UNDERSTANDING AND PREVENTING FAMILY VIOLENCE

BACKGROUND BRIEFING REPORT WITH SEMINAR PRESENTATIONS

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EXECUTIVE SUMMARY

This background briefing report presents an overview of family violence in communities throughout California and the United States. Family violence broadly refers to various forms of violent behavior among family members or intimate partners, including child abuse or neglect, domestic assault or dating violence, elder abuse, and intentional and unintentional injuries involving firearms that are in the home or accessible to children or violent persons.

Formerly, these problems were considered isolated events that occurred only among a fraction of the American population. Today, however, these problems are conceded to be widespread and occurring among families in every social and economic class. An awareness has developed to suggest that the very institution we revere as basic to people's way of life—the family—no longer invariably provides the security and nurturing that is the foundation of its value in society. Family violence leaves a scar on everyone it touches. Of course, it is devastating to the abused individual, but family violence also presents economic, legal and social costs that are potentially insurmountable or too expensive for society. If violence begets violence, and if violence in the streets is one of America's most pressing concerns, communities and governments could not hire enough law enforcers, or build enough prisons, to stem that violence if Americans fail to address violent behavior that occurs within the home.

A "WELLNESS" CONTEXT FOR FAMILY VIOLENCE

One way of framing family violence and its consequences is in a context of "wellness." Wellness is a term widely employed in public health and social work, referring to an "optimum state of health and well-being achieved through the *active prevention* of illness" (Margen, et al. 1991; emphasis added). In a wellness context, family violence represents the absence of family health. The presence of family health profoundly depends on certain lifestyle choices made by family members, and on the degree to which family members actively take precautions to avoid injuries, deal with tension and anxiety, and manage the environments in which they live and work. In the absence of family health, family violence can be characterized as a toxic agent that afflicts a host population. There may be preventive interventions, but there may also be long-term consequences that defy clinical or judicial management. This background briefing report adopts such a "wellness context," and approaches family violence as though it were a virulent toxin afflicting American families that are exposed to it, requiring a public health response to prevent additional exposures, and to control prevalent cases in the population.

A PUBLIC HEALTH PERSPECTIVE ON FAMILY VIOLENCE

If family violence continues to be considered in the conventional contexts of criminal justice, emergency department utilization, or lost productivity, family violence will be addressed only *after* it occurs. Instead, building models for understanding and preventing family violence in a public health framework is helpful, so that family violence can be addressed *before* it occurs. A public health model for preventing family violence considers four key elements essential to understanding the problem, and to designing preventive intervention strategies against the

problem (California Wellness Foundation 1993; Edelman and Satcher 1993; Mercy, Rosenberg, Powell, et al. 1993; Moore 1993; Prothrow-Stith 1989; Shalala 1993):

1) A *host* exists in settings that foster family violence, for example an at-risk adult or youth who may be injured or who may injure himself, herself, or another;

2) An *agent* of family violence exists, often in the form of kinetic energy exerted by a person or delivered by a firearm, knife, blunt object or fist;

3) A *physical environment* exists in which family violence can be exhibited and, under optimal conditions, in which family violence can be prevented;

4) A *social environment* or milieu exists, in which family violence is fostered or condoned, and which is shaped by joblessness, oppression, racism, harsh speech or invective, television and other media, alcohol and other drugs, family disintegration and a lack of social reinforcers that "reward" families for maintaining stability.

Considering family violence in a "wellness" context, and borrowing models from this public health framework, invites solutions that focus on clearly defined outcomes. For example, reducing mortality and morbidity from injuries, or increasing the proportion of families that do not experience violent behavior from within. The wellness context stimulates development of strategies and methods that borrow freely from various disciplines, because family violence itself crosses so many disciplines. Efforts to resolve family violence require a "multi-factorial" approach that can be accommodated in a wellness context, and manifested in the public health framework.

There are a number of prominent theories that have evolved from the study of family violence, and, accordingly, a set of prominent program and service models. For example, the "power and control" theory and the "social learning theory" contribute substantially to the body of clinical and practice literature on family violence. This background briefing report reviews these theories and program intervention models that evolved from them.

PREVIOUS REPORTS IN THIS SERIES

This background briefing report builds upon two similar background reports prepared recently by the California Family Impact Seminar: "Child Maltreatment and the Family " (Powell 1994[a]), and "Teen Pregnancy in California: Effective Prevention Strategies" (Powell 1994[b]). A follow-up report, "Teenage Pregnancy Prevention in California: 1995 Policy Roundtable Series Report" (Moses 1995), focused on media issues, preventing repeat pregnancies, the family dynamics that encourage pregnancies out of wedlock, and the ramifications of policy choices designed to minimize such pregnancies. The reader is referred to these earlier reports for a thorough understanding of the elements of the related factors affecting families that are also present for family violence.

INTRODUCTION

This background briefing report presents an overview of four categories of family violence:

- Child abuse
- Domestic violence, including dating violence and spousal rape
- Elder abuse, and
- Injuries that involve firearms in the home.

This report adopts a "public health framework" for understanding family violence, and presents a "wellness" context for preventing family violence. In the public health framework, this report scrutinizes the effects on families of child abuse, domestic violence, elder abuse, and firearms in the home. Particular attention is paid to the problems of underreporting and accurately determining incidence rates of these violent behaviors. Special attention is focused on each form of family violence as a women's and children's issue.

This background briefing report also presents a broad sketch of some of the successful federal, state and local programmatic responses to family violence, many of which are undergoing overhaul as part of the conservative revolution under way in Congress and in the California Legislature. A review of recent selected California legislation related to family violence is also presented.

STRUCTURE OF THIS REPORT

In this background briefing report, Chapter I provides definitions of the components of family violence, a snapshot of its incidence, the characteristics of its reported events, and a description of at-risk children and families. Chapter II reviews the prominent theories or principles that guide program interventions against family violence and the strategies to evaluate these programs. This chapter concludes with a series of "Policy Directions," adapted from recommendations on violence prevention made to the California Attorney General in 1995 as a platform from which discussion or further research can begin on these crucial problems affecting California's families. Chapter III concludes this report by summarizing federal, state, and local governmental responses, as well as unique community responses that have arisen with or without the government support.

Also included in this report are the transcripts of the five presenters at our *Family Violence* seminar. The seminar took place on February 9, 1996 in the State Capitol in Sacramento, California.

CHAPTER I: DEFINING AND CHARACTERIZING FAMILY VIOLENCE

Even when using a public health framework and relying on a "wellness" context, defining family violence is difficult. Measuring the prevalence of its component violent behaviors also presents special challenges. Definitions and characterizations of family violence in the clinical literature are notable for their inclusiveness and breadth. The epidemiologic literature focuses on atomistic, rather than holistic, approaches to understanding the component behaviors of family violence. Nevertheless, for this background briefing report, definitions for the components of family violence are presented. They form the foundation for understanding the scope of family violence, and for developing preventive interventions.

CHILD MALTREATMENT

Child abuse is characterized as a constellation of behaviors and outcomes. Some of those individual behaviors are defined below. Occasionally, this constellation might be more adequately defined by the collective term "child maltreatment." However, both child abuse and child maltreatment included behaviors or outcomes such as physical abuse, sexual abuse, general or severe neglect, emotional abuse or "psychological maltreatment," exploitation, and caretaker absence or incapacity (Powell 1994(a); California Department of Social Services 1992). The overwhelming majority of child abuse cases are perpetrated in a home environment, often by persons known to the abused child or children, even though news media accounts have inflamed public fears to the contrary. In 1991, less than one percent of all reported and substantiated cases of child abuse or neglect occurred in day care or foster care settings, supporting the characterization that most perpetrators are known or related to victims, and commit their acts at home or in surroundings that are familiar to the abused child.

Definitions

"Physical abuse" is defined as a physical injury inflicted by other than accidental means on a child by a caretaker, or by another individual living in the same residence as the abused child. Physical abuse includes willful cruelty, unjustifiable or inhumane punishment, or corporal punishment resulting in a sustained physical injury in a child. Nationwide in 1991, cases of physical abuse accounted for about 25 percent of all reported and substantiated cases of child abuse (National Committee for the Prevention of Child Abuse 1992; hereafter cited as NCPCA 1992).

"Sexual abuse" is defined as the engaging of a child in sexual activities that the child cannot comprehend, for which the child is developmentally unprepared and cannot give informed consent, and/or that violate the social and legal constraints of the society in which the acts are perpetrated (American Academy of Pediatrics 1991). Sexual abuse can also be characterized as the victimization or abuse of a child by sexual activities, including, but not limited to, molestation, indecent exposure, fondling, rape and incest. Sexual abuse in the family includes a spectrum of activities ranging from gentle seduction to violent rape. Nationwide in 1991, cases of sexual abuse constituted about 15 percent of all reported and substantiated cases of child abuse or neglect (NCPCA 1992). California State officials report this figure is substantially higher, as

much as twice this reported rate. A high proportion of children receiving child welfare services for physical maltreatment later report having been sexually abused (Kelly 1995).

"General neglect" is defined as negligent failure of a person having the care or custody of a child to provide adequate food, clothing, shelter, or supervision, where no physical injury or abuse to the child has occurred. "Severe neglect" is defined as negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed non-organic failure to thrive. The definition of severe neglect extends to include incidents of neglect in which a child is allowed or caused to be in a situation where his or her health or personal integrity are endangered, as in the cases of intentional failure to provide necessary medical care, adequate food, clothing, shelter, or schooling. Nationwide in 1991, cases of neglect constituted about 48 percent of all reported and substantiated cases of child abuse or neglect, although state-based data are rarely reported according to this typology of "general" versus "severe" neglect (NCPCA 1992; U.S. Department of Health and Human Services 1995).

"Emotional abuse" is defined as willfully causing or permitting any child to suffer, inflicting mental suffering, or endangering a child's emotional well-being. Nationwide in 1991, cases of emotional abuse constituted about six percent of all reported and substantiated cases of child abuse or neglect (NCPCA 1992).

"Exploitation" is defined as the act of forcing or coercing a child into performing activities for the benefit of the caretaker or parent that are beyond the child's capabilities or that are illegal or degrading. Deception, as a precursor to coercion, is also exploitation.

"Caretaker absence or incapacity" is defined as the absence of the caretaker or parent due to hospitalization, incarceration, or death. Caretaker incapacity involves the inability of the caretaker to provide adequate care for the child due to physical or emotional illness, disabling condition, or compulsive use of alcohol or drugs. Nationwide in 1991, miscellaneous types of abuse like exploitation, or caretaker absence or incapacity, constituted about 10 percent of all reported and substantiated cases of child abuse or neglect (NCPCA 1992).

Child Maltreatment Reporting

The incidence rate in California of reported child abuse, and the percentage of such cases that also involve violent crimes perpetrated upon children, are staggering. In 1994, there were 663,042 reported events of child abuse in California, yielding an incidence rate of 76.6 events per 1,000 children. Of these events, 345,508 cases (52 percent) also represented reported violent crimes (Children Now 1994).

Statistics in California only reflect the same terrible trends across the nation. Nationwide in 1991, the NCPCA estimated that 2.7 million children were abused or neglected. Almost four children died each day (1,383 in total) as a result of child abuse or neglect (NCPCA 1992). It is unclear whether the actual incidence of child abuse or neglect has increased over the years, or if the perceived increase is a result of better case reporting. Improved case reporting is a welcome addition to the epidemiologic study of child abuse or neglect. This is the direct consequence of

legislative or regulatory policy changes at the state level in which statutes were established to mandate reporting of such events by health care, social service, and child care providers, teachers, and others.

Nevertheless, some believe that nationally there remains the substantial problem of underreporting or incomplete reporting, such that even improved enumeration of cases probably still understates the true incidence of child abuse (Robinson 1992). Another problem affecting the adequate quantification of child abuse cases is the fact that not all "reported" cases can also be "substantiated." The definition of "substantiation" varies from state to state. In a particular state, that definition, when codified or put in practice in methods for screening out reports, can be interpreted or calculated in ways that understate the true incidence of child abuse. For example, in Missouri, unsubstantiated cases are separated into two categories, "unconfirmed" and "reason to suspect" cases, the latter of which includes events where the reported abuse or neglect cases cannot be legally or medically corroborated for various reasons. On the other hand, California calculates its figures after discounting inappropriate or incomplete reports, and relies heavily on reports from health care providers (California Department of Social Services 1991).

Coordinating data on child abuse within and between states is also difficult, because the states maintain different statutory definitions of what constitutes abuse. States also vary on the degree to which they statutorily mandate health care, social service, and child care professionals to report suspected cases of abuse. Even with such statutory mandates in place, only slightly more than half (54 percent) of all reports of child abuse or neglect in 1991 were initiated by "professional sources" (school personnel, law enforcers, social service professionals, medical personnel, and child care providers). The large remainder of cases were reported by "non-professional" sources: more than one-third of all cases (34.3 percent) were reported by friends, neighbors, relatives, or children themselves (Robinson 1992).

Factors Associated With Child Maltreatment

The factors that contribute to child abuse or neglect are complex and varied. Child abuse or neglect occurs at all levels of society, and is not limited to any ethnic or socioeconomic category. However, several risk factors are routinely associated with these events: poverty, "neighborhood dysfunction," mental health problems, substance abuse, and the presence of children with special needs (U.S. Advisory Board on Child Abuse and Neglect 1990). Nearly two-thirds of state survey respondents cited substance abuse as the most pervasive risk factor associated with child abuse or neglect, and an average of 32 percent of substantiated cases of abuse or neglect involved drugs or alcohol (NCPCA 1992). Because multiple risk factors are already associated with child abuse, the distinct problems associated with substance abuse in families disproportionately contribute to the overall risk for concurrent or subsequent abusive or violent behavior in families. In this high-risk environment, there is a tremendous need for multiple, community-based social and medical services, drug treatment facilities, substance abuse programs for women, and adequate legal and child protective service resources to determine when children should be removed from the presence of substance-abusing parents or caretakers.

The majority of perpetrators of child abuse or neglect are related to the maltreated child in some way by blood, marriage or other intimate relationship. A higher incidence of child sexual abuse was reported among single parent families versus two-parent families. Single parent families present settings in which a former spouse or partner, or new partner, serving in the role of a primary caretaker, may be familiar enough to a youngster that the child might not take adequate precautions or be appropriately vigilant against intrusive or violent behavior (Nagy, Adcock and Nagy 1994).

Other data support the hypothesis that certain categories of "relative" can be more frequently associated with particular kinds of child abuse. In cases of physical abuse, the majority of perpetrators are parents (82 percent), but in cases of sexual abuse, more often the perpetrators are other relatives (23 percent), or unrelated persons known to the child (35 percent). The average age and gender of the maltreated child also differs according to the type of abuse. In cases of sexual abuse, more than three quarters (77 percent) of the children in 1991 were female, but in cases of physical abuse, the gender distribution was nearly equal. The average age of sexually abused children of both genders was nine years old, but the average age of those physically abused was eight years old. Among neglected children, the average age was six years old (Robinson 1992).

DOMESTIC VIOLENCE

Every year in the United States approximately two million women are severely assaulted by male partners. Prevalence studies indicate that about one fifth to one third of all women in America will be physically assaulted by a partner, or former partner, during their lifetime (Council on Scientific Affairs 1992).

Definitions

In this background briefing report, "domestic violence" is defined as physical, sexual, verbal, and/or emotional abuse of an adult woman, or the threat of such force, inflicted by an intimate adult partner. In the literature about family violence, domestic violence has also been defined as "the actual or threatened physical abuse of an individual by someone with whom they have or *have had* an intimate or romantic relationship," which is a reminder that many perpetrators of domestic violence no longer actually live in the home in which they commit battery (Lee, Letellier, McGloughlin and Salber 1993). Suffering from the effects of domestic violence is not the exclusive purview of adult women. Cases of domestic violence involving adolescent women, same-sex partners, and special populations of women are also included in this discussion. Typically, however, the perpetrator of domestic violence is a current or former husband or boyfriend, who inflicts abuse on an adult women, resulting in fear, dysfunctioning relationships, and physical or emotional suffering.

Underlying Theories for Domestic Abuse

Many sociodynamic theories exist to explain the genesis of domestic violence in what otherwise might be considered loving and happy relationships. The "power and control" theory is the most

widely accepted and serves as the basis for most current program interventions. It holds that people use violence as a tool or lever to maintain power and control over others, and the use of violence is reinforced when it works every time it is used. Traditional theories to support the causes of domestic abuse are often based on personal characteristics or life experiences like stress, unemployment, poverty, substance abuse, past child abuse, and depression. But theories centered on these characteristics unfortunately fall short of explaining why the majority of persons with such problems do *not* batter their intimate partner or children. Observation has also shown that the amelioration of life problems, such as substance abuse, stress and unemployment, does not in itself end the cycle of domestic abuse in a relationship, or address the unhealthy dynamics of power and control between relationship partners.

The "power and control" model is widely adopted by social service agency workers who intervene with both perpetrators and survivors of domestic violence. This model challenges all other explanations for violence in a relationship. The model contends that the use of violence is always a choice, and that in society it is a choice that can be made in order to meet one's needs with little or no consequence. Power and control can be exerted in many manifestations.

- ***Physical violence***, in which the batterer uses physical violence to achieve power and to keep the abused partner from leaving;

- ***Isolation***, in which the batterer dictates what the partner does, where she goes, with whom she has contact, her access to a car or telephone, and the degree of relationship she is able to maintain with friends and other family members;

- ***Intimidation***, in which the batterer uses threatening looks, voices or verbal cues, gestures and actions to keep the partner in constant fear; rather than striking the abused woman, a batterer may instead demonstrate his power by punching holes in walls, damaging valued objects, or hurting pets to signify what he could do the abused woman if he chose, and to suggest through the constant threat that violence may occur again at any time;

- ***Threats***, in which the abuser threatens to commit suicide, take the children, strike at a pet, hurt or lie to the abused woman's family and friends, in order to control the partner by suggesting he has the means to carry out the threats;

- ***Using Children***, in which the batterer may threaten or use violence against children, undermine the partner's parenting, or convince children that their mother or caretaker is inadequate; in cases involving prior separation, repeat batterers may use visitation rights as an opportunity to harass, scare or continue to batter the abused woman or her children;

- ***Economics***, in which the batterer may control all of the economic resources in the family whether or not he is responsible for part or all of the family's income; batterers exert substantial control by taking any money earned outside the home by the abused woman, or by providing her with an inadequate "allowance" ostensibly to meet family needs, or by forcing her to ask for money for basics like food and household items;

- ***Male Privilege***, in which the batterer insists on making all major decisions in the relationship or family, treating the partner like a servant or forcing her to wait on his whims at all hours;

- ***Sexual Control***, in which the batterer may force his partner to engage in sexual practices she is uncomfortable with, or force her to have sex against her will; batterers often force sexual intercourse onto partners as a part of a fight or immediately after it, or during intoxication; the nexus of domestic violence with child sexual abuse may occur as a result of this power dynamic, because often batterers may also sexually abuse children, then blame the abused mother for that abuse or threaten her in order to keep the child sexual abuse a secret.

Dating Violence

Dating violence among young adults can be a precursor to more conventional domestic violence later in life. Dating violence can be defined as "a pattern of repeated actual or threatened acts that physically, sexually or verbally abuse a member of an unmarried heterosexual or homosexual young adult couple" (Wilson-Brewer 1993). There is a need for early preventive intervention among young people to demonstrate that battery is not acceptable behavior between intimate partners or spouses. However, it is difficult to design targeted interventions against dating violence. Research into dating violence intervention is scant, but at least the following measurements have been reliably reported:

- About one in ten high school students reported experiencing physical violence in a dating relationship;

- More than 70 percent of pregnant or parenting teenage mothers are battered by boyfriends or husbands, often during the pregnancy; and

- Date rape accounts for about 60 percent of all reported rapes nationwide, and the majority of rape victims are between 16 and 24 years of age (Wilson-Brewer 1993).

Dating violence is not a new phenomenon. Sexually aggressive acts between intimate adults are not uncommon, and are not always a crime. Nevertheless, with improved reporting systems and enhanced awareness in society about sexual abuse generally, more scrutiny is now paid to dating violence.

One cumbersome task in defining dating violence rests with defining "dating," which to various researchers has meant "romantic involvement," the "process of mate selection," an "amorous and/or sexually intimate relationship," or "a courtship or engagement relationship." It is not trivial to consider the question of when "dating" ends and "cohabitation" or marriage begin, because the distinctions between dating violence, domestic violence, and marital or spousal battery are often blurred. Neither age nor legal marital status are usually very good discriminating features. Perpetrators of battery usually do not initiate such behavior until after a marriage license has been issued. Thus, the signs and symptoms of domestic violence later in life may have been exhibited

during an earlier stage in the perpetrator's life cycle, at a stage more commonly associated with dating violence, regardless of chronological age. The bulk of sociological and epidemiological research into dating violence has involved college-age participants. More research involving teenagers' attitudes and responses to dating violence is needed, however.

Episodes of dating violence, like those of conventional domestic violence, are also characterized by unhealthy dynamics of power and control. Large numbers of young men in society perpetuate, or have perpetuated for them, a socialization or stereotyping that involves exercising power over young women as an ordinary attribute of their relationships. In tandem, the behaviors of many young women are characterized by passivity, dependence on males, and non-assertiveness are also perpetuated, either by young women themselves or again by stereotypes in society. Such behaviors contribute to the unhealthy dynamics of power and control, often unwittingly.

In dating violence involving teenagers, the abusive situation can seem just as entrapping as a conventional domestic violence situation, because adolescents have much less mobility than adults and cannot freely move away or change schools to avoid an abusive relationship. The legal system is not as accessible to young men and women; most cannot take legal action in their own name, and often admitting their behavior to parents or older adults in order to engage the legal system is difficult. California is one of only three states (along with Colorado and Pennsylvania) that permits minors, with their guardians, to press charges using civil and criminal laws reserved for domestic violence cases.

Moreover, the dynamics of young adulthood contribute important, but often overlooked, roles in dating violence. Adolescents are searching for independence and an identity at nearly the same ages or phases in which they are most susceptible to involvement in abusive relationships. Young adults of both genders are reluctant or embarrassed to seek professional help for any of their problems, and peer education and outreach may be an insufficient intervention. Substance abuse is often present. Parents can be diffident, unwilling to help, or physically distant and unable to provide support or guidance. School personnel may be disinterested in intervening, or constrained from doing so. The particular difficulties experienced by special populations are accentuated in dating violence, including those among gay and lesbian youth, pregnant and parenting teenagers, and African American and Asian American young adults, for whom profound cultural gender stereotypes persist.

Most program interventions against dating violence have been school-based. Curricula have been generated to provide guidance and skill-building for healthy relationships, to describe resources and agencies, and to dispel many of the negative stereotypes about gender roles that contribute to dating violence. Often the same battered women's services or shelters in a town or region will have adapted a high-school based short curriculum for use with young adults, thereby helping to reinforce the link between the hazards of dating violence and domestic violence.

Marital or Spousal Rape

The definitions used here for domestic violence and dating violence must be broad enough to accommodate cases of marital or spousal rape. However, if underreporting is a vexing problem for both domestic violence and dating violence, it is certainly a problem for measuring the incidence of marital or spousal rape. Marital rape could be defined as being substantially similar to general rape, including intercourse accomplished against an abused woman's will through the use of force, duress, menace, threat of subsequent injury, intoxication or forced administration of drugs, or intercourse with a person who the perpetrator knows is unconscious during the act. Courts in many states have now refuted the concept of a wife's implied consent to sexual battery as a component of a marriage relationship and of compulsory sexual intercourse being a husband's right. State courts have upheld the concept that although consent to sexual relations may be implied between spouses, a wife may unilaterally revoke this implied consent at any time.

Rates of Reporting Battering

One prominent feature that characterizes domestic violence is underreporting. A typical rate for reporting this crime would be one out of seven abused women (Dutton 1987). Even in those cases in which obvious injuries present evidence of domestic physical abuse, fewer than one in 100 alleged perpetrators are convicted in court (Dutton and McGregor 1991). According to a federal Bureau of Justice Statistics study performed between 1978 and 1982, slightly more than half (58 percent) of all incidents of domestic violence reported to the survey had also been reported to police, suggesting that nearly half of all such cases were unreported (Rose and Goss 1989). Research by Strauss and Smith (1993) indicated that about seven percent of assaults between spouses are reported to police, and even these few rarely result in arrest. Consequently, intervention in the form of arrest occurs in less than one in 100 marital assaults (Senate Judiciary Committee 1992). Frieze (1987) noted that 54 percent of abused women in her survey responded that they had told no one after the first incident of violence; about one half of the respondents indicated that afterward they attempted to comply with the wishes of their battering husbands or boyfriends.

Some evidence exists that, as domestic violence increases either in frequency or ferocity, abused women are more likely to seek intervention, or to exit from the marriage or relationship. Gelles (1987) reported that although only 42 percent of women in his study who had been struck once during their marriage had sought some type of intervention, fully 100 percent of the women who had been struck at least once a month for more than a year, and 83 percent of the women who had been struck at least once a week for more than a year, had obtained a divorce or separation, alerted the police, or visited a social service agency.

Why Is Domestic Violence Underreported?

In the 1986 study conducted by the U.S. Bureau of Justice Statistics, and as reported by Rose and Goss (1989), the most common reason (49 percent) for not reporting incidents of domestic violence was that the abused women considered the crime to be a personal or private matter. Twelve percent of the respondents reported they feared reprisal by the abusive man if they

reported incidents of physical abuse. Other reasons cited included women's perception that the crime of domestic violence is not important enough, and the presumption that police would not or could not do anything to resolve the situation.

Harlow (1991) added to the results presented in 1989 by Rose and Goss by finding that 48 percent of abused women did not report the crimes to police either because they thought the events to be a personal or private matter, or that they could handle the situation themselves. Rose and Goss had also presented evidence that 38 percent of women reporting incidents of domestic violence to police did so to prevent further violence, while 24 percent called police only to stop the incident that was in progress at the time of the call. These figures were bolstered by a 1990 Department of Justice study, from which Harlow concluded that 51 percent of women abused by domestic violence who did report an incident did so to prevent the battery from occurring again. Only 24 percent did so to prosecute or punish the offender.

In another study among women, Walker (1989) found that only 10 percent of abused women called police. Women who had alerted police about abusive incidents, and who responded to Walker's surveys, confided that police intervention yielded hardly any effects. In fact, calling police to the scene of abusive events reportedly often made the situation worse at home. This was due to the propensity of police to make what was perceived by the abused women to be only feeble and ineffective attempts to placate the batterer. After their departure, when the batterer realized that no restraint had been placed on him, he often continued his abuse with renewed violence, not uncommonly a few minutes after police had departed from a tense domestic scene.

However, Walker (1989) declared that in contemporary times, with more communities adopting stronger "pro-arrest" policies, the percentage of battered women receiving *effective* police intervention has improved. In that respect, media attention to domestic violence may have the corollary effects of heightening awareness that ineffective police intervention is tantamount to no intervention, and that police departments must develop and implement realistic and effective intervention strategies beyond "keeping the peace." Walker also reported that police are more aware that they are about three times as likely to sustain injuries in the line of duty while responding to a domestic dispute than in any other form of violent encounter or type of crime. Response protocols for police departments have improved, follow-up procedures have been implemented, and specialized training is now statutorily mandated for most law enforcers, all toward making the non-violent handling of explosive domestic violence situations the rule, not the exception.

Other Difficulties in Estimating the Incidence of Domestic Violence

There are other constraints on the accurate estimation of domestic violence incidence rates. These include actual or perceived educational, ethnic, or socioeconomic gradients among abused women that affect their propensity to report crimes of domestic battery, and their likelihood of receiving appropriate, timely intervention. Women in professional or managerial status positions are almost three times as likely (21 percent) to report spousal violence to police, compared to non-working women (eight percent), and to women with blue collar jobs (seven percent). Professional women are over 10 times as likely to report an incident as clerical workers (two

percent). Housewives and women in lower income and more traditionally female occupations apparently have fewer options and fewer "safe places" to seek shelter once police are involved or if the violence has escalated to a point where it occurs both within the home and outside of it (Schulman 1979). Although only 25 percent of those wives who had not sought help also held outside jobs, fully half (50 percent) of the wives who had called police, sought intervention from a social service agency, or separated from or divorced their husbands held outside jobs (Gelles 1987).

Women who are constrained by class or economic conditions also appear to suffer disproportionately. For example, Browne (1990) concluded that her figures, which were based on surveys, truly underestimated the prevalence of domestic violence among women in lower socioeconomic groups. Such surveys often do not include persons without telephones, those who do not speak English fluently, the very poor, and all individuals who are homeless, hospitalized or incarcerated. Women abused by domestic abuse who also must take care of children are probably also underrepresented in many surveys because of their participation in child-rearing duties, or because the presence of children may inhibit some women from seeking intervention or even responding to surveys about domestic abuse. Domestic violence should also be considered a risk factor for subsequent homelessness or incarceration. Browne also compared the reports made by battered women with those made by witnesses or by social service agency professionals. Brown found that battered women, especially those who had been abused over a long duration, tended to underestimate both the frequency and severity of the violence they experienced.

Hirschel, Hutchinson and Dean (1992) determined that, based on police data, repeat incidents of domestic abuse are the rule rather than the exception, again suggesting that all crimes of domestic violence are underreported. The majority of women interviewed in their study had also experienced at least one other abusive incident within the six months following the report to police of an initial abusive incident. These researchers noted that the reasons for the discrepancy in reporting repeat offenders might include the "conventional" reasons (fear of retaliation, presumption of it being a personal or private matter), as well as the prospect that, although violent, the repeat offenses might not meet a legal standard for prosecution. In such cases, the repeat batterer may select verbal or emotional abuse, rather than physical abuse, as his or her preferred mode of inflicting damage or pain, or of retaining power and control in the relationship.

Some media attention has focused on the prospect that men and women involved in battering relationships are nearly equally likely to be the batterers. However, the evidence points to the likelihood that violent behavior perpetrated by women is more likely to have been elicited in self-defense. Typically, abusive men blame the women they have abused for provoking the violence, often because of verbal abuse directed toward the man.

Why Do Women Stay in Battering Relationships?

Not all women stay in abusive relationships. Yet it would be impossible to quantify the number of separations or divorces that had been precipitated by domestic violence. Moreover, of those women who remain in abusive relationships, most do not passively endure physical abuse. In some manner they actively seek assistance in ending the violence from a variety of sources. Many

are lawyers, friends, family members, and clergy and are not legally bound to report such incidents. Often, it is the failure of these individuals and support systems, coupled with the failure of America's law enforcement and child protective service resources, that can "trap" a woman, or force her to remain in a battering relationship. A study of more than 6,000 battered women in Texas found that, on average, the women had contacted five different sources, either professional or non-professional, for assistance before leaving their home and becoming residents of battered women's shelters (National Woman Abuse Prevention Project 1992). There is compelling evidence to determine that many battered women also suffer in silence. These women endure physical abuse for a variety of social, cultural and legal reasons:

- A battered woman frequently faces the greatest physical danger when she attempts to flee. Those battered women with children who contemplate leaving the relationship must also consider the fate of their children, particularly at the actual time at which the departure might take place, a period of high vulnerability to repeat attacks, against themselves, and against the children.

- Some women may endure physical and emotional abuse to keep their families together for the sake of the children. Often, it is when the violence is directed at her children, perhaps as a surrogate for continued violence against the woman, that the abused woman will depart.

- For many women, leaving may not be an alternative because they might have nowhere to go, have few or no financial resources, or there are inadequate social service resources in the community for battered women. Financial dependence on a battering partner presents the woman with the prospect of severe economic hardship if she chooses to leave an abusive relationship.

- Because of religious, cultural or socially learned beliefs, some women may presume that they have a duty to keep a marriage together at all costs.

- Many women want the violence, rather than the relationship itself, to stop, and in fact may take many intervening steps to try to end the abuse. Leaving the home is their last resort.

Effects of Domestic Violence on Special Populations

Rural Women

Batterers commonly isolate their victims to prevent either detection of their crimes or their abused partners' escape from the relationship. In rural areas, vast distances and the comparative lack of neighbors or supportive friends intensifies that strategy of isolation. Many unique risk factors heighten the danger faced by rural abused women. For example, public transportation is often non-existent. Batterers sometimes deny their partners access to family vehicles or do not permit abused partners to obtain or renew driver's licenses.

Depending on the season, unimproved roads in rural areas often preclude flight, especially in snowy areas or those prone to spring floods. This adds to the desperation of living with an

abusive partner in very closed quarters. Emergency medical response systems in rural areas are not as sophisticated as in urban areas, and response times are extended due to distance. Seasonality in rural areas also affects employment and economic vitality. When some men are faced with long durations of unemployment or underemployment, their stress and diminished sense of self can seemingly be assuaged only by violently exerting power and control over a spouse.

Often, police or emergency medical responders in rural areas are neighbors or acquaintances of the abused woman, to whom she may be ashamed to reveal details about the abuse for fear of receiving unsupportive comments in the small town "fishbowl" of life. Weapons, particularly firearms for hunting or sport, typically are handy in rural homes, thereby increasing the opportunities to inflict physical harm with a gun. Whereas it may be common in urban areas for an abused woman to allege that she "fell down the stairs" as a means of deflecting attention to her bruises or lacerations, in rural areas such evidence can more reliably be attributed to working with farm equipment or livestock. Once a rural abused woman decides to seek protection, she usually finds that resources such as shelters or support groups are comparatively unavailable. Reluctance to spend time in the "big city" may also deter women from traveling to urban areas or the county seat, where they might otherwise visit an attorney, consider filing charges, or seek emergency protection from the courts.

Same-Sex Battering

Lesbians experience physical and psychological violence not only because they are female, but also because of their sexual orientation. Battered lesbians have few dedicated resources available to them; they frequently encounter homophobia from service providers, denial within the lesbian community, and a presumption that women do not exert power and control over others, particularly other women. Battered lesbians are probably the most underserved population of abused women. Two myths appear to perpetuate and justify the lack of attention and service provision to battered lesbian women:

1) Lesbian abuse is ostensibly mutual, suggesting that both parties consent to violence as part of the relationship; and

2) Lesbian abuse is perceived never to be as violent as abuse inflicted on a woman by a man, as in heterosexual battering relationships.

Instead, battering among lesbian women is almost never mutual, can be every bit as lethal as when men batter women, and manifests many of the same attributes and dynamics of the "power and control" model exhibited in heterosexual battering relationships.

It is also important to acknowledge that domestic violence also exists in gay male relationships, and battery by male partners represents another critical health problem affecting gay men today (Island and Letellier 1991). It is not known if domestic violence is as prevalent in gay male relationships as it is in heterosexual relationships. The same pitfalls of underreporting and of myth-based misunderstandings could possibly contribute even more to the hazardous conditions

of domestic violence in gay male relationships, compared to conventional "battering male/battered female" relationships.

Women of Color

Underreporting of domestic violence among women of color is also a substantial impediment to understanding whether there are different rates of abusive behavior in ethnic populations. Criminal justice studies in which race is considered generally focus on perpetrators, rather than on abused women. The U. S. Department of Justice has commissioned a continuous nationally representative sample of households called the National Crime Victim Survey (NCVS), which incorporates information on crimes not reported to law enforcement agencies. The NCVS demonstrates that Hispanic, African-American and Caucasian women experience nearly equivalent rates of domestic violence, suggesting that domestic abuse is not a racially-defined crime.

Anecdotal evidence, brought to light by the media attention focused on the case of O. J. Simpson, also suggests that battering men and battered women need not be of the same race. The external cultural pressures that already confront mixed-race relationships only add to the propensity of batterers to release their frustrations violently. Moreover, women of color might have an innate distrust of governments, or lack confidence that Caucasian-dominated law enforcement agencies will take seriously an allegation of domestic violence. Compounding the problem is the fact that ethnic communities have not developed support services like shelters and legal advocacy at the same rate as in the community at large, within which Caucasians are a numerical majority. Access to culturally-aware services is severely limited. Racism, both subtle and overt, fosters the disturbing tendencies not only to presume that domestic violence in ethnically-defined relationships is ordinary, but to also discount an abused woman's allegations, thereby diminishing her motivation to seek outside help.

Immigrant Battered Women

The rigors of immigrant life put battered women from other cultures in a particularly vulnerable position. Language barriers make it difficult for immigrant battered women to communicate with law enforcers, social service agencies, hospitals, attorneys and courts. These institutions are not structured to accommodate language and cultural differences, which further alienate and isolate immigrant women. Sociological issues such as dominant paternalism and the presumption of male hierarchy in a marriage also compound the problem.

These tendencies suggest to abused Asian and Hispanic women that their lives are not valued, either by their male partners or by the United States. Even across diverse ethnic groups, there are similarities based on racism and poverty that help to explain why immigrant women are particularly at risk. For example, immigrant women often follow husbands or mates to the United States after the men have arrived. Some are sponsored by husbands. Economic distress of unemployment contributes to isolation. Distrust of governments or their affiliated social service agencies deters some immigrant women from seeking help, even when it is available. Immigrant women with children are particularly fearful, given the prospect that their children would have to be abandoned if deportation becomes likely.

Some male ethnic minority batterers have been acquitted in courts by relying on a "cultural defense," thus enabling some alleged perpetrators to take advantage of "old world" attitudes that stipulate power and control, and encourage a subordinate role for women, even to the point of injury or death.

Until recently, these women were dependent upon their spouse to gain legal status. In 1994, the Violence Against Women Act (VAWA) was enacted. VAWA includes a provision protecting battered women and children. It allows women married to U.W. Citizens or permanent residents to file their own immigration papers and receive work authorization and protection against deportation without their battering spouses' approval.

Battered Women With Disabilities

Few shelters or social services are accessible to women with disabilities, or have staff members who are sensitive to their needs. A sense of dependence on a caretaking man may exist, thwarting the woman's own motivation to be independent. Their sense of isolation is intensified not only by their disability, but also by the presumption that members of the non-disabled public at large are unwilling and unable to understand their special needs.

In such relationships, the battering perpetrator may also have a substantially enhanced degree of physical power and control, can much more easily control the abused woman's access to outside information or assistance, and may be physically able to prevent her escape to a much greater degree than against an able-bodied woman. Fortunately, this special population of at-risk women may now be receiving more attention among battered women's support and service resources. For example, brochures about seeking relief from domestic violence are now available in Braille, and more shelters are adapting their physical structures to make them more accessible to persons in wheelchairs.

Prostitutes

Women attempting to escape from prostitution have more specialized needs than battered women escaping from more conventional settings. Many prostitutes lack a stable home life, even if they also have dependent children. Substance abuse is a common problem, elevating the effect of other risk factors. Many battered prostitutes may have to flee brutal pimps with only the clothes on their backs. Not unlike battered women in conventional settings, these women have few viable job skills; many did not complete high school. Most of these women have had little experience controlling and managing their own finances. Generally, prostitutes may have experienced intimate violence to a much more severe degree, including rape and sexual abuse, and often from more than one partner. Possible infection with sexually transmitted diseases heightens their difficulties. Poor self-esteem inhibits their help-seeking motivation. Even if adequate resources exist in a community for battered women from conventional settings, prostitutes face societal or judicial pressures that diminish the likelihood they will seek and receive adequate, timely intervention. Longer-term counseling is especially important for these women. Often they have come from abusive homes, have been subjected to sexism in forms fostered by pornography, and cannot envision a life beyond their immediate pressing circumstances.

Pregnant Battered Women

The March of Dimes reports that between 25 and 45 percent of all battered women are abused during pregnancy, thereby increasing the risk of birth defects, spontaneous abortion, and delivery of low birthweight babies (McFarlane, et al. 1992; Helton, McFarlane and Anderson 1987). Gillespie (1989) noted that 42 percent of women in her study reported being beaten while pregnant. In an abusive relationship, notification of pregnancy is frequently a flash point for further battering. The number of battering incidents is high during pregnancy. Both teenage and adult women who are battered while pregnant enter prenatal care later in their pregnancy than non-battered women (Campbell, et al. 1992). Battering prior to pregnancy is the primary predictor of battering during pregnancy as well (Parker, McFarlane and Soeken 1994).

Often the worst abuse can be associated with pregnancy. Either intentionally or not, battering men have a proclivity to punch and kick their pregnant partners in the stomach or lower abdomen, resulting in miscarriages and injuries to their reproductive organs (Gillespie 1989). Feelings of inadequacy may arise in a pregnant woman because she is no longer as attractive, thereby fostering comments from battering partners such as "You're so fat" or "You're ugly" or "It's your own fault." Although family pressures, including the number of existing children, are frequently cited as risk factors for battering, battered women on average do not have more children than non-battered women. Still, they are pregnant twice as often and more likely to be pregnant at the time of their injury.

Domestic Violence and the Health Care System

Women who have suffered domestic abuse seek repeated help from a variety of medical providers and institutions. Research indicates that 22 to 35 percent of women seeking emergency department treatment do so for symptoms related to domestic violence (Randall 1990a). Abused women are more likely to seek care for depression, anxiety, marital or sexual problems, and "vague medical complaints" (Stark and Flitcraft, et al. 1991).

Thus, abuse is an ongoing cycle producing increasingly severe injuries over time, battered women are likely to see physicians more frequently than their non-battered counterparts. One study showed that nearly one in five battered women had seen a physician at least 11 times for trauma, and another 23 percent had seen a physician six to 10 times for abuse-related injuries (Stark and Flitcraft 1979; Flitcraft and Stark 1989). Clearly, health care provider protocols in a variety of medical care settings, and guidance for practitioners of various clinical license categories, including nurses and physicians, are needed in order to improve detection and treatment of the consequences of domestic violence. Many such protocols and standards are now in place in health care settings throughout California and nationwide. The features of health care provider protocols, and research results on the benefits to patients of intervention and prompt reporting by health care practitioners, are reviewed below in Chapter III.

As many as one fifth to one third of all women who visit an emergency department may be there directly or indirectly because of abuse (McLeer and Anwar 1987). More than one million women per year in the United States utilize emergency services related to battering, and many others

present in the emergency department with a variety of non-trauma related complaints, including disorders related to pregnancy, suicide attempts, chronic pain syndromes, depression and sleep disorders (Strauss 1986). However, as recently as 1984, only about five percent of battered patients were identified as victims of domestic violence in emergency department records. This prompted the development of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards and practitioner protocols later in the 1980s (Goldberg and Tomlanovich 1984).

Some of the reasons for failing to diagnose battering in the emergency department include time constraints, lack of specialized training among allied and clinical health care providers, and reluctance to be straightforward with a battered patient about domestic violence (McLeer, Anwar and Herman 1989). Practitioners' own misconceptions and attitudes also affect their approach to such patients (Hamlin, et al. 1991; Sugg and Inui 1992). On the other hand, in another survey among California practitioners, emergency department staff did not see themselves as obstacles to identification of battered patients, even though their available referral resources, including lists and brochures reviewed during the survey, did not address the specific needs of battered women (Lee, Letelier, McGloughlin and Salber 1993).

The Impact of Domestic Violence on Children

The effects among children witnessing domestic violence are often traumatic, both immediately and later in the child's life. Escaping harm to their own bodies does not make children immune to the effects of family violence, especially if they are forced to listen to, watch, "take sides," or minister to the consequences of domestic violence on one or both parents or caretakers.

The implications of a child's exposure to domestic violence in his or her own home cannot be ignored. However, given the paucity of community-based resources for sheltering and assisting battered spouses and children, more often than not the long-term psychological toll on a child witness is treated insufficiently, if at all. And, even though the focus here is on witnessing violent behavior within the home or family structure, the traumatic effects on children who witness violent street crime, or violence or fear-mongering at school, or the self-destructive behavior or even suicide of a sibling, should also be acknowledged. Whatever the venue, violence scars children. In the home, however, the effect of that violence on children can truly be characterized as toxic (McCloskey, Figueredo, and Koss 1995).

While it is not known how many children annually witness domestic violence, the American Bar Association (ABA 1994) estimated the range at between 3.3 and 10 million children. The ABA also estimated that 87 percent of children in homes with domestic violence witness that abuse. These estimates are alarming but become dreadful in consideration of the fact that in many violent homes, children hear or see violent behavior daily or weekly, rather than only occasionally. Whereas violence in the street is unpredictable and acute, domestic violence is predictable and chronic.

Children who observe or hear domestic assaults against a parent at home can be harmed in more than one way: cognitively, psychologically, and in their social development. Children's exposure

to spousal battery can have short- and long-term effects, including periods characterized by fear for self, fear for their mother's safety, self-blame, rejection, detachment, and a seething urge to achieve revenge or restitution. There is compelling evidence that such a child will grow into an adult who also batters partners or children, eliciting the familiar "cycle of violence." Such children grow to view violence among intimate companions as an acceptable norm or inevitable means for addressing conflict, and exerting power and control.

From the standpoint of morbid injuries, "caught in the crossfire" best describes the injuries inflicted on child witnesses. In the long term, child witnesses suffer from nearly the same severe symptoms of post-traumatic stress disorders that disabled American soldiers returning from Vietnam (Atnafou 1995). Such disorders yield a wide range of symptoms, including:

- Persistent, recurrent experiences of the traumatic events;
- A foreshortened sense of the future;
- Avoidance of stimuli associated with the trauma;
- A broad numbing of general responsiveness;
- Feelings of detachment from others;
- Increased arousal and hypervigilance;
- Poor attention spans, or memory and learning deficiencies;
- Engaging in high-risk or anti-social behaviors; and
- A wide array of sleep disorders that, when manifested in children, seem harsher than in adults (Atnafou 1995).

In addition to those children who witness domestic violence, children who have been physically or sexually abused also readily exhibit post-traumatic stress disorders. The manifestation of such disorders varies depending on the child's developmental stage, physical proximity to such incidents, and emotional ties to, or economic dependence on, the abused adult.

Whereas the direct involvement of medical professionals has served to improve intervention programs against spousal abuse and child abuse or neglect, it befalls the health care and judicial systems to lead the way among professionals in recognizing the traumatic, deterministic effects of children having witnessed domestic violence. Even though only a minority of domestic violence cases enter a judicial phase, those that do eventually involve attorneys or judges. Consideration should be given to what children might already have seen in a violent marriage, and what they might yet see in a reconstituted home following a legal action or court intervention. Many custody cases achieve resolution, perhaps even with a relatively favorable outcome, without the attorneys and judges or other professionals taking full stock of the special needs of child witnesses. These include counseling, giving children a chance to talk openly about their fears and guilt, and providing children with the confidence that the new arrangement will not only be amicable, but safe for everyone involved.

ELDER ABUSE

Elder abuse may not be a new phenomenon, but research into its prevalence and characteristics has been performed only in the last two decades. This is a nascent field, but aptly included under

the rubric of family violence. There is no one definition of elder abuse, but nearly all cases of elder abuse are characterized by one or more of the following: physical abuse, psychological abuse, and active or passive neglect (Robinson 1992). A compounding form of elder abuse that may be present to varying degrees in any typical case could be characterized as financial exploitation, or material abuse (Wolf and Pillemer 1989). Another characteristic of elder abuse cases is the seeming deliberateness within all degrees of abuse, from slight to traumatic; however, unintentional cases of neglect related to the frailty of an elder, or actions resulting from the stress of caregiving, also qualify as cases of elder abuse. Incidents of elder abuse can take place in institutional settings, but more commonly such events occur in familiar surroundings, such as in elder's own home or, when no longer independent, in the home of a younger family member.

Similar to other forms of family violence, in elder abuse there are telltale characteristics of both the abuser and the abused person that serve as precursors, or even predictors, of abuse. Research has shown some of the characteristics of caregivers who turn abusive, and some of the reasons why such caregivers begin to abuse elders include:

- The seemingly intolerable demands of the elder;
- Dependence of the caregiver on the elder, such as continued economic dependence;
- Histories of other antisocial behavior; and
- The caregiver's own history of child abuse, possibly by the elder for which they are caring (U.S. Department of Health and Human Services 1991).

Characteristics of abused elders include advanced age (usually 75 years of age or older), widowhood, and physical and perhaps mental dependence on others (often including the recognized caretaker). Abusers tend to be residing with the abused elder, and tend to have cared for the elder for a relatively long duration. Abusers may be spouses, adult children or other relatives. When the abuser is a spouse, a pattern of abuse throughout that or other related families may be a precursor. Those persons who had been witnesses to previous abuse earlier in life often subsume interpersonal violence as an accepted or inevitable norm of behavior. A typical scenario might involve an abuser and an abused elder sharing the same home, where either party depends on the other for financial support or housing assistance.

In California during 1993, the State Department of Social Services received data on 13,666 reported cases of abuse perpetrated by others on dependent adults over the age of 65 years; another 10,532 cases of "self-inflicted abuse" were also documented. Nearly two thirds (62.6 percent) of all reported cases of abused dependent adults were committed against elders over 65 years of age. The most frequent types of abuse perpetrated by others against elders that could be confirmed by the Department (7,603 cases) included neglect (29.1 percent), "fiduciary" abuse (24.1 percent), physical abuse (23.7 percent), "mental suffering" (20.6 percent), and abandonment (1.4 percent). The most frequent types of self-inflicted abuse (6,310 cases) included physical self-abuse (87.5 percent), fiduciary self-abuse (8.9 percent), and suicidal behavior (1.6 percent).

The National Aging Resource Center on Elder Abuse (NARCEA) reported data from 24 states in 1988 that described the most common types of reported cases of domestic elder abuse, including active neglect (37.2 percent), physical abuse (26.3 percent), financial exploitation (20 percent),

emotional abuse or passive neglect (11.0 percent), and sexual abuse (1.6 percent). Data from 15 states were culled to describe the most frequent categories of alleged or convicted perpetrators, including abuse by adult children (30.0 percent), other relatives (17.8 percent), a spouse (14.8 percent), a service provider (12.8 percent), a friend or neighbor (10.0 percent), and even grandchildren (1.9 percent) or a sibling (1.7 percent). NARCEA also surveyed all the states' adult protective services and aging agencies in order to derive an estimate of the incidence of elder abuse. They calculated at least 140,000 reports of elder abuse made to adult protective service agencies in 1988, an increase from 128,000 reported cases in 1987, and 116,000 reported cases in 1986, representing annual increases of 8.5 percent and 10.4 percent, respectively (NARCEA 1988).

As with other forms of family violence, underreporting is a serious problem in elder abuse. Elder abuse cases are less likely to be reported as crimes than even child abuse and domestic violence. Despite vast underreporting in those other forms of family violence, underreporting of elder abuse is probably more critical, for several reasons:

- Fewer emergency department encounters occur in which mandated reporting would transpire;

- The co-morbid conditions of advanced age can mask symptoms of abuse or relegate them to a lower clinical priority; or because

- Not all forms of elder abuse require immediate intervention that would bring the case to the attention of the authorities.

The House of Representatives Select Committee on Aging heard testimony in 1990 that, even though there were 1.5 million case reports of elder abuse in 1988, one in five cases of elder abuse was actually reported. Though alarmingly infrequent, this represented an improvement over the elder abuse reporting rate in 1980, when one in eight cases was reported (U. S. Congress 1990).

FIREARM INJURIES IN THE HOME

This section focuses on intentional and unintentional injuries due to firearms in the home. The associations between each of the major manifestations of family violence and firearm possession, access and utilization, are stark and significant. Unlike the previous forms of family violence described above, in which a perpetrator could be easily distinguished from an abused person, this category must accommodate the fact that many injuries can be either intentional or unintentional in etiology, and may or may not involve a perpetrator or actor. Most intentional injuries involve a perpetrator. Not all unintentional injuries are self-inflicted. For example, a youngster accidentally shooting a playmate or sibling while playing with a firearm in the home is an unwitting perpetrator.

Firearms In The Home Environment

Firearms in the home represent an additional risk factor for any form of family violence. Within the public health framework of this report, firearms could be considered the "agent" in which the toxic effect of family violence enters the environment in which the "host" resides: the familiar surroundings of one's home. An episode of family violence that involves a firearm in the home provides the greatest risk factor for either intentional or unintentional injuries, particularly among young people.

Many homicides and suicides appear to be the result of impulsive behavior. Homicides can occur during arguments, often domestic arguments, when emotions run high, or when one or more parties have been drinking or abusing drugs. But persons who take their own lives often do so when confronting a severe but transient crisis (Seiden 1977). For example, many young male suicide completers (for whom the suicide rate tripled between 1950 and 1980) were not clinically depressed, but often acted alone in familiar surroundings, on impulse, or in response to "trouble at home, in school, and with the police" (Rosenberg and Mercy 1991). Recent studies of homicides and suicides in the home indicate that firearms in the home increased the likelihood of homicide three-fold (Kellerman, et al. 1992 and 1993). Therefore, it follows that the most favorable opportunities for primary prevention of firearms injuries are also in the home. Primary prevention might involve either removing firearms from home environments, population-wide distribution and utilization of locking devices, or education.

Even though adults are at-risk for injuries due to firearms, the focus here is on risks for children and adolescents who are exposed to firearms in their homes. Children and adolescents are exposed to firearms both in their physical presence, and in the media. In the context of family violence, the prevalence of firearms should be addressed in the home, both in their physical presence, and in the degree to which young people ought to be allowed to gain exposure to firearms as they are presented in the media. Addressing firearms in the home involves clarifying a set of family or parental decisions and attitudes long before it should involve a set of governmental or social decisions and interventions. This observation reinforces the notion that one important key to reducing family violence is to enhance those aspects of the family that yield primary preventive effects, such as improving communication between parents and children, setting high expectations of both parent and child, and the ability through parental discipline to reduce the exposure of children to the toxic agents of family violence.

Many of the same risk factors that are associated with other forms of family violence, such as the use of illicit drugs and a history of hand-to-hand violence in the home, are just as likely to be risk factors for firearm violence in the home. In fact, the presence of a firearm in a home triples the chance of homicide by a family member, or an intimate acquaintance, when these other risk factors are present (Kellerman 1993).

Firearm injuries, within the home and outside of it, are the second leading cause of death in the United States for all children and adults 10 to 34 years of age. In the United States in 1990, an adolescent between the ages of 10 and 19 years was unintentionally shot every 19 hours; committed suicide with a firearm every six hours; and was intentionally killed with a firearm every

three hours. In core metropolitan counties, homicide by firearm was the leading cause of death among all children aged 15 to 19 years. From 1985 to 1990, the firearm homicide rate for children 19 years and under increased 114 percent. The U.S. Centers for Disease Control and Prevention (CDC) reported that, for every firearm fatality in 1985, 7.5 nonfatal firearm injuries occurred. For the past 25 years, firearm injuries have been the leading cause of death for African American males aged 15 to 19 years, at a rate 11 times higher than the rate among Caucasian males.

Compared to firearm homicide rates in other developed countries, the rate in the United States is disturbingly elevated. Among males of all races 15 to 24 years of age in 1987, 4,223 were killed by firearms, representing a rate of 21.9 per 100,000 population. This rate is more than four times higher than the next highest developed country, Scotland, with a rate of 5.0 homicides per 100,000 population.

Issues Regarding Firearm Accessibility

Firearm accessibility shapes these events. Many children have access to firearms at home. Research suggests that half of the homes in the United States contain one or more firearms, and that guns kept at home were involved in the death of a household member 185 times more often than in the death of a stranger or intruder (Kellerman, Rivara, Somes, et al. 1992). These deaths included suicides, homicides, and unintentional fatal shootings. Unintentional discharges of firearms among children often occur when the children are unsupervised. For every 4.6 homicides and every 1.3 unintentional firearm accidents nationwide, there are 37 suicides with a firearm (Japenga 1994).

Most suicides involving firearms are committed in the home (Kellerman and Reay 1986). However, suicidal behavior in itself is less to blame than the contributing risk factor of firearm accessibility. In fact, firearms are more likely to be present in the homes of adolescents who take their own lives than in the homes of demographically similar adolescents diagnosed with similar mental illnesses who receive inpatient treatment (Brent, Perper and Goldstein 1988). In a follow-up case-control study, Brent and colleagues (1991) verified this finding in a larger sample of adolescent suicide cases, when compared to controls who were unsuccessful suicide attempters, and with a third group of nonsuicidal controls with other psychiatric illnesses. Brent and his associates concluded that the availability of firearms represented a substantial risk factor for adolescent suicide. They found that suicide completers were 2.5 times more likely to have a gun in their home than were diagnostically similar, psychiatrically ill, suicidal adolescents, suggesting that the availability of firearms represents a substantial risk factor for adolescent suicide (Brent, Perper, Allman, et al. 1991).

Regardless of the presence of mental illness among household members, however, the ready availability of firearms appears to be associated with an increased risk of suicide in the home, even in homes in which no one was previously known or suspected to be mentally ill (Kellerman, Rivara and Somes 1992). And, whether or not firearms in the home contribute to the suicide or homicide of any household member, in the same context that witnessing domestic abuse as a child constitutes a risk factor for that child becoming a perpetrator of violence later in life, the

psychological trauma of witnessing firearms violence predisposes family members to post-traumatic stress disorders and behavioral disturbances (Christoffel 1986).

The case-control study by Brent and colleagues (1991) also reviewed the average number of firearms in the households of adolescent suicide completers, the type of firearms that were available to adolescent suicide attempters, and the most common methods of storage. They found that the mean number of firearms per household for suicide completers (4.2 firearms) was significantly greater than for attempters (1.4 firearms). Relative to the two control groups in this study, suicide completers were more likely to have both long guns and handguns than suicide attempters. Suicide completers who had both long guns and handguns present in the home were slightly more likely to make use of the handgun than the long gun, although that difference was not statistically significant. Of the eight adolescent suicide completers in their study who had only long guns available to them, six (75 percent) used these weapons to kill themselves, suggesting that persons committed to the idea of suicide by firearm would be more likely to carry out the act in a home in which firearms of any kind were readily available.

Regarding the method of storage, Brent and his associates found that the majority of suicide completers who had firearms in their homes had used them, regardless of whether the firearms were stored locked, separate from or together with ammunition, or loaded. Given the presence of at least one firearm in the household, there was no statistical difference in the various methods of firearm storage among the cases and the two control groups. Other researchers concluded that a substantial portion of firearm owners disregard basic safety procedures, suggesting that programs based on educating children, rather than firearm owners, about safe-storage methods would not yield much preventive effect. Despite the lack of promising evidence about education-based storage-method programs, two researchers concluded that "we cannot say that education about safe storage practices in the home is ineffective" (Weil and Hemenway 1992). They determined that children's vulnerability to firearm violence stems from children’s fixed developmental characteristics, such as varying levels of curiosity at different stages of development. These researchers argued that placing the burden of responsibility on a child, rather than on the appropriate gun owner or user, is both "uninformed and dangerous," because children mistake firearms for toys or enjoy "acting like an adult," which they can do with dramatic effect and realism when they have a firearm in hand.

Whether or not suicide is involved, adolescents face a series of age-specific risk factors that predispose them and make them vulnerable to firearm violence in the home. Social context surrounding firearm use is complex. Among adults, "ordinary" social influences have an impact on the proclivity to use firearms, such as the glamorization of violence in the media, race, poverty, urbanization, family disruption, and the erosion of basic law and order. But among adolescents, another series of "extraordinary" social influences and developmental issues coincide with or engender risk factors for firearm violence, including: identity-definition; "rite of passage"; belief in one's own invincibility; striving for independence and autonomy; curiosity; peer group influences; immaturity or lack of judgment; impulsiveness and ambivalent behavior; substance abuse; and a perceived need for protection to ward off a lack of safety (American Academy of Pediatrics 1992). The paucity of safety education about firearms can contribute to these

developmental factors, particularly for urbanized youth who have little or no opportunity to learn about using firearms in non-violent, sporting, or hunting pursuits.

Locational and Temporal Risk Factors Associated With Unintentional Firearm Injuries

In a 1988 study by the Center to Prevent Handgun Violence of 266 unintentional handgun shootings of children, researchers compiled data on the location in the home where the shootings occurred. They found that half of the shootings occurred in the gunshot victim's own home, while 30 percent occurred in the home of a friend, 8 percent in a relative's home, 6 percent outdoors, and 5 percent in a car. Of those in a gunshot victim's own home, 84 percent were either self-inflicted or committed by a sibling, while 76 percent of the shootings at friends' homes were committed by the friends of the gunshot victim.

The researchers also compiled information on the location within the home at which the child perpetrator found the firearm. Nearly half (45 percent) found the firearm in a bedroom. Nearly another one-fifth (18 percent) found the firearm in the living room; and nearly one-tenth (8 percent) found the firearm in a car (one-quarter, 24 percent, of the firearms involved in the shootings were found in unspecified locations throughout the home).

In this survey, nearly half (47 percent) of the firearms used were owned by the gunshot victim's parents, while another quarter (28 percent) were owned by the parents of the gunshot victim's friends. Most gunshot victims (73 percent) were shot by children in their own age group; the most frequently occurring age range for shooters was between birth and four years of age (19 percent), while the most frequently occurring age range for gunshot victims was five to eight years of age (19 percent). In more than 60 percent of the shootings, no adults were on the premises when the shooting occurred; in all but three of the remaining cases where adults were on the premises, these adults were in other rooms of the home at the time of the shootings, thereby increasing the risk of unsupervised behavior.

These findings illustrate that firearms, usually handguns, used in unintentional shootings among children are most often left where children can easily get to them in the home, (e.g., in night stands, closets, dressers, and end tables) and that removing firearms from the homes of children is the best and simplest method of primarily preventing unintentional shootings. But even removing firearms from one's own home and thereby protecting one's own children is insufficient because these results also reflect the fact that children can be shot unintentionally in a friend's or relative's home, yielding the imperative that parents discuss firearm safety issues with their children, in the event that relatively easy access to a firearm presents itself outside the familiarity and safety of one's own home (Smith, Cohen and Lautman 1988).

In a follow-up study of 532 unrelated, unintentional shootings by children between 1986 and 1988, also performed by the Center to Prevent Handgun Violence using methods pioneered by Wintemute and colleagues (1987), researchers investigated the periods of the year during which pediatric unintentional shootings were more common. Even though many such shootings occurred in each month, the frequency of shootings increased dramatically during the summer months (June - August) and the holiday season (November and December); more than half (56

percent) of all the shootings occurred during these five months. And although shootings occurred on every day of the week, the highest percentage of shootings (18 percent) occurred on a Saturday, while the lowest percentage (11 percent) occurred on a Wednesday.

A clearer pattern developed when the incidents were categorized into "summer vacation" and "school year" shootings. During the school year, September to May, the peak times for such shootings were at the beginning and end of weeks (Monday, 16 percent; Saturday, 19 percent), while during the summer, the percentage of incidents during the midweek increased dramatically (e.g., Wednesdays during the school year, nine percent; Wednesdays during summer vacation, 15 percent). Afternoon hours (12 to 5 p.m.) were the most frequent time of day (42 percent) during which shootings occurred, while incidents were least likely to occur during the late night hours (12 to 5 a.m.). The findings of this follow-up study are reinforced by common sense: unintentional shootings among children most often occur when children have free, unsupervised time, such as during school vacations and toward the end of the afternoon after school (Smith, Scherzer and Lautman 1990).

Public Perceptions About the Frequency and Cost of Firearm Violence

In California, firearm-related suicides rose 89 percent between 1989 and 1993, representing about 47 percent of all suicides in the state (Nieto, Dunstan and Koehler 1994). Juvenile homicides in California rose steadily between 1987 and 1993, particularly firearm-related homicides. Although there has been a similar trend involving adults, the percentage increase of firearm-related homicides among juveniles over this five-year period is far greater than among adults (125 percent versus 65 percent).

In June 1994 The California Wellness Foundation commissioned a survey among California voters to discern their attitudes about violence and firearm ownership. The results reflected the voters' perception of crime and violence as the primary issue facing California today: one in two Californians is worried about his or her safety; two out of three Californians are worried about the personal safety of their children and relatives; and one in five are close to someone who had been abused by firearm violence. Moreover, The California Wellness Foundation survey found that women's fear for their personal safety is greater than that of men (61 percent versus 42 percent), but that women and men are almost equally worried about the security of their families (34 percent women versus 29 percent men). Parents are most concerned, and the younger their children, the greater their concern (EDK Associates 1994, cited in Nieto, Dunstan and Koehler 1994).

The costs of firearm-related injuries should concern every American, and every Californian. The Centers for Disease Control estimated that lifetime economic losses due to firearm-related injuries totaled $14.4 *billion* in 1988 nationally, a figure that would likely be higher using today's dollars (CDC 1988). Nieto and associates also examined the direct and indirect economic costs of firearm violence in California, and estimated that the average direct medical costs *per firearm-related crime* in California (i.e., emergency services and transport, hospital and physician care, mental health care costs and productivity losses) were $23,750 in 1992 dollars. The comprehensive average of indirect costs (i.e., lost wages, diminished quality of life, administrative

costs, jury awards for pain and suffering, and expenditures on safety features such as alarms, window bars and bullet-proof glass) were $214,864 *per firearm crime*. In the aggregate, direct costs of firearm-related injuries in California in 1993 totaled $568 million among non-fatal cases and $135 million among fatalities; indirect costs totaled $5.139 *billion* among non-fatal cases, and $11.853 *billion* among fatalities in California alone.

These authors also cited 1994 national figures that calculated the law enforcement and medical personnel costs involved in a typical response to a firearm-related fatality, excluding any medical care provided before the abused person's death. They found that the "cost meter" begins the moment a call is placed to police or 9-1-1 emergency dispatchers. Police officers arriving on the scene followed by forensic officers and supervisors accounted for an estimated $4,626 per episode; emergency vehicles responding and transporting accounted for $1,310; and an autopsy performed by a county medical examiner contributes an additional $1,046, suggesting that each firearm-related crime that results in a fatality costs local government a minimum of almost $7,000. These costs are above and beyond expenses borne by families, and other indirect economic losses such as lost productivity. These figures are broad and pertain to all episodes of firearm-related violence, whether in the home, workplace, or street, but when coupled with the evidence presented above regarding the availability and use of firearms in homes, they suggest that each taxpayer bears a substantial cost from each episode of firearm violence, which would be reduced if firearm-related violence in the home were diminished.

Firearms: Domestic Violence and Homicides

When spouses or others are also domestic batterers, the presence of a firearm in the home heightens the risks for morbidity and mortality that already exist in domestic violence situations. In 1992, 5,351 American girls and women were killed with firearms, a rate of 14 girls and women per day; of these, 51 percent were homicides, 44 percent were suicides, and five percent were unintentional firearm discharges resulting in fatalities (Trauma Foundation 1995).

Moreover, when assessing the relationship of the killer to the abused person in American homicides, there is an important gender difference. Male homicide victims were more often killed by intimate acquaintances (41 percent) or strangers (16 percent) than by family members (10 percent). However, among female homicide victims, women are almost as likely to have been killed by acquaintances (35 percent) and family members (30 percent) as by strangers (8 percent) (Kellerman and Mercy 1992). According to the Federal Bureau of Investigation, in 1993 nationwide more than 900 women were murdered by their husbands and another 603 were murdered by their boyfriends (FBI 1994). It should be noted that women are also perpetrators when firearms are available and accessible in the home.

Some research suggests that women and men hit each other and use other abusive tactics, such as threatening to use a firearm to settle a dispute, in roughly equal numbers (Straus and Gelles 1986). However, women are injured at seven times the rate of men in domestic disputes, and women are killed by partners more than twice as often as men. This suggests that even though women occasionally act as perpetrators, men inflict far more damage in domestic abuse settings than women. It has also been observed that men and women involved in domestic homicides kill

partners for different reasons. Men commonly assault their female partners in response to the woman's attempt to leave an abusive relationship (Wilson and Daly 1993). Women commonly assault their male partners in self-defense or in retaliation for prior acts of violence (Jurik and Winn 1990).

In addition to acute injuries, many women suffer a wide range of chronic symptoms related to the physical and emotional stress of being in a battering relationship, including chronic headaches, abdominal pain, sexual dysfunction, recurrent vaginal infections, joint pains, and sleeping and eating disorders (Randall 1990b). These symptoms often coincide with suicidal behavior. If a firearm is present in the home of a battered woman contemplating suicide, it represents an avoidable risk factor. Tragically, Winfield and colleagues (1990) found that women who have been abused by domestic violence are also more likely to attempt suicide. Battering precedes one in every four suicide attempts by all women, and one half of all suicides by African-American women (Stark and Flitcraft 1995; Koop and Lundberg 1992).

In today's media-driven western society, women are also increasingly the targets of advertising by the firearms industry, encouraging them to become firearm owners. It is difficult to calculate how many American women own firearms, but a Gallup Poll commissioned by the Smith and Wesson Company found that female gun ownership rose 53 percent between 1983 and 1986, making women the fastest-growing segment of the firearms-purchasing population. The National Rifle Association estimates that at least 17 million women own firearms. The National Opinion Research Center's 1995 General Social Surveys also found that, among women who personally own a firearm, more than one quarter (27 percent) owned a handgun, while about a third (34 percent) owned only a long gun. This survey also found more married women personally owned guns than did single women (Trauma Foundation 1995).

Regardless of the actual prevalence of firearm ownership among women, the firearms industry would like to increase the proportion, and therefore has made women the target of extensive media campaigns. Magazine advertisements for firearms focus on women's fears of intruders, their sense of vulnerability, and the defenselessness of their children. For example, one Colt Firearms Company ad in the *Ladies Home Journal* (July 1992), depicts a mother tucking her small child into bed, with the caption "Self-protection is more than your right: it's your responsibility." The implicit message is that because a woman's family depends on her, if she does not own a firearm or is not willing to use it to protect her children, she represents a "bad mother." In the electronic media, notably in a recent spate of television movies about battered but "triumphant" women, females are portrayed as being generally empowered by violence and specifically by firearm-related violence of their own commission.

These media and marketing images reinforce for women a presumed role of insufficiency or vulnerability unless they are able to "take matters into their own hands," usually violently in retribution or protection, and often with firearms. Moreover, firearm manufacturers have adapted the weight, grip size, and appearance of many best-selling handguns, creating "ladies' versions" such as the purse-sized "Lady Smith" revolver. Other manufacturers of firearm accessories have contributed to these marketing efforts, for example by offering a "quick-draw" purse (a handbag

with a secret compartment from which a concealed handgun can be fired without being removed from the purse), thigh holsters, and rifle recoil pads that slip conveniently under a bra strap.

At the local level, where retailers encourage more women to become firearms owners, staffing patterns now focus on hiring women who can provide testimonials about the danger of being an unarmed female. They also often offer special pricing for handgun safety or marksmanship courses. None of the marketing strategies employed to date have focused on methods of self-protection that do not require firearms, such as martial arts, nor have they focused on the enormous additional risks for children in a home into which a mother brings a firearm. Nor are locking mechanisms and proper storage techniques emphasized. Obviously, these marketing efforts are designed to sell a product—a firearm—rather than to "sell safety."

Occasionally, firearm ownership is perceived by female consumers as a feminist issue, although one with several facets that might not immediately be associated with "feminism" in the broadest sense. For example, some observers have suggested that initiatives toward firearm control, at the federal, state or local level, really represent a long-standing trend of "disempowering" women, rather than an effort to improve safety for both women and children. Some female consumers believe that firearm ownership tends to "level the playing field" of classical power imbalances between men and women in society, and purchasing a firearm represents a victory for female independence and freedom from these power imbalances.

A new publication, *Women and Guns*, is nationally distributed and quite profitable due to the support of advertising from the firearm industry. In the NRA's magazine, *American Rifleman*, depictions of "empowered" firearm-toting women are balanced with editorials by women extolling the virtues of firearm ownership. One such editorialist wrote, "I cannot help but wonder why so many women who can see through the propaganda of patriarchy on other issues are yet blind to the fact that their opposition to guns is itself a major capitulation to the age-old male point of view regarding what kinds of activity are 'inappropriate' for a woman . . . . The criminal and predatory segment of the male population in this country appreciates its advantage over an unarmed female populace; one needs only to look at the statistics on rape and domestic violence to see this" (Strange 1992).

This advocacy, however, fails to make the connection between woman-initiated firearm violence as a direct outcome of domestic violence, and certainly fails to point out that children, who are not responsible for the gender stereotypes in the society into which they were born, may be harmed, sometimes fatally. This advocacy may also be unwittingly complicit in generating a climate in the media in which aggressive, firearm-toting women are glamorized, as in the film *Thelma and Louise*. Such movie images of women dispatching the male rapists, perverts, bigots and abusers who rely on "power imbalances" suggests to women that firearm ownership is both necessary and desirable as a feminine quality.

In April 1993, noted feminist author and pioneer Betty Friedan, co-founder of the National Organization for Women, convened a symposium in Los Angeles entitled "Articulating Guns and Violence as a Women's Issue." The event drew men and women from the fields of firearm control, health services and public health, domestic violence prevention, government and the

media, to strategize on ways women could contribute to the firearm control movement. At the symposium, Ms. Friedan observed "It is so pernicious that the whole issue of women's empowerment we have been working on for 20 years is being co-opted by these damn gun manufacturers" (Stewart 1993). The symposium generated a set of five principles to guide the advocacy of women in this field. The group consensus was that women, as mothers, community leaders, potential and actual political leaders, and as perceived caretakers of social values, are in a unique position to influence this issue. Ms. Friedan argued that it is now time for the larger community of women to approach gun control as a feminist issue, joining women from the poorest communities who have often fought alone against the socioeconomic risk factors that contribute to domestic violence and often to firearm usage by women or against women. She observed, "There is a spiritual aspect to this subject. . . . We are in a sense addressing the highest morality in addressing this issue."

The five principles generated by the Friedan Symposium focus on the rights of communities and families to be free from firearm-related violence, rather than focusing on the issue of individual rights and responsibilities and re-interpretations of the Second Amendment, as gun ownership advocates often do. The five principles concluded that:

1) Freedom from fear is a basic human right. Women, children and families have the right to be free from firearm violence in streets, schools, workplaces, and especially in the home;

2) Firearms more often kill and maim than protect;

3) Firearm violence is a health, safety and economic issue for women, children and families, because it costs thousands of lives and billions of dollars every year, as well as the costs of family disruption, mental distress, and continuation of the cycle of violence;

4) Women of all races and classes suffer from the epidemic of firearm violence and need to mobilize to stop it without fear that gun control be characterized as a liberal, feminist issue; and

5) The means to diminishing firearm violence is public policy and legislation that limits availability of handguns and assault weapons. The result of a safer future for families justifies that firearm control (Trauma Foundation 1995).

CHAPTER II: FAMILY VIOLENCE THEORIES AND PROGRAM STRATEGIES

In this chapter, a brief overview is presented of the prevailing theories, program strategies, and of the broad policy directions that confront those who are concerned about family violence in California and throughout the nation. This overview cannot be exhaustive; theories alone about family violence could fill volumes, and the policy options are myriad. Instead, brief points are made about the array of models that have shaped programs or proposals for intervention so as to clarify the available and feasible policy directions.

UNDERLYING THEORIES AND PROGRAM PRINCIPLES

American Psychological Association Theoretical Categorization

At the root of understanding family violence is the question of "how do people become violent?" Rather than reviewing the many published accounts of environmental and genetic factors that contribute to or predispose violent behavior, it suffices to assert that the strongest developmental antecedent or predictor of a child's involvement in violence is a history of previous violence (American Psychological Association 1993; hereafter, APA 1993). The APA asserted that, although the form and the absolute level of an individual's aggression can vary considerably over his or her life span, an individual's relative level of aggressive behavior shows remarkable continuity and predictability over time, from setting to setting. For this reason, effective intervention against violent behavior during childhood is critical. This presumption, supported by its corollary assumption that "the earlier such intervention, the better," form the cornerstone for the vast array of theories and program principles that conceptually uphold most current family violence interventions.

The APA broadly outlined and categorized the various developmental antecedents that have been associated with family violence and youth violence. They include:

The Nearly Inseparable Contributions of Nature and Nurture

For example, the respective roles of inherited factors and acquired biological factors (such as birth trauma or head injury), and of learned psychosocial factors (such as stereotyped gender roles).

Family Characteristics and a Breakdown of Family Processes

These include criminal history or antisocial personality attributes in a parent, parental rejection of a child, lack of supervision, and inconsistent and physically abusive parental discipline. In addition to the breakdown of family processes, these families are also characterized by the failure to build up individual processes, such as "resiliency," or the buffering effects generated by positive interactions with parents and other adults that probably yield protective effects against violent behavior, both early on and throughout life.

School Factors and Academic Achievement

These include aggressive, disruptive or "acting-out" classroom behavior that contributes to poor school achievement and poor peer relations. The APA also pointed out that certain physical characteristics of schools ought to be scrutinized for their propensity to create a milieu that is conducive to aggression, such as high numbers of students occupying a limited amount of space, poor building design, and the imposition of behavioral routines and conformity in the school environment that contribute to feelings of anger, resentment and rejection of adult figures, including teachers.

Emotional and Cognitive Development

These include cognitive deficits that sometimes accompany Attention Deficit Hyperactivity Disorder (ADHD). The APA was prompt to point out that children with ADHD do not develop violent behavior, but when combined with other predisposing factors such as conduct problems in early grades, a diagnosis of ADHD may indicate an elevated risk status for later delinquency or violence, as much because of inadequate learning of prosocial skills and moral concepts as because of the anticipated somatic imbalances and cognitive deficits associated with ADHD. Even those youngsters not abused with ADHD, however, can suffer from poor emotional and cognitive development. Inadequate impulse control puts an individual at risk for violence only if violent acts are that person's preferred response learned through past experiences. Cues in the environment, such as the accessibility or glamorization of firearms, can trigger violent responses, depending on past associations with such cues.

Influence of Social and Cultural Factors on Cognitive Development

For example, depictions of violence in the mass media can in turn reinforce tendencies toward aggression for those children already characterized by aggressive behavior. On the positive side, the APA pointed out that early exposure to appropriate cultural influences can also help children build positive ethnic identities and a sense of belonging to a group with shared traditions and values, which may help buffer the child against those inappropriate social and cultural risk factors that are associated with violence. In the context of intervention, it seems worthwhile to focus on enhancing or upgrading these "buffering" social and cultural factors or reinforcers so as to mitigate the opposite reinforcing effects on children of violent behavior, either in the mass media or at home.

Attitudes Toward Violence in the Larger Society

The APA observed that violence is woven into the fabric of American society, and that Americans exhibit an ambivalent relationship with violence, ranging from abhorrence and shock, to embracing violence as a desirable or defining characteristic of folk heroes, sports icons, and media images. Although few Americans would claim to enjoy or encourage violence, many passively condone aggression and violence through acceptance and consumption of current film and television productions.

Poverty and Socioeconomic Inequality

The APA noted that violence is most prevalent among the poor, regardless of race. The APA Commission on Youth and Violence concluded that, despite public stereotypes, it is very likely that socioeconomic inequality, not race, facilitates higher rates of violence among ethnic minority groups, which often exhibit elevated poverty rates. Moreover, the APA observed that poverty is not just the lack of money. Rather, it defines the context in which poor people must live and interact. The urban-suburban dichotomy in society contributes to a propensity to be exposed to violent behavior more often in the inner cities. Poverty is relative deprivation as well as absolute deprivation, too, such that the current lack of basic necessities or socially desirable attributes is compounded by the awareness among poverty-stricken people that they also lack the opportunities needed to obtain them in the future. Media images of the "good life" also compound the conditions of poverty with a sense of heightened deprivation. With these observations in place, conceptually it is not difficult to assert that poverty and unemployment discourage family stability, undermine self-esteem in both individuals and families, lessen social and emotional support that could yield resilient or buffering effects, and foster family disruption.

Prejudice and Discrimination

The APA authors indicated that prejudice and discrimination foster social and psychological difficulties for all vulnerable populations. Discrimination can operate in different ways, but it is always pernicious. Even when discrimination is overturned either by the courts or by changing social mores, the legacy of fear, hate and pain in abused groups can remain, to become a salient risk factor for family violence. Discrimination also contributes mightily to economic disparity between minority and non-minority Americans. Pertinently, discrimination is enacted not only at the group level, but also at the individual level, for example through harsh speech and invective, which replaces dialogue and cooperation as the preferred mode of relating to people of other classes or races. Discrimination, whether exhibited economically, socially, or interpersonally, lowers self-esteem in discriminated persons, thereby elevating their risk status for becoming perpetrators or victims of family violence.

Access to Firearms

The APA's theoretical categorization of family violence antecedents includes the presence of firearms in people’s daily lives, at home, in the workplace, and at school. Whereas hand-to-hand violence or aggressive speech might have been the "weapons of choice" formerly for abusive family members, with firearms handy, their abuse becomes much more lethal and far-reaching. A spouse's reliance on a firearm makes an impression on a child witnessing violence in the home: the firearm itself becomes a reinforcer for aggressive behavior. Those at whom the firearm is aimed suddenly pay attention, or pay much more respect to a family member who is already has low self-esteem or an inability to interact capably with other persons. The "nature or nurture" issues of how an abusive family member became predisposed to violence become secondary in importance when a firearm is at hand. By that point, predisposition has already turned into disposition. The APA criticized both the lack of focus within existing family violence intervention programs on preventing violence with firearms, and also the long-term detrimental effects of witnessing

teachers and school administrators having to work harder at disarming students than at teaching them.

Involvement With Alcohol and Other Drugs

The APA found that nearly all its theoretical categories intersected with theoretical underpinnings of substance-abusing behavior. Alcohol lowers inhibitions against violent behavior, and the venues in which alcohol or other drugs are consumed often become the venues in which family members are abused. Moreover, the abuse of alcohol and other drugs by parents suggests to children that substance abuse is not only condoned, it is also warranted as a "tool" or "accessory" to the acting out of violent behaviors and the resolution of interpersonal conflicts. Parents who abuse controlled substances put their children at greater risk for violent victimization or neglect, and simultaneously expose their children to the risk of abuse by others outside the home.

Involvement in Antisocial Groups

The APA pointed to gang violence and participation in violent mobs as logical outcomes to the seeking by all young people for a sense of connection, belonging, peer friendship, pride, and self-definition apart from their families. Gang membership in itself should not be seen as an aberrant behavior given these reinforcing qualities. One important feature of gang membership is the tacit acceptance of, and participation in, hyper-vigilant attention to being slighted or offended by another person. Thus, disputes over girlfriends or boyfriends, territorial boundaries, rumors, perceived hostile "looks," ethnic tensions, and the sale and consumption of controlled substances, take on a much more motivating force for persons already abused by low self-esteem. Such persons compensate for their lack of self-esteem by “acting out” in order to convince themselves of their own potency or importance.

Gang demographics changed during the 1980s in the United States. Where they were formerly confined to inner cities and teenagers, gangs are now present in suburban areas and are accommodating a wider age range, with members as young as pre-teenage years and as old as their early thirties. Although young women do participate, gang activity and gang violence are overwhelmingly male phenomena. Mob violence also serves many psychosocial needs, including devaluing the targeted person or property, creating social change (in the context of political protest), or to benefit materially. Even though gang and mob violence may seem to be external to the home environment, the deficiencies that are satisfied by gang membership or mob participation are spawned at home. A "continuum of violence" is begun at home, and like a "contagion" the violence that is inflicted upon family members can be exhibited in other ways in the streets, where it may be just as reinforcing as in the home.

Exposure to Violence in the Mass Media

The final core element of the APA's theoretical categorization is one of the most pervasive and important: media portrayals of violence. American children are the heaviest consumers of television products; cable television and videocassette recording capabilities have deepened their consumption. Aggressive children who have trouble in school and in relating to peers tend to

watch more television; the violence they see there, in turn, is believed to reinforce their tendency toward aggression, further compounding their perceived academic and social failures. Viewing violence increases an individual's fear of becoming a victim of violence, with a resulting increase in self-protective behaviors and increased mistrust of or inability to communicate with others. These are seen as the seeds of family disjointedness and the root of family violence. Viewing violence increases desensitization to violence, resulting in callused attitudes toward violence directed at others, and a decreased likelihood to take action on behalf of a victim of violence when it occurs.

Behavioral apathy combines insidiously with an appetite to participate in violent behavior because it is glamorized, and because violence is apparently such a useful means of achieving one's desired ends, whatever they may be. The APA also observed that film and television portrayals of women in victim roles, and ethnic minority members in aggressive roles, exacerbates violence experienced by women and by ethnic minorities. The pervasive media images become less and less a reflection of real life, and more and more real life itself. In film and television portrayals of sexual violence, it is the message about violence, more than the titillating sexual nature of the materials, that appears to affect the attitudes of adolescents about rape and violence, both among young boys and young girls. Also, media images that depict women as erotically surrendering to a rapist and willingly being raped have been shown to increase men's beliefs that women desire rape and deserve sexual abuse.

Media images that depict battered women retaliating against battering spouses, while possibly contributing affirmatively to the perception that battering must be mitigated, contribute negatively to the satisfactory resolution of domestic violence crises. They encourage women to take matters into their own hands, violently and often lethally, rather than seeking help from social supporters, or through legitimate intervention programs like shelters and protective court orders.

The American Psychological Association concluded that the promising programs are those aimed at reducing risk factors, or at strengthening families and children, to help them resist the effects of detrimental life circumstances. The APA noted that effective programs share the following characteristics:

- Draw on the understanding of developmental and sociocultural risk factors that lead to antisocial behavior;

- Use theory-based intervention strategies that have known efficacy in modifying behavior, whose designs have been previously validated, and whose outcomes have been previously measured;

- Emphasize early intervention to interrupt the “trajectory toward violence;”

- Address aggression as part of a constellation of antisocial behaviors in children and young adults, in particular as aggression is manifested as a symptom of poor interpersonal relationship skills, cognitive deficits, attributional biases, and scholastic difficulties or under-achievement;

- Have multiple components that reinforce each other across the child's social contexts, including the family, school, peer groups, and in the media; and

- Take advantage of developmental "windows of opportunity," defined as points at which interventions are especially needed or especially likely to make a difference, including points of transition in a child's life such as entry into preschool, beginning of elementary school, immediately following the witnessing of a violent act, and during adolescence.

In its report, the APA Commission on Violence and Youth continued to comment on effective primary and secondary prevention programs, school-based programs, interventions for high-risk children, and the design and further evaluation of intervention programs. Several of the APA's recommendations regarding the entertainment and news media are noteworthy. The APA concluded that television and other media can contribute to the solutions, rather than to the problems, of youth violence.

The APA noted that research investigation of television and other media, while painting an overall negative picture of the contributing effects of televised violence on actual violent behavior, has also provided some techniques by which the effects of violence can be mitigated through the teaching of critical viewing skills. To be consistent with their legal obligation "to serve the educational and informational needs of children," television outlets can be expected to make a larger contribution to depicting value-based, violence-free characters and situations, rather than merely reporting on or portraying violent offenders and violent avengers.

The APA called upon the Federal Communications Commission to review, as a condition of license renewal, the programming and outreach efforts and accomplishments of television stations in helping to solve the problem of youth violence. The APA sought assistance from Congress in supporting a national educational violence prevention campaign, involving television programming, to address the need for publicly-funded violence prevention messages in the mass media, based on the best available scientific evidence about efficacious messages. Finally, the APA recommended revisions to the Film Rating System that would enable viewers or parents to take into account the violence content in a cinematic release, and that require film producers and distributors of cinematic and video programming to provide clear and easy-to-read warning labels for violent material so that all viewers or their guardians can make informed choices about upcoming releases.

Through these dozen broad theoretical categories and the resulting recommendations, the American Psychological Association has contributed a template from which other, more narrow theories can emerge, and on which relevant, effective interventions can be based.

Social Learning Theory and its Derivatives

Another broad theoretical template that contributes significantly to the understanding of family violence is "social learning theory." One author enumerates as many as 16 theories that can be used convincingly to explain family violence and its undercurrents or antecedents (Yegidis, 1992). Most theoretical models focus on psycholanalytic perspectives (McLeer 1988) or on sociological

perspectives (Bersani and Chen 1988). However, one theory emerges as the most useful for providing a model to practitioners and to policymakers: "social learning theory." According to its architect, Albert Bandura (1977), social learning is conceptualized by both a modeling component, and the concept of "reciprocal influence." Reciprocal influence suggests that persons influence their environments and can, therefore, shape their futures. Social learning theory as applied to family violence examines the effects of modeling on behavior, the role of stress, the use of alcohol, the presence of relationship dissatisfaction, and considers aggression as a personality style (O'Leary 1988). "Modeling" in this context represents the observation of physical aggression by the parent(s), or the direct experience of having been physically abused. Modeling increases the likelihood that an individual will use violence to resolve interpersonal conflicts.

In articulating a theory about the antecedents of family violence, Yegidis suggested that violent families can best be described and understood as being characterized by a specific set of psychosocial factors, such as modeling and other attributes of social learning theory, set against the backdrop of impoverished social conditions. Her synthesized "psychosocial-sociocultural dual theory" provides a framework for understanding, and more importantly, for intervening with violent families. First, Yegidis pointed to social, psychological and family process factors that have been correlated with violent families. Pertinent social factors include the observations that abusive families tend to be socially isolated, experience multiple environmental sources of "press" or stress, and have poor capacities for survival and coping. Characteristically, they are likely to be over-represented as ethnic minorities with educational limitations or occupational difficulties. In addition, pertinent psychological factors in Yegidis' "dual theory" include a sense of powerlessness within the abuser, who feels unable to elicit changes in his or her environment. Characteristically, they tend to be immature, inadequate copers with low self-esteem, and demonstrate strong dependency needs. In addition, important family process variables among abusers include poor communication patterns, recurrent family or marital stress, and inappropriate or escalated behavioral expectations of the person or persons they are abusing. Characteristically, family abusers experience these family process variables in the forms of role confusion or reversal, diffident step-family relationships, over-reliance on physical punishment for disciplining, and inadequate knowledge of, or interest in, child-rearing or caretaking.

Yegidis reviews the extensive literature on the relationship between stress, frustration and aggression to conclude that although stress alone does not cause violence, stress can be understood as a stimulus that serves to arouse some individuals. Therefore, in the face of a stressor, and perhaps influenced by having viewed parental aggression at an earlier time, an individual might choose a violent course of action.

Moreover, the relationship between alcohol and family violence is clear, but research reported by Yegidis suggested that there may be two important aspects to this relationship: the disinhibiting effect that alcohol has on behavior, and the expectancy effect, by which an imbiber (or one who witnesses an imbiber in action) can expect certain consequences of ingesting alcohol, such as powerfulness or powerlessness, depending on previous exposures. Thus, alcohol disinhibits family abusers, permitting and accentuating their violent behavior. The expectancy is that violent behavior following alcohol consumption can be excused, and that additional drinking may

consequently lead to further violence, with its incumbent advantages and disadvantages for abusers and abused persons alike.

Finally, to round out Yegidis' dual theory, it has been observed that some degree of marital or family discord must be present for violence to occur in a family. Yegidis noted that an analysis of a typical episode of spousal battery would exhibit a "tension-building stage," followed by an eruption that is often only verbal, then succeeded by a violent encounter. She postulated under her dual theory that abusers are individuals with aggressive-impulsive personality styles who are more likely to get angry, and become angrier, than most other individuals. Psychosocially, abusers face events in their lives impulsively, while socioculturally, abusers face events in their lives as threats or sources of tension and as opportunities for impulsivity. "Psychosocial-sociocultural dual theory" presents a worthwhile starting point for discussion about the effectiveness of existing program interventions, because interventions that do not satisfy the abuser's *dual* responses to life stressors are probably inadequate.

Resiliency and Protective Factors

Attention has justifiably focused on at-risk children and adolescents who suffer from or witness family violence, and the fact that such children often do develop more problems than low-risk children. Amazingly, however, a sizable proportion of these at-risk children become healthy, competent young adults. The first research to report on this phenomenon was Sarah Moskovitz's four-decade follow-up of 24 childhood survivors of the Nazi Holocaust. Sent from concentration camps to a therapeutic nursery school in England after the war, these children considered one woman, the nursery school teacher who provided warmth and caring, as the source of their own personal compassion or acceptance of evil in the modern world (Moskovitz 1983).

The most extensive research conducted to date on resiliency is Emmy Werner's ongoing, 40-year study of the children of Kanai, Hawaii. While she found that one third of the children having four or more risk factors for neglect or poor scholastic and social performance during their childhood were doing fine by adolescence, by age 32 two thirds of those who experienced problems during adolescence were leading successful adult lives (Werner 1989; Werner and Smith 1992). Werner and Smith found that constant feedback early in life from a few adults, not necessarily a parent, gave the resilient infants a basic trust and "a sense of coherence." Youngsters who seem able to cope more successfully bounce back in the face of change or adversity; they seem "buffered" from stress (Neighbors, Forehand and McVicar 1993). They experience less frustration in the face of obstacles, enjoy social interaction, elicit positive attention from others (both adults and peers), and do not give up easily (Rodin 1986; Berkman and Syme 1979.)

The repeated documentation of this "resiliency," the ability to bounce back successfully despite exposure to severe risks, has clearly established the self-righting nature of human development. In published accounts of the resiliency phenomenon, Bonnie Benard of the Western Center for Drug-Free Schools and Communities pointed out that even though educators need to understand and address the stresses that are part of children's lives, they need to also move beyond a simple focus on risk factors, in order to create the conditions that will facilitate children's healthy development (Benard 1991 and 1993).

Benard's profile of the resilient child suggests that he or she is one who "works well, plays well, loves well, and expects well." Such children usually possess four attributes: social competence, problem-solving skills, autonomy, and a sense of purpose and future. When assessing this profile of the resilient child, educators should look beyond superficial personality traits and the ubiquitous temptation to "blame the victim" or "fix the kid." Instead, they should examine the environmental characteristics that have fostered the development of resiliency. Children protected from adversity in families, schools and communities are characterized by caring and social support, positive expectations, and ongoing opportunities for participation. When these are lacking, resiliency falters, and children are much more susceptible to the "toxins" of family violence or the unhealthy influences of the mass media.

Benard also observed that nowhere in the literature is there evidence for either divorce as a risk factor, or "family intactness" as a protective factor, in the development of later problem behaviors like substance abuse. She noted that although divorce is a stressful life event for children and families, her research found that the availability of social support, from family members or from friends, relatives and others in the community, is the critical factor in the outcome for that child. Moreover, the family hardships created by "fatherlessness," or the proclivity in American society for some men to walk away from marital or parental commitments, yielding single-parent households, are plentiful. They are not, however, insurmountable if encouraging resiliency is an end in itself. Resilient children can develop from single-parent or foster-parent households if warmth, high expectations and consistent rules and discipline are present. To mitigate the effects of other risks and stressful life events, and to develop healthily, a child needs the enduring loving involvement of one or more adults in the care of, and joint activity with, that child. In the context of family violence, then, family preservation models of intervention should take stock of which, if either, parent or adult caregiver in a deteriorating or violent family might be the one who can provide the resiliency-inducing attention and expectations that will protect children in the short and long run, rather than prioritizing "family intactness" as the panacea for all family problems.

The attribute of "positive expectations" merits more attention. It provides an insight into how the school environment might augment the need for resiliency-inducing characteristics so lacking in a home that is abused by family violence. Schools that establish consistent and high expectations for all children, and give them the support necessary to achieve those expectations, typically generate students who exhibit academic success. Consistency about rules and discipline appears to be a key factor in defining socially constructed values, and consequently in yielding resilient children (APA and American Academy of Pediatrics 1995).

A high level of student participation in decision making and activities bolsters the positive expectations because it provides an outlet for the basic human need of feeling a sense of control over one's own life. In her research, Judith Brook found that high expectations and a school-wide ethos that values student participation also mitigated the most powerful risk factor for adolescent substance abuse: peers who use drugs (Brook, et al. 1989). In that context, the role of positive expectations outside the home might be considered an attribute that can compensate for a lack of positive (or any) expectations within the home. Therefore, these outside expectations should be fostered as a mitigator against family violence and its consequences. Positive expectations elicited

by parents or educators enable children to see themselves, and others, as winners, worthy of respect, rather than as losers, worthy of discrimination or abuse.

British researcher Michael Rutter found that even in cases of an extremely troubled home environment, "a good relationship with one parent," defined in terms of the presence of "high warmth and absence of severe criticism," provides a substantial protective effect. Only one quarter of the British inner city children studied by Rutter who had at least one good parental relationship demonstrated signs of conduct disorders, compared to three quarters of children who lacked such a relationship. Similarly, children growing up in alcoholic families found that the supportiveness of the nonalcoholic spouse was the most crucial variable in the degree to which the alcoholism impacts the family (Berlin and Davis 1989; Wyman, et al. 1992).

The concepts of consistency in rules and discipline, and of establishing high positive expectations, can be adapted not only for children from abusive or stressful families, but also for educators, and for the adult family members themselves. Benard encouraged teachers to expect high things from their own performance before expecting the same from their students. The APA and the American Academy of Pediatrics also encouraged adults to "take care of yourself and your community," by:

- staying involved in the community;
- contacting legislators about crime issues;
- complaining to television stations and boycotting advertisers that foster violence in the mass media; and
- encouraging youngsters to invest their leisure time in efforts that build pride in the community and make their neighborhoods safer and more rewarding, such as in litter clean-ups or in anti-graffiti mural painting projects.

In this context, adults need to not merely provide the conditions for their children that foster resiliency; they need to also *model* and accentuate or bolster those conditions.

PROGRAM STRATEGIES

An exhaustive itemization of suitable program intervention strategies against family violence is beyond the scope of this paper. However, several broad program intervention strategies are worthy of attention:

- Mandatory reporting laws for elder abuse;
- Domestic violence intervention strategies that include battered women's shelters and the "shelter movement" model of empowerment, batterer intervention models, and health care provider protocol models (especially among emergency responders);
- Physician-oriented intervention models, especially among pediatricians; and
- "Multisystemic Therapy" for treating antisocial behavior in youngsters.

Elder Abuse

One reason elder abuse has received more attention in research and the media in the past two decades is that the population is aging. According to the NARCEA, by 1988 all states had legislated some form of protection for elders, although they differed by definitions and mandatory versus voluntary reporting stipulations. Forty-five of the states required by law that certain professionals, and the general public in some states, report suspected elder abuse in domestic settings. These reporting mechanisms are complemented by other mandatory reporting laws affecting institutional settings.

But what type of reporting system works best for elder abuse? Mandatory reporting by health and social service professionals, similar to child abuse reporting systems, can be ineffective in elder abuse, or may detract from the rights of the abused elder. Most elders, though frail, are competent and have rights of self-determination. Despite those facts, some elders refuse treatment, or may be embarrassed that a family member is abusive. Elders may be embarrassed that they cannot avoid the infliction of abuse or defend themselves against it. On the other hand, voluntary reporting makes sense because of the stark paucity of resources, support services and judicial infrastructure that would have to be in place in order to adequately handle referred cases under mandatory reporting. Even though in 1991 the U.S. General Accounting Office reported that state officials found reporting laws effective, the federal government has not yet required states to enact standardized reporting laws.

Domestic Violence

To date, interventions have focused on women abused by male batterers. Such interventions include shelters, aggressive police response, legal action, and legislation. One very important intervention involves the role of health care practitioners who, by virtue of their medical encounters with domestic violence victims, are in a vital, unique position to report violent events or their suspicion of battery, to provide incidence data for epidemiologic studies, and to form a linkage between the person suffering from domestic violence and the appropriate follow-up care he or she will need, or to elicit the extrication of one or more parties from violent relationships.

Battered Women's Shelters and the "Shelter Movement"

Battered women's shelters present much more than just a "Band-Aid" response to the problem of domestic violence. These houses and brick-and-mortar facilities represent an important life-saving intervention. Shelters are also a critical component of the community's efforts to ensure the safety and protection of abused women and children. Making safe shelters available for battered women and their children is essential to ensure such protection, particularly for low-income, or minority women who may lack the financial or culturally appropriate resources to find safety elsewhere.

Shelters provide refuge and a safe place for women, along with other essential supportive services that are designed to mitigate the risk factors associated with domestic abuse. Such follow-up services include legal, economic and housing assistance, medical advocacy, court accompaniment,

employment and job training assistance, support groups for residents and non-residents, and child care and special children's counseling programs.

Beyond performing crisis intervention and providing essential services for abused women, advocates for, and workers in, battered women's shelters have contributed to an informal but broad-based "shelter movement." This is bolstered by an activist philosophy that encourages empowerment among all women. Safety at home, as well as safety in the streets, has been the theme of numerous "Take Back the Night" rallies and marches among women in cities all over America. Lacking such safety, concerned men and women have advocated safety nets provided by a network of public and private battered women's shelters and safe houses where women and children can endure crises and begin re-configuring their lives and families following abusive incidents.

In a "wellness" context, the shelter movement has been more widespread than the proliferation of brick-and-mortar shelter facilities because the shelter movement represents an important grassroots effort toward bringing about the types of social and attitudinal changes that are necessary to prevent and diminish domestic violence. For example, advocates for battered women, working through shelter programs, have lobbied to pass important state and federal legislation on domestic violence. Shelters or shelter-related projects are often the focal point for educating the community at large about domestic violence, for training law enforcement and other professionals who often confront domestic violence in their work, and for establishing or evaluating counseling and educational intervention programs for men who batter.

Batterer Intervention Models

Efforts at developing batterer intervention strategies have been primarily in the form of counseling or educational groups for men who abuse or batter their female partners. The earliest renditions of this strategy emerged in the late 1970s, in response to prompting from advocates for battered women, and the concerns of community-based men's groups. These consciousness-raising groups gradually adapted techniques and exercises from cognitive and behavioral therapies that reinforced their anti-sexist messages (Edelson and Tolman 1992; Gondolf 1995). By the mid-1980s, other skill-building approaches and brief therapies were developed by clinical psychologists and social workers for adaptation to the batterer population. Court-mandated counseling, encouraged by the pro-arrest laws passed in many states in the late 1980s, has dramatically increased and diversified batterer programs. These strategies range from pre-trial diversion, plea bargain and condition of bond, to conviction and sentence or probation supported by counseling.

These programs operate in a gender-based, cognitive-behavior modality. Men are confronted with the consequences of their behavior, held responsible for their abuse, have their rationalizations and excuses confronted, and are taught alternative behaviors and reactions. However, other competing modalities also exist and are practiced in intervention, including healing men's trauma, redirecting emotions and anger, and addressing couples' communications and interactions, sometimes with the battered spouse or children present (Jaffe, Wolfe and Wilson 1990). There are also variations in format, duration, training and content. Differences among experts persist over whether male batterer intervention programs ought to include more

counseling, education, or therapy; whether "brief therapy" (usually about three months) is sufficient and legitimate, or should be extended to a minimum of one year; and whether to introduce mental health concerns and treatments to batterers. All told, batterer intervention strategies are characterized by variation over philosophical iterations, and by practical programmatic practices that yield evaluable results.

Rather than ask whether batterer counseling programs work, it may be more suitable to ask what kinds of men are most likely to change their behavior, and under what circumstances. Reviews of batterer programs indicate cessation of violence in a substantial proportion of program completers (at least 60 percent), and less impressive but less well-documented reduction in verbal abuse and threatening behavior (Gondolf 1995). Methodological shortcomings, such as short-term follow-up and reliance on self-reported measures, dilute the research findings on what types of men are most likely to benefit from batterer interventions. It may be more appropriate to assess program dropout and noncompliance rates as a tool for comparing the various modalities in batterer intervention programs. Program dropout rates may be correlated with recidivism, and therefore might be supported by quantifying the continuing of safety and protection for the battered women targeted by those abusive men who dropped out or did not comply with court orders to accept batterer intervention. In sum, batterer intervention programs, while valuable, are very difficult to evaluate, a fact which diminishes their *prima facie* acceptability as a dominant intervention strategy. These programs require collaborations of practitioners, abused spouses, evaluators and the batterers themselves, which may be such a volatile mix that success cannot always be considered forthcoming from these interventions.

Health Care Provider Protocol Models

With approximately two million women severely assaulted or abused by male partners in the U.S. every year, the involvement of health care providers with experience addressing family violence provides a significant and potent opportunity to intervene. Health care practitioners are increasingly aware of the magnitude of domestic abuse. They have unique opportunities to intervene promptly in individual cases. Then, at a slower but no less vigorous pace, they have unique opportunities to advocate change on a broader, population-wide scale. One of the most important tools available to health care providers is their modern arsenal of protocols, which are to be followed in generally clinical settings, in an effort to standardize care and the gathering of pertinent information. These protocols guide the practitioner's approach to the patient, enabling him or her to match the needs of abused patients with available law enforcement, judicial, child protective and social service resources.

In addition to many state statutes that now mandate reporting of suspected domestic abuse by physicians and other practitioners, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires, and the U.S. Department of Health and Human Services, in its health status objectives for the year 2000, recommends, that hospital emergency departments employ protocols for identifying and treating victims of domestic violence (JCAHO 1992; U.S. Department of Health and Human Services 1991a). In order to receive JCAHO accreditation (to which Medicare and other reimbursements are linked), such protocols must also be in place for other forms of abuse and family violence. In the case of child abuse fatalities, protocols have been

an important resource for distinguishing sudden infant death syndrome (SIDS) fatalities from prosecutable child abuse fatalities such as the inflicted cerebral trauma of "shaken baby syndrome" (American Academy of Pediatrics 1993 and 1994).

The use of domestic violence protocols in recent years has been shown to increase the rate of identification of battered women from 5.6 percent to 30 percent (McLeer and Anwar 1989). The American Medical Association recently published health care goals for the identification and treatment of suspected victims of domestic violence (Council on Scientific Affairs 1992; Hyman, Schillinger and Lo 1995). These goals, manifested in protocols adopted by individual hospitals according to their own patient mix and level of emergency services, provide guidelines for medical settings on developing systems and procedures to identify and assess current or past abuse. Such protocols help health care providers in pertinent license categories overcome some of the barriers they commonly encounter in addressing the needs of abused women. The protocols describe the prevalence of domestic violence and the abusive cycle, profile victims and perpetrators, provide sample scripts in several languages for initiating discussion, describe legal issues to consider, and provide information for abused women about referral sources.

In a California survey, despite the JCAHO requirement for such training, only one in four emergency departments had conducted educational or specialized training sessions focused on domestic violence. Among those that had the training, the most common format (29 percent) was in a conference setting, rather than in chart review or on medical rounds. Among the 135 responding emergency departments of 397 emergency departments statewide that submitted protocols and referral lists for review, only 54 percent were specific to partner or spousal abuse, rather than more broadly to all forms of abuse (child, elder, sexual, etc.). This suggests that less than one in five California emergency departments were explicitly equipped to handle domestic violence referrals and follow-up. Of the domestic violence-specific policies submitted for review, most did not meet all JCAHO requirements for the essential elements of the protocol, including guidance on medical record entries about treatment, referrals, and notification of appropriate authorities. The authors concluded, "If hospital policies ignore the needs of battered women, these patients will continue to move anonymously through the (emergency department) doors suffering from escalating violence after each visit" (Lee, Letellier, McLoughlin and Salber 1993).

Physician-Oriented Intervention Models

In tandem with the development of mandatory health care provider protocols for reporting suspected cases of child or elder abuse, and with the burgeoning growth of emergency medicine as a recognized medical specialty in the last two decades, several types of physician-oriented intervention models have been developed. Because emergency physicians constitute the "front line" of defense against unreported family violence, their testimony and observations about the effects of substance abuse and of firearms have been taken much more seriously in recent years. Their peer-reviewed journals have also exhibited meaningful quantifications of the results of violence seen frequently in emergency departments.

"Clinical violence intervention" is defined by the three levels of prevention: primary prevention, in which professional change and attitudinal shifts are accomplished; secondary prevention, in which

the doctor-patient relationship is fostered in order to achieve the truth about domestic violence injuries; and tertiary prevention, in which health care organizations like the JCAHO, and the specialty societies for emergency physicians and pediatricians, develop guidelines for all providers to approach family violence problems in the clinic uniformly (Flitcraft 1993; Hyman, Schillinger, and Lo 1995).

Once again, pediatricians have taken the lead in developing the policy guidelines, intervention protocols, and peer-reviewed literature for their colleagues who treat both somatic and psychological consequences of family violence, (Christoffel 1992). Pediatricians led the movement for mandated reporting of child abuse in the 1970s. By addressing violence in the lives of their young patients, pediatricians can make the clinical setting responsive to the needs of youth at risk. During their contacts with young patients and, in many cases, their patients' parents, pediatricians can begin to discuss family violence, its consequences, and its prevention (Montes 1993). To be effective, however, pediatricians must first feel comfortable and knowledgeable talking about the issue. To that end, pediatricians' societies, such as the American Academy of Pediatrics, have asserted leadership in training colleagues to confront their own attitudes about family violence, as well as to recognize its effects clinically (Christoffel 1991; Wilson-Brewer 1994). The Academy has also collaborated with the Center to Prevent Handgun Violence to develop programs that encourage the safe storage and locking of firearms in the home.

More generally, physicians of all specialties and practice types are collaborating in groups like Physicians for a Violence-Free Society (PVFS), a national organization formed to help physicians assume a leadership role in violence prevention (Salber 1993). PVFS began on the premise that physicians can not only lead research and evaluation studies on violence prevention, but also must explore new ways of teaching patients about non-violent approaches to conflict resolution, and institute appropriate interventions. Because such skills are seldom taught in medical schools, PVFS and similar regional medical societies were founded, in part, to help close this gap in physicians' medical knowledge. This intervention strategy reinforces the link between violence prevention and the medical care system, and promotes the idea that physicians are obligated to play leadership roles in both their medical practices and their communities.

Through physician intervention strategies, the public health approach to family violence is heightened in importance and visibility. Early detection of violent behaviors, coupled with strategic involvement of physicians in the media and throughout their communities, is essential for this intervention to bear fruit. Through the 1990s nationwide and in California the role of physicians and other health providers as agents of violence prevention cannot be under-emphasized (Rosenberg 1994).

Multisystemic Therapeutic Strategies

The "multisystemic" approach to family preservation, and by extension, to the risk factors associated with family violence, links family violence perpetrators to causative factors within the family, peer, school and social networks of family violence perpetrators. This approach to treating serious antisocial behavior has been successfully applied to adolescents. As a result, a

family- and home-based approach has recently emerged for interventions against violence, even in families of diverse cultural and socioeconomic backgrounds.

Family preservation is a model of service delivery based on the concept that some children's problems and needs can be effectively addressed by helping their families. Family preservation services are designed to fill the psychological, social, educational, and sheltering needs of some disrupted families whose children are in imminent danger of being removed. In these cases, even when characterized by multiple deficits, the families are considered valuable resources. These services are provided in a wide variety of settings, including home, school and other neighborhood and community settings. The effectiveness of multisystemic therapeutic strategies applied in family preservation programs has also been demonstrated (Henggeler 1995; Henggeler, Melton and Smith 1992).

Henggeler and associates have developed a set of general principles for designing multisystemic interventions, which can be adapted for application in case-based or community-wide interventions against family violence, as defined in this background briefing report.

- The primary purpose of assessment in multisystemic interventions is to understand the "fit" between the identified problems and their broader systemic context;

- Multisystemic interventions should be present-focused and action-oriented, targeting specific, well-defined goals;

- Multisystemic interventions should target sequences of behavior within or between multiple "systems," or environments;

- Multisystemic interventions should be developmentally appropriate and should fit the developmental needs of youth, both those who have been exposed already to family violence, and those who exhibit elevated risk status;

- Multisystemic interventions should be designed to require daily or weekly effort demonstrated by family members, to enhance consistency and commitment by each participant;

- Multisystemic intervention efficacy must be evaluated continuously from multiple perspectives. Frequent feedback between an abusive family member, the abused family member(s), and a therapist supports the avoidance of devoting extensive time and energy to unproductive solutions which probably characterized the family's violence-prone period anyway;

- Multisystemic interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change. Interventions should emphasize the development of skills that are to be used in the natural environment. The therapist should ensure that youths and family members have the motivation and ability to maintain a positive trajectory on social and family skills when the intervention is due to expire;

- Multisystemic interventions should accentuate the positive, and interventions should use systemic strengths as levers for change, strengths like parental concern for an adolescent's welfare, or a child's artistic or athletic prowess or other involvement in pro-social behaviors or peer activities; and

- Multisystemic interventions should be designed to promote responsible behavior, and to decrease irresponsible behavior among family members, emphasizing, as in a "wellness context," that achieving personal responsibility for one's own health and welfare can be adapted to the achievement of familial responsibility for preserving the family's health and welfare (Henggeler, Melton, Smith, et al. 1993; Henggeler 1994).

Adhering to these guidelines and principles supports the efficacy of family violence intervention programs based on multisystemic interventions, given the multifactorial nature of family violence and the multitude of risk factors faced by individual family members. Evaluation components are essential in multisystemic interventions, but further research is necessary on their widespread applicability in culturally diverse family settings.

CHAPTER III: POLICY DIRECTIONS IN FAMILY VIOLENCE

The outline for policy directions presented here follows the model developed and implemented by the California Attorney General's Policy Council on Violence Prevention. Following public hearings in 1994 and 1995, these were published in the Attorney General's final report entitled *Violence Prevention: A Vision of Hope* (California Department of Justice 1995).

The Attorney General's Policy Council began its work acknowledging that violence is a multifaceted problem impacting individuals, families and communities. This background briefing report makes the same acknowledgment about family violence. In responding to violence in general, the Attorney General's Policy Council also adopted a public health framework, and stated that everyone must take responsibility for the problem of violence in society. One important aspect of achieving wellness, both individually and collectively, is the adoption of "personal responsibility" as a cornerstone of behavioral change and efforts toward improving health status. In that respect, the focus of the Attorney General's Policy Council on responding realistically, but positively, to general violence in California has also been adopted within this report.

The Attorney General's Policy Council held public hearings to receive testimony from experts and community members about the problems of violence in California. These hearings generated a thorough review of the prevalence and impact of violence, the contributing risk factors to violent behavior, and most importantly, a conceptual framework for the common ground that would support successful community action against violence. The Policy Council proposed an approach to achieving a violence-free society that involves:

- Embracing violence-free attitudes;
- Adopting an asset- or strength-based view of family and community;
- Applying effective principles to community-building, and
- Focusing on prevention at all levels.

The Policy Council considered that the following violence-free values ought to be experienced more frequently in society, and are the underpinnings of the violence-free society they envisioned:

- The inherent belief that all people matter;
- Respect for diversity;
- The expectation that all people must exercise personal and social responsibility, and
- Demonstration of a concern for the health and welfare of communities.

The Policy Council viewed adopting an asset- or strength-based view of family and community as essential, in the context that families and communities must be seen as naturally resilient and able to identify and solve their own problems. The role of family, community and government is to nurture the healthy development of individuals, with an emphasis on fostering independence, not dependence, as had been the case under older "deficit-based" models of intervention. Instead, communities must be built from within, with government in a supporting role, embodied in such

movements as community policing, school-based service delivery models, or the public health approach to violence prevention.

The Attorney General's Policy Council developed ten major common ground initiatives for multidisciplinary, community-wide responses to violence. Each of these ten major initiatives can also be successfully applied to understanding and preventing family violence in a wellness context. The Policy Council concluded that, to achieve a violence-free society, governments and communities must promote policies and strategies that:

- Increase the constructive use of media to deglamorize violence and promote non-violent social norms;
- Reduce deaths and injuries from firearms;
- Reduce violence associated with alcohol;
- Strengthen communities and schools by expanding local ownership and control;
- Support families, recognizing them as the basic institution for developing and nurturing children;
- Foster and support violence-free relationships;
- Ensure the development of healthy and responsible youth;
- Recognize that all people matter, fostering a respect for diversity;
- Advocate for personal and social responsibility, and
- Support violence prevention research and evaluation based on the public health framework.

These ten common ground initiatives apply particularly well to addressing family violence. The following expands on each initiative developed by the Attorney General's Policy Council for the reader's consideration.

The Media

Experts suggest that advocates for understanding and preventing family violence need to call upon the entertainment industries and news media to exercise more corporate responsibility by limiting exposure to the toxic agent of family violence. Violent behavior in general should not be glamorized. Specifically, portrayals of domestic violence in entertainment and the news media should not focus on vengeance or violent response as a woman's only viable response to a domestic violence situation; instead, alternatives such as shelters and batterer's intervention programs should be portrayed, affirmatively and supportively. Similarly, access to guns should be portrayed as limited only to safety-conscious adults and parents, rather than portraying guns as toys in the hands of youngsters or as tools for peacemaking in the hands of abusive adult partners. Actors who portray parents who lock up weapons, or better yet parents who emphasize violence-free methods for responding to conflicts, are doing a service to their craft, and also improving the quality of programming (Wallack 1995).

Firearms

The public health framework for reducing injuries and deaths due to firearms requires multi-faceted actions by all levels of government. As it applies to family violence, the Policy Council's firearms initiative can be adapted to focus on removing firearms from the home environment. As a guideline for community action, removing firearms from homes could support, then supplant, efforts toward educating families about locking firearms and making them as inaccessible as possible to inappropriate users in the home, such as young children or mentally disturbed members of the household.

Alcohol

Some alcohol purveyors are moving aggressively in their advertisements to discourage driving while intoxicated. It may also be time to advocate for alcohol industry-sponsored advertisements that encourage responsible drinking as a method of reducing violence toward dates, spouses, or children. Social marketing concepts that have successfully discouraged drunk driving during the last generation can be applied to discouraging violent behavior and battery as ordinary responses to stressful events in a family or home environment. Also worth noting are strategies that focus on issues of alcohol availability and pricing. For example, some communities, such as Oakland, California, are limiting availability through zoning regulation.

Community

Adopting the asset- or strength-based model for community involvement against general violence works equally well in the context of understanding and preventing family violence. Sufficient evidence exists to suggest that, despite being raised in violent homes, resiliency factors do affect and stay with some children. These resiliency factors, such as establishing high expectations and demonstrating unconditional love, have been demonstrated to elicit "buffering" or preventive effects against the destructive tendencies seen in violent relationships. Developing community standards, such as respect for the family, is deemed essential to the concurrent development of the idea that violence against family members is an intolerable set of behaviors upon which the community justifiably frowns. These include respect for the achievement of marriage, and the expectation that fathers will stay with the mothers they impregnate and the children they helped to conceive.

Family

The Policy Council's Family Initiative recommendations focused on methods to strengthen families by providing early, comprehensive, and integrated services and support programs to counter the negative effects of the multiple risk factors for violence like poverty, substance abuse, and physical and mental disorders. These methods are akin to those required to reduce the tide of family violence. Pertinently, communities could be organized in ways that enable families to develop and practice relationship skills, such as parenting, communicating, conflict and anger management. Teaching these relationship skills should be based in traditional and non-traditional

delivery systems, taking full advantage of ethnic and cultural diversity, thus enhancing the successfulness of targeted family interventions.

Relationships

In the same context that the Policy Council recommended that society adopt the belief that "there is no excuse for domestic violence," in understanding and preventing family violence, it is essential to broaden the "no excuses" concept to encompass elder abuse, child abuse, domestic violence, and the intolerability of youngsters having easy access to firearms in the home. The existing social tendency to "look the other way" or to not get involved should be thwarted so that both individuals and groups will consider it ordinary behavior to intervene against episodes of family violence, thus acting individually and collectively to remove the toxic agent from the host environment, the family.

Youth

Even though the factors that perpetuate youth violence are complex and require comprehensive and thoughtful solutions, the Policy Council's focus on early intervention in childhood also applies to understanding and preventing family violence. Children should be exposed to strong social cues that violence against a family member is neither ordinary nor acceptable behavior. This would in turn encourage negative reaction, opposition, and capability to act against family violence episodes if children are ever exposed to them. Media accounts or portrayals of strong-willed, upright children who respond affirmatively, but promptly, against domestic violence may do more good than media portrayals of children who take up a gun or knife in retribution against an adult for abusive behavior. This family violence youth initiative recognizes the relatively short window of opportunity to demonstrate to youngsters that appropriate behavior within families is loving, nurturing, and supportive, not violent, vengeful and victimizing.

Respect for Diversity

Essential to the violence-free society envisioned by the Policy Council is expansion of the social value of respect for all people, which leads to respect for diversity. Empathy, compassion, integrity, civic duty and community service are components of that value. Each of these has its proper place in the family and home environment. Absent these conditions, however, the toxic effects of family violence can be spawned. Respect for diversity in a family means recognizing similarities as well as differences, so that the latter do not outweigh the former. The respect for diversity initiative should focus on the commonality of interests among members of a family or within a home setting, even if they individually may exhibit diverse expectations, attitudes or achievements.

Responsibility

Instilling personal and social responsibility, balancing the need for personal gain with community welfare, and developing a community-wide expectation in the ordinariness of delayed gratification, are essential elements in encouraging responsible, non-violent behavior. In families,

placing an emphasis on the primacy of the family over its individual members, and on the importance of delaying an individual member's gratification for the good of the other members, are important manifestations of the Policy Council's responsibility initiative.

Research

Just as the Policy Council called for research and improved evaluation capabilities within violence prevention programs, more research is needed in the root causes of family violence, and in evaluating those interventions that are successful so that unsuccessful ones are abandoned. Limited resources at the state and local level require that inefficient or cost-ineffective programs be jettisoned. Foundation and private grant supporters should be equally vigilant in their efforts to fund those research and interventions programs that present the most likely prospects and opportunities for success (Metzger and Strand 1993). Family violence research initiatives should focus on recent research evidence on the impact of media, the role of social marketing, and on community-based, asset-oriented programs that foster resiliency in youngsters to enable them to ward off the toxic effects of whatever degree of exposure to family violence they endure.

The Attorney General's Policy Council concluded that "violence is everyone's business," and similarly, understanding and preventing family violence is everyone's business. With increased attention and action, the tide of family violence sweeping this nation can be stemmed by developing a society that reaffirms every person's worth, asserts the importance of violence-free values, builds on factors that buffer individuals from the toxic effects of exposure to family violence, and fosters resiliencies to those negative aspects of modern westernized life that preclude society’s promises from being fulfilled.

CHAPTER IV: FEDERAL, STATE AND LOCAL RESPONSES TO FAMILY VIOLENCE

FEDERAL RESPONSES TO FAMILY VIOLENCE

The federal government has responded to the evidence about family violence by providing direct and indirect funds for clinical and social research or data collection, and by supporting state-based intervention programs through grants from the federal Child Welfare Services and Social Services Block Grant programs, among others. Such federal programs are authorized by three prominent federal statutes: the Child Abuse Prevention and Treatment Act (enacted 1974), the Family Violence Prevention and Services Act (enacted 1984), and the Older Americans Act (enacted 1984, amended 1987). The collective importance of these three legislative responses was prominently supported by the Executive Branch in 1984, when the Final Report of the Attorney General's Task Force on Family Violence was issued (Department of Justice 1984). The Attorney General's Task Force report addressed all forms of violence in the family, rather than only spousal abuse, which had been perceived as the "main" or primary threatening form of family violence in America. The Task Force recommended that federal incentive funds be used for three purposes:

- Conducting family violence prevention and awareness campaigns;
- Training criminal justice personnel; and
- Helping to maintain shelters.

In the following subsections, a brief description is provided about federal responses to the various manifestations of family violence.

Child Abuse

The Child Abuse Prevention and Treatment Act (CAPTA; P.L. 93-247) is often cited as the primary federal Act that addresses child abuse or neglect. However, historically the CAPTA contribution has been relatively small, in terms of federal expenditures, when compared to the Child Welfare Services program. CAPTA was targeted in 1995 by the current, more conservative Congress, under the banner of welfare reform, for consolidation into a system of human services block grants to the states. Under the Personal Responsibility Act of 1995, entitlements to CAPTA assistance have been combined with 22 other child welfare, family preservation, and adoption assistance programs into the single Child Protection Block Grant, which is a component of the larger "Temporary Assistance to Needy Families Block Grant to the States."

Under proposed provisions of the fiscal 1996 federal budget, states may use portions of their Child Protection Block Grant monies for state-based child abuse or neglect prevention programs, for programs designed to identify and assist parents or families considered at-risk for abusing or neglecting their children, and to support children in foster care who are removed from abusive environments. The fiscal 1996 federal budget proposed capping the states' entitlements to the Child Protection Block Grant at $3.9 billion nationally, or roughly 4.4 percent of the entire Welfare Block Grant to the States. California is slated to receive about 21 percent of the entire

national Child Protection Block Grant, through a 1996 appropriation of roughly $81.9 million (Federal Funds Information for States (FFIS) 1995).

CAPTA entitlements have been block granted to the states. The Act stipulates that states develop mandatory reporting systems, legislate confidentiality statutes, and provide resources and personnel for prompt investigation of reported cases of child abuse or neglect. CAPTA was the vehicle for innovation in:

- Recognizing and treating child abuse;
- Initiating grant programs for state-based intervention programs designed to minimize the association between substance abuse and child abuse;
- Providing for demonstration grants to public or private nonprofit organizations to support identification, research and treatment activities;
- Offering fiscal support for state-based prosecution of alleged child abusers under the Victims of Crime Act (referenced below);
- Training grants for continuing medical and nursing education curricula on identifying child abuse or neglect;
- Emergency intervention grants for mental health, shelter, and youth service organizations; and
- Challenge grants to encourage states, including California, to develop child abuse trust funds to support long-term research or intervention.

CAPTA is currently administered within the Department of Health and Human Services.

Child Welfare Services Program

The Child Welfare Services (CWS) Program constitutes Title IV-B of the Social Security Act. Funds are provided under this program for child welfare-related services, including activities designed to protect children in at-risk situations, such as investigation of reported cases of abuse and neglect, preventive and supportive services, and removal of children from homes for their own protection. The majority of these funds are expended in the states for foster care expenses. FY 1996 funding has not yet been approved. The House of Representatives' CWS appropriation for FY 1996 is slated to total $250.7 million nationally, of which California's share would be $27.1 million, down from an appropriation of $31.5 million in FY 1995.

California's Child Welfare Services Act is augmented with federal CWS program funds on a 66 percent matching basis, and operates under the auspices of the State Department of Social Services. This state program provides response to allegations of child abuse or neglect, ongoing services to abused children and their families, and services to children in foster care who have been temporarily removed from their own homes. Unfortunately, the federal CWS program's

resources for prevention and intervention alternatives to foster care are capped, while foster care is an open-ended entitlement program.

Domestic Violence

The federal Family Violence Prevention and Services Act (P.L. 98-457) authorized funds to assist states in preventing family violence, providing immediate shelter for abused adults and their dependents, and providing technical assistance and training pertinent to family violence programs. The Act was expanded in 1991 by the Child Abuse Prevention, Adoption, and Family Services Act (P.L. 100-294). Earlier in 1995, the categorical grants funded through the Family Violence Prevention and Services Act were targeted for inclusion in the new Justice Assistance Program Block Grant to the States. Congress stipulated at that time that the funding for this Act and other current categorical grant programs enacted in the Violent Crime Control Act of 1994 would be derived from the federal Violent Crime Reduction Trust Fund.

Historically, the Family Violence Prevention Act authorized demonstration grant programs to the states for establishing, maintaining and expanding family violence prevention and treatment programs, for law enforcement training, and for a national clearinghouse on family violence prevention, with a special focus on education and awareness about elder abuse. Presumably, all such programs would continue, but on a state-based, expenditure-capped formulaic block granted basis. Historically, all programs under the Family Violence Prevention Act have been administered by the U.S. Department of Health and Human Services, Administration for Children and Families, except for the law enforcement training and technical assistance grants, which are administered by the Office of Justice Programs within the U.S. Department of Justice. The proposed Justice Assistance Program Block Grant to the States was budgeted in FY 1996 at approximately $13.3 billion nationally; the California share of that appropriation would total $279.3 million (FFIS 1995).

Support Services for Persons Who Experience Family Violence

The Victims of Crime Act (P.L. 98-473) established the Violent Crime Reduction Trust Fund as a resource for services to victims of crime. Contributions to the fund are made by certain persons convicted of federal offenses. The emphases of this Act involve establishing state programs for compensating those who experience a criminal episode; developing crime victim assistance programs that benefit those who experience sexual assault, spousal abuse or child abuse; and providing and administering state grants for programs related to the investigation and prosecution of reported child abuse cases, authorized under the Child Abuse Prevention and Treatment Act.

At the state level, the eligible services provided under the federal Victims of Crime Act include temporary shelter and other emergency services; crisis intervention services, including toll-free hotlines; services related to court appearances such as transportation, child care, translation and escort services; follow-up counseling services; and supplemental payment for forensic medical examinations. The Victims of Crime Act is administered by the U.S. Department of Health and Human Services. The Victims of Crime Act proposed appropriations for FY 1996 total

approximately $12.2 billion nationally; the California share of that appropriation would total $256.2 million.

Office of Justice Programs, Working Group on Family Violence

An important omnibus federal initiative to thwart family violence in all its forms is manifested in the Working Group on Family Violence, a group established by U.S. Attorney General Janet Reno in November 1993. The Working Group is comprised of representatives from five federal agencies: the Office for Victims of Crime (OVC), the Office of Juvenile Justice and Delinquency Prevention (OJJDP), the National Institute of Justice (NIJ), the Bureau of Justice Assistance (BJA), and the Bureau of Justice Statistics (BJS). The Office of Justice Programs (OJP), the Office of the Assistant Attorney General, and the Office of the General Counsel to the Department of Justice are also involved, with the lead responsibility for the Working Group assigned to staff at the NIJ and OJP.

The Working Group on Family Violence is the successor to the U.S. Attorney General's Task Force on Family Violence established during the first Reagan Administration. This task force generated a 1984 report on family violence that, until 1993, guided federal policy and interagency cooperation to diminish the incidence and long-term effects of family violence. That report concluded that "A great proportion of those who assault both strangers and loved ones were raised in violent households. This is learned behavior. To tolerate family violence is to allow the seeds of violence to be sown into the next generation" (U.S. Department of Justice 1984).

Through the Working Group, the OJP takes an active leadership role in providing assistance to federal and state courts, prosecutors, law enforcers, corrections officials, victim assistance staffs, and others who respond to family violence nationwide. Given the important role of the criminal and civil justice systems, the limited federal resources available to address family violence, and the ambitious goals relative to family violence that were embodied in the 1994 Omnibus Crime Bill, it is important for OJP and the Working Group to examine current efforts, prioritize the use of available funds and resources, and coordinate efforts within the participating agencies. The goals of the Working Group include coordination and planning; knowledge dissemination throughout the federal bureaucracy; identifying and assessing needs for research, evaluation, training, data collection, and demonstration programs; developing an annual report to the Assistant Attorney General on family violence programs; reviewing and commenting on proposed legislation affecting family violence; and participating in national meetings on family violence.

Bureau of Justice Assistance. Among many duties, the BJA operates a discretionary grant program to fund innovative approaches to family violence and to replicate their results throughout the nation. Currently, five BJA discretionary grant-funded programs are in place:

- Violence Against Women Demonstration and Technical Assistance pilot projects, including a project in Santa Clara County, California

- Domestic Abuse Response Team (DART), a project in the Philadelphia District Attorney's Office to contact victims of domestic violence within 24 hours of an arrest, and to offer multi-service coordinated intervention

- Interagency Strategies on Domestic Violence and Stalking, exploring the relationship between domestic violence and substance abuse, and the relative importance of stalking behavior on overall domestic violence

- Regional Seminar Series for States on Implementing Anti-Stalking Codes

- Intervening in Family and Domestic Violence: A Resource Manual for Community Corrections Professionals

The BJA also administers a formula grant program, in which funding levels are determined by the strategy proposals submitted to BJA by each state. In 1993 and 1994, 38 states and territories received funding for family violence projects funded from this program, including, for example:

- Hawaii's Multi-Agency Family Violence Program

- Massachusetts' Attorney General's Elderly Protection Project

- Vermont's Chittenden Unit for Special Investigations, a multijurisdictional effort focused on child abuse and sexual assault

- Texas' San Felipe Domestic Violence Program, focusing on Hispanics and Native Americans

- Philadelphia's Victims of Child Abuse in Substance Abusing Families Program (ChildSAF), a program focusing on "vertical prosecution" and pre-and post-conviction services involving social workers

- St. Paul's Model Child Protection/Probation Enhancement Program

- Ft. Lauderdale's Police Department Domestic Violence Shelter

Bureau of Justice Statistics. The BJS collects, analyzes, publishes and disseminates statistical information on crime, including victimization, offenders, and the operations of justice systems at all levels of government and internationally. BJS programs that relate to family violence and which are under the review of the Working Group include:

- National Crime Victimization Survey, which began in 1973 and which provides measures for rape, robbery, assault, larceny, burglary and motor vehicle theft by surveying more than 50,000 household units and more than 101,000 persons age 12 and older annually.

- National Electronic Injury Surveillance System, a BJS program contracted to the Consumer Product Safety Commission, to obtain injury data related to intentional injuries, especially those related to domestic violence.

- Survey of Prison and Jail Inmates, of which several components pertain to the experience of child and sexual abuse among convicted persons.

National Institute of Justice. The NIJ, in addition to its responsibilities for coordinating the Working Group, focuses on research and evaluation of existing programs, rather than on direct services or grant programs. Many programs are contracted, including the National Criminal Justice Referral Service. The NIJ also has the seminal role of publishing evaluation results for wide dissemination in the field, including such monographs as "The Impact of Juvenile and Criminal Court Processing on Child Victims of Sexual Abuse," and "The Criminal Justice and Community Response to Rape." NIJ also elicits partnerships with other federal agencies and private foundations to achieve its goals of coordinating the nation's efforts toward evaluating family violence research.

Office of Juvenile Justice and Delinquency Prevention. The OJJDP provides national leadership and resources to prevent, treat and control juvenile delinquency, improve the effectiveness and fairness of the juvenile justice system, and address the problem of missing and exploited children. The following substantial programs are currently funded:

- National Court Appointed Special Advocates

- Improving the Juvenile and Family Court's Handling of Child Abuse and Neglect Cases: A Model Training and Technical Assistance Program

- Training and Technical Assistance to Law Enforcement Agencies

- Advanced Training for Law Enforcement on Investigation of Missing and Exploited Child Cases

- Effective Screening of Child Care and Youth Service Workers

- Transitional Living Component for Homeless, Runaway, and Sexually Exploited Youth

- Paul and Lisa, Inc. (Westbrook, Connecticut) Program Prevention and Intervention Efforts

- Child Find Mediation Program

- Training and Technical Assistance for Non-Profit Missing and Exploited Children's Organizations

- Missing and Exploited Children Prevention and Services

- Project Nino Seguro (in Chula Vista, California)
- Funding Support to Increase Capacity of Vanished Children's Alliance
- Proposal to Provide Services to Recovered Previously Missing Children and Their Families
- Missing Children Field-Initiated Programs
- Child Abuse Prosecution Training and Technical Assistance
- National Network of Children's Advocacy Centers
- Model Treatment and Services Approaches for Mental Health Professionals Working With Families of Missing Children
- Investigation and Prosecution of Parental Abduction Cases
- "Remember, They're Children": Using Video to Train Law Enforcement
- Missing and Exploited Children Comprehensive Action Program
- Study of Child Abuse Offenders
- Incentive Grants for Local Delinquency Prevention Programs

Office for Victims of Crime. The OVC was established in 1984 as a component of the Victims of Crime Act, and provides discretionary and formula grants to applicant states and cities, with priority given to those programs that provide assistance to victims of sexual assault, spousal abuse, or child abuse. Current discretionary grant program projects include:

- Children's Justice Act Discretionary Grant Program for Native Americans
- Multijurisdictional, Interagency Model for Investigating and Prosecuting Cases of Child Pornography and Juvenile Prostitution
- Victim Assistance in Indian Country Program (for "on-reservation" victim assistance programs)
- National Scope Training and Technical Assistance Projects
- Colloquium of the American Professional Society on the Abuse of Children
- Police Executive Research Forum
- Parents of Murdered Children

- Training and Technical Assistance for Federal Criminal Justice Officials
- National Symposium on Child Sexual Abuse (in Huntsville, Alabama)
- Four Corners Indian Country Victims' Rights Conference.

The OVC formula grant program currently funds such projects as the Victim Assistance State Grant Program, for domestic violence and child abuse survivors, focusing on state-based programs for shelters, crisis intervention, group therapy, court accompaniment, transportation, and counseling. Other OVC resources include the State Crime Victim Compensation Program, Support for Grieving and Bereaved Children, and the Resource Package for Children Required to Testify in Federal Court.

Other Federal Programs

Robinson (1992) has identified four other ancillary federal programs that contribute to a national response to family violence:

- Social Services Block Grant (SSBG; Title XX of the Social Security Act)
- Community Services Block Grant Program (CSBG)
- Alcohol, Drug Abuse and Mental Health Block Grant Program (ADAMH), now subsumed into the Substance Abuse Block Grant Program;
- Family Preservation and Support Services Program (FPSSP).

Social Services Block Grant

The Social Services Block Grant provides funds to states for a range of social services. In turn, states have broad flexibility in determining the type of services they will provide, and can establish state-specific eligibility requirements. Federal law does stipulate that services be directed toward several goals, including "preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests." However, many states, including California, use SSBG funds to support their adult protective services agencies, which in turn sponsor locally-developed elder abuse projects. SSBG proposed appropriations for FY 1996 total about $2.4 billion nationally; the California share of that appropriation would total $289.3 million.

Community Services Block Grant

The Community Services Block Grant (CSBG) program assists the states in fighting poverty, and addresses the effects of poverty in communities. The CSBG program is administered within the U.S. Department of Health and Human Services through the Office of Community Services, which distributes grants to the states, and in turn to local community agencies or public agencies

working on antipoverty projects. States are not required to submit detailed reports on the characteristics of populations served.

The National Association for State Community Service Programs, a nonprofit organization with federal financial support, has sponsored a voluntary survey among state- and local-level participants in CSBG-funded programs, yielding some data about CSBG support of family violence programs. The Association's FY 1992 summary reported that, among all uses, 20 percent of CSBG funds were used for emergency services, 13 percent for employment activities, and 14 percent for nutrition. In this context, emergency services incorporates a range of activities germane to family violence, including crisis intervention, information and referral, counseling, emergency cash assistance and shelter, and access to state-based child protective services systems. CSBG proposed appropriations for FY 1996 total approximately $389.6 million nationally; the California share of that appropriation would total $35.1 million, which represents a maintenance of the funding level for the CSBG compared to its FY 1995 appropriation.

Alcohol, Drug Abuse and Mental Health Services Block Grant

The Alcohol, Drug Abuse and Mental Health Services (ADAMH) Block Grant assisted the states through grant programs for prevention, treatment and rehabilitation activities addressing drug and alcohol abuse, and mental health services for targeted underserved populations. In 1995, Congress consolidated all the grant programs in the ADAMH Block Grant with other categorical grant programs funded by other federal legislation into the Substance Abuse Block Grant. In its previous incarnation, the ADAMH had been administered by the Public Health Service within the Department of Health and Human Services; this is not expected to change. Funds are allocated to states according to formulas based on each state's population of targeted groups at greatest risk for substance abuse and mental illness, and on total taxable resources of each state.

Some victims of domestic violence and child abuse would receive interventions through community mental health centers, crisis intervention services that might include referrals to shelters, and possibly through intervention programs for acknowledged batterers, that had been funded under the ADAMH Block Grant, and that will likely continue under the Substance Abuse Block Grant. However, with regard to mental health and counseling services, in California these are not priority populations. Proposed appropriations for the Substance Abuse Block Grant in FY 1996 total approximately $1.2 billion nationally; the California share of that appropriation would total $164.1 million, which also represents a maintenance of the funding level for the programs now included under the new block grant, compared to their collective FY 1995 appropriation.

Family Preservation and Support Services Program

The Family Preservation and Support Services Program (FPSSP) was enacted as part of the 1993 Omnibus Budget Reconciliation Act. The FPSSP is a categorical grant program authorizing approximately $1 billion nationally for five years, which is distributed on a formula basis according to designated program needs and population size. The FPSSP provides California with community-based prevention, family preservation and support services, designed to promote family stability. Federal statute required service providers to participate cooperatively with other

public and private agencies, and to engage in five-year plans of action (Brown and DeLapp 1995). In its initial years of funding, the California allocation from the FPSSP is the largest of any state.

STATE LEGISLATIVE RESPONSES TO FAMILY VIOLENCE

This section presents a brief overview of recent California legislation regarding several forms of family violence. The statutes summarized here amended or added to the Health and Safety, Penal, and Welfare and Institutions Codes.

Many states, including California, have recently enacted statutes to clarify that, although marital rape and general rape are distinct, both are traumatic and unjustified and call for their investigation, prosecution and punishment to be handled similarly to other types of rape cases. A review of recent California legislation on family violence follows. Of particular recent legislative interest, California recently adopted a new Penal Code definition of spousal rape (Chapter 595, Statutes of 1993); established new sentence enhancements for spousal rape versus general rape (Chapter 1188, Statutes of 1994); and adopted "special circumstances" provisions to existing spousal rape statutes, such as in cases where one spouse intoxicates another with the intention of rape (Chapter 177, Statutes of 1995).

Selected 1992 Legislation

Domestic Relations: Domestic Violence Crimes

Chapter 184, AB 2439 (Archie-Hudson), and Chapter 1209, AB 2762 (Lee), Statutes of 1992. Chapters 184 and 1209 authorize a court to order a defendant convicted of specific domestic violence crimes to pay restitution, as a condition of probation and in lieu of a fine, to a domestic violence shelter, or to the abused individual to cover counseling costs or any other reasonable costs which resulted from the defendant's criminal behavior. Additionally, Chapters 184 and 1209 provide that when a married person causes injury to a spouse through criminal acts of spousal abuse, spousal rape and violation of court orders to prevent domestic violence, the separate property of the offending spouse must be exhausted before any community property from the dissolved marriage can be used to discharge the liability for restitution. Chapter 1209 also made it a misdemeanor to violate any order enjoining a party from contacting repeatedly by mail with the intent to harass.

Criminal Procedure: Child Abuse Reporting

Chapter 459, Statutes of 1992, SB 1695 (Royce). Chapter 459 added "child visitation monitors" to the roster of mandated reporters (child care custodians, health practitioners, employees of a child protective agency, and commercial film and photographic print processors), and expanded the definition of "child care custodians" to include district attorney investigators, inspectors, and family support officers not working with court-appointed counsel, as well as peace officers.

Criminal Procedure: Domestic Violence Citizens' Arrests

Chapter 555, Statutes of 1992, AB 2336 (Conroy). Chapter 555 mandates that a peace officer responding to a domestic violence call must make a good faith effort to inform the abused person of his or her right to make a citizens' arrest, including advice on how to make such an arrest safely.

Criminal Procedure: Domestic Violence Court Proceedings

Chapter 863, Statutes of 1992, AB 2628 (Lee): Chapter 863 grants courts the power to order that an accused person be personally present when the accused is charged with a misdemeanor offense involving domestic violence, or a misdemeanor violation of a court order relating to domestic violence. Chapter 863 also provides that a court may permit an initial arraignment on felony or misdemeanor charges (except for those defendants who were indicted by a grand jury) to be conducted by two-way electronic audio-video communication between the defendant and the courtroom, in lieu of the defendant's physical presence in the courtroom if the plaintiff alleges traumatic effects from being in physical proximity to the defendant.

Selected 1993 Legislation

Crimes: Domestic Violence, Diversion

Chapter 221, AB 226 (Burton), Chapter 589, AB 2211 (Goldsmith), and Chapter 850, AB 1165 (Polanco), Statutes of 1993. Chapter 221 requires the court to order the offender to pay for some or all of the fees to attend a batterer's program or other diversion intervention, as long as the defendant is able, and to stipulate that the minimum period of participation in diversion is at least 12 months, plus a certain amount of community service work. Under Chapter 221, criminal proceedings for the divertable offense can be reinstated whenever it is evident that the defendant has engaged in criminal conduct of any kind, thus rendering him unfit and ineligible for the diversion program. Chapter 221 also transfers the authority to approve a batterer's treatment program for diversion purposes to the Department of Corrections, along with the authority to renew the program's approval annually. Chapter 589, redefines domestic violence to mean intentionally or recklessly attempting to cause, or actually causing bodily harm to a wife, husband, parent, permanent resident of the home, or a person related by blood to the abuser, or putting any of the aforementioned persons in imminent risk of bodily harm. Chapter 850 also raised the maximum administrative fee to process a request or application for diversion which judges can levy from $150 to $500.

Criminal Procedure: Domestic Violence, Videotaping Testimony

Chapter 344 authorizes the videotaping of an abused spouse's testimony at a preliminary hearing for a case in which the defendant has been charged with spousal rape or inflicting corporal injury on specified persons resulting in traumatic conditions. The specified persons include a spouse, or any person of the opposite sex with whom the inflicting defendant is cohabitating, or any person who is the mother or father of the defendant's child. Under Chapter 344, if the abused person's

prior testimony given at the preliminary hearing is admissible, then the videotaped testimony may also be introduced as evidence at trial.

Crimes: Sex Offenses, Spousal Rape

Chapter 595 adds a definition of spousal rape to the Penal Code to make it substantially similar to general rape, including sexual intercourse accomplished against the abused person's will through the use of force or violence, menace or fear of immediate bodily injury; the prevention of the abused person's resistance by any intoxicating, anesthetic or controlled substance administered by or with the knowledge of the accused; threats to retaliate in the future against the abused person, or another person, with the reasonable possibility that the perpetrator is likely to carry out the threat; threats to incarcerate, arrest or deport the abused person, or another person, where he or she holds a reasonable belief that the accused is a public official; or intercourse with a person who the accused knows is unconscious and unable to provide consent during the act. Chapter 595 abolished the misdemeanor alternative formerly available to judges for spousal rape, and made it a felony punishable by state imprisonment for three, six or eight years, with a statute of limitations of six years. Additionally, Chapter 595 extended the time of reporting the alleged violation to one year, the same period as allowed persons abused by general rape, and included spousal rape on the roster of sex crimes for which a convicted, but released, offender must register.

Selected 1994 Legislation

Crimes: Domestic Violence, Battered Women's Protection Act

Chapter 140, Statutes of 1994, known as the Battered Women's Protection Act of 1994, expands the Spousal Abuser Prosecution Program by requiring the Maternal and Child Health Branch of the California Department of Health Services (DHS) to administer a comprehensive domestic violence program, including a grant program for battered women's shelters. Chapter 140 also established an advisory council for the purpose of providing consultation to the DHS regarding implementation of that grant program, and required the DHS to work in close collaboration with the advisory council in determining the allocation of appropriated funds, and the solicitation of proposals from potential grant recipients. Chapter 140 also expressed many legislative findings and declarations, including the Legislature's intent to fund the Spousal Abuser Prosecution Program by appropriating $30 million over fiscal years 1994 and 1995, with $11.5 million annually to the DHS for administration of the comprehensive shelter-based program under the Maternal and Child Health Branch, and $3.5 million to the California Department of Justice for the prosecution program. Chapter 140 was enacted to address a chronic lack of funding that had rendered the prosecution program ineffective. Authors of the bill cited publicity from the murder case involving O. J. Simpson as the impetus that finally spurred the Legislature to act. Chapter 140 addressed both the abuser and the abused person by establishing the intent to provide funds for "vertical prosecution" (the assignment of a specially trained deputy district attorney or prosecution unit to a case from beginning to end), and for shelters and transitional housing.

Family: Elder Abuse

Chapter 594, Statutes of 1994, SB 1681 (Mello.) Chapter 594 expands the roster of professionals required to report incidents of elder abuse provisions to include members or support staff of independent living centers, clients' rights advocates, court investigators, Alzheimer's Disease Day Care Resource Centers, vocational rehabilitation facilities, or any other private assistance agencies that provide health or social services to elders or dependent adults. Chapter 594 expanded the situations in which confidential information regarding elder abuse could be revealed to include members of a multidisciplinary team, as defined, and between agencies or long-term care ombudsman programs. Chapter 594 also made it a crime for any persons to cause a dependent adult to suffer; inflict unjustifiable physical pain or mental suffering on a dependent adult; willfully cause or permit an elder or dependent adult to be injured where the accused is responsible for the adult's care or custody; or cause or permit the elder or dependent adult to be placed in a situation that endangers his or her person or health. The author acknowledged the potential restrictions on an elderly person's rights of self-determination if all possible scenarios under Chapter 594 could be played out, but he advocated heartily for passage on the grounds that elder abuse is a growing, yet largely preventable, crime and social condition.

Family: Domestic Violence, Registration of Protective Orders

Chapter 872 requires counties to implement a system by which the State Department of Justice (DOJ) would be notified electronically of all issuances, modifications, extensions, or terminations of protective orders, with the electronic transmission of certain information to the DOJ at the time an order is initially issued. Chapter 872 also establishes a Domestic Violence Protective Order Registry, maintained by the DOJ, and allows law enforcement agencies to enforce protective orders that they receive electronically from the Registry. Chapter 872 also ensures rapid entry of restraining order information into the DOJ's Registry, and the distribution of information packets throughout the court system, to make the process of applying for a restraining order less confusing during a stressful time. Finally, Chapter 872 adds the California Highway Patrol to the list of law enforcers authorized to take custody of firearms or deadly weapons present at the scene of a family violence incident involving threat to human life or physical assault.

Child Welfare Services: Permanent Status for Family Preservation Programs

Chapter 961, Statutes of 1994, AB 3364 (Bates). Chapter 961 provides that any county having operated a family preservation program on a pilot project basis for three consecutive years, may convert from pilot projects, as established by prior state law, to ongoing, permanent programs using monies that, without the family preservation program, would have been used for foster care. Chapter 961 also provides authorization for such counties to request a permanent transfer of funds from the foster care allocation to family preservation programming.

Crimes: Sex Offenses, Spousal Rape

Chapter 1188, Statutes of 1994, SB 59 (McCorquodale). Chapter 1188 includes the offense of spousal rape within enumerated sections of the Penal Code that deal with other sexual and violent

crimes. Chapter 1188 was enacted to change various provisions in the law so that the crime of spousal rape would be addressed like general rape and other violent felonies.

Selected 1995 Legislation

Crimes: Spousal Rape

Chapter 177, Statutes of 1995, SB 208 (Solis). Chapter 177 modifies special circumstances applied to spousal rape to include situations in which a person is prevented from resisting the rape because of having been administered an intoxicating or anesthetic substance, and in which the defendant knew, or should have known, about such a condition.

Crimes: Domestic Violence Protective Orders

Chapter 246, Statutes of 1995, SB 591 (Solis). Chapter 246 requires that, both parties to a mutual restraining order must present written evidence of abuse. Chapter 246 applies specifically to cases in which the court can determine that both parties have acted primarily as aggressors, and that neither party acted primarily in self-defense. Also, Chapter 246 requires local standards for law enforcement officers' responses to domestic violence calls (1) encourage or require the arrest of domestic violence offenders, (2) when appropriate, discourage but not prohibit, dual arrests, and (3) encourage officers to make reasonable efforts to determine the primary aggressor in any incident.

Child Abuse: Transfer of Reports Among Authorized Persons

Chapter 391, Statutes of 1995, AB 1440 (Davis). Chapter 391 amends the Penal Code to authorize that copies of reports made by health practitioners regarding suspected child abuse, and copies of health assessments completed in compliance with state law, be disclosed to other specified, authorized persons within county health departments.

Family: Domestic Violence Protection Act Amendments

Chapter 598, Statutes of 1995, AB 878 (Rogan). Chapter 598 provides that orders enjoining a party from behaviors such as stalking, destroying personal property, contacting repeatedly by mail with intent to harass or annoy, disturbing the peace of the other party, and making certain annoying telephone calls, could be added to the existing roster of *ex parte* orders that could lead to further prosecution under the Domestic Violence Protection Act.

Civil Procedure: Domestic Violence Actions

Chapter 602, Statutes of 1995, SB 924 (Petris). Chapter 602 extends the statute of limitations for injury or death suffered as a result of domestic violence, as specified, up to three years from the date of the last incident of domestic violence by the defendant.

Health Care: Domestic Violence Insurance Coverage

Chapter 603, Statutes of 1995, AB 1973 (Figueroa). Chapter 603 prohibits health insurance plans and disability insurers from enrolling, insuring or covering someone who has a history of prior injuries that are the result of domestic violence.

Crimes: Domestic Violence Probation and Diversion

Chapter 641, Statutes of 1995, SB 169 (Hayden). Chapter 641 eliminated diversion as an option for a defendant charged with a misdemeanor domestic violence offense. Chapter 641 also incorporated new procedures and requirements throughout California pertaining to the collection of information needed by the state to evaluate the performance of a batterer's intervention program. Minimum standards for such programs were established, including the requirement for concurrent substance abuse counseling when court documents reveal that a domestic violence defendant is concomitantly suffering from, or under arrest for, substance abuse.

Crimes: Domestic Violence Death Review Teams

Chapter 710, Statutes of 1995, SB 1230 (Solis). Chapter 710 authorizes counties to establish "domestic violence death review teams," similar to interagency child death review teams, to assist in identifying and reviewing domestic violence deaths. Chapter 710 also requires the Attorney General to develop a protocol for developing and implementing these teams, and to direct the Department of Justice to coordinate state and local efforts that address fatal domestic violence.

Family: Domestic Violence Protective Order Registry

Chapter 731, Statutes of 1995, AB 233 (Kuehl). Chapter 731 requires that the Domestic Violence Protective Order Registry maintained by the Department of Justice include information about any temporary restraining orders, injunctions, and child custody and visitation terms through the existing California Law Enforcement Telecommunications System (CLETS). The information should include the name, race, and date of birth of the alleged perpetrator, and the date of issuance and expiration of such orders, for easy interpretation by law enforcers statewide.

Elder Abuse: Investigative Reports

Chapter 813, Statutes of 1995, AB 1836 (Figueroa). Chapter 813 provides that when a county adult protective services agency is required to report incidents of elder abuse to law enforcement agencies, the law enforcement agency must in turn furnish a copy of its investigative report to that county adult protective services agency, and vice versa. This statutorily ensures that California county agencies communicate clearly with each other when particularly important actions occur with regards to elder abuse cases, especially when several agencies are cooperating on the same case or cases. The statute now reflects the key role of law enforcement agencies in the information loop about elder abuse cases.

Child Abuse: Birth Certificates

Chapter 880, Statutes of 1995, SB 750 (Killea), The Welfare and Institutions Code authorizes each county to designate commissions to provide child abuse or neglect prevention and intervention programs. These commissions have been funded by a $4 portion of the $7 fee charged to most applicants for certified copies of birth certificates. These monies are deposited either into a county's children's trust fund or to the State Children's Trust Fund. Chapter 880 provides that any county board of supervisors, having established a county children's trust fund, may increase the fee for a certified copy of a birth certificate by up to $3 for deposit in the fund.

Evidence: Role of Interpreters

Chapter 888 further expands the requirements for a sworn interpreter to be available to any witness who is incapable of understanding or speaking English in any action or proceeding relating to domestic violence. The rules and pertinent court forms necessary to implement Chapter 888 will be developed by the State Judicial Council.

Family: Restraining Orders Issued by Municipal Courts

Chapter 907, Statutes of 1995, AB 935 (Speier): Chapter 907 amends the law to authorize a judge of the Municipal Court to issue a temporary restraining order following allegations of specified acts of domestic violence when such an order cannot be obtained in a timely manner from a judge of the Superior Court. Chapter 907 also added new provisions to the maximum duration of domestic violence protective orders. Under this new law, the personal conduct, stay-away, and residence exclusion orders contained in a domestic violence protective order are also stipulated to have a maximum duration of three years, and may be renewed, either for an additional three years or permanently, without a showing of further abuse since the original order was issued.

Law Enforcement: Domestic Violence Training

Chapter 965, Statutes of 1995, SB 132 (Watson): Chapter 965 adds to the existing requirement that certain law enforcement officers take a course every two years on the handling of domestic violence complaints. Chapter 965 also specified that certain new elements would be included with the information collected with an officer's domestic violence incident report.

SELECTED LOCAL RESPONSES TO FAMILY VIOLENCE

While the local, regional and county-level responses to family violence are too numerous to itemize for this report, some are noteworthy. Many are funded by the federal and state programs described above. The overall violence prevention strategies adopted by Contra Costa County, California, and the important local or regional role fulfilled by "Family Violence Councils," are described below.

Contra Costa County Health Services Department Prevention Program

Through its Prevention Program, the Contra Costa County Health Services Department addresses many aspects of preventable illness and the social conditions that spawn violence in communities within this East Bay Area county. Throughout all its projects, the Prevention Program has adopted a "Spectrum of Prevention" model to address six levels of preventive intervention. This spectrum model is easily applied to the county's work in violence prevention (Cohen and Swift 1993; Swift 1987). Some of those projects include innovative approaches to firearm utilization surveillance, countywide annual "Keep the Peace" days, projects designed to deglamorize gang membership among young men in West County inner cities, and a vigilant survey of the utilization and citing of licensed firearm dealers within the county limits. The six levels or "colors" of the spectrum, in ascending or descending order but always in sequence, include:

- Strengthening individual knowledge and skills;
- Promoting community education;
- Educating health providers;
- Fostering coalitions and networks;
- Changing organizational practices; and
- Influencing policy and legislation.

The Prevention Program and its Violence Prevention Coalition determined that in 1993, there were nearly twice as many firearm deaths (147) as motor vehicle deaths (85) within the Contra Costa County limits. Alarmed by the rising number of victims of firearm violence arriving in the county's emergency rooms, the Prevention Program staff determined that regulating gun dealers, within constitutional limits, was one way to begin reducing the number of firearms in the county, and thereby prospectively reducing the number of firearm-related mortalities. The Prevention Program and the Violence Prevention Coalition surveyed federally-licensed firearm dealers in the county to assess their degree of compliance with federal and state laws. They also explored ways in which local jurisdictions can regulate firearm dealers in their areas, through zoning, business licensing practices, and conditional-use ordinances (Feinson, Kraut and Soto 1995). The Prevention Program researchers determined that in 1993 there were 700 federally-licensed firearm dealers within the county, more than the number of schools, grocery stores and gas stations combined. Of that number, two thirds, (462, or 66 percent), did not have the required State Certificates of Eligibility, four fifths (573, or 81 percent) operated in residential neighborhoods, and nearly three quarters (509, or 73 percent) did not possess the required local business licenses at the time of the survey.

Because California is one of 41 states with preemption laws that prohibit local jurisdictions from passing ordinances on firearm sales and distribution that are stricter than state laws, the issue of local ordinance and countywide controls on firearm sales and ownership is already hotly contested. The willingness of chiefs of police in small towns or cities, such as in Isleton (Yolo County), to authorize issuance of an expanded number of concealed weapons permits to qualified applicants, is an important county-level firearm-related public policy issue often presented to readers of California newspapers. However, California communities like those in Contra Costa County that seek to regulate dealers are able to pursue certain regulations such as zoning

ordinances and conditional-use permits to restrict the areas in which dealers can locate their establishments, impose tougher safety and liability conditions on their operations, and generally elevate the community's awareness about the presence of firearms and firearm dealers in their midst.

Family Violence Councils

"Family Violence Councils" exist in communities nationwide, but some of the model California programs, like that in Santa Clara County, present useful additions to the panoply of interventions against family violence available to counties and regions. Typically, a Family Violence Council is a coordinated program based on mutual agreements among community leaders to respond to the various forms of family violence exhibited in a community, with attention given to cultural competencies, assets, and special needs. In 1991 in Santa Clara County, the Board of Supervisors adopted an ordinance creating its Family Violence Council, to coordinate agencies and the court system, victims of family violence (and abuse of several specific forms), health providers and law enforcers in an effort to intervene against and prevent family violence. The Council was also charged with making recommendations to the Board of Supervisors on an ongoing basis, encouraging and promoting public education about family violence, and implementing and reporting on the administration of domestic violence diversion programs within the county, according to recommendations previously issued by the State Attorney General (Edwards 1992; Schecter and Edelson 1995).

Family Violence Council meetings give individuals and agency representatives the opportunity to identify weaknesses within their systems, express their frustrations, plan strategies together, allocate resources, and clarify structural issues that confront them. Ideally, exchanges and cooperation exhibited during Family Violence Council meetings can have synergistic effects within the systems at large, fostering greater opportunities for community-level or locally-inspired successful interventions.

Creating and maintaining a Family Violence Council, however, requires careful planning and an understanding of the local political and legal culture. Family Violence Councils might not survive in all counties, notably rural or border counties. In successful models, however, Family Violence Councils are spawned when a group of local leaders are identified who then agree that the reduction of family violence in their midst is an important local or regional social policy goal. Often local health providers or leaders of medical and nursing societies are prime movers in this effort because they see the health care burden and costs to the local community when treating family violence victims in hospitals and clinics that are known to members of the community, or that regularly receive local media attention. "Agitated" or frustrated health providers, such as pediatricians or emergency physicians, have presented evidence to county boards of supervisors as an instigating event toward the development of Family Violence Councils (Edwards 1992).

Typical members of a Family Violence Council include judges (civil, family, juvenile, and criminal), court staff, prosecuting attorneys, law enforcers, elected representatives from cities, counties and occasionally the district representative of the official representing that community in the Legislature, probation chiefs, battered women's shelter directors, social workers, medical

society representatives, victim's rights advocates, counselors, and substance abuse interveners. A judge is an ideal convener of a Family Violence Council, and in the Santa Clara and San Diego County models, having a rubric of judicial oversight during Family Violence Council meetings gives *prima facie* importance to Council proceedings and to the Council reports and recommendations subsequently presented to Boards of Supervisors. Involving law enforcers and health providers serves to ensure that "front-lines" coordinators can serve the interests of those involved in subsequent, sub-acute services. The work of Family Violence Councils may be catalytic, ongoing, time-limited, or periodic, but each phase of its development or life span should culminate with recommendations to the Board of Supervisors, with accountability for implementing recommendations then vested in elected representatives and law enforcers.

SEMINAR PRESENTATIONS AND HANDOUTS

FAMILY VIOLENCE

FRIDAY, FEBRUARY 9, 1996
9:00 A.M. - 11:30 A.M.
STATE CAPITOL, ROOM 4203
SACRAMENTO, CALIFORNIA

AGENDA

8:30 - 9:00 A.M. ***CONTINENTAL BREAKFAST***

9:00 - 9:10 A.M. ***WELCOME, INTRODUCTIONS AND SEMINAR OVERVIEW***

Anne Powell, M.S.W., Project Director
California Family Impact Seminar

9:10 - 9:30 A.M. ***KAISER PERMANENTE INTERREGIONAL TASK FORCE ON FAMILY VIOLENCE***

Barbara (*Bobbi) E. Famularo, RN, MBA,* Regional Maternal and Child Health Coordinator, Kaiser Permanente Northern California Region, Kaiser Interregional Task Force on Family Violence; Lt. Col., U.S. Air Force, N.C.R., Reservist, 60th Med. Group.

9:30 - 10:00 A.M. ***MARCH OF DIMES THE PREVENTION OF BATTERING DURING TEEN PREGNANCY PROJECT***

Priscilla Enriquez, M.P.H., Director of Program Services, March of Dimes Birth Defects Foundation, Greater Bay Area Chapter.
Tracey Rattray, M.S.W., M.P.H., Project Coordinator, The Prevention of Battering During Teen Pregnancy Project, March of Dimes Birth Defects Foundation, Greater Bay Area Chapter.

10:00 - 10:20 A.M. ***THE ROLE OF MEDIA IN COMMUNITY VIOLENCE PREVENTION STRATEGIES***

Lori Dorfman, Dr.P.H., Co-Director, Berkeley Media Studies Group.

10:20 - 10:40 A.M. ***FAMILY VIOLENCE AND THE MULTISYSTEMIC THERAPY MODEL***

Don Kingdon, Ph.D., Chief, Children and Adolescent Services, Ventura County Mental Health Department.

10:40 - 10:55 A.M. ***BREAK***

10:55 - 11:30 A.M. ***QUESTION AND ANSWER PERIOD***

SPEAKER INFORMATION AND BIOGRAPHICAL STATEMENTS

Barbara (Bobbi) E. Famularo, RN, MBA, Regional Maternal and Child Health Coordinator
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Asst. to Director, Utilization Management
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In her current position as Regional Maternal and Child Health Coordinator, Bobbi Famularo led the effort to establish the Northern California Kaiser system as an authorized Perinatal Region for the State of California. As Region Ten Coordinator, she facilitates the work of the Regional Perinatal Council and has created, developed and initiated their region wide programs in high risk perinatal transport coordination, pre-term birth prevention, diabetes and pregnancy, and extracoporeal membrane oxygenation (ECMO), and perinatal substance abuse treatment. Ms. Famularo has 25 years of progressive professional nursing experience in maternal child care and health care administration. She has served as the first functional unit manager in the Northern California Kaiser region managing all human and fiscal resources for nursing, reception and appointment personnel at the South San Francisco facility.

Priscilla Enriquez, M.P.H., Director of Program Services
Tracey Rattray, M.S.W., M.P.H., Project Coordinator
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Priscilla Enriquez is responsible for maternal and child health programs and policies. Ms.Enriquez has worked in the fields of children's advocacy in child health and welfare, and substance abuse prevention.

Tracey Rattray administers The Prevention of Battering During Teen Pregnancy Project. Ms. Rattray has worked on the development of a media campaign for the project, provides training to professionals and co-administers the newly formed Teen Moms Shelter in San Francisco. Her past experience includes planning and evaluation of a broad range of projects concerning adolescent reproductive health and providing training to health professionals on a variety of public health issues.

Lori Dorfman, Dr.P.H., Co-Director
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Lori Dorfman conducts research on news media operations and media content. Dr. Dorfman's current research examines how television news frames health issues and how local television news portrays youth and violence. She has published articles on public health and mass communication issues and is a co-author of *Public Health and Media Advocacy: Power for Prevention*, (1993: Sage Publications). Dr. Dorfman has served as a consultant for government agencies and community programs and has conducted media advocacy training for public health leadership and community groups across the country. Previously she was a research associate with the Media and Policy Analysis Center of the Marin Institute for the Prevention of Alcohol and Other Drug Problems and conducted evaluation research with the Association for Women's AIDS Research and Education.

Don Kingdon, Ph.D., Chief
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Don Kingdon is Chief of Children and Adolescent Services for Ventura County Mental Health. Ventura County has been nationally recognized for more than a decade for its leadership in the development of innovative systems of community-based treatment for children and adolescents with serious behavioral problems.

Introductions and Welcome
Anne Powell, M.S.W.
CAFIS Project Director

Good morning and thank you for taking the time to attend today's seminar. We hope that you will find the presentations interesting and provocative. Let me begin by acknowledging and thanking The Henry J. Kaiser Family Foundation for their support of this program. I also want to acknowledge and thank John Hough who very ably drafted the background briefing report for CAFIS. John's background as staff for the California Medical Association, his doctoral degree in public health, and his stint as an Assembly Fellow last year made him well-qualified to do this work. I hope you find the report valuable.

You should have received a packet as you arrived today. The packets contain a great deal of information. There is the evaluation form, an agenda, biographical statements for each speaker, and a hard copy of some of the overheads and slides the speakers will be using for their presentation.

I am going to take a few minutes to talk about the problem of family violence and hopefully provide a context for the presentations. This has been probably one of the most challenging seminars we have ever organized. First, most people do not look at the issue of violence that occurs within the family comprehensively. Rather, the attention is focused on "child abuse" or "domestic violence" or "elder abuse."

Our goal with this seminar is to provide you with information about family violence, about how each of the categorical forms of violence intersect. I am disappointed to say that we have not been able to fully achieve this goal. One of the most significant impediments to this effort stems from the fact that government and others have categorized the different types of violence that occur within the family setting. This is not to say that those who have been dealing with different aspects of family violence have been wrong in what they have been doing. Rather, the current fragmentation represents the stage we are at in the evolution of our understanding and response to family violence.

In the 1960s and '70s, the medical community began to identify the phenomenon of the battered child or non-accidental trauma. Their efforts led to mandated child abuse reporting, which in turn generated the demand for state and federal child welfare programs to respond to this abuse. Thus, at least theoretically, there is now a system for identifying child abuse, reporting its occurrence, and addressing the problem.

This example illustrates that our thinking about what is now termed as family violence began with the identification and response to one part of family violence—child abuse. Similarly, attention to elder abuse and domestic violence led to the development of programs for each of these other aspects of family violence.

The evolution of programs and policies for each of these distinct areas of family violence has just begun to converge. What we hope to accomplish with today's seminar and the background

briefing report is to provide you with some information regarding the three areas of family violence—child maltreatment, elder abuse and domestic violence—and some cutting edge examples of where historically segregated prevention and intervention efforts are coming together.

We hope that you leave the seminar with a better understanding of the challenge now facing those attending to family violence, will begin to look at the problem from a family perspective, and will then begin to formulate prevention and intervention strategies that support comprehensive approaches to address family violence.

Before our speakers begin, I do want to pose some issues for you to be thinking about. What are the similarities and differences between the different components of family violence—child abuse, elder abuse and domestic violence? Is there a relationship between them? Is there a need to reformulate individual programs to address broader family violence issues?

After all the time that we have spent reviewing the issue, I wish I could offer some answers to these questions today. However, we truly are just beginning to see the possibilities for change.

I do think there are some very significant information gaps that need to be addressed in order for policy and program development to continue. The first gap concerns data, particularly population-based prevalence data. The data currently collected for each type of family violence is incomplete and inconsistent with data about other types of family violence. This precludes comparison of data for each area of family violence. Secondly, and very much linked to the first issue, is the lack of uniformity in the reporting mechanisms and systems. This is in large part a function of inconsistency with regards to mandated reporting—who is required to report and to which agency(ies).

While the problem with data is in large part one of logistics and capacity, the issue of reporting is more complex and brings into play the question of government's role. While the case can easily be made for governmental protection of children and the frail elderly, some would disagree that women (the primary victims of domestic violence) should receive similar status.

Let us now turn to our speakers. I have asked individuals from four unique programs to discuss their work on family violence. Their work encompasses development of a variety of prevention and intervention services, as well as policy development for service professionals and communities. There are some interesting similarities and differences in how each addresses family violence, and where they are in the broader continuum of prevention and intervention strategies.

After they describe their programs, each speaker will conclude with remarks about policy and other issues which they are confronting that are relevant to you as state policymakers.

Kaiser Permanente Interregional Task Force on Family Violence
Barbara (Bobbi) E. Famularo, R.N., M.B.A.

Bobbi Famularo is the Regional Maternal and Child Health Coordinator at Kaiser Permanente Northern California Region. She is also a Lt. Col. in the U.S. Air Force Reserves, 60th Medical Group at Travis Air Force Base. Ms. Famularo will talk about a number of issues after briefly describing her role as Regional Maternal and Child Health Coordinator at Kaiser Permanente Northern California Region. Ms. Famularo will discuss the work of the Interregional Kaiser Permanente Task Force on Family Violence—how it came about, its purpose, and the outcome. She will then talk about the development of the training module for health care professionals, Teens: Pregnant and Battered*. If time permits or possibly later in the program, I hope that she can also discuss her work on family violence within the military.*

I am honored to have this opportunity to speak to you, and to share with you Kaiser Permanente's commitment to improving assessment and intervention for our families that are at risk through sexual and physical violence. I will begin by discussing our Perinatal Program, then talk about the design for identifying at-risk pregnant women and then close with a look at how this journey has expanded to a family violence initiative.

In 1989, the state of California designated the Kaiser Permanente Medical Care Program Northern California Region as Region X, a full participant and part of the statewide plan to regionalize perinatal care. The Regional Perinatal Council was formulated and has met quarterly since its inception to discuss perinatal issues and establish the best practice models for maternal and child health within our region. My role was and still is to provide administrative support and assistance and to represent our region at the meetings of the regional perinatal programs of California, which are held under the auspices of the Department of Health Services Maternal and Child Health Plan.

The Council is composed of twenty-one members from a cross-section of perinatal care providers representing the multidiscipline and multifacilities throughout our region. The Council's mission statement states: "To collaborate with a regional focus through the process of coordinated communication amongst the key stakeholders in perinatal care to establish the best practice models for maternal and child health. Through the multidisciplinary constituents, standards and guidelines will be developed that link this region together as a proactive forerunner for the health care industry in the maternal and child health care arena. The scope of these models will represent a new paradigm of perinatology and not be bounded by age."

The Council has identified five clinical priorities and created four regionwide programs to enhance perinatal outcomes through a proactive integrated approach. The programs include preterm birth prevention, diabetes in pregnancy, perinatal substance abuse, and transport coordination. These programs are at various levels of implementation and evaluation. Most noteworthy are the findings from our regional preterm birth prevention program. Although all pregnant women go through a risk assessment process—and our delivery rate is approximately 28,800 deliveries per year—we discovered that in 1994 approximately two-thirds of the women who delivered prematurely did not have any of the risk factors that were identified on the risk assessment form,

such as incompetent cervix, multiple gestation, previous pregnancies delivered prematurely. Therefore, we needed to ask ourselves, are there other "silent" risk factors, either behavioral or psychosocial, that put these women at risk?

Through our analysis, we found recent studies demonstrating that one in five teens and one in six adult women experience abuse during pregnancy [see Handout #1]. Abuse is related to late entry into prenatal care and low-birthweight infants. This was defined by Barbara Parker, Judith McFarlane, and Karen Soeken in an article they authored in *Obstetrics and Gynecology*, Volume 84, Number 3, September 1994, "Abuse During Pregnancy: Effects on Maternal Complications and Birth Weight in Adult and Teenage Women." [See Handout #2.] Within our region alone, this staggering statistic translates to as many as 4,032, or 15 percent, of our pregnant women per year who could be at risk for sexual and physical violence and consequently incur maternal complications and low-birthweight infants.

To this end, we held an interregional domestic violence conference in January 1995, in order to increase our staff's awareness and introduce assessment skills and intervention strategies. We invited community agencies such as the March of Dimes. Two of the speakers included Judith McFarlane and Patricia Salber, board certified emergency department physician, co-founder and president of Physicians for a Violence-free Society, and currently our national physician marketing director for Kaiser Permanente.

In our evaluation following this conference, we realized that we could not stop here. We strongly felt a responsibility to create a national interregional family violence initiative for Kaiser Permanente. Our family violence initiative includes:

- The creation of a task force—the goals are included in Handout #3.
- The development and the implementation of a domestic violence legislative survey to compile data nationwide.
- Development of a training module for healthcare professionals entitled *Teens: Pregnant and Battered*. We plan to make this training module available nationwide through Physicians for a Violence-free Society, complementing their existing domestic violence screening module.
- Sponsor an inter-regional *Teens: Pregnant and Battered* conference in partnership with the March of Dimes and Physicians for a Violence-free Society. Speakers included such noteworthy individuals as Dr. Barbara Stagger, Dr. Ed Melia, Priscilla Enriquez from March of Dimes, and Denise Peebles from the East Bay Perinatal Council.
- Sponsorship of a family violence conference scheduled May 10th which will include breakout sessions on such topics as child abuse, same sex abuse, and elder abuse. Numerous community agencies as well as military health care professionals will be invited.

In closing, I would like to share with you a component of the *Teens: Pregnant and Battered* training module. Please keep in mind that these same prevention strategies apply to adult women as well.

What can we do to prevent violence as professionals, as family members, as community members? [see Handout #1]. As health care professionals, when a pregnant teenager presents in the clinic or in the emergency department, it is important to explain the cycle of violence and the potential effect upon her unborn child. There are many ways that we can provide patient education: through pamphlets and resource books available in your departments or from social services or health education. Give them to her and go over the contents if possible. Put posters in the women's bathrooms that explain related risk to themselves and their unborn fetuses. By catching these teenage girls at risk for violence, we can attempt to prevent escalation.

As health care professionals, we need to support and conduct research activities which determine the prevalence and effectiveness of intervention for battered pregnant teenagers. Through research and data collection, community leaders can provide advocacy and the development of legislation which further protects battered pregnant teenagers and hopefully decreases the incidence of violence to this vulnerable population.

As family members, we need to learn how to support each other and recognize the signs of angry and inappropriate behavior. We need to reach out and help ourselves and/or our family members to seek professional assistance if this inappropriate behavior affects the stability and harmony of the family.

As community members, we need to participate in events which educate our communities about the prevalence of this epidemic and the specific actions that need to occur. Community awareness and behavior can be influenced through media events such as the recent O.J. Simpson trial. The trial brought domestic violence out of the closet, hidden and not talked about, and into our living rooms and consciousness. It heightened individual and community awareness and illustrated the physical, emotional and financial costs. We as health care professionals and advocates have a responsibility now to work towards improving the overall health of our family and community.

We as health care professionals can offer intervention by learning to recognize the signs of abuse. We can make a difference with our patients, our communities and our future. Thank you.

The Prevention of Battering During Teen Pregnancy Project
March of Dimes Birth Defects Foundation, Greater Bay Area Chapter
Priscilla Enriquez, M.P.H., and Tracey Rattray, M.S.W., M.P.H.

Priscilla Enriquez is Director of Program Services, and is responsible for maternal and child health programs and policies. Tracey Rattray is Project Coordinator of The Prevention of Battering During Teen Pregnancy Project and co-administrator of the newly formed Teen Moms Shelter in San Francisco. They will describe: (1) The problem of battering of pregnant and parenting teenagers; (2) The unmet needs unique to this population; (3) The March of Dimes' interest in this issue; and (4) The program developed to respond to these needs.

Priscilla Enriquez, M.P.H.

The Prevention of Battering During Teen Pregnancy Project was developed by the March of Dimes to unmask the issue of domestic violence during teen pregnancy. We utilized three approaches. I am happy to be here with Lori Dorfman who will talk about *media advocacy,* which was our first approach. There are basically three tenets to media advocacy: one is setting the agenda, the second is shaping the debate, and the third is impacting public policy. I truly believe that our project has been able to meet all three criteria.

The second approach has been to utilize *public education*, which is a traditional health education approach, developing educational resource materials to raise awareness. Our public education materials include a fact sheet—"Domestic Violence and Teenage Pregnancy," *The March of Dimes Resource Guide: Options for Battered Pregnant and Parenting Teenagers in the San Francisco Bay Area*, and brochures and posters that we have developed through this campaign. [The fact sheet and brochure appear as handouts #1 and #2; the other materials may be obtained from the March of Dimes.]

The third piece of this campaign has been to conduct *training to providers* to assess for domestic violence among pregnant teens. We decided to conduct training because we wanted to respond to prevalence data, which I will talk about later, and the state's new mandated reporting law on domestic violence.

I want to acknowledge several people. Tracey Rattray, the Project Coordinator, provided the leadership for a successful campaign. I would also like to acknowledge the Teen Pregnancy and Violence Prevention Coalition in San Francisco, which is the group that formed the bread and butter of this campaign. They are the experts who helped to identify the problem, identify the need, and develop solutions.

The information Bobbi Famularo presented is taken from a training module developed in collaboration with the March of Dimes, Physicians for a Violence-Free Society and Kaiser Permanente [see Handout #3]. I would like to acknowledge Patricia Salber, who is the president of Physicians for a Violence-free Society, and also Ed Melia and Bobbi Famularo, who has been instrumental with efforts at Kaiser and has been a great partner in our collaboration.

Most importantly, I would like to acknowledge the Battered Women's Shelter Program, Carol Motylewski, chief of the Domestic Violence Section at the Maternal and Child Health (MCH) branch of the Department of Health Services and her domestic violence staff. They have been instrumental in spearheading efforts on domestic violence prevention across the state. And lastly, Anne Powell, for hosting this Family Violence Seminar today.

I would like to give you a historical overview of why the March of Dimes is involved in the prevention of domestic violence during pregnancy. What is the March of Dimes all about? The mission of the March of Dimes is carried out through what we call the Campaign for Healthier Babies, which basically has three objectives: to reduce infant mortality, to reduce low birthweight, and to increase access to prenatal care. In other words, the March of Dimes is concerned with maternal and child health issues.

We are also the first national organization to develop a protocol on assessing for domestic violence during pregnancy. Many domestic violence organizations across the country have used the protocol effectively. Locally, in the greater Bay Area, we funded two grants for hospitals and clinics to develop their own protocols and to train their staff on how to assess this abuse. Therefore, given that solid foundation, we felt that we wanted to seek funding to create a family violence prevention campaign in the Bay Area, and the response has been enormous.

Why focus on teens? There are four reasons. One is prevention. We believed that preventing domestic violence was a sound public health approach. We wanted to address domestic violence within a maternal and child health context, and thus focused on teen pregnancy. The coalition that we gathered informed us that this was the population at greatest risk, that they were falling through the service delivery cracks. We also wanted to prevent repeated abuse. We believed that starting young was a way to prevent a young girl from becoming an adult woman in a prolonged battering relationship. In researching the data, oftentimes adult women in battered relationships feel trapped, that they cannot get out, because they have been in this relationship for years and years. We did not want that to happen.

Secondly, we wanted to be very political. We knew that the state and the Governor were focusing on teen pregnancy, and we decided to be part of that mission. We also believed that teen pregnancy, and this is reiterated by our coalition, was a very media-friendly topic. When you are conducting a media advocacy campaign, you want to be able to address an issue that will capture the media's attention. The last convincing piece was the data, and that was probably the driving force behind why we focused on battered pregnant teens.

Twenty-one to 30 percent of adolescent women have had at least one violent episode in their relationship. Teenage women are at somewhat greater risk than adult women for battering during pregnancy. In one study 20 percent of teenage women ages 13 through 19, or one in five, and 17 percent of adult women had experienced battering during their pregnancy. This was really stunning data.

Another study found that 66 percent of a sample of 535 pregnant adolescents had a history of physical abuse. Interestingly, this is further corroborated by a Bay Area adolescent group home,

which reported in one year that two-thirds of their clients had experienced physical abuse. In adolescent relationships, there is a link between physical and sexual violence. In David Boyer & Debra Fine's study of pregnant adolescents, of those sexually abused, 60 percent had been hit by a partner in the relationship compared to 29 percent among those who were not sexually abused.

Moreover, pregnancy in and of itself is a risk factor for battering. Oftentimes, battering begins during pregnancy. And the perpetrator will often direct his abuse in the chest or in the abdomen area. Another study found that 61 percent of pregnant teens reported at least one unwanted sexual experience. Sixty-five percent of those reported more than one experience.

There are also obviously perinatal issues, which is what we are concerned about today. Pregnant teens who are battered have significantly higher rates of poor weight gain, first or second trimester bleeding, smoking, and alcohol and drug use during pregnancy than nonbattered pregnant teenagers. Battered pregnant teens are also at risk for HIV and other sexually-transmitted diseases. Parker and her colleagues in 1994 reported that women who are battered while pregnant were one and a half times more likely to deliver a low-birthweight infant than nonbattered pregnant women.

Who are the perpetrators? Boyfriends make up the largest percentage, 51 percent, followed by "others" at 26 percent, which consists of girlfriends, parents or other relatives. The third subset is husbands or ex-husbands,16 percent. Strangers consist of only 4 percent. And finally, multiple perpetrators, such as a boyfriend and a parent, are at 3 percent.

So these are the reasons why we focused on the problem of battered teens. What I would like to do now is give you an overview of what we finally called our "Do It For Yourself, Do It For Your Baby" campaign. We developed the campaign using the voices of those most affected. We conducted three very diverse focus groups of teenagers. One focus group consisted of pregnant teens in a group home. I believe they were mostly Latino and African-American. The second group was mostly Latino pregnant or parenting teens. The third group was mostly upper-middle class white teenagers in a suburb of the Bay Area.

The message was consistently clear. We developed a poster and brochures superimposing the words they told us that friends, boyfriends, and parents tell them when they are pregnant: You're so fat. You're so ugly. No one else will love you. No one else wants you. You're so lucky you've got me [see Handout #2].

We also developed a radio public service announcement (PSA) using nontraditional means. We were fortunate as part of our campaign to partner with an urban hiphop station called Wild 107. The PSA integrates the voices of teens from our press conference:

> (PSA message #1)
>
> "I'm the Assistant Director of the San Francisco Bureau of Victim Services and we are very, very concerned about pregnant teenagers who are victims of battering."

"Hi. This is JoJo Wright [disc jockey]. If you are a teen that is pregnant, and you've been hit, slapped, forced to have sex, anything against your will, then you need help, and you can call the March of Dimes' confidential referral line at 1-800-693-2247. And Wild 107 would like to urge you to do it for yourself and do it for your baby."

(PSA message #2)

"You are looking at a child who may be born with health difficulty. I have scarring on my face and my body. And you say that this is a woman that you love. Why would you hit her? You don't hurt anything you love."

"Hi. This is JoJo Wright [disc jockey]. If you are a teen that is pregnant, and you've been hit, slapped, forced to have sex, anything against your will, then you need help, and you can call the March of Dimes' confidential referral line at 1-800-693-2247. And Wild 107 would like to urge you to do it for yourself and do it for your baby."

The PSA airs on a radio station that caters to the teen population that we wanted to target. The radio station began their community violence prevention campaign with our PSA and teen violence issue. We were very fortunate.

Another strategy that we utilized for the media campaign was to work with the Evans Group, which is a public relations advertising firm that helped develop the collateral materials, the posters, etc. All of their services were donated. The result of our campaign—the coalition, the public education materials, and the media campaign—was unprecedented media coverage in radio, print, and television. And it continues today, which has been a very fortunate byproduct of our project.

After a press conference that was held in July, we were the lead story on the five o'clock news in San Francisco, and we were written up in the *San Francisco Examiner* by columnist Stephanie Saltel, a very prestigious opportunity in the San Francisco media community. What we really appreciated was that we were also featured in the alternative press, not just in the *Chronicle* and the *Examiner*. We got a really wonderful story about the development of the teen mom's shelter in the *Bay Guardian*, which is an alternative weekly newspaper in San Francisco.

Recently, our project and the issue of battered pregnant teens was featured on the Mark Walberg Show, which is a national talk show. I am going to show a clip of First Cut, which is a local show made by teens for teens, and again it utilizes the voices of those most affected:

Hey, good morning, everyone. How are you guys doing? Listen, we are going to be taking a look back to the beginnings of punk today. You guys are going to want to stick around for that, but first we've got something a little more serious to talk about.

That's right, it is serious. And it is something a lot of people don't realize is going on in teen relationships: battering. Guys abusing their girlfriends. What a lot of teens don't realize is that there is a way out.

> "I don't know why it started or how it started. I'd never been in a relationship where a guy hit me. Most of my friends said that they hit their girlfriends. And he kept hitting me and hitting me and it was just really bad. I know it happens, you hear about it a lot. I couldn't believe that he would want to hurt me so bad. It is a really big problem, and I think it is bigger than any of us even realize."
>
> It is estimated that one in three teen relationships involves abuse. Star Forward got caught up in one of the worst kind when she was just 15. "I didn't really know how he was going to be, because he was kind of like the first time. I wasn't sure if it would happen again, but like I said, I didn't really know the cycle or how it was going to be," said Star.
>
> But like most abusive relationships, the cycle continued. Star and her boyfriend made up, the bruises went away, and she hoped he would change. But the beatings only got worse. "He would pick me up and then start beating me up like I never could imagine. He beat me so bad I had two black eyes that were so swollen I couldn't even see. He broke two of my eardrums and cracked some of the bones in my fingers," said Star.

You can see from a survivor how important this issue is. Lastly, I would like to address the community's response. The other fact about media advocacy is that it is fine and well to develop all this lovely material, campaign literature, and have press coverage, but what happens after that? You need to respond to the attention that you raise in the community by resolving to develop solutions to the problem that has been "unmasked."

The campaign led to the formation of the Teen Pregnancy Violence Prevention Coalition, which is a multidisciplinary group representing law enforcement, social services, youth providers, and public health agencies. And again, as I said earlier, they are the bread and butter of this campaign. It was through their efforts that we further defined the gap in services and identified solutions for battered pregnant and parenting teens. Tracey Rattray will discuss the response from the community and how the campaign affected institutional and public policy changes.

Tracey Rattray, M.S.W., M.P.H.
[See Handout #4 for a brief description of The Prevention of Battering During Teen Pregnancy Project.]

The members of the Violence Prevention and Teen Pregnancy Coalition reflect a rich diversity of county government representatives including representatives from social services and police departments, Adolescent Family Life Program (AFLP) providers, medical providers, domestic violence providers, and others. I think it has been this group that has really contributed to the strength of the campaign and the response we have been able to generate in the community. Battered teens come in contact with every one of these organizations, and I think it was really helpful for each of these individuals to have a forum where they could act together.

The first task of the Coalition was to determine referrals for battered teens for the 800-number we have associated with the campaign. We had developed a media campaign with an 800-number.

When we got to the point when we were going to release the campaign and we were going to make a recorded telephone message that had referrals for battered teens, we realized there were not any. We really had to stop and say, Wow, what are we going to do? Where are we going to send young women who respond to the information that we are putting out there to the public?

I think right now what I will do is tell you about a case study that was told to me by a case manager at the TAP (Teenage Parenting) Program, which is our local AFLP provider. This case study illustrates many of the problems in providing referrals to battered pregnant and parenting teenagers. This is a true story about one of their clients, Mary, who is 16 years old.

Mary has one child and lives in the Mission District of San Francisco with her mom. Mary's boyfriend is Keith who is 21 years old. He is the father of the child, and he is physically abusive to Mary. Mary's case manager learned about this after working with Mary for about six months and developing a relationship with her. Mary finally opened up and told her that there were problems in her relationship with Keith. Mary's mother is unable to protect Mary from the violence or to offer much guidance, but she is not an actively abusive parent. This is just sort of negligence. It is not a case where Child Protective Services (CPS) would be involved.

After discussing the situation and reviewing the abuse with her case manager, Mary was ready to leave the relationship and find safe shelter. The case manager called battered women's shelters in San Francisco to see if there was a place where Mary could stay. They were unable to accept an unemancipated teenager. The case manager called local youth shelters for runaway teens and other teens who were having problems at home. But those shelters are not licensed to accept a teen with a child. The case manager called the San Francisco police department to see if there was something they could do, but the police department said they could only respond to cases at the time of the violent incident. Mary continued to live at home and be battered by Keith. Mary, as she continued to meet with her case manager, said the violence was escalating as her boyfriend felt validated by the O.J. Simpson verdict.

We have a lot of complex issues here, and what we wanted to do was to draw a map of all the options that were available to a battered pregnant and parenting teen so that we would know what and where is a realistic place where we can refer certain girls under certain circumstances and what are all the options associated with this problem [see Handout #5]. The chart is fairly complicated, but I think that it can be best appreciated by reviewing it in a detailed way and reading the footnotes, which were prepared by Wendy Seiden from Legal Services for Children—they are an invaluable accessory because at first glance it looks like there are a lot of options for battered pregnant and parenting teens. We wanted to include all of the possible services available to battered teens. However, there are numerous legal and other constraints associated with each option, and those constraints are outlined clearly in the footnotes.

I want to review one portion of it, to highlight some of the problems and gaps in services that teens face when they are in a battered relationship. Please follow under "What Can Teens Do," and the first option states, "Find safe shelter." The second option is "Get a restraining order." Now, for an adult woman, this is a fairly easy procedure. For a teen, if the perpetrator is not her parent, then she must ask an adult to be a guardian ad litem in order to get a restraining order.

That is not a complicated legal procedure; however it sounds really complicated. If somebody told me I had to get a guardian ad litem before I had to do something, that would really sort of halt some progress for me. And it prevents teens from getting restraining orders against their perpetrators and from getting the legal protection that is so essential at a time when they choose to leave a relationship.

Another barrier that a teen may encounter is under "Report Abuse." We can report abuse to the police, the Child Protective Services, or to the school. There is a great deal of confusion about the role of the police versus the role of CPS. It differs county by county. We have had great success in San Francisco county in getting the San Francisco police department and Children's Protective Services in one room with us to discuss gaps and cross-referrals. The police were referring cases to CPS. CPS was referring those cases back to the police. Nothing was happening. We have got a clearly outlined MOU now between the police department and CPS and our Teen Moms Shelter about exactly what types of cases are referred to which department and what kind of action will follow those referrals. We are going to attempt to develop those same relationships in the other eight counties that we are serving.

We have had other excellent results in terms of analyzing the gaps in services illustrated by this chart, which really gave us a platform for action. We have been involved in advocating with the domestic violence shelters in San Francisco. Now all domestic violence shelters in San Francisco will accept unemancipated teenagers. And what really was the barrier was some apparent confusion about legal liability. Legal Services for Children and San Mateo Legal Aid Society came to our assistance and provided some consultations with domestic violence agencies in San Francisco. The agencies now realize that there is no prohibition which prevents them from taking unemancipated pregnant teens. I have heard from other domestic violence shelters in other counties that they know that the San Francisco shelters are accepting unemancipated teens and now they are considering accepting such clients as well. I think we are starting the wheel rolling; having shelters see that if one did it then they can probably do it too is really, really helpful.

Another role that our project has been playing in assisting the shelters to accept teens is to provide them with staff training in how to integrate adolescents into an adult-centered living situation. Many domestic violence shelters have cooperative living arrangements that a teen may or may not fit in. Teens often have different health care needs. They certainly have different mental health care needs. They are in different stages of development. We have been doing training and in-services with domestic violence shelters in order to make those services more appropriate for teenagers.

We are also doing training with teens themselves. We have subcontracted with Sangre Latina, which is a street theatre group in the Bay Area, to do street theatre presentations with teens about how to recognize signs of violence in a relationship before they turn into physical violence. Some of the things that we show teens to look for are things like: Does her boyfriend try to isolate her; Does he control where she goes after school; Does she have to wear his jacket to school as though she is a piece of his property; Is he obsessively jealous?

We often see that teens confuse jealousy and love and that violence gets mixed up with this. We try to clarify this for teens so they can get out of relationships before that relationship turns violent. The third level of training we are doing is with medical providers. Again, that is in conjunction with Kaiser Permanente and Physicians for a Violence-free Society, via the conferences that Bobbi mentioned in her talk.

Perhaps most exciting is that the results of our work enabled us to open a new shelter for battered pregnant and parenting teens. We formed a collaboration with Florence Crittenton Services as the lead agency, and applied for a grant from the State Department of Health Services, Maternal and Child Health Branch, and received funding to open one of two shelters in the state, targeted for battered pregnant and parenting teens. It is in operation right now in San Francisco. We have six beds for teens and their children and also have a crisis line that battered teens can call for advice. Often they will call the crisis line ten times before coming in to talk about: Is this relationship violent; Should I leave; When should I leave; How do I leave; I do not want to leave; I changed my mind. Then they call back. So the crisis line is a very important intervention for teens before they are ready to leave that violent relationship.

Finally, I wanted to mention three policy recommendations that we have come up with based on the work that we have done. These are mostly ideas and suggestions that have come from the Violence Prevention and Teen Pregnancy Coalition. One is continued legislative and administrative support for the state's battered women's shelter program, with an emphasis on data collection and prevention, as well as intervention.

Two is continued support for prenatal care for undocumented women. Undocumented women are at very high risk for domestic violence, and often a medical setting is their only source of support and intervention.

Third, the Coalition would like to recommend waiving the requirement that a teen obtain a guardian ad litem before she can get a restraining order against her perpetrator. While this is not a complicated legal procedure, this requirement can prevent some teens from obtaining the legal protection so necessary when they choose to leave a relationship. This is the most dangerous time for any woman in a domestic violence situation—when she leaves. And we need help to protect the teens during this time.

The Role of Media in Community Violence Prevention Strategies
Lori Dorfman, Dr.P.H.

Lori Dorfman is a Co-Director of the Berkeley Media Studies Group (BMSG). With support from the California Wellness Foundation, BMSG has undertaken a media advocacy program for youth violence prevention. She will discuss her work relating to violence prevention as well as offer comments about the role of the electronic media in violence prevention. [For a more complete discussion of media advocacy, please contact CAFIS to request a copy of Media Advocacy: A Strategy for Advancing Policy and Promoting Health*.]*

I am going to talk about media advocacy and the use of the news media for advancing policy initiatives. I am just going to focus today on television news in most of my examples, although we work in other mediums, including print. I am also talking about youth in general rather than just family violence, since the project that we are involved in is The California Wellness Foundation's Violence Prevention Initiative. That project is where a lot of these examples will come from.

News in general is important. Why is television news important for violence prevention? At BMSG, we took a look at what is on local television news regarding teens and violence [see Handout #1]. Then the question was, What is a "good" news story about youth violence? I have a very particular definition of what I mean by a "good" news story that I want to share with you, because it is not the usual definition that people have when they think of good news stories. There is a lot of complaining that goes on about the news: There is always bad news. We never see anything good about kids. We never see anything good about young people. And while much of that is true, there is a very particular way I want to think about news stories if what I am trying to do is advance social policies that are going to make a difference and prevent violence before it starts.

There are two main functions of the news. Media advocacy draws on these. The first is *setting the agenda*. The saying is, the media doesn't tell us what to think, but they tell us what to think *about*. Since we are talking about family violence, we will take the example of the O.J. Simpson trial. During the trial, this country was talking about domestic violence. We were talking about it in our public conversations. We were talking about it in our private conversations. It did not mean the news told us what we thought about domestic violence, but it did mean we were talking about domestic violence. That is what setting the agenda means.

But the news does more than that. It does not just tell us what the topic is, it draws boundaries around those topics by including some things and excluding other things. That is called *framing.* That is how the public debate gets shaped, by what kinds of exclusions and inclusions there are on the news.

I focus on television because that is the news that most people pay attention to. It does not mean newspapers are not important, newspapers are extremely important. Policymakers read newspapers, especially the opinion pages. Assignment editors at television stations read newspapers and get ideas for stories. A lot of us here read newspapers. But television is by far

and away the number one place today where people are getting their information. They say that this is the information they trust the most and they rely on the most.

We took a look at television news. I will not go over the whole study, but I want to give you a taste of what we looked at. We wanted to see what is being presented about youth and violence on local television news [see Handout #2]. We did a content analysis that examined 12 days of local television news from across the state, one full broadcast each day from each of the affiliate stations, one independent station, and one Spanish language station from all the major markets. That amounted to 281 broadcasts for over 213 hours of news. We found that there was very little about young people on the news. When there was information about young people on the news, it was usually in the context of violence.

We found that, first of all, crime dominates local television news. It is the number one topic across the news. That does not surprise you. There is more news on other topics taken together, but crime is the single most frequent topic on the news. Youth accomplishment stories are rare. The only time we saw things that we called "youth accomplishment" were for very extraordinary acts. An 18-year-old won the Miss America contest. That was a youth accomplishment. Many of you maybe remember Vicky VanMeter, the 11-year-old who flew solo across the United States. That was the kind of youth accomplishment we saw on local California news.

There were occasionally other accomplishments from young people on the news, usually sports stories, and sometimes somebody would win a contest at a science fair or a spelling bee. But there was really not very much about what young people are contributing to families and communities.

We also found that when young people show up in the context of news, it is as both victims and perpetrators, sometimes both in the same story. We didn't find more perpetrators than victims, as some people think. The main thing that we found was that the news stories neglect the context of violence. That is very important from a public health perspective because what we are concerned about is context and the social conditions that exacerbate violent situations, the kinds of things that we are trying to control for prevention.

What that means is that public health perspectives were virtually absent. We rarely heard about prevention. There were a couple of stories that mentioned prevention. Our analysis included the week when President Clinton unveiled his health care reform proposal and he mentioned violence, emergency rooms, and the cost of violence. A couple of times during that time, Jocelyn Elders also mentioned violence.

Interestingly, there was one story where violence was really presented as a public health issue. It was a story about what the health department was doing in Contra Costa County. I do not know if most of you are familiar with what is going on in Contra Costa County. [There is a description of their activities earlier in this report.] They are taking some very innovative actions. It is very encouraging that they were able to break through the television news with a different kind of story because they were doing something different. They were taking a unique approach, and that gives me a lot of hope that we can get some of these approaches the attention they deserve.

Our most important finding is that television news is not including the public health perspective on violence. By that I mean prevention. The news is talking about violence from a criminal justice perspective. Discussion about violence prevention is not going to happen in the land of news without our involvement and without our help. Journalists are not going to figure this out for themselves. That is not their job. Their job is to report on events and incidents that happen, and they come to us as background sources for those events, as they came to the March of Dimes on the issue of teen battering.

This means we have a responsibility to understand how to express what we are doing in preventive terms so that journalists will understand to expand the story. The public can then understand and debate in terms of solutions. This means we have to think about the problem definition a little bit differently [see Handout #3]. The news tends to focus on individuals, and individuals and personal responsibility are important. But they are often focused on to the exclusion of social accountability.

News from a public health perspective means shifting from defining the problem at the individual level to defining it at the societal level. It means we have to be able to talk about it with that kind of definition in mind. It means rather than having a short-term focus, thinking about long-term policy perspectives. Instead of using the mass media to change personal behavior, it means thinking about the news media as a tool for changing policies, influencing social factors and influencing decision makers. We have got to start thinking of the media in this context. And that is what media advocacy is.

Media advocacy is the strategic use of mass media to support community organizing to advance a social policy initiative. Media advocacy is not about getting our program name out there, or about getting an issue out there just for the sake of getting it in the news. As we know, violence is in the news. Media advocacy is not about getting more violence in the news.

As a matter of fact, we know that people fear crime despite the decline in the crime rate. So the problem is not getting the issue out there, the problem is *how* is it getting out there? How is it being shaped? Is it being done strategically? Is it linked to policy solutions and public policy initiatives? Sometimes being strategic means *not* using the media. The policy focus could be local, statewide, federal, or corporate. It might be whether a battered women's shelter will admit unemancipated teens, as we heard earlier.

So this is different than the way most of us have thought about using media in the past. For example, information campaigns or the social marketing initiatives have, in general, an individual focus. Their objective is to get the right message to the right person in the right way at the right time so they can do the right thing, do the healthy behavior, whatever the case may be: not battering, eating better, exercising more.

For some of us here, all we needed to hear was that if you exercised more, you would live longer, and we started exercising more. It was an information gap. We just needed more information. For some others of us, we heard the information, we knew if we exercised more we would live

longer, and we wanted to do that, we even had the desire, but we were working long hours, or the price for the health club was too high, or we didn't have the right tennis shoes, whatever it was. There are other things at play than just information.

Media advocacy, rather than focusing on the individual, focuses on the group, a population-based model [see Handout #4]. Instead of informing the person about the problem, which is usually the way media campaigns are organized, media advocacy is about pressuring decision makers so the policy will be enacted. Rather than using the media to get out a "healthy" message, it is about using the media to raise voices. It is about power and social change. The problem is the power differential, not an information gap.

The basic question about choosing a media strategy is this: Will improved health status come about primarily, not exclusively, but primarily, as a result of individuals getting more knowledge about personal health behaviors or as a result of groups getting more power to change social and economic conditions? When we are talking about a young woman in a high school who has to wear the jacket of her boyfriend, that is a power issue, not an information issue. That's a power problem.

The history of public health tells us unequivocally that when groups get more power to change social and economic conditions, it makes a difference in the population's health. This is a problem because of the news media's tendency to focus almost exclusively on individuals. This comes from a journalist's desire to have an audience empathize with a personal story.

A lot of the journalists I know went into journalism for the same reasons I went into public health: they wanted to make the world a better place. The way they feel they can do that is by focusing on a person through which to tell the story, because the audience will empathize and have some compassion for the person and, hopefully, the issue. The problem, as the research shows us, is that when news stories feature individuals to the exclusion of those other social factors, then when you ask audiences, What should we do about this problem? they answer in ways that tend to blame the victim.

Individualism runs very strong in our country. Let me give you an almost absurd example: A news story from the *San Francisco Chronicle*, headlined "San Francisco Housing Agency Criticized For Rundown Units, Finances." It is a pretty good story actually, because if you are talking about social conditions, housing is fundamental. But I want to read you the caption of the picture to illustrate the problem we face with journalists and the news media. "Sherry Williams, right, who has waited three years for the Housing Authority to fix her leaky roof, confronted maintenance superintendent Lenore Iglesias. He blamed her for the problem, saying, 'the housekeeping could be better.' "

Now, it is really hard to figure out what housekeeping has to do with a leaky roof. That is why I say it is kind of an extreme example, but it is featured with a big picture. Someone wrote that caption, and they are trying to highlight the irony, I'm sure. But here is an example of the struggle in any news story, that struggle that we should be concerned about from a public health perspective, between individual responsibility and social accountability.

The three key elements of media advocacy that Priscilla Enriquez mentioned are (1) setting the agenda, (2) shaping the debate, and (3) advancing the policy [see Handout #5]. Setting the agenda and shaping the debate take advantage of what we know about how the news is constructed and what its function is in society. Advancing the policy is what a media advocate does, with a media advocacy initiative.

Before you even start talking about media, it's best to answer three strategy questions. The first question is, What are the issues, or what is the problem? The second question is, What is the solution? Finally, Who has the power to make things happen? You have to know the answers to these questions before you can proceed with any media initiative.

When I say, What is the solution? I do not mean something generic and general such as, the community really has to come together for teens. I mean something very specific. We can talk for days about the problems, but when somebody says, What should we do about it? we tend to be vague. I am talking about being very specific.

For example, if the problem is battered teens who are pregnant who want to get out of their relationship, the solution is a safe place to go. Well, there are barriers to that safe place to go. One barrier is the difficulty in getting a simple restraining order. Removing that barrier is a very specific policy goal. And the next question is, Who has the power to do that? Now, if the person or body that has the power to change that says, Oh, you're right. We never thought of that. Well, okay, all right. Let's change it. Boom. It is changed. You have no use for media advocacy. There is no reason to use this as a tool.

If, on the other hand, that person is reluctant, promises or does not come through, does not understand the full magnitude of the solution and why it is important to take that action, then pressure in the newspapers and on the opinion pages can be an enormously powerful tool. Other media strategies have a broad audience, which is usually the group with the problem. In this case, the focus for the media advocacy initiative might be one person. That is, the person with the power to make the change.

Let me now give you example from a group that was working on gun issues. A local paper covered that group's protest outside a gunshop that is famous for doing something illegal called "shadow sales" when somebody purchases the firearm for another person.

I just want to read you one line from this story, which is at the very end. After one of the speakers was interviewed, the question was asked, "Well, what can we do about these shadow sales?" And the speaker says, "There's really nothing that can be done." If that is the case, why is he protesting? You need to know ahead of time the answer to the three strategy questions.

Similarly, the previous March of Dimes speakers found that they needed something to tell those who might call the 800-number before they put their media campaign on the air. That work has to be done first. Your overall goals, outcome objectives, and policy objectives should be in place

first and then, if necessary, your media advocacy objectives [see Handout #6]. Media is low in this hierarchy.

Framing is very important to media advocacy. Getting attention, as it turns out, is not the difficult part. We can do that. The difficult part is; How do you frame your issue so it is not focused exclusively on the individual but expands to include social conditions? We do not just want portraits, we want portraits sitting on the landscape. We want to know where that person is, how did this happen, and what are some of the social conditions.

Handout #7 is an example from the *Oakland Tribune*. It was a front-page story on a Sunday, with the headline: "Violence Up Across the State". It was really quite a terrific story, it talked about trends, and had a lot of data and other information. What I call a good news story is one with a solution. That kind of information was in there. But when you turned the page, you saw the second headline, "Crime. Juveniles Blamed." We thought this was an irresponsible headline. It was there for a technical reason, because violence within a certain age group had increased, but it was a bad focus for the headline.

So we wrote a letter to the editor of the *Oakland Tribune*, and I want to read you one paragraph from this letter [see Handout #8 which also includes a responding letter to the editor]. We had two objectives with this letter. First, we wanted to tell them this was a bad headline. But not only that, we had policy positions that we were interested in advancing. Our "sound bite" version of the policy positions we worked on were: (1) fewer guns; (2) less alcohol; and (3) more resources for prevention.

We tried to highlight this in our letter. This letter was not just about shaking our finger at the *Tribune* saying, "You guys did a lousy job." It was an opportunity to advance our policy positions. The paragraph reads,

> Too often youth are scapegoated and cast aside. The children of Alameda County do not manufacture firearms; they do not sit on planning commissions that allow alcohol on nearly every inner city street corner; they did not take the actions that increased classroom size and reduced the school budget. When kids are killing kids, that tells us more about our society than our children.

These things were not children's responsibilities. They are responsibilities we have as a community.

I hope that I have made it clear that you cannot have a media strategy without an overall strategy [see Handout #9]. You have to know what you want before you go asking for it. Second, public health issues are far too important—matters of life and death—to be left exclusively to public service time. With media advocacy, we're talking about the city desk, we are not talking about the public affairs department.

Media advocacy focuses on policy to create healthy and safe environments in which people can have healthy relationships and make good decisions. If you want to say media advocacy in one

line, you say, in the words of San Francisco station KFOG news analyst Scoop Nisker, “If you don’t like the news, go out and make some of your own.”

Family Violence and the Multisystemic Therapy Model
Don Kingdon, Ph.D.

Don Kingdon, Chief of Children and Adolescent Services in the Ventura County Mental Health Department, will discuss an innovative family treatment program called multisystemic therapy that Ventura County is utilizing throughout its county programs for families. He will describe: (1) Multisystemic therapy and how it was developed by Drs. Scott Henggeler and Sonja Schoenwald at the Medical University of South Carolina Department of Psychiatry and Behavioral Sciences; (2) Evaluation findings of the model's effectiveness; (3) The complement of other services necessary for multisystemic therapy to work; and (4) Ventura County's decision to augment their children and family services to include this service component, their progress in implementing it, and the impact it has had to date.

I would like to basically describe two related changes in the way public mental health does business. What I am going to be describing to you is what was originally called the Ventura model back in the early 1980s. Then Assemblywoman Cathie Wright, now Senator Wright, sponsored legislation that allowed Ventura County to demonstrate that we could reform not too effective programs into one community mental health system (I will be talking about the reasons it was not effective). The model has become known as the California Systems of Care Model. The state's Department of Mental Health has embraced it. Senator Wright continues to sponsor legislation that supports it. Seventeen counties have replicated it. Interestingly enough it has become the agenda of more conservative parts of government as opposed to typically where we get our support. The other topic I will be talking about is the integration of multisystemic therapy, developed by Drs. Henggeler and Schoenwald at the Medical University of South Carolina, into this model. And hopefully by the time I am done you will understand why those two things fit together.

To borrow from medicine a bit, what we really have struggled with in the mental health field is the same thing that you probably struggle with in health care, that you can have a great syringe, a way to get medicine to the people, and the wrong medicine in the syringe and be ineffective. Or you can have a terrible syringe that nobody wants to have anything to do with that hurts, but have great medicine and still not get the medicine to the people. That is really the core of why these two things fit together. The system reform as we see it is really that new syringe, hopefully less painful, less traditional, and able to get the medicine to people more quickly and less painfully. However, the improved medicine was missing when we reformed the system ten years ago. Dr. Henggeler has begun to provide that for us with multisystemic therapy, the actual content of treatment, not just where the treatment was delivered. And again, hopefully, that will make some sense to you as we go through this.

Many of you may know that there was a community mental health movement throughout the '60s and '70s. It was an attempt to bring the mental health model of clinic treatment into the community. Back then people did not even think children had mental health problems. As a matter of fact, it was not too long ago that people assumed children never got depressed. Much of that has changed. But the original community mental health movement was largely built on, without offending anyone hopefully, a private model of care which is 50 minutes an hour once a

week in the clinic. You come down and get something and hopefully it works; you go away and, hopefully, you come back again. But as many people have found, people do not necessarily come back again.

The problem as we saw it, as Randy Feldman and Supervisor Lacey saw it, at that time was that there was no clear-focused population [see Handout #1]. In other words, what happened in the mental health system was first-come, first-serve. People showed up at clinics, they got treatment. It was actually often the most organized families that were able to get to those clinics. I am sure many of you experienced in your agencies the referral process kind of dead-ending at that point.

So mental health really did not have any idea who it was supposed to treat. It pretty much treated those who showed up. The other problem that we had was, even when we got a hold of them, we really couldn't describe to people what we did. So we found ourselves, as many of us do, going back to the Legislature every year and saying, "Well, we did the best we could, but it's gotten worse and we need some more money." That did not work eventually. Over time the Legislature figured out, I guess, that we were not being successful and began to erode the funding that was available to community mental health, both at a national and local level.

The third problem we had, and this was really identified by people delivering services, was that a whole bunch of agencies were involved in this family's lives—uncoordinated, disconnected, with different goals and outcomes and categorical streams of funding. We were probably making the families worse, despite the number of appointments they were supposed to make and often weren't able to make. This was a real problem.

Fourth, we found that a lot of money was being spent, when you looked at the entire categorical system, although mental health did not have a lot of money. Between the years 1984 and 1994, there was a 400-percent increase in the funding available to separate children from their families and put them in group homes. That does not include foster care, that is just the money available to have to put kids in group homes. So actually, what was happening was that we were investing heavily in one aspect of our service system and neglecting other aspects of our service system. It was a lot of money, it just wasn't being directed in the right way. It was our intention to redirect some of that.

Lastly, even if we wanted to communicate outcomes, we were not able to because we did not count or measure them. One of the things that Randy speaks about, and I think it had a lot to do with our support from Senator Wright, is that we have acknowledged and accepted, as painful as it may be to us, that the taxpayer is really the investor and our Legislature decides how our taxpayer dollars are being spent. We learned how to talk to the taxpayer and the Legislature and give feedback as to what we are and are not able to accomplish. And I think that has been a big change.

What basically happens if you do not have a clear sense of who you are going to serve is that grant funding often dictates [see handout #2]. Population service priorities shift. How many times have we invested in early intervention and ten years later found that we didn't have enough money left—for some of us on grants, three or two or even one year later? Healthy Start, I think,

is a good example of a wonderful attempt to change the way we do business. But again, grant funding often limits how long those kinds of reforms can last.

Cultural groups are excluded or overly included. Certainly our correctional population, we will all admit, is overinclusive of certain cultural groups. On the other hand, sometimes in California in special education we do not see representative samples of certain cultural groups. Probably even more important today, is that private insurance is dramatically cutting back mental health benefits available to families through benefit caps, through benefit limitations and sometimes through even just cutting that benefit out completely. What that leaves then is the public mental health system and its agency partner, most notably special education, as a safety net for those families who no longer have mental health benefits.

Without defined goals, it is pretty clear that we cannot tell people what we do or what our values are [see Handout #3]. You can see pretty clearly what the problems are in the handout. There are probably about 160 distinct state programs administered by many more agencies. Without partnerships, what happens in our service system is that kids need to be moved from place to place to get service, instead of the service delivery system moving to the child and to the family. We are asking children to adjust to multiple placements as opposed to getting better from a mental health perspective. Certainly we will talk about this later in terms of solutions, wraparound and some of the other things in family preservation.

The other thing that happened is that we had tremendous amounts of duplicative case management. We have been involved in the last year in trying to knit together the pediatric settings where children find themselves under children's medical services. Everybody does case management now. Families often have two, three, four and sometimes even five case managers. Case management is an activity that we all perform. Obviously one of the solutions is to leverage some of that case management and establish single points of responsibility.

One of the biggest problems we have in the health care field—in mental health, specifically—is that we tend to count units of service and not outcomes [see Handout #4]. We can be very process-oriented. We can tell you that we served 1,600 kids this year, but when somebody asks, What did you accomplish? we cannot answer that question very well and we cannot associate costs with what we have accomplished (or cost avoidance). Again, this is what I think Senator Wright has found valuable in the Ventura model, that it is possible to get up in front of the Legislature and have a human service agenda and also be conservative in terms of taxpayer responsibility. Certainly that has a lot to do with her support.

Lastly what this leads to is the picture shown in Handout #5. This has been found repeatedly in the human services field. The most money goes to a small number of kids. Whether that is appropriate or not, I will leave to you. It is just the reality in the human service field. Orange County did a study a few years back and came up with what they called the 8 percent problem. What they found, essentially, is that 8 percent of the kids in the juvenile correctional system use 70 percent of the resources.

Many of us look at the correctional system and say, Well, it is broken. But for quite a few kids, it does operate as a deterrent. For this core 8 percent, though, it doesn't. As a matter of fact, corrections is probably a safer—and I will not say healthier—but at least a safer place to be than, for many of them, their neighborhood. It is that 8 percent that we began to focus on in Ventura, to change their patterns of utilization.

We often talk about early intervention and preventive care. What's important to us is that it needs to be financed with existing dollars. As far as we are concerned, and we have accepted this reality, there is a finite amount of taxpayer dollars available for this system. There is not going to be a lot more. We can augment that with grants from various foundations, but all of those grants are time limited. If there is a finite amount of taxpayer investment dollars available for human services, we need to be very efficient in how we spend that money.

This is probably the core of the whole model. We would like to intervene early in a child's life using money that we no longer spend for incarceration and out-of-home placement, as opposed to using grants and other time-limited forms of funding.

So what is the solution? As we heard earlier, you never tell anyone what the problems are without the solutions. Essentially, what came out of this is what's been called the Ventura Planning Model and is now called The California Systems of Care Model. It has five steps [see Handout #6]. One of the important things about these five steps is that they are all necessary, but none of them sufficient in and of themselves.

If any of you have been involved in a collaborative where a bunch of agencies get together and talk, what you find is you have implemented the third phase—you have got a bunch of people together at the table to talk, but it becomes sort of circular and in the end you really do not get anywhere. We would suggest that you have missed the other stages. They are very painful. The early stage, probably the first step in this, is one of the most painful. It is acknowledging that you do have to find this 8 percent and serve them differently.

Many people come to the table with many agendas. Often we hear, what about this group and what about that group, what about early intervention, what about prevention? We certainly agree with all of those approaches, but in a capped health care, managed care environment, the key to controlling cost is to find your high utilizers and serve them better. Certainly health care has demonstrated that. How many people go to the hospital for surgery anymore? Surgeries that once required long-term hospitalization are now performed in offices. That was done largely to control the costs associated with health care. We need to do the same thing in mental health. And to do that we need to identify a group of these kids and their families that we can find and target.

In Ventura County, that originally meant kids who were in the social services system, from shelter care through group homes. In the future, it will be all children who are recipients of AFDC. Our goal—we have 10,400 people in Ventura County who receive AFDC—is that all of the kids in those families that require mental health services will get them, again financed not through a grant, not through new money, but through the existing system.

One of the early partnerships that developed was with education. That has expanded from Head Start through high school. The other system where we needed to change patterns of utilization was the correctional system, both in institutions and in the community on probation.

Our original target population came through this process of looking for these high utilizers in the system and providing care to them. It would not have been effective if we had used the clinic model, because these are not the kids that are going to show up at the clinic. We needed to deeply imbed our services in other delivery systems.

The second step in this process is that once you figure out who you want to serve, and it could be pregnant teens, you need to establish clear goals and measurable objectives. Often we jump from who we want to serve to what the services are going to be and skip the next two steps, goals and measurable objectives. These next two steps are very important for a number of reasons. For us, early on, ten years ago, it was nothing very complicated. Randy Feldman, our director, feels very strongly about simple language. It was nothing more than we wanted to keep kids at home, in school and out of trouble. Nothing more complicated than that. But the goals were all measurable, they were all countable: we could count how many days kids were in school before and after what we did. We could count their achievements, we could look at their recidivism, and we could tell whether or not they were ending up back in correctional institutions.

The third step, after you have established your goals, is to begin to develop the partnerships necessary to achieve your goals. The reason this is important is that you will find that many of the agencies that you would be partnering with, serving families and communities, already have people focused on many of the things you want to accomplish. So your goal becomes to leverage those resources together instead of creating a whole new resource. Partnership formation is a very important step, but not the first step in the process.

What you often find after you develop a target population and a clear and measurable objective, is that there are partners you would have forgotten had you started with trying to pull everybody to the table. The ones we left out early on were the families themselves. If you want to keep kids at home, you have got to do stuff that works for families. And we certainly did leave families out early on.

Fourth, after you finish all of that, you begin to fill in service gaps instead of designing services from the beginning. So what you find is that there are, for instance, shelters that are unable to serve the population you are targeting. Your job becomes to reform the existing services and then fill in whatever gaps are necessary to improve the services.

Lastly, while you are doing all of this, you measure everything you do and you put it into taxpayer-friendly language and legislative-friendly language so your elected officials can be clear on what the goals are, what it is that you are accomplishing, so that they can continue to fund you. In that, we have been very successful.

With all of that then, that is basically the syringe. What is the medicine we put inside? One of the problems that we had initially is that although we were very successful in redirecting quite a few of these kids out of residential care and back into the community, once we got them into the community we were a bit lost, honestly, in what we would do with them. We began searching for a clinical model that was very different from the clinical models that we had operated with. Most mental health clinicians have been taught that you do not want to get involved at the family home, you do not want to go to the school because that is going to contaminate your clinical work, you need to stay pure in your office, bringing people there to accomplish what you need to accomplish.

We had a lot of retraining to do and we eventually did turn to multisystemic therapy (MST), developed by Drs. Henggeler and Schoenwald. Let me just give you kind of an overview of what multisystemic therapy is [see Handout #7].

The core element of multisystemic therapy is that it moves from an individual pathology model, in other words what is wrong is located inside the person, to what is called a socioecology model. That means that the problems are multi-terms–the individual has a role, but the larger society probably has the more important role in determining what it is you are going to do in treatment.

Let me give you three basic principles, and hopefully, some of these by example will be pretty clear. One is that individuals grow in structure and restructure of their environments. In other words, we are not victims. We make things happen around us, we are part of what happens around us, and for some of us violence, whether we like it or not, is the solution. For some kids who have been exposed repeatedly to media and other kinds of violence, they have been trained that violence is a solution to problems, a fast solution. It gets things done quickly and for most or many of them, the after-affects are not as bad or not as much a deterrent as we would like to believe. Multisystemic therapy does not accept that this is the solution, but does accept that this happens—that for some kids and some families, violence is a very quick solution to a problem.

The second principle is that the environment influences the individual in a reciprocal relationship. In other words, there is a cycle. Probably one of the biggest myths about the juvenile corrections population is that they are victimizers. As a matter of fact, most of them have been victimized and are victimizing all in the same day. Many of them experience both ends of that continuum. And so there is this reciprocal relationship that they experience between being victimized and victimizing over and over again in a number of settings. Over time, of course, the environment is as much the issue as what goes on inside families. Although personal responsibility is certainly the core of much of what we do in treatment, we need to move beyond that and understand the context. I think that is what multisystemic therapy is trying to do.

The third principle is that behavior is influenced both by the immediate environment, the family, but also by the context that the family lives in. A good example of this is the poorer you are, the less choices you have. Many of us in the mental health field approach treatment as trying to help people have more choices. Many of the earlier treatments focused on people taking responsibility, but Dr. Henggeler and others have said that that is not enough. You need to acknowledge that if

you are an individual in poverty, your choices are going to be more limited, your access to certain resources is going to be more limited, and ultimately it will affect your sense of personal power.

So if the therapist comes in and says, Okay, we've got to change how you deal with your child, you as a parent in poverty may feel like you have much power to change anything. Certainly the treatment approach would need to adjust to that kind of an experience.

There are a couple of other important things that Dr. Henggeler has pointed out. One is that intervention from the mental health perspective needs to be ecologically balanced. Basically what he means is that you have to see clients in the home to understand them. Seeing them in your office is not going to work because you will get a slice of behavior that is appropriate or not for the office. You will miss all the things that you need to understand and the interventive potential available in the home, the school and community. We have gone so far as to expect that a therapist will go to a 7-Eleven and see who you are hanging out with and track some of that, and also hopefully intervene in those kinds of situations.

One of the other important things that Dr. Henggeler has pointed out is that we need to be optimistic. People change. They may not change in the direction we would like, but they do make what he calls ecological transitions. You can cause people to change in a direction or at least help people to change in a direction that is positive; they are going to change anyway, whether you are there or not. They are going to be making changes every day, it is a natural part of life. It is not something stimulated by the therapist. It may be guided, hopefully, in a more optimistic direction.

The other thing that he has impressed us with is that therapy is not expert advice. As a matter of fact, expert advice is probably the problem and was the doom of much of the early community mental health movement. Therapy is consensus building. It is sitting with the family and assisting them to come to a consensus about what it is they want to change. It is a very different approach than coming in with expert advice. It may have a lot to do with—as we get into welfare and other kinds of reform—why parent training is not necessarily always the best step. Not every parent thinks they are a bad parent. A referral to parent training when a parent does not think they are a bad parent, is usually going to lead to a high no-show rate. So the early phase of treatment in this model is to build consensus. What is it they want to work on? We need to accept that what they may want to work on is very different from what we would like them to work on.

Lastly, and this is probably the most difficult point for a therapist to accept, failure tells you as much as success. I think this is one of the important parts of this model, that it does allow mental health professionals and the families they deal with to form hypotheses about why it is that Johnny is not going to school, to do some intervening, and still fail and not have Johnny go to school and yet not give up. Often what leads to residential and sometimes more restrictive placement is that our system is so focused on success or failure that we tend to just deal with kids more and more restrictively, not using our failures as a hypothesis about what we need to change. Dr. Henggeler's model expects that the therapist will predict failure, know when it is going to occur, and be able to modify things to accept and change some of the failures associated with them.

So with all of that, let me describe some of the clinical interventions. What is the therapist actually going to do with the family? I am just going to go through the nine basic principles. Again, I apologize if I get a little too technical here. But I think it is important to try to understand this.

(1) The initial assessment changes from trying to figure out a diagnosis, to focusing on the problem and the context of the problem and the environment. A good example is that most of our schools have zero tolerance for weapons. A therapist might address that problem by saying to the child, You can't bring a weapon to school. In contrast, therapists in a multisystemic model would walk with the child to school and find out why it is that he feels he needs a weapon. They may find that to get to and from his home and school, a weapon is not a bad idea. Just the wrong solution. But to a ten-year-old who does not know any other solutions and sees a lot of weapons on TV, representing personal power, it might be the best solution that he or she can come up with at that time.

The multisystemic therapy would say, Do not undervalue the child's attempt at a solution. Help them change the solution. Zero tolerance does not do that. Multisystemic therapy would say, you have to go into the school, get involved in the school (at least at that child's level) and get the school to understand why it is that the child feels the need to have some kind of protection as they go to school.

(2) Intervention needs to be present and action focused. If you want people to change, you have got to help practice stuff. You cannot just sit and talk about it, you have to help them find things that they want to do and help them practice right now. No MST therapist leaves a family without some kind of daily homework. And again, this is mutually agreed upon. A family is doing something every day, whether the therapist is there or not, and practicing the kinds of things necessary to change the interactions within the family, within the community, and within the schools.

(3) Intervention targets sequences of behavior. It is okay to start with little steps and build up. You do not have to start at the end goal. This is sometimes where parent training and some of the other referrals that we make fail. They look at an ideal and expect families to be able to adjust up to that ideal, without understanding that baby steps can be very important and that there are differences in parenting style. If I was to compare many parents on the East Coast to parents in the inner cities here, I may find a much more dictatorial style of parenting. A parent's expectation may be that they do not want their child outside during certain hours of the day, whereas here that may seem a bit dictatorial. Back there it is actually very valuable. So it is important to accept that families are going to approach their children differently, depending on the environment they find themselves in.

(4) Interventions must be developmentally appropriate. One of the classic interventions in corrections is to cause the kid to stay at home all the time with their parents. Guess what happens. Conflict starts and the child freezes. Adolescents traditionally do not like to spend a lot of time with their parents. They like to spend time elsewhere. The correctional system wonders

why it is they are having to re-book the kid for fights between mom and dad, mom and brother, and brother and brother, largely because the intervention itself is developmentally inappropriate.

(5) Intervention needs to require daily effort and practice. It is not just when the therapist is there, but it is in-between, too.

(6) The therapist needs to continuously evaluate results. Again, failure is okay, as long as you evaluate it and change the things you are doing in response.

(7) Interventions must generalize. What that basically means is that if you want to teach a kid how to do better in school, how to go to school, how to respond to teachers differently, you have got to go teach that behavior in school. You must work with the child in school as opposed to in another environment and expecting them to transfer that with them.

(8) Interventions need to use strengths to leverage change. We need to value people's attempts at what they are doing and look for strengths. There is a lot of talk about that, the wraparound model. Some of you have probably heard about it. Carl Dennis in Chicago does an excellent job of presenting it. Basically the focus is to find the client's strengths and make them stronger, and over time the weaknesses will become less prominent.

(9) Lastly, interventions must promote responsible behavior. This is one of the areas our therapists most stress with parents of adolescents, that you cannot abdicate parenting, as much as you might like to, just because your adolescent's response to you is not the response you would like. You have got to keep hanging in there.

Very briefly, I want to call your attention to evaluation outcomes [see Handout #7]. Dr. Henggeler has had tremendous success with correctional populations. I think it is very important. What he has been able to show is that if you use this model, you can change the future for serious offenders in the correctional system. One of the good things about his research in the Simpsonville, South Carolina Project, too, is that he does use a control group. It does not mean that he has a bunch of parents who like to control their kids more. From a researcher's perspective what it means is that he is comparing the alternative treatment group, to treatment as usual, and seeing very positive effects.

Probably one of Dr. Henggeler's most important findings is in the generalization study, which is shown in Figure 2. He uses what is called survival analysis, which is health care analysis. Essentially, he has found that not only does the treatment model work in the moment, but kids and families are able to sustain the changes over time in terms of reduction in recidivism, reductions in the kinds of problem behaviors that got them into the juvenile justice system in the first place, and reductions in out-of-home placements. That is one of the reasons we applaud Dr. Henggeler's work. It is one of the first approaches that has been able to show strong effects with this population.

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