

Violence: A Community Health Approach

By JOHN MORRISSEY

Violence permeates every corner of our society, from trauma within families to abuse of intimate partners to confrontations in schools and neighborhoods. The direct injury is usually evident, often graphic and sometimes sensationalized. But the siege mentality and health consequences stemming from violence experienced, witnessed or feared are wounds in their own right.

For health care systems now accountable for people's health instead of just acute ills, violence looms as a risk factor complicating odds of success.

"In a number of ways, both directly and indirectly, we know that violence has an impact on health, and therefore the health care system," said Rachel Davis, managing director at Prevention Institute, Oakland, California. "Directly, it contributes to injury, disability and premature death. We also know that violence is linked with mental health problems — for example, post-traumatic stress disorder, major depressive episodes."

The side effects of violence include extra stress on health care operations.

"Among high utilizers in the health care system, some of the common characteristics include a history of violence, substance abuse and mental health problems," Davis said. "So for a hospital system to understand that this is one of the likely contributors to high utilization is really important."

Preventing violence is becoming a priority of Catholic health care's mission focus on health disparities of the poor and vulnerable. Englewood, Colorado-based Catholic Health Initiatives, for one, has identified violence as "one of the greatest threats to healthy communities: It's a threat to

human dignity, it's a threat to health, it's a threat to social systems," said Diane Jones, CHI's vice president for healthy communities. Commitment to nonviolence is "inherent in the charism of our founding religious congregation," she added.

Remedial responses typically involve shielding people from further exposure to the violence already rampant in their world and patching up and counseling the injured individuals. Those interventions cover secondary prevention, which seeks to avoid the violence that's out there, and tertiary prevention, or mitigating the damage already done. These protective endeavors are essential to reduce human suffering, but increasingly they are seen as no longer enough.

To make a dent long term, experts say, the strategy has to include primary prevention. That means tackling environmental and economic opportunity shortcomings endemic to violence-prone areas, in efforts to thin out the crushing layers of stress and tinderbox-sparking influences that result in violence.

LEARNED BEHAVIOR

"Most violence is not inevitable, it's preventable," Jones asserted. A learned behavior, it can be "unlearned" or headed off outright by understanding what increases the risk of violent behav-

ior and fostering enough resilience to those risks — among individuals, within their family and social net, and throughout the community — to counteract the stress, she said.

Jones said CHI “will always take care of victims, that’s part of what we do. But if we really are going to make a systemic difference in the world, we need to prevent violence before it occurs. We need to figure out how to move upstream: Just as we look to prevent disease and disability, we need to figure out how to prevent violence.”

In areas as urban as West Baltimore and as Middle America as Des Moines, initiatives are reclaiming abandoned housing, addressing conditions that spawn gang activity and ramping up job opportunities in high-unemployment zones.

Violence often follows injured victims and perpetrators into the hospital, causing safety and productivity issues.

CHI already has committed millions of dollars to specific primary prevention aims, said Colleen Scanlon, senior vice president and chief advocacy officer, who leads CHI’s violence prevention initiative. Across the country, she said, “others are beginning to recognize that a commitment to violence prevention should be a part of the work of a health care system, if we are really about building healthy communities.”

HEALTH EFFECTS

Ample studies connect violence with higher rates of chronic illness, stunted brain and physical development in children exposed to constant, toxic stress, mass retreat into unhealthy eating and exercise habits and a breakdown of community resolve to help one another cope.

Neighborhood fear can slow physical activity to a crawl, said Amy Hetheron, marketing and communications director of Wheaton Franciscan-Iowa, Waterloo. “We have had people say, ‘I would like to walk more, but my neighborhood’s not safe.’ So that’s a good example of the expectation of patients today, to engage in their health care and to be a part of the solution as well. They’re a part of reducing health care costs, too, and so they have to take accountability for their actions.

If they want to walk and want to get out, but they don’t feel safe, then that adds fuel to the fire.”

Davis said, “When there is violence or fear of violence, there’s a disinvestment in those communities. So for example, supermarkets might be less willing to locate in those neighborhoods, and we know there is a correlation between supermarkets and eating more fruits and vegetables.”

Most of all, she said, “Violence and the fear of violence really diminishes social networks and trust,” which are “a necessary component of a community’s being able to come together and act on behalf of the common good.” Lack of neighborhood cohesion contributes to a fivefold increase in incidence of violence, said Davis. A dearth of employment also is a contributor.

“Lack of economic opportunities is a risk factor for child maltreatment, intimate partner violence, sexual violence, youth violence and suicide,” she said.

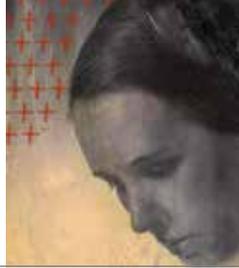
Ultimately, the ramifications of violence spill over into hospitals. A study presented at an American Public Health Association annual meeting¹ showed that 1 in 3 hospitalized gunshot victims were uninsured and Medicaid covered 27 percent, at a mean charge per admission of \$59,620. Lifetime health care costs for women who have been battered are much higher than for those who haven’t been, said Davis, “and this continues to be true even after the battering has ended.” And violence often follows injured victims and perpetrators into the hospital, causing safety and productivity issues. (See sidebar, page 11.)

COMMUNITY FRAMEWORKS

The Prevention Institute published a framework for addressing and preventing community trauma, recommending a focus on three areas in particular:

- Improving the physical environment, reducing deterioration and creating space for positive interaction
- Building a strong social-cultural environment to counter the symptoms of community trauma and support healing and connection among people
- Bettering economic opportunities for youth and adults in highly affected localities to include job training and placement for youth and for formerly incarcerated members of the community

These undertakings may seem well beyond the



scope of health care systems, but in West Baltimore, Bon Secours Hospital has been hard at work on all of them for years, even decades. Neighborhood decay, joblessness and violence-related stress, all affecting health in the community, provoked the institution into rehabbing and renting thousands of abandoned buildings, establishing a community site for job training, job place-

ment and social services, and turning trashed-out vacant lots into inviting green spaces.

The big picture envisions hospitals and neighbors as “partners in co-creating healthy communities,” said Curtis Clark, vice president of mission for Bon Secours Baltimore Health System.

In Baltimore, “We’re taking care of the need that presents itself, and in this community that’s

VIOLENCE VISITS HEALTH CARE SETTINGS

As hospital systems assess whether or how to move out into community-oriented prevention of violence, they can’t overlook the threats accruing in their own patient-care settings. Consequences of community chaos, from gang-related gunfights to the opioid addiction crisis, walk in off the street — or are carried in — and put health care personnel at risk. It isn’t a new problem, but it has been getting bigger.

A study published in April 2016 catalogued the rise of workplace violence in health care, especially among the front-line nurses and other personnel staffing emergency departments. The *New England Journal of Medicine* article¹ by James Phillips, MD, an attending physician in the emergency department at Beth Israel Deaconess Medical Center, Boston, described the workplace violence as “an underreported, ubiquitous and persistent problem that has been tolerated and largely ignored.” His research indicated nearly 75 percent of all workplace assaults between 2011 and 2013 occurred in health care settings. Nearly 40 percent of nurses reported verbal assaults, and 13 percent reported physical abuse.

The journal’s report echoed a study a year earlier from the Centers for Disease Control and Prevention² on occupational traumatic injuries among workers in health care facilities. From 2012 to 2014, injuries associated with

workplace violence increased from 4 percent to 5 percent for every 10,000 worker months. During that span, violence nearly doubled for nurses and nursing assistants. And nursing assistants had more than twice the rate of workplace-violence injury (14 percent) as nurses (6 percent).

As part of overall guidance to its ministries on how to create a safe and healing environment, Catholic Health Initiatives, based in Englewood, Colorado, includes “how to deal with situations of violence — what we can do to reduce the incidence of that, de-escalate these kinds of behavior,” said Colleen Scanlon, senior vice president and chief advocacy officer. “And if the violent event does occur, what kind of things do you do to make everyone else safe and secure, have appropriate resources and personnel on hand?”

Sometimes the appropriate resources have come to include a presence of security officers, and not just in predictable urban environments. In rural Seymour, Indiana, the CEO of Schneck Medical Center made the decision to post armed guards around the clock starting Feb. 1, 2016, after a series of discussions with staff members about violence that frequently got emotional.

The CEO, Warren Forgey, remembers “nurses in tears, saying, ‘This is not what I became a nurse for, I wanted to take care of people, but they won’t

let me take care of them, I’m now in fear, I don’t want to come to work.’”

“We have staff members who have been hit, bitten, spit upon, items thrown at them, in addition to the verbal abuse.” The vast majority of the attacks come from people addicted to opioids and seeking — or demanding — to replenish supplies.

The stress is double when workers come in from a violence-prone neighborhood, said Aliya Jones, MD, chair of the Bon Secours Hospital Department of Behavioral Health. In West Baltimore, workers bring their stressful life with them, she said, and “don’t have the same amount of emotional reserves as the ones who get to go home to the suburbs ... and don’t have to worry about paying their bills or taking care of their children, or if their parents are safe and well. They’re expending emotional reserves all day long.”

— John Morrissey

NOTES

1. James P. Phillips, “Workplace Violence against Health Care Workers in the United States,” *The New England Journal of Medicine* 374, no. 17 (April 28, 2016): 1661-69.
2. Ahmed E. Gomaa et al., “Occupational Traumatic Injuries among Workers in Health Care Facilities — United States, 2012-2014,” *Morbidity and Mortality Weekly Report* 64, no. 15 (April 24, 2015): 405-10.

been what we understand now as these very grave social determinants of health,” Clark explained. “They’ve been at our front door for a long time, so while we are a mission-driven organization, and that really is the heart of who we are, a lot of our work has to do with geography. It just simply is where we sit.”

The prevention mission at CHI, which crystallized in 2009 as the intra-system program United Against Violence, has put down roots in 35 locations across 13 states, fueled by \$15 million in seed

Green spaces are a source of community pride, so much so that workers say drug dealers respect the effort and do not accost them or intrude on the area being cleaned up.

funding authorized by system leadership. The initiatives vary according to what each community has determined as its own top priority: youth violence in Lexington and Bardstown, Kentucky; Tacoma, Washington; Colorado Springs and Des Moines, Iowa; family violence in Pueblo, Colorado; Garden City, Kansas; Baudette, Minnesota; and Grand Island, Nebraska; neighborhood violence in Dayton, Ohio; intimate partner violence in eight North Dakota cities.

After more than seven years of intense organizing, “We have truly gotten to the point where it’s part of our DNA,” said Scanlon. “The organization (through the efforts of United Against Violence) knows that CHI is really living that commitment out, that we have dedicated resources and time and personnel, financial resources as well, to try to bring this commitment to life in a very meaningful and effective way in the communities that we serve.”

The things to try are legion, but the potential for positive results appears to be significant when people are given the chance to be gainfully employed, trained for moving up in the work world and counseled to overcome barriers to staying out of trouble. In cities such as St. Louis, and throughout the CHI violence prevention initiative, programs in the schools, from elementary through high school, have been shown to chip away at the social and cognitive risk factors for being violent or victimized.

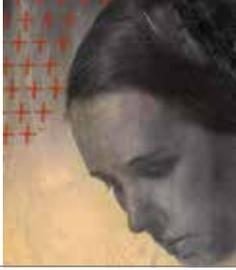
NEIGHBORHOOD CLEANUP

At one point in the 1990s, there were 7,000 vacant properties in West Baltimore. The three blocks leading up to Bon Secours Hospital were two-thirds vacant, said George Kleb, executive director of housing and community development for Bon Secours Baltimore. The hospital purchased a critical mass of residential properties to redevelop housing in a big way, and it converted a former school property into a service center to support people moving into the new housing, as well as the broader community, Kleb said. Then it reached out to community residents to decide on the next steps in rejuvenating the neighborhood.

One problem given high priority was the proliferation of empty lots, a haven for criminal activity and breeding ground for vermin, as well as being a community black eye. A relatively simple solution addressed neighborhood deterioration, joblessness, lack of education and rehabilitation of ex-convicts. Called Clean and Green, the program, funded by the city, uses landscaping as an intervention. Every six months, it hires four workers, usually men ages 18-24 who are at particularly high risk of being mired in the violence subculture, to clean up lots and learn skills to improve their community, said Talib Horne, executive director of Bon Secours Community Works, the services provider located at the former school property. He has heard from many individuals that if they could make more than the \$10 an hour they get as drug sellers, they would give up dealing on street corners. The program pays \$11 an hour.

The city funding pays to clean up and maintain about 50 lots a year. About 600 have been turned into parkland so far, after which the lots are transferred to community associations. Green spaces are a source of community pride, said Horne, so much so that workers say drug dealers respect the effort and do not accost them or intrude on the area being cleaned up. The workers themselves receive other benefits such as help passing a high-school-equivalency exam and an education in financial basics.

Often the work force is drawn from people getting out of prison or juvenile detention, a community-designated priority population. A program for incarcerated members of the community visits three state jails to start the process of re-entry. A



van picks up people upon their release on parole, and the next day they are signed up for job readiness skills, housing, child support advice, substance abuse counseling — whatever their barriers to success are, said Horne.

TARGET POPULATIONS

Other cities have emphasized targeting young people ages 16-24 in high-crime areas. In St. Louis, a city program provides high-school-equivalency exam prep, which reduces the likelihood of committing crimes by giving the target population more options, said Carl Filler, the mayor's director of strategic policy initiatives and community partnerships and who also heads violence prevention programs.

The city opens bank accounts for people with a stable record of employment, teaching financial literacy “so they don't get in trouble with payday loans,” he said. A jobs program employs 1,500 young people per year.

Health care can be an employment haven, Filler added. Youth who are undecided on a job path often are advised to get into health care because it is a growing field, pay is good and they can start as a nursing assistant without more than a high school education and move up.

A Bon Secours program in Baltimore trains residents to be certified nursing assistants or geriatric assistants and afterward get placed in jobs under a partnership with local nursing homes and hospitals, said Horne. The goal is to find employment at a livable wage for 90 percent of those who pass the certification exam, partly by customizing entry-level training to actual positions in demand.

FOCUS ON CHILDREN

The success of primary violence prevention hinges significantly on starting early. Adverse experience, especially in early childhood, “violates that brain development as well as physiological development and has long-term impact,” said Jones of CHI.

The landmark “ACE” study conducted from 1995-1997 by the Centers for Disease Control and Prevention and Kaiser Permanente² on adverse child experiences, including exposure to violence, showed that after four or more such experiences “without the compensatory factors in place,” aver-

age life expectancy is 20 years shorter, said Davis of Prevention Institute.

Evidence-based and evidence-informed processes have been proven to increase the resilience of children to family and community factors playing into physical and emotional trauma, said Jones. For example, home visitation by professionals experienced in teaching parenting skills and encouraging child activities can make a sizable impact on having children grow up to be non-violent and healthier, she said.

School life can be an incubator of violence, but it also can offer a chance to learn alternatives while increasing the odds of reaching working age with the proper education and life skills to be gainfully employed. Many of the CHI initiatives are set in and around school, taking on bullying, dating relationships, early substance abuse and gang recruitment and violence.

In Tacoma, a focus on youth violence and school suspensions or expulsions for violent behavior was able to demonstrate big reductions

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in bullying and suspensions for it, through a concentrated effort, CHI's Jones said. Some actions were elementary: Replacing a swath of broken concrete at an apartment complex with an athletic field gave kids “a healthy way to express their feelings, good, bad and indifferent, and they had an organized approach and were able to play soccer,” she said.

Besides getting along, more kids affected by the Tacoma program stayed in school, which is becoming recognized increasingly as a must for success as they reach adulthood. In St. Louis, where a high number of suspensions were being dished out at public elementary schools, a program analyzed school policies and trained school staff to “work to reduce those disproportionate

suspensions, knowing that for elementary school students, it doesn't seem like there are a lot of good reasons to have them in an out-of-school suspension," said Filler.

The cause of primary prevention needs to be concerned with "keeping people engaged in school in spite of what may be some of the challenges that they're having," said Davis, "and how we are connecting school to career, for example, and putting the support in place not just for the individual but also fostering the social connections and networks at the community level."

GRASSROOTS PERSPECTIVE

Health care systems can be conveners and facilitators of substantive anti-violence efforts, as long as they don't presume too much about a preferred direction. Bon Secours learned that after convening meetings with neighborhood residents.

"Our strong feeling was that drugs and drug-related crime would be the No. 1 issue," said Kleb. "But when we went to vote on it with our community partners, there was an overwhelming landslide for rats and trash." Though initially that seemed a head-scratcher of a preference, at second glance the connection was clear: Illegal activity and associated violence tended to happen in neglected areas where dealers could operate with anonymity, he explained.

It was a lesson in scrapping the top-down, problem-focused culture of health care diagnosis and delivery in favor of a grassroots perspective.

"We had to really learn to listen and follow, and in the end, we engaged more people in [the priorities of] rats and trash, cleaning up and planting trees, making improvements to lots and things like that, than we ever would have if we were starting down drug dealers on the corner," Kleb summarized. "So it was definitely a cultural change."

CHI sees violence as an epidemic and a public health matter, "and because it's a public health issue, we believe it's preventable," said Scanlon. "We want to work with communities on that prevention, but we see ourselves as a partner in identifying and designing and implementing the violence prevention plan."

Often a focus emerges from "a very serious or profound incident of violence," she said, but absent that impetus, patterns of types of violence for consideration can be gleaned from public health agencies, law enforcement, community organizations or perhaps universities with public health schools.

Smaller health care systems with limited ability to dive into violence mitigation and prevention can identify existing programs to support financially and with in-kind resources, said Hetherington of Wheaton Franciscan-Iowa. For example, a community health needs assessment by Covenant Medical Center, Waterloo, one of three system hospitals, identified violence as a problem in the Cedar Valley area based on interviews with community organizations, schools and churches and information gathered after citizens filled out questionnaires.

Although violence was deemed outside the scope of Covenant's provider mission, the health system has reached out to area initiatives related to violence that needed its assistance. "We can't tackle violence (prevention) on our own, so this is one way we can support it," Hetherington said.

For the University of Northern Iowa in Cedar Falls, the hospital used its printing facility to publish student pamphlets by the local Sexual Assault Response Team (SART) on scenarios of what constitutes date rape and abuse, along with information of SART health care locations and rape crisis hotlines. For the area YWCA, it supported bringing in Ruby K. Payne, PhD, co-author of *Bridges Out of Poverty*, to do workshops on the root causes of poverty and associated violence.

A common thread in violence prevention is the belief that any effort, large or small, adds up.

"No single strategy can do a ton; taken in concert — transportation, education, employment — all those pieces together start to add up and chip away at a problem that initially seems a daunting task," said Filler.

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NOTES

1. Min Kyeong Lee et al., "Longitudinal Trends in Firearm Related Hospitalizations in the United States: Profile and Outcomes during the Years 2000 to 2008" (presentation at American Public Health Association annual meeting, Boston, Nov. 4, 2013), apha.confex.com/apha/141am/webprogram/Paper286262.html.
2. Vincent J. Felitti et al., "Relationship of Child Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults," *American Journal of Preventive Medicine* 14, no. 4 (May 1998): 245-58.

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