



*Research Report*

*A Coordinated  
Approach to  
Reducing Family  
Violence: Conference  
Highlights*

National Institute of Justice



American Medical Association

Physicians dedicated to the health of America



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## **A Coordinated Approach to Reducing Family Violence**

...We've all got to join together and start persuading America that unless we invest in community initiatives that look at the family and the child as a whole, we will never be able to build enough prisons 18 years from now....

Hon. Janet Reno  
U.S. Attorney General

Family violence has become as American as guns on our streets and murders in our movies....Until now, domestic violence was something the Federal Government didn't bring up....We have moved from an era of closing our eyes and denying our problems to doing the tough, hard work of saving families to save futures.

Hon. Donna E. Shalala  
Secretary of Health and Human Services

***A Coordinated Approach to  
Reducing Family Violence:  
Conference Highlights***

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## Introduction

In the early 1960's, C. Henry Kempe, M.D., drew national attention to the problem of child abuse as a common cause of injury and death, and he emphasized the need for physicians to diagnose such injuries so that children at risk could be identified and protected from further mistreatment. By the 1970's, women's advocates had raised public concern about the problem of domestic violence, provided more shelters for battered women, and increased the number and scope of legal services available to them. During the late 1970's and early 1980's, reports of elder abuse and neglect became widespread. The statistics documenting this epidemic of family violence in the United States reveal an annual incidence of abuse by family members that is conservatively estimated at 2–4 million for children, nearly 4 million for women, and 1–2 million for older adults.

In the past, advocates for each of these groups have rarely talked to one another about coordinating prevention and intervention strategies. Furthermore, professionals within the various specialized fields that deal with these personal tragedies are often separated by discipline-specific systems, languages, and routines. Many health, justice, and social service professionals believe that the remaining barriers dividing those who work to protect families and communities against violence and abuse must be overcome. This report discusses highlights of the National Conference on Family Violence: Health and Justice, convened in March 1994 to foster a collaborative approach to family violence between the health, justice, and social services communities. More than 400 professionals attended the conference and met in work groups with some 80 national experts (see Appendix A).





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## Professional Collaboration

**Roles of health and justice professionals.** Both health and justice professionals play significant roles in the identification, intervention, and prevention of family violence. Health care providers are often the primary identifiers of battered women and children, and the physician's ability to detect abuse or risk of abuse is key to protecting the patient and facilitating legal action. If the abuse or risk of abuse goes undetected or unreported in the health care setting, the patient may return home to further violence that often escalates and may prove fatal. Because abuse and neglect occur in a social rather than medical context, intervention by professionals in the fields of social services, law enforcement, and justice must accompany or closely follow that by medical practitioners so that survivors are afforded immediate protection and provided with the knowledge, information, and support necessary to escape continued violence.

Perhaps the most significant teaching tool of the conference was a plenary session featuring a two-part dramatization of the roles played by health and justice professionals in dealing with family violence (see "The Case of Linda and Gary"). The dramatic script, based on an actual case,<sup>1</sup> presented an appalling recitation of multiple abuses inflicted on multiple victims within a single family, including wife-battering, marital rape, attempted murder, child abuse, and elder abuse. In addition, the case touched on many societal factors that support or otherwise figure in domestic violence (e.g., perceptions of women as inferior to men, the proliferation of firearms) and introduced the profile of coercive, controlling behavior that characterizes many perpetrators of abuse.

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## **“The Case of Linda and Gary”**

Linda, who has been repeatedly battered by her husband, Gary, has a daughter, Beth (age 12), by her first husband, now deceased. Linda and Gary have a son, Carl, age 5; Linda had two other pregnancies that, because of abuse, were terminated by a miscarriage and an abortion. Two years ago, Gary began drinking heavily and also became harsher with Carl, slapping the child for not waiting on his father. Gary’s elderly mother moved in with the family a year ago, and, at various times since, he has abused her verbally, appropriated her Social Security checks, and withheld her medications. Ten months ago, Gary bought a gun; two months later, he forced Linda (at gunpoint) to ingest pills and alcohol, after which he called the police and reported her as being drunk, suicidal, and high. She was taken to the emergency room, interviewed, and released with prescriptions for Prozac and Xanax. Linda became increasingly anxious and fearful and, within a few months, tried to commit suicide by overdosing on these drugs.

Most recently, Linda had been uneasy about what she regarded as Gary’s inappropriate attention to her 12-year-old daughter. In addition, Linda learned that Gary had spent or misappropriated all of the money left to her and Beth after the death of her former husband. Finally, she worked up the courage to confront Gary with her concerns about his interest in Beth; he responded by verbally abusing Linda, raping her, breaking her jaw, and trying to drown her by shoving her head into the toilet. Beth, who was a witness to this violent scene, called the police. On their arrival, one officer seized Gary’s gun (which had never been licensed), the other officer phoned for an ambulance, but neither officer

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arrested Gary (although there was a mandatory arrest policy in the city). Gary followed the ambulance to the hospital; although he wanted to accompany Linda into the room where she would be examined and interviewed by medical staff, he was prohibited from doing so and sent to the waiting room.

The doctor reviewed Linda's medical chart, which documented her previous suicide attempt and record of alcohol and drug usage. He and the nurse recognized that the injuries Linda had sustained were quite probably inflicted deliberately. They questioned Linda directly about a history of physical and psychological abuse, recommended that she speak to a social worker, and assured her that their major concern was to protect her and her children. Gary was told only that Linda needed an X-ray and further tests. Linda left the emergency room, picked up the children (who had been left in her mother's care), and returned home. She spent a sleepless night, thinking about what the doctor had told her. The next morning, she contacted the victim advocate whose card had been given her at the hospital, and, together, they proceeded to court, where the advocate helped Linda obtain a 14-day court order restraining Gary from contacting her or the children.

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**Identification of abuse.** The dramatization highlighted a number of key procedures for health professionals. Of major importance, the physician or other health care provider should ask the appropriate questions—in a suitable manner. Failure to do so may result in the patient’s denial of abuse and the fabrication of a story about how she was injured. In Linda’s case, both the nurse and doctor in the emergency room recognized her injuries and probed for information about previous problems. Significantly, the physician told Linda that he cared, that she was not alone, that many women suffered similarly, and that help was available. When no injuries are visible, however, a victim of abuse may not be forthcoming about her situation and her fears. The health care provider should always interview the child or adult away from anyone who might possibly be the perpetrator of abuse. (In the dramatization, the abusive husband wanted to accompany his wife but was asked to remain in the waiting room.)

**Victim safety.** One model for educating health care providers—Project SAFE, or Safety Assessment For Everyone<sup>2</sup>—instituted in Hartford County, Connecticut by Anne Flitcraft, M.D., and Kate Paranteau provides steps that physicians can use when interviewing patients to help them devise a practical safety plan; as Dr. Flitcraft has observed, safety assessment is to family violence as cardiopulmonary resuscitation is to cardiac arrest. Every hospital or clinic should have someone on staff who can help the patient plan for her safety and explain the patient’s rights and available legal options. (In the dramatization, Linda was referred to a social worker immediately.) Within the health system generally, improved coordination between medical personnel and social workers would facilitate prompt reporting to child or adult protective services.

Within the broader justice network, securing the safety of survivors of abuse demands communication and cooperation among judges, police officers, and prosecutors. At the conference, justice professionals cited protecting female victims as their top priority. As former prosecutor Sarah Buel<sup>3</sup> said: “My prosecution does nothing if I can’t keep her alive. So the first thing I want to do is sit down with that victim and tell her, ‘My job is

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your safety.” In her discussions with survivors, Buel uses a five-page safety plan developed by the Pennsylvania Coalition Against Domestic Violence.<sup>4</sup>

The police play a key role in protecting family members by enforcing orders of protection and arresting perpetrators who violate them. Fredrica Lehrman, an attorney who chairs the Domestic Violence Litigation Group (Association of Trial Lawyers of America), also pointed out that, in some States, police officers responding to a domestic violence call are required by law to arrest “the primary physical aggressor.” (This was the situation in Linda’s community, but the law was not enforced in the dramatization.)

**Victim needs.** In their efforts to protect patients, health and justice professionals should be willing to listen to what the patient or client needs before proposing a solution or legal remedy. Leslye Orloff, founder of a domestic violence program for predominantly Spanish-speaking women (Ayuda, Inc.), noted that “We must not blame victims who choose to return to their batterers, and we must not punish or sanction those who are not yet ready or able to leave and survive independently from their abusers.” The victim may attempt to leave several times before she succeeds.

Mark Lachs, M.D., M.P.H. (Chief of Geriatrics, New York Hospital-Cornell University Medical Center), called attention to a variation on this theme: an elderly victim who has clear decisionmaking capacity may choose to remain with an abusive caregiver, and that decision must be respected. “In these situations,” he said, “we can only offer guidance to victims as to what services might be available to extricate themselves from an abusive situation. Even if they refuse, our concern sends a message that we are available in the future should they rethink their options.” Only if later they are diagnosed as “incompetent” can these persons be removed from an abusive or neglectful environment, “even though their prior wishes indicate they would choose to stay.”

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Survivors of abuse also sometimes change their minds about proceeding with a criminal case, and Buel stressed the importance of listening carefully to victims who may be ambivalent or reluctant about proceeding; however, she indicated that, after listening to a victim's concerns, she may discuss the possibility of moving forward without the victim's testimony in situations where she has "spontaneous utterances and... the police have done a good job in writing the report, where they have documented the injuries, the demeanor, taken photographs."

**Multiple victims.** Other safety issues come into play when more than one family member has been abused by the same perpetrator. Eleanor Cain, Director of the Division of Aging (Delaware Department of Health and Social Services), spoke to the critical issue of coordination of protective services when an abuser, at one time or another, has victimized family members from a number of generations who live together in the home: "The older woman [in the dramatization] who had been abused by her son needs just as much attention as the younger woman who is pregnant and...is raising her children....Every single one of them needs the same attention as maybe the one [e.g., Linda] that is being focused on right at that very moment."

In the same vein, Susan Schechter, M.S.W. (University of Iowa's School of Social Work), cautioned that, without careful interdisciplinary case collaboration, policies and practices that make one group of victims safer may unwittingly endanger or harm another. Schechter illustrated this point with examples from her clinical experience at AWAKE (Advocacy for Women and Kids in Emergencies), a project at Children's Hospital in Boston serving abused women and children. She described how the mother of a child brought into the emergency room with severe injuries faced the dilemma of possibly losing custody by refusing to identify the source of the child's injuries and, at the same time, knowing that the batterer had threatened to kill her if she revealed what he had done to the child. "In the face of such pressure," Schechter commented, "without any meaningful protection or support from the community and its institutions, the mother's most intelligent action was to stay silent."

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In a second example, Schechter mentioned cases in which children of mothers who had recently fled an abusive relationship were themselves sexually abused during unsupervised visits with their fathers. She asked, “Why...were we having such trouble explaining to the health care providers, the courts, the child protection system, and the guardian *ad litem* the central role that domestic violence perpetrators play in jeopardizing the emotional and physical safety of these children?”

One outcome of concerns about children caught in such situations was the issuance of a challenge to the American Bar Association (ABA) by then ABA President, R. William Ide<sup>5</sup> to prepare a report on domestic violence and its impact on children. (An overview of this report is presented as Appendix B.)

**Victims and the legal system.** A major challenge for justice professionals, according to Judge Leonard Edwards (Santa Clara County, California, Superior Court), is to develop a coordinated system within the community to ensure that the victim is not re-abused by the system designed to protect her. If several persons have been abused by the same perpetrator, various aspects of the case would be handled by different courts. Alleged child abuse would be handled by juvenile court, while the custody case, the civil suit, criminal case, and divorce proceedings may all be handled by different lawyers, different judges, and different courts, each operating on a different schedule and issuing different, perhaps contrary, orders. Furthermore, as in “The Case of Linda and Gary” (see page 4), if an elderly mother were to seek legal remedies for the abuse she has suffered, she would have to file a separate action alleging abuse by her son.

To integrate these efforts toward legal remedies, Judge Edwards proposed a strategy involving the establishment of a local, multidisciplinary family violence coordinating council to coordinate the work of the justice system and receive input and recommendations from members of other systems, including health and social services. Another proposed improvement in the judicial system is the establishment of Unified Family Courts in every State.<sup>6</sup> This type of court is described by Ide as “a specialized judicial tribunal with well-trained, adequately supported,

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and highly motivated personnel, who would hear all issues affecting parents and children. Such a court would better ensure that domestic violence is not addressed by a court in isolation from its legal implications on the safety and welfare of the children in that family.”



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## Professional Education

**Interdisciplinary communication.** According to Felton Earls, M.D., Professor of Human Behavior and Development (Harvard School of Public Health), the principal impediment to collaboration in the fight against violence is the absence of a “new language to share what we know about communities, on one hand, families, on another hand, and individual differences on a third hand, if you find anyone with a third hand to juggle this problem.” Similarly, Mark Lachs, M.D., identified the need for empathy and communication between the medical and criminal justice professions. Each profession is guided by specific rules and procedures and each has its own language. But since survivors of family violence often need timely and coordinated assistance from both professions, Dr. Lachs observed that in order to share information, health and justice professionals need to understand the other’s language as it pertains to such cases. For example, in dealing with cases of elder abuse or neglect, Dr. Lachs noted that he uses the term “decisionmaking capacity,” but his justice colleagues refer to the same attribute as “competency.” Dr. Lachs concluded, “If we can’t develop a common language, then we need to provide each other with a translator or at least a glossary.”

**Sensitivity training.** Another major challenge for health and justice professionals is learning to deal with the uncertainty and unpredictability of most family violence cases. For example, it was pointed out that a battered woman may make many attempts to leave an abusive relationship before she finally succeeds. Providing supportive services, patience, and understanding during this difficult and dangerous time is essential, but this approach can be somewhat at odds with the emphasis on achieving goals and solving problems that is typical of health and justice professionals. Education for all professionals must address these issues, stressing the need to listen carefully to what the patient or client wants.

**Victimization issues.** In dealing with victims, health, justice and social service professionals also need to assess the entire family system, not just one part of it. Violence is often learned within

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the family, and there may be multiple victims and multiple perpetrators, extending beyond the nuclear family. Cathy Widom, Ph.D. (School of Criminal Justice, State University of New York at Albany), noted the direct links between abuse in the home and crime on the street: “Being abused or neglected as a child increases a person’s risk for arrest as a juvenile by 53 percent, as an adult by 38 percent, and for violent crime by 38 percent.” Widom added that her findings indicate that “being neglected [as a child] also increases the risk of engaging in criminally violent behavior.”<sup>7</sup> In addition, abuse at early ages increases the risk of revictimization.

Dean Kilpatrick, Ph.D. (Crime Victim Research and Treatment Center) remarked that women who were victims of rape or physical assault as children are at much higher risk for being assaulted again than are women who had no prior victimization. In his national random sample of adult women, Kilpatrick also found that those who had been victims of rape or physical assault were at higher risk for post-traumatic stress disorder and drug and alcohol abuse.

Joseph F. Sheley, Ph.D. (Department of Sociology, Tulane University) discussed findings from his research exploring the link between family and the acquisition of firearms by serious juvenile offenders and inner-city urban high school students.<sup>8</sup> He reported a high prevalence of gun ownership and transport in these two groups: 83 percent of the serious delinquents owned at least one firearm (67 percent acquired their first gun by age 14), and 65 percent owned at least three firearms; nearly a quarter (22 percent) of the students possessed a gun at the time the survey was completed, and 6 percent reported owning three or more guns at the time of the survey. Sheley stated that “nearly all of the serious delinquents carried guns; most routinely. About a third of the students carried guns; a third of those routinely.... In both samples, exposure to guns, crime, and violence in the family was high.” Family and friends were rated by the study cohort as being a source of guns second only to street sources. In addition, Sheley noted the “enabling” role played by family: “[T]he available evidence points to a cultural and structural complex whereby family in some general sense fails to constrain

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gun-related behavior by its children, may encourage such behavior, and, in some cases, may directly facilitate such behavior.”

Childhood and family abuse may also be linked to elder abuse and neglect. Mark Lachs noted that abusers of elderly persons are usually adult children or spouses of the victim. And although there are many causes of elder abuse and neglect, the family cycle of violence theory is that abused children grow up not only to abuse their own children, but to seek retribution on their aging parents. In this era of specialization, health and justice professionals need to bridge the gaps within their own systems and be willing to discuss family violence cases with colleagues who see other members of the same family.

The need for education through continual dialogue among professionals and through increased understanding of the causes of family violence is intricately connected to the need for multidisciplinary research. Areas of current research in family violence, sponsored by the National Institute of Justice, are discussed in Appendix C.

The National Conference on Family Violence: Health and Justice marked the beginning of an important collaboration between the justice, law enforcement, social services, medical, and other professions to focus their energy and efforts on reducing family violence. Those individuals and organizations involved as conference planners and participants signalled their readiness to take up the challenge of safeguarding adults and children against the abusive and injurious treatment that sadly occurs in many American homes.



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## Notes

1. The script for the dramatization, “The Case of Linda and Gary,” was written by Joan Zorza, Senior Attorney at the National Center on Women and Family Law’s New York City-based National Battered Women’s Law Project.
2. Additional Project SAFE Materials are available from the Hartford County Medical Association, 1000 Asylum Avenue, Hartford, CT 06105. Kate Paranteau is Project SAFE Director, Domestic Violence Training Project and Anne Flitcraft, M.D., is Project SAFE Medical Director, Associate Professor of Medicine, University of Connecticut School of Medicine.
3. Sarah Buel, J.D., formerly affiliated with the Bunting Institute at Radcliffe College, is currently Assistant District Attorney of Norfolk County in Quincy, Massachusetts.
4. For information on how to obtain a copy of this safety plan, contact the Pennsylvania Coalition Against Domestic Violence (PCADV) at 717-545-6400.
5. R. William Ide III served as President of the American Bar Association from August 1993 to August 1994.
6. According to the National Center for Juvenile Justice as of February 1995, 11 States (Nevada, South Carolina, Virginia, Pennsylvania, Delaware, Hawaii, New Jersey, Connecticut, Rhode Island, Vermont, and New York) have family court systems in place; 3 States (Kentucky, Illinois, and California) have experimental family court programs; Florida is developing a family court system; Missouri recently enacted legislation to establish a family court system; 3 States (Minnesota, Mississippi, and Alabama) have specific family court districts or circuits; and 6 States (Maryland, Kansas, Colorado, Utah, Oregon, and Washington) are actively considering the establishment of a family court system. The remaining 25 States neither have nor are considering family courts.

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7. A summary of this research is in Widom, Cathy Spatz, *The Cycle of Violence*, Research in Brief, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, October 1992. See also Widom, Cathy Spatz, *Victims of Childhood Sexual Abuse—Later Criminal Consequence*, Research in Brief, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, March 1995.

8. A summary of this research is in Sheley, Joseph F., Ph.D. and James D. Wright, Ph.D., *Gun Acquisition and Possession in Selected Juvenile Samples*, Research in Brief, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, and Office of Juvenile Justice and Delinquency Prevention, December 1993.

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# Recommendations From Ten Work Groups

## National Conference on Family Violence: Health and Justice

The recommendations presented below were consolidated from work group deliberations in the areas of assessment, interventions, media, prevention, and professional education. They represent the views of conference participants. They stress the importance of interdisciplinary collaboration, empowerment of victims, perpetrator accountability, violence prevention, and the strengthening of families and communities.

### Assessment

*Develop an effective, multidisciplinary, communitywide assessment process that maximizes safety for all family members.*

### Strategies

All communities should:

- Form multidisciplinary family violence coordinating councils.
- Develop and distribute interdisciplinary glossary of terms and resources.
- Establish standards for minimum community resources necessary to ensure the safety of all family members.
- Develop community intervention referrals available to front-line screeners: these should include mental health services, social services.
- Investigate appropriate case tracking systems by computer to enhance civil tracking and medical tracking of survivors.
- Evaluate the effectiveness of the assessment process from the perspective of survivors and health and justice professionals. Provide feedback on outcomes of interventions to screeners.

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- Promote research on the effectiveness of universal screening and the benefits and risks of mandatory reporting.
  - Develop a mechanism for the confidential sharing of appropriate and relevant information both between and within the health and justice systems.
  - Develop routine procedures for assessment that will preserve information that may be necessary for intervention by other systems.
  - Promote early self-identification through public education about health, legal, and community services.

*Conduct early universal screening emphasizing safety of the family, which is sensitive to different racial, cultural, and socio-economic characteristics of the family, and with an awareness that multiple forms of abuse/violence may occur within the same family.*

### **Strategies**

- Develop a form/protocol for screening that includes risk assessment.
- Utilize health, social, and justice groups to develop and distribute guidelines and protocols to be used by first-line screeners. (Second level assessment—Develop mobile 24-hour crisis intervention team available to the community.)
- Develop curricula and continuing education/training for all professionals, including cross-disciplinary training (for health care providers, social services, police, judges and others). Consider linking training to licensure requirements. Implement training through impaired provider programs to reach professionals who are survivors or abusers.
- Fund studies to analyze the impact of universal screening including forms and protocols, outcomes-based research.
- Encourage self assessment and community assessment through public education.



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## **Interventions**

In the area of interventions, the goal of health, justice, and social service systems is to stop violence and abuse. In accomplishing this goal, communities must:

- Protect and support victims.
- Empower victims to protect themselves.
- Hold offenders accountable for past and future behaviors.
- Demand that abusers change their behaviors so that their membership in our community engenders no fear.

Therefore, each community should create a family violence coordinating council to coordinate these efforts at the local level.

## **Philosophy and Rationale**

Individual communities are in the best position to understand the needs and resources of that community and that the efforts of family violence councils should therefore be community-driven. Communities are also in the best position to prioritize community needs with respect to family violence and to allocating increasingly scarce resources. Interventions for family violence must be tailored to all specific forms of family violence under consideration (including, but not limited to: child abuse and neglect, child sexual abuse, partner abuse, emotional abuse, abuse of physically and mentally handicapped adults and children; and elder abuse, neglect and exploitation). Furthermore, specific approaches to family violence must be sensitive to the cultural, linguistic, and other diverse populations in which family violence occurs as interventions are contemplated.

The council should be composed of representatives of all persons and agencies who deal with family violence. There should be no barriers to membership, and the full spectrum of all inter-

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ested parties in the community should be encouraged to join.  
These may include:

Physicians

Nurses, nurse practitioners, clinical nurses, midwives

Medical administrators

Legislators

Judges

Victims

Victim advocates

Law enforcement

Educators

Social workers

Clergy

Pharmacists

School nurses

Substance abuse counselors

Prosecutors

Attorneys

Probation and parole officials

Corrections officials

Mental health providers

Researchers

Community-based organizations

Rehabilitated offenders of family violence

Concerned community members

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The general purpose of the Council shall be as follows:

- To effectuate coordination between hospitals, service agencies, police departments and the courts with victims of family violence and abuse. Such coordination occurs at the *systems level* in which the broad implementation of programs and efforts must be integrated as well as at the *service/case level*, in which services delivered to any individual victim of family violence must be organized. The council should also facilitate communication by members of the health, justice and other systems *between* the systems level and the service level.
- To provide opportunities for the various disciplines to educate each other and to facilitate cross-training for all health care providers.
- To promote and evaluate interventions that have been found to be effective.
- To improve the response to family violence and abuse so as to reduce its incidence.
- To identify and enumerate areas where interventions are known to work and need only to be coordinated; to elucidate areas lacking effective programs wherein new interventions must be developed for health, justice, and social services.
- To promote the development and support of hospitals and health care system-based intervention programs.
- To promote the development and replication of family-centered community-based intervention programs.

Besides providing leadership on interventions and rehabilitation, family violence councils also will be in an ideal and unique position to address prevention, community education, assessment, media, and the integration of these functions.

Strategies of the Council should include:

- Developing and/or revising more policies and procedures for interagency coordination and cooperation at both the system and service/case levels.

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- Convening conferences that focus upon family violence in the community.
  - Promoting educational programs in primary and secondary schools.
  - Providing professional education.
  - Identifying health and justice intervention and rehabilitation methods that have been shown to be effective in other disciplines (e.g., substance abuse) that can be applied to the family violence area.
  - Searching for cross-disciplinary approaches.

As a part of any family violence coordinating council there shall be a health care systems committee. The purpose of the health care systems committee shall be as follows:

- Develop cross-system intervention protocols for health care providers dealing with individuals who might be victims of child abuse, domestic violence, or elder abuse.
- Develop and provide training for all members of the health care community in these intervention protocols.
- Provide a forum for the resolution of problems common to the health care and legal communities as they relate to areas such as evidence, reporting, and confidentiality.

*The American Medical Association should assume a major leadership role in identifying, pursuing and obtaining long-term funding for interventions so that the victims of family violence are adequately protected and assisted.*

Funding priorities should include:

- Trained advocates who have flexibility in their roles. Advocates should be accessible at all sites in the health and justice systems. Ideally, advocates should be recruited from the communities in which they serve.
- Improved access/outreach services directed at victims, as well as novel approaches/programs to reach underserved communities.

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- Shelters and other protected environments for all victims.
  - Mental health and substance abuse services.
  - Rehabilitation needed to provide offenders with the knowledge, attitudes and behavioral skills to develop nonviolent, parenting partnerships and caregiving choices in their relationships.

In addition, the American Medical Association should convene meetings with other national health care associations to assist in securing necessary funds and in the long-term development process for family violence intervention programs.

Every community should have a comprehensive, culturally sensitive and accessible intervention system for family violence that links health, justice, mental health, social service, and educational systems. It is essential to respect and preserve the dignity, legal rights, and safety of the affected individuals.

This intervention system must include:

- A family violence advocate/specialist in all practice settings who serves as a bridge to and among all community resources. This professional must be knowledgeable in health, justice, social services, mental health, education, and all forms of family violence throughout the life cycle.
- Better training and sensitization for health, social service, mental health, justice and educational intervenors, coordinated over time and across systems to enhance the ability to provide appropriate, long-term assistance in cases of abuse, battering, and neglect.
- Comprehensive management information systems and technologies to link health care, justice, social services, mental health, and educational systems consistent with confidentiality guidelines.
- Identification, evaluation, and replication of existing model family violence intervention programs, e.g., a Unified Court model, hospital-based models, etc.

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- Appropriate short-term and long-term followup services for all affected individuals.

## **Media**

Violence in America, including increased portrayals of violence in the media against children, adults, and the elderly, has reached such epidemic proportions that media consumers, providers, and professionals must take action to reverse this trend. Traditionally, consumers and media providers have endured an adversarial relationship. We believe that future efforts to address the problem should be inclusive and collaborative in nature. We are urging consumers, providers, and professionals to participate in creating a new climate of socially responsible perspectives on violence. We hope that the AMA and ABA would provide the leadership necessary to promote this initiative.

*Establish a national coalition of professional organizations (including health, justice, education, and child advocacy groups) to promote safe, nonviolent families and society. This group will work in partnership with the media, to examine violence in the media, and to promote socially responsible approaches.*

## **Strategies**

- Create a national resource center.
- Collect sources of data.
- Identify experts.
- Encourage continued research.
- Educate the media and the public.
- Provide media with resources—media kits, etc.
- Develop forums for sharing information and strategic planning.
- Encourage development of media education efforts to help prevent violence.
- Outreach with State, local violence prevention efforts.
- Acknowledge excellence.

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- Establish multidisciplinary criteria for media excellence in violence prevention.
  - Encourage media organizations to give awards for promotion of nonviolence.
  - Include award recipients on national advisory board.
  - Market nonviolence.
  - Create public service announcements (PSAs) to raise awareness.
  - Encourage health and justice professionals to form liaisons with local media.
  - Produce programs in partnership with media to promote alternatives to violence.

## **Prevention**

*Prevention of family violence should be viewed in terms of social justice and affirmation of basic human rights, rather than retributive criminal justice. We support the shift of social, economic, and political resources toward strengthening communities and families in their many forms. This means ensuring equitable access to employment, education, housing, and health care.*

### **Strategies**

- Collaboration of health, criminal justice and the private sector to regulate products that increase the potential for family violence or magnify its consequences (i.e., alcohol and other drugs and firearms).
- Ratification and implementation by the United States of the United Nations Convention on the Rights of the Child and other human rights conventions.
- Inclusion of representatives of groups with the highest rates of victimization at every level of decisionmaking around issues of family violence.
- Development and employment alternatives to violence and aggression as a means to resolve conflict at all levels of society.

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*Effective primary prevention programs must be implemented through the sustained allocation of human and financial resources at the Federal, State, and local levels. Primary prevention must encompass the cooperation, integration, and sharing of information by the health, justice, social service, and education systems, both public and private, in allocating funding and resources in culturally responsive, community-empowered efforts. Programs of proven effectiveness should be funded by reallocating existing funding and allocating new resources.*

### **Strategies**

- Instead of building more prisons, using the money to fund community-based, community-controlled, systematically evaluated prevention programs that build on strengths. Develop, systematically evaluate, and disseminate new, effective primary prevention programs.
- Primary prevention should be sustained over the long term as a core public health function by generating new revenue (e.g., surcharge on marriage licenses, taxes on alcohol and ammunition).

*Because violent behaviors are learned within the context of family, community, and society, the unlearning of these behaviors and the substitution of more appropriate behaviors must take place within the context of the family, community, and society. Therefore, we recommend the establishment of community-based, community-controlled prevention systems that would include:*

- A vehicle to foster communication and coordination among public and private entities.
- Violence prevention community education efforts, with a focus on early interventions that are comprehensive, and multidisciplinary.
- Home visitation programs of proven effectiveness to reduce violence to children and elders and to improve maternal health.
- Life skills education, including conflict resolution, goal-setting, caregiving, etc.



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- Parenting and caregiving education and support.
  - Programs that focus on perpetrators as well as victims. Individuals in high-risk situations such as job loss, divorce, child custody, HIV, elder care situations and adolescent transition stages should be included. Services for family violence prevention must be made available to all persons in need of services without regard to race, ethnicity, gender, sexual orientation, or ability to pay.
  - Comprehensive public school violence-prevention education, beginning in preschool years and available to all families, which includes training in stress management, conflict resolution, parenting and caregiver skills, substance abuse, and gender relationships.

*Recognizing that all human beings are valuable, we must design and implement a national public awareness and educational campaign to convince the American people that family abuse, neglect, and exploitation are not okay.*

### **Strategies**

- Promote the formation of broad-based community boards representing public and private systems to further a national agenda aimed at preventing family violence through education, promotion of legislation, identification of service gaps, and development of resources.

And, since firearms contribute substantially to death and disability caused by family violence:

- Control the manufacture and sale of ammunition and its components.
- Tax weapons, ammunition, and ammunition components sufficient to pay for the results of firearm violence.
- Mandate recurring licensing and training of owners of firearms.
- Ban assault weapons and the ammunition that supports them.

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- Promote continuing public dialog on who can access firearms, with special attention to juveniles and persons who show mental instability or violent behavior.

## **Professional Education**

Family violence is a public health crisis in the United States. We are speaking on behalf of those whose lives have been affected by violence and whose voices are too often unheard.

*Mandatory comprehensive education about family violence across the life span must become a standard component in undergraduate, graduate, and continuing education curricula in all health, justice, and other helping professions.*

### **Strategies**

- As a central component, professional education must include the perspectives and participation of survivors and/or advocates in its development and delivery. Education should utilize appropriate interactive and experiential models and should be integrated throughout the professional curriculum.
- Education on family violence for health, justice, and social services professionals must be fully valued. Those who provide such instruction should be given professional recognition and support. Professional education activities, including resource and faculty development, implementation and evaluation, must be adequately funded.
- Professional education requires an interdisciplinary approach; didactic and practicum/clinical educational programs should include approaches to facilitate interdisciplinary contact and collaboration.
- The educators must reflect the diversity of our society.
- Family violence content must be a component of the licensure and certification for all health and justice professions.
- The AMA, working with other organizations, should quickly develop and widely disseminate a “Patient to Plaintiff” video/instructional guide that incorporates the response of various disciplines to all forms of family violence.

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- The U.S. Department of Health and Human Services and Department of Justice should fund the development and dissemination of publications on model professional educational programs as well as directories of all educational programs on family violence.
  - The Federal Government, professional associations, private foundations, and educational institutions should foster the development and continuation of high-quality research on family violence.
  - Federal incentives should be provided for expansion of family violence professional education.

*Professional associations should join with accrediting bodies for educational institutions, postgraduate programs, and continuing education courses to develop and support core family violence curricula that incorporate the following educational principles. Each professional organization will establish a time frame, with specific measurable goals, for instituting these reforms. Professional schools and associations should examine, modify, and develop curricula, as appropriate, to include these principles.*

All family violence professional education—from the undergraduate level through continuing education programs—should:

- Foster awareness and sensitivity to cultural diversity.
- Formally address interrelationships among (and the uniqueness of) each form of family violence.
- Explore how power and control affect relationships (i.e., victim-victimizer, professional-professional, and professional-victim/victimizer).
- Develop awareness and understanding of the language, culture, responsibilities, and needs of the other disciplines.
- Teach that violence as a primary means of resolving conflict is not acceptable.
- Incorporate and value skill development.
- Teach how to establish, maintain, and value the relationship with one's community and its resources.

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- Encourage continuous evaluation and improvement of the system's effectiveness.
  - Be provided in an empathic and caring environment.
  - Acknowledge that professional groups will include survivors and/or perpetrators of family violence at various stages of awareness, defenses and healing; be prepared to provide linkages to appropriate services for these individuals.

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## Appendix A

### **The National Conference on Family Violence: Health and Justice**

To facilitate communication and understanding between the health and justice systems and foster a collaborative approach to the problem of domestic violence, the American Medical Association (AMA) invited a broad range of organizations across relevant disciplines to send interested representatives to the National Conference on Family Violence: Health and Justice. The conference was funded by the National Institute of Justice (NIJ), the Centers for Disease Control and Prevention, the Ford Foundation, the Robert Wood Johnson Foundation, and the Maternal and Child Health Bureau. Complete conference proceedings are available through the AMA Department of Mental Health.<sup>1</sup>

This colloquy, cosponsored by 83 organizations within the health, social services, and justice systems, grew out of an earlier AMA initiative designed to train physicians to recognize the signs and symptoms associated with domestic abuse, develop effective techniques for interviewing patient-victims, meet State-mandated reporting requirements, and make appropriate referrals to resources offering protection, treatment, and other types of assistance.

More than 400 professionals attended the three-day conference held March 11–13, 1994, in Washington, D.C. Participants met in work groups, under the leadership of some 80 national experts, to address family violence issues in a variety of contexts; in addition, the groups developed recommendations (Section 2 of this report) for a more coordinated, communitywide approach to reducing both the effects and incidence of such violence. The conference's six plenary sessions dealt with family violence from a unique perspective (i.e., across the life cycle), focused on a particular factor contributing to or exacerbating family violence (e.g., substance abuse, alcohol, or firearms), or, in one instance, featured a dramatized case study that cut across the major issues explored in the conference. Keynote speakers in-

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cluded Janet Reno, Attorney General; Donna Shalala, Secretary of Health and Human Services; and Joycelyn Elders, then Surgeon General.

Two major ideas—central to improving services targeted to survivors of family violence and at-risk families—were articulated and supported in almost every presentation or address:

- Researchers and practitioners in health, justice, and social service systems should share information and work cooperatively at the local level.
- Approaches to assessment, prevention, and intervention should be adjusted to meet the complex needs of families in which violence and abuse occur.

These issues were explored through key discussions at the conference on roles of health and justice professionals and the challenges of identifying cases of abuse, ensuring victims' safety, and prosecuting the perpetrator.

## **Notes—Appendix A**

1. Contact Jean Owens at AMA: 312-464-5066.

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# **National Conference on Family Violence: Health and Justice**

## **Organizations Involved in Conference Planning**

National Association of State Units on Aging

American Psychiatric Association

National Association of Women Judges

American Hospital Association, Hospital Research and  
Educational Trust

American Nurses Association

Family Service America

ABA Center of Children and the Law

Police Executive Research Forum

National Victim Center

National Association of Social Workers

International Association of Chiefs of Police

American College of Obstetricians and Gynecologists

American Medical Association

American College of Physicians

National Center for Prosecution of Child Abuse,  
American Prosecutors Research Institute,  
National District Attorneys Association

ABA Family Law Section

Office of Senator Paul D. Wellstone

National Center on Women and Family Law





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## Appendix B

### The Impact of Domestic Violence on Children

According to the ABA report, *The Impact of Domestic Violence on Children*,<sup>1</sup> an estimated 3.3 to 10 million American children witness domestic violence annually. A result of the National Conference on Family and Violence: Health and Justice, this report reviews the legal literature and reform proposals developed in the area of domestic violence; it includes recommendations for legislation and other policy action, and proposals for what the bar and individual attorneys should do to reduce domestic violence and its adverse impact on children.<sup>2</sup> The literature review revealed that the overlap between households with both domestic violence and child abuse is estimated at 40–60 percent, although only preliminary empirical evidence is available about these interrelationships. However, witnessing violence produces detrimental emotional effects on children, regardless of whether or not they have been physically injured.

To ensure the safety of such children, the report stresses that the law should enable victims of domestic violence to obtain orders of protection on their own and their children's behalf, and that these orders should, when necessary, provide for the removal of the abuser from the home, child custody, possession of the residence, child support, and appropriate safe visitation (or denial of visitation). Police should assess the danger to children as well as to adults in the home, and mandatory arrest for violating orders of protection should include violations of provisions restricting contact between the perpetrator and his or her children. There should be intra- and inter-court tracking systems and means for protecting children during the course of judicial proceedings.

Furthermore, to ensure safety and support for adult and child victims, the report calls for:

- Continued education on domestic violence and its effect on children for all personnel involved in domestic cases.
- Participation in community-based family violence councils.

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- Development of protocols and other mechanisms for cross-court and interagency referrals, case consolidation, and protection against conflicting court orders.
  - Prohibiting firearms purchase and possession by perpetrators of domestic violence and child abuse.
  - Using the “best interests test” to deny custody to perpetrators of domestic violence.
  - Increasing pro bono and community legal services for victims.
  - Providing court interpreters for non-English speaking women.

Finally, the report describes the unfortunate dilemma of battered women being blamed for “failure to protect” their children. “Courts and child welfare agencies have an affirmative duty, before removal as well as in reunification decisions, to promote the safety of the victim-parent (typically the mother) and her children.”

## **Notes–Appendix B**

1. A copy of “The Impact of Domestic Violence on Children” by Howard Davidson, Director of the ABA Center on Children and the Law, can be obtained for \$6.00, plus \$2.00 shipping costs, by calling 1–800–285–2221.
2. At the National Conference on Family Violence: Health and Justice, R. William Ide, III, President of the ABA, called for a report focusing on domestic violence and its impact on children, to be submitted to him before the end of the ABA Annual Meeting in August 1994.

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## Appendix C

### Family Violence Research Program, National Institute of Justice

As a major part of its research focus, the National Institute of Justice (NIJ) supports projects that (1) investigate the genesis, control, and prevention of violent behavior in families; (2) examine the effects of such behavior on all family members; (3) evaluate the responses to domestic violence made by various justice system entities; and (4) measure or predict both the incidence and prevalence of family violence on a nationwide basis. NIJ's Family Violence Research Program is currently funding 25 projects that address issues of interest to practitioners, policymakers, and professionals, including:

- Role of alcohol and drug abuse in domestic violence.
- Effectiveness of civil protection orders.
- Divorce mediation and spousal abuse.
- Childhood victimization and adult violence.
- Prosecution of domestic violence cases.
- Assessment of family violence interventions.
- Impacts of arrest on the social control of violence among intimates.
- Children of battered women.
- Justice system processing of child abuse cases.
- Developmental antecedents of partner violence.

The National Institute of Justice Research Plan for 1995–1996 affirms NIJ's ongoing commitment to supporting research and evaluation studies related to reducing all kinds of violence, including family violence. Research areas of broad general interest are studies of offenders and offenses, violent situations, firearms violence, responses to violent offenders, and violence against

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women; grant applicants are encouraged to submit proposals in these areas, but, since the Institute's emphasis is on investigator-defined research, they are not limited to them.

Copies of NIJ's 1995–1996 Research Plan may be obtained from the National Criminal Justice Reference Service (NCJRS) by calling 800–851–3420; NCJRS can also be accessed by e-mail [askncjrs@aspensys.com](mailto:askncjrs@aspensys.com). Completed proposals must be received at the National Institute of Justice by the close of business on June 15 and December 15, 1995 and June 17 and December 16, 1996. Extensions of these deadlines will not be permitted.





For more information on the National Institute of Justice, please contact:

**National Criminal Justice Reference Service**

PO Box 6000  
Rockville, MD 20849-6000  
800-851-3420  
e-mail: [askncjrs@ncjrs.aspensys.com](mailto:askncjrs@ncjrs.aspensys.com)

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