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Strengthening the Collaboration between Public Health and Criminal Justice to Prevent Violence

By Deborah Prothrow-Stith

Over the last two decades in the United States, I, public health practitioners, policy makers, and researchers have charted new territory by increasingly using public health strategies to understand and prevent youth violence, which has traditionally been considered a criminal justice problem. The utilization of public health approaches has generated several contributions to the understanding and prevention of violence, including new and expanded knowledge in surveillance, delineation of risk factors, and program design, including implementation and evaluation strategies.

While public health activities generally complement those of criminal justice, confrontations, challenges and turf issues within this cross-disciplinary enterprise remain inevitable. Continued progress is dependent upon expanded efforts and greater collaboration within both disciplines. This article addresses two objectives that have implications for future research and prevention activities:

- Review the history and implications of addressing violence as a public health problem; and

- Compare and contrast public health and criminal justice approaches to violence.

VIOLENCE AS A PUBLIC HEALTH PROBLEM

Understanding Public Health

Before discussing the role of public health in violence prevention, it is important to explain what is meant by public health because polling data show that there is not widespread familiarity with the profession.[1] Contrasting medicine with public health is illustrative and provides a context for understanding the basic tenets and approaches within public health.

Harvey Fineberg, former Dean of the Harvard School of Public Health and current President of the Institutes of Medicine, highlights several important distinctions in his momentous comparison of the two disciplines as shown in Figure 1. Medicine responds to the health problems (diseases) of individuals with efforts to treat, cure, reduce harm

and prevent further complications. In contrast, public health addresses the health problems of populations (neighborhoods, cities, states, age cohorts, employee groups) using epidemiology to identify the major problems, understand risk factors, follow rates of morbidity and mortality, design implement and evaluate programmatic and policy oriented prevention strategies.

 [FIGURE 1 OMITTED]

In addition, the basic sciences of medicine (physiology, pathology, anatomy, histology, etc.) are substantially different from those within public health (epidemiology, economics, sociology, political science, behavioral sciences, etc.) Also, public health in the United States is a much younger discipline than medicine with a less well funded and developed infrastructure.[2] However, despite its relative youth, public health is responsible for many of the contemporary contributions to increased longevity and holds substantial promise for similar impact on violence prevention.

The Case for Addressing Interpersonal Violence Using Public Health Strategies

There are at least four reasons why interpersonal violence became an important concern for public health professionals in the United States: (1) the contact health professionals have with victims and perpetrators of violence, (2) the magnitude of the problem, (3) the characteristics of violence, and (4) the application of public health strategies to both understanding and preventing violence which has yielded significant positive findings and offers further promise.

Contact with Victims and Perpetrators

In 1978, in a fairly common emergency room experience, a patient threatening to go out and seek revenge after being treated for injuries received during a fight precipitated a physician's search for prevention strategies.[3] "Stitch them up and send them out" was the standard of care at that time. Nevertheless, the predictable and regular contact physicians and nurses have had with victims and perpetrators of violence, particularly in emergency departments, has caused many to begin to address this problem.

To this day, emergency room recidivism and the high mortality rates associated with violent injury continue to compel medical personnel toward violence prevention efforts. The American College of Emergency Physicians has included violence prevention on the agenda of their annual meetings since the late 1980s. The *Journal of the American Medical Association* has annually published a special issue of its journal dedicated to violence since 1998. The American Medical Association has published protocols and manuals for health providers on domestic violence, youth violence, child abuse, and rape and sexual assault.

New strategies, materials and protocols for clinical intervention and prevention are regularly introduced and evaluated reflecting the responsiveness of health care providers to the repeated contact they have with the tragedy of violence.

Magnitude of Violence

Homicide rates in the United States are mind boggling when compared to those of other industrialized nations not at war. Not only is the United States homicide rate 10 to 25 times higher than most industrialized nations, but the homicide rates actually rival some less developed countries facing war or considerable social, political, and economic turmoil.[4] The only good news in the disproportionately large rates of homicides in the United States is that it validates the preventable nature of violence.

Nonfatal episodes of violence are also a significant part of America's tragedy. The United States Federal Bureau of Investigation estimates that 1.8 million Americans are victims of violence each year with adolescents at the greatest risk for victimization.[5] Homicide is the leading cause of death for African Americans ages 15-24 and the second leading cause of death for all adolescents 15-19.[6] A complete representation of the magnitude of violence is not available, however, because there are not reliable and consistent measures of nonfatal episodes of violence. In a biannual national survey of 13,000 adolescents, the Youth Risk Behavioral Surveillance System (YRBSS), 33% of respondents reported being in a least one physical fight in the previous year (boys 43% and girls 24%) and 4% reported being medically treated for injuries sustained in a fight during that same time period.[7]

Unreported and poorly reported episodes of violence (including intimate partner violence, child abuse, school assaults, etc.) represent an even larger part of the burden of injury requiring public health attention.

Characteristics of Violence in the United States

Public health strategies are required for violence prevention because criminal justice strategies primarily target stranger violence committed during another crime, not the significant problem of acquaintance, family and intimate violence. Contrary to the stereotype, much of the violence experienced in the United States occurs among people who know each other. A typical homicide in the United States involves two people who know each other, are under the influence of alcohol, get into an argument and have a handgun. In homicides of children and adolescents (0-17) in the U.S., 22% are killed by a parent, 5% by another family member, 36% by an acquaintance and 11% by a stranger.[8] Even in the unlikely situation where all of 25% classified as an unknown relationship were all committed by strangers, the majority are committed by family, friends and acquaintances.

In the cases of homicides and violence against women, the acquaintance nature of violent injury is even more compelling. According to the 2000 National Crime Victimization Survey, 62% of rape and sexual assaults came at the hands of a person the female victim called a friend or acquaintance with 18% identified as intimate partners.[9] In the National Violence Against Women Survey, 25% of the women said that current or former spouses,

cohabiting partner, or a date had raped or physically assaulted them during their lifetime.[10]

The stability of the significant presence of acquaintances, friends and family among the perpetrators of violent injury (rape, assaults and homicides) begs for prevention strategies beyond aggressive criminal justice efforts of blame and punish. Prevention in the setting where a victim and perpetrator know each other requires the policy, public awareness and education, and change in social norms that fall under the purview of public health.

Application of Public Health Strategies

Over the last two decades, public health professionals have applied traditional public health strategies to violence prevention. They have brought a different perspective and orientation to bear on the problem by applying public health techniques and strategies which complement and strengthen the criminal justice approach. Public health brings an analytic approach that identifies risk factors and important causes that could become the focus of preventive interventions.

Major risk factors for youth violence have been identified as outlined in Figure 2. These factors operate at different levels as illustrated in Figure 3. The individual and family levels have not only been the primary focus of research on violence, but also have dictated the public policy responses to violence. These risk factors, understood through the population-based approach of public health, highlight the importance of the macro influences such as poverty at the neighborhood level, gun availability and social norms. The larger circles of community, society and world influences come into greater focus through public health lens.

Figure 2. Risk Factors for Youth Violence

- Poverty and Income Inequality

- Access to Guns

- Alcohol and Other Drug Use

- Witnessing Violence and Victimization

- Biologic/Organic Abnormalities

- Social and Cultural Factors/Culture of Violence

Adapted from Murder is No Accident, Prothrow-Stith 2004

[FIGURE 3 OMITTED]

Public Health Defines Violence

A prevailing definition of violence within the public health profession was offered by the National Center for Injury Prevention and Control at the United States' Centers for Disease Control.[11] CDC classifies both unintentional injuries (accidents) and intentional injuries (violence) as public health problems, as illustrated in Figure 4. Intentional injuries are divided into self-directed violence (suicides and suicide attempts), and interpersonal violence (assaults and homicides) (Figure 5). Violence is defined by the CDC, as 'the threatened or actual use of physical force or power against another person, against oneself, or against a group or community that either results or is likely to result in injury, death, or deprivation'.

[FIGURES 4-5 OMITTED]

This definition highlights the breadth of behaviors involved and does not limit it to physical violence. Also, the labels "perpetrator" and "victim" are often assigned based on the outcome of a fight (the person more injured is often labeled as the victim) with very little regard to the events leading up to the event and the roles of participants. Because public health is concerned with prevention and reduction of risk factors, the labels, victim and perpetrator, particularly with youth violence are less helpful. Behaviors like spanking children, tackling on the football field, rough play among peers all illustrate the important role of the receiver's interpretation.

Public Health and Youth Violence Prevention in the United States

Over the last two decades, violence has been increasingly accepted within mainstream public health as a problem for its consideration. The major contribution resulting from designating violence as a public health problem is the acknowledgment that violence is preventable, not inevitable. Violence prevention leadership within public health has emerged from the Centers for Disease Control and Prevention (CDC), the Surgeon General's office, and many state and local health departments.

The U.S. Centers for Disease Control established its Violence Epidemiology Branch in 1983, for the study of homicide and suicide. This application of basic epidemiology and reporting techniques became part of the impetus for public health professionals across the country to confront the issue. In October 1985, then Surgeon General C. Everett Koop convened an invitational meeting, the Surgeon General's Workshop on Violence and Public Health, in Leesburg, Virginia. The professionally interdisciplinary meeting focused on assault and homicide, child abuse, rape and sexual assault, domestic violence, elder abuse and suicide. The workshop and its proceedings, published in a special 1986 issue of Public Health Reports, were instrumental toward mainstreaming the issue of violence prevention for public health professionals. In 1994, the Centers for Disease Control established the National Center for Injury Prevention and Control and every Surgeon General after Dr. Koop has encouraged the public health community to use its strategies to understand better and prevent violence.

In summary, the public health efforts to understand and prevent violence utilize standard methods and strategies including epidemiology, community outreach, screening, community based programs, health education, behavior modification, public awareness, and education campaigns. Prevention strategies resemble efforts taken to prevent smoking, increase seat belt use and promote child car seats. Though only two decades old and mostly comprised of relatively isolated initiatives scattered across the country, public health efforts to violence prevention demonstrate the potential for the same level of success the public health approach has had with reducing smoking and deaths from car crashes in the United States.

The analogy between violence prevention and other public health problems is not flawless, yet experience to date employing comparable techniques and strategies suggest that these efforts will continue and expand. The public health approaches to violence prevention that have evolved over the last two decades are described in many resources available through the National Center for Injury Prevention and Control at the Centers for Disease Control and its website, www.cdc.gov/ncipc.

PUBLIC HEALTH AND CRIMINAL JUSTICE

Public health's venture into violence prevention has not always been well received. Many issues divide public health and criminal justice including fundamental principles, core approaches, proactive vs. reactive strategies, prevention efforts vs. a punitive response to violence in addition to the usual issues arising out of cross disciplinary collaboration such as different jargons, efforts to protect one's turf and competition for funding. In many ways the differences between public health and medicine discussed earlier are analogous to the difference between public health and criminal justice.

The public health and criminal justice systems have been historically separate in their conceptualization of approaches to violence and the development of activities to reduce or prevent violence. The public health field has approached the issue through efforts to identify the risk factors related to violent behavior. The criminal justice system has approached the issue through efforts to identify and assign blame for criminal behavior, maintain public safety, and remove violent offenders from the community.

Historically, society has relied almost exclusively on the criminal justice system to respond to violence well rooted in a few assumptions: 1) violence is an individual's criminal choice, 2) punishment or the threat of punishment is a deterrent to violent acts, and 3) violence is an inevitable aspect of the behaviors of some people. Police, prosecutors, public defenders, judges, probation officers and prison guards are a part of a sophisticated system designed to respond to crimes after they have been committed by identifying, apprehending, prosecuting, punishing, and controlling the violent offender. Their primary function is not prevention. The prevention efforts that are a part of the criminal justice system are found in the passage of laws and the deterrence resulting from enforcement.

Viewed from the perspective of those interested in reducing violence, the criminal justice system's responses have had only limited success. Inherent limitations in the reactive nature of the criminal justice system are partly responsible. Deterrence, the mainstay prevention strategy has limited prevention capacity (particularly in the context of violence among acquaintances and family). Rehabilitation, a form of prevention, is offered after a conviction and at variable levels of implementation from state to state.

Despite the fact that the juvenile justice system was created with a fundamental belief in the potential for prevention and rehabilitation among children, its major responsibility is punishment, particularly in this political climate. Many states are eliminating specialized juvenile justice systems for criminal offenses and incorporating youth into the adult criminal process.

Police and many of the laws they enforce are geared toward predatory violence that occurs among strangers on the street. As a result, the many episodes of violence among family, friend and acquaintance that emerge from insults, frustrations, festering disputes, and that take place in intimate settings are less well addressed. Both the family and acquaintance characteristics of violence in the United States and the need for a more comprehensive set of prevention activities create the context for cooperation between public health and criminal justice. The two disciplines could offer complementary approaches.

Interdisciplinary Challenges

While there are examples of effective collaboration between public health and criminal justice, the professional associations, conferences, programmatic efforts and academic publications remain distinct, for the most part. More effective collaboration beyond the existing silos of activity and competitive strategies would greatly improve society's capacity to save children from the devastating impact of interpersonal violence. Currently, both disciplines are defensive; criminal justice for its failure to meet societal expectations to control youth violence and public health for the slowness with which it has recognized and taken on the problem. However, considerable tension emerges from the divergent perspectives of the two disciplines and the fact that there are inadequate resources directed to addressing violence, which fosters competition rather than collaboration.

Public health is primarily focused on identifying causality (or its approximation) and intervening to control or reduce the risk factors; it has little interest in assigning blame or ensuring appropriate punishment, and does not discriminate between victim and offender. The public health community may agree that justice must be done, but is not professionally committed to the process. The criminal justice system, on the other hand, is deeply and morally rooted in 'justice' and criminal offenders being properly identified and punished. In this field there is less emphasis on the precursors or factors that may have led to the violent event. The criminal justice system is likely to consider external factors that might have motivated the offender to engage in violence as less important as they are largely irrelevant to judgment of guilt and innocence. Often public health efforts

to understand and identify risk factors particularly those associated with a specific episode of violence are characterized as a search for excuses or a rationalization (read defense) for what is understood within criminal justice as an individual's malicious choice, a crime.

The more public health embraces multilevel socioecological models for understanding human behavior, the greater the threat to the principles of individual choice and responsibility. This tension between public health and criminal justice is unproductive. It threatens effective collaboration and frustrates the opportunity to pool resources and expertise at a time when resources are seriously inadequate and the problem is increasing. Healing this rift requires a more collaborative spirit from both disciplines. Public health 'purists' must get beyond a religious dependence upon science and recognize the invaluable contributions and practical experiences of the criminal justice professionals. The criminal justice 'moralists' must, in turn, recognize the limitations of a largely reactive agenda that focuses on blame and punishment.

Moving beyond these obstacles and successfully exploiting the complementary qualities of public health and criminal justice approaches, requires following the examples of those who have put aside professional jealousies and utilized the expertise that both disciplines bring to the issue. This not only leads to a more creative process but also enhances productive working relationships.

Delineating Disciplinary Responsibilities: Primary, Secondary and Tertiary Prevention

Conceptual frameworks that can alleviate interprofessional tension, facilitate definitions of roles in addressing the problem, and assist in developing a broader perspective on programmatic strategies, involves breaking the spectrum of violence into levels that reflect different points of intervention (Figure 6). This framework, used frequently in public health circles, structures approaches to problems into three stages: primary prevention, secondary prevention (or early intervention), and tertiary prevention (or treatment / rehabilitation). These distinctions have proved valuable in thinking about intervention efforts even though their boundaries are not discrete. In this discussion, it might be best to think of these distinctions in terms of concentric circles that widen out in space and time from a central point which is the occurrence of some violent event.

[FIGURE 6 OMITTED]

Primary prevention, which by definition addresses the broadest level of the general public, might seek to reduce the level of violence that is shown on television or to promote gun control. This would be an effort directed toward dealing with the public values and attitudes that may promote or encourage the use of violence.

Secondary prevention is distinguished from primary prevention in that it identifies narrowly defined subgroups or circumstances that are at high risk of being involved in or occasioning violence, and focuses its attention on them. Thus, secondary prevention efforts [dagger] might focus on urban poor, young men and women who are at

particularly high risk of engaging in or being victimized by violence, and educating them in nonviolent methods of resolving disputes or displaying competence and power.

Tertiary prevention is distinguished from secondary and primary prevention in that it is a response to a violent event, not purely a preventive measure. Its focus is on trying to reduce the negative consequences of a particular event after it has occurred, or on trying to find ways to use the event to reduce the likelihood of similar incidents occurring in the future. Thus, one might think of improved trauma care, on the one hand, and increased efforts to rehabilitate or incapacitate violent offenders, on the other hand, as tertiary prevention instruments in the control of or the response to violence.

Primary prevention instruments are those that can affect larger and larger populations, ideally at relatively low cost. Thus, primary prevention instruments tend to be those providing information and education on the problem of violence through the popular media; for example the recruitment of Bill Cosby to the cause of using the media to prevent adolescent violence, or Sarah Brady's efforts to advocate for gun control laws and educate the public about the risks of handguns, rather than providing nonviolence training to the entire population. There are, of course, the ultimate long-term primary prevention goals which have to do with eliminating some of the root causes of violence such as social injustice and discrimination.

Tertiary prevention has generally involved incarceration. The major activities of the criminal justice system have historically involved the roles of the police, the courts, and the prison system in responding to criminal or violent events. Most resources have been directed to investigating and punishing criminal behavior. In the area of secondary prevention, the police have focused efforts on 'situated' crime prevention and the juvenile justice system has made attempts at early intervention with youthful offenders, although the courts and probation system frequently ignored youth until their criminal behavior reached a relatively high level of concern. Primary prevention efforts have focused on elementary school drug and violence prevention education by the police, as well as on controlling commodities such as drugs, guns, and alcohol.

This model of three levels of prevention can be very useful when applied specifically to the issue of interpersonal violence. In the past, the criminal justice system has addressed each of the three points of intervention to varying degrees as represented, yet the bulk of the efforts have focused on the response to serious violent behavior with moderate attention to early identification and intervention and limited efforts in the area of primary prevention. The role and activities of the public health system are newer, less extensive, and therefore, less evolved than that of the criminal justice system.

Traditionally public health responded by treating the violence-related injury in the emergency setting. Today a new generation of committed health practitioners, community violence-prevention practitioners, social workers, and community activists have devised numerous intervention programs to serve medium- to high-risk adolescents. At the primary prevention level, efforts have focused on gun control and safety, and enhanced public awareness of risk factors and the tree characteristics of most violence to

dispel myths and modify societal values around the use of violence. Additionally, some educational interventions (for example violence prevention curricula) have been applied to broader, less high-risk settings. Again, much of this work is relatively recent and therefore has not yet established a long track record to assess fully its effects. Finally, public health has applied its analytical expertise to enhance greatly the understanding of risk factors, allowing for a broader vision in the planning and development of preventive approaches.[12] In the area of secondary prevention, public health has been involved in the development of educational interventions specifically focused on behavior modification of high-risk individuals, particularly children and youth. Programs and curricula are currently- in place across country addressing many of the risk factors for violence including nonviolent problem solving and conflict resolution techniques.[13]

Over the last three decades, the criminal justice system has increased its involvement in primary and secondary prevention efforts, highlighting and funding school-based and community-based initiatives to reduce children's access to guns, teach conflict resolution, and provide need social services and to evaluate best practices in prevention. In 1974, with the passage of the Juvenile Justice and Delinquency Prevention Act, U.S. Department of Justice assumed primary responsibility for delinquency prevention programs creating the Office of Juvenile Justice and Delinquency Prevention (OJJDP). OJJDP encourages the development of model delinquency prevention programs and engages a multidisciplinary audience in violence prevention activities. It has been responsible for designating and highlighting "Blueprint" programs as models and funding their replication.

One such program is the Boys Clubs of America Targeting Programs for Delinquency Intervention. Other community groups refer at-risk boys to the program, who are then recruited. Early evaluations of these programs seem promising. Data indicates 39% of the boys did better at school and 93% who completed the program have not been further involved with the juvenile system.[14] These types of interventions reflect an important interface between the criminal justice and public health professions. With further attention and the dedication of resources of the public health system to this issue and the broadening vision of criminal justice, a more reasonable balance between prevention and treatment can be achieved in the future.

Boston, Massachusetts, with its dramatic and sustained decline in youth violence, serves as a model of multilevel programmatic activity with exemplary integration between public health and policing strategies.[15] Two decades of activities within public health and criminal justice and most importantly within the broader community of parents, teens and survivors of violence resulted in the creation of an extensive set of programs for youth throughout the City. Boston's efforts reflect the range needed to reduce both the extent of violent behavior and respond to the violence that does occur. It is not only an example for elected officials and community activists; it is also a model for professionals within public health and criminal justice.

CONCLUSION

Public health professionals began over two decades ago addressing the problem of violence because of their witness to its tragic toll on American children and understanding the limitation of the existing practice within criminal justice. The contributions made by public health professionals toward efforts to prevent violence have been tremendous. The continued application of public health strategies to the understanding and prevention of violence is essential to further progress.

Also, the interface between public health and criminal justice must be continually explored to ensure complementary strategies and activities. While examples of collaboration between the two disciplines exists, more effort must be placed in overcoming some of the inherent obstacles in order to create and fund a joint research and action agenda.

Recently, our national rates of violent crime have fallen, however in smaller towns, among girls and in younger children the rates are or appear to be on the rise. Also, even with our lower national rates there is far too much preventable injury daily. The emphasis of the public health system will always be on prevention and the criminal justice system must place priority on aggressive responses to violence, but much possibility lies in enhancing the collaborative effort between both disciplines.

Table 1. Public Health vs. Medicine

Public Health	Medicine
Primary focus on population	Primary focus on individual
Public service ethic, tempered by concerns for the individual	Personal service ethic, conditioned by awareness of social responsibilities
Emphasis on prevention, health promotion for the whole community	Emphasis on diagnosis and treatment, care for the whole patient
Public health paradigm employs a spectrum of interventions aimed at the environment, human behavior and lifestyle, and medical care	Medical paradigm places predominant emphasis on medical care
Multiple professional identities with diffuse public image	Well-established profession with sharp public image
Variable certification of specialists beyond professional public health degree	Uniform system for certifying specialists beyond professional medical degree

Lines of specialization organized, for example, by:	Lines of specialization organized for example, by:
* analytical method (epidemiology)	* organ system (cardiology)
* setting and population (occupational health)	* patient group (pediatrics)
* substantive health problem (nutrition)	* etiology, pathophysiology (oncology, infectious disease)
* skills in assessment, policy development, and assurance	* technical skill (radiology)
Biologic sciences central, stimulated by major threats to health of populations; move between laboratory and field	Biologic sciences central, stimulated by needs of patients; move between laboratory and bedside
Numeric sciences an essential feature of analysis and training	Numeric sciences increasing in prominence, though still a relatively minor part of training
Social sciences an integral part of public health education	Social sciences tend to be an elective art of medical education
Clinical sciences peripheral to professional training	Clinical sciences an essential part of professional training

Harvey Fineberg, MD, PhD, Dean, Harvard University School of Public Health, 1990. adapted from the web page of the Association of Schools of Public Health.

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