

benefits for veterans of certain service in the United States merchant marine during World War II.

S. 268

At the request of Mr. BUMPERS, the name of the Senator from Arkansas [Mr. PRYOR] was added as a cosponsor of S. 268, a bill to authorize the collection of fees for expenses for triploid grass carp certification inspections, and for other purposes.

S. 275

At the request of Mr. GRASSLEY, the name of the Senator from Kansas [Mr. DOLE] was added as a cosponsor of S. 275, a bill to establish a temporary moratorium on the Interagency Memorandum of Agreement Concerning Wetlands Determinations until enactment of a law that is the successor to the Food, Agriculture, Conservation, and Trade Act of 1990, and for other purposes.

SENATE RESOLUTION 37

At the request of Mr. PACKWOOD, the name of the Senator from Maryland [Mr. SARBANES] was added as a cosponsor of Senate Resolution 37, a resolution designating February 2, 1995, and February 1, 1996, as "National Women and Girls in Sports Day."

ADDITIONAL STATEMENTS

DOMESTIC VIOLENCE AS A HEALTH CARE ISSUE

• Mr. SIMON. Mr. President, one of the finest things that has happened in the U.S. Senate since I've been here was the election of PAUL WELLSTONE.

I was reminded of that the other day when I was catching up on my reading and read in the magazine *Tikkun* his article on domestic violence as a health care issue.

It really goes beyond discussing it as a health care issue.

He talks about the necessity to have education and be sensitive and to protect all of our citizens better than we are now protecting them.

I ask to insert into the RECORD the Paul Wellstone article.

The article follows:

DOMESTIC VIOLENCE AS A HEALTH-CARE ISSUE
(Paul Wellstone)

Domestic violence is a crime. Surely this statement is not a matter of contention or debate anymore—or it certainly should not be.

But it wasn't too long ago that we did have to make the argument, because domestic violence was a secret, something that happened behind closed doors, a "family matter." Police would be called; they would arrive; and they would leave. And then they would be called again. And again.

Now, of course, it's different, because everyone knows that domestic violence is a crime as pervasive—if not more so—than murder, armed robbery, or drug dealing. The only argument now involves what to do about this seemingly intractable problem.

Domestic violence is a health-care issue. Now this is something new. Once this perspective on the problem is introduced, however, informed opinion-makers pause a moment, think about it, and say, "Oh, yes, of course it is."

But what are the implications of approaching domestic violence in this way?

Evidence indicates that domestic violence is the leading cause of injury to women, more common than auto accidents, muggings, and rapes by strangers combined. Indeed, it is the most frequent cause for women to seek attention at hospital emergency rooms. Not surprisingly, the health consequences of domestic violence include bruises, broken bones, birth defects, miscarriages, and emotional distress, as well as long-term mental health problems.

Although domestic violence touches men as well as women, we know that women and children are the primary victims. We know that the very place in which a woman and her children should feel the safest and most protected—their home—is all too often the most violent, dangerous, and even deadly place. The emotional and physical well-being of women and children is compromised when they suffer or witness abuse. And the costs are staggering.

As a member of Congress, steeped in the current health-care debate, I can't and won't let this information simply be stored away to be trotted out as factoids for rhetorical purposes: Congress is on the threshold of actually doing something to address the domestic violence health issue.

In the course of the national debate over health care, we have been hearing the arguments for comprehensive reform. The prevalence of domestic violence and the toll it takes on the nation's health are two of the reasons we need health-care reform that includes universal coverage, and a good, affordable package of benefits.

The victims of domestic violence are living, breathing, suffering women and children. They, along with other Americans who need care, give a soul to this debate that goes beyond technical discussions of "employer mandates," "hard and soft triggers," and all the other process jargon that so easily takes center stage in a Washington debate.

Health-care reform—to meet the needs of victims of domestic violence—needs to include universal coverage, elimination of pre-existing condition clauses, public-health efforts to prevent domestic violence, and training for health-care providers to identify, treat, and refer victims. It should contain a benefits package that includes a visit to a doctor who will routinely ask about abuse and violence in the family just as she asks about a history of smoking or heart disease.

Universal coverage would mean that a woman who stays in a relationship because she is dependent on an intimate partner for health coverage for herself and her children would know that coverage was guaranteed even if she left the relationship.

Leaving an abusive relationship is already terribly difficult; many of the women involved worry about not being able to support their children or themselves. Many are ashamed to let relatives know of the abuse. And, when women do leave abusive partners, they must worry that the rage behind the abuse will become homicidal. A woman seeking to leave an abusive relationship should not have to worry about loss of health insurance for herself and her children—especially when experience shows that victims of abuse are heavy users of the health-care system.

When congressional discussion turns to "universal coverage" as being only a goal, or meaning 95 percent (or so) of the population, I will be reminding my colleagues about these women and their children.

Along with universal coverage, we need to prohibit insurance companies from denying coverage to people because of preexisting conditions. Eliminating preexisting condition clauses would protect women who are

now denied coverage because their medical records explicitly indicate they have been battered, or because of repeated health problems that have occurred as a result of domestic abuse and violence.

The federal government should be a leader in developing and implementing innovative community-based strategies to provide health promotion and disease prevention activities for the prevention of violence by training providers and other health-care professionals to identify victims of domestic violence, to provide appropriate examination and treatment, and to refer the victims to available community resources.

This should include the development and implementation of training curricula that teach health-care providers to identify and name the symptoms, the promotion and importance of developing a plan of action should the abuser return, and how to refer their patients to safe and effective resources. Already we have taken some steps in this direction by adopting my Violence Reduction Training Act, which is now being implemented by the Centers for Disease Control and Prevention.

A comprehensive benefits package would include clinic visits that gather a complete medical history and entail an appropriate physical exam and risk assessment, including the screening for victims of domestic violence, targeted health advice and counseling, and the administration of age-appropriate immunizations and tests.

This type of clinic visit would mean that a doctor would ask about a history or incidents of violence as part of her regular medical history interview. Doctors already ask about their patients' medical history with cancer, smoking, diet, or heart disease. Sadly, family violence is not something about which doctors, or other health professionals, often inquire.

Some of my congressional colleagues and my constituents will continue to remind me that passing this type of health-care reform is going to be expensive. Of course it is. But we are already spending the money one way or the other. The annual medical costs alone of reported domestic violence injuries are astounding: A study conducted at Chicago's Rush Medical Center found that the average charge for medical services provided to abused women, children, and older people is \$1,633 per person per year. This would amount to a national cost of \$857.3 million. Many of these costs are borne by emergency departments—the most expensive way to provide these services.

As with the current discussion surrounding the criminal nature of domestic violence, we are now at the point of asking: given that domestic violence is a health issue, what do we do?

One of the important things that we can do is to pass comprehensive health-care reform that is universal, comprehensive, and affordable. By passing comprehensive reform, Congress will be taking an important step to prevent and reduce the incidence of domestic violence.

Passing health-care reform will not be a panacea for the victims of family violence. In the same way that police cannot solve the crime of domestic violence, health-care professionals are not going to solve this problem.

If we are to break this cycle of violence, we must recognize that all of us in the community are stakeholders. We all need to be involved: health-care providers, educators, business people, clergy, law enforcement officers, advocates, judges, media, and community residents.

But there is another level in this debate. Even if Congress enacts health-care reform and even if communities start to deal with this escalating problem, as a country we are still faced with a whole host of problems that we are only beginning to comprehend. For instance, we now have to ask about the responsibility of the healthcare community to provide leadership for community collaboration. And how should the role of health-care providers intersect with others in the community?

Furthermore, the provider is now confronted with serious ethical questions such as whether physicians should be mandated to report information about abuse and if so, to whom? Is the obligation to notify the law enforcement or legal systems greater than the responsibility to respect the victim's autonomy? If a victim asks that there be no action, should a doctor or nurse or therapist honor the request? And what are the responsibilities of health professionals with regard to the perpetrators? What is the role of neighbors who hear much too much through thin walls?

I don't have all the answers to these types of questions. Indeed, since we have just opened the door to this discussion, I'm not sure anyone does. But that, in part, is the point. We have now initiated this debate, and we have begun talking as a community—knowing full well that because of this conversation we will begin solving one of the most devastating social and medical problems facing every one of us.

For the last two years, my wife Shelia and I have been traveling throughout Minnesota, convening gatherings and attending events where such issues are being discussed. The conversations are having an impact. We are seeing community action throughout the state, and we are seeing a tremendous number of providers, judges, and police getting involved. My own experience in Minnesota makes me believe that similar efforts nationwide will also be successful.

We must begin this discussion with a sense of urgency—peoples' lives and safety are at stake. ●

ON ECONOMIST ARTICLE

● Mr. SIMON. Mr. President, a few months ago, we passed the dubious milestone of having 1 million inmates serving time in prison. That number is expected to soar further as Congress and the States respond to the public's fear of crime by enacting longer prison terms for drug offenders and other criminals.

Before we head full-steam down this prison-building path, I think we need to consider carefully whether we are being smart about how we punish criminals. Last year, I asked my staff to survey prison wardens around the Nation for their views on our crime policies. The results were surprising. Only 39 percent recommended building more prisons. But 65 percent said we should use our existing prison space more efficiently, by imposing shorter sentences on nonviolent offenders, and longer prison terms on violent ones.

A few States, such as Florida and Georgia, have begun to respond in this way. They have begun to look at innovative ways to free up prison space by sentencing nonviolent criminals to "intermediate sanctions," such as home detention and work release. As a recent

article in the Economist noted, these programs are highly cost-efficient. In Florida, for example, these alternative programs cost only \$6.49 per day per felon, compared with nearly \$40 per day for prison.

And, the programs don't compromise public safety. As the Economist reported, "A 6 year survey by the National Council on Crime and Delinquency shows that in Florida, people sentenced to such penalties are less likely to be arrested within 18 months of their release than similar offenders who had been sentenced to between 12 and 30 months in jail."

That is what I call being both tough on crime and smart. It is an approach Congress should consider before it spends billions more on another incarceration binge. I ask that the full text of the Economist article be reprinted in the RECORD.

The article follows:

[From the Economist, Nov. 19, 1994]

ALTERNATIVES TO PRISON—CHEAPER IS BETTER

RICHMOND, VA.—Self-preservation requires American politicians to be slap-'em-inside tough on crime these days. The argument for toughness stands on uncertain ground: the number of Americans in prison has more than doubled since 1982, now standing at over 1m, and yet notified violent crime has risen by two-fifths, according to the Federal Bureau of Investigation. Still, the voters want to lock the villains up, and the politicians reckon they had better get on with it. The next question is how much it will cost the taxpayer.

In Virginia, whose capital has the country's second-highest homicide rate, the General Assembly recently met in extraordinary session to lengthen prison terms for violent criminals and—like 13 other states and the federal government—to abolish discretionary parole for newly convicted felons. That needs nearly 30 new prisons. Some say this could cost \$2 billion. The new Republican governor, George Allen, says that the true cost is closer to \$1 billion, and that the state's prison population would anyway have doubled, without the new measures, by 2005.

But the Democrats who control the legislature balked even at that figure, and have given Mr. Allen only about \$40m to erect a handful of the work camps needed to accommodate the queue of prisoners waiting for space in the local jails. Mr. Allen, who has promised not to raise taxes, will have to go back to the Assembly next year and try to find the rest of the \$370m that he describes as a down-payment for safer streets. It costs \$19,800 a year to keep an inmate behind bars. It is doubtful whether the governor can raise what he needs by cutting expenditure elsewhere and selling off surplus state properties. Many state agencies are still operating on recession budgets. The sale of state land and equipment is expected to net a paltry \$26m.

On the other side of the country, in Oregon, where parole was abolished in 1989, a cheaper way of coping with over-full prisons is being tried. Oregon's voters are not keen on paying more, either: the advocates of tougher penalties for crimes against property failed to get enough signatures to put their proposal on the ballot last year, presumably because it would have cost \$300m a year. So the state legislature, in providing more money for the corrections department, said that most of it should go into alternatives to prison for non-violent offenders.

That would free some existing prison space for more dangerous criminals.

This approach has already been tried in states with some of the highest incarceration rates in the nation, among them Florida and Georgia. So-called "intermediate sanctions" for non-violent felons—for instance, house arrest or work programmes—are cheap. In Florida, they cost only \$6.49 per day per felon, compared with prison's near-\$40 a day. They may also be working. A six-year study by the National Council on Crime and Delinquency shows that in Florida people sentenced to such penalties are less likely to be arrested within 18 months of their release than similar offenders who had been sentenced to between 12 and 30 months in jail.

Texas, though, stays old-fashioned about its prison problem: it throws money at it. Twice this year, the Texas legislature has taken \$100m from other parts of the state government to pay for more prisons. The voters, who rejected a \$750m bond issue for schools, backed \$1 billion for the Corrections Department. The trouble is that new parole restrictions look like further increasing the demand for Texan prison space. In the Lone Star state, getting into prison may prove tougher than getting out of it. ●

ON PRISON WARDEN SURVEY

● Mr. SIMON. Mr. President, there has been much talk recently about rewriting last year's Federal crime bill. That talk has focused on spending billions more for prison construction and longer sentences, while drastically reducing funds for prevention programs.

I urge my colleagues to think hard about whether these changes represent smart policy. Last month, I conducted a survey of 157 wardens, and I asked them to comment on our present crime policies. By large margins, the wardens warned that our overwhelming emphasis on building prisons just isn't working. They urged a far more balanced approach to crime-fighting, that mixes punishment, prevention, and treatment.

The Daily Southtown, in a recent editorial, called on Congress to listen to the advice of these experts, rather than moving rapidly ahead with policies that may be politically popular, but ultimately shortsighted. That is a message we would all do well to heed.

I ask that this editorial be reprinted following my remarks.

The editorial follows:

[From the Daily Southtown, Dec. 8, 1994]

WARDENS' VIEW ON CRIME: MANDATORY SENTENCING WON'T SOLVE PROBLEM

Is "locking them up and throwing away the key" the most effective approach to reducing crime? Not if you listen to the prison wardens across the country who are in charge of the nation's inmates.

Some 157 prison wardens were surveyed by a U.S. Senate subcommittee, and 85 percent of them said the politically popular approach—mandatory, longer incarceration—didn't work.

The survey was conducted at the request of Sen. Paul Simon (D-Ill.). The survey showed that "the idea we can solve our crime problem by putting more people in prison just has not worked," Simon said. The senator said most of the wardens favored approaches