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CRIME, COMMUNITIES, AND PUBLIC POLICY

EDITED BY

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A COMPREHENSIVE APPROACH TO VIOLENCE PREVENTION: PUBLIC HEALTH AND CRIMINAL JUSTICE IN PARTNERSHIP

Howard Spivak
Deborah Prothrow-Stith
Mark Moore*

Violence and its consequences of death and disability have become issues of growing concern over the past decade in the United States (U.S. Public Health Service, 1990). Although violence and intentional injury (the major physical consequence of violence) have been serious problems for far longer than that, the public's perception and, in fact, the available statistics suggest a significant increase in the level of violence experienced in this country in recent years (Centers for Disease Control, 1983, 1990). Not only are the consequences of serious injury or death considerable for individuals personally affected, but violence is increasingly taking its toll in terms of fear and frustration for many communities. To date, effective solutions and responses have eluded the nation as a whole. Many law enforcement experts agree that the problem of violence cannot be controlled by the criminal justice system alone. In particular, these experts believe that prevailing social conditions regarding family stability, education, and other societal institutions affect the behavior of juveniles (FBI, 1992, p. 279).

Efforts by the criminal justice system and others to address this problem have been episodic and inconsistent and have lacked a comprehensive and coordinated vision. The growing magnitude of this problem not only demands continued attention but also requires new and creative approaches and partnerships if we are to effectively stem the growing tide of violence.

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VIOLENCE IN THE UNITED STATES

Before entering into a discussion of solutions and approaches, it is essential to recognize the extent and the characteristics of violence in the United States (Spivak, Prothrow-Stith, and Hausman, 1988). This country has the fifth highest homicide rate of all nations reporting such data. Not only is the U.S. homicide rate 10 to 25 times higher than most industrialized nations, but our homicide rates rival some less developed countries facing war or considerable social, political, and economic turmoil (Wolfgang, 1986, p. 400).

In 1991, of the 24,703 murder victims in the United States, 93 percent of Black victims were killed by Black offenders, and 85 percent of White murder victims were killed by White offenders. Firearms were used in seven out of ten murders (FBI, 1992, p. 17). Homicide in this country has become the twelfth leading cause of death overall, the second leading cause of death for teenagers and young adults, and the leading cause of death for African-American men and women ages 15 to 34 (Centers for Disease Control, 1990). Each year over 20,000 individuals die by homicide, hundreds of thousands are injured by assault, and millions are fearful of the risks and potential destruction of intentional injury.

ADOLESCENTS AT RISK

Adolescent violence should be a major concern for all Americans. The decade from 1980 to 1990 saw the juvenile violent crime arrest rate for Blacks increase by 19 percent; for Whites it increased 44 percent, while the rates for the "other" race category declined 53 percent (chiefly because of the large increase of Asian youth). Increases in the crime rate are predicted through the next decade. A common misconception of violent crime is that it is just an inner-city, Black problem. But that is simply not so. The recent escalation of adolescent violent crime rates in the past several decades cuts across race, class, and lifestyle (FBI, 1992, pp. 279-289).

There are some children who are more susceptible and more at risk of becoming victims or perpetrators of violence. Those at higher risk tend to be male, be poor, live in urban areas, and have witnessed much violence or been victims of violence during early childhood development. The social condition of poverty wrecks

havoc on many communities and is a factor for many adolescent high-risk behaviors (Prothrow-Stith, 1992).

One American child in every five lives in poverty. Among children under age six, one in four is poor. One-third of these children are Black. There are 13.4 million poor American children. Nearly two of three poor families with children had one or more members in the work force in 1990 (Children's Defense Fund, 1992). The economic, political, social, and familial problems that breed violence in very poor neighborhoods are formidable. No single institution can bring about the kind of change needed to restore a sense of safety and order to everyday life. Children and adolescents have little choice in their environment and educational opportunities or in the racism, sexism, and parental upbringing that may have shaped the personal choices that place them at risk in war-torn communities. Inner-city adolescents are often painfully aware of how different their neighborhoods are from their more affluent peers. Most teenagers understand and respond to real opportunity when it is offered. But when there is no hope for a better future, adolescents may by default choose what makes them feel better, what the media portray as glamorous and exciting, and what counteracts the grinding boredom of poverty with few options in sight. Our poorest adolescents have armed themselves and become guerilla fighters against each other in a way that has no name, no political ideology, and no end in sight (Prothrow-Stith and Weissman, 1991).

CHARACTERISTICS OF VIOLENCE

While the statistics of violence may not be surprising to some, the nature of this violence is unknown to many. Contrary to the stereotypes of violence promoted by the media as predominantly involving strangers or occurring in the context of criminal behavior such as racial harassment, robbery, or drug dealing, much of the violence experienced in this country is far more intimate and occurs in the context of personal relationships (Spivak, Prothrow-Stith, and Hausman, 1988). In fact, the typical homicide involves two people who know each other, who, under the influence of alcohol, get into an argument that escalates with the presence of a gun or knife. Only 15 percent of homicides occur in the course of committing a crime, as compared with over 50 percent that stem from arguments among acquaintances (Centers for Disease Control, 1982). This 50 percent takes place in

family relationships (e.g., child abuse, elder abuse, spouse abuse) or among friends (interpersonal peer violence). In the remaining 35 percent, the relationship between victim and perpetrator is unknown.

The perpetrator and victim of violence share many traits. They are likely to be young and male and of the same race. They are likely to be poor and to have been exposed to violence in the past—especially family violence. They may be depressed and use alcohol and/or drugs (Prothrow-Stith and Weissman, 1991). This incongruity between public perception and actual circumstances has resulted in demands for resources and solutions that address only part—possibly the smaller part—of the problem. While certainly not discarding established anti-crime and anti-violence strategies, we must recognize the diversity of violent circumstances that exist and must build a broader base of efforts that not only responds to violent events but also focuses on preventive services.

THE CRIMINAL JUSTICE RESPONSE TO VIOLENCE

Historically, American society has relied almost exclusively on the criminal justice system to both respond to and prevent violence. This is rooted in the beliefs that violence is criminal, that those who commit violence should be punished, and that the threat of punishment is a potential deterrent to violent acts. A large, elaborate set of institutions has been developed to achieve these goals. That system includes police, prosecutors, public defenders, judges, probation officers, and prison guards. It is designed principally to respond to crimes after they have been committed by identifying, apprehending, prosecuting, punishing, and controlling the violent offender. It is guided not only by the practical goals of reducing crimes of all types (including violence) but also by the normative goal of assuring justice to victims and the accused.

The public health and criminal justice systems have been historically separate in their conceptualization of approaches to violence and the development of activities to reduce or prevent violence. The public health field has approached the issue through efforts to identify the risk factors related to violent behavior. The field turns to this issue in reaction to the magnitude of intentional injuries that are present in health care settings. The criminal justice system has approached the issue through efforts to identify

and assign blame for criminal behavior, maintain public safety, and remove violent offenders from the community.

Viewed from the perspective of those interested in reducing violence, the criminal justice system's responses have had only limited success. Part of the reason is inherent limitations in the overall approach of the criminal justice system. First, it is more reactive than preventive in its basic orientation. True, deterrence may produce some preventive results. True, too, the criminal justice system has sought to rehabilitate offenders through special programs in prisons and to prevent children from becoming violent offenders through the development of the juvenile justice system, whose most fundamental goal is to prevent future criminal activity by children. Nonetheless, the criminal justice system comes into play only after a crime episode has occurred.

Second, the criminal justice system—particularly the police—is focused primarily on the predatory violence that occurs among strangers on the street. The violence that emerges from nagging frustrations and festering disputes and takes place in intimate settings is far more difficult for the criminal justice system to deal with than stranger-inflicted violence that arises from greed or desperate need and that takes place in the open. Robbery and burglary—and the violence that attends them—are more traditional and central to the criminal justice system's business (and consciousness) than aggravated assaults that spring up among friends in bars, lovers in bedrooms, or teenagers at dances.

Despite such limitations, no one seriously questions the importance of these institutions and their approach to the control of violence. Questions, however, do properly arise about the comprehensiveness of this approach.

THE PUBLIC HEALTH RESPONSE TO VIOLENCE

Public health practitioners have recently stepped up to the problem of violence, bringing different orientations and techniques to complement and strengthen the criminal justice approach. The public health system has noted that violence affects the nation's health statistics as well as its crime statistics. As noted earlier, violence is a prominent contributor to mortality and morbidity. In just one year, homicide and intentional injury may represent as much as \$60 billion in short- and long-term health care costs and lost productivity for those who are injured or disabled by violence (Rice, Mackenzie, and Max, 1989). These facts alone should warrant

attention by public health professionals, as well as the broader spectrum of human services professionals, and give society even more reason to be concerned about violence.

In addition, the public health community has been drawn to this issue by the growing conviction that its techniques of analysis and prevention might be usefully applied to violence. Public health brings an analytic approach to problems that concentrates on identifying risk factors and important causes that could become the focus of preventive interventions. It also brings a record of accomplishment in controlling "accidental" (unintentional) injuries through both environmental manipulations (e.g., seat belts and childproof caps on medicines) and behavioral change (e.g., laws and educational campaigns to reduce drunk driving). These techniques may be valuable in the analysis and prevention of violence as well. This approach seems particularly plausible as we learn more about what occasions violence in society, including what factors put individuals, especially youth, at risk of either committing or being victimized by violence, and as we learn the limitations of the criminal justice system in dealing with some of these contributing factors.

OPPORTUNITIES FOR EFFECTIVE COLLABORATION

On the surface, the predominantly reactive stance of the criminal justice system and the pro-active perspective of the public health community would appear both complementary and potentially productive. There are, in fact, several examples of collaboration between these disciplines that have been substantially effective. Interdisciplinary programs are now standard practice in the areas of child abuse and sexual assault. For example, the recommended plan for treatment of rape victims by criminal justice, medical, public health, and mental health systems is a model collaborative effort: Community groups staff and train hotline volunteers who offer crisis counseling, criminal justice assistance, and information. Trained staff are available to accompany victims to hospital emergency departments and police interviews. Emergency room staff specially trained to deal with rape victims administer the appropriate tests and treat the victim. After the immediate emergency services are complete, a referral is made to a mental health counseling service that offers short- and long-term services to the victim and the victim's family. Trained staff at police departments will handle the rape victim's complaint. The criminal jus-

tice system uses victim-witness staff to keep the victim up to date with case information, give the victim an orientation to the courtroom and a description of what to expect in a hearing or a trial, and provide information on parole hearings, escaped prisoners, appeals, and other issues (Rosenberg and Fenley, 1991). Criminal justice interventions and health services together are key in the identification of cases, treatment of victims, possible rehabilitation of offenders, and early identification of at-risk situations prior to more serious injury being inflicted.

In the area of unintentional injury, specifically drunk driving, there has been a very successful partnership between the educational strategies of the public health sector for behavior change and the threats of punitive action and the monitoring practices of the criminal justice system. The public health sector launched a series of preventive interventions in schools and in the media to educate children and adults on the risks of drinking and driving and about strategies to avoid the risks. Concurrently, the criminal justice system imposed stiffer penalties, enhanced enforcement of drunk-driving laws, developed screening techniques such as roadblocks, placed more responsibility on establishments that serve alcohol, and increased treatment requirements for those arrested for drunk driving. Together, these approaches not only have changed the behaviors of at least some individuals but also have substantially influenced public attitudes with respect to the unacceptability of drinking and driving. Scientific evaluations of the efficacy of drunk-driving legislation, enforcement, and health education indicate that the legal and social sanctions met with some success. Between 1980 and 1984, the number of fatal crashes involving alcohol declined by 20 percent (Hingson, Howland, and Levenson, 1988).

CHALLENGES TO EFFECTIVE COLLABORATION

Unfortunately, the collaboration of public health and criminal justice in the area of violence prevention has been wrought with tension. Some of this may stem from a basic failure to effectively reduce the problem of violence that has put both disciplines on the defensive: criminal justice for its failure to bring the problem under control and meet societal expectations; public health for the slowness with which it has recognized and taken on the problem. However, much of this tension probably comes from the divergence of perspective of the two disciplines and the fact that there

are inadequate resources directed to addressing violence, which has forced the disciplines to compete rather than collaborate.

Public health is primarily focused on identifying causality (or its approximation) and intervening to control or reduce risk factors. It has little interest in assigning blame or meting out punishment and does not discriminate between victim and offender. The public health community may agree that justice must be done, but it is not professionally committed to the process. The criminal justice system, by contrast, is deeply and morally rooted in "justice" and criminal offenders being properly identified and punished. There is less emphasis on the precursors or factors that may have led to the violent event. The criminal justice system is less likely to consider external factors that might have motivated the offender to engage in violence because it sees these issues as largely irrelevant to judgment of guilt and innocence. At worst, the claims that these other factors were causally important in the particular instance seems like a rationalization or an apology for what was a criminal deed. This rift is further exacerbated by the fact that the criminal justice profession continues to develop preventive agendas, such as first offender programs and community policing initiatives, and probably feels that its "thunder" and leadership are in jeopardy of being stolen by the arrival of another professional player onto its turf.

This tension is clearly unproductive. It threatens effective collaboration and frustrates the opportunity to pool resources and expertise at a time when resources are seriously inadequate and the problem is increasing. Healing this rift requires a more collaborative spirit from both disciplines. The public health "purists" must get beyond their science and recognize the invaluable contributions and practical experiences of the criminal justice professionals. The criminal justice "moralists" must, in turn, recognize the limitations of a primary agenda of assigning blame and assuring justice is done.

If we are to get past these initial reactions and successfully exploit the complementary qualities of these two approaches to violence, it is essential to put aside professional jealousies. More important, we must better define the perspective, roles, and expertise both groups bring to the issue. This will lead not only to a more creative process but also to establishing productive working partnerships. The history of positive interaction between the two disciplines, as noted earlier, establishes an experiential base on which future collaboration can be built.

A CONCEPTUAL APPROACH TO ORGANIZING THE COLLABORATION

One conceptual framework that can alleviate this interprofessional tension, facilitate definitions of roles in addressing the problem, and assist in developing a broader perspective on programmatic strategies involves breaking the spectrum of violence into levels that reflect different points of intervention. This framework, used frequently in public health circles, structures approaches to problems into three stages: primary prevention, secondary prevention (or early intervention), and tertiary prevention (or treatment/rehabilitation). These distinctions have proved valuable in thinking about intervention efforts even though their boundaries are a little fuzzy. In this discussion, it might be best to think of these distinctions in terms of concentric circles that widen out in space and time from a central point, which is the occurrence of some violent event.

Tertiary prevention is distinguished from secondary and primary prevention in that it lies on the opposite side of the violent event from the other two. Its focus is on trying to reduce the negative consequences of a particular event after it has occurred or on trying to find ways to use the event to reduce the likelihood of similar incidents occurring in the future. Thus, one might think of improved trauma care, on the one hand, and increased efforts to rehabilitate or incapacitate violent offenders, on the other hand, as tertiary prevention instruments in the control of or the response to violence.

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

Secondary prevention is distinguished from primary prevention in that it identifies and focuses attention on relatively narrowly defined sub-groups or circumstances that are at high risk of being involved in or occasioning violence. Thus, secondary prevention efforts might focus on urban poor, young men who are at particularly high risk of engaging in or being victimized by violence, educating them in non-violent methods of resolving disputes or displaying competence and power.

Of course, the relative risk level of groups or circumstances is a continuum—with some people and circumstances at very high

risk (say, a person who has been victimized by violence in his or her own home, also surrounded by violence in school, entering a bar in which members of a rival gang are drinking), and others at relatively low risk (say, a happily married professor, who owns no weapon more lethal than a screwdriver, writing on his computer at home). Moreover, it is generally true that the higher-risk groups are smaller than the lower-risk groups.

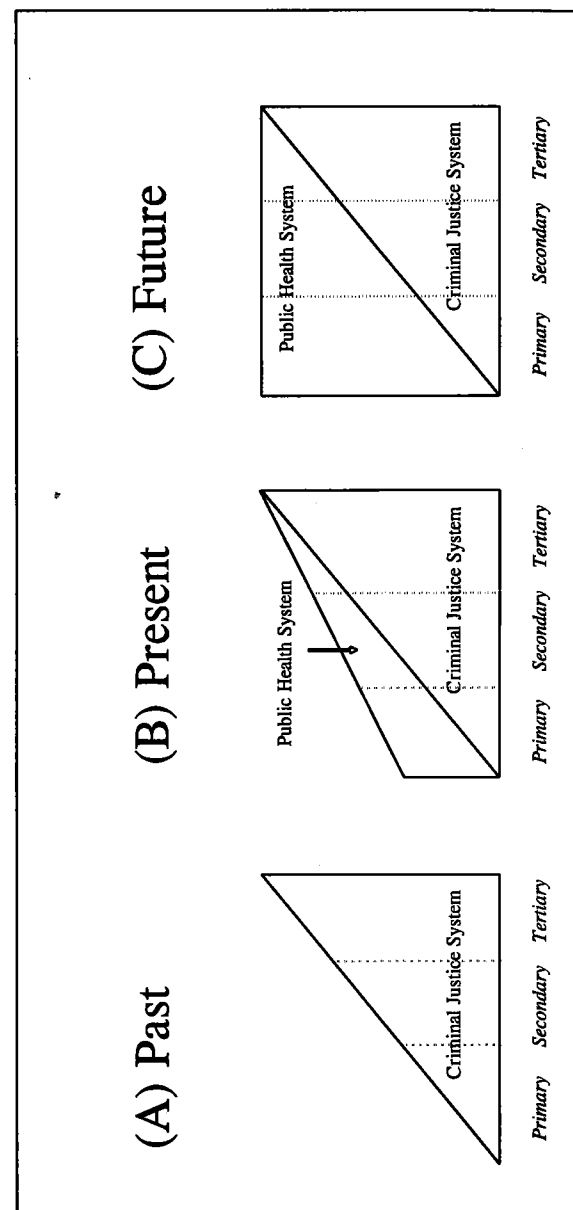
Primary prevention instruments are those that can affect larger and larger populations, ideally at relatively low cost. Indeed, the need to reach very large populations requires primary prevention efforts to have low costs per individual reached. Thus, primary prevention instruments tend to involve providing information and education on the problem of violence through the popular media rather than providing non-violence training to the entire population. Examples of the former approach include the recruitment of Bill Cosby to the cause of using the media to prevent adolescent violence (*USA Weekend*, 1992) and Sarah Brady's efforts to advocate for gun control laws and educate the public about the risks of handguns. There are, of course, the ultimate long-term primary prevention goals that have to do with eliminating some of the root causes of violence such as social injustice and discrimination.

This public health model can be very useful when applied specifically to the issue of interpersonal violence. In the past, the criminal justice system has addressed each of the three points of intervention to varying degrees, as represented in Figure 1 (panel A). However, the bulk of criminal justice efforts have focused on the response to serious violent behavior, with moderate attention to early identification and intervention and limited efforts in the area of primary prevention.

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

FIGURE 1:

Model for Violence Prevention Activities



Adapted from Deborah Prothrow-Stith, with Michael Weissman, *Deadly Consequences* (New York: Harper Collins, 1991), p. 226. Used with permission of the authors.

With the more recent involvement of the public health system, attention has been broadened with enhanced efforts in the preventive arena. The public health agenda has focused primarily on prevention and early intervention, playing only a small role in the treatment of individuals with serious violence-related problems. As reflected in Figure 1 (panel B), the role and activities of the public health system are newer, less extensive, and, therefore, less evolved than those of the criminal justice system. Traditionally, public health has responded by treating the violence-related injury in the emergency setting.

Today, a new generation of committed health practitioners, community violence-prevention practitioners, social workers, and community activists have devised numerous intervention programs to serve medium- to high-risk adolescents. At the primary prevention level, efforts have focused on gun control and safety and on enhanced public awareness of risk factors and the true characteristics of most violence to dispel myths and modify societal values around the use of violence. Additionally, some educational interventions (e.g., violence prevention curricula) have been applied in broader, less high risk settings. Again, much of this work is relatively recent and therefore has not yet established a long track record to fully assess its effects. Finally, public health has applied its analytical expertise to greatly enhance the understanding of risk factors, allowing for a broader vision in the planning and development of preventive approaches (Spivak, Prothrow-Stith, and Hausman, 1988; Prothrow-Stith and Weissman, 1991).

In the area of secondary prevention, public health has been involved in the development of educational interventions specifically focused on behavior modification of high-risk individuals, particularly children and youth. A number of curricula are currently in use addressing both the risks of violence in solving problems and conflict resolution techniques (Spivak, Prothrow-Stith, and Hausman, 1988; Prothrow-Stith and Weissman, 1991).

It is important to note that the criminal justice system has, more recently, increased its involvement with primary and secondary prevention efforts. For example, some criminal justice professionals have become involved in gun control initiatives. The Juvenile Justice and Delinquency Prevention Act of 1974 gave the Justice Department primary responsibility for delinquency prevention programs. The Office of Juvenile Justice and Delinquency Prevention was designed in part to encourage the development of model delinquency prevention programs. One such initiative is

the Targeting Program for Delinquency Intervention, sponsored by the Boys Clubs of America. At-risk boys are referred to the targeting program by other community groups. Early evaluations of the program seem promising. Data indicate that 39 percent of the boys did better at school and that 93 percent who completed the program did not become reinvolved with the juvenile justice system (Boys Clubs of America, 1986). These types of interventions reflect an important interface between the criminal justice and public health professions.

With further attention and the dedication of resources of the public health system to this issue and the broadening vision of criminal justice, a more reasonable balance between prevention and treatment can be achieved in the future. As represented in Figure 1 (panel C), efforts can be broadened to reflect more fully the range of efforts needed to both reduce the extent of violent behavior and respond to the violence that does occur. The emphasis of the public health system will be on prevention, with the criminal justice system prioritizing the response to violence, but with both disciplines working together across the spectrum.

THE MODEL ILLUSTRATED IN OTHER AREAS

To illustrate the advantages of this approach, it is useful to review how it has worked successfully in other areas. One example, which on the surface appears to be a considerable stretch from violence, is the multi-disciplinary approach that has been developed to deal with tobacco use. It is important to note that while this example illustrates a collaboration between public health and the medical care system, it represents a useful analogy to the possible collaboration between public health and criminal justice.

Smoking is a major contributing factor to death and disability in this country. Significant inroads have been made in turning the tide on this major health threat. What was once a valued, sexy, and socially acceptable behavior is now viewed as a disgusting, unhealthy, and socially unacceptable behavior. Heroes in the media used to smoke all the time; now they rarely do. Nationally, the number of people who smoke has declined dramatically. And smoking was and still is a learned behavior, one that can be unpleasant or distasteful to start but is extremely difficult to stop.

The strategy to deal with smoking involved a three-pronged approach: (1) primary prevention for those not yet smoking to teach the reasons for not starting and to support the decision not

to start; (2) secondary prevention to encourage stopping or reducing use for those who already started smoking, which often involves helping individuals to identify alternative behaviors to replace smoking behavior; and (3) treatment in the form of surgery, chemotherapy, or other medical interventions for those smokers who have developed cancer or other health consequences of their behavior. Broad public initiatives to alter the societal values that encouraged smoking were also established to support the above efforts. This was done through legislation (e.g., package labeling, advertising constraints, restrictions on sales to minors, establishment of smoke-free environments), public education, and pressure on media to change images and role models. Although, as stated earlier, this is an example of a public health/medical care interface, it represents an important success that suggests possibilities for a public health and criminal justice collaboration in addressing violence.

A similar approach could and should be taken with respect to violence. Primary prevention strategies and more targeted secondary prevention efforts need to be applied that pro-actively value and teach non-violent behaviors in response to anger and conflict. This is particularly important given the growing evidence that violence is a *learned* behavior.¹ Well-child health visits in neighborhood health centers provide an ideal window of opportunity for early intervention. Peter Stringham, a pediatrician at the East Boston Neighborhood Health Center, incorporates a violence prevention protocol for families, from the newborn visit through the teenage years. Teaching our children social skills is as important as teaching them the academic subjects that we now emphasize in our society. This will in no way eliminate the underlying societal stresses that influence violent behavior but can affect and direct responses to these stresses toward a pro-social and productive outcome. Curricula that emphasize decision-making, non-violent conflict resolution, and development of self-esteem do currently exist, but they are terribly underutilized and are viewed as an "add-on" in academic settings rather than as a basic component of education. A move to place more emphasis on the use of such curricula, with enhanced investment in social

¹ See Prothrow-Stith and Weissman, 1991; Allen, 1981; Bandura, Ross, and Ross, 1963; Eron and Huesmann, 1984; Liebert, Neale, and Davidson, 1973; Slaby and Quarfoth, 1980; Straus, 1991; Vissing et al., 1991).

and support services for families and youth, would be an important step in countering the learned use of violence by our youth. Such a move would also require that the education, human service, and public health institutions play major roles in effecting these changes in our communities.

Indeed, the recognition that education designed to teach non-violent behaviors might be an important part of a combined public health/criminal justice response to the problem of violence helps to remind us that the modern view of how the law operates on behavior in society has become far narrower than it once was. In our modern conceptions of the law, we imagine it operating on individual behavior primarily through its incentive effects—the promise of punishment for misconduct made concrete and credible through individual prosecutions. In the classic writings on law, however, a great deal of attention was devoted not only to the passage of laws and to their application to individual cases, but also to their *promulgation* throughout the society (Friedman, 1975). Extensive efforts to educate citizens as to why the laws were necessary helped to ensure both their justice and their efficacy. Unless citizens knew about the law—its spirit as well as its letter—they could not reasonably be held accountable for failures to obey it. If the purposes of the law were not made clear, then voluntary compliance, which was crucial to the law's effect, could not be assured.

The public health community's interest in non-violence education can be viewed as the modern rediscovery of the importance of explaining to and educating the public about violence, as well as simply having laws and applying them. It also incorporates an important modern discovery about the promulgation of obligations: Persuading people to comply with an important obligation is often far easier when one can show individuals that it is in their best interests to do so and when one can help them comply with the law. Persuasion and assistance are often more effective tools than accusation and blame. Still, it often helps in persuading and assisting if there is a broad social rule against violence that becomes part of the context for the education. Thus, behavioral change may depend on a combination of education and laws that used to be called promulgation.

Gun control legislation efforts represent an important example of the interconnection between education and laws. Although there is growing support for increased handgun ownership restrictions as a primary prevention strategy, legislation alone is unlikely to create great change in violent injury rates in the foreseeable

future. With over 60 million handguns in circulation in the United States, an understanding and acceptance of the risks of handgun ownership and carrying are as important as legislative restrictions to reducing intentional handgun injuries (Bureau of Alcohol, Tobacco, and Firearms, 1991).

A secondary-level strategy requires a more targeted effort. It requires early identification of individuals who are at high risk for violence or are already beginning to exhibit violent behavior, as well as the development of treatment services for such individuals. Secondary prevention represents an important interface between the human service and the criminal justice systems because the early identification of individuals at high risk for violence requires considerable collaboration. Points of early identification occur in schools, health facilities, police departments, courts, and a variety of other community institutions. Professional training in early identification and appropriate evaluation and treatment is necessary. This is not an easy process. Professional definitions and institutional boundaries have been established that encourage limited, one-dimensional approaches.

Treatment interventions (tertiary prevention) for the most seriously affected individuals represent a key focal point for the criminal justice system. Violent behavior cannot be condoned; punishment is an appropriate response to violent crimes or episodes, and some individuals with serious pathology are not able to live in the general society. While it is essential that we understand how violent behavior evolves, we must deal with it firmly to maintain safety within our communities.

Although tertiary prevention falls most extensively into the criminal justice realm, with incarceration as the major strategy, public health needs to work along with the prison system in the area of rehabilitation. Without increased attention to rehabilitative efforts, including supportive services for those returning from prison to the community, most will continue to leave the prison system without the skills to avoid violence in the future. Public health must advocate for and support drug and alcohol treatment services, job training efforts, conflict resolution, and violence prevention skills. In addition, the development of more extensive behavior change interventions must be addressed. To date, successful rehabilitative efforts have been limited, further reinforcing the need for more attention focused on this area.

Finally, the broader societal context that promotes and inadvertently encourages violence needs to be addressed. Again, this is clearly an area requiring collaboration. Changing societal val-

ues is an enormous undertaking that requires a broad base of energy and support. Legislatively, measures such as gun control and media guidelines on violence must be drafted, advocated, and passed. Prevention directed at individuals and communities must be supported and reinforced by professional associations and advocacy efforts that cross traditional boundaries. Resources for children and families must be identified that allow adequate investment in schools, health care, employment opportunities, human service supports, mental health, and, yes, police and courts. This requires a unified vision.

CONCLUSION

Table 1 outlines various strategies that can be used to address violence in each of the three prevention areas—primary, secondary, and tertiary. Some of the activities listed are specific to either the criminal justice profession or the public health profession; others reflect areas of collaboration and overlap between the two disciplines.

Public health focuses on prevention by addressing underlying causes; criminal justice focuses on responding to criminal behavior with the expectation that prevention will grow from the threat of punishment. Both of these systems have important roles to play, and their different perspectives are both complementary and reflective of the continuum necessary to reverse the pattern of growing violence. A process of building communication and collaboration between the fields is essential. Increased communication can be facilitated and enhanced through conferences that recognize the need for cross-disciplinary dialogue, efforts to synthesize perspectives in joint publications, and collaborative research projects that integrate the skills of both professional disciplines.

Collaborative programmatic efforts will move this process even further and will help to establish concrete working relationships between the disciplines of public health and criminal justice. An example of concrete collaboration could be accomplished in joint community training efforts. As part of a violence prevention curriculum in the schools, police officers could provide training on safety behavior to low- to moderate-risk children and adolescents. This has already been accomplished in other programmatic areas described earlier in this chapter.

TABLE 1: Classification of Preventive Strategies

Primary Prevention

- reduced availability of guns (gun control)
- reduced use of alcohol and drugs
- reduced media violence
- behavioral education, anger and conflict resolution
- promulgation of laws
- threat of punishment
- parent education
- street safety measures
- social support services
- community awareness
- risk-factor identification and reduction

Secondary Prevention

- early identification and screening
- behavior modification
- early intervention in schools, emergency rooms, juvenile justice system
- counseling, family support services
- risk-factor reduction

Tertiary Prevention

- jail/prison
- rehabilitation services

Essential to such programmatic collaboration is a closer, more cooperative interface at the federal level between the Department of Health and Human Services and the Department of Justice. Similarly, collaboration at the state and local levels must occur among educators, public health professionals, law enforcement agencies, the legal justice system, and human services systems. Continued fragmentation of funding will thwart collaboration; joint funding and promotion of interdisciplinary program development will greatly enhance collaboration. Some individuals within each of these professions have recognized the need for a comprehensive agenda and have begun this important dialogue. More individuals need to enter this process, and the institutions that greatly influence the bigger picture and provide the resources for all of our work must create the opportunities for this to happen. There is so much to be gained.

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