



The History of Violence

AS A PUBLIC HEALTH ISSUE



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The History of Violence as a Public Health Issue

When and how violence was recognized as a matter for national—and then global—public health intervention

Violence is now clearly recognized as a public health problem, but just 30 years ago the words “violence” and “health” were rarely used in the same sentence. Several important trends contributed to a growing recognition and acceptance that violence could be addressed from a public health perspective. First, as the United States became more successful in preventing and treating many infectious diseases, homicide and suicide rose in the rankings of causes of death. Tuberculosis and pneumonia were the two leading causes of death at the turn of the 20th century. By mid-century, the incidence and mortality from these infectious diseases along with others such as yellow fever, typhus, poliomyelitis, diphtheria, and pertussis were dramatically reduced through public health measures such as sanitary control of the environment, isolation of contagious disease cases, immunization, and the application of new therapeutic and medical techniques. Since 1965, homicide and suicide have consistently been among the top 15 leading causes of death in the United States.^{1,2}

There are other reasons why violence became a greater focus for public health. The risk of homicide and suicide reached epidemic proportions during the 1980s among specific segments of the population including youth and members of minority groups. Suicide rates among adolescents and young adults 15 to 24 years of age almost tripled between 1950 and 1990.³ Similarly, from 1985 to 1991 homicide rates among 15- to 19-year-old males increased 154 percent, a dramatic departure from rates of the previous 20 years for this age group.⁴ This increase was particularly acute among young African American males. These trends raised concerns and provoked calls for new solutions.

Another important development was the increasing acceptance within the public health community of the importance of behavioral factors in the etiology and prevention of disease. It is now generally accepted that prevention of three of the leading causes of death in the United States—heart disease, cancer, and stroke—rests largely on behavioral modifications such as exercise, changes in diet, and



smoking cessation. Successes in these areas encouraged public health professionals to believe that they could accomplish the same for behavioral challenges underlying interpersonal violence and suicidal behavior. Finally, the emergence of child maltreatment and intimate partner violence as recognized social problems in the 1960s and 1970s demonstrated the need to move beyond sole reliance on the criminal-justice sector in solving these problems.



Calls for Action

These trends and developments led to the publication of several landmark reports that highlighted the public health significance of violence. In 1979, the Surgeon General's Report, *Healthy People*, documented the dramatic gains made in the health of the American people during the previous century and identified 15 priority areas in which, with appropriate action, further gains could be expected over the course of the next decade.⁵ Among the 15 was control of stress and violent behavior. This report emphasized that the health community could not ignore the consequences of violent behavior in an effort to improve the health of children, adolescents, and young adults. The goals for violence prevention established in this report were translated into measurable objectives in *Promoting Health/Preventing Disease: Objectives for the Nation*.⁶ These objectives called for substantial reductions by 1990 in: (1) the number of child-abuse injuries and deaths, (2) rate of homicide among black males 15 to 24 years of age, (3) rate of suicide among 15 to 24 year olds, (4) number of privately owned handguns, and (5) improvements in the reliability of data on child abuse and family violence. In 1985, the *Report of the Secretary's Task Force on Black and Minority Health* identified homicide as a major cause of the disparity in death rate and illness experienced by African Americans and other minorities relative to non-Hispanic whites.⁷ And the

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1979

A report from the Surgeon General of the United States: *Healthy people: The Surgeon General's report on health promotion and disease prevention* identifies violence as one of the 15 priority areas for the nation. The report states that violence can be prevented and should not be ignored in the effort to improve the nation's health.

1980

The first measurable objectives for violence are established for the nation by the Department of Health and Human Services – *Promoting Health/Preventing Disease: Objectives for the Nation*.

1981

CDC epidemiologists begin one of the first collaborative efforts with law enforcement to investigate a series of child murders in Georgia.

1983

CDC establishes the Violence Epidemiology Branch to focus its public health efforts in violence prevention.

1989 *Report of the Secretary's Task Force on Youth Suicide* provided a comprehensive synthesis of the state of knowledge about youth suicide and recommended a course of action for stemming the substantial increases that had occurred over the previous three decades.³

Response to the Call

The emergence of violence as a legitimate issue on the national health agenda spurred a variety of responses from the public health sector during the 1980s. In 1983, the CDC established the Violence Epidemiology Branch, which was integrated into the Division of Injury Epidemiology and Control (DIEC) three years later. The creation of DIEC was a direct consequence of a National Research Council (NRC) and Institute of Medicine (IOM) report, *Injury in America: A Continuing Public Health Problem*.⁸ This report recommended establishing a federal center for injury control within the CDC and called for funding that would be commensurate with the size of the problem. Support for the NRC/IOM report recommendations contributed to a gradual increase in the number of staff and the size of the budget devoted to violence prevention research and programmatic activities at the CDC.

Further evidence of increased concern from the public health community during the 1980s was provided by the Surgeon General's Workshop on Violence and Public Health in 1985.⁹ This workshop was the first time that the Surgeon General clearly recognized violence as a public health problem and encouraged all health professionals to respond.

Applying the Tools of Epidemiology

During the same period, the CDC undertook a number of high-profile epidemiologic investigations, looking into a series of child murders in Atlanta and a suicide cluster in Plano, Texas.^{10, 11} These investigations helped to demonstrate that epidemiologic research methods could successfully be applied to in-



1985

The Surgeon General's Workshop on Violence and Public Health focuses the attention of the public health world on violence and encourages all health professionals to become involved.

CDC investigates a pattern of suicides in Texas, the first demonstrated use of field epidemiological techniques to identify suicide clusters.

The Report of the Secretary's Task Force on Black and Minority Health is released and underscores the importance of addressing interpersonal violence as a public health problem and identifies homicide as a major contributor to health disparities among African-Americans.

1986

CDC establishes the Division of Epidemiology and Control.

1989

Report of the Secretary's Task Force on Youth Suicide is released.

cidents of violence. Public health professionals contributed to the understanding of violence through the use of epidemiologic methods to characterize the problem and identify modifiable risk factors. In particular, efforts were made to: (1) describe the problem of homicide and suicide as causes of death, (2) monitor public health objectives for homicide and suicide, (3) examine epidemiologic characteristics of different types of homicide, (4) characterize homicide as a cause of death in the workplace, (5) describe patterns of homicide and suicide victimization in minority populations and among children, (6) study physical child abuse, and (7) quantify the risks of homicide and suicide associated with access to firearms.¹²⁻¹⁴

Determining What Works

Beginning in the early 1990s the public health approach to violence shifted from describing the problem to understanding what worked in preventing it. These efforts were bolstered by a number of appropriations from Congress. In 1992, the CDC received its first appropriation aimed at curbing the high rates of homicide among youth. The following year, the CDC published *The Prevention of Youth Violence: A Framework for Community Action*, an influential document that outlined the steps necessary to implement a public health approach to



youth violence prevention.¹⁵ By 1993, numerous violence-prevention programs were being developed and undertaken in schools and communities across the United States. In 1993, the CDC received its second appropriation for youth violence and used it to evaluate some of the more common prevention approaches being tried across the United States. These evaluation studies were among the first randomized control trials to specifically assess the impact of programs on

1990

“Violent and Abusive Behavior” is included as 1 of 22 public health priority areas in *Healthy People 2000*, the national disease-prevention and health-promotion strategy. It calls for “cooperation and integration across public health, health care, mental health, criminal justice, social service, education, and other relevant sectors.”

CDC establishes The Youth Risk Behavior Surveillance System to monitor priority health risk behaviors among adolescents, including violence-related behaviors that contribute markedly to the leading causes of death and disability in the United States.

1992

CDC receives its first congressional appropriations for youth violence prevention.

violence-related behaviors and injury outcomes. Overall, they helped demonstrate that significant reductions in aggressive and violent behavior were possible with applied, skill-based violence-prevention programs that address social, emotional, and behavioral competencies, as well as family environments.

The achievements made in the prevention of youth violence throughout the 1980s and 1990s were published in *Youth Violence: A Report of the Surgeon General*, which provided a comprehensive synthesis of the state of knowledge about youth violence, including what was known about the different patterns of offending, risk and protective factors within and across various domains (e.g., peer, family, school, and community), and about the effectiveness of prevention programs.¹⁶ The report also highlighted the cost effectiveness of prevention over incarceration and set forth a vision for the 21st century.

The early successes in youth-violence prevention paved the way for a public health approach to other violence problems such as intimate partner violence, sexual violence, and child maltreatment. Efforts were made to document each problem, understand the risk and protective factors associated



1993

A special issue of *Health Affairs* addresses violence as a public health issue – the first special issue to examine violence as a public health problem.

CDC establishes the Division of Violence Prevention within the newly created National Center for Injury Prevention and Control. The Division leads CDC's efforts to prevent injuries and deaths caused by violence.

CDC publishes *The Prevention of Youth Violence: A Framework for Community Action* to mobilize communities to effectively address the epidemic of youth violence sweeping the nation.

with each type of violence, and begin building the evidence-base for prevention. In 1994, for example, the CDC and the National Institute of Justice collaborated on the first national violence-against-women survey. Conducted over the next two years, the survey produced the first national data on the incidence, prevalence, and economic costs of intimate partner violence, sexual violence, and stalking.¹⁷ In 1994, Congress passed the Violence Against Women Act (Title IV of the Violent Crime Control and Law Enforcement Act)—landmark legislation that established rape prevention and education programs across the nation, in Puerto Rico and six other U.S. territories and called for local demonstration projects to coordinate the intervention and prevention of domestic violence. The CDC was given the federal responsibility to administer both efforts. The appropriations for these programs and their subsequent reauthorization from Congress were instrumental in building the infrastructure and capacity for the prevention of intimate partner violence and sexual violence at the local and state level.

Moving Forward in a Global Context

As public health efforts to understand and prevent violence gained momentum in the United States, they garnered attention abroad. Violence was placed on the international agenda

in 1996 when the World Health Assembly adopted Resolution WHA49.25, which declared violence “a leading worldwide public health problem.” The resolution requested the WHO to initiate public health activities to: (1) document and characterize the burden of violence, (2) assess the effectiveness of programs, with particular attention to women and children and community-based initiatives, and (3) promote activities to tackle the problem at the international and country level. In 2000, the WHO created the Department of Injuries and Violence Prevention to increase the global visibility of unintentional injury and violence and to facilitate public health action. The organization’s *World Report on Violence and Health*, published in 2002, is used throughout the world as a platform for increased public health action toward preventing violence.¹⁸



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1994

CDC and the National Institute of Justice collaborate on the National Violence against Women Survey. The survey, conducted in 1995-1996, provides the first national data on the incidence and prevalence of intimate partner violence, sexual violence, and stalking.

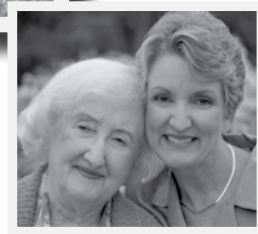
Congress passes the Violence Against Women Act (Title IV of the Violent Crime Control and Law Enforcement Act) which includes support for coordinated community responses to prevention intimate partner violence and state grants for rape prevention and education.

1996

The World Health Assembly passes a resolution and declares that “violence is a leading worldwide public health problem.”

Next Steps

As we move into the 21st century, public health is placing greater emphasis on disseminating and implementing effective violence-prevention programs and policies. The need to document and monitor the problem and identify effective programs and policies through research remains critically important. Nevertheless, a strong foundation has been laid for future success.



1999

CDC publishes *Best Practices of Youth Violence Prevention: A Sourcebook for Community Action*.

The U.S. Surgeon General releases the *Call to Action to Prevent Suicide* report.

2000

WHO creates the Department of Injuries and Violence Prevention.

CDC receives congressional appropriations to establish 10 National Academic Centers of Excellence for Youth Violence Prevention.

2001

The U.S. Surgeon General releases a comprehensive report synthesizing the state of knowledge on youth violence and its prevention.

The *National Strategy for Suicide Prevention* is released by the Department of Health and Human Services.

CDC receives first congressional appropriations for child maltreatment prevention.

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2002

WHO publishes the first *World Report on Violence and Health*.

The National Violent Death Reporting System launches in six states. This was the first state-based surveillance system to link data from multiple sources with the goal of enhancing violence prevention efforts. In 2004, the system is expanded to include 17 states.

2006

CDC launches Choose Respect, the first national communication initiative designed to prevent unhealthy relationship behaviors and dating abuse

2007

CDC publishes a study that estimates the medical and productivity-related costs of violence in the United States exceed \$70 billion each year.



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