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Violence as a Public Health Issue

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The prevention of crime and the prevention of violence involves complex cooperation among many parts of our society. Many of the known measures which ameliorate violence occur outside the criminal justice system—within families, communities, and by way of health promotion activities.

Interpersonal violence is now widely accepted as a public health problem, rather than being seen entirely, or mainly, a matter for the criminal justice system. Internationally, violence is a focus of the work of World Health Organisation and the United States Government's Centers for Disease Control and Prevention.

This paper points out the importance of a rigorous focus on the well-being of populations, and public health's use of population-wide data to aid understanding of the problems and identifying solutions. In this way, public health can make a valuable contribution to violence prevention and cover a much broader spectrum than can the criminal justice system alone.

Seeing interpersonal violence as lying within the injury area of public health, with its focus on population-level risk factors, highlights the importance of concerted, intersectoral approaches to preventing and dealing with interpersonal violence.

In September 1999, the Australian Institute of Criminology ran a roundtable seminar on "Public Health Perspectives on Interpersonal Violence", an earlier version of this paper shaped much of the discussion on the day.

Adam Graycar
Director

The Public Health Approach to Interpersonal Violence

Some years ago, William Foege, an international leader in the injury prevention area and a former Head of the United States Centers for Disease Control and Prevention stated that "Throughout history, the chief causes of premature mortality have been infectious diseases and violence" (Foege 1987, p. 1407). This paper explores the implications of seeing violence as a public health issue rather than as an issue of primary concern to the criminal justice system.

What makes interpersonal violence a public health problem? Most commentators state simply that the high levels of morbidity and mortality caused by interpersonal violence make it a public health problem (see, for example, Rockett 1998). Others (for example, Mercy et al. 1993) argue that since public health interventions have potential to reduce the incidence of violence and / or its impacts, it is a public health matter. Both approaches are sound, but neither fully answers the question. Health, as we know, is about well-being, part of which is minimising the amount and impact of injury and disease. John Last, for example, provides a definition of public health which is well-regarded:

> Public health is one of the efforts organized by society to protect, promote, and restore the people's health. It is the combination of

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> sciences, skills, and beliefs that is directed to the maintenance and improvement of the health of all the people through collective or social actions. The programs, services, and institutions involved emphasise the prevention of disease and the health needs of the population as a whole. Public health activities change with changing technology and social values, but the goals remain the same: to reduce the amount of disease, premature death, and disease-producing discomfort and disability in the population. Public health is thus a social institution, a discipline, and a practice (Last 1988, p. 107).

It is not self-evident, from this or other definitions, that violence (that is, violent behaviour) is specifically a public health problem. It is certainly not an area exclusive to public health. What is apparent, however, is that *injury*—particularly physical and psychological injury—resulting from interpersonal violence clearly falls within this definition of public health.

This link has been recognised in the international community in recent years. The initiatives of the World Health Organisation (WHO) and its related bodies have been prominent. The "Third International Conference on Injury Prevention and Control", held in Melbourne in 1996, produced a draft resolution on "Violence as a Public Health Priority" for presentation to the WHO. As a result, on 25 May 1996 the 49th World Health Assembly adopted a policy statement on "The Prevention of Violence: Public Health Priority", sponsored jointly by the Republic of South Africa and Australia. The resolution concludes that WHO "*Declares that violence is a leading worldwide public health problem* ..." (World Health Assembly 1996).

The resolution goes on to propose steps that WHO and member nations of the World Health Assembly can take to prevent and control violence. The WHO Centre for Health Development in Kobe, Japan, is implementing part of the work plan: it conducted an International Symposium on "Violence and Health" in October 1999 and has published the *Global Atlas on Violence and Health* (World Health Organization Centre for Health Development 1999). WHO is also preparing another publication entitled *World Report on Violence*, to be released in year 2001.

Like WHO, though in a more subdued manner, Australia has declared interpersonal violence to be a public health issue. At the national level, interpersonal violence has been identified as a problem to be addressed within the injury prevention and control component of the *National Health Priorities* which were adopted in 1994. Specifically, the National Health Goals and Targets focus on interpersonal violence as a component of intentional injury. Australian governments have set the following specific goals:

- reduce mortality due to interpersonal violence; and
- reduce morbidity due to interpersonal violence.

In discussing the background to this, the policy document states the injury prevention and control community is in a position to make a significant contribution to the prevention of violence in three ways.

- Promoting the recognition, by government and the community, that violence is a health problem which, like other health problems, can be prevented through the use of surveillance and other data collection systems, the identification of high risk groups, and the development and implementation of preventive strategies.
- Contributing to programs that address the barriers to prevention. For example, social norms and attitudes and models that accept violence and the public perception that violence is inevitable.
- Defining violence as an important public health problem.

This approach draws public health and other health professionals into the growing constituency actively seeking to reduce the level of violence in the community (Commonwealth Department of Human Services and Health 1994).

While this seems like a solid basis for policy, its implementation has been patchy. This is highlighted by the inadequacy of the health sector's approach to monitor the incidence, prevalence, and impact of interpersonal violence in the Australian society, as well as the outcomes and impacts of prevention programs. Only two (very inadequate) indicators in this area are included in the injury prevention and control component of the national health priorities: the death rates for homicide among people aged 0–9 years and those aged 20–29 years (Commonwealth Department of Health and Family Services and Australian Institute of Health and Welfare 1998, pp. 76–77). More recently, following the appointment of the National Injury Prevention Council, more detailed consideration has been given, at the national level, to the strategic issues in injury prevention. The Council's April 1999 reports *Directions In Injury Prevention* (Department of Health and Aged Care 1999(a); 1999(b)) provide a far sounder basis for progress.

The Public Health and Criminal Justice System Approaches to Violence

One can readily contrast, along a number of dimensions, the public health approach and the criminal justice system approach to social problems. The public health approach uses a consistent model regardless of the problem: whether it is the eradication of a communicable disease like smallpox or the reduction in morbidity and mortality from a non-communicable disease like diabetes. This is because it is firmly based

on theory of causation and intervention. In systems terms, the public health approach is one of:

- defining the problem and collecting data about it;
- identifying the causes, risk factors, and protective factors linked to the problem;
- developing and testing interventions to find out what works in what circumstances; and
- disseminating new knowledge about what works and has an impact on a population-wide basis (Mercy et al. 1993).

This may be contrasted with the traditional approach of the criminal justice system, which has traditionally dealt with problems after they have already occurred. The traditional criminal justice system approach focuses on:

- retribution;
- general and specific deterrents;
- incapacitating an offender usually through imprisonment;
- rehabilitation, either within the prison system or in a non-custodial setting; and / or
- restoration, with the goal of restoring harmony and reintegrating people back into society.

The public health approach, at least on the face of it, holds a far greater potential for longer-term success than does the criminal justice system as described here.

Another approach to characterise the public health approach is to observe that it focuses on:

- community health, not primarily law enforcement and public order;
- victims, not primarily offenders, and recognise that perpetrators of violence are often victims of violence as well;
- violence between intimates, as well as between strangers;
- complex systems of causality, not simply the behaviour and intentions of offenders;
- upstream approaches to prevention (including primary prevention), not mainly secondary and tertiary prevention where we deal with the problems after they have developed;
- a concern for the underlying socioeconomic determinants of violence, not only the most proximal risk factors;
- a focus on populations, not primarily on individuals;
- a multi-disciplinary basis, not limited to one discipline or profession;
- mutually respectful collaboration between the professionals and the populations involved, not primarily a service delivery orientation; and
- evidence-based practice, as disseminated through peer-reviewed journals.[1]

As other authors have pointed out, however, the issue is not really as simple as presented here. Clearly, an increasing focus on victims is developing within the criminal justice system. The criminal justice system is also concerned with prevention (for example, through contemporary approaches to problem-oriented policing) and some police services are making use of population level data rather than simply focusing on processing individual offenders. Restorative justice interventions are also important. Nevertheless, the contrasts given above highlight the differences in approach between the two fields.

At this point, it is worth pausing to consider the ideological issues which underlie the criminal justice and public health focuses respectively. In the area of crime and criminal justice, we frequently come from an ideological base which stresses moral responsibility and blame, as Braithwaite has emphasised in his writings about reintegrative shaming (Braithwaite 1989). The operation of the criminal justice system, particularly the courts, is a process of apportioning blame and it does so (in Braithwaite's terms) in a stigmatising manner. A population health focus, on the other hand, while not in any sense condoning behaviour which breaches society's standards, focuses less on blaming the offender (frequently seeing the offender as a victim of social circumstances), and more on the need to understand and deal with the causes of violence or the risk factors for violence.

These ideologies may lead to quite different perceptions of the causes of violence and the appropriate interventions for preventing violence and dealing with violent people. The key issue is that the various sectors need to complement each other and interrelate strategically. Unfortunately, this has not been easy, as *serious challenges exist in implementing public health approaches to violence prevention*. These are seen at both the conceptual and the practical levels. They were neatly summarised in the 1997 National Health Priority Areas' (NHPAs) progress report on injury prevention and control:

Within the NHPAs process, self-harm has been categorised as a mental health issue, and violence principally as a legal or criminal issue. If a population view is taken, it can be seen that similar groups are at the highest risk of self-harm and violence. The same groups are at the highest risk of accidental injury. Intervention strategies for each of these issues are targeting similar populations, but there is little formal coordination at policy and program management level (Commonwealth Department of Health and Family Services and Australian Institute of Health and Welfare 1998, p. 53).

The report points out that the National Campaign Against Violence and Crime (now National Crime Prevention) was largely an initiative of, or within, the Commonwealth Attorney-General's portfolio and that "health sector involvement is peripheral" (Commonwealth Department of Health and Family Services and Australian Institute of Health and Welfare 1998, p. 52).

Injury Prevention and Control: A Public Health Approach

As indicated above, within the Australian approach to national health goals and targets, interpersonal violence is located within the *injury prevention and control* stream of population health. Although most injury prevention inventions are intensely practical (fitting air bags to motor vehicles is an example), the field has a relatively comprehensive theoretical base. Its key feature is the proposition, now supported by empirical research, that injuries are not accidents. As with other health problems, injuries (both intentional and unintentional) tend to be located in identifiable places, at identifiable times and in identifiable populations. This is an important theoretical advance (dating only from the post-World War II period) over the earlier perception that injuries are accidents: unpredictable, random events determined by fate (National Committee for Injury Prevention and Control 1989, pp. 6–7).

Another important advance in injury prevention theory was the application of the epidemiological model to the identification of the mechanisms of injury (Haddon 1972). Specifically, scholars began to conceptualise injury in terms derived from infectious disease epidemiology, focusing on the host (the injured person), the agent that creates the injury, the vector or vehicle that conveys the agent, and the environmental factors within which the incident occurs. They argued that injury is best understood in terms of the agent of injury involved, and that the agent is energy. Accordingly, injury prevention and control turned its focus from assumed inadequacies of the victim (for instance, lazy, ignorant, and careless) to the injurious transfer of energy.

This theoretical orientation is both the greatest strength and the greatest weakness of traditional injury prevention and control theory. Its strength was highlighted by Robertson 1992 (perhaps the dominant injury epidemiologist with an impressive track record in the prevention of motor vehicle injuries) when he stated:

> In almost every sport that involves a ball, the good players learn to keep their eyes on the ball. The ball in injury epidemiology and injury control is energy, the necessary and specific cause of injury. The researcher who focuses on hypotheses specifying how concentrations of particular types of energy occur in contact with human beings is likely to produce the most useful results. If a hypothesized causal factor is substantially removed from the energy exchange in space or time, it usually has a weak or nonexistent correlation to injury rates (Robertson 1992, p. 212).

Focusing on the risk factors most proximate to the injury-creating event has led injury prevention planners to adopt a hard-line view of strategic priorities. Given what we have seen in the past as being the three central strategies of injury prevention, namely education, enforcement, and engineering (Waller 1985, pp. 39–45), injury prevention planners concluded that education is of little utility (low cost-effectiveness in seeking to change people's behaviour through increased knowledge of hazards and how to avoid them). In addition, the creation and enforcement of regulations has potential but will generally fall down at the level of enforcement. By default, many concluded that the most effective (including cost-effective) approaches to avoiding injury are passive strategies where the person does not have to gain and apply knowledge, nor exercise volition. The fitting of air bags to motor vehicles is an example of a passive, engineering injury prevention strategy. While some injury prevention personnel attend to broader, deeper causal webs, their approaches have rarely been documented and have made little contribution, so far, to the theory of injury causation and prevention.

The injury field within public health can be criticised for drawing attention mainly to serious physical injuries, leaving hidden other domains of injury. These include, importantly, the impacts of psychological violence within the family which many women report as being even more damaging than physical injuries. Common forms of psychological violence against women and children are intimidation, lack of affection, emotional abuse and neglect, and material abuse and neglect (Browne and Herbert 1997, pp. 8–22).

Intentional injury is a challenge to injury theory. Having evolved as a field addressing unintentional ("accidental") injury, the theoretical basis for addressing intentional injury, including interpersonal violence, is not well articulated. Key injury prevention and control texts either mention intentional injury only in passing or not at all. Some observers (for example, Centers for Disease Control and Prevention 1997) argue that strategically differentiating between intentional and unintentional injury is useful in developing intervention programs. Others (for example, Overpeck and McLoughlin 1999) take the opposite view, arguing that it is more effective to collapse these categories as they inhibit understanding and effective program implementation. While others (for example, Shield, personal communication) see utility in the concept of a gradient of intentionality.

The traditional triad in public health (agent, host, and environment) needs to be modified to deal with intentional injury. The concept of agent has to be expanded to deal with:

- the agent proper (the injurious transfer of energy caused, for example, by a bottle striking a person's head);

- the vehicle (the bottle itself); and
- the person who wielded the weapon, especially the person's motivations or intentions to create injury. It can be argued that the injury prevention and control field's emphasis on passive interventions (for example, soft ground covers for children's playgrounds) has limited application when the injury is inflicted intentionally.

The Risk Factors Approach

Public health has leaned heavily on the concept of risk factors. These have been defined in Last's *Dictionary of Epidemiology* as:

> An aspect of personal behaviour or lifestyle, an environmental exposure, or an inborn or inherited characteristic, which on the basis of epidemiological evidence is known to be associated with health-related condition(s) considered important to prevent (Last 1988, p. 148).

One must be cautious to avoid simplistic applications of risk factors to understanding and preventing violence, remembering the adage that "for every complex problem there is a solution which is simple, and wrong!" As Last has indicated, the risk factor approach directs us to *associations* between phenomena. While these associations are sometimes causal, in other circumstances the apparent association is mediated through other factors. These are sometimes called risk markers. In the case of interpersonal violence, frequently risk factors are interrelated and are cumulative in their effects.

A recent review of the risk factors for violent behaviour summarised them as follows:

- having a history of violent behaviour;
- being male;
- being a young adult;
- having experienced difficulties in childhood, including inadequate parenting;
- troubled relationships within the family and low levels of school achievement;
- having problems of psychotropic substance abuse, especially problematic alcohol use; and
- having severe mental illness, the symptoms of which are not adequately controlled; and being in situations conducive to violence (McDonald and Brown 1997).

Increasingly, however, the risk factor approach is being subjected to criticism. Within the injury prevention and control field, the risk factor approach underlies the transfer of energy concept of injury causation. It was suggested above that the focus on the transfer of energy is both the greatest strength and the greatest weakness of the injury prevention and control field within public health. Robertson (1992), quoted above, has highlighted the strengths: the more proximate the intervention to the injury-creating transfer of energy, the more effective the intervention will be.

The down side is, of course, that many injury incidents, especially the intentional injury that we see in interpersonal violence, have multiple interacting causes. Focusing entirely on the factors which are most proximate to the energy transfer means that we run the risk of becoming "prisoners of the proximate", as McMichael (1999) puts it. We ignore the causal chain of events which culminate in the injury. Furthermore, as McMichael points out, we fall into the trap of failing to recognise how risk factors operating at the population level (in addition to the individual level) also shape the epidemiology of violence and provide intervention points.

Emphasising the personal risk factors leads to the danger of falling into victim-blaming, an approach common in the injury field in earlier years when "accidents" were seen to occur primarily because people were, for example, ignorant, lazy, stupid, or immoral. The contemporary approach is to attempt to gain a deeper understanding of why some individuals and, perhaps even more importantly, some population groups have elevated levels of individual risk factors and constellations of risk factors. The answers are often found in social structural analyses, especially in inequalities of opportunity.

The so-called *"new public health"*, with its emphasis on the strategies of advocating, enabling, and mediating to change society and enhance people's life chances, provides a framework for understanding the societal-level risk factors associated with interpersonal violence (International Conference on Health Promotion 1986; Baum 1998). While this will seem self-evident to some, a recent study has highlighted the gap between perception and action. A review of articles published in public health and medical journals that discussed violence as a public health problem revealed that, while authors were inclined to identify social and structural causes for violence, they suggested interventions that targeted individuals' attitudes or behaviours would improve public health practice.

> While public health professionals may see the causal relationships between social factors and violence in populations, the toolbox from which we draw may limit us to interventions directed towards the agents of injury (such as firearms) and individual-level variables such as knowledge, attitudes, and behaviors. Thus in some sense the toolbox may define the mindset (Winett 1998, p. 506).

Herein lies a challenge to practitioners who are concerned about the population-level risk factors.

Yes, interpersonal violence is certainly a significant public health problem. Some of the pathways to prevention and harm minimisation are to be

found in public health. The challenges we face include further developing the conceptualisation of the problems, developing more and better information on the extent and the nature of the problems and, in terms of prevention, on what works, with whom, and under what circumstances. A key element of this will continue to be improving our skills at strategic collaboration between the various sectors including the criminal justice system, medicine, and public health.

Notes

[1] This listing is partly based upon (Moore 1993, 1995; Beaglehole and Bonita 1997).

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