

Violence: A Public Health Epidemic

BY JANE H. WHITE

The nation's epidemic of violence has finally captured the attention of policymakers in Washington, DC. Significantly, in the final hours before its year-end recess, Congress passed the Brady Bill, instituting a five-day waiting period on the purchase of handguns nationwide and requiring states to conduct computerized background checks on the purchasers. This legislation, named for President Ronald Reagan's press secretary, James Brady, who was critically wounded in the assassination attempt on the president, has been introduced in nearly every session of Congress since 1987. The powerful gun lobby had prevented passage until now.

Enactment of the Brady Bill, signed into law on November 30, continues the historical focus on violence as an issue for the criminal justice community. In her role as the nation's chief law enforcement officer, Attorney General Janet Reno has brought increasing attention to the dire problems of violence in her outspoken testimonies before Congress and interviews with the press.

Moreover, attention to the growing epidemic of violence has spread beyond the criminal justice community to the healthcare sphere. President Bill Clinton linked violence to healthcare reform when he presented his reform proposal to Congress on September 22, 1993, referring to "the outrageous costs of violence in this country." The president has convened the Interdepartmental Work Group on Violence Prevention, which brings together leaders from seven cabinet agencies, including the Department of Health and Human Services (HHS), to work on the problem.

Healthcare leaders are stepping forward to offer a public health approach to preventing and "treating" violence, building on and complementing the criminal justice approach. HHS Secretary Donna E. Shalala recently noted, "Of all the health and human services challenges we face, perhaps the most devastating and, ironically,



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the most preventable is the epidemic of violence sweeping across the nation."¹ Surgeon General Joycelyn Elders, MD, testified before Congress this fall on violence and health, particularly the effects of television violence. The Atlanta-based Centers for Disease Control and Prevention (CDC) has placed a top priority on violence prevention. At the provider level, hospital trauma centers nationwide face daily the health implications of violence.

This article sets out the parameters of the public health approach to violence prevention as developed by leading CDC researchers. It also describes the attention to violence and the healthcare community's role in helping stem the tide of violence.

A PUBLIC HEALTH APPROACH TO VIOLENCE

A new vision for violence prevention has emerged from within the public health community. Many policy observers cite the October 1985 Workshop on Violence and Public Health convened by then Surgeon General C. Everett Koop, MD, ScD, as the public health community's first major consideration of violence prevention. In 1991 CDC formed its National Center for Injury Prevention and Control, which includes in its mandate the monitoring and researching of violence.

Mark L. Rosenberg, the national center's acting associate director for public health practice, articulates the parameters of the public health approach to violence prevention. In essence, "CDC has diversified its portfolio" to include many other issues besides traditional disease control, such as the prevention of smoking, injury, and violence, he said at a late October 1993 meeting in Washington, DC, on "Mass Communication and Social Agenda-Setting," cosponsored by the Annenberg Washington Program and the Harvard University School of Public Health.

Violence as a Public Health Issue Violence has become a public health problem for several reasons,

Rosenberg told participants at the October meeting. First, the magnitude of the impact of violence on the nation's health makes it a public health problem. The statistics are numbing. In the 1980s more than 215,000 Americans died, and 20 million received nonfatal physical injuries, as a result of violence.²

Violence affects certain population groups disproportionately. For instance, Rosenberg said, homicide is the number one cause of death for young black men and black women. Adolescents and young adults in general are another subgroup that violence disproportionately affects. Homicide is the second leading cause of death for Americans aged 15 to 34, and "the average age of both violent offenders and victims has been growing younger and younger in recent years," note CDC's James A. Mercy and colleagues.³ Other groups increasingly affected by violence include women, children, and the poor. For example, more than 1.5 million women seek medical treatment annually for injuries related to domestic violence.⁴

The health-related cost of violence to society is staggering. For instance, the lifetime cost of all firearm-related injuries in 1990 was estimated at \$20.4 billion by University of California, San Francisco, health services researchers Wendy Max and Dorothy P. Rice.⁵ Ted R. Miller, who directs the Safety and Health Policy Program at the National Public Services Research Institute in Landover, MD, and colleagues have developed lifetime cost estimates by crime category (rape, robbery, assault, arson, and murder). In total, they estimated that the medical and psychological costs per year for people aged 12 and older averaged \$10 billion (1989 dollars) for these five crime categories during 1987-90.⁶ Physical- and mental-health-related productivity losses resulting from these violent crimes totaled \$23 billion; and reduced quality of life was estimated at nearly \$145 billion, according to Miller and colleagues. Although some researchers in the criminal justice community believe these numbers are overestimates, they have been widely cited by CDC, the National Research Council of the National Academy of Sciences, and other healthcare groups.

Beyond the sheer magnitude of the impact of violence on the public's health, at the October meeting CDC's Rosenberg cited two additional reasons why violence is a critical issue for the healthcare community. He said that the public health approach to violence "complements the

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criminal justice approach. We focus on the prevention side," while criminal justice deals with the perpetrators of violence after the fact. Lastly, violence is a problem to be solved, "not a condition we have to accept," said Rosenberg. The public health community brings a rigorous scientific and epidemiological approach to problem solving and can offer new ways of looking at this issue.

Principles of the Public Health Approach The healthcare research community can bring an important, fresh perspective to the crisis of violence. Rosenberg set out three principal contributions of the public health approach at the October meeting.

First is a "paradigm shift to primary prevention" of violence, injury, and death, said Rosenberg. The criminal justice model reacts to violent activity. The public health approach aims to understand root social and behavioral determinants that may lead to violence and then takes steps to prevent such violence.

A second principle of a public health approach is to draw on and develop the scientific basis for effective prevention—"something that has been missing from this field."⁷

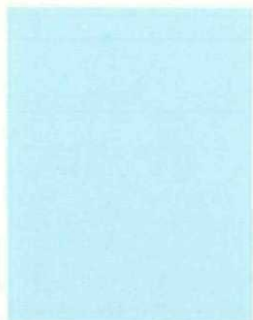
This scientific approach to prevention has four basic steps. These steps are not necessarily linear; public health policymakers and researchers may work on all four at once, explained Rosenberg at the October meeting. The steps are:

- To define the problem, which includes data collection and surveillance activities
- To identify risk factors and to ask the "why" questions
- To develop interventions, ask what might work, and then test the interventions
- To implement effective interventions, which includes demonstration programs, training, increased public awareness, and, most important, evaluation to understand the intervention's true effectiveness

The third important contribution of a public health approach to violence is that it brings together a diverse array of scientific disciplines, organizations, and communities, working on a common goal. The tradition in public health of "integrative leadership can [be important in helping] to build a national network" to work together on the epidemic of violence, said Rosenberg at the October meeting. "This approach," he noted, "is in direct contrast with our society's traditional response to violence, which has been fragmented along disciplinary lines and narrowly

focused in the criminal justice sector."⁸

Public health advocates point to the recent successes of this collaborative approach in preventing motor vehicle deaths, promoting designated drivers, and reducing cigarette smoking. For violence prevention, "the bad news is that there are no designated drivers in the gun area" and no easy prevention target, said Franklin Zimring of the University of California, Berkeley, at the October meeting. Zimring is widely cited for his pioneering scientific work on firearm research. He sug-



gested that a public health approach to reducing gun violence will more likely follow "the paradigm of trying to persuade people to give up cigarettes."

INCREASING POLICY LEADERSHIP ATTENTION

The urgency of the violence crisis in America has most recently gained the attention of policymakers in Washington, DC, and healthcare leaders nationwide. Through a nationwide campaign to educate physicians and heighten public awareness, the

ROLE OF THE HEALTHCARE COMMUNITY

Former Surgeon General C. Everett Koop, MD, ScD, issued a call to the healthcare community in 1991: "The professions of medicine, nursing, and the health-related social services must come forward and recognize violence as their issue and one that profoundly affects the public health" (see C. Everett Koop, "Foreword," in Mark L. Rosenberg and Mary Ann Fenley, editors, *Violence in America: A Public Health Approach*, Oxford University Press, New York City, 1991, p. v). Since then, some progress has been achieved; in particular the American Medical Association has mounted a nationwide campaign to increase physician recognition of violence. But much remains to be done.

For hospitals, the trauma center is the point of entry for most violence victims. "Although the delivery of trauma care to the victims of violence does not address any of the underlying social causes of that violence, the trauma system is an essential component of a unified response to violence," explained trauma surgeon Donald D. Trunkey, who is professor and chairperson of the Department of Surgery, Oregon Health Sciences University ("Impact of Violence on the Nation's Trauma Care," *Health Affairs*, Winter 1993, pp. 162-170). "Nearly 55 percent of trauma deaths occur instantly after injury. Since it is impossible to treat these fatal injuries in a timely fashion, the only practical way to address these deaths is through

prevention. Prevention also would have a profound impact on early and late deaths within the hospital and would even reduce permanent disability," continued Trunkey.

Thus strengthening the U.S. trauma system would be one step forward for the healthcare community in addressing violence. Currently only about 25 percent of the country's geographic area is served by trauma systems. Additionally, Trunkey noted that a number of hospitals have closed trauma units in recent years, primarily for economic reasons, including perceived cost of uncompensated care, high operating costs, inadequate reimbursement from public assistance programs, and reduced compensation for trauma patients under the Medicare prospective payment system. Among the top five reasons for closing trauma centers is that physicians are unwilling to be on call.

Anne Flitcraft, MD, of the University of Connecticut Health Center, calls on the medical community to take primary, secondary, and tertiary prevention steps to address domestic violence. For primary prevention, she says, the healthcare community must address barriers to physicians' participation in recognizing and treating domestic violence and must "recognize ways in which the medical profession may be helping to perpetuate a harmful environment" ("Physicians and Domestic

Violence: Challenges for Prevention," *Health Affairs*, Winter 1993, pp. 154-161). A positive step in this regard was the formation of the National Coalition of Physicians against Family Violence, with more than 75 member organizations.

Secondary prevention occurs at the doctor-patient encounter level and includes identification, validation, appropriate early intervention, assessment and treatment of medical needs, and referral to law enforcement and/or community-based domestic violence services. Flitcraft urges a broad range of healthcare disciplines, including nursing and social work, to work together to improve interventions.

Hospitals and systems become involved at the level of tertiary violence prevention. However, Flitcraft noted, "The role of health care organizations in a comprehensive response to domestic violence is the least developed." The Joint Commission on the Accreditation of Healthcare Organizations expanded its guidelines in 1992 to encourage hospital staff education and protocols on domestic violence. Beyond these guidelines, however, Flitcraft believes that "tertiary prevention of domestic violence will require health care organizations to incorporate and invest in crisis intervention, emergency hospitalization for shelter, counseling, support groups, and advocacy, rather than simple identification and referral."

American Medical Association (AMA) is placing a priority on violence as an issue that affects the population's health. At its June 1993 house of delegates meeting, AMA presented two major reports on family violence: first, relating it to alcohol and drugs; and second, setting out a framework for understanding the psychological impact of violence on individuals. A year earlier, AMA devoted two issues of *JAMA* to violence and health.

Congress convened several hearings in fall 1993 on the health implications of violence, particularly relating to the impact of television violence. Congressional activities culminated in the passage of the Brady Bill in late November—a Thanksgiving gift to the nation, representing a loosening of the gun lobby stranglehold on Congress.

The Clinton administration has also placed a high priority on violence prevention. The president's Interdepartmental Work Group on Violence Prevention will coordinate federal anti-violence efforts and will report to the president early this year. The group is cochaired by Peter Edelman, counselor to the HHS secretary, and Philip Heymann, deputy attorney general.

The violence prevention group is subdivided into six areas: youth violence, family violence (including child abuse, domestic violence, and elder abuse), intercommunal or hate violence, sexual assault, firearms, and positive and negative influences of media. Each subgroup is preparing a report that will cover the problem's size and scope, current policies and programs (both public and private), proposed federal and other sector remedies, and a research and evaluation agenda.

According to Shalala, some goals of the violence prevention group are to improve antiviolence curricula and mediation training in schools, create youth development initiatives, improve the use of alternative interventions and sentencing for youth showing promise of changing their violent behavior, support community-based efforts to prevent violence and eliminate hate crimes, prevent family violence through a stronger emphasis on family preservation, support strategies to reduce gun violence, work with the media to deliver antiviolence messages, examine the connection between substance abuse and violence, support evaluations of prevention strategies to learn what works best, and assist local law enforcement efforts.⁹

Edelman and CDC Administrator David Satcher discuss the hopes of the federal task force:

A public health approach "brings a new set of ideas and, importantly, a new set of people getting involved in the issue of violence," said Harvard University's Mark Moore.

If we are successful in these efforts, the benefits will be enormous. Most important will be the lives saved, the injuries and disabilities prevented that would have resulted from violence, and the improved quality of life in our communities. There will also be economic savings. . . . These benefits will be immediate; we will not have to wait 20 or 30 years to see the results of prevention efforts as we do with other public health problems such as heart disease and cancer.¹⁰

NEW IDEAS AND PEOPLE

Many leaders in the criminal justice sector welcome the addition of the healthcare community as an ally in addressing violence. A public health approach "brings a new set of ideas and, importantly, a new set of people getting involved in the issue of violence," said Mark Moore, professor of criminal justice policy and management, Harvard University, at the October meeting. A heavy emphasis on prevention may be easily misconstrued as "blaming the victim"; thus care is needed in implementing violence-prevention activities.

This is not to suggest that solving the problem of violence is the sole responsibility of the healthcare community. Rather, what we in healthcare can do is to build on the efforts of the criminal justice sector and offer new insights and perspectives into this dire societal issue. The highest levels of government are now taking steps to tackle this public epidemic. It is critical that the healthcare community be part of this effort as well. □

NOTES

1. Donna E. Shalala, "Addressing the Crisis of Violence," *Health Affairs*, Winter 1993, pp. 27-30.
2. James A. Mercy et al., "Public Health Policy for Preventing Violence," *Health Affairs*, Winter 1993, pp. 7-29.
3. Mercy et al.
4. Anne Flitcraft, "Physicians and Domestic Violence: Challenges for Prevention," *Health Affairs*, Winter 1993, pp. 154-161.
5. Wendy Max and Dorothy P. Rice, "Shooting in the Dark: Estimating the Cost of Firearm Injuries," *Health Affairs*, Winter 1993, pp. 171-185.
6. Ted R. Miller, Mark A. Cohen, and Shelli B. Rossman, "Victim Costs of Violent Crime and Resulting Injuries," *Health Affairs*, Winter 1993, pp. 186-197.
7. Mercy et al.
8. Mercy et al.
9. Shalala.
10. Peter Edelman and David Satcher, "Violence Prevention as a Public Health Priority," *Health Affairs*, Winter 1993, pp. 123-125.