REPORT OF

THE SECRETARY'S BLUE RIBBON PANEL

ON VIOLENCE PREVENTION

January 15, 1993

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VIOLENCE PREVENTION

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Dr. Franklyn G. Jenifer, Chair

SUMMARY STATEMENT

Secretary Sullivan of the Department of Health and Human Services (DHHS) requested that a number of expert consultants from multiple disciplines and representatives from the minority communities meet with him to discuss concerns expressed in the African American community about the Department's ongoing and proposed violence-related prevention and research activities. As a result of this meeting a Blue Ribbon Panel was established, with Dr. Franklyn G. Jenifer, President of Howard University, as Chair. The Panel met on November 10, and December 13-14, 1992, and, after a detailed review of relevant Departmental programs and activities, found no specific evidence that DHHS was conducting what had been alleged as inappropriate research. As a result of their review, Panel members made suggestions to improve the Department's programs, strengthen their relationship with the minority communities, and minimize potential misunderstandings.

CHARGE TO THE PANEL

The Secretary charged the Panel to review Department violence prevention programs and advise him on:

- the validity of allegations about inappropriate research
- ways to strengthen the Department's programs;
- the viability of the public health approach to addressing the problems of violence and aggression;
- how to go about better understanding and preventing violence; and,
- how to assure that the Department's violence activities are open, accessible, and supported by the community.

PANEL FINDINGS AND CONCLUSIONS

Panel members agreed that the problem of violence in America should be declared a national emergency, and that appropriate levels of resources should be committed to addressing this problem. The magnitude of the problems posed to our society by violence are enormous; the homicide rate among young African American males has reached epidemic proportions. Panel members further agreed that it was not only appropriate but critical for the Department to be addressing this problem.

Materials describing the Department's research and prevention activities (Appendix E) were provided to Panel members, and Federal agency staff were available to answer questions and provide background information throughout the review process. Based on review of this material, within the constraints of the time available and the restrictions governing the confidentiality of information, the Panel developed findings and recommendations for each of their specific charges, as follows:

Review of allegations:

- After reviewing all of the DHHS abstracts (224) of research related, even vaguely, to anti-social, aggressive, and violent behavior, and a subsequent more in-depth summary analysis of 28 research projects which Workgroup B (Research) identified for closer scrutiny, the panel did not find any evidence to support allegations that DHHS was conducting research which was (1) attempting to establish a genetic correlation between race and violent behavior, and/or (2) targeted solely at African American male youth, ages 5 to 9 years, which involved the use of medication to control their behavior.

- The panel thought that the public perception that such research existed stemmed from the fact that research is supported by the National Institutes of Mental Health (NIMH) on the treatment of Attention Deficit Hyperactivity Disorder (ADHD) involving protocols which include, as one of the interventions, the use of medication. This research is distinct from research on antisocial, aggressive, and violent behavior. However, the panel thought that the research on

ADHD being conducted was not only appropriate, but probably long overdue, since the medications involved are physician prescribed and have been in use for almost 50 years without adequate assessment of alternatives and long term outcomes for the patients. Present research allows for an assessment of efficacy of the medication, and of alternatives that do not involve medications.

Strengthen DHHS programs on violence:

- The DHHS prevention programs (e.g. psychosocial, community based interventions) are appropriate in direction and represent important efforts directed at a major public health problem. These efforts should be expanded.

- The DHHS efforts to address the public health issues related to violence should be as broad as possible, involving other Departments and Agencies. The DHHS should serve as the lead Department and develop a mechanism for interdepartmental coordination. Considering the importance of such coordination, this effort should be authorized at the highest levels possible with adequate resources provided (e.g. up to $1.0 billion for prevention research and to implement prevention programs). The Centers for Disease Control and Prevention (CDC) should be designated as the lead agency in the DHHS for violence prevention activities.

- Panel members in Workgroup B (Research) expressed concern that constraints of time and confidentiality of information did not permit them to review in complete detail those projects with a research protocol that included interventions involving medication. Therefore, they recommended that the Department should have an advisory committee to provide continuing input into and oversight of PHS and Departmental research programs on violence. They further recommended that this committee should reflect minority community interest and have minority members.

- The Federal government, in conjunction with States and local communities, should mount aggressive public community education and information campaigns to maximize the potential

for success of a public health approach to the problem of violence and to support implementation of violence prevention strategies.

- Safeguards, including informed consent, which are in place to address the ethical implications of research that examines violent and aggressive behaviors should be reviewed and enhanced as necessary. Minority scientists, professionals and community leaders should participate in this review, and the design and implementation of required policies, procedures and mechanisms.

- NIH should consider ways to enhance the review of violence-related research projects, and the potential use of findings from such research, to assure that social, ethical, and cultural sensitivities are considered, e.g.:

  -- Ensure adequate minority representation on institutional review boards, study sections and advisory councils, scientific advisory boards, and other review committees or councils to identify, discuss, and resolve ethical, legal, political, and social issues in grant proposals prior to award.
  -- Conduct sensitivity training for all NIH review committee members to facilitate greater cultural/ethnic sensitivity to minority issues in the review process, and
  -- Identify minorities to serve as a liaison between the research community and the general community. Expertise from the African American and other minority communities should be called upon to participate in the review of violence-related research to assess scientific merit.

Viability of the Public Health Approach

- The underlying concept of the public health approach is valid as one of the strategies that should be used to address the prevention of violence. However, Departmental efforts must be part of a broader approach which recognizes the full dimensions of the problem of violence, including its social context. It must be broad-based, involving multiple Federal Departments and programs.

- The panel supported the violence prevention goals and strategies reflected in the draft PHS document "Youth Violence Prevention: A Proposed Initiative and Status Report of PHS Activities." The program activities of this draft initiative were all reviewed, except for the NIMH research activities, which were considered by Workgroup B (Research).

Better understanding of violence

- HHS should evaluate possible outcomes from changes in the level of violence on television and in popular culture. The three major networks have agreed to begin to reduce the amount of violence on television. NIH should also look at the role and influence of violence in media, entertainment, and popular culture (e.g. toys) on the prevalence and incidence of violence in our society.

- PHS should diversify and expand its research portfolio by encouraging more interdisciplinary research that considers the total human experience, including, for example:
  - the study of environments in which violence takes place, including the influence of the social environment that often condones violence as a solution to problems (e.g., military use).
  - a critical look at the role of anger, values, perceived injustice, family situations, racism, poverty, employment, self-esteem, identity and empowerment, role models (particularly male role models), peer groups, presence of firearms, white collar crime and its impact on violence in society, and behavioral characteristics associated with hate crimes, and
  - the development of culturally sensitive diagnostic criteria and interventions, taking into account how minority populations perceive mental illness, different cultural norms for behavior and how specific cultural experiences may impact on disease development and presentation.

Assure Support by the Community

- Violence prevention interventions, programs, and research should be community-based, where appropriate and feasible. DHHS-supported programs addressing violence are most effective when they involve active participation and leadership at the local level, and therefore have community confidence, address the violence-related problems of these communities and their residents, are implemented in partnership with communities, and, to the maximum extent possible, involve minority scientists. A model that could be used is the sickle cell disease program which required advisory boards constituted of community members. University based researchers were required to work with these community boards to educate the public and set research priorities.

- A public education program should use appropriate role models to deliver the message, including a variety of minority spokespersons who are not exclusively entertainment and sports figures. The development of such a strategy requires full input from minority professionals and community members. Public education activities should inform individuals and communities about:

  -- the nature and magnitude of the problem
  -- the purpose and nature of research and its importance for violence prevention
  -- proven or promising violence prevention programs and where to find help in implementing such activities
  -- promoting a violence-free environment
  -- treatment programs for victims, families and communities, including how to ameliorate post traumatic stress in victims and witnesses of violence, and
  -- how to mount innovative and effective violence prevention programs.

- DHHS should convene national and regional conferences on violence prevention, co-sponsored by appropriate minority organizations and associations to further develop the body of knowledge on violence prevention, to identify the most promising areas for continuing or

future research, to assess ethical considerations, to understand community priorities and to strengthen the collaborations between government and minority scientists, professionals and their organizations.

- The Department should explore all appropriate opportunities to increase the participation of minority researchers, health practitioners, organizations, and community leaders in violence-related research and programmatic activities. Particular attention should be given to the development of models for accomplishing this, including improvements that can be made using the cooperative agreement mechanism.

EPILOGUE

The panelists wish to express their thanks and appreciation to Secretary Sullivan for convening this panel. The Panel also wants to thank Secretary Sullivan for his attention to violence and the toll that it is taking on American society, in particular the African American community. The tragic loss in lives and human potential demand that this nation rapidly address and prevent violence. Finally, we wish to reiterate that the Secretary and the Department enhance involvement of minority communities in violence prevention and research.

APPENDIX A

AGENDAS

SECRETARY'S BLUE RIBBON PANEL ON VIOLENCE PREVENTION

AGENDA

Tuesday, November 10, 1992

8:30 - 8:45	**Opening**	Dr. Franklyn G. Jenifer, President Howard University
8:45 - 9:00	**Welcome**	Dr. Louis W. Sullivan Secretary
9:00 - 9:20	**Statement of the Problem**	Dr. Reed Tuckson, President, Charles R. Drew University
9:20 - 9:40	**DHHS Overview:** • **Public Health Service** • **Administration for Children and Families**	 Dr. James O. Mason Assistant Secretary for Health Ms. Donna Givens Principal Deputy Assistant Secretary
9:40 - 10:00	**BREAK**	Reception area
10:00 - 12:00	**Concurrent Work Groups**	Work Group A - Prevention Deputy Secretary's Conf. Room Work Group B - Research Secretary's Conference Room
12:00 - 1:00	**LUNCH**	Secretary's Dining Room
1:00 - 3:00	**Continue Concurrent Work Groups**	
3:00 - 3:20	**BREAK**	Reception area
3:20	**RECONVENE**	Stonehenge Conference Room
3:20 - 3:30	**Public Health Perspective**	Dr. Deborah Prothrow-Stith
3:30 - 4:00	**Work Group Reports**	Rapporteurs, Work Groups A & B
4:00 - 4:45	**Discussion**	Dr. Louis W. Sullivan Secretary
4:45 - 5:00	**Closing Remarks and Next Steps**	Dr. Franklyn G. Jenifer

SECRETARY'S BLUE RIBBON PANEL ON VIOLENCE PREVENTION

December 13 and 14, 1992

SUNDAY, December 13
Holiday Inn Capitol Hill
550 C Street, S.W.

3:00 - 6:00	**Concurrent Work Group Sessions**	
	Workgroup A - Prevention	Columbia North Room
	Workgroup B - Research	Columbia South Room
6:30 - 7:30	**SOCIAL HOUR**	Lewis Room

MONDAY, December 14
Hubert H. Humphrey Building
200 Independence Ave., S.W.

9:00 - 12:00	**Concurrent Work Group Sessions**	
	Workgroup A - Prevention	Deputy Secretary's Conference Room
	Workgroup B - Research	Secretary's Conference Room
12:00 - 1:00	**LUNCH**	Secretary's Dining Room
1:00 - 3:00	**Panel Reconvenes:**	Stonehenge
	Work Group Reports	
	o Work Group A - Prevention	Ms. Ophelia Long Rapporteur
	o Work Group B - Research	Dr. David Satcher Rapporteur
	Discussion and Development of Panel Report	Dr. Franklyn Jenifer Chair
3:00 - 3:30	**BREAK**	Reception area
3:30 - 5:00	**Presentation of Panel Report**	Dr. Louis W. Sullivan Secretary
5:00	**Adjourn**	

SECRETARY'S BLUE RIBBON PANEL ON VIOLENCE PREVENTION

WORK GROUP A - Prevention

Rapporteur: Ms. Ophelia Long
Departmental Staff Liaison: Dr. Rueben Warren

SUNDAY, December 13
Holiday Inn
Columbia North Room

3:00 - 3:15	**Welcome**	Ms. Ophelia Long
3:15 - 3:30	**Approval of Minutes** - November 10 meeting **Charge to the Work Group**	Ms. Ophelia Long
3:30 - 4:00	**Operational Definition of Violence**	Dr. Mark Rosenberg
4:00 - 4:15	**Public Health Approach to Violence Prevention**	Dr. Mark Rosenberg
4:15 - 5:45	**Review of PHS Activities for Violence Prevention:** o CDC's framework for violence prevention and organizing the PHS initiative o Agency-by-Agency review o Update on new and planned activities by Agency	Ms. Ophelia Long
5:45 - 6:15	**Discussion - How We Can Work Together** o Leadership o Existing and future mechanisms o Conclusions	Ms. Ophelia Long and Panel
6:30 - 7:30	**SOCIAL HOUR**	Holiday Inn Lewis Room

MONDAY, December 14
Hubert H. Humphrey Building
Deputy Secretary's Conference Room

9:00 - 10:30	**Continue discussion of conclusions**	
10:30 - 10:45	**BREAK**	Reception area
10:45 - 12:00	**Finalize conclusions**	Ms. Ophelia Long and Panel

SECRETARY'S BLUE RIBBON PANEL ON VIOLENCE PREVENTION

WORK GROUP B - RESEARCH

Rapporteur: Dr. David Satcher
Departmental Staff Liaison: Dr. John Diggs

SUNDAY, December 13
Holiday Inn
Columbia South Room

3:00 - 3:15	**Welcome**	Dr. David Satcher
3:15 - 3:30	**Approval of Minutes** - November 10 meeting **Charge to the Work Group**	Dr. David Satcher
3:30 - 4:00	**Report on Follow-up Action Items**	
	o NIH Peer Review Process	Dr. John Diggs
	o Representation of Minorities and Women on NIH Review and Advisory Panels	Dr. John Diggs
	o NIH Mechanisms of Support for Investigators	Ms. Lily Engstrom
4:00 - 5:00	**Discussion**	
6:30 - 7:30	**SOCIAL HOUR**	Holiday Inn Lewis Room

MONDAY, December 14
Hubert H. Humphrey Building
Secretary's Conference Room

9:00 - 9:45	**Review of Selected Abstracts:**	
	o NIDA Portfolio	Dr. Maisha Bennett Dr. Marvin Snyder
	o NIMH Portfolio	Dr. Henry Tomes Dr. Alan Leshner
9:45 - 10:30	**Discussion:**	
	o Proposals to Enhance the Environment for Research	Dr. John Ruffin
	o Improving the Research Portfolio	Dr. David Satcher and Panel
10:30 - 10:45	**BREAK**	Reception Area
10:45 - 12:00	**Finalize conclusions**	Dr. David Satcher and Panel

APPENDIX B

PANEL MEMBERS

Appendix B

SECRETARY'S BLUE RIBBON PANEL ON VIOLENCE PREVENTION

MEMBERS

CHAIR: DR. FRANKLYN G. JENIFER, *President, Howard University*

DR. DAVID BAINES, *Private Practice and Association of American Indian Physicians*

DR. MAISHA BENNETT, *Association of Black Psychologists*

MR. LAWRENCE DARK, JD, *Executive Assistant to the President for Equal Opportunity Programs, WK Kellogg Fellow, University of South Carolina*

DR. JANE DELGADO, *President and CEO, COSSMHO*

DR. WILBERT GREENFIELD, *National Association for Equal Opportunity in Higher Education (NAFEO)*

MS. TESSIE GUILLERMO, *Executive Director, Asian American Health Forum*

DR. LENNEAL HENDERSON, *William Donald Schaefer Center for Public Policy, University of Maryland*

MS. SADAKO HOLMES, *Executive Director, National Black Nurses Association*

MR. IVAN HOPKINS, *President, Howard University Student Association*

MR. DERRICK HUMPHRIES, JD, *Black Congress of Health, Law and Economics*

DR. H. MICHAEL LEMMONS, *Congress of National Black Churches*

DR. FREDA LEWIS-HALL, *Department of Psychiatry, Howard University Hospital*

MS. OPHELIA LONG, RN, *CEO & Administrator, Oakland Highland Hospital*

REV. JOSEPH LOWERY, *President, Southern Christian Leadership Conference*

DR. ROBERT MURRAY, *College of Medicine, Howard University*

DR. EDMUND PELLEGRINO, *Director, Center for the Advanced Study of Ethics, Georgetown University*

DR. DEBORAH PROTHROW-STITH, *Associate Dean, Harvard School of Public Health, former Commissioner of Public Health, Massachusetts*

MS. MARLA ROBINSON, *Research Associate, Joint Center for Political and Economic Studies*

DR. DAVID SATCHER, *President, Meharry Medical College and Chairman, AMHPS Foundation*

DR. MARIAN SECUNDY, *Professor and Director, Program in Medical Ethics, Howard University*

DR. MITCHELL SPELLMAN, *Dean Emeritus for International Projects, Harvard University Medical School*

DR. HENRY TOMES, *Executive Director, Public Interest Directorate, American Psychological Association*

DR. REED TUCKSON, *President, Charles R. Drew University, Los Angeles, CA*

DR. RONALD WALTERS, *Chairman, Department of Political Science, Howard University* [Dissenting]

APPENDIX C

FEDERAL PARTICIPANTS

Appendix C

SECRETARY'S BLUE RIBBON PANEL ON VIOLENCE PREVENTION

Federal Resource Persons and Other Participants

Department Participants

DR. LOUIS W. SULLIVAN, *Secretary*

MR. KEVIN MOLEY, *Deputy Secretary*

MS. ROBIN CARLE, *Chief of Staff*

MR. ARNOLD TOMPKINS, *Assistant Secretary for Management and Budget*

MR. JOHN GIBBONS, *Acting Assistant Secretary for Public Affairs*

MS. JACKIE WHITE, *Executive Secretariat*

DR. WILLIAM BENNETT, *Special Assistant to the Secretary*

DR. JAMES O. MASON, *Assistant Secretary for Health*

MS. JO ANNE BARNHART, *Assistant Secretary, Administration for Children and Families (ACF)*

DR. AUDREY F. MANLEY, *Deputy Assistant Secretary for Health*

MS. DONNA GIVENS, *Principal Deputy Assistant Secretary, ACF*

DR. BERNADINE HEALY, *Director, National Institutes of Health (NIH)*

DR. WILLIAM ROPER, *Director, Centers for Disease Control and Prevention (CDC)*

DR. JOHN W. DIGGS, *Deputy Director for Extramural Research, NIH*

DR. JOHN RUFFIN, *Associate Director for Minority Programs, NIH*

DR. RUEBEN WARREN, *Assistant Director for Minority Programs, CDC*

DR. MARK ROSENBERG, *Acting Associate Director for Public Health Practice, CDC*

MS. CAROL BEHRER, *Associate Commissioner, Family and Youth Services, ACF*

DR. ALAN LESHNER, *Deputy Director, National Institute of Mental Health, NIH*

DR. WENDY BALDWIN, *Deputy Director, National Institute of Child Health and Human Development, NIH*

DR. MARVIN SNYDER, *Deputy Director, National Institute of Drug Abuse, NIH*

MR. LORAN ARCHER, *Deputy Director, National Institute of Alcoholism and Alcohol Abuse, NIH*

MS. LILY O. ENGSTROM, *Assistant Director, Office of Extramural Research, NIH*

MS. GERRIE MACCANNON, *Special Assistant for Crosscutting Initiatives, Office of Minority Health, PHS*

DR. JEAN ATHEY, *Director, Injury Prevention and Emergency Medical Services for Children, Bureau of Maternal and Child Health, HRSA*

DR. MYRON BELFER, *Special Assistant to the Acting Administrator, Substance Abuse Mental Health Services Administration (SAMHSA)*

MR. WILLIAM RILEY, *Program Manager, Family Violence Prevention, ACF*

MS. MARSHA LISS, *Special Assistant to the Director, National Center on Child Abuse and Neglect, ACF*

MR. ALEX ROSS, *Senior Policy Analyst, Office of the Assistant Secretary for Health*

MS. JUDITH CARPENTER, *Executive Assistant to the Deputy Assistant Secretary for Health*

MS. S. DENISE ROUSE, *Special Assistant to the Deputy Assistant Secretary for Health*

MR. TIMOTHY THORNTON, *Public Health Advisor, CDC*

MS. PHYLLIS ZUCKER, *Acting Director, Office of Health Planning and Evaluation, PHS*

MS. LORRAINE FISHBACK, *Acting Director, Division of Policy Analysis, Office of Health Planning and Evaluation, PHS*

Other Participants

DR. RUSSELL MILLER, *Senior Vice President and Vice President for Health Affairs, Howard University*

DR. KENNETH SHINE, *President, Institute of Medicine, National Academy of Science*

APPENDIX D

SUMMARY OF DELIBERATIONS OF PANEL WORKGROUPS

Appendix D

SUMMARY OF DELIBERATIONS OF PANEL WORKGROUPS

The Secretary's Blue Ribbon Panel on Violence Prevention met on November 10 and December 13-14, 1992, to review and discuss the Department's ongoing and proposed violence-related prevention and research activities. The panel discussed the overall impact of violence in communities and then divided into two workgroups to review in more detail the Department's activities in research and prevention of aggressive behavior and violence:

- Workgroup A - Prevention activities supported by the:
  - Centers for Disease Control and Prevention (CDC),
  - Health Resources and Services Administration (HRSA),
  - Substance Abuse and Mental Health Services Administration (SAMHSA),
  - Indian Health Service (IHS),
  - PHS Office of Minority Health (OMH), and
  - Administration on Children and Families (ACF).

- Workgroup B - Research activities supported by the:
  - National Institute of Mental Health (NIMH),
  - National Institute for Alcohol Abuse and Alcoholism (NIAAA),
  - National Institute for Drug Abuse (NIDA); and
  - National Institute for Child Health and Human Development (NICHD).

To support the panelists' deliberations, Federal resource persons from the relevant Agencies within the Department were available to answer questions and provide background information throughout the review process. A large volume of written materials was provided to all panelists in advance of the meeting (see Appendix E for a list of this information), including the draft PHS document

"Youth Violence Prevention: A Proposed Initiative and Status Report of PHS Activities," and detailed information on individual research projects, including:

1) One-page abstracts for each of 224 research projects related, even vaguely, to antisocial, aggressive, and violent behavior that were supported by the NIMH (179), NIDA (26), NIAAA (11), and NICHD (8).

2) Summary analysis of the research projects, the NIH reviewer comments, and the funding rationale for supporting the research, for each of 28 of the 224 research projects which Workgroup B (Research) identified for closer scrutiny. The summary analyses were reviewed by pairs of reviewers consisting of one Workgroup member and one Federal agency staff.

3) Summary analyses of an additional 36 research projects on Attention Deficit and Hyperactivity Disorder (ADHD), which, due to the press of time, had not been individually reviewed by an assigned workgroup member. These research projects did not focus on antisocial, aggressive, and violent behavior per se.

Some of the Panelists were concerned about the compressed timeframe and the restrictions governing confidentiality of information on individual research projects (e.g., grant applications and NIH reviewer comments). Some of the Panelists felt that the abstracts alone did not provide sufficient information to enable them to reach definitive conclusions. Consequently, individual members were extended an opportunity to review the complete grant files on site at NIH. However, none of the Workgroup members availed themselves of this opportunity.

DISCUSSION

WORKGROUP A - PREVENTION

Rapporteurs: Dr. Mitchell Spellman

Ms. Ophelia Long

Panelists

Dr. Mitchell Spellman
Ms. Ophelia Long
Dr. David Baines
Dr. Wilbert Greenfield
Ms. Tessie Guillermo
Ms. Sadako Holmes
Dr. Derrick Humphries
Dr. H. Michael Lemmons
Rev. Joseph Lowery
Dr. Deborah Prothrow-Stith
Ms. Marla Robinson
Dr. Reed Tuckson

Federal Resource Staff

Dr. William Roper, CDC
Dr. Mark Rosenberg, CDC
Ms. Carol Behrer, ACF
Dr. Rueben Warren, CDC
Ms. Gerrie Maccannon, OMH
Dr. Jean Athey, HRSA
Dr. Myron Belfer, SAMHSA
Mr. William Riley, ACF

Workgroup A reviewed the Department's ongoing and proposed violence related prevention activities. Each member of the workgroup underscored the enormous magnitude of the problems posed to our society by violence, which has reached epidemic proportions. In particular, the rate of homicide among young African American males has reached the level of a national emergency. The data presented by PHS described the scope of the problem, but it was agreed that much better information and a broader understanding of the causes of violence are needed. The group was particularly concerned about how social, economic, political, ethical, legal, environmental, and cultural conditions contribute to this problem. There is also a need to understand how our society views violence as a solution to problems. Finally, there is a need to implement interventions that research has demonstrated can prevent, redirect, or ameliorate violence, such as home visiting programs, training in conflict resolution, limiting exposure to violence on television, decreasing

access to firearms, improving self-esteem of minority children through programs such as Afrocentric education, as well as broad scale approaches to improve the general socioeconomic and environmental conditions of minority communities.

For purposes of assessing as well as designing appropriate programs, the group agreed on a definition for violence, as follows:

> **Violence is the threatened or actual use of physical force or power against another person, against oneself, or against a group or community which either results in, or has a high likelihood of resulting in injury, death, or deprivation. The injuries resulting from violence may be either physical or psychological. Violence includes suicidal acts as well as interpersonal violence such as rape, domestic violence, child abuse, elder abuse, or assault. Assaults include youth violence, hate crimes, and assaults against HIV-infected persons. Violence may also be institutional, consisting of the abuse or misuse of power inflicted systematically upon a community or group. When violence is fatal, it results in suicides or homicides.**

The viability of a public health approach to violence was thoroughly discussed, focusing on the following factors:

- The public health approach offers four principal phases in addressing a specific problem:
  1) define the problem, with data collection
  2) identify causes, with risk factor identification
  3) develop and test interventions with evaluation research, and
  4) implement interventions and evaluate effectiveness, with community intervention demonstrations, training and public awareness programs.

- The public health approach is interdisciplinary. It can mobilize a broad range of disciplines, including medicine, education, social epidemiology, and social services, all of which are critical to the study of violence.

- The public health approach is based on primary prevention--to prevent the violence from occurring at all. This is different from the medical model which treats people once they are injured, and the criminal justice approach which identifies a solution once a violent act occurs.

- The public health approach calls for the application of research findings to the real world to implement appropriate interventions. It was underscored that research is a critical component of each of the four phases.

- The public health approach will still require careful evaluation of prevention interventions, much as we now accept the necessity to conduct lengthy and costly clinical trials to evaluate medical interventions (e.g. drugs and treatment modalities).

The Panel concluded that the public health model could make a significant contribution to efforts to address violence. Discussions stressed the need to understand certain principles in coming to this conclusion. First, public health efforts to prevent or control violence and related injuries and deaths must take into account the social context in which violence occurs. This context includes the marked economic and social disparities among Americans that contribute to the etiology of violence. Poverty, joblessness, the lack of meaningful education and employment opportunities, and the effects of drug and alcohol abuse all promote violence by generating a sense of frustration, low self-esteem, and hopelessness about the future. Panelists agreed that racism also contributes to violence, both directly--through the anger caused by the experience of racial discrimination--and indirectly, by denying certain segments of society the opportunities to succeed. Driven by greed, economic discrimination may take the form of "redlining," whereby housing and financial opportunities are denied to individuals on the basis of race or ethnicity. The abuse and misuse of power may not only provoke a violent response from the individual victims, but, when inflicted systematically upon a community or group, actually constitutes institutionalized violence. The social context of violence also includes the exposure that many in our society have to violence in their families, communities, and the media.

The Panel noted that a public health solution to violence in America will still require the empowerment of communities to deal effectively with the causes as well as the effects of violence. This, in turn, will require the direct participation of these communities in planning, implementing and evaluating community violence prevention programs. Leadership should be drawn from the community level, and partnerships should be sought with community organizations that are actively working to prevent violence. Special attention should also be given to communities at high risk for violence. The need to increase the racial and ethnic diversity of scientists and practitioners engaged in violence prevention, and to involve minority and ethnic institutions and organizations, such as the Historically Black Colleges and Universities, was stressed.

It was emphasized that public health efforts alone cannot solve the social ills of our society -- they are not meant to replace the social, educational, economic, and legal work needed to remedy the underlying social problems of our nation. However, public health offers a preventive approach based on intervention before people become victims. Public health can apply practices and principles that have been successful with other health problems to violence and the prevention of violent injuries. The treatment of hypertension is one such model. Concurrent with medication, patients are taught to make lifestyle changes in the areas of nutrition, exercise, smoking cessation and stress management. Similarly in the area of violence prevention, another phenomenon with complex causality, concurrent lifestyle changes are required.

The complexity of social and economic factors of violence are such that the work group felt that they are well beyond the ability of any single Agency or Department to address. A larger blueprint is needed. Federal leadership at the highest levels, interdepartmental collaboration, and appropriate resources could underwrite a national effort to address violence, to include multiple Federal agencies, with DHHS serving as the lead Department empowered to direct development of an action oriented program. Appropriate coordination and advisory mechanisms would be required. Such an effort would have to be multi-faceted. Issues would have to include self-directed injuries (e.g. suicide) as well as interpersonal injuries (e.g. homicide), and substance abuse as well as the availability and cost of trauma and acute care health services.

The value of a more aggressive, large-scale, national public education campaign was stressed. In this regard, it was suggested that DHHS seek spokespersons and role models for this campaign that go beyond those often chosen for visibility (e.g. athletes and entertainers). People with lifestyles more aligned with the people they wish to inform and educate should be chosen as spokespersons.

Minority organizations and communities should play a critical role, in research as well as in prevention demonstrations. Community ownership of research projects, even if done in the university setting, should support an approach to research wherein science is not imposed, but used to help the community. Prevention programs should have community confidence, be implemented in partnership with communities, and the inclusion of minority investigators. The controversy surrounding the proposed University of Maryland conference "Genetic Factors in Crime" serves as an unfortunate case in point, where misunderstandings and insensitivities can hinder efforts. The workgroup suggested that it would be helpful to further review and document this event as a case study for future reference. They also suggested strengthening the role of the Institutional Review Boards (IRBs) by having them consider whether the ethical as well as scientific aspects of research proposals are appropriate.

WORKGROUP B - RESEARCH

Rapporteur: Dr. David Satcher

Panelists

Dr. Maisha Bennett
Mr. Lawrence Dark
Dr. Jane Delgado
Mr. Lenneal Henderson
Mr. Ivan Hopkins
Dr. Freda Lewis-Hall
Dr. Robert Murray
Dr. Edmund Pellegrino
Dr. Marian Secundy
Dr. Henry Tomes
Dr. Ronald Walters

Federal Resource Staff

Dr. Bernadine Healy, NIH
Dr. John Diggs, NIH
Dr. John Ruffin, NIH
Ms. Lily Engstrom, NIH
Mr. Loran Archer, NIAAA/NIH
Dr. Wendy Baldwin, NICHD/NIH
Dr. Alan Leshner, NIMH/NIH
Ms. Martha Liss, ACF
Dr. Marvin Snyder, NIDA/NIH

Workgroup B reviewed and discussed the Department's violence-related research activities supported by four of NIH's Institutes: National Institute of Mental Health (NIMH); National Institute of Alcohol Abuse and Alcoholism (NIAAA), National Institute on Drug Abuse (NIDA); and, National Institute of Child Health and Human Development (NICHD).

In assessing the viability of a public health approach to violence, Workgroup B focussed on the special considerations critical to conducting research in this area. Recent events such as the controversy over the proposed University of Maryland "Genetic Factors in Crime" conference remind us that the suspicions in the African American community fostered by such research tragedies as the "Tuskegee Studies", still exist. The youth violence prevention program surfaced at a time when these suspicions ran highest.

The community reaction to, and controversy surrounding, the Department's violence-related research activities was not unlike the difficulties experienced in the early days of sickle cell disease research

when there was alarm in the African American community that such research would lead to genocide and discrimination. Based on the erroneous perception that those with sickle cell disease might be considered somehow genetically inferior, fear ran high that screening and early intervention programs would be used as tools of discrimination. However, the establishment of community advisory boards that worked with researchers to recruit clients, set priorities and conduct public education programs did much to eliminate community fears and ensure the success of research and intervention programs. The Workgroup suggested that a similar approach, including NIH-sponsored community education and involvement programs, could be used to create a more receptive climate for research on violence prevention.

The controversy generated by perceptions of the Department's violence-related research has led to broader discussions of the ethics of conducting this type of research and whether there are areas of inquiry that, although scientifically appropriate to pursue, should not be investigated in the current social and political climate. On the whole, the Workgroup recognized that there is a need to conduct research on pathologically aggressive children, although this type of aggression is very specific and limited to a small number of persons. Moreover, there is a need to conduct research in anti-social, aggressive, and violent behavior, but that such research should not focus on specific racial or ethnic groups.

Much needs to be learned regarding the etiology of aggressive behavior and its contributing biological factors, such as elevated blood lead levels leading to biochemical changes, effects of environmental toxins, exposure to intrauterine drugs and alcohol, and poor nutrition. Factors such as poverty, racism, joblessness, low self esteem, hopelessness, child abuse and neglect, exposure to violence, and the lack of meaningful education and employment opportunities also contribute to youth violence and should therefore be studies as well. Research is needed to identify the safety and efficacy of various treatment modalities, such as psychosocial interventions, use of medication, or both. The group discussed the need for culturally sensitive diagnostic criteria that take into account how minority populations perceive mental illness, how specific cultural experiences may impact on disease development and presentation, and different cultural norms for behavior.

Members of the Workgroup, however, did agree that the ethical implications of violence-related research need to be examined and that NIH should consider mechanisms of enhancing the review of proposed violence-related research projects to ensure that a variety of cultural, ethical, legal, social, economic, and political sensitivities are considered. One such enhancement would be to ensure appropriate representation of racial and ethnic minorities, as well as multiple disciplines, on study sections, advisory councils, Institutional Review Boards, and other review bodies in order to more readily identify, discuss, and resolve social, ethical, legal, and culturally sensitive issues in grant proposals prior to award. In this way, incidents similar to the University of Maryland proposed conference can be minimized.

NIH should continue to ensure that adequate ethical safeguards exist to protect subjects, especially children, such as informed consent processes and involvement of the affected communities in decision making. Means of enhancing these safeguards include representation of minorities on IRBs and the participation of minority investigators in protocol design and implementation. An example of an opportunity to implement the workgroup's suggestions is NIMH's planned cooperative agreements with six institutions to test various treatment modalities for Attention Deficit Hyperactivity Disorder (ADHD). The workgroup suggested that particular attention be paid to: 1) the manner in which patients are recruited, 2) culturally sensitive diagnostic assessments, 3) the informed consent process, and 4) racial and ethnic variations in response to medication.

There is also a need for the Department to increase the participation of minority researchers, practitioners, organizations, community leaders and members in violence-related research and intervention activities. There are a number of ways to encourage such participation, including the use of a variety of support mechanisms, such as cooperative agreements that are essentially collaborative partnerships between the researchers and the Federal Government. The workgroup discussed the need to assist minority researchers in proposal preparation and submission. One way the Department could achieve this goal would be for NIH to convene technical assistance workshops and consider pairing minority scientists with experienced investigators in developing grant proposals. Other approaches include sensitizing NIH initial review groups to not weigh negatively against proposals that do not provide sufficient data on minority groups as this data is scarce and, in some cases, unavailable. In their recommendations, review groups should balance science with

opportunity. The workgroup discussed perceptions that there is an apparent insensitivity by NIH review groups to smaller schools and to researchers that they do not know. Reviewers should be encouraged to look at the diversity of investigators and institutions that can participate in the research enterprise.

The workgroup considered the need for PHS to diversify and expand its violence-related research portfolio by encouraging more interdisciplinary research and research that considers the total human experience. There is a need for additional research on factors contributing to anti-social, aggressive, and violent behavior and on ADHD, including social, economic, political, psychological and nutritional factors. A critical examination should be made of the role of anger, personal/community values, perceived injustice, family, poverty, unemployment, self-esteem, empowerment, role models (particularly male role models), peer groups, presence of firearms, white collar crime, and behavioral characteristics associated with hate crimes as they relate to violence. We need to clarify the purpose of and basis for diagnosing violent behavior, understand variations in drug metabolism and its short and long term side effects, study the epidemiology of various disorders in children and among minorities, develop more culturally sensitive diagnostic criteria, and identify the potential adverse effects of long term therapy.

APPENDIX E

BIBLIOGRAPHY OF MATERIALS PROVIDED TO THE PANEL

Appendix E

BIBLIOGRAPHY OF MATERIALS PROVIDED TO THE PANEL

Information Provided to the Panel in Advance of the Meetings

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APPENDIX F

GLOSSARY OF TERMS

Appendix F

GLOSSARY OF TERMS RELATED TO VIOLENCE PREVENTION

Departmental Agencies Involved in Violence Prevention

DHHS	Department of Health and Human Services
PHS	Public Health Service
ACF	Administration on Children and Families
CDC	Centers for Disease Control and Prevention
NIH	National Institutes of Health
SAMHSA	Substance Abuse and Mental Health Services Administration
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
OMH	PHS Office of Minority Health
NIMH	National Institute of Mental Health
NIAAA	National Institute of Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NICHD	National Institute on Child Health and Human Development

Commonly Used Terms

Public Health — One of the efforts organized by society to protect, promote, and restore the people's health. It is the combination of service skills and beliefs that is directed to the maintenance and improvement of the health of all people through collective or social actions.

The programs, services, and institutions involved emphasize the prevalence of disease and the health needs of the population as a whole.

Public Health activities change with changing times and social values, but the goals remain the same: to reduce the amount of disease, premature deaths, and disease-produced discomfort and disability in the population. Public health is, thus, a social institute, a discipline, and a practice.

Epidemiologic Surveillance	The ongoing and systematic collection, analysis, and interpretation of health data in the process of describing and monitoring a health event. This information is used for planning, implementing, and evaluation of public health interventions and programs.
Research	Includes basic biomedical research as well as prevention research. This prevention research is supported by prevention agencies, such as SAMHSA, HRSA, and CDC. Prevention research relates to research for each step of the public health approach. This includes data collection to describe the problem, risk factor identification, intervention design and evaluation and prevention effectiveness research.
Environmental Causes of Violence	Political, economic, legal, social, and cultural decisions which result in the creation of an environment which fosters violent behavior.
Institutional Review Boards (IRB)	IRBs are required in all institutions conducting research on human subjects. The boards are required to review all applications submitted to NIH to ensure that ethical safeguards have been adhered to and that researchers conducting research comply with the ethical safeguards.