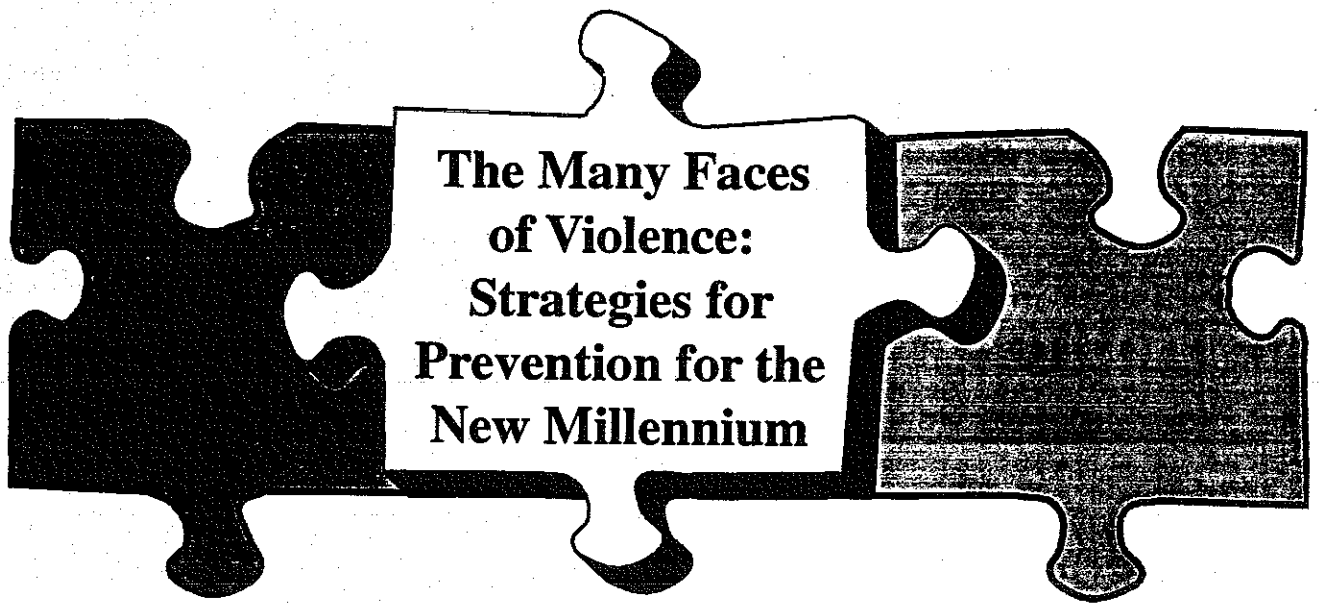
The University of North Carolina at Chapel Hill School of Public Health presents the

20th Annual Minority Health Conference



February 19 - 20, 1998
The William and Ida Friday Continuing Education Center
Chapel Hill, North Carolina

Sponsors:

The University of North Carolina at Chapel Hill School of Public Health
- Minority Student Caucus
- Student Union Board
- Minority Health Research and Education Center Committee
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North Carolina Department of Health and Human Services
- Office of Minority Health

North Carolina Central University Department of Health Education

Durham Chapter, The Links, Inc.

20th Annual Minority Health Conference

The Many Faces of Violence:
Strategies for Prevention for the New Millennium

William & Ida Friday Continuing Education Center
Chapel Hill, North Carolina
February 19-20, 1998

PROGRAM

Thursday, February 19, 1998

Time		Location
8:00 am	**Registration & Continental Breakfast**	*Central Atrium*
9:00 am	**Introductions & Welcome** *Tonya Stancil, MS* Co-President, Minority Student Caucus Doctoral Student, Department of Epidemiology School of Public Health University of North Carolina at Chapel Hill *Lamont Bryant, MS* Co-President, Minority Student Caucus Doctoral Student, Department of Environmental Sciences & Engineering School of Public Health University of North Carolina at Chapel Hill *Michael Hooker, PhD* Chancellor University of North Carolina at Chapel Hill *Sohini Sengupta, MPH* Co-Chair, Minority Health Conference Doctoral Student, Department of Health Behavior & Health Education School of Public Health University of North Carolina at Chapel Hill *Matt Garvin* Co-Chair, Minority Health Conference Master's Student, Department of Epidemiology School of Public Health University of North Carolina at Chapel Hill	*Grumman Auditorium*

9:15 am	**Message from the Dean** *William L. Roper, MD, MPH* Dean, School of Public Health University of North Carolina at Chapel Hill	*Grumman Auditorium*
9:30 am	**State of the State/State of the Nation** *Delton Atkinson, MPH* Director National Center for Health Statistics Research Triangle Park, NC	*Grumman Auditorium*
9:45 am	**Keynote Address:** ***"Public Health Approach to Violence Prevention"*** *W. Rodney Hammond, PhD* Director, Division of Violence Prevention Centers for Disease Control and Prevention Atlanta, Georgia	*Grumman Auditorium*
	Presider: *Carol Runyan, PhD, MPH* Associate Professor Department of Health Behavior & Health Education School of Public Health University of North Carolina at Chapel Hill	
	Co-Presider: *Renee Johnson*, Master's Student Department of Health Behavior & Health Education School of Public Health University of North Carolina at Chapel Hill	
11:00 am	**Poster Session/Break**	*Central Atrium*
11:15 am	**Panel Discussion:** ***"Cultural Perspectives on Community Violence"***	*Grumman Auditorium*
	Panel: *Bernadette Leite, MEd* Research Project Coordinator Founder/Director of KAL Institute of Minority Health Research Emory University Atlanta, Georgia	
	Glenn W. Solomon, PhD, MPH Department of Adolescent Medicine Health Sciences Center University of Oklahoma Oklahoma City, Oklahoma	
	"Líderes Campesinas" *Elia Gallardo, JD* Staff Attorney Organización en California de Líderes Campesinas Pomona, California	

"The Use of Youth Gang Activity Markers in Eradicating Youth Violence"
Cliff Akiyama
Youth Violence Consultant
University of Virginia
Charlottesville, Virginia

Presider: *Carol Parks, PhD, MS*
Instructor
Department of Health Behavior & Health Education
School of Public Health
University of North Carolina at Chapel Hill

Co-Presider: *Rashmi Agarwal,* Master's Student
Department of Health Policy & Administration
School of Public Health
University of North Carolina at Chapel Hill

12:30 pm **Lunch (On Your Own)** *Trillium*

1:45 pm **CONCURRENT SESSIONS:**

Adolescent Homicide *Dogwood Room A*

"Adolescent Homicide and Violence"
Tamera Coyne-Beasley, MD, MPH
Assistant Professor Pediatrics/Internal Medicine
Faculty Research Fellow at the Cecil G. Sheps Center
for Health Services Research
Department of Pediatrics, Division of Community Pediatrics
University of North Carolina at Chapel Hill
Chapel Hill, North Carolina

Presider: *Jennifer Lipkowitz,* Master's Student
Department of Health Behavior & Health Education
School of Public Health
University of North Carolina at Chapel Hill

Co-Presider: *Cynthia Gary,* Master's Student
Department of Health Behavior & Health Education
School of Public Health
University of North Carolina at Chapel Hill

Female Homicide *Dogwood Room B*

"Female Homicide in North Carolina: A Statewide Study of Patterns and Precursors"
Kathryn E. Moracco, MPH (Beth)
Research Associate
The Injury Prevention Research Center
University of North Carolina at Chapel Hill
Chapel Hill, North Carolina

Presider: *Semra Asefa,* Master's Student
Department of Health Behavior & Health Education
School of Public Health
University of North Carolina at Chapel Hill

Co-Presider: *Tara Cox,* Master's Student
Department of Nutrition
School of Public Health
University of North Carolina at Chapel Hill

Occupational Homicide

Redbud Room A

"Workplace Violence: A Critical Challenge for Public Health"
Dana P. Loomis, PhD, MSPH, MS
Associate Professor
Department of Epidemiology
School of Public Health
University of North Carolina at Chapel Hill

"Risk Factors for Robbery and Employee Injury in Convenience Stores"
Scott Hendricks, MS, Doctoral Student
Department of Biostatistics
University of North Carolina at Chapel Hill

Presider: *Felicia Solomon,* Master's Student
Department of Epidemiology
School of Public Health
University of North Carolina at Chapel Hill

Co-Presider: *Bindi Patel,* Master's Student
Department of Health Behavior & Health Education
School of Public Health
University of North Carolina at Chapel Hill

Youth/Gang Violence

Grumman Auditorium

"S.A.G.E. Project: An Intervention to Reduce Adolescent Violence"
Phillip W. Graham, MPH
Health Analyst
Research Triangle Institute
Research Triangle Park, North Carolina

Verna Lamar, MPH
Research Analyst
Research Triangle Institute
Research Triangle Park, North Carolina

MariaTheresa Viramontes
Executive Director
East Bay Public Safety Corridor Partnership
Oakland, California

Presider: *Alan Muriera,* Master's Student
Department of Health Behavior & Health Education
School of Public Health
University of North Carolina at Chapel Hill

Co-Presider: *Rosa Rodriguez,* Doctoral Student
Department of Epidemiology
School of Public Health
University of North Carolina at Chapel Hill

Children and Violence *Redbud Room B*

Lavdena Adams Orr, MD
Director, Assistant Professor of Pediatrics
Child and Adolescent Protection Center
Washington, DC

Presider: *Diane Johnson*, Master's Student
Department of Maternal and Child Health
School of Public Health
University of North Carolina at Chapel Hill

Co-Presider: *Fauzia Khanani,* Project Director
Project LinCS
Center for Health Promotion & Disease Prevention
School of Public Health
University of North Carolina at Chapel Hill

3:00 pm **Poster Session/Break** *Central Atrium*

3:30 pm **CONCURRENT SESSIONS:**

Gun Control *Dogwood Room A*

"Gun Violence Prevention and Gun Control in North Carolina"
Lisa Price, MSW
Executive Director
North Carolinians Against Gun Violence Fund
Chapel Hill, North Carolina

"CPHV Educational Programs for the Health Professional"
Marielle Haywood-Posey, MEd
Associate Director
Education Division
Center to Prevent Handgun Violence
Washington, DC

Presider: *Armide Bien-Aime*, Master's Student
Department of Health Behavior & Health Education
School of Public Health
University of North Carolina at Chapel Hill

Co-Presider: *Allison Aiello,* Master's Student
Department of Environmental Sciences & Engineering
School of Public Health
University of North Carolina at Chapel Hill

Domestic Violence *Dogwood Room B*

"Intimate Partner Violence, National Women's Health Project: Five Steps to Wellness"
Tanya Murphy
Policy Associate
Intimate Partner Violence
National Black Women's Health Project
Washington, DC

"Líderes Campesinas"
Virginia Ortega
Domestic Violence Specialist
Organización en California de Líderes Campesinas
Pomona, California

"Domestic Violence & Health Care Providers"
Shalini Gujavarty, JD
Legal/Program Coordinator
Manavi
Union, New Jersey

Presider: *Michelle Arnaudy*, Master's Student
Department of Maternal and Child Health
School of Public Health
University of North Carolina at Chapel Hill

Co-Presider: *Angela Sy,* Master's Student
Department of Health Behavior & Health Education
School of Public Health
University of North Carolina at Chapel Hill

Elder Abuse *Redbud Room A*

"Elder Abuse: Its Meaning to Caucasian, African, and Native Americans"
Margaret Hudson, PhD, RN
Associate Professor of Nursing
Department of Adult & Geriatric Health
School of Nursing
University of North Carolina at Chapel Hill

"Elder Abuse: An Overview"
Sharon Wilder
Regional Ombudsman
Triangle J Council of Governments
Research Triangle Park, North Carolina

Jill Al-hafez
Regional Ombudsman
Triangle J Council of Governments
Research Triangle Park, North Carolina

Presider: *Menoj Menon, MPH*
Center for Minority Aging
Alumnus, Department of Health Behavior & Health Education

Co-Presider: *Kenric Maynor,* Master's Student
Department of Health Policy & Administration
School of Public Health
University of North Carolina at Chapel Hill

Youth/Gang Violence Intervention *Redbud Room B*

"S.A.F.E. Haven Collaborative"
Randi McCray
Youth Representative
Activity Facilitator at Youth Fair Chance
S.A.F.E. Haven
New Haven, Connecticut

Dorothy C. Browne, DrPH, MPH, MSW
Project RAPP
Department of Maternal & Child Health
School of Public Health
University of North Carolina at Chapel Hill

Presider: *Dana Bonas*, Master's Student
Department of Epidemiology
School of Public Health
University of North Carolina at Chapel Hill

Co-Presider: *Tonya Stancil,* Doctoral Student
Department of Epidemiology
School of Public Health
University of North Carolina at Chapel Hill

5:00 pm **Adjourn**

6:00 pm **Social: Fusions New World Cuisine**
454 West Franklin Street
Chapel Hill, North Carolina
(A map is located in your conference packet.)

Friday, February 20, 1998

8:00 am **Registration & Continental Breakfast** *Central Atrium*

9:00 am **General Session:** *Grumman Auditorium*
"Interventions with African-American Men Who Batter Women"
Ulester Douglas, MSW
Men Stopping Violence
Atlanta, Georgia

Sulaiman Nurridin, MA
Men Stopping Violence
Atlanta, Georgia

Presider: *Thaddeus Thompson, PT,* Master's Student
Department of Health Policy & Administration
School of Public Health
University of North Carolina at Chapel Hill

Co-Presider: *Lamont Bryant, MS,* Doctoral Student
Department of Environmental Sciences & Engineering
School of Public Health
University of North Carolina at Chapel Hill

10:15 am **Poster Session/Break** *Central Atrium*

10:30 am **Panel Discussion: *"Is Violence Preventable?"*** *Grumman Auditorium*

Panel:
Ambrose Lane, Jr.
Director
Circle of Hope Project
Washington, DC

Diana Wells, RN, MSW, MPH
Nurse Advocate
The Beacon Project
Chapel Hill, North Carolina

Presider: *Sheryl Taylor, MPH*
WATCH Project Manager
Lineberger Comprehensive Cancer Center
University of North Carolina at Chapel Hill
Alumna, Department of Health Behavior & Health Education

Co-Presider: *Yvonne Owens,* Master's Student
Department of Health Behavior & Health Education
School of Public Health
University of North Carolina at Chapel Hill

11:45 am **Conference Wrap-Up** *Grumman Auditorium*
William T. Small, MSPH
Associate Dean & Senior Advisor for Multi-Cultural Affairs
School of Public Health
University of North Carolina at Chapel Hill

12 noon **Adjourn**

20TH Annual Minority Health Conference

The Many Faces of Violence: Strategies for Prevention for the New Millennium

February 19-20, 1998

PLANNING COMMITTEE

Sohini Sengupta, Conference Co-Chair
Matt Garvin, Conference Co-Chair
Rashmi Agarwal
Michelle Arnaudy
Barbara Chavious
Cynthia Gary
Sonya Goode
Diane Johnson
Renee Johnson
Carol Runyan
Victor Schoenbach
Felicia Solomon
William Small
Sheryl Taylor
Christie Vann

SPECIAL THANKS TO:

Rosa Laney
Colleen Sullivan
Judy Beaver

Previous Minority Health Conference Titles and Keynote Speakers

1977
Perspectives on the Health of the Black Populations
Floyd McKissick, JD
President, Soul City Company
Soul City, North Carolina

1978
Health Policy Impacts: On and By Minority Peoples
John L.S. Holloman, MD
Past President
NYC Health and Hospitals Corporation
New York, New York

1979
Reaching Minorities Where They Are: A Challenge to Health Professionals
Bailus Walker, Jr, PhD
Administrator
Environmental Health Administration
Government of the District of Columbia

1980
The Deprivation of Life: Death and Disease in Minority Communities
E. Frank Ellis, MD, MPH
Regional Health Administrator, DHHS, Region V
Chicago, Illinois

1981
Dying for a Job: Health Status of Minorities in the Workplace
George L. Lythcott, MD
Special Assistant to the Surgeon General
U.S. Public Health Service, DHHS
Rockville, Maryland

1982
The Minority Elderly — We're Still Here
Theodore R. Sherrod, MD, PhD
Professor
Department of Pharmacology
University of Illinois at Chicago

1983
Quality Health Care: A Birthright?
Clay E. Simpson, PhD
Director, Division of Disadvantaged Assistance
Bureau of Health Professionals
Health Resources and Services Administration
Hyattsville, Maryland

1984
Fact vs Fiction: Crisis In the Workplace
Aileen T. Compton, PhD
Manager, Health Safety and Environmental Affairs
Research and Development
Smith Kline and French Laboratories
Philadelphia, Pennsylvania

1985
Current Issues In International Health Care Practice
John W. Hatch, DrPH
Professor of Health Behavior and Health Education
School of Public Health
The University of North Carolina at Chapel Hill

1986
Policy Implications for Improving Health In Minority Communities
Charles Cook, MD
Former Chief, Adult Health Section
NC Department of Human Resources
Raleigh, North Carolina

1987
Healthy Lifestyles: Preserving the Public's Health
Jesse F. Williams, MD
Director, Cumberland County Health Department
Fayetteville, North Carolina

1988
Improving Minority Health Status: A Public Health Challenge
Iris Shannon, PhD
Associate Professor
Rush College of Nursing
St. Lukes Medical Center
Chicago, Illinois

1991
Innovative Approaches to Minority Health Issues
Ronald Ferguson, PhD
Associate Professor of Public Policy
The Kennedy School of Government
Harvard University

1992
Beyond the Rhetoric: Developing Solutions to Minority Health Issues
Deborah L. Coates, PhD
Director, Institute for Healthier Babies
March of Dimes Birth Defects Foundation
White Plains, New York

1993
Operation Prevention: Mobilizing Community Action
Spencer Holland, PhD
Director, Center for Educating African-American Males
Morgan State University

1994
Youth and Families of Color: What's Going On?
Linda A. Randolph, MD, MPH
Clinical Professor, Department of Community Medicine
Mt. Sinai School of Medicine
New York, New York

1995
Healthy People of Color 2000: Are We On Track?
David Satcher, MD, PhD
Director, Centers for Disease Control and Prevention
Atlanta, Georgia

1996
Healthy People of Color 2000: Intervention Strategies
Byllye Avery, MEd
Founder and Past President
National Black Women's Health Project
Swarthmore, Pennsylvania

Helen Rodriguez-Trias, MD
President's Commission on Teen Pregnancy
Past President, American Public Health Association

1997
Communities of Color Fighting Back: Our Role in the Cancer Crisis
Gerald Durley, EdD, M Div., Director
Health Promotion Research Center
Morehouse School of Medicine
Atlanta, Georgia

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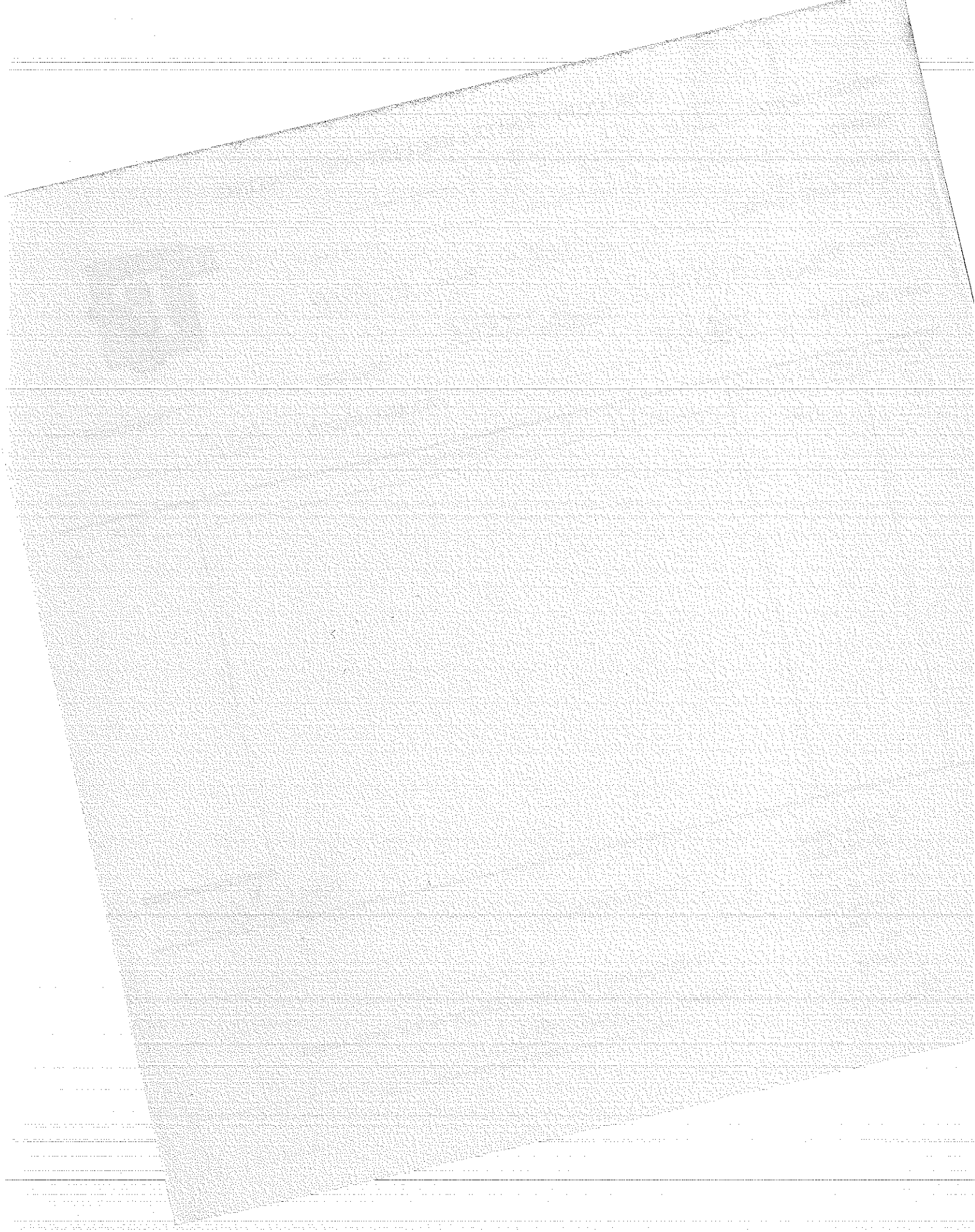

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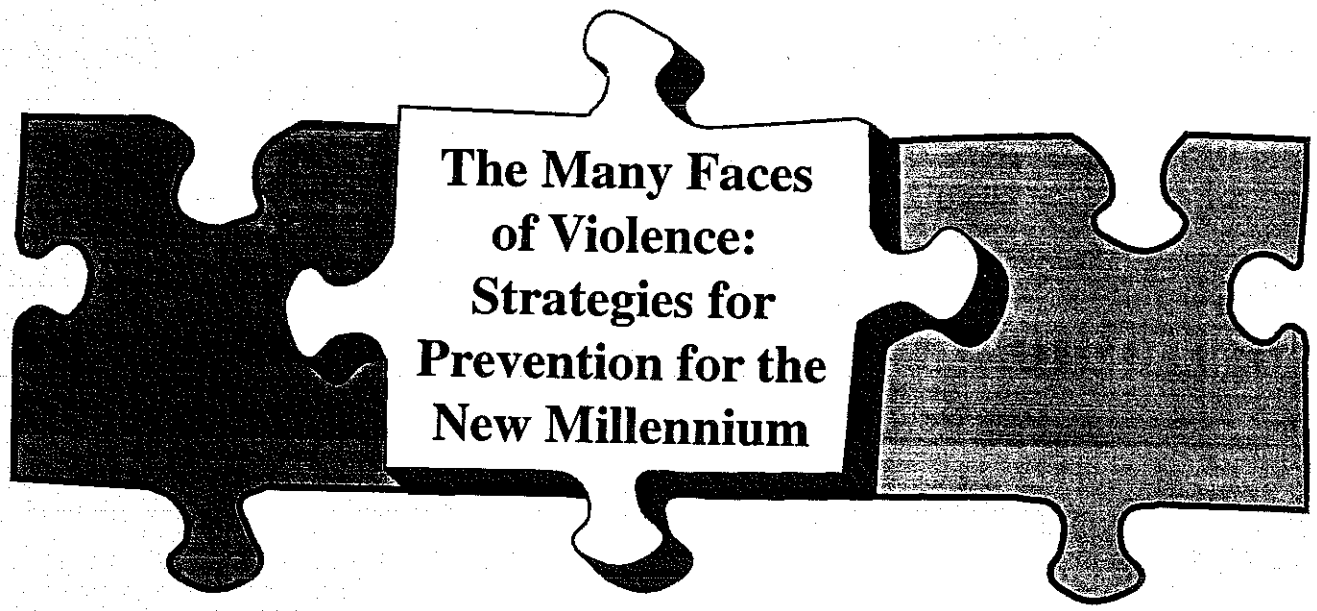

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February 19-20, 1998

PROGRAM

Thursday, February 19, 1998

Time		Location
8:00 am	**Registration & Continental Breakfast**	*Central Atrium*
9:00 am	**Introductions & Welcome** *Tonya Stancil, MS* Co-President, Minority Student Caucus Doctoral Student, Department of Epidemiology School of Public Health University of North Carolina at Chapel Hill *Lamont Bryant, MS* Co-President, Minority Student Caucus Doctoral Student, Department of Environmental Sciences & Engineering School of Public Health University of North Carolina at Chapel Hill *Michael Hooker, PhD* Chancellor University of North Carolina at Chapel Hill *Sohini Sengupta, MPH* Co-Chair, Minority Health Conference Doctoral Student, Department of Health Behavior & Health Education School of Public Health University of North Carolina at Chapel Hill *Matt Garvin* Co-Chair, Minority Health Conference Master's Student, Department of Epidemiology School of Public Health University of North Carolina at Chapel Hill	*Grumman Auditorium*

9:15 am

Message from the Dean — *Grumman Auditorium*
William L. Roper, MD, MPH
Dean, School of Public Health
University of North Carolina at Chapel Hill

9:30 am

State of the State/State of the Nation — *Grumman Auditorium*
Delton Atkinson, MPH
Director
National Center for Health Statistics
Research Triangle Park, NC

9:45 am

Keynote Address: — *Grumman Auditorium*
"Public Health Approach to Violence Prevention"
W. Rodney Hammond, PhD
Director, Division of Violence Prevention
Centers for Disease Control and Prevention
Atlanta, Georgia

Presider: *Carol Runyan, PhD, MPH*
Associate Professor
Department of Health Behavior & Health Education
School of Public Health
University of North Carolina at Chapel Hill

Co-Presider: *Renee Johnson*, Master's Student
Department of Health Behavior & Health Education
School of Public Health
University of North Carolina at Chapel Hill

11:00 am

Poster Session/Break — *Central Atrium*

11:15 am

Panel Discussion: — *Grumman Auditorium*
"Cultural Perspectives on Community Violence"

Panel:
Bernadette Leite, MEd
Research Project Coordinator
Founder/Director of KAL
Institute of Minority Health Research
Emory University
Atlanta, Georgia

Glenn W. Solomon, PhD, MPH
Department of Adolescent Medicine
Health Sciences Center
University of Oklahoma
Oklahoma City, Oklahoma

"Líderes Campesinas"
Elia Gallardo, JD
Staff Attorney
Organización en California de Líderes Campesinas
Pomona, California

"The Use of Youth Gang Activity Markers in Eradicating Youth Violence"
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12:30 pm **Lunch (On Your Own)** *Trillium*

1:45 pm **CONCURRENT SESSIONS:**

Adolescent Homicide *Dogwood Room A*

"Adolescent Homicide and Violence"
Tamera Coyne-Beasley, MD, MPH
Assistant Professor Pediatrics/Internal Medicine
Faculty Research Fellow at the Cecil G. Sheps Center
for Health Services Research
Department of Pediatrics, Division of Community Pediatrics
University of North Carolina at Chapel Hill
Chapel Hill, North Carolina

Presider: *Jennifer Lipkowitz,* Master's Student
Department of Health Behavior & Health Education
School of Public Health
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School of Public Health
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Female Homicide *Dogwood Room B*

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Research Associate
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Department of Health Behavior & Health Education
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Co-Presider: *Tara Cox,* Master's Student
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Occupational Homicide

Redbud Room A

"Workplace Violence: A Critical Challenge for Public Health"
Dana P. Loomis, PhD, MSPH, MS
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"Risk Factors for Robbery and Employee Injury in Convenience Stores"
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Youth/Gang Violence

Grumman Auditorium

"S.A.G.E. Project: An Intervention to Reduce Adolescent Violence"
Phillip W. Graham, MPH
Health Analyst
Research Triangle Institute
Research Triangle Park, North Carolina

Verna Lamar, MPH
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MariaTheresa Viramontes
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Children and Violence *Redbud Room B*

Lavdena Adams Orr, MD
Director, Assistant Professor of Pediatrics
Child and Adolescent Protection Center
Washington, DC

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Lisa Price, MSW
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North Carolinians Against Gun Violence Fund
Chapel Hill, North Carolina

"CPHV Educational Programs for the Health Professional"
Marielle Haywood-Posey, MEd
Associate Director
Education Division
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Washington, DC

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Domestic Violence

Dogwood Room B

"Intimate Partner Violence, National Women's Health Project: Five Steps to Wellness"
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Policy Associate
Intimate Partner Violence
National Black Women's Health Project
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"Líderes Campesinas"
Virginia Ortega
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Organización en California de Líderes Campesinas
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"Domestic Violence & Health Care Providers"
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Legal/Program Coordinator
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Presider: *Michelle Arnaudy*, Master's Student
Department of Maternal and Child Health
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Co-Presider: *Angela Sy,* Master's Student
Department of Health Behavior & Health Education
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Elder Abuse

Redbud Room A

"Elder Abuse: Its Meaning to Caucasian, African, and Native Americans"
Margaret Hudson, PhD, RN
Associate Professor of Nursing
Department of Adult & Geriatric Health
School of Nursing
University of North Carolina at Chapel Hill

"Elder Abuse: An Overview"
Sharon Wilder
Regional Ombudsman
Triangle J Council of Governments
Research Triangle Park, North Carolina

Jill Al-hafez
Regional Ombudsman
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Co-Presider: *Kenric Maynor,* Master's Student
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Youth/Gang Violence Intervention *Redbud Room B*

"S.A.F.E. Haven Collaborative"
Randi McCray
Youth Representative
Activity Facilitator at Youth Fair Chance
S.A.F.E. Haven
New Haven, Connecticut

Dorothy C. Browne, DrPH, MPH, MSW
Project RAPP
Department of Maternal & Child Health
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Department of Epidemiology
School of Public Health
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Co-Presider: *Tonya Stancil,* Doctoral Student
Department of Epidemiology
School of Public Health
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454 West Franklin Street
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"Interventions with African-American Men Who Batter Women"

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Men Stopping Violence
Atlanta, Georgia

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10:30 am **Panel Discussion: *"Is Violence Preventable?"*** *Grumman Auditorium*

Panel:

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Director
Circle of Hope Project
Washington, DC

Diana Wells, RN, MSW, MPH
Nurse Advocate
The Beacon Project
Chapel Hill, North Carolina

Presider: *Sheryl Taylor, MPH*
WATCH Project Manager
Lineberger Comprehensive Cancer Center
University of North Carolina at Chapel Hill
Alumna, Department of Health Behavior & Health Education

Co-Presider: *Yvonne Owens,* Master's Student
Department of Health Behavior & Health Education
School of Public Health
University of North Carolina at Chapel Hill

11:45 am **Conference Wrap-Up** *Grumman Auditorium*
William T. Small, MSPH
Associate Dean & Senior Advisor for Multi-Cultural Affairs
School of Public Health
University of North Carolina at Chapel Hill

12 noon **Adjourn**

20TH Annual Minority Health Conference

The Many Faces of Violence: Strategies for Prevention for the New Millennium

February 19-20, 1998

PLANNING COMMITTEE

Sohini Sengupta, Conference Co-Chair
Matt Garvin, Conference Co-Chair
Rashmi Agarwal
Michelle Arnaudy
Barbara Chavious
Cynthia Gary
Sonya Goode
Diane Johnson
Renee Johnson
Carol Runyan
Victor Schoenbach
Felicia Solomon
William Small
Sheryl Taylor
Christie Vann

SPECIAL THANKS TO:

Rosa Laney
Colleen Sullivan
Judy Beaver

Previous Minority Health Conference Titles and Keynote Speakers

1977
Perspectives on the Health of the Black Populations
Floyd McKissick, JD
President, Soul City Company
Soul City, North Carolina

1978
Health Policy Impacts: On and By Minority Peoples
John L.S. Holloman, MD
Past President
NYC Health and Hospitals Corporation
New York, New York

1979
Reaching Minorities Where They Are: A Challenge to Health Professionals
Bailus Walker, Jr, PhD
Administrator
Environmental Health Administration
Government of the District of Columbia

1980
The Deprivation of Life: Death and Disease in Minority Communities
E. Frank Ellis, MD, MPH
Regional Health Administrator, DHHS, Region V
Chicago, Illinois

1981
Dying for a Job: Health Status of Minorities in the Workplace
George L. Lythcott, MD
Special Assistant to the Surgeon General
U.S. Public Health Service, DHHS
Rockville, Maryland

1982
The Minority Elderly — We're Still Here
Theodore R. Sherrod, MD, PhD
Professor
Department of Pharmacology
University of Illinois at Chicago

1983
Quality Health Care: A Birthright?
Clay E. Simpson, PhD
Director, Division of Disadvantaged Assistance
Bureau of Health Professionals
Health Resources and Services Administration
Hyattsville, Maryland

1984
Fact vs Fiction: Crisis In the Workplace
Aileen T. Compton, PhD
Manager, Health Safety and Environmental Affairs
Research and Development
Smith Kline and French Laboratories
Philadelphia, Pennsylvania

1985
Current Issues In International Health Care Practice
John W. Hatch, DrPH
Professor of Health Behavior and Health Education
School of Public Health
The University of North Carolina at Chapel Hill

1986
Policy Implications for Improving Health In Minority Communities
Charles Cook, MD
Former Chief, Adult Health Section
NC Department of Human Resources
Raleigh, North Carolina

1987
Healthy Lifestyles: Preserving the Public's Health
Jesse F. Williams, MD
Director, Cumberland County Health Department
Fayetteville, North Carolina

1988
Improving Minority Health Status: A Public Health Challenge
Iris Shannon, PhD
Associate Professor
Rush College of Nursing
St. Lukes Medical Center
Chicago, Illinois

1991
Innovative Approaches to Minority Health Issues
Ronald Ferguson, PhD
Associate Professor of Public Policy
The Kennedy School of Government
Harvard University

1992
Beyond the Rhetoric: Developing Solutions to Minority Health Issues
Deborah L. Coates, PhD
Director, Institute for Healthier Babies
March of Dimes Birth Defects Foundation
White Plains, New York

1993
Operation Prevention: Mobilizing Community Action
Spencer Holland, PhD
Director, Center for Educating African-American Males
Morgan State University

1994
Youth and Families of Color: What's Going On?
Linda A. Randolph, MD, MPH
Clinical Professor, Department of Community Medicine
Mt. Sinai School of Medicine
New York, New York

1995
Healthy People of Color 2000: Are We On Track?
David Satcher, MD, PhD
Director, Centers for Disease Control and Prevention
Atlanta, Georgia

1996
Healthy People of Color 2000: Intervention Strategies
Byllye Avery, MEd
Founder and Past President
National Black Women's Health Project
Swarthmore, Pennsylvania

Helen Rodriguez-Trias, MD
President's Commission on Teen Pregnancy
Past President, American Public Health Association

1997
Communities of Color Fighting Back: Our Role in the Cancer Crisis
Gerald Durley, EdD, M Div., Director
Health Promotion Research Center
Morehouse School of Medicine
Atlanta, Georgia

THE NATIONAL BLACK WOMEN'S HEALTH PROJECT

INTIMATE PARTNER VIOLENCE AND AFRICAN AMERICAN WOMEN

1211 Connecticut Avenue, NW Suite 310, Washington, D.C. 20036

• Intimate violence, including physical and sexual abuse in childhood, rape and battering, is a pervasive threat to Black Women's health.

• Research has documented links between intimate violence and a host of negative health outcomes that extend beyond immediate effects of death and direct injury.

• Physical abuse, sexual abuse, and partner violence tend to be intercorrelated, but both separately and in combination they are associated with lower self-esteem, perceived health status, and life satisfaction, and with higher risk for depressive symptoms, unhealthy behavior, and difficulties in interpersonal relationships.

• Forty percent of Black women report coercive contact of a sexual nature before the age of 18. Yet there is very little research on the health-related effects of violence that specifically focuses on Black women.

The following findings are from a study entitled, *Intimate Violence and Black Women's Health.**

• Black women report high rates of partner violence. Rates of severe partner violence are higher for low-income Black women as compared to higher income Black women. Black women who have unemployed husbands have particularly high rates of severe violence.

• Black women experiencing sexual abuse were more likely to experience unprotected sexual intercourse and unintended pregnancy. Sexually abused women were more likely to report having a partner who refused to wear a condom.

• Sexually abused women were more likely to report having an abortion. In fact, 40% of sexually abused women reported having an abortion compared to 14% of other women. Another way of looking at the data--30% of women reporting an abortion also had a history of sexual abuse. The proportion of higher income abused women reporting an abortion was particularly high (50% compared to 28% for low-income abused women).

• Black women who had a history of childhood physical or sexual abuse were more likely to report using unhealthy substances--tobacco, alcohol, and drugs(73%). The proportion of women reporting childhood abuse who used two or more substances was nearly double that of women who did not report such abuse.

• Twenty-three percent of women experiencing severe violence in the past year had thought about taking their own life, compared to 4% of other women.

• Women with a history of childhood abuse reported a lower perceived quality of doctor-patient relationship than women without histories of childhood abuse. Over 30% of abused women averaged less than "good" in their ratings of perceived quality of the doctor-patient relationship compared to 20% of non-abused women. The figure was highest for sexually abused women (34%).[1]

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[1]Nancy Felipe Russo and Jean Denious, Arizona State University; Gwendolyn P. Keita, the American Psychological Association; and Mary P. Koss, the University of Arizona. Contact: Lori Valencia Greene (202) 336-5931

Violence is on the rise and has reached crisis levels in the African American community. Domestic violence, specifically physical abuse by an intimate partner, is the leading cause of mortality and morbidity among women. Last year, between three and four million women were battered by their husbands or boyfriends.

Societal attitudes and misconceptions about domestic violence often prevent women from seeking support and or protection from friends, family, the police, courts or health care providers. These attitudes and misconceptions are based on myths that blame the victim.

Such factors as unemployment, poverty, poor housing, lack of financial resources, job loss, increasing isolation from family, a lack of social supports, homelessness, poor social and educational skills, pregnancy, being raised in a violent home, all contribute to family disorganization and family violence and a victim that only sees hopelessness.

When the primary care giver's physical and mental health is threatened by violence, then her children also suffer the devastating effects of violence. Children in homes where domestic violence occurs are at higher risk for alcohol, drug abuse and juvenile delinquency than children from nonviolent homes. Juvenile delinquents are four times as likely to be from homes where the father battered the mother. Also, when children witness violence between their parents and other adults, they may learn violence as a way of life and may later become involved in abusive relationships.

With funding secured from the Centers for Disease Control and Prevention, the National Black Women's Health Project launched a Domestic Violence Initiative at its National Conference, "Empowered Women: Challenging Violence and HIV/AIDS Globally," in Baltimore on June 23, 1995. This conference brought together more than 700 women from through out the U. S., Africa, Brazil and the Caribbean. The opening plenary was devoted to the issue of domestic violence and was followed by a full day of featured speakers and workshops dealing exclusively with developing strategies to address domestic violence in Black communities.

In conjunction with the annual conference, we convened our first teen conference. The theme of this conference was Empowered Teens: Challenging Teen Pregnancy, STDs/AIDS, and Violence. More than 300 teens attended. The NBWHP initiative focused on identifying strategies to address the incidence of domestic violence in one community in Atlanta, GA, called Mechanicsville.

NBWHP's five steps to wellness provides the foundation of its community empowerment process and are as follows:

AWARENESS
In this stage the stakeholders/coalition received information and facts describing the problems, issues and concerns, and shared their personal and professional experiences confronting and dealing with issues.

COALESCING
In this stage the stakeholders/coalition created a shared view of the problems, issues and concerns, and built consensus on the priority order of solution strategies.

TRANSFORMATION
In this stage the stakeholders/coalition moved outside itself to conduct public forums, and focus groups with their constituencies; gathered input and information and made presentations to build a broader base of support to impact the crisis.

TAKING CONTROL
In this stage the stakeholders/coalition identified individual, organizational governmental and community resources, and a plan of action that was necessary to address the problem.

MAINTENANCE
In this stage the stakeholders/coalition, armed with a shared view of the facts, designed and implement viable strategies/model programs to address the crisis.

The critical core of NBWHP's community empowerment strategy is consensus building, education, mobilization and activation of the community (its residents and all other stakeholders) to address the issues impacting it.

Organización en California de Líderes Campesinas, Inc.
Farmworker Women's Leadership Network

Description of *Líderes Campesinas* Presentation

Approximately three to five million migrant farmworkers currently work in the United State's agricultural sector. Women comprise approximately half this population. The farmworkers *Líderes Campesinas* works with are typically from Latin America, speak only Spanish, and have an average income of $2,000 to $7,000 per year. Work in the agricultural sector tends to be seasonal with some harvest seasons lasting as short as a month. Farmworkers work in a variety of agricultural settings: nurseries, food processing canneries, and field work.

The farmworker population is extremely poor and isolated from mainstream society because of both language and cultural barriers. The transience of migrant life results in further isolation. Migrant farmworkers typically do not establish roots in a community and therefore have little knowledge of the services available to them. The isolation has become still greater in recent years with the growth of anti-immigrant sentiment throughout the United States.

Isolation from mainstream society is a characteristic common to most special populations. This isolation makes accessing services of any kind difficult and in many cases impossible. In our four years of working with victims of violence, we have found that most immigrant women endure years and often decades of violence in silence. *Líderes Campesinas* is a private, nonprofit organization that is dedicated to bettering the lives of farmworker women and their families by ensuring that this isolated community has access to domestic violence/sexual assault information and services. In order to meet the special needs of farmworker women, *Líderes Campesinas* utilizes an innovative public health education model that focuses on the training of developing farmworker women leaders as outreach workers. With a focus on leadership development and women's rights, *Líderes'* peer to peer domestic violence/sexual assault education model ensures culturally competent, grassroots dissemination of important information. *Líderes Campesinas* works with two hundred and fifty farmworker women representing twelve farmworker communities throughout the state of California. *Líderes* has organized a farmworker women committee in each of these twelve communities including two committees representing the indigenous, Mixteco community. *Líderes Campesinas* and its members are committed to educating other farmworker women on the many dangers farmworker women and their families face.

Our presentation will discuss the barriers farmworker women face if they are victims of violence with a special focus on immigration barriers. We will discuss how *Líderes'* unique public health education model attempts to address these barriers and assists victims of violence in accessing the services they need.

Southern California Office
611 South Rebecca Street
Pomona, CA 91766
(909) 865-7776 Phone/Fax

Northern California Office
965 Mission Street, Suite 700
San Francisco, CA 94103
(415) 357-0607 Phone
(415) 357-0599 Fax

Ombudsman Quarterly

An Elder Rights Quarterly Newsletter
Region J Ombudsmen, Triangle J Area Agency on Aging

Volume 1, Issue 1 Summer 1994

You're an OmbudsWHAT?

Just what is an Ombudsman?

An Ombudsman is a professional that investigates complaints from the public and serves as an advocate for long term care residents. Advocacy includes educating individuals about their rights and complex rules or regulations governing the long term care system. An Ombudsman can be requested to serve as a mediator for conflict resolution should a resident encounter difficulty exercising rights.

North Carolina's Long Term Care Ombudsmen work with residents and family members of people in long term care facilities, concerned citizens, nursing homes, rest homes, and public agencies to enhance the quality of care and the quality of life of residents in long term care facilities.

We are here as a resource for **anyone** who may have questions about long term care regulations and policies. We will attend care plans or family meetings. We will provide training to staff, resident councils, or family councils on a variety of subjects. And we are here to listen to residents or families who want to discuss their situation. Please be assured that anything you tell us is confidential and will not be repeated without permission!

The three Ombudsmen in Region J, which covers Chatham, Durham, Johnston, Lee, Orange, and Wake counties, are **Jill Al-Hafez, Sharon Wilder, Wendy Sause**. Please feel free to call us anytime at **919-549-0551**. If you are hesitant to call long distance, just let us know at the beginning of the call and we will call you back.

TRIANGLE J CENSUS INFORMATION FOR 1998

The following information is from the 1990 census, with projections adjusted to 1998 by the State Data Center. Percentages are based on County 60+ totals.

County	*60+*	*60+ E.D.**	*%*	*60+ Ethnic*	*%*	*60+ Rural*	*%*
Chatham	9,191	1,568	17	1,612	18	7,770	85
Durham	25,696	3,825	15	7,838	31	3,685	14
Johnston	17,503	4,662	27	2,530	15	12,268	70
Lee	9,416	1,570	17	1,477	16	5,765	61
Orange	13,286	1,555	12	2,266	17	6,145	46
Wake	63,776	7,864	12	11,354	18	13,867	22
Region	**138,868**	**21,044**	**15**	**27,078**	**20**	**49,500**	**36**

** Economically Disadvantaged*

DEMOGRAPHICS AND OUTCOMES IN ADULT PROTECTIVE SERVICES CASES

WHO ARE THE ADULTS AND THEIR FAMILIES?	WHAT IS HAPPENING TO THEM?	WHAT DO THESE ADULTS AND THEIR FAMILIES NEED?
• In FY95/96, 6,459 individuals received Adult Protective Services • Women comprised 64 % of the total cases; and men comprised 36 %. • The majority of those receiving Adult Protective Services were elderly. 75% were 60 years of age or older. • 59% of persons reported were White-Not Hispanic, and 39% were Black-Not Hispanic. • Most of the adults reported were living in our communities. 75% lived alone or with family members, while 20% lived in a facility or institution.	• Abuse, neglect or exploitation were found in 35 % of the cases. • The most common form of mistreatment found was neglect. 56% of the situations involved self neglect and 26% involved caretaker neglect. • When caretaker neglect was found, the most frequently named perpetrator was an adult child, followed by a facility staff, spouse, and other relatives. • In 10% of the cases abuse was found and 8% of the cases involved exploitation.	• Factors which may have contributed to mistreatment of adults living at home were: – inadequate knowledge of the health care needs of the disabled adult, – substance abuse problems – mental/emotional impairment of caregiver • The primary factor identified as contributing to mistreatment in facilities was inadequate supervision/management in the facility. • The most frequently identified services needed to address the problems of abuse, neglect and exploitation were: – placement, – in-home aide services, – medical or health care, – counseling, and – mental health services

Source: North Carolina Department of Human Resources, Division of Social Services, Adult Protective Services Register, 1995

☎ Important Telephone Numbers ☎

CARELINE—1-800-662-7030

Provides information and referral to North Carolina's vast system of health care, social services, mental health services, volunteer and other human services. **This is the number to call when you are not sure where to call.**

Alzheimer's Association-Eastern Chapter—1-800-228-8738

Provides information, education and support regarding Alzheimer's disease and related disorders.

Departments of Social Service—see the local numbers below

To file a complaint regarding a domiciliary home or receive information about placement into a facility. To report suspected abuse of an older adult. To obtain information regarding Medicaid and SSI.

Chatham County-(919)542-2759 **Lee County-(919)774-4955**
Durham County-(919)560-8000 **Orange County-(919)732-8181**
Johnston County-(919)989-5300 **Wake County-(919)212-7001**

Duke Family Support Program—1-800-672-4213 or in Durham-660-7510

Provides information and education on all aspects of Alzheimer's disease and other memory disorders. Provides information and referral, on-going individual support, and family support groups for caregivers. Publishes The Caregiver newsletter which is free to citizens of NC.

Friends of Residents in Long Term Care (F.O.R.)—(919)782-1530

Advocacy organization to improve long term care services.

Governor's Office of Citizen's Affairs—1-800-662-7952

Health Care Financing Administration—Regional Office-(404)331-2229

Provides direction for the states for certification of nursing Homes under Medicare and Medicaid. Its mission is to promote the timely delivery of appropriate, quality health care to its beneficiaries.

Long Term Care Ombudsman Program—local (919)558-9401 or (919)558-9404/ state (919)733-3983

Provides advocacy for residents in long term care facilities. Provides information regarding regulations and issues regarding long term care facilities for the general public. Provides training on residents rights and other important issues for long term care staff and the public.

Medical Review of North Carolina—1-800-722-0468.
Information on appeals procedures following Medicare denial of Part A benefits.

Medicare Fraud and Abuse Hotline—1-800-368-5779
To report incidents of Medicare fraud or abuse.

Medicare Intermediary—Blue Cross/Blue Shield—(919)688-5528
Information and questions on Medicare Part A claims and benefits.

Medicare Carrier—Equidor—1-800-672-3071
Information and questions on Medicare Part B claims and benefits

National Insurance Consumer Helpline—1-800-942-4242

North Carolina Board of Medical Examiners—(919)828-1212
To report complaints regarding a physician.

North Carolina Division of Facility Services—(919)733-7461
To file complaints regarding nursing homes and domiciliary homes or for questions regarding policies and regulations for these facilities.

North Carolina Retired Governmental Employees' Association—1-800-356-1190
Provides information for state retirees.

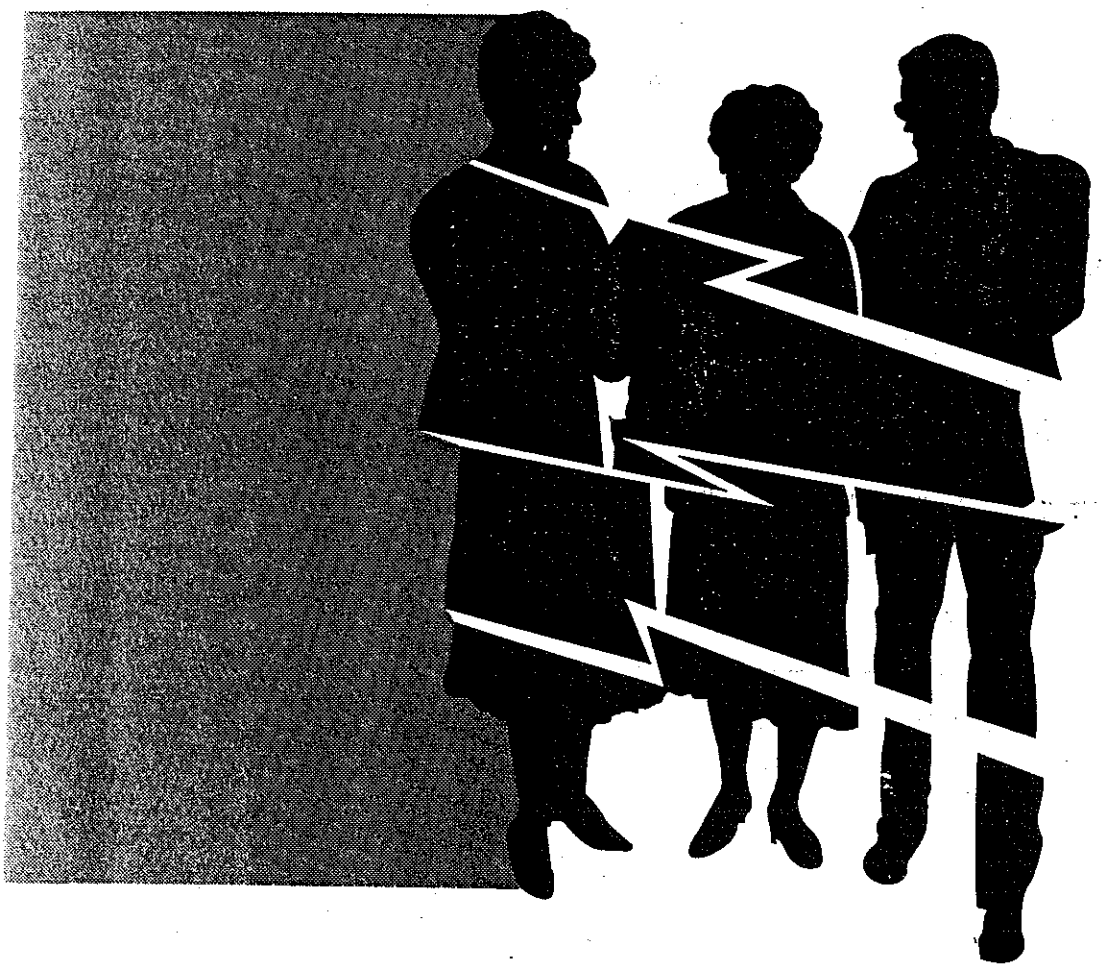
Senior Health Insurance Information Program(SHIPP)—1-800-662-7777
Assists consumers aged 65 and older with questions or problems regarding Medicare, Medicare supplemental insurance, and long term care insurance.

Social Security Administration—1-800-772-1213
Provides information on eligibility and benefits of Social Security.

Social Security Disability Hotline—1-800-638-6810
Provides information and referral service for those with questions or problems regarding the Social Security disability program or Supplemental Security Income Program.

For Local Broadcasters

MINORITY COMMUNITY BULLETIN



ELDER ABUSE & NEGLECT

The National Eldercare Institute on Elder Abuse
and State Long Term Care Ombudsman Services
Washington, D.C.

Message From the Administration on Aging

All of us must do everything possible to protect older Americans from abuse wherever they are. Abuse against Older Americans must stop.

The Administration on Aging (AoA) has taken the lead within the Department of Health and Human Services to address the problem of elder abuse. Although we are just beginning to learn about the dynamics, we know that it is a very complex issue in terms of its root causes, manifestations and solutions. We know that many deny that it occurs. We know that the public must be urged to take a role in stopping abuse.

This publication developed by the National Eldercare Institute on Elder Abuse and State Long Term Care Ombudsman Services with funding from AoA is especially designed for leaders in minority communities. It contains information for use by communications media in promoting public awareness concerning what elder abuse is, how to recognize it, and where to go for help.

We hope that this material will be of current and future use to broadcasters across the country. We urge you to use it in spreading the news about the problem of elder abuse -- and more importantly, we hope it will be useful for identifying the steps that can be taken with minority communities to prevent or remedy abusive situations.

Joyce T. Berry, Ph.D., Commissioner
U.S. Administration on Aging
Washington, D.C.

November, 1992

This publication will help your station contribute to the *prevention* of elder abuse. It contains facts, sample PSAs and ideas for local programming. By addressing elder abuse, you can improve the well-being of older persons and families in your community.

WHAT IS ELDER ABUSE?

Elder abuse is the mistreatment or neglect of an elderly person, usually by a relative or other caregiver. It happens wherever older people live...in their own homes and in care facilities such as nursing homes.

Elder abuse may include physical violence, threats of assault, verbal abuse, financial exploitation, physical or emotional neglect, or sexual abuse.

✦ ✦ ✦ ✦ SCOPE OF THE PROBLEM ✦ ✦ ✦ ✦

- ❒ Elder abuse is one of the most under-recognized and under-reported social problems, among all cultural and racial groups. It is far less likely to be identified than child abuse.
- ❒ The national incidence of abuse in domestic settings may be as high as 2 million cases per year.
- ❒ Researchers estimate that only 1 in 14 incidents of elder abuse actually comes to the attention of law enforcement or human service agencies.
- ❒ Elder abuse will likely be a growing problem in the next century as the population of those age 60+ increases from the current 41 million to 72 million by the year 2000.

✦ ✦ CULTURAL/ETHNIC CONSIDERATIONS ✦ ✦

- ❒ Limited research data make it difficult to get a clear picture of the incidence of elder abuse in minority communities. Nevertheless, what we do know about elder abuse risk factors suggests that minority elders may be at particular risk.
- ❒ Research suggests that because abuse of the elderly is so opposed to minority family ideals - family unity, support and respect - it may be reported less by minority groups. This makes it more difficult to identify cases and to assist elderly victims and their families.
- ❒ Among older minorities, those 75 and older, those who live alone, and those who are isolated are among the persons most vulnerable to abuse. Lack of financial resources can also contribute to the incidence of elder abuse within the family.
- ❒ Another major risk factor for elder abuse is family stress. Factors that are associated with family stress -- poverty, substance abuse, unemployment, and lack of access to supportive services -- are common in minority families, making it encumbent upon us all to pay attention to this problem.

WARNING SIGNS OF ABUSE/NEGLECT

AMONG ELDERLY VICTIMS

The following indicators do not necessarily signify abuse or neglect, but can be important clues to possible abuse or neglect.

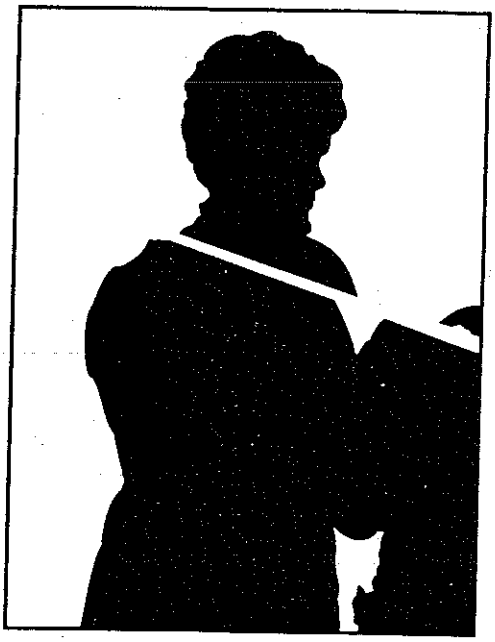
- ☐ Bruises, burns, or cuts
- ☐ Dehydrated or malnourished appearance
- ☐ Anxiety, confusion, withdrawal, or depression
- ☐ Lack of cleanliness, grooming
- ☐ Sudden withdrawals or closing of bank accounts
- ☐ Overly medicated or overly sedated
- ☐ Expressions of shame, embarrassment, fear

"Elder abuse goes unreported because the older victim is ashamed of it, is unable to report it, or fears reprisals if they speak up."

AMONG FAMILIES/CAREGIVERS

- ☐ Older person not allowed to speak for himself without the presence of the caregiver
- ☐ Threats, insults, aggressive behavior
- ☐ Withholding of basic support (food, drink, adequate clothing/shelter)
- ☐ Attitude of indifference or anger toward the older person
- ☐ Problems with alcohol or drugs
- ☐ Previous history of abuse
- ☐ Use of older person's money and possessions without consent

WHO ARE THE ABUSERS?



- More than two-thirds of older abuse perpetrators are family members of the victim, typically, serving in a caregiving role.

- The abusers are likely suffering from:

  - **stress** brought on by the strain of caregiving coupled with marital problems, lack of money/unemployment, overcrowded living conditions, or lack of needed health or social services;
  - **alcohol and drug** problems;
  - **emotional problems** such as resentment of the elder's dependency; retaliation against a parent for past mistreatment; lack of love and friendship in the relationship; misplaced anger for social and economic injustices; or
  - **dependency** on the elder for basic needs such as housing or money.

THE KEY BROADCAST MESSAGES

ABUSE OF OLDER PEOPLE MUST STOP!

Help is available for elder abuse victims & families!

By conveying these two messages to their audiences, broadcasters can significantly impact community awareness of the problem and aid older people and family members in getting the assistance they so desperately need.

WHAT IS AVAILABLE FOR THE VICTIM?

A variety of resources are available to help victims, families and the general public in addressing elder abuse.

☐ ***Investigation***

A key service is the investigation of the reported abuse. Confidentiality is maintained both for the victim and the person who identifies or reports the case. Friends, neighbors, relatives, and professionals (such as clergy, bankers, and nurses), are among those in key positions to help in identifying cases of elder abuse.

☐ ***Supportive and In-Home Services***

Help for both the victim and family is available. Homemaker service, personal care assistance, daycare, and transportation are among the services most often required in elder abuse situations. Often victims also need legal help for such things as applying for Medicaid, paying bills, or filing consumer complaints. Older people have a right to refuse services if they do not want assistance. In most situations, however, services help to alleviate the problem which led to the abuse.

☐ ***Prosecution of Elder Abuse***

Police, district attorneys, and judges are also involved in serious cases of elder abuse. Unfortunately, as in other forms of family violence, the victim is often reluctant to go to the police and to press charges against a family member. Elder abuse service staff work with the victim and law enforcement officials to overcome barriers to prosecution of elder abuse cases. Educational programs for police, sheriffs, and local magistrates are underway in many communities to heighten the awareness of law enforcement's role in combating elder abuse.

☐ ***Guardianship and Placement***

In some elder abuse cases, the victim may be so debilitated that it is questionable whether or not she/he is able or competent to make decisions about personal safety, health, nutrition, living arrangements or use of money. These cases are brought to the courts for an investigation and, if necessary, the appointment of a guardian. Because guardianship severely limits individual rights, this step is very serious and can be taken by a court only after careful consideration of the case. Alternatives to guardianship which help the older person maintain as much autonomy as possible include: bill paying services, powers of attorney, representative payee arrangements, supportive living situations, limited guardianship, and other programs and services.

☐ ***Ombudsman Assistance***

Residents of nursing homes and board and care homes are also potential victims of abuse. Through the federally mandated Long Term Care Ombudsman Program, each state and community provides a cadre of trained advocates to help uncover abuse cases and resolve complaints in these facilities. These programs work with other federal and state investigators to address what might otherwise be deeply hidden problems.

HOW THE ELDER ABUSE SYSTEM WORKS

❒ ***Referral and Investigation***

Every state has designated an agency to be responsible for receiving and investigating reports of elder abuse. The purpose of the investigation is to substantiate whether or not abuse occurred and to offer services for the victim and family. The investigation staff - whether state or county employees - have been specially trained to recognize the signs of abuse and to respect individual elders' rights. They are under obligation to maintain confidentiality in the course of the investigation.

❒ ***Toll Free Telephone Lines***

Many states have initiated toll free telephone lines for receipt of abuse reports. In some states, the line is to be used for any type of domestic violence (child, elder and spouse abuse); in others, the line is solely for elder abuse.

❒ ***Data and Information***

All states compile data concerning reports of elder abuse. In some states, the data is available by county or region. State information systems have the capacity to provide profiles on the perpetrators, victims, and type(s) of abuse involved. Some states publish annual reports covering their elder abuse programs.

❒ ***Public Education***

Most states have laws that require certain professionals such as doctors, nurses and paramedics, to report incidents of elder abuse to the proper authorities. Many states have initiated activities to inform mandated reporters about their duties under state law. They have also developed a range of pamphlets, brochures, fact sheets, and training materials. State and local elder abuse staff are available to provide training and speeches on elder abuse.

✦ ✦ ✦ ✦ WHERE TO TURN FOR HELP ✦ ✦ ✦ ✦ and Additional Information

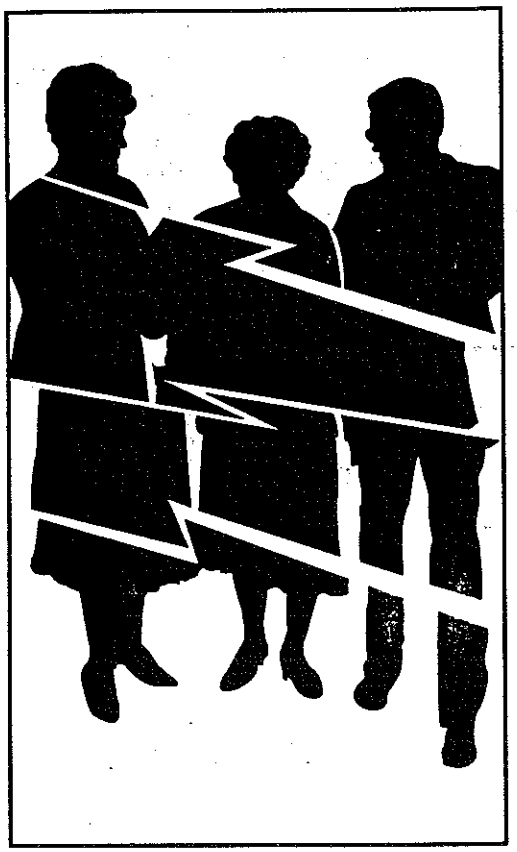
Locating Key State and Local Contacts

A list of the key state contacts who can direct you to state and local personnel, organizations and program resources on elder abuse accompanies this publication. The list includes the state toll-free lines.

✦ ✦ ✦ WHAT RADIO STATIONS CAN DO ✦ ✦ ✦

Stations are in a key position to assist in educating the public about the problem of elder abuse. This attention may encourage those who know of a case to identify it and get help for the older person. Elder abuse programming may influence an abuser to stop and get help.

> *"Only with the support of the general public can we ensure that cases are brought to light and effectively addressed."*



❶ Spearhead a public awareness campaign in cooperation with the local aging agencies including the area agency on aging.

❷ Schedule a series of talk shows or listener call-in shows on the topic of elder abuse. Invite guest such as law enforcement officers, mental health counselors, ombudsmen and adult protective service investigators to discuss the local aspects of the problem. Topics could include: community services in support of victims; maintaining elder rights; caregiver support and training to prevent abuse; prosecuting cases of abuse.

❸ Publicize the elder abuse telephone report line for your listening area. Encourage listeners to identify elder who may be abused and in need of help. (Stress the confidential nature of the elder abuse report.) Encourage elders who are being abused to seek assistance.

❹ Encourage victims and abusers to discuss the problem with others whom they trust, such as a minster, social worker, doctor, friend, etc. Encourage listeners to volunteer in service programs for the elderly - particularly in nursing home ombudsman programs, at domestic violence shelters, and as respite caregivers. Such volunteer service can help in the prevention of elder abuse.

✦ ✦ ELDER ABUSE SAMPLE PSAs ✦ ✦

:
Older people in our community are oftentimes victims of abuse. But not all abuse is inflicted by others. Some people choose dangerous or unhealthy lifestyles. Others have no choice: they just can no longer take care of themselves. This is called self neglect! They need help. If you know an older person who is alone and not getting the proper care, call protective services. Professionals there will handle your call confidentially. You don't even have to give your name. Again, that's adult protective services - (telephone). Stop the cycle of pain.

:
Unexplained bruises, frequent falls, broken bones, excessive loss of weight, and poor hygiene are not normal parts of getting older. Elder abuse may be the problem. If you think an older person in our community is being abused or neglected, call Adult Protective Services at (telephone). They can help. People there will handle your call confidentially. That's Adult Protective Services, (telephone). Your call will go a long way to making life a whole lot better for the older person and their family. Help stamp out this serious problem.

:
There are people who are taking advantage of older folks every day. Fraud schemes include insurance, home improvement and Social Security scams. Perpetrators use high pressure techniques. Some are even family members of the victims. Maybe you have noticed some of the signs: a senior who is suddenly cashing checks for unusually large amounts, or a stranger spending a lot of time at an older person's house. Call Adult Protective Services at (telephone). Ask them to look into the matter. Your confidential report could prevent an older person's life savings from ending up in someone else's pocket.

✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦

ELDER ABUSE SAMPLE EDITORIAL

✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦✦

Although most people are aware of the problem of child abuse and neglect, many do not realize that the elderly can also be victims of family violence and mistreatment. As with cases of child abuse, some professionals --doctors, nurses, and counselors, for instance -- are required to report suspected cases in most states. In every area, however, non-professionals are encouraged to voluntarily report suspected cases.

Reporting elder abuse is not an invasion of privacy. In our view, reporting is simply a means of connecting people in need with those who can do something about it. It is a method of finding out the facts and protecting the well-being of older people. We know that in many situations, older people may want to call someone themselves for assistance, but don't because of embarrassment and fear of reprisal. Others may not know that assistance is available.

Abuse is a hidden problem and victims are often unable to get help for themselves. That's why we encourage the reporting of elder abuse, neglect and exploitation. We all must help to protect the rights of older people and stop abuse and family violence.

If you believe you know someone who is a victim of elder abuse, place a confidential call to (.......reporting number) and ask them to look into the situation.

✦ ✦ CASE EXAMPLES ✦ ✦

The following are examples of the kinds of abusive situations which occur in every community. Adult Protective Services workers can provide important, even life-saving, interventions in all these sorts of cases.

CASE #1**

Mr. Madeline, age 70, is confused and often does not know his name or recognize his family. He is incontinent, and needs constant supervision. In order to cope with the situation, his daughter ties her father in a chair for several hours at a time. She often leaves Mr. Madeline home alone while she is out running errands.

CASE #2**

Mrs. Morgan is 81, has difficulty walking and is losing her sight. She has been supported in her home with homemaker service and home delivered meals for six months. Her daughter is involved in her care as well. She recently told a friend that she has been forced to give several valuable pieces of jewelry to the homemaker, who threatened not to return if she didn't get a "special present" every month. Mrs. Morgan is afraid that her daughter will put her in a nursing home if she does not get along with the homemaker.

CASE #3**

Mr. and Mrs. Jones called their minister for help. They had no food. When church visitors brought donations, they found that the water and gas service had been terminated. A live-in adult granddaughter frequently borrows large amounts of money and had used a considerable amount of their resources to fight several DWI charges. She often brings friends home whom the couple fear. She is physically abusive and threatens them. They don't want to cause trouble but wish their granddaughter would move.

****

There are many stories like these in every state across the nation. Every day in cities, towns and rural communities, the intervention and assistance provided through Adult Protective Services agencies play critical roles in eliminating abuse of older people. Their coordination and collaboration with social services, law enforcement and other agencies in essence saves the lives of many elders and enhances the well-being of many who suffer needlessly each day.

<u>There are likely to be hundreds of untold stories in your community</u>. You can help elders who are being abused and their families by letting them know that <u>help is available</u> and that <u>there are people who care</u>.

SUGGESTED QUESTIONS FOR TALK SHOW

1. Everyone understands that an older person who is beaten up has been abused. What other kinds of situations are labeled "abuse" and "neglect"?

2. In our community, what kind of elder abuse situations are most common?

3. Are people who abuse older people generally strangers, or family members?

4. What kind of people are abused?

5. What are the "causes" of elder abuse?

6. Can elder abuse be prevented?

7. What public agencies in this community help elder abuse victims?

8. When a situation is brought to the attention of (Adult Protective Services/the proper authorities), what usually happens next?

9. What kind of help is available to people who have been abused?

10. You mentioned that family members who care for older people sometimes abuse or neglect them because they don't know what else to do. If such a family member knows he or she could use help, where should they go to get that help?

11. What can we as citizens do to prevent and stop elder abuse?

12. If someone in our listening audience is being abused or knows of someone who they think might be abused, what should they do?

13. If anyone would like additional information about elder abuse, whom should they contact?

Special Appreciation

We gratefully acknowledge the following media and service specialists who contributed to these materials: **Rick Bacon**, Program Manager, Aging and Adult Services Administration, Washington; **Nancy Caliman**, Project Director, National Caucus and Center on the Black Aged, Washington, DC (formerly with WGAY-FM, Washington, DC); **Carmen Cunningham**, Director of Affirmative Action; New York State Office on Aging, New York; **Barbara Ellis**, Program Specialist, Department of Aging, Texas; **Lou Horner**, Director of Older Americans Division, Aging and Adult Services, Colorado **Carolos Jaques**, Radio Announcer, WSMX-AM, Wala Wala, WA; **Cristina Lopez**, Project Director, National Council of LaRaza, Washington, DC; and **Carmen Rodriguez**, Case Worker, District of Columbia Adult Protective Services, Washington, DC;

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Institute Organizations

National Association of State Units on Aging (NASUA)
American Public Welfare Association (APWA)
National Citizen's Coalition for Nursing Home Reform (NCCNHR)

Additional Information

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When Problems Arise in a Nursing Home

By Cornelia Poer, MSW
Italicized text inserted by Ombudsmen in adaptation for this newsletter.

Sometimes *residents and* families are concerned about voicing complaints because staff may "take it out" on *you or your* family member. You should never be afraid to speak up on *your or* your family member's behalf. How, when, and who you talk to may make a difference in the responses that you receive. The following suggestions may help if problems arise:

• Ask questions and educate yourself about concerns. Lack of understanding may make something seem to be a problem when it actually is not. For example, in the early weeks of placement, you may be concerned about the emotional response *that may come from being in a new environment.* Both you and your family member will need time to make the adjustment to the nursing home with its unfamiliar schedules and new environment.

• When you speak out, be clear about your concerns and identify an acceptable outcome. Generalized complaints are difficult to address because the staff does not know exactly what it is you want. Be reasonable in what you expect and be prepared to negotiate.

• Do not wait until the straw breaks the camel's back. It is important not to let concerns build up until you reach your boiling point. Problems can usually be handled better when they are handled early by both you and the staff. On the other hand, do not complain about every little thing that bothers you. You may come across as someone who is hard to please, and the staff may stop trying to please you if you complain too often.

• Talk to the appropriate staff member. Expressing concerns with one discipline about another should be avoided. Take your comments to the staff member who has the authority to address them.

• Speak with staff members you get along with and not those with whom you have had difficulty with in the past. We all get along better with some people than with others.

• Request a *resident/*family/staff conference or participate in resident care planning meetings. This is your right as a *resident and* family member *(if the resident wants you to be there or if the resident is incompetent).* Work together with the staff to provide the best possible care for *you or* your family member.

• A picture is said to paint a thousand words, so be aware of your outward appearance when you talk with a staff member. If you look angry, the individual may become defensive. Take time to calm down so that what you say, and not how you look, will be taken seriously.

• Do not argue. Be aware of your tone of voice. You may look calm but your voice may indicate otherwise. The voice can diffuse or escalate the emotional tone in the situation.

• Try not to focus on all the negatives. Make comments about the positive aspects of care. This can help create a balance.

• Use patience and avoid excessive demands. Staff may be busy with an equally demanding task at the time. Try to put yourself in their situation to increase your understanding of their job.

• Express an appreciation to the staff when they have worked with you to resolve problems, even if you had to compromise.

• Remember, there are no winners or losers. Work together with the staff to provide the best care for your family member.

If you need any assistance or would like to talk about any unresolved concerns, please remember to call your Ombudsmen at 919-549-0551.

Reprinted with permission from
The Caregiver - Summer 1993
Duke Family Support Program

The Duke Family Support Program is a wonderful resource for those caring for individuals with memory loss. The Caregiver is their newsletter and is free to anyone in North Carolina. Their number is 919-660-7510 or 1-800-672-4213.

Preventing Mistreatment in Long Term Care Facilities

By Wendy Sause and Sharon Wilder

Since elder mistreatment is a serious and growing problem, too often unacknowledged, it is the focus of our first article. To help prevent this mistreatment we must all educate ourselves about the facts on abuse and its prevention. The following information offers beginning guidelines for stopping abuse before it happens. Definitions are adapted from Domestic Mistreatment of the Elderly: Towards Prevention, Some Dos and Don'ts by AARP.

Types of Mistreatment:

Neglect

Neglect is the unintentional or intentional failure of the caretaker (facility) to fulfill a caretaking responsibility. For example, not assisting a resident in changing and cleaning in a timely manner, if he/she is incontinent, withholding food or neglecting to provide an appropriate diet, not giving appropriate medications, or not assisting the resident in bathing and grooming when assistance is needed.

Mental/Psychological Abuse

Psychological abuse is the infliction of mental anguish by demeaning, name-calling, insulting, humiliating, threatening, etc. Calling a person a derogatory name, threatening to withhold services, or teasing a person with dementia because some employees think it is "cute" are all examples of this type of abuse.

Physical Abuse

This is what we typically think of when abuse is mentioned: the infliction of physical pain or injury, physical coercion, confinement, slapping, burning, pushing, inappropriately restraining, etc. Examples would be rough handling a person to get them into bed or while transferring them, restraining a resident

to "get them out of your hair", or hurrying or pushing a resident along while they are trying to walk and need to take time.

Financial Abuse

Financial abuse includes illegally or unethically exploiting by using funds, property, or other assets of a resident for personal gain. Taking gifts or money for services that are normally part of your job, accepting gifts or money from a person who has dementia and is unable to judge the situation competently, or are all examples of financial abuse.

The best way to deal with any type of abuse is to stop it before it happens. Below are some suggestions that may help in this prevention.

Residents

- Be involved in your care! Go to your care planning meetings, get a list of medications and treatments that are prescribed for you, ask the names of everyone involved in your care. Remember that you have a right to see your medical records!

- Keep in touch with friends and relatives outside the facility. Let others know how you are doing, what is happening in the facility, and invite them to visit. The facility should provide you with a private place to talk on the phone, meet with your company, and assistance with mailing.

- Stay organized. Try to be aware and let others know that you know where all your belonging are kept.

- Do not sign anything unless you fully understand the document. If you can not read it or don't understand the full meaning, have a person you trust read and explain it to you.

- Take care of each other, watch for abuse of other residents, especially those who have dementia or are unable to communicate.

- Speak up!! If you feel uncomfortable with a situation or the way you are being treated, speak to the Social Worker, Director of Nursing, or the

Administrator about it. Let them know you expect a response how they will handle the situation.

• Know your rights! The Bill of Rights for residents of nursing homes and domiciliary homes are state and federal law. Ask the Social Worker of your facility for a copy of the rights, if you don't have one, or contact one of the Ombudsmen.

Families

• Participate in your family member's care, especially if they are unable to do so. Go to care plan meetings (ask a staff person if you currently are not being invited), attend family nights/council meetings, and listen to how your relative feels about the care.

• If you live a long distance from the facility, ask the social worker to talk to you before the care plan meeting and send you a copy of the plan. Talk to your relative at a certain time each week/month and really listen for concerns. Let resident/ staff know that you care and that you can be called when a concern arises.

• Fully understand any documents that you are given to sign on behalf of your family member.

• With your family member's consent, be familiar with financial records, insurance, debts, and sources of income.

• If you ever feel uneasy or concerned about any changes in your relative's health status or situation, talk to the appropriate person immediately. If you think that abuse is happening and feel uncomfortable talking with staff, call one of the Ombudsmen or your County Department of Social Services.

• Know the rights of residents living in long term care facilities. Ask the Social Worker or contact one of the Ombudsmen for a copy.

Take Another Look.....

In recent articles of the Ombudsman Quarterly we have discussed ways to prevent abuse in facilities and how to report suspected abuse to Adult Protective Services. In this issue we will address signs of abuse of which everyone should be aware. This may be especially important for family members and visitors of a resident who is not competent and able to explain their situation to others. **Please be aware that not all of these signs automatically indicate abuse, however all should be discussed with staff at the facility.**

Possible signs of physical abuse or neglect:

• Unexplained injuries — All injuries should be investigated by facility staff and information shared with the resident, family and/or legal representatives. The facility staff should devise a plan to try and prevent further injuries no matter what the cause. You may ask for a physician's evaluation if you feel there are physical concerns that are not being addressed by the staff.

• Injuries may include the following: bruises, welts, lacerations, fractures, burns, broken teeth and injuries in various stages of healing.

• Laboratory findings indicating medication overdose or under medication. Improper medication administration may also be detected by observing if the resident is chronically tired or unresponsive.

• Unexplained venereal disease or genital infections (such as herpes, chlamydia).

• The formation of decubitis ulcers which are commonly called bed sores. (This could be caused by neglecting to change a resident, for long periods of time, while wet with urine).

• Poor personal hygiene (for example, chronic uncleanliness or odor, not changing clothes daily or as needed, chronically unclean teeth or dentures, dried feces on the body).

• Lack of compliance with medical regimen (i.e. needed treatments, medications, or diet are not provided).

Possible signs which may indicate psychological abuse or neglect:

- A normally outgoing and active resident becomes extremely withdrawn from normal activities and/or depressed and agitated
- A resident becomes fearful of the staff, particularly of a specific staff person
- Hearing reports that staff threatens or belittles the resident
- There are no activities provided for social stimulation to meet the resident's needs. (Even if many activities are held, if there are not any in which the resident can participate and no attempts are made to provide this stimulation, it can be considered neglect.)

The above are just a few common signs of abuse and neglect. If you are concerned that you are observing any of these signs or any other behavior about which you have questions, please speak directly with the Director of Nursing, Administrator or Supervisor-in-Charge of the facility. When examining the situation with these personnel ask the following of them and yourself:

1. Are there any diseases or diagnosis that are causing the problem? (For example some diseases may cause a person to bruise easily or some people with Alzheimer's disease may become agitated.)

2. Has there been a recent incident, such as a fall, that has caused the injury?

3. Is there a particular time (morning/evening, particular day of the week, etc.) that the resident seems to obtain injuries?

4. Is there a specific staff person of whom the resident is fearful or who you have heard being verbally abusive? What is the person's name or description?

5. Is there a specific incident about which the resident has told you? What were the circumstances of the situation?

6. What is the plan for the staff to investigate and follow up on your concern?

7. How is the staff going to try and protect the resident from further injury or neglect?

We encourage everyone with any concerns to keep a journal noting days and times of visits with the resident and his/her particular state. If there are specific injuries that you are concerned with, have the resident or family members take a picture of the area to assist with documentation of these concerns.

If you feel that the staff is being unresponsive to your concerns or if you are uncomfortable approaching the staff about this type of situation, please call Adult Protective Services at the local department of social services or the Regional Ombudsmen at (919) 549-0551.

For copies of the previous articles we have published on abuse please call the Ombudsmen at (919)549-0551.

How far you go in life depends on your being..

Tender with the young,

Compassionate with the aged,

Understanding of the sick,

Sympathetic with the striving and

Tolerant of both the weak and the strong
because someday in life

You will have been one or all of these.

—George Washington Carver
with revisions

Understanding Guardianship

Sometimes family members are faced with the situation when a loved one no longer possesses the capacity to make informed choices or reasonable decisions. This situation could be brought about in different ways—Alzheimer's disease, a stroke, or a head injury for examples. No matter how it happens, if there are no pre-planned options such as a power of attorney, a family may need a legal way to intervene on their loved one's behalf.

Guardianship is a legal process that includes a court proceeding where someone is appointed and authorized to be the substitute decision-maker (or **guardian**) for an incompetent adult (or **ward**). Incompetence means that a person is unable to manage his or her own affairs or to make or to communicate important decisions.

In order for a person to have a guardian appointed, a petition alleging incompetence must be filed with the Clerk of Superior Court. This is best done where the person who is alleged to be incompetent is located. A petition is a written request for a hearing to declare a person incompetent. It can be filed by anyone who knows the person, including a facility staff person, family member, social service professional, or close friend.

When a petition is filed, a date and time for the hearing are set by the Clerk of Superior Court. A copy of this petition is served on the person who is alleged to be incompetent (the **respondent**), wherever the person is currently residing. The respondent has the right to be present at the hearing and to be represented by an attorney (called a **guardian ad litem**). If the respondent can not afford an attorney, the court will appoint one. The petitioner must notify other involved parties, legal representatives, and family members of the petition.

During the hearing (called an **adjudication hearing**), the petitioner is required to present evidence that the respondent is incompetent. Either the Clerk of Superior Court or a jury will then decide if the evidence sufficiently proves that the respondent is incompetent. If the Clerk or the jury is not convinced that the respondent is incompetent, the petition will be dismissed. If the Clerk or jury decides that the respondent <u>is</u> incompetent, additional evidence will be heard about who should be appointed as guardian. Once

Four state universities join to study minority aging

By Jane Stancill
STAFF WRITER

Hoping to narrow the health gap between whites and minorities, four UNC campuses are creating a Center on Minority Aging with a $3.1 million grant from the federal government.

Researchers and students from the University of North Carolina at Chapel Hill, N.C. Central University, East Carolina University and Fayetteville State University will team up for research and community health-education programs across the state.

The program was announced Thursday at the Chapel Hill headquarters of the UNC system. It's one of six in the nation to win federal funding for more research into minority health issues.

The center will be based in Chapel Hill under the N.C. Institute on Aging, which was created three years ago by the General Assembly.

Minority health research is becoming more important as the population ages and the gap between the health of whites and blacks widens, said Elizabeth Mutran, professor of health behavior and health education at the UNC-CH School of Public Health.

In recent years, study after study has confirmed that blacks suffer more hypertension and diabetes and have higher death rates from different types of cancer. They also have less access to quality preventive health care.

"Our focus and our hope is to help reduce the health differentials between minority elders and white elders," said Mutran, who will direct the new center. "This is an important development in the state of North Carolina."

Researchers from the state's two medical campuses, UNC-CH and ECU, will draw on the experience of NCCU and FSU, which have a long tradition of reaching out to the black community.

John Hatch, professor of health education at NCCU, has worked to set up health clinics for minorities in rural Mississippi and on the streets of Boston. He will coordinate the community outreach part of the project.

"There is a shorter life expectancy, by about five years — in both men and women — between Afro-Americans and whites," he said. "But precious little, if anything, has to do with human biology. We're talking about human behavior, patterns of living, lifestyles and education."

For example, black American men have the world's highest prostate cancer death rate, he said.

"I think that's ridiculous and outrageous," Hatch said. "We need to do something about it. We know that early detection can be a giant step forward."

The need for such initiatives will only grow as baby boomers age, he said. Today, the elderly make up 12 percent of the population but are responsible for spending about 35 percent of the nation's health care dollars.

"It's a national challenge," Hatch said. "Unless we promote healthier lifestyles and prevent chronic diseases, we simply can't pay for it."

Bringing together four schools with different strengths is key to the program, said Gordon DeFriese, acting director of the Institute on Aging.

"This is an exciting opportunity to make the UNC system work like a system," he said. "We picked four institutions that have relatively complementary skills and put them together."

In the process, they hope to lure more African-American students into the fields of health education and research.

The legislature created the Institute on Aging three years ago, appropriating about $500,000 annually. That led to UNC researchers applying for the federal money, which will come from three agencies in the next five years. The university system was one of more than two dozen in the country to compete for the funding; six were chosen.

"The General Assembly of North Carolina bet on this," DeFriese said. "We think we've made their bet pay off."

Jane Stancill can be reached at 932-2013 or janes@nando.com

The News & Observer
Friday, January 30, 1998

20th Annual Minority Health Conference

The Many Faces of Violence: Strategies for Prevention in the New Millennium

February 19-20, 1998

SPEAKER ADDITIONS:

CHILDREN AND VIOLENCE

Thursday, February 19, 1998
1:45 pm – 3:00 pm

Jonathan Kotch, MD, MPH
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Associate Chair of Graduate Studies
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PANEL DISCUSSION: *"IS VIOLENCE PREVENTABLE?"*

Friday, February 20, 1998
10:30 am – 11:45 am

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20th Annual Minority Health Conference

The Many Faces of Violence: Strategies for Prevention for the New Millennium

February 19-20, 1998

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20th Annual Minority Health Conference
THE MANY FACES OF VIOLENCE:
STRATEGIES FOR PREVENTION IN THE NEW MILLENNIUM
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Chapel Hill, North Carolina

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20th Annual Minority Health Conference

The Many Faces of Violence: Strategies for Prevention for the New Millennium

February 19-20, 1998

EXHIBITORS

The Beacon Program
University of North Carolina at Chapel Hill

Center for Minority Aging
University of North Carolina at Chapel Hill

Center to Prevent Handgun Violence
Washington, DC

Center to Prevent School Violence
Raleigh, North Carolina

The Clothesline Project
University of North Carolina at Greensboro
Greensboro, North Carolina

Donate Life
University of North Carolina at Chapel Hill

Family Violence and Rape Crisis Center
Pittsboro, North Carolina

First Step Campaign
Raleigh, North Carolina

Injury Prevention Branch
North Carolina Dept. of Health & Human Services

Injury Prevention Research Center
University of North Carolina at Chapel Hill

The Minority Health Project
School of Public Health
University of North Carolina at Chapel Hill

Minority Student Caucus
School of Public Health
University of North Carolina at Chapel Hill

North Carolina Society for Public Health Education
Raleigh, North Carolina

Office of Minority Health
North Carolina Dept. of Health & Human Services

Orange County Commission on Women
Hillsborough, North Carolina

Orange County Rape Crisis Center
Chapel Hill, North Carolina

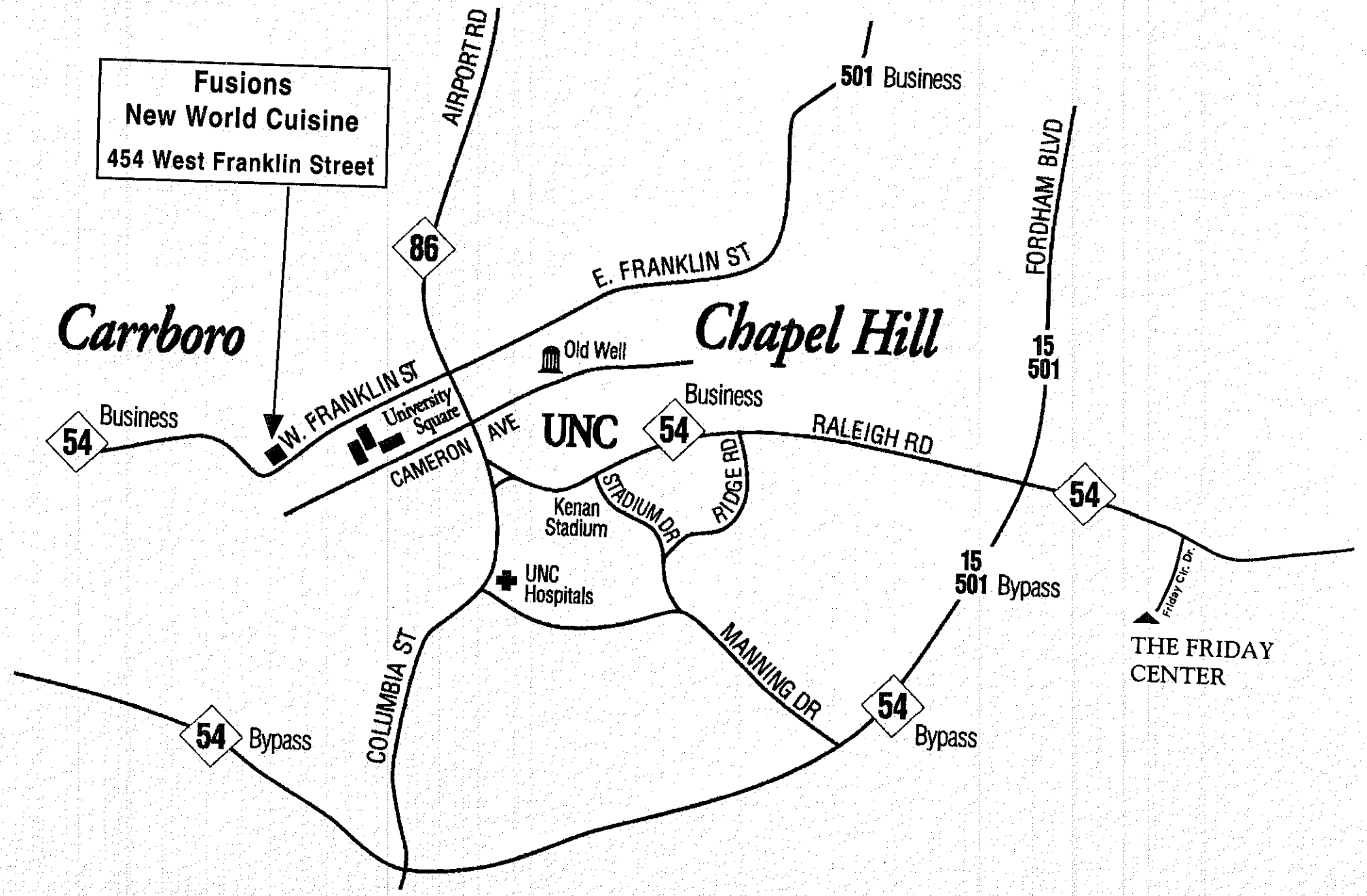
Orange/Durham Coalition for Battered Women
Durham, North Carolina

Prevent Child Abuse North Carolina
Raleigh, North Carolina

Project Esperanza
Raleigh, North Carolina

School of Public Health
University of North Carolina at Chapel Hill

Map to Social at Fusions New World Cuisine



20th Annual Minority Health Conference

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Evaluation Form

(Please complete and return to the registration desk)

1. What were your primary objectives in attending this Conference? (check all that apply)
   - ❑ to learn about the topic of violence
   - ❑ to enhance understanding of issues affecting communities of color
   - ❑ to network with other Conference attendees who share similar interests
   - ❑ requirement of course or instructor
   - ❑ other (please specify):_____

2. Were your objectives met by this Conference?
   - ❑ Yes
   - ❑ No

3. The most valuable aspect of this Conference was_____

4. The least valuable aspect of this Conference was_____

5. At next year's Conference,

   I would like more_____
   I would like less_____

6. I would like to have future Conferences focus on the topics of:

   1. _____
   2. _____
   3. _____
   4. _____
   5. _____
   6. _____

7. Overall, I would rate this Conference:
   - ❑ Excellent
   - ❑ Very Good
   - ❑ Average
   - ❑ Below Average
   - ❑ Poor

8. How many Minority Health Conferences including this one have you attended?_____

9. Would you recommend this Conference to others?
   - ❑ Yes
   - ❑ No

10. Please check all the categories that apply: I am currently
    - ❑ An interested or concerned community member
    - ❑ A student:
        - ❑ At UNC-CH
        - ❑ Other institution (name)_____
    - ❑ Alumnus/alumna of the UNC School of Public Health
    - ❑ A faculty/staff member
        - ❑ At UNC-CH
        - ❑ Other institution (name)_____
    - ❑ Employed in the health and/or human services field
    - ❑ Other (please specify)_____

11. How did you hear about the Conference?
    - ❑ Word of mouth
    - ❑ Internet
    - ❑ Brochure in the mail
    - ❑ Brochure from someone else
    - ❑ Newspaper
    - ❑ Radio or television
    - ❑ Notice posted on bulletin board
    - ❑ Faculty member
    - ❑ UNC student groups (e.g., Minority Student Caucus or SUB member)
    - ❑ Other_____

12. Please list here the names and addresses of any organizations or individuals that you would like to add to our mailing list to receive notice of next year's Conference:

    _____

    _____

    _____

13. Past evaluations have indicated a need for more opportunities to network.

    Did you attend the social?
    - ❑ Yes
    - ❑ No

    Please tell us how the Conference social facilitated the opportunity to network with other Conference attendees:

    _____

    _____

    _____

14. How far did you travel (one way) to attend this conference?_____miles

20th Annual Minority Health Conference

The Many Faces of Violence: Strategies for Prevention in the New Millennium

ABSTRACTS OF POSTER PRESENTATIONS

February 19-20, 1998
Chapel Hill, North Carolina

A Comprehensive Community Model for Coordinating Violence Interventions

By Kim Kies, MA, MPH

Early efforts to decrease violence in our nation's communities have been dissected into interventions focused on specific forms of violence following the lines of the funding agencies. More recent interventions appear to be focused on community driven efforts that assess and mobilize the community's assets rather than merely the deficits when designing interventions. Various approaches to reducing violence are now in place, each demonstrating positive effects, and yet we are still experiencing violence in our homes and on the streets.

This poster advocates a much more comprehensive and coordinated approach to reducing violence that encompasses the strengths of the public health model (prevention, promotion, and policy), applied anthropology, law enforcement / policy, the school system, media outreach, and primary care physicians. The model inherently draws upon the assets that the community already exhibits by forming a centralized task force of community experts governed by an external advisory committee to regularly assess the interventions that exist, how broad the interventions reach, and possible gaps or barriers for their success. The centralized task force must also coordinate more focused task forces for the core areas aimed at criminal justice / law enforcement, the school system, media advocacy, community leaders, and primary care physicians towards common goals and evaluate their progress. The main approaches of these task forces should be aimed at preventing violence from occurring, promoting anti-violent values and attitudes, and protecting those that are currently in violent situations.

Sedgwick County (Kansas) community health assessment focus group results also demonstrate that communities must make an investment in helping to develop interventions in each of the mentioned core areas. The nexus of both minority and majority cultural values and priorities as well as the interaction of the two are key components in designing effective violence interventions in all core areas.

Hence, the key to reducing violence in our communities does not involve simply distributing more resources to formulate more interventions, but also to step back and coordinate the interventions toward a common mission or goal. Effective interventions must also use cultural values to design appropriate violence reduction programs for each community. The proposed model serves as a template that every community can use to coordinate and drive its own mission or goals in reducing violence.

Karin Yeatts
Department of Epidemiology

THE FUNCTIONAL CONSEQUENCES OF ASTHMA AND ASTHMA-LIKE SYMPTOMS IN AFRICAN-AMERICAN AND WHITE CHILDREN. KB Yeatts*, CM Shy (University of North Carolina at Chapel Hill, Chapel Hill, NC 27599-7400, USA)

This study describes the functional consequences of and health care utilization for wheezing and diagnosed asthma in a school-based population from which 40% of the students are African-American. Asthma and wheezing were measured in 2059 eighth graders with the International Study of Asthma and Allergies in Children (ISAAC) video questionnaire. Children with wheezing symptoms as well as diagnosed asthma were identified. We also obtained information on their physical activity limitations, school attendance, and sleep disturbances due to wheezing symptoms or asthma. Physician-diagnosed asthmatics and wheezers were 2.6 (95% confidence interval (CI) 1.9, 3.6) and 1.8 (95%CI 1.4, 2.2) times more likely, respectively, to have missed school days because of wheezing symptoms than asymptomatic children. Diagnosed asthmatics were 7.8 (95%CI 5.5, 11.2) times more likely to have sleep disturbances and 20.5 (95% CI 13.9, 30.5) times more likely to have limitations in physical activity than asymptomatic children, while wheezers were 4.7 (95%CI 3.5, 6.1) and 6.3 (95% CI 4.8, 8.1) times more likely to have sleep disturbances or limitations in physical activity, respectively. Compared to asymptomatic children, diagnosed asthmatics were 49 (95% CI 30.0, 79.8) times as likely to report a clinic visit for asthma or wheezing, whereas wheezers were 4.8 (95% CI 3.0, 7.5) times as likely as asymptomatic children to visit a clinic for wheezing. We found that children with wheezing symptoms experienced functional consequences comparable to those of children with diagnosed asthma. However, these wheezers were essentially untreated for their symptoms. While the wheezers may have a less severe form of asthma than diagnosed asthmatics, the functional consequences of wheezing are likely to impair school performance and physical activity.

Health Risk Factors of African American Women and Heart Disease: A Descriptive Analysis

June P. Robinson, B. S., M. S., (ABD)

During the past decade, a considerable amount of information has been disseminated through the literature regarding the health risk toward developing heart disease and other hypokinetic conditions as a result of one's lifestyle. However, little attention has been made toward these risks and their effects on women, particularly African American women.

This poster presentation will provide a descriptive analysis of current research reported in the past decade surrounding health risk factors of women with particular emphasis on the health status of African American women and heart disease. Recommendations for preventing and controlling and or reducing the risks of many of these health risk factors will also be addressed. Health risks factors to be addressed include hypercholesterolemia, hormonal levels and postmenopausal women, obesity and inactivity, and high blood pressure, and contraceptive use.

The Influence of Control Perceptions on the Development of Hopelessness and Dysphoria Following Domestic Battering

Caroline Clements, Ph.D. The University of North Carolina-Wilmington
and
Daljit Sawhney, M.S. Finch University of Health Sciences/ The Chicago Medical School

We examined the relationship between perceptions of control over abusive outcomes and dysphoria and hopelessness following battering within the theoretical context of the hopelessness theory of depression (Abramson, Metalsky & Alloy, 1989). Study participants had a history of returning to abuser. Respondents exhibited dysphoria but not hopelessness. They displayed helplessness attributions for the abusive incident that resulted in shelter contact. They expected to be able to control abusive outcomes in the future.

Consistent with Walker (1984), our results seem to indicate that an acknowledgment of helplessness over the occurrence of abuse is associated with shelter contact. It is possible that higher expectations for control over future abusive outcomes are associated with increased likelihood of returning to abuser. We discuss our results in terms of their implications for empowerment models of domestic violence.

IS PARENTAL PERCEPTION A SIGNIFICANT FACTOR IN CHILDHOOD IMMUNIZATION RATES?

Maisha Kambon, MPH Candidate, Rollins School of Public Health at Emory University
Sheree Marshall Williams, Ph.D.

The current immunization rate for the nation's 2-year-olds is approximately 78%. This rate is well below the national goal to immunize 90% of the nation's 2-year-olds by the year 2000. Unlike the often named primary barriers to childhood immunization (e.g. race/ethnicity, educational attainment, SES status), parental perception as a barrier has yet to be thoroughly analyzed. This study attempts to consider the role of parental perceptions as a factor in the initiation of childhood immunizations. The 1994 National Health Interview Survey, Immunization Supplement, was utilized to analyze childhood up-to-date status of 0 to 35 month-olds and assess the relationship between parental perception of childhood immunization and the primary risk factors for underimmunization . Descriptive and predictive analyses were conducted to examine the relationship of identified risk factors to parents' perceptions of their child's up-to-date status. These findings indicate that parental perception of up-to-date shot status of childhood immunizations should be considered as a factor impacting vaccination behavior. Results from this research will yield new insights into how parental (specifically maternal) perceptions of the child's immunization influences actual immunization coverage. Learning objectives include (1) identifying the risk factors for childhood underimmunization, (2) determining whether parental perception is a significant factor in childhood immunization levels, and (3) articulating the relationship between parental perception and the identified risk factors.

"What Should Everyone Know About Research Studies?"

Fauzia Khanani, BA

Purpose: Health education brochures are useful community dissemination tools. The purpose of this brochure is to provide a guide for African American communities who are often asked to be part of research studies. This guide would allow African Americans to know what questions they need to ask and have answered before they agree to participate in any type of research involving human subjects. **Methods:** This brochure is a product of Project LinCS (Linking Communities and Scientists), a CDC funded project, whose goal was to examine ways to improve the relationship between researchers and communities, specifically looking at participation in HIV preventive vaccine trials. The development of this brochure was a collaboration between the Project LinCS investigators and African American Community Advisory Board members from the Durham, NC site of the Project. There were two steps in the brochure development. Initially, Project LinCS' researchers indentified potential questions. These questions were presented to and revised by the CAB. **Outcome:** A four column double-sided, color brochure was developed that is culturally appropriate for African American communities. The questions were divided into sections related to study participation issues that community members need to have answered prior to making a decision of whether or not to participate in any given study. **Conclusion:** This brochure is a useful tool for both researchers who may be going out into communities and communities that may be asked to participate in research studies. It will bridge the gap between researchers and communities in understanding community-based research. For researchers, it will provide a list of questions that they must be able to have answers for before they embark into a community looking for participants. The brochure will also provide an insight for researchers to identify concerns of participation that may exist in communities. For communities, it will provide a guide of questions that researchers should answer for them before they make a decision about participating. It will also provide communities with a better understanding of research in general and specifically about a study they may be asked to participate in.