

**Healthy People 2020 Progress Review: Violence Across the Lifespan
Injury and Violence Prevention and Occupational Safety and Health
April 18, 2013**

HOWARD KOH: Thank you so much, and welcome everyone to the second Healthy People 2020 Progress Review. I'm Dr. Howard Koh, the Assistant Secretary for Health at the Department of Health and Human Services and it's my great pleasure to welcome you again, and if it is your first time, we hope you will join us on a regular basis as we examine the progress made toward national Healthy People 2020 objectives.

This is a long-standing tradition of periodically taking stock of Healthy People goals and objectives to see if we made progress making our nation healthier and meeting or moving toward our targets. For these Progress Reviews, we focus on and discuss an issue of public health importance that is supported by two Healthy People 2020 Topic Areas. We do this pairing to reflect shared subject matter between the two Topic Areas and also to break down silos of public health concerns. So today we're very pleased to talk about violence across the life span, to welcome federal and non-federal stakeholders.

Before we go further, I really want to thank so much the many of you who helped coordinate these Review groups, particularly our Office of Disease Prevention and Health Promotion and our core planning group.

Next slide, please.

This slide shows the Progress Review overview. I did mention that violence across the lifespan is the theme and today we're going to hearing more about the impact of violence in all age groups, and where we've made progress and where we need to do to more as a Nation. The objectives are found in, first, the Injury and Violence Prevention Area and then, secondly, the Occupational Safety and Health Topic Area. We have joined these two Topic Areas to talk particularly about workplace violence when we hear from our community-based partner.

Before we do that we're going to be hearing from Health and Human Services officials, who will talk about their research and programs in moving the Nation closer toward reaching the targets. Since this whole effort is interdisciplinary, we are absolutely thrilled that we have colleagues from the Department of Justice, the Department of Labor, and the Department of Education, who are also joining us to field questions from the audience.

The next slide shows the evolution of Healthy People over the years and we're very proud of this slide because Healthy People 2020 represents the fourth iteration of this historic project. You can see on the slide how the overarching goals have evolved over the decades, how the number of Topic Areas has grown dramatically from some 15 in 1990 to 42 today, just reflecting the growing complexity of our work.

The Topic Areas for Healthy People 2020 now include new Areas like Emergency Preparedness--- very relevant in the news lately-- Global Health, LGBT issues, Social Determinants, and many other very exciting themes. All of this can be captured on <http://www.HealthyPeople.gov>, so we hope that you will regularly consult that website because we're very proud of the progress we've made in making that accessible and available to people across the Nation and, indeed, around the world.

The next slide shows you some screen shots from that website. Again for Healthy People 2020, we have some 42 Topic Areas and 1,200 objectives. You can use the data on this website to customize your search and we are working very, very hard to meet this data available to diverse users and make this an area that people can use for action in their communities. This is a very much a collaborative, stakeholder-driven process. We're very proud of that process that has led us to this webinar today that joined efforts in Injury and Violence Prevention and Occupational Safety and Health.

The next slide shows the public health impact of injury and violence as a Healthy People Topic Area. Injury and violence represent leading cause of death for people ages one through 44, which may not be well-recognized by the public health community. So that's a very important teaching point. Then, of course, injury and violence affects people of all ages-- some 181 thousand deaths in the year 2010. That's one death for every three minutes. Those deaths encompass areas like homicide, particularly for younger people, poisoning, falls, for people who are age 65 and older, and motor vehicle traffic deaths for people of all ages. If you add this all up, this is some 30 million emergency department visits a year and over 500 billion dollars annually in medical care and lost productivity.

The next slide summarizes the public health impact for occupational safety and health, the other key Topic Area we're reviewing today. You can see here that there are some 49 thousand deaths a year from work-related illnesses, almost three million workers injured in 2010, and some 137 thousand work-related assaults the led to people being seen in emergency departments. You add all this up and there's tremendous cost to the healthcare system, as well.

The next slide shows what this webinar will look like for the rest of the hour-and-a-half, with some outstanding presenters from the federal family and also from the community and then, of course, as I mentioned, key federal partners who are involved in a Question and Answer.

We're going to be hearing from my good friend and colleague Dr. Linda Degutis, who is Director of the CDC National Center for Injury Prevention and Control. She'll be talking about the Injury and Violence Prevention Topic Area. Then, we'll be hearing from Dawn Castillo, Director of the Division of Safety Research at the CDC National Institute for Occupational Safety and Health. We are very pleased to have a community leader, Matt London, who is a health and safety specialist at the New York State Public Employees Federation, who'll be talking about their experience in reducing worksite violence. And then for the question-and-answer, we have Federal partners-- Paul Kesner, who is Director of the Safe Supportive Schools Program at the U.S. Department of Education; Thomas Feucht, Executive Senior Science Advisor at the National Institute of Justice; and William Wiatrowski, the Associate Commissioner for Compensation and Working Conditions for the Bureau of Labor Statistics, U.S. Department of Labor. But of course, I cannot continue before giving special thanks to our wonderful friend and long-time colleague and leader, Dr. Ed Sondik, who will be kicking off with a data presentation from the Director of the National Center for Health Statistics. I just want to say that Dr. Sondik has been a national leader in health statistics and public health for his whole career. He has been a tremendous supporter for Healthy People and has been a champion of Healthy People for decades. On a personal note, I can't think of anyone who is more dignified, professional, absolutely committed to mission, and it is very bittersweet for me to say that this will be Dr. Sondik's last presentation as part of the Healthy People Progress Review effort before he transitions on to a new chapter in his career and away from the National Center for Health Statistics. So, Dr. Sondik, we want to give you a special thanks, express our appreciation for your years of dedication and leadership in the world of public health.

And so with that, I'm going to turn this over to my wonderful friend and colleague, Dr. Don Wright, Director of the Office of Disease Prevention and Health Promotion.

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ED SONDIK: I'm looking for the third slide, the one beyond that...which picks up on the talking point that Dr. Koh made of the impact of injury and violence in terms of the leading causes of death. It's the fifth overall leading cause of death-- that's unintentional injury- and for ages one through 44, it's the first leading cause of death, as you can see on the slide. It's followed by homicide and suicide. So the impact overall from this Topic Area, it's really enormous.

The next slide fleshes this out even a bit more, showing that, of these 180-181 thousand deaths, seven percent...go to the next slide, please... seven percent of all injury deaths. They represent five percent of all hospital discharges for industry and, as Dr. Koh mentioned, over 32 million emergency department visits.

In the next slide, we turn to causes. There are four major causes involved here. Motor vehicle traffic, which as you can see actually had a considerable decline since 2006. Poisoning, which has actually doubled since around the year 2000, going up in large part because of opioid poisoning, In fact, opiates are 40 percent, at least 40 percent, are involved in all the injury deaths from poisoning. Falls have also increased; we'll talk more about that in a minute. Firearms have actually been relatively constant over time.

Look at the next slide at the figures by age. We can see that there are really three distinct patterns here. There's the pattern for falls, which increases without end as people age. There's the motor vehicle traffic and firearms, which peak in the late... teens or early twenties. And then there's poisoning, which peaks around age 50. That's all in terms of injury deaths. If we turn to non-fatal injuries on the next slide, we have two additional causes involved. There's "struck by" or "against," which has to do with people being struck by objects or against objects in a variety of different ways and also over-exertion. We see pretty much the same pattern that we saw before for the non-fatal...for the fatal. Although, here we see for the non-fatal, as we saw for the fatal...we can see that falls, in fact, is a kind of a U-shaped curve, interestingly enough, and I think really not well-known... that this increases as much as it does for young children. This is a very complex area and we're going to kind of peel it apart a bit piece-by-piece.

A subset of all of this is in work-related injuries. So, if we can move to the next slide and then the slide after that... This is work-related injuries for ages 16 and above. What we can see here is that these work-related injuries have declined, in fact they're below the 2020 target at this point, although clearly it's early in the decade so we're not quite sure as to where we'll be going, but it's interesting that we do have a relatively smooth pattern here.

We can open this up a bit more in the next slide and look at this in terms of the work-related injuries that are actually treated in emergency departments. This is about half of all the industry injuries that we saw in the prior slide. What's distinctive here, I think, is that the injuries are higher in males than they are in females and higher at the younger age groups from 15 up to 24. There's been a dip and then these work-related injuries increase and they're, again, significantly higher in the 85 and above compared with the earlier age groups.

On the next slide, we go from injuries to injury deaths. Again, this is in the age group 16 and above. Here we can see that the most significant difference, I think, is not by race and ethnicity, although there are some differences there, but the differences between males and females, where the male rate is much, much higher than the female. Again, that's in injury deaths..

Turning to the next slide, we can look at this more specifically by age. What we see again is a relatively uniform trend by age, except when we get to age 45, when the rates begin to climb, for 45 to 54, up to 65 and above, where the rate is much higher. So, here we see the low points being from ages 20 up to age 44 and then we see an increase.

Now, looking at... on the next slide... the industry in which these deaths occur, there are four major industries that we see. The first is agriculture and, while we see the figures kind of going up and down, the overall trend here is slightly down. The trend it's much more steeply down in mining, where, although what we saw in 2010 were a couple of major incidents, which moved the curve up.

The curve is also down in transportation and construction and, if we look at all industry, we see a figure that is pretty much flat when we look at it overall over this time period from 2004 to 2010. One might think, given the industries that are identified here as the ones with the highest rates, that this would show up geographically. If we go to the next slide, in fact it does. We can see that the highest rates are in West Virginia in red, Wyoming, and Alaska, and the lowest rates were in Massachusetts, California, New York, and New Jersey.

So, from injury and from work-related injury, we turn next, next slide, to violence-related injuries, assaults and homicides. If you can go to the first data slide, what is striking in this, looking at homicides by sex and age, is that the curve here for males... how much higher this is, starting at age 15 and then peaking at age 25 and then declining again. If we home in on the box... the table, and look at homicide in males aged 20 to 24, the striking feature of this graph is the rate in black males aged 20 to 24, which is on the order of 20 times higher... a little bit less than 20 times higher than it is in the white population, and the Asian population.

Going to the next slide, we can look at... at again the ages 15 to 24 and homicide, and look at the method. Again, what's striking here both for males and females is the red part of these pie charts, which represents deaths or homicides using firearms. Cutting and piercing is much less and the other methods are much less than firearms. If we summarize this on the next slide...

Summarizing this is really the burden of violence in ages 15 to 24. About... almost 47 hundred homicides and 585 thousand assaults. We look more at the assaults on the slide following. These were the assaults that were picked up as treated in emergency departments and, again by age, this reflects the figures that we were just looking at, with the peak being in the 18 to 24 age group, and then the decline... very much what we saw earlier. Again, let's look at another aspect of this and look at violence against children and adolescents. One of the most surprising figures in this, I think is children's exposure to violence. The overall exposure of children to violence-- this is either directly or witnessing violence-- is over 50 percent, almost 55 percent. It's really a striking figure. We can see how this varies for males and females. Even though the male figure is higher than the female figure, we're still talking about a figure that's well over 50 percent. We can see, by age, that the

exposure... the probability of being exposed increases by age and we can see that there's a difference by race, but these differences are not statistically significant and they're relatively the same, which I think is a factor that that some might find surprising.

One aspect of violence is shown on the next slide... that's bullying, bullying on school property. It's very high... I was surprised by this when I saw it...that we're talking about a total that is 20 percent... The target here 17.9 percent. Another surprising figure here might be that the figure for females, 22 percent, is higher than the figure for males, at 18 percent. While the figures declined by grade, we're still talking about a figure of 15 percent having experienced bullying on school property in the twelfth grade. Still another aspect of violence is physical fighting. This figure is over 30 percent, the target being 28.4 percent. The figure here is higher for males than it is for females and we also see that the gradient in, if you will, the right direction, by grade, but we're still talking about a minimum of over 25 percent in grade twelve. If we break this out by race, we see there are differences by race, but I think it's important to look at the Black, Hispanic or Latino, and white figures and see that these figures still are well over 25 percent... essentially...close to 30 percent. So it's really a significant figure. It's a high figure.

Now, again, another piece of this... this important area is work-related violence, focusing on assaults and homicide. Now here we target even in a more narrow way at work-related assaults by injury... assaults by industry, rather... that we found treated in emergency departments. Again, surprising figures, at least they were to me, is that that public administration and healthcare are industries that rank the highest here in terms of the rates of work-related assault injuries.

If we go to the next slide and we go from injury to homicide by perpetrator type... these, again, are work-related homicides by perpetrator type-- the large blue areas represent homicides that were committed during robberies. If we then look at what type of work setting... in the next slide... was involved, these are all work settings that we would think could well be the victims of robberies, ranging here from supermarkets up to the highest figures for restaurants.

This brings me to the last slide on key points. I'd point out here that all of the slides, I think, showed us that, when we look by age, that younger age groups were disproportionately impacted by the non-fatal injuries in both work and non-work environments. I mentioned that half of all children and adolescents have been exposed to violence. I think it's a surprising and extremely important figure. Third, the burden of violence extends beyond homicides to include non-fatal physical assaults and bullying and that the patterns differ by age, by settings by race, which calls for the need for targeted prevention strategies that are particular to each of these. I would add to these bullets the rise of poisonings in injury, an extremely important point that only has recently been pointed out and the role of drugs, legal and nonlegal drugs.

DON WRIGHT: Thank you, Dr. Sondik, for that very comprehensive overview of this important topic. At this time, we want to turn things over to Dr. Linda Degutis. Dr. Degutis is Director of the National Center for Injury Prevention and Control at the Center for Disease Control and Prevention in Atlanta, So, Dr. Degutis...

LINDA DEGUTIS: Thank you. I'd like to thank Dr. Koh and Dr. Sondik for their introductions and for setting the stage for the presentation that I'm going to make here. At the National Center for Injury Prevention and Control we're committed to saving lives, preventing violence, and injuries and lowering the health and societal costs of violence and injury.

As mentioned before by Dr. Koh, injuries are the leading cause of death among children, youth and adults between the ages of one and 44, and there are approximately 180 thousand deaths each year. The Injury Center has worked for over 20 years to use science to create real-world solutions to these problems. We work across sectors with many diverse federal and nonfederal partners to make people safer in all environments. Next slide.

Our focus areas in the Injury Center are four: motor vehicle-related injury prevention, prevention of prescription painkiller overdose, prevention of traumatic brain injury, and prevention of violence against children and youth. Our intent is to address high-burden issues where promising and proven practices are available and to be more flexible in responding to emerging issues. All of these are critical priority issues that are associated with HP2020 objectives, but today I'll be talking about our work in violence prevention. Next slide.

Violence occurs across the lifespan and we know that the risk starts at birth and continues through older ages. We're supporting work in each area. We recently released a tool called Essentials for Childhood that documents what children need to grow up healthy and the kind of environment they need in order to decrease some of the risks for later impacts of violence. Our national Intimate Partner and Sexual Violence Survey is the first ongoing survey of its kind in over ten years. Data from that survey in 2010 showed that one in five women and one in 71 men had been raped in their lifetime. The rape prevention education program that we fund provides funding to strengthen sexual violence prevention efforts in all fifty states, the District of Columbia, Puerto Rico, and six U.S. Territories. Next slide.

There are over a dozen objectives in HP2020 that relate to reducing violence experienced by children and youth. We need progress in these areas and it's critical, as we saw in Dr. Sondik's presentation, as violence contributes a substantial public health burden for young people. We know that youth who are victims of violence are at greater risk for subsequent violence, including later perpetration and victimization. In addition, young victims of violence are at increased risk for a range of lifelong health consequences. These include obesity, chronic diseases, depression, alcohol and other drug abuse, and eating disorders. There is also a substantial financial burden. For child maltreatment alone, the total lifetime cost for health care, child welfare, criminal justice, and the value of lost future productivity and earnings are 124 billion dollars each year. We're focused on putting science into action to prevent violence and I'm going to share a few examples of our current programmatic research and surveillance activities that are moving us towards reaching the HP2020 objective. Next slide.

Having learned a great deal about what works, we have put some of these initiatives together and are using them in our Stryve program, which is striving to reduce youth violence everywhere. For example, the blueprints for the violence prevention program at the University of Colorado has identified over 30 programs that have been rigorously evaluated and shown to be effective. A challenge is that many communities are either not aware of these strategies or they lack the capacity to implement them. Our initiative Stryve is working to provide the help that these communities are seeking. There are two prongs to the initiative: funding for local health departments to implement Stryve. These sites are working with a coalition of folks from across sectors, including education, law enforcement, and public policy to create a comprehensive plan, implement that plan based on the best available evidence and track and measure improvement. We provide virtual training and technical assistance through Stryve online to help communities nationwide, including the communities that are funded. This includes

information on what has worked and guidance on how to select, implement, and sustain an integrated approach. Next slide.

Another of our initiatives is a research initiative - that is the Academic Centers of Excellence in Youth Violence Prevention. We've learned a great deal about how to prevent violence, but we still need more research to understand it better. We need to understand how to help high-risk communities. This research activity is designed to reduce youth violence in defined high-risk communities by connecting academic and community resources to implement and evaluate prevention strategies. These Centers take the best available research evidence based on peer interventions, family interventions, and community interventions, and they implement strategies as part of a comprehensive approach in neighborhoods and then assess the impact on a range of youth violence outcomes.

The photo that you see in this slide was taken at a community celebration with the ACE in Colorado. The ACE team was explaining the importance of having good data to drive decisions. The young woman in the photo is holding up a sign that says, "Without data, you're just another person with an opinion." We want to stress the importance of having this data and using it to drive these initiatives. Nationwide, we know that young people of color are disproportionately affected by youth violence. All of the Stryve and ACE grantees are working in communities with a high proportion of minority youth. For example, ACE communities are 85 to 95 percent minority. Rates of poverty and unemployment range from 40 to 80 percent. We know that the lessons that we learn from working with these communities will allow us to better understand the partnership and capacity required for successful implementation and the effects of comprehensive prevention strategies in the communities where these efforts are needed most.

Past CDC-funded research in North Carolina shows that school-based teen dating violence prevention programming can result in significant and sustained reductions in physical and sexual teen dating violence. This program is currently being widely disseminated around the country. The challenge is that we don't know what works to prevent teen dating violence in high-risk urban communities. So, we have designed the Dating Matters program for youth in high-risk urban communities to promote healthy non-violent relationships. This initiative includes school-based strategies aimed at building youth skills that support healthy relationships, programs to enhance parenting skills and communication training to enable teachers to recognize and respond to the risk factors for dating violence. In addition, it includes tools for working with organizations and neighborhoods to keep youth safe. We are conducting a rigorous evaluation comparing the Dating Matters approach to standard school-based practice which is Safe Dates, a program that is implemented in eighth grade. Over five years, the programming will be delivered to the tens of thousands of youth, parents, educators, and community members. The lessons learned will guide future dating violence prevention work in high-risk communities. Next slide.

We know that surveillance data is critical for guiding prevention and monitoring the results of our initiative. The CDC School Associated Violent Death Surveillance System, or SAVD, is a partnership with the Departments of Education and Justice and we have members of those Departments here, Tom Feucht and Paul Kesner. We have collaborated with both agencies on SAVD and multiple other projects over the years. The information collected each year from media databases, police, and school officials about all school-associated violent deaths in public and private, elementary, middle, and senior high schools throughout the U.S. provides us with a baseline for creating a prevention initiative. The SAVD data shows that between 14 and 34 school-age children are victims of homicide on school grounds or on their way to and from school each and every year.

We know that most school-associated violent deaths occurred during transition time, immediately before and after the school day and during lunch. We also know that homicide, which is the leading cause of death among youth aged 5 to 18, data from this study indicates that between one and two percent of these deaths happen on school grounds or on the way to or from school. We summarize the SAVD deaths each year in the Department of Education Indicators of School Crime and Safety document. Next slide.

Finally, I'm going to talk a little bit more about the National Violent Death Reporting System (NVDRS). Although we have had extensive data on violent death, the information from various sources has not been integrated. Since 2003, NVDRS has linked data from death certificates, coroners' and medical examiners' reports, law enforcement, and laboratory reports at an incident level. It gives us a comprehensive picture of each incident. For all violent deaths in participating states, which are the states in purple, we have gathered this information. The NVDRS also provides more complete information on local deaths that include circumstances that contributed to a violent death, the relationship of the victim to the suspect, and it links death with an incident to examine multiple-victim homicides, and homicide followed by suicide. NVDRS also provides a comprehensive data and functionality that no other system offers in a fast, efficient manner they can be used to inform decision-making on violence prevention strategies at the state and local level. The states that have NVDRS implemented are actively using the data to inform their violence prevention activities.

For example, former New Jersey Governor John Corzine's office used NVDRS to standardize how gang-related activity was defined and measured. This was used as part of the Governor's anticrime strategy to plan interventions to reduce gang violence, such as providing alternative programs for youth, to reduce gang membership, and to help convicts adjust as they leave prison.

Recently, in the plan that was issued by the President, the plan to protect our children and our communities by reducing gun violence, there was a call for an expansion of NVDRS to all 50 states to help inform future research and prevention strategies. This goal is consistent with the HP2020 objectives that we are taking steps to prepare for. Next slide.

So, we have multiple resources at NCIPC for preventing violence across the lifespan and these are all accessible through our website, but in conclusion, I'd like to say that the Injury Center is committed to preventing violence across the lifespan, including child maltreatment, youth violence intimate partner violence, sexual violence, elder maltreatment, and suicide. I have shared just a few of the activities of the work being done to reduce violence against children and youth and to reach our HP2020 objective. These activities can have lifelong benefits for children by reducing burden from violence and by changing their trajectory for subsequent violence and related health consequences. Again, please check our website for more details about these and other activities, Thank you.

DON WRIGHT: Thank you, Dr. Degutis, for that very informative presentation. At this point in the program, we want to transition to look at violence in the workplace. Our next speaker is Dawn Castillo. She's Director of the Division of Safety Research for the National Institute for Occupational Safety and Health. So, Dawn...

DAWN CASTILLO: Good afternoon. It's my pleasure to participate in this Review and report on progress in meeting HP2020 objectives for Occupational Safety and Health, with a focus on objectives associated with preventing workplace violence. Next slide.

More than 154 million Americans work in the United States, and they typically spend 40 percent of their waking hours at work. As illustrated in Dr. Koh's and Dr. Sondik's presentations, large numbers of workers are injured or or die at work each year and societal costs are substantial. These deaths and injuries can be caused by unique hazards associated with work, such as the heavy machinery and dangerous chemicals used by agricultural and construction workers, but they're also too frequently caused by violence that encroaches into the workplace and impacts workers across a variety of industries. As Dr. Degutis pointed out in her presentation, injuries and violence are preventable.

In addition to broad-based prevention measures reported by Dr. Degutis, there are unique steps that employers, workers, and government agencies can take to protect workers from injuries and violence. Employers have a legal responsibility to provide workplaces free of recognized hazards. Next slide.

I will be reporting on efforts by the National Institute for Occupational Safety and Health, or NIOSH, to prevent injuries, specifically injuries associated with violence, among the millions of workers in the United States who toil day in and day out to make a living and whose products and services power the economic engine of this country. NIOSH is the federal agency responsible for conducting research and making recommendations for the prevention of work-related injury and illness. Our mission is to improve worker safety and well-being by generating new knowledge and transferring that knowledge into practice for prevention. We do this by conducting scientific research, developing guidance and authoritative recommendation, conducting outreach, and responding to requests for technical assistance and evaluations of work hazards. Next slide.

NIOSH is the lead federal health agency for addressing 16 Occupational Safety and Health objectives. These include objectives to reduce deaths and injuries generally and by specific industry sector, as well as other health outcomes, such as pneumoconiosis deaths and noise-induced hearing loss. Two of the objectives are specific to workplace violence, one to prevent work-related homicides, the other to reduce non-fatal assaults. NIOSH emphasizes research to practice and conducts research in partnership with stakeholders who are in position to make changes in the workplace. This includes employers and their representatives, such as trade organizations, worker representatives, such as unions and coalitions, government agencies, including agencies responsible for enforcing and regulation such as the Occupational Safety and Health Administration, or OSHA, and manufacturers who produce work machines, equipment, and personal protective equipment. Next slide.

Violence against workers is pervasive. On average, more than 600 Americans have been murdered at work each year in the last decade. In 2009, more than 137 thousand workers were treated in emergency departments for assaults and, based on employer report, 41 thousand workers missed at least one day of work. The median days of lost work for these workers, who may or may not have been seen in an emergency department, was eight days. We know that countless numbers of additional workers, for a variety of reasons, do not report their injuries or assaults to their employers, may not seek treatment, and may be assaulted or threatened without physical injury or lost work time. The psychological impact on workers, including those who are threatened or bullied without physical signs of injury, are unmeasured nationally, but they can be substantial and debilitating. Next slide.

As suggested by data presented by Dr. Sondik, workplace violence can take many forms. For example, most workplace homicides are associated with robbery and homicides are clustered in establishments such as restaurants, retail stores, and the taxicab industry. Racial minorities and foreign-born workers have higher rates than other workers in some of these high-risk industries, including the retail industry. Nonfatal work-related assaults are most commonly associated with violence when workers provide services, such as the patients in healthcare settings and students in educational settings. Other types of workplace violence include violence between co-workers and workers being assaulted by intimate partners and acquaintances while at work, which occurs across all industries. While intimate partner violence is less common than other types of fatal workplace violence, as presented by Dr. Sondik, it disproportionately impacts working women, with one quarter of the work-related murders of women in 2010 committed by relatives and other personal acquaintances. The complexity of workplace violence and diverse array of impacted industries with unique working environments make workplace violence especially challenging. Prevention strategies vary by type of violence and industry, which have different physical and social environments. Next slide.

NIOSH has conducted and supported research that has characterized the workplace violence problem and identified and evaluated promising intervention strategies. Employers, states and municipalities, and OSHA have translated the current knowledge base into prevention efforts. Shown on this slide are three documents produced and distributed by OSHA with recommendations for preventing workplace violence in three high-risk industries. The presentation by Matt London that will follow my presentation will provide a more detailed example of how his organization, the New York State Public Employees Federation, has translated available evidence into practice to protect New York state employees from workplace violence.

On the next couple of slides, I will give examples of ongoing research to address industry-specific violence prevention. The examples were chosen to be illustrative of the unique ways in which violence plays out in different workplaces and the need for prevention strategies to be tailored to the types of workplace violence and unique social and physical environments of different workplaces. Next slide.

The first example is workplace violence in the taxicab industry. Taxicab drivers have especially high homicide rates and twice as many taxicab drivers are murdered at work as are killed in motor vehicle crashes. The nature of taxicab driving has numerous inherent risks for workplace violence, including working alone, handling cash, and often working in remote locations. Numerous cities are using security cameras and bulletproof partitions to protect taxicab drivers. However, the effectiveness of this equipment has not been demonstrated. NIOSH is wrapping up an evaluation of the effectiveness of these two interventions to protect taxicab drivers. The research has been conducted in partnership with regulators and taxicab associations and these partners will help in the dissemination and application of the findings to taxicab driver safety. Next slide.

The second example is workplace violence in health care. Healthcare personnel have high rates of nonfatal assault. Personnel in psychiatric facilities have an especially high rate. Violence is perpetrated by patients and family members and there's also evidence of bullying between nurses. NIOSH is currently evaluating several types of interventions. We're working with the Veterans Health Administration to evaluate a program in psychiatric facilities that uses regular meetings of the staff and patients to discuss violent incidents and ways to prevent them. We are also working with academic partners to evaluate recently enacted legislation in New Jersey that requires comprehensive violence prevention programs. And we're working with a large number of stakeholders, including healthcare

associations, such as the American Nurses Association, and a professional training company to develop and evaluate a free online training course that healthcare personnel can take for a continuing education unit that would raise their awareness about workplace violence and prevention measures. Matt London, the next presenter, was one of the stakeholders engaged in the development and evaluation of this course. Next slide.

Again, the examples I have provided for the taxicab and the healthcare industry were chosen for illustrative purposes. NIOSH and grantees have conducted research across workplace violence type and a variety of industries. NIOSH's webpage on workplace violence, shown on this screen, includes links to scientific article citations, publications, and other resources on workplace violence prevention.

Thank you for the opportunity to present information on NIOSH efforts to prevent workplace violence. I'd also like to remind folks that we have two of our key federal partners who are participating and they're available to answer questions following the presentation. We have Bill Wiatrowski from the Bureau of Labor Statistics. The Bureau of Labor Statistics collects a large part of the data that are used to track Healthy People 2020 objectives. And we have Dr. Mikki Holmes, who can speak to OSHA efforts to prevent workplace violence. Thank you.

DON WRIGHT: Thank you, Dawn, for sharing your perspective on violence in the workplace. At this time, we're going to share with you a promising practice. Matt London is our next speaker. He is a health and safety specialist with the New York State Public Employees Federation. Matt...

MATT LONDON: Thanks for the opportunity to briefly describe the importance of violence in the workplace and some of the things that our union has been able to do. I work for PEF, a public sector union that represents many professionals who work for New York state government agencies. Our members provide vital services to the community, including to citizens who may pose a significant risk of violence. Dr. Koh and Ms. Castillo described many of these work settings. The union's role is to not only bargain over salaries and other aspects of compensation, but also over working conditions, including workplace health and safety.

This table describes the high annual incidence rates for direct care workers in the state's office of mental health. The aides have virtually full-time contact with patients and the category secure aides work in forensic hospitals. Jill is a psychiatric nurse who was working at a state-run psychiatric center. She was brutally assaulted by a patient who had a long history of violence. Jill was working alone and it wasn't until another patient heard Jill's head being bashed against the wall that a call for assistance was made. Jill's boss callously told her that the patient had nowhere else to go and thus would remain there. The local police informed her, quote, "You knew that it was risky when you took the job." Jill lost two months work, but the trauma remains to this day. It was two years later that another PEF psychiatric nurse was murdered. Judi was working alone conducting a home visit to a patient. She had not been informed of this patient's relevant history and was brutally murdered with a hammer.

As a result of the statistical toll, as well as the human impact, personified by Jill and Judi, PEF began to focus on workplace violence prevention in the late 1990's. Our first priorities were to provide support to our injured members and to learn more about the problem. We joined with the University of Maryland School of Nursing and obtained a NIOSH intervention research grant, looking at workplace violence in psychiatric settings. We were later able to parlay that into a similar grant, studying the problem in social service settings. The goals were to document the problem of workplace violence in those settings,

identify risk factors, and begin to develop prevention strategies. Our first step was to partner with sister unions and with management in those agencies. We used participatory action research methods, believing that the front-line workers themselves had valuable information to provide. After getting increasingly immersed in this work for six to seven years, PEF decided to launch a public health-style campaign to tackle the problem of workplace violence. Using the knowledge obtained from the NIOSH research, PEF convened a series of day-long sessions around the state. PEF targeted those members who worked in high-risk settings, as well as those who were already on a union health and safety committee or in a leadership position. The goals were to educate them on the issue and to mobilize them into taking action. The union worked with legislators to draft legislation and launched a campaign. This included telling the workers' stories to the press, testifying at hearings, and holding rallies.

While the campaign utilized injury and cost statistics, we also wanted to put a human face on the problem. PEF developed a booklet that included photos of ten assaulted workers post-assault, as well as the victims telling the story of what happened and the impact of their assault. Many of these brave members participated in the trainings and in the advocacy. Their personal testimony was very powerful. The day-long trainings were very successful. Virtually all the attendees became engaged in the issue, both raising the topic in their workplace and also participating in the legislative campaign.

With the assistance of PEF members and sister unions, the law was passed in 2006. This comprehensive statute covers virtually all public employers in New York state. It's administered by the state OSHA plan through the state Department of Labor. Employers are required to assess the risk of workplace violence and identify and implement risk reduction strategies. It requires that a system be utilized for recording all workplace violence incidents and it requires that all employees be trained in the various elements of their employer's program. Unlike other workplace health and safety regulations, the concept of workers as experts is explicitly recognized and union representatives and front-line employees must be included in the development and implementation of the program. These regulations took effect in 2009. The regulations draw heavily on NIOSH's and OSHA's research and guidance documents that Dawn described earlier. The successful state workplace violence prevention programs start with the commitment of top management and with extensive employee involvement. The risk evaluation is critical to ensure that prevention efforts are effective and appropriate for that particular workplace. Unfortunately, at this time, we have little reliable data that demonstrate a specific reduction in workplace assaults. This is due to the recency of the law, non-uniformity in data collection methods and formats, a presumed increase in reporting due to the requirements of the law itself, and to increased awareness of the problem. However, we know that there's been a dramatic increase in workplace violence prevention efforts. Our advocacy and education and the power of the law have resulted in most public employers focusing on this issue, many for the first time.

NIOSH has described the various sources of workplace violence. In addition to patient or client perpetrated incidents, we have also begun focusing on co-worker conflict in workplace bullying. Partnering again with the Maryland School of Nursing, we obtained a NIOSH research grant focusing on co-worker conflict and bullying. As with our other work, we've partnered with sister unions and with employers. Working with five state agencies we offered a survey to all of their employees. As you can see, we obtained almost 13,000 completed surveys, with a very high response rate. Next. Using a variety of questions derived from the work of other leading researchers, just under half of all respondents reported experiencing at least one of these six negative acts at work during the prior six months. Using a standard definition, ten percent indicated that they had been bullied at work during that period. Those

who had been bullied were severely impacted both at work and at home. The more frequent the bullying, the more serious the impact.

How do we reduce co-worker conflict and bullying? Although there are measures that individuals should take, we're also trying to identify organizational causes and responses. We recommend that employers develop policies with clear norms of behavior. An explicit system for reporting and investigating complaints should be created. Some elements of that system are described here. Additionally, the organization should reduce stressors to the extent feasible. These include job insecurity, mandatory overtime, et cetera. Finally, supervisors play an important role. In most organizations, supervisors are not selected for their ability to manage people, nor are they trained or evaluated on that ability. This we believe contributes to many of the problems, both from bullying bosses, but also from managers who are incapable of managing.

So what have we learned? The NIOSH-funded research conducted with the University of Maryland continues to inform PEF's work and advocacy on this issue. We've been able to accomplish what we have done by working in coalition. The enactment of strong regulations has resulted in a significant increase in worksite-based violence prevention activities. This problem will likely never be solved... never be fully solved, excuse me. Thus, the programs need to be evaluated and updated on a regular basis. No matter where you work, workplace violence should never be accepted as part of the job.

Unfortunately, the problem continues. Mark G., a teacher in a youth detention facility for girls was assaulted by one of the students. Next. Only with ongoing attention to the problem will significant improvements occur. Though difficult to do rigorously because of myriad confounders, evaluation studies are critical. Worker safety is inextricably linked to the safety of the individuals being served by our members and to that of the public at large. Thank you.

DON WRIGHT: And thank you, Matt, for sharing your work in violence prevention in the workplace. At this point in time, we're going to move into the Question and Answer portion of today's Webinar. I would invite all the participants to use the chat function on your screen to submit questions for review. We already have a long list of questions that we want to get to immediately. Dr. Degutis, I think you are best prepared to answer this first question. Dr. Sondik's slides showed that falls drastically impacted the senior citizens. What is being done to address this population?

LINDA DEGUTIS: Thank you. Yes, I think this is a really important issue, an important area to focus on. We've been working with some of our health department partners in New York, Colorado, and Oregon to address falls and preventing them using a comprehensive approach. Each of these states is implementing three evidence-based community fall prevention programs that are targeted towards adults at different levels with respect to their ability to exercise and to move. These are called Stepping On which is a program that has been designed specifically for older adults. Then there's Tai Chi Moving for Better Balance. Then there's the Otago Exercise Program, which was developed and studied in New Zealand. Each of these states is also disseminating a toolkit that we designed for healthcare providers. The goals of this toolkit are to increase fall prevention in clinical practice settings and to link clinical referrals to the community programs. This is in its second year and is a comprehensive approach that is expected to demonstrate measurable decreases in fall injuries within those places that have implemented it by the end of this five-year funding period. The toolkit actually allowed practitioners to assess the risk of falls in their patients and it's based on a simple algorithm that was adapted from the American and British Geriatrics Societies' Clinical Practice Guidelines, their basic information about falls,

case studies, conversation starters, and standardized gait and balance assessment tests with instructional videos. There are also educational handouts about fall prevention that are specifically designed for patients and their friends and family.

DON WRIGHT: Thank you, Dr. Degutis. I'm going to have to reach out to our representative from the Bureau of Labor Statistics dates for our next question--Bill Wiatrowski--the question that was submitted was that--most of the data for the Healthy People 2020 Occupational Safety and Health objectives are from the Bureau of Labor Statistics. Are there any specific data for health disparities in this area?

BILL WIATROWSKI: Thank you very much for the question. The Bureau of Labor Statistics provides some of the data used in Healthy People 2020 related to work-related fatal work injuries, as well as non-fatal injuries and illnesses. In the area of fatal work injuries, we get a comprehensive census of every fatal work injury that occurs in the country over the year, roughly between 45 hundred and five thousand each year. For the non-fatal data, we do a survey of employers to gather information about non-fatal injuries and illnesses that have occurred during the year. We count somewhere between three--and-a-half and four million non-fatal work injuries each year and we're only able to get comprehensive details about about the worker and about the circumstances surrounding the particular injury for a subset of those cases. In many cases we have difficulty getting some of the information, specifically things like race and ethnicity. So, we do have a concern that we're sometimes not able to provide the most comprehensive data about some subsets of population, for example, Hispanics or or immigrant populations, and that we may not be able to get as comprehensive data as we would like. So, there is a potential that there are some disparities between groups of workers that we're not able to provide comprehensive data about.

DON WRIGHT: Thank you, Bill. The next question I will send to Dr. Sondik. One of our participants is asking.. saying they're curious to know how work-related is defined. Does it include domestic violence or homicides that happen in the workplace?

ED SONDIK: Thanks for the question. Actually Dawn touched on this. It does include that. It's interesting; she emphasized the disparity here. There was one slide that was called the percent distribution of work-related homicides by perpetrator type. If you look at females, 25 percent of those homicides are committed by relatives, compared with three percent for males. So, there's quite a disparity. Dawn, you may want to say something about that. But the data is collected.

DAWN CASTILLO: So, the work-related incidents are generally defined...that any injury occurred when someone is at work or in the course of doing work. So, when intimate partner violence encroaches into the workplace, we could capture that.

DON WRIGHT: Thank you, Dawn, Dr. Sondik. Dr. Degutis, the next question is for you. How is the Injury Center responding to President Obama's plan to protect our children from gun violence?

LINDA DEGUTIS: Thank you. We are responding to it by following the directive that he has issued. One of the requests in his directive was that we develop a research agenda for a gun violence prevention project and we are now working...we have a contract with the Institute of Medicine, in collaboration with the National Research Council, to appoint an ad hoc committee of external experts to develop a proposed public health research agenda on the causes and prevention of gun violence. The goal of the committee is to identify gaps in knowledge, to better understand the causes of gun violence, and

prevention strategies to reduce the public health burden of gun violence. The questions generated will be in alignment with the President's directive. There is a public meeting taking place at the IOM and NRC next week, April 23.

DON WRIGHT: I want to reach out to some of our other federal partners. Perhaps... I'm sorry... perhaps individuals from the Department of Justice or Department of Education. Would any other federal... Would you like to share what is being done to prevent violence in the school system?

TOM FEUCHT: This is Tom Feucht at the National Institute of Justice. Thanks for including us. Our partnership with CDC is terribly important one. Of course, just tracking the data in the first place and looking at school-associated violent death is critical part to knowing the nature of the problem and the type of preventive strategies that would work. We've been conducting some important research around police officers in schools and trying to look at the most effective way to allocate scarce law enforcement resources to ensure the safety of kids. Of course a lot of what the SAVD data show is that school-associated deaths don't always happen in the schools. In fact, schools are pretty safe places overall. We're also looking at things like routes and neighborhoods that kids go through on their way to school.

PAUL KESNER: This is Paul Kesner from the Department of Education. I concur. Thanks so much for having us as part of this. I believe that some of what Tom just said is what we're looking at, as well. The data is showing that schools are pretty safe places to be, so what we've been doing is enhancing some of our training for bus drivers, looking for signs of bullying, that sort of thing. We have also been using the data to drive some of our technical assistance efforts. You know we found, through the efforts of <http://www.StopBullying.gov>, that there are a variety of resources out there that folks can use to help target and talk with young people about some the concerns about bullying. In addition, we've also been working with helping to develop some strategies for teaching our teachers, some in-class on strategies for possibly violent situations, situations that may arise and giving them some ways to to target their own behavior in addressing this concern.

DON WRIGHT: Thank you, both Tom and Paul. We have... Dawn, would you like to speak?

DAWN CASTILLO: I was just going to add that NIOSH has just recently been looking at violence against teachers. We've done a survey in Pennsylvania that shows that about ten percent of teachers on an annual basis are subject to violence, often from the students. We've had some initial discussions with the Injury Center about partnering to look at the schools on a wholistic basis, looking at safety of the children, as well as the staff within the schools.

DON WRIGHT: Thank you, Dawn, Tom, and Paul. It's great to see such wide participation across the federal family in preventing violence in the schools. The next question I'm going to send to Dawn and to Dr. Holmes from OSHA. What is OSHA's role in preventing workplace violence?

MIKKI HOLMES: Hi. Thanks for including us today. OSHA has done a lot of work in terms of guidelines out to different types of workplaces and those are all posted on our website. We also track, kind of, what's going on in the states. We also have all the laws listed that have been passed as it relates to workplace violence. We have ten regions and we have workplace violence coordinators in each of those regions that reach out to workplaces throughout their region to talk about workplace violence. We've often been doing outreach with our own inspectors, so that when they're doing inspections they can reach out to employers and identify steps they can take to help improve the safety at their workplaces.

DON WRIGHT: Do you want to add to that, Dawn?

DAWN CASTILLO: OSHA is a tremendous partner for us. They are very important to employers. So, when they conduct the outreach and they share the findings on the research, they're listened to. So, we value that partnership and their efforts to leverage some of the science.

DON WRIGHT: Great. Thank you. Dr. Sondik, another question for you. Does exposure to violence in children include violence in video games?

ED SONDIK: Tom Feucht might want to join in with this. It does not include that. There are 44 different types of violence that are included that range from very direct violence to somewhat indirect violence, but that aspect is not included, and I must say that's exactly the same question that I asked when I first looked at this data. It is quite surprising, the high-level here and I think it's very important. Tom, do you want to add anything to that?

TOM FEUCHT: I think that focusing on young people, as your data showed, is terrifically important. One of the things that NIJ has developed in the last few years and other agencies, as well, is a focus on teens and their relationships. This involves all sorts of things, teen dating, some of the bullying that occurs in different media, and so on. We've got a portfolio of research that's up on our website that people can visit, if they want to look at some of that. These are really important issues because youth are at such risk and also because of the developmental and preventive opportunities that we have in working with young people.

ED SONDIK: Let me just add something. If you look at the slide, it's difficult to see, I know, over the internet, but if you download the slide, there is a footnote that goes into some of these types of violence, that mentioned some of these types of violence. Just let me mention it because I really think it's quite important. They are conventional crime, child maltreatment, peer and sibling victimization, sexual victimization, witnessing an indirect victimization, school violence and threat, internet harassment and and threats. Again, video games are not included in that list.

DON WRIGHT: Thank you, Ed. The next question is for you, Dr. Degutis. What percent of poisonings are intentional versus accidental?

LINDA DEGUTIS: Hi. Okay. Thank you. If you're talking about fatal poisonings, one of the issues that we have or one of the difficulties we have is really identifying what proportion of them really are intentional, because many of the poisonings that appear to be unintentional may actually be intentional. We're trying now to develop ways to tease that out and identify where people are actually taking an overdose intentionally. But from the medical examiner's standpoint and death certificates... we've talked with a number of people who say that they still have difficulty in figuring out what's intentional and what's unintentional. So, it's area where we need some more work.

DON WRIGHT: Thank you, Dr. Degutis. Dr. Sondik, do you have some additional thoughts on this this question?

ED SONDIK: She's actually right on. One of the areas we would definitely like to know more about is cause of death and information related to that. But the information that we do have... we put it together... our best estimate at this point would be that 70 percent of these poisoning deaths are accidental, 15 percent are suicide, and eight percent are undetermined. We don't know. So, the great

majority, we would have to say at this point, are unintentional. I emphasize what I mentioned earlier: these are both legal and illegal drugs. The opioids are a growing problem here.

DON WRIGHT: Thank you, Dr. Degutis, Dr. Sondik. The next question is for Dawn Castillo. One of our participants asked, "I'm a safety professional and current board member of the American Society of Safety Engineers. We have 34 thousand members focusing on workplace safety. What are the correlations from non-workplace violence to problems in the workplace, if any?"

DAWN COSTILLO: Thank you and I'll note that the American Society for Safety Engineers is one of our valued partners given the role that they play in workplace safety. So, there are there are some overlaps. You know we talked about the fact that intimate partner violence is not limited to a home and that it often encroaches into the workplace. Then some of the violence that you see...you know, we've talked about fighting among children and violence. Ultimately, though, they're the types of events that lead to criminal acts and criminal acts are very much an issue within the workplace. So, I hope that answers the question.

DON WRIGHT: Another question for any one of the panelists. There seems to be an increase in prescription overdoses. What is the reason behind this trend? Dr. Sondik or Dr. Degutis?

LINDA DEGUTIS: Hi. This is Dr. Degutis. We're seeing a number of things that we think may be contributing to this trend, We're certainly seeing an increase in the number of prescriptions that are written for opioids and the number of opioids that are distributed that really track the trend, or the increase, in prescription drug overdoses. So we think that has a great deal to do with it. This increase is parallel. As the supplies of the medications have increased, we have seen an increase in morbidity and mortality. The supply is larger than ever; there are all kinds of new opioids that have come on the market. We find that, basically, the quantity of prescription painkillers sold to pharmacies, hospitals, and physicians' offices was four times higher in 2010 than in 1999. Enough prescription drugs were prescribed in 2010 to medicate every American adult around the clock for a month. This would be a dose every four hours around the clock for a month. So, even though most of these were originally prescribed for a medical purpose, a lot of them end up in the hands of people who misuse or abuse them. So, we think it's supply and demand.

ED SONDIK: I would only add to that that there are other avenues for obtaining these drugs, in addition to legitimate prescriptions, and then maybe handing them off, avenues from out of the country, for example. It may be that, but it also may be that people simply don't understand the dangers involved and the different susceptibilities for different people to these drugs.

DON WRIGHT: Thank you, Dr. Sondik and Dr. Degutis. Another question for Dawn Castillo or perhaps our OSHA representative. There have been questions regarding leading indicators for workplace violence and consensus standards. What are the best resources to use and, potentially, the best measures?

DAWN CASTILLO: I'm not aware of any consensus standards per se, but there have been a number of regulations that have been promulgated at the state level and there's also the guidance documents that OSHA has promulgated that we described. Within all of those there are some core principles that include having very strong reporting practices so that any assaults, whether or not they result in physical injury or not, are reported to the employers so that they can understand what the burden is in the workplace and so that they can react to that. Another core principle is doing very rigorous hazard assessment to assess, in that physical environment or that social environment of that workplace, what

are the hazards for the workers and, therefore, what can be done from the employer's perspective to protect them. And then another core principle is the engagement of staff with management in identifying the solutions, given that they're the ones who are actually doing the job and they often can come up with solutions that the employer might not recognize. I don't know if you have anything to add to that, Mikki.

MIKKI HOLMES: I would add also the sharing of information once that data is collected, the importance of sharing it with the employees, especially those employees who are likely to get exposed with the key people who could benefit from it.

DON WRIGHT: Thank you, Dawn and Mikki. One final question and it actually focuses on violence in the school. So, I'll reach out to Linda Degutis or perhaps Paul Kesner from the Department of Education. Are there any good tools available, curriculum or videos, to teach youth about de-escalation techniques in the event of a violent event in the schools?

LINDA DEGUTIS: This is Linda. There are quite a range of school-based violence prevention tools and strategies that are being used. We're not recommending any specific single item, but they are quite a few that do have some evidence base. I don't know if Paul has something else he would want to add to that.

PAUL KESNER: Linda, I would say check out the <http://www.StopBullying.gov> site. There are resources there. There are some vignettes where examples are given of different ways of responding, some practice situations. It's an excellent resource and different resources that are based on the needs of a certain school or certain group are available there.

DAWN CASTILLO: And one other thing. The Blueprints document that I mentioned a bit earlier that has at least thirty demonstrated effective programs. If you go to our website, it has links to those programs. That's another place.

DON WRIGHT: Thank you, Paul and Dr. Degutis. There's one final question and I will answer it myself. We've had a large number of participants in today's webinar that have asked about Dr. Sondik's slides. Those slides will be posted on the NCHS's Healthy People website. You can reach that site by <http://www.cdc.gov/nchs/>. So, Dr. Sondik's slides will be available. Unfortunately, we've come to the end of our question-and-answer time, although we still have a number of questions cued up. At this time, I want to turn things over to Dr. Wanda Jones, the Principal Deputy Assistant Secretary for Health to close out today session.

WANDA JONES: Thank you, Dr. Wright and thank you to all the presenters. I think anyone tuning in to this webinar today couldn't help but really be appalled, but also to some degree very heartened. The impact of violence and injury across the lifespan is something that...you know, many folks think it's something for young people or they don't associate falls necessarily and yet we see these devastating numbers for the elderly. Many folks are not even thinking of the workplace and the range of violence and injuries that happen in the workplace. So, to look at this very holistic discussion today, to see these data and to really realize we have much work to do, but we've done a lot. We're beginning to build this evidence base. We're beginning to look forward and we're really taking steps forward so that I'm hopeful, by the end of the decade, that we will see some significant progress on some of these numbers. Really salute the partners because we, HHS, couldn't do this alone. Having the Department of Labor, the Department of Justice, the Department of Education working with us, in addition to many other partners

that our partners have, working on these projects is really helping us have greater impact than any of us could hope to have alone, as we leverage our resources, leverage our knowledge and really help people take the action they need to take to protect themselves, to protect their families and their communities. So thank you all very much for your commitment, for your insights, and for some of the issues and challenges you have so beautifully described today. We all have a lot of work to do, but I'm greatly heartened, as much as I am stunned by figures that we heard, that we could have all been medicated every four hours for a month because of the level of prescription drug painkiller usage. It's just astounding.

Thank you, Dr. Wright. Thank you to the Healthy People 2020 team. Let me turn it back to you, but thank Ed, as well--Dr. Sondik. You've been a long-time friend and colleague and have been a tremendous influence on my career and I just can't say enough for how much your presence in these Reviews has made a difference and the leadership that you've provided at the National Center for Health Statistics. So thank you. We wish you all the best you shift your priorities to your grandchildren, taking good care of the things that matter. Thank you really very much, it's really been a great pleasure and privilege to be involved.

DON WRIGHT: Thank you, and with that, we'll close out this month's Healthy People Progress Review on Violence Across the Lifespan.

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