommendations of the Leesburg Workshop back into Washington, D.C., and hold a press conference on Wednesday morning to make our findings public. However, I believe we've been given an opportunity to start the public education effort in a very important way.

Special Senate Hearing

I'm pleased to report to you that at 11:00 a.m. on Wednesday morning, we will be appearing before the Senate Subcommittee on Children, Families, Drugs, and Alcoholism to report on what will have transpired at this workshop. We are going at the invitation of the Chair of that Subcommittee, Senator Paula Hawkins of Florida, who has been a strong voice in the Congress on behalf of human life and family values.

I say "*we*" have been invited because Senator Hawkins has graciously asked six of our 11 work–group chairpersons to appear with me. They are Douglas Sargent, Anne Flitcraft, Lee Ann Hoff, John Waller, Jean Goodwin, and Jordan Kosberg. They will speak not for themselves, obviously, but on behalf of all of us. I deem it a great privilege to travel in such company. In fact, I'm delighted to go to Capitol Hill with any company at all. But especially with these six.

It's getting late and I know many of you are eager to exchange greetings with colleagues, visit the special presentations arranged in the meeting rooms as part of the "information exchange" this evening, and prepare for tomorrow's work.

So I will close with a little quotation from one of my favorite American writers, Henry David Thoreau. He seems appropriate for this setting.

In his marvelous book, *Walden*, Thoreau wrote, "It is characteristic of wisdom not to do desperate things."

So let us turn to our work with patience and wisdom, and not out of desperation. Instead, let us pledge that despair is over . . . for *all* our people.

And let's start here.

Thank you.

Plenary Session II

Interpersonal Violence and Public Health Care: New Directions, New Challenges

Presented by Marvin E. Wolfgang, PhD
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Criminal Law, University of Pennsylvania*
Monday morning, October 28, 1985

The Founding Fathers of our nation had the wisdom and foresight to remind us in the Preamble of the Constitution of the great challenges and goals that lay ahead. Six national purposes, charges, and mandates for the future were boldly inscribed there as part of the national consciousness. As a nation we have sought in common cause to fulfill those purposes. To nurture and preserve that more perfect union after which our forebears sought, the nation has had to remain vigilant to protect its spirit and body from threats from both without and within. One of the most damaging and pernicious internal threats that has taken on major proportions over the course of our history is violence in its many forms and gravities.

Deep and longstanding concern about our nation's violent past and present produced the presidential appointment of the National Commission

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on the Causes and Prevention of Violence in 1968. For the first time at the national level this dark side of our heritage was illuminated systematically and in depth. The summary of the 13-volume report prepared by the Violence Commission chronicled with precision this enduring and pervasive national malady (U.S. Violence Commission 1969). Among the community of nations most similar to our own in culture and history, those modern, stable democratic states of Western Europe, our nation was planted at the summit in levels of lethal interpersonal criminal violence and collective civil violence. More recent documentation confirms these observations and suggests that America is also an international leader in nonlethal forms of assaultive conduct (Archer and Gartner 1984; Wolfgang and Weiner 1985). Indeed, as the Violence Commission established, the 1960s witnessed levels of violence which were substantially greater than those of preceding decades and ranked among the most violent in our history.

Since the 1969 report of the Violence Commission, levels of violence in our national community have increased dramatically, if we use official police records of criminal violence; or they have remained fairly stable since 1973 but at much higher levels than those documented by police sources, if we use reports of criminal victimizations (U.S. Department of Justice 1984; Weiner and Wolfgang 1985). Our nation not only suffers losses of stature and moral example because of its levels of violence, which exceed the proportions of kindred nation states, but also finds itself at its zenith in this ignobling respect.

Focus on "Tranquility"

The Violence Commission elected to carry out its charge by focusing on the means "to establish justice and to insure domestic tranquility," the first two national purposes penned in the Preamble to the Constitution. Tensions between justice and public tranquility and order were guiding concerns in the quest of the Violence Commission to understand and to prevent violence. In that analytical and philosophical context, violent disorder was dissected with the cutting instrument of criminal law and the system of criminal justice. Although various theories were used to reveal the causes of violence, the primary inquiry was from the viewpoint of violative and unlawful behavior.

The Founding Fathers seemed prescient in their deliberations and constitutional framing. They inscribed another viewpoint and objective into this nation's first legal document: namely, the promotion of the general welfare. Now this workshop on violence is fueled by that original national purpose. The disorders of violence are as much a challenge to the general

health and welfare of our nation as they are to its system of justice and law. Our objective at this assembly is to wed to the insights and advancements of law, order, and stability, those of public health and welfare.

Fused to "America the Beautiful" has been "America the Violent." Ours is a land in which people inflict morbidities and exact premature mortalities in enormous proportions and in many different ways. The nation has been, and continues to be, fearful of these assaults and related victimizations (Weiner and Wolfgang 1984).

The formal promotion of the public health initiative in response to violence is dated with the presentation of the U.S. Surgeon General's national health agenda, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* (U.S. Department of Health and Human Services 1979), which identified 15 priority areas that, with properly targeted preventive interventions, would improve appreciably the health of the nation. This document was the wellspring from which soon flowed quantified and feasible policies to reduce violence and other threats to the national health and vitality (U.S. Department of Health and Human Services 1980). Our current workshop on violence, a direct outgrowth of these milestone precedents, can inaugurate a major and continuing enterprise by health care professionals to prevent and to heal the many wounds inflicted by violence on our nation's physical, emotional, and cultural corpus.

A Catastrophe and a Challenge

Many sources can be consulted to document the extent and character of these lethal and nonlethal interpersonal exchanges. Some of these sources are more reliable and nationally representative than others. However, one need not search much beyond the pages of the background papers prepared for this workshop to obtain a measured and riveting picture of the catastrophe and challenge which confronts the nation (U.S. Surgeon General 1985). Consider the most grave interpersonal exchanges. Homicide ranked as the 11th leading cause of death of Americans in 1980. Approximately 24,000 Americans died by the hand of another in that year, resulting in 690,000 potential years of life lost. These deadly assaults comprised one-seventh of all deaths by injury (Baker, O'Neill, and Karpf 1984). Most grimly, for a young black male aged 15 to 24, homicide is now *the* most likely cause of death. Indeed, over his lifetime, a black male is burdened by one chance in 21, compared to one chance in 131 for a white male, of dying in a lethal encounter (U.S. Department of Justice 1985). But the proportions of lethal exchanges are dwarfed by the numbers of morbid

nonlethal incidents. More than 1.5 million aggravated assaults of Americans age 12 or older were reported in 1980, representing a substantial number, indeed, of instances in which a deadly drama might have unfolded and been played out to a lethal conclusion.

These lethal and gravely assaultive episodes have their contexts of occurrence which shape the likelihood and character of the injurious interplay. It is fitting that the patterns in interpersonal violence which form the primary focus of this workshop are those imbedded in the family. The national tranquility is deeply afflicted by these disturbances in the domestic microcosm.

That intimate nuclear family unit which broke bread together at dusk and which huddled close to hearth and home forms a rich part of the national lore and folk imagery. But the American family has also had its darker side which has rarely turned public. As we are finding increasingly, the family united in common purpose and objective is frequently more a myth than a reality. Domestic life is often rent from within, making enemies of intimates. Domestic tranquility is, as we are becoming more aware, threatened profoundly by its internal dissentions, disruptions, and injurious and deadly conflicts.

Tallies vary, but convergent data point to between five and 20 percent of the adult population as being enmeshed in some form of spousal abuse, comprising approximately four million domestic partners. Nearly 50 percent of those husbands who batter their wives do so with brutal regularity, three or more times a year. Other data, from the National Crime Survey, indicate that nearly one-third of the nation's abused women are serially victimized. Spousal abuse may, in fact, be the foremost cause of injury to women.

Nor are the nation's children immune from assaults and batterings and sexual attacks by their parents and other guardians and caretakers. A recent national survey projected that nearly 1.5 million children and adolescents are subjected to abusive physical violence each year (Gelles and Cornell 1985).

Many abused children are sexually violated, forcefully or through the implicit threats of a parent or caretaker in a position of authority and power. Scant information exists but some figures are enlightening and alarming. In 1984, nearly 125,000 cases of sexually abused male and female children were reported to authorities. Prevalence figures for women who were sexually abused before age 16 run between 25 and 50 percent. Peak abuse ages for male and female children fall between 9 and 12. Between one-quarter and one-half of the abuse cases involve a family member or relative.

Little reliable information has been marshalled about the extent and outcomes of domestic violence suffered by the elderly. What few studies have been conducted are more exploratory than comprehensive. In view of the patterns and proportions of other forms of familial violence, it is unlikely that we will be heartened when these hidden figures are uncovered.

The domestic crucible is becoming increasingly recognized as having profound effects, both immediate and long-term, on its members who experience violence directly or indirectly. Physical pain and suffering and related physical morbidities are the more obvious distressing outcomes. Disturbances in emotional and social development and in important cognitive skills are, likewise, the insidious legacy of domestic violence. These consequences are now documented with greater regularity, as you are all aware.

Long-Lasting Effects

Of equal concern is the effect that domestic violence, particularly against our nation's children, can have on shaping similar behavioral forms beyond the domestic circle. Perhaps most disquieting, children who are battered, or who witness physical assaults among other family members, are more likely to carry the force of these episodes into their nonfamilial interactions in the form of a heightened chance of employing violence as a presumed legitimate interpersonal strategy. The legacy of the violent family is the enhanced risk of applying variations of this same violent behavior in contexts beyond the family setting.

The proportions and gravity of family violence and its facilitation of collateral forms of interpersonal violence argue persuasively for selecting the family as the locus of a primary initiative to apply health care approaches to the reduction and control of violence. The benefits and conquests of the medical and public health models are well known with respect to controlling and, in some cases, eradicating disease and the behavioral contributions to poor hygiene and health. Descriptive and analytical epidemiological research and practice have met great challenges of disease and injury on many fronts: in identifying high-risk populations, in tracing the mechanisms by which theoretical risk is turned into actual malady, and in applying the tripartite prevention strategy — primary, secondary, and tertiary interventions — based on epidemiological breakthroughs into preventive and control regimens. Agents, environments, and hosts have each been proper foci in meeting the challenge of disease control.

The instruments of the health care provider, the conceptual and meth-

odological perspectives employed in public health care, and the modalities of assistance and intervention that are practiced routinely in the health care setting have a legitimate and firm place as part of our national armament against interpersonal violence. Past medical and health care applications in this area, primarily in application to crime in general and to violent crime more specifically, have been restricted to a subordinate part of criminal justice and social problem perspectives. These applications formed what has been termed the "rehabilitative ideal" in criminology and criminal justice. Medical models of disease and pathology were transplanted from their indigenous public and private health settings and installed within the coercive regimes of our courts, prisons, and correctional facilities. The agents of crime and violence were the target of secondary prevention strategies. As substantial recent reviews of these efforts have shown, this restricted initial wedding of medical philosophies with criminal and penal philosophies has had impoverished results (Martin, Sechrest, and Redner 1981; Sechrest, White, and Brown 1979).

Discontent with the rehabilitative ideal has recently turned many of our colleagues to search for alternative ways to control serious behavioral outcomes such as lethal and nonlethal violence. Proposals of deterrence and incapacitation circulate widely and are undergoing continued close scrutiny. These strategies have unclear feasibilities and uncertain magnitudes of effect (Blumstein, Cohen, and Nagin 1978).

The time is propitious for public health perspectives to enter the arena of disciplinary and theoretical thought about the etiology of violent conduct. There are now no clear and strong positions about how to proceed in containing and, perhaps in some cases, eradicating interpersonal violence. The wisdom of many perspectives — particularly one such as your own which has won many battles against injurious hosts, agents, and environments — should contribute substantially to efforts to curb the advancement of interpersonal violence.

As central to the public health approach as its conceptual and methodological armaments is the position that health care is best learned, performed, and maintained when it is ingrained as part of individual and community hygiene, as part of daily routines and salient perceptions of what constitute good health practices. Preventive and control strategies which do not enlist the routine cooperation of those who are to benefit from these strategies can have some success but not as much as they might. Both the American public and those health care practitioners charged with securing the public safety and welfare must learn to consider violence prevention and control as part of their daily requirements and responsi-

bilities. The American people must feel free to appeal to family life centers, drop-in crisis centers, and in-home service programs, to name but a few of our emerging responses to violence, without fear of social stigma, reprobation, or sanction. Our nation must feel as comfortable controlling its violent behavioral urges and practices as it does in controlling bacterial, viral, and physical mechanisms of morbidity and death.

The responsibility to stand firm against interpersonal violence is not the exclusive preserve and discharge of our contemporary public caretakers and monitors — our law enforcers. Although criminal justice approaches may have their place and effectiveness as part of violence control strategies — such as the recent Minneapolis study of police response patterns to domestic violence suggests (Sherman and Berk 1984) — these strategies do not enlist the sensibilities and commitment of our communities. Public health care has been a leader in taking steps to form alliances and networks to make health concerns permanent public priorities and part of personal practices. Winning the public to the cause of treating violence as a health concern may well be, along with its research and methodological equipment, one of the major contributions of public health services.

Many participants here today, who represent diverse disciplines, travel in partnership to a common understanding of interpersonal violence and, by virtue of that understanding, seek to treat the causes and correlates of that violence. But there are barriers to reaching this common understanding, many of which have been articulated by the contributors to the workshop *Source Book*.

An Expanded Data Base

Epidemiological approaches to describing and analyzing violence require reliably gathered and valid information. Particularly important are longitudinal data that span the lifecourse of subjects and reflect the many settings, domestic and otherwise, which influence the origins and development of violent behavior. These data must include persons who are subjected to violent assaults and those who are responsible for assaults as well as the situations in which assaults occur. In the lexicon of health care, basic, extensive, and quality information is needed about hosts, agents, and environments. With these data, the progression and vicissitudes of violent careers, as we now refer to them in our criminological pursuits, can be examined effectively and precisely.

The collection and maximum utilization of primary data sources is, then, a priority which needs continued and substantial support. Because lifespan data often demand substantial time for collection and analysis, practitioners

who seek to use and apply the fruits of such research data must be patient while they are gathered and analyzed. Moreover, to realize our goal of diminishing the ravages of interpersonal violence, solid evaluation of programs which respond to these physical onslaughts must be initiated. All who are here should recognize this need. Greater efforts to conduct proper assessments of violence reduction and control modalities are integral to rational efforts to establish and perpetuate those modalities which, in a word, work.

Law and Liberty

Our analytical and social service initiatives must be joined to considerations of law and justice. Complex issues of personal and collective freedom and protection collide in the arena of violence legislation about dangerousness. Protective service action exemplifies this legal tension. What are the proper limits of intervention? At what point may health care practitioners legally and coercively enter domestic settings? When might such entry constitute an unlawful intrusion, a violation of freedom and liberty that may be more deleterious than those practices which the empowerment legislation was intended to curtail?

No less controversial and complex are legal issues about how to control responsibly the explosive armaments which take so many lives each year. We must acknowledge that firearms are used to kill people in the United States in frighteningly great numbers. Socio-cultural differences aside, the ready accessibility of firearms in the United States and their near inaccessibility in Japan probably play a major role in the 10,715 criminal homicides by firearms in the United States in 1980 in contrast to only 48 in Japan. Without this mechanism of death so generally and easily accessible, people would not kill, and people would not die, as frequently as they do.

The resolution of these and other legal questions is a pressing concern which many here in attendance have already begun to address. More attention to these issues will be required as public health care focuses on physical violence and dangerousness.

To meet the needs of data preparation and analysis, of program evaluation, and of framing informed and effective legislation, greater public health efforts to confront violence must be focused and collective.

Surgeon General Koop's challenge to cleanse and to treat the national wounds of our present violence — a challenge he has laid squarely before each of us — can be met only if there is a broad-based, comprehensive agenda and an alliance of participants. Initiatives must be clearly articulated, feasible, and nationally coordinated for the optimum benefit to ensue.

The Surgeon General's office has been and will continue to be a seat of leadership in that enterprise.

But violence cannot be countered by government alone. The strengths of community and common cause are also required to promote health and well-being in our land. An alliance between public and private sectors should promote progress toward reducing violence. Some major private sector initiatives, such as the Eisenhower Foundation, presently exist and provide comprehensive plans for future action (Curtis 1985).

In summary, our common challenge is one of forging a national agenda and alliance in response to interpersonal violence and, by so doing, to promote and safeguard the general welfare. At the vanguard of this enterprise is the authority and good offices of our entrusted advocate of the public health, the Surgeon General. Perhaps this workshop marks the commencement of a dialogue which will culminate in a message from our nation's chief public health officer about the clear and present danger posed to the American people by violent conduct.

Toward achieving, in concert, the goal of forcing a decrease in our nation's violence, we must act with vigor, imagination, and resolve.

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Violence and Public Health

Presented by William H. Foege, MD
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Monday morning, October 28, 1985

I can't pretend to tell you much about the problem of violence. You come already schooled in the subject, convinced of its importance, and concerned by its impact. I will instead make a few observations about how this compares with other public health problems and what we can learn from our public health experience regarding how to pursue the problem of violence.

An Historical Preview

Throughout history, the two leading causes of early or premature death have been infectious diseases and violence. Infectious disease control started 190 years ago with the work of Jenner, when he developed the first vaccine, smallpox vaccine. Infectious disease control continued along with many nonspecific social changes, such as better nutrition, better housing, and education. In the past 50 years, we have returned to some specific tools, including vaccines, antibiotics, and pesticides.

On the other hand, violence has defied the best minds in health, politics, religion, and law enforcement, and therefore has often appeared to be inevitable. This and other forms of fatalism must be actively opposed. That we live in a cause-and-effect world is as true with violence as with infectious diseases, an important observation for both public health people and educators.

Another important observation is that public health is in the business of continually redefining the unacceptable. This changes the social norm which in turn changes the problem. For example, 35 years ago, polio was the inevitable price of summer in this country. With the widespread use of polio vaccine 30 years ago, the social norm in this country quickly changed. However, for the hemisphere as a whole, the social norm has been polio control or relatively low levels of polio disease. On May 14 of this year, the Regional Director of the Pan American Health Organization announced that polio would be eliminated from this hemisphere by 1990.

With that one announcement, the social norm changed, and it instantly became unacceptable to have any cases of polio in this hemisphere.

This conference is an important step in redefining the unacceptable in interpersonal violence. It is a major step in enlisting the public health structure of this country in changing the social norm. It should be understood that many have seen violence as being unacceptable just as many saw polio as being unacceptable. But until recently, violence has not been regarded as a public health problem. Rather, it has been viewed as a law enforcement problem, or as a transportation problem, or a welfare problem. Dr. Koop is largely responsible for putting this on the public health agenda.

Recent Developments

In 1977, a group began looking at morbidity and mortality in this country to advise on the 12 most important things that could be done in prevention. They made popular the notion of not only looking at the leading causes of death but also looking at the leading causes of years lost before age 65. While heart disease, cancer, and stroke lead the list of causes of death, the leading causes of years lost prematurely are accidents, cancer, heart disease, homicide, and suicide. Therefore, three of the five leading causes of premature death are related to violence. It was because of this finding that we started a program of violence epidemiology at CDC and hired Dr. Mark Rosenberg who has training in both psychiatry and epidemiology to head that program.

In 1979, the Surgeon General published his book *Healthy People*, outlining the 15 priority areas requiring national attention in prevention. Also in 1979, the first meetings of health people from around the country were held to develop the 1990 objectives, a set of over 220 specific objectives of where the United States should be in health by 1990. These include specific objectives on homicide rates, child abuse rates, and suicide, as well as on specific risk factors. This national prevention strategy is a landmark in public health, and it is important that violence is a part of the strategy.

In 1985, the National Academy of Sciences and the Institute of Medicine published *Injury in America — A Continuing Public Health Problem*. It pointed out that injury, both intentional and unintentional, remains the major unaddressed public health problem of our day. While injury accounts for 4.1 million years of life lost before age 65 each year, heart disease and cancer combined account for only 3.8 million years lost before age 65. Yet, we spend $1.622 billion per year on research for the latter and only seven percent of that amount on injury research.

Basic to every successful public health effort has been the development of an appropriate surveillance system. This was true of the public health pioneers, such as Jenner, Snow, and Semmelweiss, who did limited but rigorous surveillance of a microcosm; but it is also true of the institutional pioneers who have developed surveillance of cities, provinces, and then entire countries.

The first nationwide surveillance system for any disease in this country was not instituted until 1950. That system was developed for malaria and made the startling discovery that indigenous malaria had quietly disappeared from this country some time in the 1940s without being noticed. We did not organize another nationwide surveillance program for five more years. In 1955, because of a problem with polio vaccine which still contained virulent virus, a nationwide poliomyelitis surveillance program was launched, literally overnight.

Global surveillance for a disease was not developed until the late 1960s as part of the smallpox eradication program. While it may appear late to develop violence surveillance programs, in fact, surveillance in general is in its infancy.

Surveillance is essential if there is to be a concerted effort in violence control. We must define all aspects of the problem, collect relevant and correct data, analyze that data in order to define interventions, and measure the impact of those interventions. There are no short cuts. While we are beginning to get better mortality data by age, sex, time, and geography for homicide, we are only beginning to understand the dimensions of nonfatal outcomes. As Mark Rosenberg has pointed out, that may represent an even larger social problem than mortality. And we are a long way from knowing how best to use that information to suggest the generic changes most likely to have a favorable impact.

The Context of Violence

While good national surveillance is one key lesson, another is the need to understand violence in its broad context. Most certainly, we should view intentional and unintentional violence together. The surveillance network needs are similar; the risk groups overlap; the risk factors, such as alcohol and depression, overlap; and the instruments, such as cars and guns, overlap. But in addition, violence is not limited to physical injury. Deprivations of many kinds are forms of violence. Discrimination is a form of social violence, as is poverty. Indeed, Gandhi once said that poverty is the worst form of violence. And the threat of nuclear war constitutes a violent cloud over all of us.

While study requires us to narrow the focus, just as we do when studying the nervous system or the gastrointestinal system, this study must be done within a conceptual framework that understands the broad scope of violence. It is important to capture the momentum of nonviolent movements and prevent fragmentation of our efforts. The recognition of the International Physicians for the Prevention of Nuclear War for this year's Nobel Peace Prize is a significant indication of anti-violence movements which should be incorporated in the total effort.

Role of Health Departments

Health departments should be seen as crucial and essential but not sufficient. This is a lesson learned in many areas, even in what is regarded as standard public health. Health departments are simply not strong enough, sufficiently influential, nor rich enough to carry out programs by themselves. Around the world, we see this with immunization programs which become possible only when political leaders and others provide their support. In the United States, polio immunization rates were as low as 65 percent in 1977. It was not until the executive and legislative branches of government became involved with the states and counties, as well as education departments, PTAs, volunteer groups, etc., that immunization rates in this country went to 80 percent, 90 percent, and finally to 97 percent. This comes close to a program of perfection, but it could not have been done by health departments alone.

With violence, it is even more important to have the largest diversity of professional and volunteer groups possible if a significant impact is to be realized.

What then should be the role of health departments? *First*, health departments could assist to get violence into the mainstream of public health. Public health could provide the constituency that anti-violence now lacks. *Second*, health departments could be involved in problem definition, an area of considerable experience and expertise. *Third*, health departments could be involved in the education of politicians and those who could change what is now done, education of children through the development of appropriate curricula, and education of the public by providing information to the media. *Fourth*, health departments should develop intervention strategies and evaluate their impact. *Fifth*, health departments must work to keep this interest from being a fad. They must develop the stabilizing interest to sustain a search for answers into the future. This is particularly true if early intervention efforts turn out to be misplaced.

It is important for the Federal Government to provide leadership, as is being done with this conference. But it is essential that you not wait for the Federal Government to develop a program. Most health programs at the federal level have evolved because of convincing demonstrations at local levels. This was true for the immunization program which was built on many private, local, and state demonstrations. One of the telling examples is the use of child restraints in this country. The Federal Government for a variety of reasons could not or did not provide leadership. A pediatrician and local health officer in Tennessee worked at county and then the state level to get the first child restraint law passed in Tennessee. In only a few years, all states had followed the example.

It is important to promote a groundswell of trials, demonstrations, and suggestions from private sources as well as local and state health departments. Many pilot projects of varied types increase the chance of funding some interventions that are worth replicating. You force the federal establishment best by demonstrating something so compelling that it has to be replicated (as with child restraints).

International Implications

Finally, remember the international aspects of violence. We saw the disparity in homicide rates by country and the exceptionally high burden of violence endured by many. Although the developing world is quite correctly concerned with reducing its infectious disease rate, some Third World countries are already losing more premature years to violence than to infectious diseases. A broad perspective in studying violence and developing intervention strategies will serve the world most completely.

Smallpox is the only disease to have been eliminated from the world. As a person interested in that program, as well as international health generally, I can assure you that you are on the ground floor of something more fundamental and ultimately more important than smallpox eradication. The single most important lesson of smallpox eradication was the demonstration that it is possible to plan a rational health future. What you are now doing is a step — a vital step — in planning a rational future for combatting violence.

Plenary Session III

Interpersonal Violence: A Comprehensive Model in a Hospital Setting — From Policy to Program

Presented by Karil S. Klingbeil, MSW, ACSW
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Over the past several years, there has been an increasing focus on famiily violence: the issues, the characteristics, the components, the etiology, and intervention/prevention strategies. This focus on violence comes at a time when we have evidenced dramatic changes in the health of our citizenry. Many successful advances in treating illness and communicable disease are well known. The attention to traumatic injuries, then, and the development of major emergency facilities and trauma centers across the nation have literally forced health care providers to deal with all types of catastrophic injuries. Included are trauma injuries from interpersonal violence, both intra-family violence and extra-family violence. Gunshot wounds, knifings, physical beatings from other "lethal" weapons, sexual assaults, elder abuse, and the psychological aftermath plague the provider. The picture that has