

# Closing the Gap

A newsletter of the Office of Minority Health, U.S. Department of Health and Human Services



## Violence Prevention – Who’s Responsible? *Public Health, Criminal Justice, or Both*

Brigette Settles Scott, MA and Kerrita McClaughlyn

Despite the extensive damage that violence and related injuries inflict on society—many Americans view violence as simply a criminal justice problem. Experts have struggled to make the case that the public health system has an equally important role in helping to reduce the impact that violence and intentional injury impose on the public.

*“Violence...*

*costs our society thousands of years of potential life lost.”*

“Violence, intentional injury, and related prevention efforts should be viewed from both dimensions. The world sees violence and injury as a criminal justice issue and therefore has been unable to work on the prevention aspect of it in a more thoughtful way than the building of new prisons,” said Dr. Beverly Coleman-Miller, editorial director, *Minority Health Today* magazine and violence prevention expert. “Violence and injury are public health problems and they are preventable.”

Violence disproportionately affects the minority community through high rates of homicide, suicide, sexual assault, intimate partner abuse, and related fatalities.

According to the *Violent Victimization and Race, 1993–1998* study released in 2001 by the U.S. Bureau of Justice Statistics, in 1998, 110 American Indians, 43 African Americans, 38 Whites, and 22 Asian Americans were victims of violence per 1,000 persons of each population, ages 12 or older.

### Violence

“Violence is a learned behavior. It can be unlearned, as can many public health problems. For example, a healthy diet, exercise, and regular doctor visits can help prevent cardiovascular disease and diabetes. Violence is experienced in the United States as an epidemic. This disease of violence has symptoms and signs that lead to death. The key words—epidemic, signs, symptoms, morbidity, mortality—clearly, that’s a health-related conversation,” said Dr. Coleman-Miller.

On an average day in America, 53 people die from homicide, a minimum of 18,000 people survive interpersonal assaults, 84 people commit suicide, and as many as 3,000 people attempt suicide.

“Violence costs the health care system millions of dollars each year in rehabilitation, direct and long-term patient care, and costs our society thousands of years of potential life lost,” added Dr. Coleman-Miller.

### Barriers to Putting Violence on the Public Health Agenda

“The barriers within the medical community are logistical—hospitals generally do not have the money and other resources to treat injuries from violence and to provide resources for prevention efforts. Violence is costly and the victims of intentional injury are often uninsured—placing the burden of costs on the hospitals. Victims often need complicated, immediate care and long-term follow-up, which further drains resources. Hospitals are frustrated and confused about how to handle these medical emergencies while continuing to remain financially solvent.

Further compounding matters is the fact that many hospitals do not see themselves as mechanisms for prevention. To quote a hospital administrator, “If this was a preventable disease, the government would not have called it ‘intentional’ injury,” said Dr. Coleman-Miller.

The good news however, is that some health practitioners have begun to understand the importance of violence prevention and are becoming advocates for programs within the public health system. For example, domestic violence has created a national movement among health care providers, including the American College of Obstetricians and Gynecologists (ACOG), the American Medical Association (AMA), and other mainstream advocacy groups. Physicians for a Violence-free Society—which promotes violence prevention by developing leadership and advocacy in the health care community—has been successful in developing programs on a variety of violence prevention topics. Its domestic violence, child abuse, youth/school violence, elderly violence, hate crimes, and gun violence

*...continued on page 2*



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## Inside

Elder Abuse	3
Workplace Violence	4
Suicide and American Indian Youth	6
Intimate Partner Violence	8
Hidden Violence	10
Domestic Violence	12
Resources	14
Conferences	16



programs are specifically geared toward health care providers.

Its most recent publication—*Physicians Guide to Domestic Violence: How to Ask the Right Questions and Recognize Abuse*—is a how-to guide that provides guidelines for working with victims of violence in the practice setting.

The Centers for Disease Control and Prevention (CDC) has focused on violence prevention since the early 1980s, beginning with efforts to prevent youth violence and suicide. Early in 1994, CDC was further funded to strengthen efforts to prevent family and intimate partner violence.

The Division of Violence Prevention, part of CDC's National Center for Injury Prevention and Control, was created to focus on youth violence, family and intimate violence, suicide, and firearm injuries. Current activities target primary prevention of violence through a public health approach that complements the approaches used by criminal justice, education, and the many other disciplines that work in this area. Some of the projects supported by the Division include:

- **The National Youth Violence Prevention Resource Center** that provides parents, teenagers, health care providers, law enforcement officials, and other professionals and concerned citizens a single, user-friendly point of access to critical information regarding youth violence and about the effective strategies to control and prevent such violence.

The center includes a bilingual (Spanish/English) toll-free telephone information line (1-886-SAFEYOUTH or 1-886-968-8484), an Internet site (<http://www.safeyouth.org>), technical as-

sistance, and a clearinghouse of information and resources.

- **Research projects** that evaluate community-based intimate partner violence prevention/intervention programs, research related to violence and reproductive health, and supporting the development of surveillance systems to monitor firearm injuries and related risk behaviors (e.g., safe storage, carrying weapons).

A coordinated effort between the public health and criminal justice system is essential to reducing violence in the U.S.

"The criminal justice system can not be our primary response to violence—nor should it be our only response," states Dr. Coleman-Miller. Although the criminal courts are an important component of any overall violence reduction strategy, the response has largely been reactive rather than preventive making the associated costs exorbitant.

"Aside from the criminal justice costs associated with violence—that is property damage, security, prosecution, and incarceration—the most significant cost is the cost of shattered lives. Loss of quality of life and loss of productivity not only have significant public health implications but impact every facet of our society," said Dr. Coleman-Miller. Heavy emphasis on implementing public health programs geared toward violence prevention and early intervention is essential to reducing the toll that violence has on society.

*For more information on violence prevention in minority communities, go to <http://www.omhrc.gov> or call 1-800-444-6472.*

*For additional information on Physicians for a Violence-free Society, go to <http://www.pvs.org> or call 415-821-8209. ❖*

## "Closing the Health Gap" Campaign

The U.S. Department of Health and Human Services (HHS) is partnering with ABC Radio Networks to bring the best consumer health information to African Americans and inform, educate, challenge, and empower individuals and families to adopt healthy lifestyles.

The campaign will provide healthy lifestyle tips and information on local sources of health care and public health programs. It also will combine the radio networks' broadcast resources with HHS' health information expertise, and will involve civic organizations and community groups across the country. Listen to the health messages on ABC Radio, including the Tom Joyner and Doug Banks shows, and watch for an announcement of a special event to encourage people to visit a health professional and take charge of their health.

*For more information, visit <http://www.healthgap.omhrc.gov> or call 1-800-444-6472. ❖*

# Elder Abuse

## *A Growing Concern in the African American Community*

By Brigette Settles Scott, MA

Each year hundreds of thousands of older persons are abused, neglected, and exploited by family members and others. Many victims are people who are frail, vulnerable, and depend on others to meet their most basic needs.

Currently, elder abuse is defined by state laws, and state definitions vary considerably from one jurisdiction to another in terms of what constitutes the mistreatment of the elderly. Generally accepted definitions are:

- **Physical abuse** is the willful infliction of physical pain or injury, e.g., slapping, bruising, sexually molesting, or restraining.
- **Sexual abuse** is the infliction of non-consensual sexual contact of any kind.
- **Psychological abuse** is the infliction of mental or emotional anguish, e.g., humiliating, intimidating, or threatening.
- **Financial or material exploitation** is the improper act or process of an individual, using the resources of an older person, without his/her consent, for someone else's benefit.
- **Neglect** is the failure of a caretaker to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness, e.g., abandonment, denial of food or health-related services.



According to the first-ever *National Elder Abuse Incidence Study*, released in 1998, our oldest elders (80 years and over) are abused and neglected at two to three times their proportion of the elderly population—with female elders abused at a higher rate than males.

While the study indicates that White elders are victims of abuse more often than other racial and ethnic groups (eight out of ten times

for most types of maltreatment), the incidence of abuse among elderly African Americans is a growing concern. Blacks are over-represented in nearly all types of maltreatment relative to their proportion of the elderly population. More specifically:

- **Emotional/psychological abuse** was the second most frequent type of maltreatment, with 35.5 percent of victims. African American elders were over-represented (14.1 percent) as victims of this type of maltreatment.
- **Physical abuse** was the third most frequent type of elder maltreatment, with 25.6 percent of abuse victims. African American elders comprised approximately 9.0 percent.
- **Financial/material exploitation** was the fourth most frequent type of maltreatment, with 30.2 percent of all elder abuse victims. Again, African American elders were over-represented, and comprised 15.4 percent of abuse victims of this type.
- **Abandonment** accounted for only 3.6 percent of all victims of elder abuse. Interestingly, the percentages of White victims (41.3 percent) and African American victims (57.3 percent) for this type of abuse were very close, but with the African American population significantly over-represented than its proportion of the elderly population (8.3 percent).
- **Self-neglecting** elders were predominately White (77.4 percent), while 20.9 percent were African American and 1.7 percent were other or unknown. The African American elderly are two-and-a-half times more likely to be self-neglecting than their proportion of the elderly population.

*For more information on elder abuse or to view the entire study, go to <http://www.aoa.dhhs.gov/abuse/report/default.htm>* ❖

### Need more information on elder abuse? Consider the following:

**The National Center on Elder Abuse (NCEA)**, funded by the U.S. Department of Health and Human Services' Administration on Aging, is a resource for public and private agencies, professionals, service providers, and individuals interested in elder abuse prevention information, training, technical assistance, and research. *For more information, go to <http://www.elderabusecenter.org>*

**The National Committee for the Prevention of Elder Abuse (NCPEA)** is an association of researchers, practitioners, educators, and advocates dedicated to protecting the safety, security, and dignity of America's most vulnerable citizens. *For more information, go to <http://www.preventelderabuse.org/>*

*Understanding and Combating Elder Abuse in Minority Communities* details proceedings of a 1997 conference sponsored by the NCEA and funded by the Archstone Foundation. Single copies are available at no cost from the Archstone Foundation. *For more information, go to <http://www.archstone.org>*

# Breaking New Ground

## *Public Health Takes on Workplace Violence*

By Brigette Settles Scott, MA and Kerrita McClaughlyn

The threat of violence occurring in the workplace is a daily risk that many Americans face. A large number of recent immigrants and other racial and ethnic groups traditionally hold jobs in industries that are plagued by incidents of violence in the workplace.

The problem is particularly acute for taxicab drivers, convenience store clerks and other retail workers, security guards, and others working in industries with high percentages of minority workers. These deaths often go unnoticed or are not chronicled in the media as often as other more sensational acts of co-worker violence such as the February 2001 shooting at the diesel engine plant in Chicago, or the December 2001 shooting at an Indiana factory

### Workplace Violence At-A-Glance

Its most extreme form, homicide, is the third leading cause of fatal occupational injury in the United States. According to the *National Census of Fatal Occupational Injuries (CFOI), 2000*, Bureau of Labor Statistics, there were 677 workplace homicides in 2000, accounting for 11 percent of the total 5,915 fatal work injuries in the United States. Of the 677 workplace homicides, 11 percent of the offenders were a co-worker, former co-worker, or a customer of the victim.

CFOI reported that people in sales occupations experienced a high number of workplace homicides—53 percent of a total 386 deaths. In 2000, there were 70 taxi driver/chauffeur work-related deaths, of which 60 percent were homicides. Of the 142 police, detective, and supervisor deaths in 2000, 35 percent were homicides.

Homicide is not the only act of violence to occur in the workplace. Between 1993 and 1999, an average of 1.7 million non-fatal violent acts were committed against persons who were at work or on duty, according to the *Violence in the Workplace National Crime Vic-*

*timization Survey (NCVS), 1993-1999*, published in December 2001.

NCVS further reports that the most common types of non-fatal workplace violent crimes include simple and aggravated assaults, rapes and sexual assaults, and robberies.

From 1993 to 1999, law enforcement personnel were victimized while at work or on duty at the highest average rate of 261 per 1,000 persons—the highest rate of the occupations examined. Mental health professionals followed with a workplace victimization rate of 68.2 per 1,000 persons, and retail sales personnel saw a rate of 20 per 1,000 persons.

### Who's at Risk?

According to the National Institute for Occupational Safety and Health (NIOSH), workers are most at risk if their jobs involve routine contact with the public or exchange of money. Workers are also at increased risk in situations such as working alone or in small numbers, working very late or very early hours, or working in high crime areas. Other factors include, having a mobile workplace such as a taxicab or police cruiser, working with unstable or volatile persons in health care, social services, or criminal justice settings, guarding valuable property or possessions and working in community-based settings.

### The Need for More Public Health Involvement

Prevention efforts have largely focused on creating a safe working environment—and less on the implications workplace violence presents to the overall health care field. Recognizing the need to increase public health's role in the prevention of workplace violence, the Centers for Disease Control and Prevention funded a workshop in April 2000 that brought together representatives of industry, labor, academia, and government to identify areas within workplace violence that are not well understood.

As a result of the workshop, a report was released in February 2001, *Workplace Violence - A Report to the Nation*, by the University of Iowa's Injury Prevention Research Center, that identifies workplace violence as a significant public health problem, and stresses the need for research in this area. Moreover, the report also states that although workplace violence causes millions of in-

<i>Fatal Occupational Injuries by Worker Characteristics and Event or Exposure, 2000</i>	Total Number of Fatalities	Transportation Incidents-%	Objects/ Equipment-%	Assaults/ Violent Acts-%
	5,915	43.5	17.0	15.7
White	4,240	46.7	17.0	12.8
Black/African American	574	42.2	17.4	23.0
Hispanic/Latino	815	33.1	18.8	15.8
American Indian/Alaska Native	33	42.4	--	15.2
Asian	171	21.1	7.6	56.7
Native Hawaiian/Pacific Islander	14	--	--	35.7
Other races or not reported	68	35.3	16.2	29.4

Source: U.S. Department of Labor, Bureau of Labor Statistics. Categories not shown are falls, exposure to harmful substances, and fires and explosions. Dashes indicate no data reported or data that did not meet publication criteria

*Workplace...continued on page 5*

juries and billions of dollars in costs, our understanding of workplace violence is still in its infancy. Additional research—particularly in areas of data collection and intervention—is critically needed in order to reduce the toll workplace violence has on American workers.

“We have been viewing the problem of workplace violence too narrowly, and in so doing, we’ve not been able to get on top of it. It’s not just a crime issue, or a private industry issue, or a labor issue. It’s a much broader public health problem,” said Dr. James Merchant, Dean of the University of Iowa’s College of Public Health in a press statement.

Dr. David Banks, Adjunct Associate Professor of Behavioral and Social Sciences at the University of Maryland University College adds that the public health sector, including specialists such as nurses, are uniquely qualified to help prevent workplace violence in their institutions by observing predictors such as stressful work conditions.

“Public health professionals such as health educators can also do a great deal to stem the effects of workplace violence by providing holistic and other health services helping survivors deal with the aftermath of the issue,” he said.

Workplaces in both the public and private sector can greatly benefit from workplace violence preparation. Benefits range from preservation of life to cost reduction. They include: risk reduction, improved employee morale, increased feelings of security, enhanced supervisory skills, early identification of issues, business cost reduction, improved capability to resolve conflicts in positive manner, and reduced legal liability.

“It’s important for us to remember that workplace violence occurs in a variety of settings and is not limited to any particular profession, economic, or racial/ethnic group. All the data show that it affects folks across the board and is not related to race or socioeconomic status,” said Dr. Banks.

*For more information on workplace violence, go to <http://www.cdc.gov/niosh> or call 800-35-NIOSH (800-356-4674).* ❖

## Workplace Resources

***Dealing with Workplace Violence: A Guide for Agency Planners***, a handbook developed by the Office of Personnel Management and the Interagency Working Group on Violence in the Workplace, is the result of a cooperative effort of many Federal agencies sharing their expertise in preventing and dealing with workplace violence. It is intended to assist those who are responsible for establishing workplace violence initiatives at their agencies.

*For more information, go to <http://www.opm.gov/workplac/>*

**The National Institute for Occupational Safety and Health (NIOSH)** provides a comprehensive Web site that includes information on workplace violence such as reports and fact sheets, alerts on how to prevent homicide in the workplace, risk factors and prevention strategies, and links to other sites providing information on violence.

*For more information, go to <http://www.cdc.gov/niosh/homepage.htm>*

**The National Institute for the Prevention of Workplace Violence** educates employers, unions, and employees about the growing threat of violence in the workplace and how to effectively deal with it. It focuses on preventative efforts and prepares clients to respond appropriately should an incident of violence occur. It also provides facts and figures on workplace violence and studies and guides, including “A Supervisor’s Guide for Responding to Violence, Threats, or Any Inappropriate Behaviors.”

*For more information, go to <http://www.workplaceviolence911.com>*

**The National Workplace Resource Center on Domestic Violence**, a program of the Family Violence Prevention Fund (FVPPF), is a collaboration between the FVPPF, employers and unions across the nation. Through the project, employers and unions offer information to employees and union members, develop workplace policies, and strive to ensure that workplaces across America are supportive of the special needs of employees who are facing domestic violence.

Project materials include *Domestic Violence: A Union Issue*, *A Workplace Training Kit for Unions* and its companion video, *Domestic Violence: Unions Respond*. Both provide unions with tools to educate their members about domestic violence and to develop effective prevention and intervention strategies.

Developed by FVPPF, the Kit includes comprehensive training outlines and materials designed to facilitate training sessions that increase awareness about domestic violence in the workplace and educate union leaders and members about how to successfully address the problem.

*For more information, go to <http://endabuse.org/programs/workplace/>*

***Violence in the Workplace, 1993-99***, a special report by the Bureau of Justice Statistics, was released in December 2001. Report looks at the following issues:

- Trends in workplace violence;
- Occupational differences in victimization rates (police officers experienced workplace violent crime at rates higher than all other occupations—261 per 1,000 persons);
- Racial and ethnic differences (the workplace violent crime rate for whites—13 per 1,000 in the workforce—was 25 percent higher than the black rate of 10 per 1,000 and 59 percent higher than the rate of 8 per 1,000 for other races);
- Victimization in various job locations (private sector and Federal employees were victimized at similar rates); and
- Weaponry used (more than 80% of all workplace homicides were committed with a firearm).

*For more information on workplace violence, go to <http://www.ojp.usdoj.gov/bjs/pub/pdf/vw99.pdf>*

## Warning Signs for Suicide

Most people who are depressed do *not* kill themselves. Suicide is considered a possible complication of depressive illness in combination with other risk factors because suicidal thoughts and behavior can be symptoms of moderate to severe depression.

These symptoms typically respond to proper treatment, and usually can be avoided with early intervention for depressive illness.

Any concerns about suicidal risk should always be taken seriously and evaluated by a qualified professional immediately.

### Suicide Risk Factors

It is important to note that while many people experience one or more risk factors and are not suicidal, there are some signs to look for:

- One or more diagnosable mental or substance abuse disorders;
- Impulsivity;
- Adverse life events;
- Family history of mental or substance abuse disorder;
- Family history of suicide;
- Family violence, including physical or sexual abuse;
- Prior suicide attempt;
- Firearm in the home;
- Incarceration; or
- Exposure to the suicidal behavior of others, including family, peers, or in news or fiction stories.

*If you need help, or if anyone you know needs help, call 800-SUICIDE (800-784-2433) to connect with a crisis center in your area. ❖*

*Source: National Institutes of Mental Health*

## Suicide Epidemic Continues Among American Indian Youth

By Jody Vilschick

Suicide has been the second leading cause of death for 15 to 24-year-old American Indians and Alaska Natives for the past 15 years, so prevention continues to be a priority issue for Native American communities and the mental health providers with whom they work.

"The physical, environmental, social, and psychological conditions that confront American Indian youth are well documented. They face alarming rates of unemployment, alcohol and substance abuse, devastating health conditions such as diabetes, nutritional deficiencies, below standard living conditions, and suicide," says Denis Nissim-Sabat, PhD, senior policy analyst for the American Psychological Association.

The devastating effect of these conditions becomes apparent when looking specifically at adolescent males.

In 1990, American Indian/Alaska Native males ages 15 to 24 had a suicide death rate of 49.1 per 100,000 resident population, compared to a rate of 23.2 for White males in the same age group. African American, Asian/Pacific Islander, and Hispanic males in the same category all had similar rates—15.1, 13.5, and 14.7, respectively.

The suicide death rate for American Indian/Alaska Native males ages 15 to 24 fluctuated in the 1990s, decreasing to 36.6 in 1999. American Indian male youth still have a higher suicide death rate than the rate of 17.2 per 100,000 for all other males in the same age group.

For the Seneca Nation of Indians, headquartered in Irving, NY, suicide prevention counseling is an ongoing project, but one that has been successful.

Karla Carol Button, a suicide prevention counselor for the Seneca Nation of Indians' Human Services Unit said, "We try to see how serious they are—whether they're capable of carrying out a suicide plan, whether they even have a plan."

Youth are referred to the Health Services Unit through their parents or other family members, or one of the three local high schools. The word has gone out during the past few years about the availability of suicide prevention counseling—with measurable results. Button reports that the last successful suicide occurred five years ago.

Still, there have been a number of attempts. "Usually it's when they're drinking—alcohol is a very big problem, it's so idolized in American culture—and someone's who's drunk does something stupid. Recently, one boy stabbed himself," Button says.

Button also cites an extremely low high school graduation rate and limited job opportunities. "A lot of what's available around here are jobs in smoke shops and gas stations—not really a satisfying career," Button says. "A real jobs program and the jobs to go with it would really help increase the self-esteem of our youth."

The good news Button offers is that for those who do graduate high school, there are a variety of scholarships available for Seneca youth. "New York State gives each Indian student over a thousand dollars a semester and they're usually eligible for other grants," she says. "Plus the Seneca Nation has its own tuition program that funds books and supplies."

But the big problem is a pervasive lack of self-esteem among the tribe's youth. "Seneca culture is very important to building self-esteem," Button says. "That has been stripped away from us over the years—especially through the boarding school program of the late 1800s and early 1900s. Our culture is important because you must figure out who you are first and where you come from to figure out where you are going."

During the 1800s, throughout the United States, the Federal government took young American Indian children between the ages of 3 and 16 from their homes and families and placed them in boarding schools, where

*Suicide...continued on page 7*

they were systematically alienated from their culture and religion.

"Their purpose was to kill the Indian but save the human being," says Harry Hill, a suicide prevention counselor for the Native American Community Services of Buffalo, NY, and a member of the Iroquois Confederacy in upstate New York. "Parents would walk days to get to their kids, and when they got to the school, they were told the kids were somewhere else. The kids were simply told their parents were dead. Can you imagine a young child being told 'your mama is dead'?"

Hill blames the generations of abuse—mental, physical, sexual, and emotional—that American Indians experienced for the high suicide rates in the American Indian community. "There have been generations of Native Americans dealing with multiple losses, but without their culture to support them and help them through these losses," he says.

Hill, through the Native American Community Services, twice a year provides month-long workshops for at-risk American Indian youth who live in urban settings. "We focus on Native American culture and our own teachings to help them deal with suicide and look beyond it. One student described suicide as 'disrespecting the Creator,' and that's really true.

"The Creator has given everyone a gift, a talent, and a work to do. Our job is to walk through our days and accomplish the work we have been given. It is our job to seek it and to find it," Hill says. He considers the program very successful—in the four years working with the program in Buffalo, there's only been one suicide of a youth who participated in the program; and in the seven years in which he presented the program in Ontario, Canada, there weren't any suicides among participating youth.

In the boarding schools, American Indian were taught to value anything but their own identity and culture. "A sense of shame pervades our self-image," Hill says. "So when it comes time to deal with the idea of suicide or when life gets hard, there's nothing to help the individual deal with the process."

"Another risk factor, across all populations, is exposure to suicide—whether you know someone, or you've seen a movie about it or read a book about a successful suicide," Hill says. "Most Native American kids have a family member who's committed suicide. Whether we like it or not, suicide is a part of our lives right now."

According to the American Indian and Alaska Native Mental Health Organization, the American Indians most likely to successfully commit suicide have the following social characteristics:

- Often a male between 15 and 24 years of age;
- Single;
- Under the influence of alcohol just before his suicide attempt;
- Has lived with a number of ineffective or inappropriate parental substitutes because of familial disruption;
- Has spent time in boarding schools and has been moved from one to another;
- Has been raised by caretakers who have come into conflict with the law;
- Has often been jailed at an early age;
- Has experienced an emotional loss, such as divorce, desertion, or death in the family; and/or
- Has experienced a past loss through violence of someone to whom he felt attached.

"Sometimes just being there and listening is the key way to prevent suicide," Hill says. Recently he received a call from a family of a young suicide, asking him to come speak with and counsel the family, including aunts and uncles. "Unknown to me at the time, one of uncles who was there was also the perpetrator of child abuse of the youth who died," Hill says. "That uncle came to me and confessed to me, asking me to help him, so he too didn't commit suicide from the guilt of what he'd done to the boy. He became aware of his own sickness through just talking, and wanted to get help to prevent the damage from going on."

*For more information, go to the National Strategy for Suicide Prevention Web site at <http://www.mentalhealth.org/suicideprevention> ❖*

## The Saga Continues...

Death is knocking at the door much more frequently as a result of suicide than many care to admit or are even aware. The Centers for Disease Control and Prevention (CDC) reported that more teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease **combined**. Consider the following facts from *The Surgeon General's Call To Action To Prevent Suicide, 1999*, and other CDC reports:

- Despite the low overall rate of suicide among African Americans, between 1980 and 1996, the rate of suicide among African American males aged 15-19 years increased 105 percent, and almost 100 percent of the increase in this group is attributable to the use of firearms.
- Suicide rates are higher than the national average for some groups of Asian Americans/Pacific Islanders. In Hawaii, the suicide rate for this group is 4 percent higher than the rate for the rest of the population. Asian American women have the highest suicide rate among women age 65 and older.
- During the past decade, the suicide rate among Hispanic youth has been increasing, and compared with White youth, Hispanic youth show higher prevalence of suicidal behaviors, including suicide attempts. More specifically, in 1999, the Youth Risk Behavior Surveillance System, in a nationwide survey of high school students found that in the 12 months preceding the survey, Hispanic students were significantly more likely than White or Black students to have reported a suicide attempt.

*For more information on the Surgeon General's report, go to <http://sreports.nlm.nih.gov/NN> ❖*

# A Safe Haven on the Reservation

## *Protecting Women from Intimate Partner Violence*

By Kerrita McClaughlyn

American Indian women are disproportionately affected by intimate partner violence (IPV) and one organization is trying to do something about it. American Indian organizations and tribal agencies are organizing shelter, legal, and preventive responses.

“Violence against women is the number one public health problem in Indian country,” said Cecilia Firethunder, public education specialist for Cangleska, Inc., a non-profit agency serving the women of the Oglala Sioux Tribe.

According to Firethunder, Cangleska was created to help counteract the effects of violence on Native families and society.

“A society with a tradition of respect for women and strong matriarchal lines had disintegrated into rampant violence against women, widespread alcohol abuse and high rates of unemployment,” she said. These socioeconomic and sociological issues fueled the cycle of violence, so Cangleska, Inc. was formed to address these underlying problems. It has raised funding to provide counseling services for women and men, spent years petitioning the justice system to take the issue seriously, and performed grass roots education and training in the community.

“IPV is very high in our communities—it’s higher than what people want to accept,” said Firethunder.

American Indian women were victimized by an intimate partner at rates higher than others—23 per 1,000 women as opposed to 11 per 1,000 Black women, 8 per

1,000 White women and 2 per 1,000 Asian women, according to the Bureau of Justice Statistics’ report *Violent Victimization and Race, 1993-1998*.

“IPV impacts the entire social system—from healthcare and social services to education,” said Firethunder. “We’re here to do what we can to stop it.”

America has the impression that IPV only occurs between a man and a woman and does not affect society, according to Firethunder. “It impacts families of both men and women, as well as all our social systems,” she said.

### **Holding the Community Accountable**

On the Pine Ridge Reservation in South Dakota, Cangleska has partnered with the Oglala Police Department, the Oglala Housing Department, the Oglala Tribal Court, the Oglala Tribal Prosecutor’s Office, and the Judiciary Committee to create a coordinated community response to violent crimes against women.

“Thirteen years ago we became the first reservation to create mandatory arrest laws for violence against women. We’ve expanded the laws to include other crimes, including stalking, because 17 percent of American Indian/Alaska Native women are stalked, compared to 8 percent of all women in the general population,” Firethunder said.

“We’ve made sure that everyone is aware of the law and that training throughout the justice system is ongoing. We make sure that the entire system is responsive—training cops,

courts, prosecutors, judges, and other people in the system,” she added.

Cangleska also provides civil legal assistance services to battered women through the Stronghold Civil Legal Office, which serves each of the nine districts on the Pine Ridge Reservation, and educates the community on its available services and the rights of battered women. Cangleska conducts sensitivity training to increase awareness of the interpersonal aspects related to battered women services, and on the intricacies of the tribal court system.

This program has made Pine Ridge a model for tribes across the country. In their Sacred Circle training center in Rapid City, Cangleska trains tribes from across the country who have received grants from the government to conduct violence prevention programs.

“We’ve trained hundreds of Indian tribes. We train them on how to set up shelters and to improve police response and arrests. We also improve how prosecutions are conducted and we train tribes to address their own perceptions and responses,” said Firethunder.

According to Firethunder, the Pine Ridge Reservation has a population of approximately 2800 people, with half of the population 18 years or younger.

“We have 1800 men on probation for domestic violence. This is not because our men are more violent—it’s because we have

*Intimate...continued on page 9*

### ***What is Intimate Partner Violence (IPV)?***

IPV is actual or threatened physical or sexual violence, or psychological/emotional abuse. Some of the common terms used to describe intimate partner violence are domestic abuse, spouse abuse, domestic violence, courtship violence, battering, marital rape, and date rape. Intimate partners include current or former spouses, boyfriends, or girlfriends (including heterosexual or same-sex partners).

- In 1999, there were 671,110 violent acts committed against females by intimate partners, down from 1.1 million in 1993.
- Between 1993-1998, 75 percent of American Indian women reported their offender to be a non-stranger.
- Approximately 8 in 1,000 women and 1 in 1,000 men age 12 or older experienced a violent victimization perpetrated by a current or former spouse, boyfriend or girlfriend.

Source: Bureau of Justice Statistics—*Violent Victimization and Race, 1993-1998* and *Intimate Partner Violence and Age of Victim, 1993-1999*.

## Intimate Partner Violence



*"Violence against women is the number one public health problem in Indian country."*

Cecilia Firethunder

### *Intimate...continued from page 8*

made sure that the entire system holds men accountable," she said. "When a call goes into a 911 operator, we make sure it's followed through until the end. We made sure that the cops knew the law, and we trained them to make sure that evidence is gathered, and the person responsible is held accountable."

### **Programs and Services Offered**

Beyond providing legal services, Cangleska also provides shelters, programs for batterers and abused women, and public education programs.

"We have two shelters on the Reservation and one in the city nearby. Here in South Dakota we have a strong network of White and Indian women—it's one of the things we're so proud of. In the rural areas it's White and Indian women working side by side to protect women. We can bring women to a network of shelters across the state to get them away from their environments," said Firethunder.

"Our staff are all trained to be advocates no matter what their position. Our courthouse is right next to us so anyone on staff is able to obtain temporary protection and custody orders for women and their children as soon as they arrive," Firethunder said.

Cangleska also provides a very comprehensive men's rehabilitation project called the batterers program. The staff also proactively educates youth by going into schools and conducting workshops with them, about their perceptions about violence. They hope to prevent the cycle of violence before the children become adults.

A new area on which Cangleska hopes to have an impact is in the medical/health aspect of sexual violence. "We're looking at Indian Health Service—looking to influence emergency rooms to respond to sexual assault," said Firethunder.

"Women don't report rapes because they don't think anything will happen. Fifty percent of women coming into our emergency rooms will not allow themselves to be examined for sexual assault and have a rape kit test," Firethunder said. "Their perception is that they were drunk, so they deserve it and so they won't report it."

Cangleska has worked to separate the violence from the alcohol. The agency has worked to convince law enforcement that alcohol doesn't cause violence, and has succeeded in encouraging judges to send men to violence management classes, along with alcohol abuse classes.

"Indian women are raped at a greater rate than women of all other races," Firethunder said. Cangleska has taken a lead in trying to address this staggering statistic. Their first issue is the legal system—"We try to get numbers on the prosecution of rape cases. We work with the U.S. Attorney's office and the FBI because if a rape crime happens on the reservation, the local cops turn it over to the FBI," she said. The second issue is that there's a lack of resources and services like rape crisis centers and counseling services and the crime of rape is going to require these services.

"When we work in the schools, we try to teach girls to pull together and to protect themselves and if they've been raped to heal from rape," said Firethunder.

"For me as an Indian woman, I felt it was important for me to help to provide the services our women need to heal from the pain they've suffered from violence in their lives."

*For more information on Cangleska, Inc., contact Cecilia Firethunder at 605-455-2244. ❖*

# Domestic Violence

## *The Hidden Secret of the LGBT Community*

By Kerrita McClaughly

**D**omestic violence is a problem in American society that cuts across all socioeconomic, gender, racial, and ethnic lines. Although the problem is readily discussed in society at large, the focus is often on heterosexual relationships. This often obscures the fact that same-sex domestic violence occurs at a similar rate as heterosexual relationships.

The problem of domestic violence in the lesbian, gay, bisexual, and transgender (LGBT) community is highlighted in the 2001 preliminary report by the National Coalition of Anti-Violence Programs (NCAVP). NCAVP is a network of 27 community-based organizations responding to violence affecting LGBT and HIV-affected individuals.

*Closing the Gaps* with Rachel Baum, MSW, national program coordinator for NCAVP and the New York City Gay and Lesbian Anti-Violence Project, about the report, *Lesbian, Gay, Bisexual, and Transgender Domestic Violence in 2000*, and the problems affecting the LGBT community.

### **CTG: How prevalent is domestic violence in the LGBT community?**

**BAUM:** It is estimated that the incidence of domestic violence (DV) in the lives of lesbian, gay, bisexual and transgender (LGBT) people parallels that in the lives of straight people (25-33 percent). However, reporting is assumed to be even lower than among straight women. The academic studies on this topic are so few at this point, we cannot update the estimated prevalence with scientific certainty, but we can use information from the few studies that have been done, as well as from the reports and anecdotal experiences of providers who serve LGBT survivors of violence.

### **CTG: What are some of the barriers preventing the community from discussing the problem?**

**BAUM:** Shame and denial are very powerful barriers. As is true with so many other marginalized groups there is a sense of not wanting to air “dirty laundry”. In the case of LGBT people there is defensiveness about our relationships. Since there are so many people who would already pathologize our relationships, condemn our families, and deny our right to be, there is a strong opposition to offering more “ammunition” to the “antis” to bolster their arguments. Not wanting to taint our image, as we fight for civil rights and recognition, is a strong silencer for those who may be suffering from DV.

### **CTG: How prevalent is domestic violence in minority communities and what are the barriers they face?**

**BAUM:** As I mentioned earlier, the prevalence of DV is believed to cut across demographic lines as well as sexual orientation and gender lines. Given our data and experiences as providers, there is no reason to believe that more or fewer LGBT people of color experience or perpetrate DV than non-minorities. Of course this goes against many people’s stereotypes about people of color being more violent or “passionate”, but these stereotypes are not exclusive to LGBT people but they do cross over.

Additionally, there is the issue of access to resources. Many of the programs that have been developed to address violence within and against the LGBT community are not sensitively and appropriately meeting the needs of people of color. This includes outreach. Most of these programs exist within the larger mainstream LGBT community.

Many men who have sex with men, women who have sex with women and gender variant people do not relate to the larger community or even define under the terms we use, like “gay” or “queer”. This is particularly true in communities of color and immigrant groups. Therefore, we face a barrier on the front end to getting services to people who aren’t out or don’t connect with the larger mainstream community and won’t come out for services.

### **CTG: How is the problem of domestic violence in the LGBT community being addressed?**

**BAUM:** LGBT-specific anti-violence projects only exist in a smattering of places around the country. There are LGBT people and allies currently working at women’s shelters and other DV programs around the country who have taken on reaching out to LGBT victims. Unfortunately, this is all very limited.

There is also a critical need to educate DV and mental health service providers, law enforcement, medical professionals, and other service providers on issues specific to the LGBT community—to ensure that all services are sensitive, appropriate, and accessible. For example, we’ve found that when straight DV agencies expand their services to specifically meet the needs of the LGBT community, these services are usually geared toward lesbian and bisexual women and sometimes to transgender women, but rarely to men of any sexual orientation or gender identity. Even these services are usually limited and are still sometimes inappropriate due to insufficient staff training.

*Hidden...continued on page 11*

**CTG: Where can the LGBT community turn for help?**

**BAUM:** It is important to look at the laws in an area. In some states LGBT people can actually access an order of protection and order to vacate through civil court, and victims should be made aware of that option. In other states LGBT people must go through criminal court, which means a greater offense must occur (potentially a more dangerous threat or more serious injury) and the person must have the abuser arrested. We know most victims of DV already don't want to have their partner arrested, and with the history of LGBT people's relationship with the police and prison system this aversion is often exacerbated. If the LGBT person is an immigrant or a person of color, it is likely that their fear of using law enforcement will be even greater.

A third legal possibility is that the state does offer orders of protection to LGBT people through civil or criminal court. However, this could deter a person from coming forward to seek protection if there could potentially be criminal prosecution for violation of other laws. Still, other states do not offer protection to LGBT people from intimate partner violence at all. It is important that local providers and law enforcement are aware of local statutes and make victims aware of their options.

Not everyone, however, will choose to address DV through use of the criminal justice system and it is important that we have resources available for each person to make choices about the best approach for their own situation.

**CTG: What other resources are needed to help eradicate or limit the problem in the community?**

**BAUM:** We need laws changed for better access to DV shelters (equal access ordinances like the one in San Francisco for example), increased access to the legal system, education for law enforcement and service providers, research to better construct programs and to better identify the problem, and money for outreach and response programs for both victims and perpetrators.

**CTG: Is there anything that you would like to add that I did not ask, that you think is missing, or that you think is relevant to the issue?**

**BAUM:** When I do trainings for mainstream (straight) DV agencies and providers one of the first things I tell them they can do to make their services more acces-

sible and welcoming for LGBT people is not to make assumptions about any client who walks through the door. So often if advocates see a man coming they run in and lock the doors. There is a need for us to use our instincts to be safe, but also a need to ask questions before making assumptions. When doing client intakes or taking hotline calls, try not to use gender-specific pronouns to refer to the client's abuser until the client has identified the appropriate pronouns. This will allow one less obstacle to a person trying to come forward for help, but afraid of facing homophobia or transphobia.

If you think it is too difficult to have a conversation without using gender-specific pronouns, go back and read this interview again, you'll find none. Anti-Violence Project (AVP) staff often train and seek to collaborate with other providers in their areas in hopes of reaching and serving more LGBT victims of DV but not all providers are open to this kind of training or collaborations or to doing this work. There are still huge gaps in service.

*For more information on the National Coalition of Anti-Violence Programs and the New York City Gay and Lesbian Anti-Violence Project, go to <http://www.avp.org> or call 212-714-1184. ❖*

## Special Issues in Lesbian, Gay, Bisexual, and Transgender Domestic Violence

1. "Outing" or threatening to out a partner to friends, family, employers, police, or others.
2. Reinforcing fears that no one will help a partner because s/he is lesbian, gay, bisexual or transgender, or that for this reason, the partner "deserves" the abuse.
3. Alternatively, justifying abuse with the notion that a partner is not "really" lesbian, gay, bisexual or transgender; i.e., s/he may once have had or may still have relationships with other people, or express a gender identity, inconsistent with the abuser's definitions of these terms.
4. Telling the partner that abusive behavior is a normal part of LGBT relationships, or that it cannot be domestic violence because it is occurring between LGBT individuals.
5. Portraying the violence as mutual and even consensual, especially if the partner attempts to defend against it, or has an expression of masculinity or some other "desirable" trait.

# Providing Services to Combat Domestic Violence in New York City's Minority Communities

Guest Article by James B. Gwynne, MPA, JD

**D**omestic violence—an important policy issue in the United States since the 1970's—is also known as partner abuse, spouse abuse, or battering. It is one facet of the larger problem of family violence that occurs among persons within a family or other intimate relationships, and includes child and elder abuse, and affects everyone—women, men, children, and seniors. According to the American Medical Association, family violence usually results from the abuse of power or the domination and victimization of a physically less powerful person by a physically more powerful person.

The June 2001 *National Crime Victimization Survey* (NCVS), reports that in 2000, 53 percent of all victims of violent crime identified the offender(s) as an intimate, relative, friend, or acquaintance. Further data published in the October 11, 2001, issue of *Morbidity and Mortality Weekly Report* concluded that from 1981-1998, women were 1.6 times more likely to die of an intimate partner homicide than were men. And, rates among African Americans were 4.6 times the rates of Whites—with rates the highest among females age 20-39 years.

## The Many Faces of Abuse

While all races and ethnic groups are nearly equally at risk of domestic violence, racial and ethnic minorities tend to have fewer resources available and face unique legal, social, and economic challenges. For example, the NCVS suggests that 22 to 50 percent of homeless women and children became homeless after fleeing abuse.

## Domestic Violence Resources

**Institute on Domestic Violence in the African American Community**  
<http://www.dvinstitute.org>

**National Latino Alliance for the Elimination of Domestic Violence**  
<http://www.dvalianza.com/>

**National Lawyers Guild, National Immigration Project**  
<http://www.nlg.org/nip/domestic-violence/domvioindex.htm>

**The New York Asian Women's Center**  
<http://nyawc.org>

**NOW Legal Defense and Education Fund  
 Immigrant Women Program**  
<http://www.nowldef.org/html/issues/imm/index.shtml>

Ethnic and immigrant survivors of domestic violence are further challenged by language barriers, lack of the necessary skills to navigate the health and social systems, or competing cultural practices that constrict choices in seeking safety from violence. One article, *With No Place to Turn: Improving Advocacy for Battered Immigrant Women*, Family Law Quarterly, Summer 1995, noted that a battered immigrant woman who attempts to flee may have no access to a bilingual shelter, financial assistance, or food. It is unlikely that she will have the assistance of a certified interpreter in court, when reporting complaints to police or a 911 operator, or even in acquiring information about her rights and the legal system.

Judith Kahan, executive director of the Center for the Elimination of Violence in the Family, concurs, and adds, "The most difficult families to re-house and start on their way to an independent life are undocumented immigrant families. Often, women have come to the U.S. to stay with or marry a citizen or green-card holding man. If that man is abusive, it is not unusual for the woman to become his virtual prisoner. When she breaks free, she has no way to support herself or her children. It is almost impossible for families like these to find affordable housing or feed themselves."

Further compounding matters is the fact that each cultural community faces unique and special challenges when dealing with the issue of domestic violence. For example, Census 2000 data demarcated 16 different Asian ethnicities—where each community is distinct and separate—each with its own history and culture.

"Many Asian communities have devoted very few resources to helping the victims and stopping abusers of domestic violence—choosing to see it as simply an argument between husband and wife. Furthermore, many abused Asian women remain silent because they lack confidence in themselves and believe that they somehow deserve the abuse," said Tuhina De O'Connor of the New York Asian Women's Center.

"Many immigrant Asian battered women are afraid to seek help based on the perception that their sex, race, and immigration status will work against them. It's unfortunate, but Asian women are often murdered by their partners after long histories of abuse that no one ever knew about or was willing to acknowledge; still others commit suicide because they see no other escape from the physical and emotional torture," said De O'Connor.

*Domestic...continued page 13*

### A Closer Look: New York City Programs

State and city agencies have been working for nearly 30 years to combat domestic violence—and New York is no exception. The New York State Office for the Prevention of Domestic Violence has been on the frontline—enacting laws, developing system-wide protocols and policies to address the many issues faced by victims of domestic violence. New York City has also implemented numerous initiatives to combat domestic violence, based on a comprehensive approach that includes prevention, offender accountability, and intervention strategies. However, even the most progressive agencies face a plethora of issues among abused women that compound their ability to effectively deliver services. Culturally and linguistically appropriate services are often difficult to undertake due to poor self-esteem, low expectations, limited educational backgrounds and work histories, and impoverished social networks.

New York City has several programs designed for and working with specific minority communities. Some examples that are notable for their multiple efforts to incorporate racial, ethnic, and culturally appropriate services into their programs in support of abused women and their children include:

- **The Center for Elimination of Violence in the Family (CEVF)** in Brooklyn was started in 1976, when its founders, the Brooklyn YWCA, National Congress of Neighborhood Women, and the New York City Mayors Task Force on Rape, recognized the need for a public shelter for battered women. In 1977, the first publicly funded domestic violence shelter in New York State opened.

The Center's resident community includes African-American residents of Bedford Stuyvesant, Caribbean residents of Flatbush, and the predominantly Latino and Chinese residents of Sunset Park, which are among the City's top ten precincts reporting domestic incidents.

Shelter is provided to 132 survivors of domestic abuse at a time, sheltering between 350 and 450 women and children annually. The mostly immigrant families are usually headed by women with an average of two children. The Center provides workshops like *Mom's Survival Skills*, and those that deal with the issues of empowerment and economic literacy to help formerly abused women take control of their lives.

The Center also offers programs like *Children's Growing Place* and *Children's Club House* that aim to stop the cycle of domestic abuse by focusing on the children of battered women. In addition, multicultural teams of educators and social service workers reach out to Brooklyn's largely immigrant neighborhoods, and social workers counsel teens in more than a dozen high schools to prevent relationship abuse before it becomes deadly. Multilingual staff offers counseling and referrals to more than 7,000 callers each year via a 24-hour hotline.

- **The New York Asian Women's Center (NYAWC)** in Manhattan's Chinatown was launched in 1982 by a small group of Asian women who wanted to address battering in their community. Today, NYAWC has the only licensed shelter in New York State

that specifically serves Asian women. Each year the Center receives over 3,000 hotline calls and offers intensive counseling and advocacy assistance to over 250 Asian immigrant women and their children.

- **The Urban Women's Retreat (UWR)** was founded in 1984, in central Harlem. The majority of residents are from the five boroughs, predominantly African American and Hispanic, who are young mothers in their twenties with children residing with them. The shelter is also open to single women, and provides services to a few women in their senior years. Placement into the facility is made largely through the Retreat's telephone hotline that provides counseling and referrals on a 24-hour basis.

The staff works with the individuals to address the entire domestic violence syndrome—feelings of fear, helplessness, and low self-esteem. They also assist with establishing realistic life goals and concrete plans to achieve them.

- **The Violence Intervention Program, Inc., (VIP)** was established in 1984 in East Harlem, in recognition of the lack of bilingual/bicultural non-residential and residential services available to battered Latinas. VIP operates eight safe dwellings with a total bed night capacity of 46. The sites provide residents with crisis intervention, individual counseling, support groups, advocacy services, accompaniment, and assistance with identifying and securing safe, affordable, permanent housing.

In 1997, VIP expanded its non-residential services by opening a branch in the Bronx. In both offices, VIP provides crisis intervention, individual counseling, support groups, and advocacy services to battered women. Both programs also provide individual counseling and support group services to the children/adolescents of the battered women receiving services. In addition, since late 1995, VIP has operated the New York State Spanish Domestic Violence Hotline program (1-800-942-6908). This 24-hour Spanish domestic violence statewide hotline, the only one of its kind in the US, receives an average of 3,000 calls a year.

While this country has experienced a dramatic decrease in all kinds of domestic violence since the early 1990s, the struggle for those caught in the cycle of violence continues. Programs like these, at the forefront of the battle to end domestic violence, have recognized the need to deliver culturally competent care and services.

*James B. Gwynne, MPA, JD, is Director of Projects for the National Latino Alliance for the Elimination of Domestic Violence (Alianza). He also consults and trains on domestic violence, family violence, and teen abuse related issues. He can be reached at [jbgwynne@aol.com](mailto:jbgwynne@aol.com)*

*For more information, go to the National Coalition on Domestic Violence Web site at <http://www.ncadv.org>* ❖

### **American Foundation for Suicide Prevention**

120 Wall Street, 22nd Floor  
New York, NY 10005  
888-333-AFSP Toll-free  
<http://www.afsp.org>

### **Asian & Pacific Islander Institute on Domestic Violence**

942 Market Street  
Suite 200  
San Francisco, CA 94102  
415-954-9964  
<http://www.apiahf.org>

### **The Center for Mental Health Services**

P.O. Box 42490  
Washington, DC 20015  
800-789-2647  
<http://www.mentalhealth.com>

### **Family Violence Prevention Fund**

383 Rhode Island Street  
Suite 304  
San Francisco, CA 94103-5133  
415-252-8900  
<http://endabuse.org>

### **L.A. Gay and Lesbian Center**

STOP Partner Abuse/Domestic Violence Program  
1625 North Schrader Blvd.  
Los Angeles, CA 90028  
323-860-5806  
<http://www.laglc.org/domesticviolence>

### **Lesbian and Gay Community Center of New Orleans**

2114 Decatur  
New Orleans, LA 70116  
504-945-1103  
<http://lgccno.org/>

### **Mending the Sacred Hoop**

S.T.O.P Violence Against Indian Women Technical Assistance Project  
202 East Superior Street  
Duluth, MN 55802  
888-305-1650  
218-722-2781  
<http://www.msh-ta.org>

### **National Coalition Against Domestic Violence**

1532 16th Street, NW  
Washington, D.C. 20036  
800-799-7233 Hotline  
202-745-1211  
<http://www.ncadv.org>

### **National Center for Injury Prevention and Control**

Mailstop K65  
4770 Buford Highway, NE  
Atlanta, GA 30341-3724  
770-488-1506  
<http://www.cdc.gov/ncipc/>

### **National Criminal Justice Reference Service (NCJRS)**

NCJRS Publication Ordering  
P.O. Box 6000  
Rockville, MD 20849-6000  
800-851-3420  
<http://www.ncjrs.org/>

### **National Domestic Violence Hotline**

800-799-SAFE (800-799-7233)  
P.O. Box 161810  
Austin, TX 78716  
<http://www.ndvh.org/>

### **National Institute for Occupational Safety and Health (NIOSH)**

NIOSH Publications  
4676 Columbia Parkway, Mail Stop C-13  
Cincinnati, OH 45226-1998  
800-35-NIOSH (800-356-4674)  
<http://www.cdc.gov/niosh/homepage.html>

### **National Youth Violence Prevention Resource Center**

P.O. Box 6003  
Rockville, MD 20849-6003  
866-SAFEYOUTH (866-723-3968) Toll-free  
800-243-7012 (TTY)  
<http://www.safeyouth.org>

### **New York City Gay and Lesbian Anti-Violence Project**

240 West 35<sup>th</sup> Street, Suite 200  
New York, NY 10001  
212-714-1141 Hotline  
<http://www.avp.org>

### **Sacred Circle**

722 St. Joseph Street  
Rapid City, SD 57701  
877-RED-ROAD Toll-free

## New Disparities in Health Report

***Trends in Racial- and Ethnic-Specific Rates for the Health Status Indicators: United States, 1990-1998***, a new report released in January 2002 by Department of Health and Human Services (HHS) Secretary Tommy G. Thompson shows significant improvements in the health of racial and ethnic minorities, but also indicates that important disparities in health persist among different populations.

The report presents national trends in racial- and ethnic-specific rates for 17 health status indicators during the 1990s. The health status indicators are part of Healthy People 2000, an HHS-led effort to set health goals for each decade and then measure progress toward achieving them.

The report shows that despite overall health improvements, in some areas the disparities for ethnic and racial minorities remained the same or even increased.

The indicators reflect various aspects of health and include infant mortality, teen births, prenatal care, low birthweight as well as death rates for all causes, including heart disease, stroke, lung and breast cancer, suicide, homicide, motor vehicle crashes, and work-related injuries. Infectious diseases such as tuberculosis and syphilis are also included.

"Our goal is to eliminate disparities in health among all population groups by 2010," Secretary Thompson said. "While we are making progress, this report shows how far we still have to go."

"A clear lesson for public health is that efforts to achieve progress for all must be targeted and tailored to the needs of specific groups," said Dr. Jeffrey P. Koplan, director of the Centers for Disease Control and Prevention, which prepared the report.

HHS agencies are now working on Healthy People 2010, the nation's public health agenda for the current decade, and have identified a set of Leading Health Indicators that are being tracked nationwide and in states and communities.

"*Trends in Racial and Ethnic-Specific Rates for the Health Status Indicators: United States, 1990-1998*" can be viewed or downloaded at <http://www.cdc.gov/nchs>❖

## Violence Prevention Resources on the Internet

***Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0*** is a set of recommendations designed to promote consistency in the use of terminology and data collection related to intimate partner violence. This document was developed through an extensive consultation process. It is published by the National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention.

For more information, go to <http://www.cdc.gov/ncipc/pub-res/intimate.htm>

**The National Institute for Occupational Safety and Health (NIOSH)**, has added a new Spanish-language section to its Web site to serve the Nation's growing Spanish-speaking population.

The new section includes Spanish-language versions of several NIOSH workplace safety and health documents relevant to industries and occupations in which large numbers of Spanish-speaking workers are employed.

For information, go to <http://www.cdc.gov/niosh> and click "NIOSH En Español."

**The National Strategy for Suicide Prevention (NSSP)** represents the combined work of advocates, clinicians, researchers, and survivors around the nation. It lays out a framework for action to prevent suicide and guides development of an array of services and programs that must be developed. The program is a collaboration between the Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration, National Institutes of Health, and the Centers for Disease Control and Prevention.

For more information, go to <http://www.mentalhealth.org/suicideprevention/strategy.asp>



## Register Now for National Leadership Summit

**T**he National Leadership Summit to Eliminate Racial and Ethnic Disparities in Health, originally scheduled for September 2001, has been rescheduled to July 10-12, 2002.

The Summit, expanded to accommodate 2,500 participants, will be on an open-registration basis. Participants will include individuals from traditional and non-traditional organizations addressing minority health issues at the local, state, tribal, and national levels, as well as funders and policymakers. In addition to the identification and highlighting of successful programs, participants will be able to attend "skills building sessions" aimed at providing participants with information and skills to enhance their efforts at the local level.

Participants will receive a "community tool kit," containing descriptions of community-based programs, technical assistance documents, resource documents, and policies which are aimed at eliminating disparities.

The Summit supports Departmental efforts related to Healthy People 2010, the Nation's health agenda, as well as the Departmental Initiative on Eliminating Racial and Ethnic Disparities in Health.

For information on registration, exhibiting, co-sponsorship, or general information about the Summit, please contact BETAH Associates, Inc., toll-free at 1-888-516-5599 or visit us online at <http://www.summit.omhrc.gov>❖

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Office of Public Health and Science  
Office of Minority Health Resource Center  
P.O. Box 37337  
Washington DC 20013-7337

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Official Business  
Penalty for Private Use \$300

# Closing the Gap



## Conferences: 2002

### March 1, 2002

*Assembling Pieces of the Puzzle*—24th Annual Minority Health Conference Social Determinants of Health.

For more information, visit <http://www.minority.unc.edu/sph/minconf/2002/satellite/index.htm>

### April 5, 2002

*Reducing Disparities in Health Outcomes: The Role of Population-Based Medicine in Clinical and Public Health Practice*—Celebrating National Minority Health Month.

The Johns Hopkins University Urban Health Institute, Baltimore, MD.

For more information, go to <http://urbanhealthinstitute.jhu.edu> or call 410-522-9800 ext. 148.

### April 10-13, 2002

*Suicide Prevention: Opportunities and Challenges Along the Continuum of Health and Illness*—American Association of Suicidology 35th Annual Conference. Washington, D.C.

For more information, go to <http://www.suicidology.org/index.html>

### May 12-15, 2002

*Injuries, Suicide and Violence: Building Knowledge, Policies and Practices to Promote a Safer World*—6th World Conference on Injury Prevention and Control, Montreal, Canada.

For more information, call 877-213-8368.

### May 28-31

*Research and Practice in Sexual Violence Prevention: Enhancing the Dialogue*—2002 National Sexual Violence Prevention Conference. Chicago Marriott Downtown, Chicago, IL.

For more information, call the Illinois Coalition Against Sexual Assault at 217-753-4117.

### July 10-12, 2002

*National Leadership Summit to Eliminate Racial and Ethnic Disparities in Health*. Hilton Hotel and Towers, Washington, D.C.

For more information, go to <http://summit.omhrc.gov> or call Betah Associates at 888-516-5599.