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Youth Violence Prevention:

How Does the Health Care

Sector Respond?

Overview—This background paper examines the health care sector's response to the complex problems associated with youth violence, identifies the unique challenges health professionals face in dealing with young victims and perpetrators of violence, and raises questions about the ability of health professionals in various types of practice settings to assume a more proactive role in preventing youth violence.

Violent episodes involving children as both victims and perpetrators—most notably the school shootings in Colorado, California, and several other places across the nation—have raised youth violence to the fore of the nation's public health agenda. As the country has confronted repeated images of children killing children, public awareness of this critical public health problem has intensified. These images of violence also raise questions about how and to what extent various sectors of society, particularly the health professions, can respond.

Violence in the United States has historically been relegated to the domain of the criminal justice system—not conceptualized or defined as a major concern of health care providers or the public health system as a whole. In the recent flurry of public debates and conferences, policymakers and prevention experts have tended to view schools as the focal point for youth violence prevention initiatives. Although few policies have concentrated on the role of the health care sector, leading medical and health organizations have called for health care providers and systems to play an increasingly significant role in identifying and intervening with children and adolescents at risk for violence.

YOUTH VIOLENCE IN THE UNITED STATES

Despite the perceptions of a deepening crisis, epidemiological data from the Centers for Disease Control and Prevention (CDC) and the Department of Justice (DOJ) indicate that juvenile violent crime, as measured by arrests, has actually declined significantly since the early to mid-1990s. According to DOJ's Office of Juvenile Justice and Delinquency Prevention (OJJDP), the number of juveniles arrested for violent crime decreased 19 percent from 1994 to 1998.¹ Juvenile arrests for murder are 48 percent below the peak in 1994. While the recent school shootings have generated a prevailing sense of American schools as increasingly unsafe, violence at schools has also been in decline in recent years. Although the number of multiple-victim

homicides at schools has increased since the early 1990s, the *1999 Annual Report on School Safety*, a survey prepared jointly by the Departments of Education and Justice, indicates that school-related crime declined from approximately 155 crimes for every 1,000 students ages 12 through 18 in 1993 to about 102 crimes in 1997. In fact, students are now nearly three times more likely to experience serious violence away from school than in school or traveling to or from school.²

Confidential self-reports by adolescents paint a somewhat different picture of youth violence, however. For example, the recent U.S. surgeon general's report on youth violence notes that violent acts among high school seniors increased nearly 50 percent over the past two decades. And, unlike many of the arrest-based indicators, neither this rate nor the proportion of such students engaging in violence has declined since 1993.³

Despite the recent downward trends in arrest rates, American children and adolescents are both the victims and perpetrators of violence at rates far higher than their counterparts in any other industrialized nation. Youth violence remains one of the nation's leading public health problems and policy challenges.

Children and Adolescents as Perpetrators of Violence

According to the CDC's annual Youth Risk Behavior Surveillance Survey, in 1999 approximately 17.3 percent of students carried a weapon (with 6 percent carrying a gun) in the 30 days preceding the survey.⁴

BACKGROUND PAPER

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While weapon-carrying may reflect the profound fear that many children experience in their schools and neighborhoods, and not necessarily a propensity for violence, children commit a startling high proportion of violent crime in the United States. The Justice Department reports that, in 1997, juveniles under 18 were involved in 17 percent of all arrests for violent crime, including 14 percent of arrests for murder, 17 percent of arrests for rape, and 14 percent of arrests for aggravated assaults.⁵

The establishment of effective interventions requires an understanding of the developmental processes that place some children on paths towards violence. The surgeon general's report on youth violence identifies two onset trajectories for violence. One, which begins before puberty, is often characterized by sequences of escalating behaviors that lead from early aggression to defiant and antisocial behavior to actual violence. These youth "generally commit more crimes, and more serious crimes, for a longer time." Their violence sometimes continues into adulthood. The other, more common, trajectory begins around ages 13 and 14 and peaks between 16 and 18. If youths have not initiated violence by age 20, it is highly unlikely they will ever become serious offenders.⁶

In recent years, a great deal of research has attempted to identify both risk factors and protective factors—the personal attributes and contextual conditions that respectively increase or reduce the likelihood that a child or adolescent will become involved in violent behavior. In April 2000, the DOJ OJJDP released the results from the Study Group on Serious and Violent Juvenile Offenders, a two-year initiative that brought together experts to analyze and synthesize current research on the predictors of youth violence.⁷ This report adds to an extensive body of research that documents that numerous individual, familial, social, and situational factors place children and youth at risk for violent perpetration. The Study Group Report highlighted the following:

- *Individual factors*—Emotional disorders (such as depression, social withdrawal, nervousness, and anxiety); hyperactivity, concentration problems, and risk-taking; aggressiveness; early initiation of violent behavior; involvement in other forms of antisocial behavior (such as smoking, early sexual behavior, and stealing); beliefs and attitudes favorable to deviant or antisocial behavior; academic failure, truancy, and dropping out of school.
- *Family factors*—Parental criminality, child maltreatment, poor family management and parenting

practices, parental attitudes favorable to substance use and violence, low levels of parental involvement, parent-child separation, delinquent siblings, poor family bonding and family conflict.

- *Social/neighborhood factors*—Poverty, community disorganization, availability of drugs and firearms, exposure to violence and racial prejudice, neighborhood adults involved in crime, delinquent peers and gang membership.
- *Peer factors*—Delinquent siblings, delinquent peers and gang membership.

Children and Adolescents as Victims of Violence

The Justice Department reports that children and adolescents are significantly more likely than adults to be crime victims. In 1996, of the 22.3 million adolescents (ages 12 through 17) in the United States, 1.8 million reported being the victims of sexual assault, 3.9 million reported having been victims of a serious physical assault, and almost 9 million reported having witnessed serious violence during their lifetimes.⁸ While it is difficult to obtain reliable data on nonfatal violent injuries, the National Ambulatory Medical Care Survey documented that, in 1995, children and adolescents 17 years of age or younger had 517,000 hospital emergency department visits for assault-related injuries.⁹ According to the *1999 National Report on Juvenile Offenders and Victims*, 2,100 juveniles under the age of 18 were murdered in the United States in 1997—approximately 6 a day. Adolescents are now more likely to die as a result of gunshot wounds than of all natural causes combined.¹⁰

While recent mass shootings in upper-income and rural communities have generated enormous media attention,¹¹ it is important to remember that the distribution of lethal and nonlethal violence in the United States is uneven. Severe violence tends to be disproportionately concentrated in big cities. According to the Justice Department, 25 percent of murders of juveniles occurred in 8 of the more than 3,000 counties in the United States, while 90 percent of counties did not have a juvenile murderer. With violence an intrinsic element of daily life in many urban neighborhoods, it is not surprising that surveys indicate that most school-aged children from inner-city communities encounter severe violence as either a victim or a witness.

Psychologists emphasize that the impact of violence on children depends on multiple, interacting factors, including the child's age, developmental level, and

internal resources; the family and community context in which the violence occurred; and the availability of family and/or community supports. Young children under five who experience chronic violence are particularly vulnerable to a loss of recently acquired developmental skills (such as bowel control or advanced speech), developmental delays, and behaviors indicative of anxious attachment to caretakers. The violence exposure or victimization of school-aged children and adolescents is associated with impaired school functioning and increased anxiety, depression, stress, and hopelessness. Some children, particularly pre-adolescents and adolescents, develop a diminished perception of risk that can lead to dangerous acting-out behaviors. Particularly worrisome is the fact that many children immersed in violent environments develop a heightened tendency to perceive social interactions as threatening and to view violence and aggression as acceptable ways to resolve conflict. In fact, chronic violence exposure is one of the most potent risk factors for an increased propensity to commit subsequent acts of violence.¹²

Recent Federal Legislative and Programmatic Responses

As policymakers and experts from different disciplines debate the interacting causes of youth violence, solutions and policies have been proposed from all sides of the political spectrum: gun control measures, limitations on the Internet and entertainment industry, tougher juvenile criminal penalties, and increased resources for school-based mental health services and prevention programs, to name a few. In the 106th Congress, S. 254, the Violent and Repeat Juvenile Offender Accountability and Rehabilitation Act of 1999, sponsored by Sen. Orrin Hatch (R-Utah), passed the Senate but was rejected by the House due to its inability to resolve controversial gun control provisions. The legislation combined “get-tough” criminal provisions (for example, authorizing juveniles age 14 years or older who commit serious violent felonies to be tried as adults) with support for programmatic, preventive interventions (for example, school safety and violence prevention training for school personnel and early childhood educators). Taking a different tack in the 107th Congress, Rep. Lamar Smith (R-Tex.), chairman of the House Judiciary Crime Subcommittee, excluded both Democrat-favored gun control provisions and enhanced punishments for juvenile offenders sought by Republicans from his Consequences for Juvenile Offenders Act of 2001. The bill, H.R. 863, would authorize \$1.5 billion in juvenile crime prevention grants to the states. At this writing, the bill is awaiting

action by the full House; no companion measure has been introduced in the Senate.

Numerous federal agencies target youth violence in schools through a myriad of initiatives. An inventory of federal activities addressing violence in schools compiled by the CDC’s Division of Adolescent and School Health included six large-scale surveillance and monitoring projects; 17 separate evaluations of interventions, initiatives and programs; 42 additional research projects, research syntheses, and application activities; 27 resource development activities (such as manuals and publications on “best practices”); 24 programmatic activities (such as grants to schools and communities for prevention-related activities); and support for seven resource and technical assistance centers.¹³

One of the major and most widely acclaimed federal youth violence initiatives has been the Safe Schools/Healthy Students Initiative, a joint program involving the Departments of Education, Health and Human Services, and Justice. In August 1999, the Clinton administration announced more than \$100 million in grants through this initiative for programs to reduce youth violence through the establishment of school-based community partnerships emphasizing comprehensive linkages between school districts, law-enforcement officials, mental health authorities, and community-based organizations. In September 1999, the Department of Education distributed an additional \$35 million to 97 school districts in 34 states to recruit, train, and hire school drug and school safety coordinators. In April 2000 the administration announced \$41 million in grants to fund 23 new school-based community partnership programs. In August and September 2000, the administration expanded program funding: \$20 million was distributed to 58 school districts in 30 states to establish or expand elementary school counseling programs and \$45 million was earmarked to 113 school districts in 35 states to hire middle school drug prevention and safety coordinators.

VIOLENCE PREVENTION AS A PUBLIC HEALTH RESPONSIBILITY: THE ROLE OF THE HEALTH CARE SECTOR

Rising rates of youth homicides in the late 1970s and early 1980s lead to the reframing of youth violence from a juvenile justice issue to a pervasive public health problem.¹⁴ The surgeon general’s report on youth violence affirms that the problem is a “high-visibility, high priority concern in every sector of U.S. society.” This “rethinking” was part of a growing recognition

that violence—domestic violence as well as street crime—is an important challenge to the public health of all Americans. In 1983, the CDC elevated violence to its list of public health priorities that require systemic, interdisciplinary public health responses. (As a discipline, public health entails the assessment of threats to the health and safety of a given population (for example, the citizens of political subdivision such as Los Angeles or the state of Vermont or the citizens of the United States as a whole).) As a result, public health planners have to an increasing extent taken violence into consideration as they make plans to reduce factors that jeopardize the health and safety of all citizens. Public health approaches to violence prevention emphasize primary prevention (that is, preventing violence before it occurs); community-based interventions, outreach, and educational programs; epidemiological surveillance; and cross-disciplinary, integrative interventions. *Tracking Healthy People 2010*, which spells out a comprehensive set of health objectives for the nation, devotes an entire chapter to injury and violence prevention; some of the initiative's youth-related objectives explicitly address physical fighting and weapon carrying by adolescents.¹⁵

Within the federal government, the CDC is playing an increasingly active role in setting the nation's violence prevention agenda through a diverse set of activities that include designing, implementing, and evaluating youth violence prevention projects; providing technical assistance to state and local agencies and organizations; funding and supporting innovative interventions and research projects; and violence monitoring and surveillance. In September 2000, the CDC awarded \$7 million to ten colleges and universities to establish National Academic Centers of Excellence on Youth Violence. These centers will address youth violence by developing and implementing community response plans, training health care professionals, and conducting research into risk factors for youth violence and the effectiveness of interventions. CDC also released the *Best Practices of Youth Violence Prevention* sourcebook which “details the four key strategies to preventing youth violence: parent and family-based strategies, home visiting, social and conflict resolution skills, and mentoring.”¹⁶

Finally, the Department of Health and Human Services (DHHS), along with nine other members of the Commission for the Prevention of Youth Violence, recently pledged to increase its involvement in community-based coalitions and programs to prevent youth violence, implement screening and response

protocols to identify children and youth at risk, seek related professional education opportunities, and advocate for violence prevention.¹⁷

RECOMMENDATIONS AND POLICIES OF MEDICAL AND HEALTH ASSOCIATIONS

While a sizable number of health care providers question whether violence prevention is an appropriate role for health care professionals to assume, associations and organizations representing physicians, nurses, and mental health providers have increasingly started to view youth violence as a public health problem to be addressed by health care providers and health systems. Consequently, these associations have established policies, practice guidelines, and recommendations designed to increase involvement in preventive services.

Physicians

The American Medical Association (AMA), which has designated violence as one of the top public health problems in America, addresses violence through its internal policies, programs, and initiatives. The organization has established a National Advisory Council on Family Violence and devotes a portion of its Web site to violence prevention initiatives and policies. Emphasizing that physicians need enhanced training in diagnosing, treating, and managing violence-related cases, the AMA's House of Delegates is encouraging the development of educational advisories, materials, and resources to assist physicians in identifying, counseling, and referring individuals at high risk of violent injury. Consequently, the AMA has endorsed the CDC's ongoing initiatives to (a) evaluate and develop training programs designed to train physicians in violence prevention and appropriate interventions and (b) develop surveillance methodologies for physicians to track violence-related injuries.

Supporting the efficacy of comprehensive, interdisciplinary prevention initiatives, the AMA encourages physicians to develop relationships with educational and social service providers. The AMA, therefore, recommends that state and county medical societies collaborate with state and local health departments, criminal justice and social service agencies, and local school boards in the development of violence control and prevention activities. In Colorado, which has become a locus for violence prevention programming and advocacy since the shootings at Columbine High School in Littleton, the Colorado Medical Society

created a special task force in conjunction with the Colorado Psychiatric Society to investigate issues related to the increase in gun-related mass assaults.

To address youth violence, the AMA endorses SAVE (Stop America's Violence Everywhere), a school- and community-based informational campaign sponsored by the AMA Alliance, an organization of 50,000 physicians' spouses. The SAVE campaign distributes to schools materials that encourage nonviolent styles of coping and behavior. AMA Alliance members also provide information to principals, teachers, students, and community leaders about strategies that can be implemented to reduce violence. As another component of the overall campaign to prevent youth violence, the AMA has spoken out against excessive media violence. On a policy level, the organization supports modifying the entertainment ratings system and, on a clinical level, urges physicians to counsel parents about the effects of media violence on children's development.

The American Academy of Pediatrics (AAP) released a policy statement in 1999 outlining the role of pediatricians in youth violence prevention. Calling violence prevention critical to its strategic agenda for promoting optimal child health and development, the AAP urges pediatricians to address violence in four major areas: clinical services, community advocacy, research, and education. The organization's Task Force on Violence stresses that physicians are uniquely situated to intervene with children who are experiencing or are at-risk for violence and recommends strongly that pediatricians increasingly be taught to recognize violence-related risk factors and diagnose and treat violence-related problems. The AAP, therefore, proposes that violence assessment and screening become basic components of medical training and pediatric care.

The AAP further suggests that when physicians identify risk factors for violence or violence-related problems, appropriate treatment or referral to additional services, such as mental health counseling, should occur. To promote and improve injury surveillance, the AAP proposes that emergency department visits and hospitalization records document the circumstances surrounding violent injuries through the use of standardized external cause-of-injury codes (also known as E-codes). Part of the International Classification of Diseases Coding Systems, E-codes are found on billing forms and provide information indicating whether an injury was caused by an accidental or intentional event. E-code data enhance the documenting of violence rates and provide the basis for preventive counseling and the

establishment of epidemiological profiles that become critical for population-level prevention initiatives. Danielle Laraque, M.D., who is chief of the Division of General Pediatrics at Mount Sinai Medical Center and serves on the AAP's Committee on Injury and Poison Prevention, urges the implementation of polices that will encourage more comprehensive and consistent E-coding. "Data is a tool to be able to define the problem," Laraque says. "E-coding is important to be able to pull out the specific diagnosis and intent. . . . If you cannot define the problem, then it is very hard to build coalitions and actually build interventions."¹⁸

Psychiatrists and Psychologists

The American Psychological Association (APA), through its Board for the Advancement of Psychology in the Public Interest, has placed its highest priority on issues related to youth violence. The organization has undertaken several projects to address youth violence, including the APA Commission on Violence and Youth, which disseminates research and information on children's risk factors for violence and effective interventions. The APA has also lobbied for enhanced resources for mental health professionals who are on the front line dealing with violence related issues. In the last year, the APA teamed with MTV to develop a national Youth Anti-Violence Campaign, which includes the distribution of a free "Warning Signs" guide on violence prevention. The APA has also established a task force to develop a comprehensive protocol and curriculum to train Emergency Medical Services Personnel in youth violence prevention.

Describing violence as a public health problem of epidemic proportions, the American Academy of Child and Adolescent Psychiatry (AACAP) has launched the Violence Initiative, which recommends that psychiatrists become more involved in youth violence prevention and treatment. Calling for increased collaboration among physicians, psychiatrists, and educators in comprehensive prevention initiatives, the organization encourages psychiatrists to shift their emphasis from an individual to a community-wide perspective. With violence prevention at the top of the agenda, AACAP is exploring strategies to facilitate psychiatrists' playing a greater role in education, research, clinical interventions, political lobbying, policy, and prevention. David Pruitt, M.D., the past president of the AACAP, has called for several policies to reduce youth violence: enhanced coverage for mental illness to ensure accurate diagnosis and comprehensive treatment; more school-based mental health clinics where trained professionals are available to evaluate and provide early intervention;

and prevention, intervention and education programs to educate parents and teachers about the early warning signs for youth violence.

Nurses

The American Academy of Nursing (AAN) has established an Expert Panel on Violence to develop policy recommendations addressing the role of nurses in youth violence prevention. Ann Burgess, chair of the panel, proposes that nurses contribute to prevention efforts in the multiple practice settings where nurses are located—including hospitals, clinics, schools, and homes. Burgess recommends that nurse training programs address more thoroughly the profile characteristics that place children at risk for aggressive and violent behavior and suggests that greater emphasis be placed on the evaluation and documentation of both the early warning signs for violence and the violence-related injuries.¹⁹

The National Association of School Nurses (NASN) has updated its position statement on the role of the school nurse in violence prevention, calling for school nurses to “be active members of crisis intervention teams and curriculum committees, and be involved in the development and planning of intervention and prevention programs.”²⁰ Moreover, the NASN urges schools and communities to work together to focus on anger management, the introduction of counseling and peer mediation programs, and the development of programs to foster problem-solving and conflict resolution skills.²¹ These goals are echoed in a recent report by the Urban Institute, *Problem Behavior Prevention and School-Based Health Centers: Programs and Prospects*, that proposes that school-based health centers become a locus for the delivery of primary and secondary prevention interventions, including mental health and violence prevention services, for children and adolescents.²²

Many of these professional associations joined with the DHHS to form the Commission for the Prevention of Youth Violence.²³ In addition to the four pledges taken by each of the members, the commission spelled out seven priorities for action in its December 2000 report:

- Supporting the development of healthy families.
- Promoting healthy communities.
- Increasing access to insurance and mental health services.
- Enhancing early identification and intervention for youth and families at risk.

- Reducing access to and risk from firearms.
- Reducing exposure to media violence.
- Ensuring national support and advocacy for solutions to violence through research, public policy, legislation, and funding.²⁴

While the intentions and initiatives of these professional societies regarding violence prevention are commendable, they are relatively recent. As a result, there is, as yet, little to point to in the way of concrete results or outcomes.

PROMISING PREVENTION APPROACHES IN THE HEALTH SECTOR

In accordance with the recommendations of health care policy and advocacy organizations that individuals and institutions accept a greater role in youth violence prevention, numerous preventive practices, programs, and interventions have been established. While it is beyond the scope of this background paper to review and classify all of the ways in which the health care sector intervenes to address the consequences of youth violence, interventions vary across different specialties and disciplines (for example, pediatricians, nurse practitioners, and trauma surgeons), settings (such as community-based clinics, hospitals, schools, and home-based programs) and target populations (including low-risk or high-risk children and adolescents, victims of violence, and families). Promising intervention models include the following:

Prioritizing Violence Prevention within Community-Based Health Clinics

For more than 20 years, the pediatrics department of the East Boston Neighborhood Health Center has implemented a well-regarded violence prevention program. In 1987, Ronald Slaby, M.D., collaborated with the program’s founder, Peter Stringham, M.D., to develop a series of curricula and interventions. Pediatricians are now trained through the program to (a) take a thorough history of children’s involvement with violence as aggressors, victims, or bystanders; (b) educate parents about strategies to help children develop behavioral patterns and thoughts that lead to nonviolent problem solving; and (c) provide follow-up visits to support the changes children and their parents make to help prevent violence. The staff have also worked with schools and community organizations to change community norms about violence and to develop violence

prevention programming. A longitudinal evaluation of adolescents seen at the health center found that a simple screening instrument used during health maintenance visits successfully identified those youth who were at greatest risk for future violence-related injuries.²⁵

Hospital-Based Prevention Programs

The Injury Free Coalition for Kids, funded by the Robert Wood Johnson Foundation and consisting of hospital-based programs in nine cities, is designed to decrease childhood injuries by creating safer environments for children.²⁶ While each program has developed a range of injury-reduction activities, such as safe playground initiatives, motor vehicle or bicycle safety programs, and injury surveillance programs, the programs also target violence prevention and reduction. St. Louis Children's Hospital, the Children's Hospital of Philadelphia, the Harlem Hospital Injury Prevention Program, and the Harbor-UCLA Medical Center have developed violence prevention programs for children and adolescents based on strategies such as conflict resolution, anger management, youth development activities, or the provision of positive role models. Children's Memorial Hospital of Chicago has developed KidStart, a program that encourages children's artistic self-expression to decrease the acute and delayed stress effects associated with children's experience of violence. Pittsburgh's Mercy Hospital has created the Goods for Guns program, which seeks to reduce children's firearm injuries by providing gift certificates in exchange for unwanted guns. An ongoing evaluation of Harlem Hospital's Injury Prevention Program illustrates the potential of hospital-based prevention programs. Since the implementation of the initiative, the Northern Manhattan Injury Surveillance System has documented a 46 percent decrease in violent injuries among Harlem children under age 17. During the same time period, children of similar ages in a neighboring community without the comprehensive prevention program (Washington Heights) experienced a 93 percent increase in violence-related injuries.²⁷

Partnering between Mental Health Professionals and Police Officers

To address the psychological trauma of chronic and/or acute exposure to community- and home-based violence, the Justice Department has funded programs in nine cities that bring together mental health professionals and police officers to intervene with children who have witnessed or experienced violence. Based on an intervention initially developed by the Yale Univer-

sity Child Study Center and the New Haven Police Department, the Child Development Community Policing Program encourages child development experts and police officers to provide each other with training, consultation, and support. Program components include child development and psychology training for community-based police officers, and a clinical consultation service through which clinicians who work collaboratively with police supervisors are on call for referrals and immediate clinical guidance in the aftermath of a child's traumatic experience. Researchers from the National Center for Children Exposed to Violence are currently planning an evaluation that will assess the program's effectiveness in reducing the long-term consequences of child traumatization.

Nurse Visitation Programs

A nurse visitation program established in the early 1980s in Elmira, New York, has been shown to significantly reduce factors associated with youth violence. Following in the tradition of public health nursing, which has a long history of home visits to disadvantaged families, the comprehensive program, which began during a woman's pregnancy and continued for two years after the birth of the child, provided weekly home visits, counseling, and well-baby care. Evaluations of the intervention's effectiveness have shown that, in addition to dramatically reducing child maltreatment (the primary goal of the program), the program had long-lasting effects on juvenile delinquency and violence. At age 15, the children of low-income, unmarried mothers who received the home visits had 56 percent fewer arrests and significantly fewer convictions and violations of probation and lower substance use than a randomly selected comparison group of children.²⁸ Persuaded by positive evaluations of home visitation programs, the CDC's Division of Violence Prevention has identified nurse home visitation as an effective "best-practice" strategy for youth violence prevention.²⁹

BARRIERS TO INVOLVEMENT OF HEALTH CARE PROVIDERS

As a direct result of the high incidence of morbidity and mortality resulting from youth violence, clinical practice guidelines are increasingly recommending that health care practitioners provide violence prevention services in routine clinical care. In the most recent edition of the *Guide to Clinical Preventive Services*, the United States Preventive Services Task Force states that "there is currently insufficient evidence to recommend

for or against clinician counseling to prevent morbidity and mortality from youth violence.” The task force asserts, however, that several risk factors related to youth violence (such as ready availability of weapons, inadequate social-problem solving skills, and abuse of alcohol and illicit drugs) “may be amenable to interventions by the individual clinician acting in the office setting” and recommends that, in settings where the prevalence of violence is high, clinicians should counsel adolescents and young adults about risk factors that may increase the likelihood of intentional injuries. In March 2000, the American Academy of Pediatrics’ Committee on Practice and Ambulatory Medicine added violence prevention to its “Recommendations for Preventive Pediatric Health Care.” This preventive schedule, which sets the standards and guidelines for pediatric procedures, now encourages violence prevention services (for example, counseling on gun safety, anger management, and gangs as well as assessment of signs of low self-esteem and depression) to be practiced during all routine visits starting with prenatal care and continuing throughout childhood and adolescence.

Despite the critical role that hospitals, clinics, and health care professionals can play in preventing and treating youth violence—and the growing body of research pointing to promising violence prevention interventions—implementation rates for preventive services within the health care sector remain surprisingly and disturbingly low. A national survey published in the *Archives of Pediatrics and Adolescent Medicine* in 1999 found that most pediatricians never or rarely screen for exposure to violence or access to weapons.³⁰ A recent survey of pediatricians in California confirmed that a majority of pediatricians are not screening their adolescent patients for risk factors associated with violence or counseling those who may be at risk for violence.³¹ Similarly, a survey of pediatricians, family physicians, and pediatric nurse practitioners found that while a substantial majority believe that they should counsel on firearm safety, only 38 percent actually do so.³² Consistent with these findings, 76 percent of residents and 83 percent of practitioners rated their medical training as inadequate to provide violence prevention counseling. And there is little evidence to suggest that health care personnel from the domains of nursing, psychology, or other medical specialties are receiving more comprehensive violence training or implementing violence prevention services at significantly higher rates.

Given that reducing the morbidity and mortality resulting from youth violence is a priority on the national health agenda, why has the health care sector

been relatively slow to respond to this public health crisis? Howard Spivak, M.D., head of the Division of General Pediatrics and Adolescent Medicine at the New England Medical Center and chair of the AAP’s Task Force on Violence, criticizes both the medical establishment and managed care organizations for failing to prioritize violence prevention. “While there is growing recognition of the toll that violence takes on the cost of health care,” Spivak states,

there is little to demonstrate that the recognition has translated into financial reimbursement for either violence prevention efforts or for the appropriate kinds of responses that need to be put in place when people with violence injuries appear in the health system.³³

It has only been recently that there has been the acknowledgment that violence falls within the domain of health care, not the criminal justice system. “We must be less concerned with assigning blame, and more concerned with promoting health,” Spivak stresses. Arthur Elster, M.D., the director of clinical and public health practice and outcomes at the American Medical Association, agrees that the medical community’s response to youth violence has lagged behind progress made in addressing other social problems, such as domestic violence. He contends that health care providers must approach violence from a public health perspective and understand that they can address youth violence within individual clinical settings and health systems and on a policy level.³⁴

Mount Sinai’s Laraque, who has helped to formulate the AAP’s youth violence prevention policies and programs and who has extensive experience working in community-based violence prevention initiatives and instructing residents on preventive practices, urges health care practitioners to incorporate violence prevention screening and counseling as a basic element of anticipatory guidance. She suggests that the majority of clinicians working with children and adolescents believe that they should intervene to reduce the consequences of violence. “Most pediatricians feel this is within their domain of what they should be doing,” Laraque says. “But if you look at knowledge and attitudes and then look at actual practice, far fewer are actually practicing that.”³⁵ Surveys of physician attitudes and behaviors support her observations. For example, a recent study published in the *Annals of Internal Medicine* revealed that 84 percent of internists and 72 percent of surgeons believe that physicians should be involved with gun injury prevention, but less than 20 percent engage consistently in firearm injury preventive practices.³⁶

Laraque points to several institutional and educational barriers that pediatricians and other health care providers face that may inhibit their implementation of youth violence preventive services.³⁷ These barriers include the following:

- *Inadequate training in violence prevention*—A 1998 national survey of directors of pediatric residency programs found violence and weapon carrying to be among the topics in adolescent medicine least likely to be covered adequately in medical training.³⁸ The failure of medical and nursing schools to integrate comprehensive violence education and prevention into health care training constitutes one of the most significant barriers to consistent practitioner involvement in preventive practices. A recent survey found that although a majority of pediatricians in California had in fact received some form of training in violence prevention, 74 percent reported that they were not confident in their ability to provide adequate violence prevention counseling.³⁹ Laraque argues that meaningful change must take place at the training level for health care personnel to develop the knowledge and skills necessary to assess and intervene with at-risk children and adolescents. In recent years, some medical schools have begun to implement curricular changes. Three medical schools in the Boston area—Boston University, Tufts, and Harvard—have revised their health care training curricula to provide students with extensive training and experience in dealing with youth violence prevention and treatment. UCLA’s School of Medicine has instituted an innovative “Doctoring Curriculum” that integrates the identification and treatment of violence into all three years of the curriculum.
- *Lack of knowledge*—Health care providers’ lack of knowledge of what they can do to intervene to prevent or treat the consequences of youth violence remains perhaps the most significant barrier. Surveys suggest that even clinicians who frequently encounter victims of violence or at-risk youth often do not know how or where to intervene. Practitioners who have not received adequate training or experience in screening, counseling, or dealing with mental health issues may be particularly reluctant to involve themselves in domains they perceive to be outside their duty of care or their own expertise. Evaluations of educational interventions, however, indicate that appropriate training and professional development can improve health care personnel’s familiarity with youth violence-related issues and perhaps their willingness to provide preventive counseling. For example, the *Archives of Pediatric and Adolescent Medicine* reported the results of an evaluation of a one-time 2½-hour violence prevention program provided to pediatric residents. Over 90 percent of the residents stated that they would utilize the prevention skills learned in the training; the evaluation confirmed that the number of physicians discussing guns or violence increased significantly after the program.
- *Insufficient time and reimbursement*—The current fiscal climate often imposes time limitations on the physician-patient interaction, leaving little time to be spent on preventive screening and counseling, both recognized as essential components of good clinical practice. A recent study of the determinates of preventive counseling in pediatric care found that while the issue of time was not a primary factor influencing the likelihood of preventive counseling, physicians who were concerned about time were significantly less likely to counsel their patients.⁴⁰ Similarly, the very nature of most insurance, which tends to pay for treatment, may serve as a disincentive to traditionally nonbillable prevention efforts. Moreover, medical professionals may see violence prevention as a “social service” benefit rather than a medical one, further reducing the likelihood that counseling will take place. Prevention advocates, thus, stress that health care systems and insurance companies must implement coverage policies and schedules that provide health care personnel with the time, resources, and incentives to incorporate violence prevention services into routine care.
- *Insufficient funds/resources*—Meaningful youth violence prevention cannot happen without a commitment of resources. An analysis of the factors associated with pediatrician’s involvement in preventive violence interventions indicates that resource availability is essential in enabling physicians to provide interventions for at-risk patients.⁴¹ Above and beyond the need for appropriate coverage for clinician counseling, mental health services, and adequate follow-up care, the establishment of preventive programs or initiatives, the training of practitioners, and the preparation and distribution of basic education and referral materials require the investment of funds. Moreover, many experts believe that in order to achieve maximum effect, the resources of hospitals, clinics, health systems, managed care organizations, insurance companies, and the government must be directed in a united effort.

- *A lack of coordination between health care providers and other sectors, institutions and organizations*—Where should health care providers turn when they identify a child or adolescent whom they suspect may be a potential victim or perpetrator of violence? Some analyses suggest that the lack of collaboration among health care systems and other sectors may be the most significant barrier preventing at-risk adolescents from receiving effective treatment and services. While prevention experts and health care analysts assert that comprehensive, multisectoral community interventions are the most effective means to ensure that vulnerable children are identified and receive adequate care, few communities have established an interconnected and collaborative violence response system. Traditional barriers between systems have resulted in fragmentation, with hospitals and clinics frequently disconnected from school systems, community-based organizations, and the mental health, juvenile justice, and child welfare systems.
- *Concerns about patient confidentiality*—Some practitioners and health policy analysts list the need to protect patients' confidentiality and the concomitant fear of lawsuits for violating confidentiality as barriers that inhibit health care providers from intervening in domains (such as domestic violence, mental health issues, and firearm safety) where their actions may be perceived as an invasion of privacy. Laraque suggests that these concerns may be somewhat unfounded. She points out that health care providers who are mandated to break confidentiality when they suspect child abuse have a similar responsibility to intervene when they suspect that a youth is a potential victim or perpetrator of violence.
- *Need for valid, user-friendly screening measures*—While screening measures exist that can alert health care providers to children or adolescents who exhibit risk factors associated with violent behaviors or emotional problems, they are typically not used during routine health visits. According to Laraque, health care providers may be more likely to screen for risk factors on a regular basis if some of the standardized screening measures frequently used for research purposes could be translated into brief, user-friendly formats more applicable to practice settings.

INVOLVEMENT OF MANAGED CARE ORGANIZATIONS

Few managed care organizations appear to have put into practice the basic violence response procedures

suggested by prevention experts and health organizations; only a handful have funded or implemented meaningful violence prevention initiatives. Where these efforts do occur, they tend to be undertaken by organizations that are focused on care management and population outcomes (see Allina example below). Traditional insurers, who see themselves primarily as financing rather than delivering care, are even less likely to mount youth violence prevention efforts.

Not surprisingly, violence prevention advocates view this inaction as short-sighted. Spivak, for example, takes managed care organizations and insurers to task for their lack of consistent and substantial support for violence prevention procedures and programs. "Insurance companies know what the long-term costs associated with violence are," he says. "Their decision making is not always rooted in data, but in short-term implications. There is very little long-term vision."⁴²

While few health maintenance organizations (HMOs) or insurers have established significant violence prevention initiatives, policies, or programs, even as the nation has debated prevention responses following the Columbine shootings, concerns about the medical and social costs of violence have persuaded a small number of health systems to invest in youth violence prevention.

Allina Health Systems' Initiatives

Among managed care organizations across the United States, the Allina Health System has been in the vanguard in its commitment to preventing and reducing violence. No health care system in the nation has launched a more comprehensive, multifaceted, and innovative set of initiatives to reduce and prevent the health consequences of violence.

Allina Health System is a not-for-profit health care system serving Minnesota and areas of Wisconsin, North Dakota, and South Dakota. The system's operating units include clinics, health plans, hospitals, and other care facilities, as well as other health-related and non-health-related businesses. David Strand, Allina's chief operating officer, says that the health system chose to focus on violence prevention because it is consistent with Allina's view that its healing mission extends to the community. He stresses that violence, like other illnesses and diseases targeted by medical interventions, is both costly and preventable. Indeed, as the first place where victims, perpetrators, and individuals at-risk for violence are often seen, health systems have a unique opportunity to intervene.⁴³

Allina's focus on violence prevention has garnered abundant praise and awards. Mary Ellison, director of

the Minnesota Department of Public Safety, calls Allina “a major player” in the state’s comprehensive violence prevention efforts. She credits the health system with focusing the state’s medical community on issues associated with violence.⁴⁴ Largely as a result of its violence prevention initiatives, in 1998 Allina was awarded the prestigious Foster G. McGaw Prize for Excellence in Community Service.

Allina’s violence initiatives include the following components:

Partners for Violence Prevention. In 1996, the Allina Foundation and the United Hospital Foundation collaborated to provide a \$1 million grant to establish a comprehensive community-based initiative to prevent violence and injuries in St. Paul’s low-income West Seventh community. Confronting head-on the traditional barriers between the health care system and other community agencies and businesses, the goals of the three year project are (a) to create an interconnected violence response system among health and social service providers, (b) to improve the methods for identifying and supporting victims of violence who enter systems of care, and (c) to mobilize members of the West Seventh community to recognize violence in its various forms and to act to decrease its impact. Major partners in the initiative include a community-based primary-care clinic, the neighborhood’s central hospital and emergency department, the St. Paul Police and Fire Department, as well as a coalition of community social service and health care agencies. Tim Rumsey, M.D., the medical director of a family clinic heavily involved in the initiative, says that the aim of the program is ultimately “to provide a seamless web of services which will prevent, detect, and decrease the impact of violence in the homes, institutions, and on the streets” of the neighborhood.

Through the integrated initiative, hospital and clinic staff and residents receive specialized training in violence prevention and treatment and have developed and incorporated a primary care violence prevention protocol and violence screening measures. Medical staff also work with community agencies (such as shelters and counseling centers) to provide more seamless treatment for patients affected by violence. The St. Paul Police and Fire Department, collaborating with the program’s participants, has established a new violence response curriculum and guidelines for emergency service personnel who are often a violence victim’s first connection to the health care system. In addition, in order to improve communication among the different providers, medical staff, law enforcement officials, and

social service personnel work together to collect and share information about violence-related incidents.

Violence Classification System. As an essential component of its overall violence prevention strategy, Allina sought to gather systematic information about the types and prevalence of violence related-injuries within the communities it serves. To meet this goal, Allina introduced E-codes into its overall clinical services. Presently collected on a voluntary basis at a rate over 90 percent in all of the hospitals and health plans in Metropolitan Minneapolis, E-codes have already provided critical information on concentrations of violence. E-code data have demonstrated, for example, that approximately half of all intentional injuries in the Twin Cities occur in three neighborhoods that contain only 25 percent of the urban population. According to Strand, “The data are a way of beginning the dialogue about what is going on (in those neighborhoods) and what are ways to address it.” E-code information, Strand points out, will ultimately allow for the more efficient targeting of resources and the establishment of more effective violence prevention strategies. Strand notes that E-codes have already provided a mechanism encouraging the health community to link up with the law enforcement community in new and innovative ways.⁴⁵

Violence Screening and Training. Allina has developed and adopted screening protocols to identify individuals at-risk for violence; all physicians at Allina’s clinics are being trained to screen for risk factors associated with violence. The health system has also targeted family violence as a clinical priority. As a result, Allina’s Clinical Issues Committee has developed a three-hour family violence curriculum for health care professionals and a family violence screening and response tool. Today, 100 percent screening for family violence has been implemented at all of Allina’s hospitals and clinics.

Statewide Violence Coalition. Allina played a critical leadership role in the convening of the Governor’s Task Force on Violence as a Public Health Problem. The Task force resulted in the development of the Minnesota Health Care Coalition on Violence, which has implemented a comprehensive strategy to reduce violence through out the state. Strand serves as the chairman of the coalition (See Appendix for more details about the coalition).

Violence Prevention Research Network. Seeking to increase knowledge about strategies to address violence, the Allina Foundation has developed the only fund in Minnesota earmarked for health care violence prevention research. A total of \$278,000 has been

distributed to six community-based research projects. The projects involve collaborations between researchers and local communities and have addressed distinct violence-related topics: assessment of violence risk-factor screening instruments, cost and risk factors for work-related assaults, rural domestic violence, injury surveillance, and screening for sexually aggressive children. Moreover, the foundation has committed funds to inform key healthy policy decision makers about advances in violence prevention. Working in collaboration with the University of Minnesota Center for Violence Prevention and Control, the Allina Foundation has sponsored and funded public lectures on prevention featuring researchers and national experts.

Allina Foundation staff have also written or promoted significant research reports addressing the role of health care in violence prevention. For example, the foundation prepared a critical review of the research on home visiting as a strategy for preventing child maltreatment. The review has been disseminated to health plans across the state and influenced Allina's own policy to cover the costs of home visits for low-income subscribers.

Phillips Partnership. Working closely with the Minneapolis police and other law enforcement agencies, the Phillips partnership—created through the efforts of Honeywell and Allina—has worked to reduce crime in the challenged Phillips neighborhood. A public health approach to crime has yielded a dramatic reduction in violent crime.

Examples from Other Health Plans

Other, less comprehensive violence prevention initiatives include the following:

Blue Cross and Blue Shield of Minnesota, St. Paul. This health plan spearheaded the development of the Minnesota Action Plan to End Gun Violence. Blue Cross provided leadership, coordination, planning, and resources (over \$100,000) to develop a broad-based strategy to reduce gun violence. Distributed monthly by Minnesota Public Radio's magazine, the prevention plan presents and highlights ideas for reducing handgun and media violence. In addition, through collaborations with community organizations, public health agencies, the media and other health plans, Blue Cross held community forums that led to the establishment of Students Stop Guns, a school-focused prevention campaign aimed at children ages 8 through 15. One component of this intervention was an anonymous tip line for students to report weapons in school. Blue

Cross has continued to support violence prevention by sponsoring community activities, such as the Youth Summit on Reducing Teen Violence. Dan Johnson, the director of community affairs for Blue Cross of Minnesota, encourages other health plans to invest in community solutions to violence. "The important first step (for health plans) is recognizing violence as a public health, not just a criminal justice, problem," Johnson says.⁴⁶

Kaiser Foundation Health Plan of the Mid-Atlantic, Rockville, Maryland. This plan has included violence prevention in a campaign to improve the health of children and adolescents. One program, Real Alternatives to Violence for Every Student (RAVES), uses school-based drama performances to help fifth- and sixth-grade students understand the choices and consequences of violence. Available at no cost to schools and community organizations in the Washington-Baltimore metropolitan area, the RAVES program teaches conflict resolution, refusal skills, self-affirmation, and anger management. The program also connects younger students with high school student mentors. According to the program's literature, Kaiser opted to target youth violence prevention based on the longstanding realization that violence must be treated as a health problem.

United Health Care of North Carolina, Charlotte. Working in collaboration with North Carolina State University's Center for the Prevention of School Violence, this health plan, which is an operating unit of United Health Group, developed an initiative to provide grants to public schools implementing violence prevention projects. Through this initiative, over 40,000 North Carolina children have attended school-based violence prevention programs, which utilize an array of prevention strategies, including conflict resolution, teacher training, social skills development, mental health counseling, parenting classes, and youth service.

Kaiser Permanente of California, San Francisco. This plan has sponsored and funded a series of violence prevention initiatives. The health plan joined with community, medical, and governmental groups and agencies to create the One Less Gun, One More Life initiative, a program launched to reduce the number of guns in San Francisco neighborhoods. In 1997, Kaiser collaborated with the state of California to fund the Violence Prevention Education Program, a comprehensive effort to reduce violence among middle school students. In recent years, Kaiser has offered at one of its clinics in Oakland a 12-week conflict resolution class for families concerned about their children's potentially violent behavior. Taught by a psychologist, the class reaches both parents and children and teaches anger

management, conflict resolution, and the importance of parent role modeling.

Harvard Pilgrim Health Care, Boston. A finalist for the AAHP Community Leadership Award in 1997 and 1999, Harvard Pilgrim Health Care has been targeting violence perhaps longer than any other health plan in the nation. In 1984, this mixed-model health maintenance organization HMO launched its Abuse and Trauma Intervention Program, a coordinated, interdisciplinary approach to improving care for survivors of violence. In 1991, the Harvard Pilgrim Health Care Foundation established the Violence Prevention Project, a comprehensive initiative to educate, mobilize, and support violence reduction efforts. Emphasizing community health promotion, the foundation has co-produced a documentary on trauma and violence, established a media campaign encouraging children and adolescents to make healthy decision around violence and health, and distributed over 4,000 informative violence prevention kits to schools and community-based organizations. In 1999 the foundation distributed more than \$300,000 in violence prevention grants to community organizations. The Violence Prevention Project has been recognized by the Office of the Massachusetts Attorney General, the Harvard School of Public Health, and the American Academy of Pediatrics.

Harvard Pilgrim also participates in the Massachusetts Prevention and Managed Care Roundtable, a forum developed in 1996 to bring together community prevention practitioners, managed care organizations, and government representatives to explore and establish linkages across a spectrum of organizations to enable the development of mutually beneficial prevention and health promotion policies. Although the roundtable has emphasized substance abuse preventive services, the collaborative forum offers a model of a comprehensive, multifaceted effort to enhance the inclusion of community-based prevention services in health care delivery systems and to develop principles that will guide collaborations among managed care organizations and community-based prevention programs.

CONCLUSION

The reluctance of health care practitioners, health care systems, and the managed care industry to respond consistently and aggressively to a deadly and costly public health problem raises a perplexing set of questions: Given the incidence of morbidity and mortality resulting from violence, why has the health care sector as a whole been relatively slow to incorporate basic

youth violence prevention procedures? And, given that there are long-term financial incentives to implement prevention approaches that reduce the demand for more expensive acute care, why have so few health care organizations chosen to fund, implement, and collaborate on violence prevention efforts?

The answers seem rooted in a number of factors that influence the behavior of practitioners, insurers, and health plans. First, individual practitioners confront significant barriers to action including inadequate training, knowledge, reimbursement, and assessment tools, to name a few. Second, insurers and managed care organizations appear to be balancing short-term financial goals against the uncertainty of future savings from prevention efforts with high turnover populations. Third, the social service nature of many prevention activities makes it easy for practitioners, insurers, and delivery systems to assign responsibility for these activities to other nonhealth professionals and institutions. And fourth, even if professionals, managed care organizations, and insurers wanted to initiate prevention efforts, their ability to predict who will be the victim of (or engage in) violence is limited.

If these obstacles can be overcome, it is clear that there are a number of promising policies and approaches that health care professionals and managed care organizations can support in the short term to begin to respond to the daunting problems related to youth violence, such as the implementation of violence prevention curricula, violence screening measures, and violence classification and surveillance systems (E-codes). Abundant opportunities exist for individuals to become involved in violence prevention efforts as care providers within clinical settings, as medical managers and organizers within health systems, or as advocates within organized medicine or in communities. In the longer term, professionals and managed care organizations will have to decide whether to collaborate with juvenile justice, social service, child welfare, and educational systems in developing community-wide comprehensive violence prevention and mental health programs.

Allina's Strand is particularly adamant that health plans seeking to address violence ought to establish broad-based efforts, as have occurred in Minnesota. Strand stresses that successful initiatives also require individuals at different levels throughout the organization—including the chief executive officer—to be committed to a long-term effort. While acknowledging that nonprofit health systems may be more likely to invest in social prevention initiatives, he argues that from a financial cost-benefit perspective alone, for-profit

managed care organizations should integrate violence prevention in basic services. “These social issues really are at the heart of our health care issues,” Strand says.⁴⁷

Questions for Discussion

- What is the appropriate role for health care providers in general—and managed care organizations in particular—in responding to the complex problems associated with youth violence?
- What are the barriers physicians and other health professionals face? What can be done to remove them?
- Are there coverage and reimbursement policies that strengthen or serve as a barrier to effective violence prevention, intervention, and rehabilitation efforts?
- Are policy initiatives needed to encourage health plans—both public and private—to provide more coverage for violence-related prevention and treatment, including expanding and coordinating mental health benefits? How would this be accomplished?
- Are evaluations and cost-benefit analyses available? Would they persuade private-sector managed care organizations of the efficacy and long-term profitability of violence prevention approaches?
- Allina and Harvard Pilgrim are community-oriented, nonprofit health care systems. What policies, regulations, or actions can encourage for-profit managed care organizations to implement violence prevention initiatives?
- What safety and screening measures can be implemented to identify risk factors for violence? Do these screening questions raise issues of confidentiality?
- Epidemiologists and prevention experts emphasize that violence coding and surveillance are key to a systematic and coordinated prevention strategy. Are there policies or incentives to encourage more hospitals, health systems, and managed care organizations to implement violence coding (E-codes)?

APPENDIX

Violence Prevention in Minnesota: A Case Study on the Minnesota Health Care Coalition on Violence

In step with the epidemic of gun violence experienced throughout the United States during the early and mid-1990s, violence in Minnesota climbed to troubling proportions. In 1994, The Minnesota Department of Health and Family Support released a report indicating that homicide had become the leading cause of death for Minneapolis children ages 15 through 19. During the 1996-97 school year, Minnesota schools reported 1,119 incidents involving dangerous weapons. The increasing rate of violence prompted the *New York Times* to label the city, “Murder-opolis.”

David Strand, Allina’s chief operating officer, realized that health care systems could no longer afford to ignore this growing threat to health and safety. “I was very struck at the time that if (violence) was the number one public health problem,” Strand recalled, “then why is there very little time, energy, resources looking at the issue?” Strand, who contends that health plans must seek collaboration in areas where they are otherwise competitors, sought out the involvement of other health care organizations in the state, including hospital

systems and physicians. Allina approached then Gov. Arne Carlson to convene a task force to explore how Minnesota’s health care community could identify ways to reduce and prevent violence. As a result of the leadership from the health care organizations, the Governor’s Task Force on Violence as a Public Health Problem was formed. Comprised of chief executive officers from Minnesota’s largest health plans, representatives from the state’s medical associations and hospitals, as well as law enforcement officers, public officials from different state agencies, and child and community advocates, the task force met monthly over a five-month period. In 1996, the task force released a final report, “The Violence Epidemic: The Role of Minnesota’s Health Care Organizations and Professionals in Prevention and Treatment,” which outlined a series of concrete recommendations.

The Task force’s report highlighted that, in addition to the incalculable emotional costs, health care costs associated with violence in Minnesota totaled in the hundreds of millions of dollars each year—more than \$75 per year for every individual in the state. The task force encouraged the state’s health care community to approach the problem of violence through innovative policymaking strategies. Rather than relying upon public funds and governmental direction, the task force

opted to pursue voluntary, community-wide efforts to establish private sector participation, investment and support. “The goal of the Task Force,” the report stated, “is to achieve changes in policies and direct initiatives that emanate from the private sector and do not require governmental intervention but will be planned and carried out in close cooperation with the public sector as a partnership.”

As an initial step to encourage participation in the violence prevention initiative, the task force developed a “contract” for health care organizations to sign as a public commitment to address violence. The task force also established an action plan containing a series of specific tasks for organizations to undertake. The key elements of the action plan included the following recommendations:

- The development of a larger coalition—a Health Care Coalition on Violence—to coordinate ongoing statewide and regional efforts.
- Violence-related data collection and research initiatives.
- A workplace violence strategy.
- A plan to improve health care coverage and payment policies related to violence.
- Practice guidelines related to violence.
- Primary violence prevention initiatives.
- Violence-related services coordination and referral.
- Health care education and training related to violence.
- Coordination of health care related efforts with other violence initiatives.
- Funding strategies.

Minnesota’s Health Care Coalition on Violence

Following the task force report detailing strategies that the state’s health care systems could implement to reduce and prevent violence, the Minnesota Health Care Coalition on Violence was formed. With much of the leadership originating from the state’s managed care organizations, the coalition is composed of representatives from health plans, health care systems, and community organizations. Strand serves as the coalition’s chairman.

As envisioned by the governor’s task force, the coalition represents a state effort to establish an

industry-led, nonbinding public-private partnership. While operating independent of government oversight, the coalition reports to its government sponsors, the State Commissioners for Public Safety and Public Health, every six months to update progress. Strand stresses the significance of this independent structure. “We didn’t want money from the state,” he says, “because we thought that if we took money, the state would feel more of a sense of a need to control us. We really thought this (initiative) would work better if it was private sector led and financed.”

Ellison says that the coalition has become an important component of the state’s comprehensive violence prevention campaign. Minnesota receives funds from the Federal Safe and Drug Free School Program and earmarks additional state funds for violence prevention, education, and youth development. A major priority of the state’s efforts has been the creation of a coordinated five-year media campaign to reduce violence. Ellison credits over 500 organizations, including the coalition, as being actively involved with the antiviolence program. “The biggest thing you have going in Minnesota is that there are multiple players at multiple levels focusing on this issue,” Ellison says.⁴⁸

The coalition created five working committees, each chaired by health care leaders, to oversee the fulfillment of specific objectives: practices, guidelines, and training; health plan coverage and policy; workplace violence prevention; primary prevention; and data collection and research.

In 1998, the coalition created a Violence Prevention Achievement Award to recognize health care organizations that are reaching specified milestones in implementing a comprehensive violence prevention strategy. According to Strand, the coalition intentionally created criteria (“violence prevention milestones”) to function as a quasi-accreditation process. To encourage the organizations to implement the prevention steps, the coalition purposefully utilized the competitiveness of the health care marketplace. “[The coalition] thought that these organizations are so competitive that if they think one of the other organizations is going to get this award and they will not, they will work hard to get it,” Strand says. “What do you know? The first year we did it, every major organization in town applied for the award.” The 13 milestones include implementing a violence prevention initiative and collaboration with a community organization; adopting family violence prevention, workplace violence prevention, and primary prevention standards and policies; sponsoring violence prevention training for health care professionals; and

implementing E-codes on injury claims. In January 1999, the Governor's Task Force on Violence as a Public Health Problem and Minnesota's Health Care Coalition on Violence presented the achievement awards to 12 health organizations.

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