Defining Violence

Understanding the causes and effects of violence

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5 Violence in the United States

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Introduction

Former Surgeon General, C. Everett Coop has said that 'The professions of medicine, nursing, and the health-related social services must come forward and recognize violence as their issue and one that profoundly affects the public health' (Rosenberg et al., 1991). The epidemic of violence in America is a public health crisis of epic proportions.

Americans take pride in espousing a social contract that respects the rights of individuals, promotes equality, and values the sanctity of life. The history of the United States began with a violent and bloody revolution. American heroes are traditionally violent. Violence permeates American society. Part of the American tradition lies in glorifying the violent past, and the present. American children learn that the West was won by violence and many Americans believe that it is their right be armed, despite the fact that studies show that a firearm is more likely to be used against the owner or the owner's family than to defend oneself (Kellermun et al., 1993). Despite the perception of an American Dream of peace and harmony, more people are killed by violence in the United States than any other industrialized country in the world, and the majority of these homicides are committed with a firearm. Violence so permeates American society that many believe that it is an immutable part of the human condition.

Nationally, more than 30,000 people die each year as a result of violence (Kellerman et al., 1993) Each year in the United States, approximately 20,000 persons die from homicide, and a similar number die from suicide (Rosenberg et al., 1991; Baker et al., 1992) Homicide is the fourth leading cause of death for children between one and fourteen years of age, and ranks second for ages fifteen to twenty four. Among African Americans fifteen to

thirty-four years of age, it is the leading cause of death (Baker et al., ...). If all Americans died at the same rate as young African American men, approximately 260,000 persons would die from homicide each year (F.B.I., 1993). For infants less than one year of age excluding the perinatal period, homicide is the leading cause of death as a result of injury (Waller, 1985). Homicide rates are highest for young men between the ages of 15 and 34 years. It is estimated that firearms are responsible for 60-80 per cent of the homicides in the United States. The United States leads all countries in the industrialized world in homicide deaths.

Table 5.1
Homicide rates for males, all ages, 1989-1990 by country
All rates are deaths per 100,000 population

U.S. Black	65.6
U.S. All	**15.5**
U.S. White	8.6
Scotland	4.0
Hungary	3.8
Canada*	2.9
Portugal	2.4
Austria	1.9
Switzerland	1.4
Denmark	1.2
Japan	0.7
England & Wales	0.6

Source: WHO Annual and National Center for Health Statistics
*1989 only

In public health, injuries are defined by the notion of intentionality (see chapter 1). Unintentional injuries are those events previously described as accidents, such as drowning, falls and motor vehicle crashes. Intentional injuries include homicides, assaults, suicides and those resulting from legal intervention by the police or armed forces. Problems arise with deriving a definition based on intentionality. Public health records such as death certificates, hospital discharge data, and coroners' reports do not record intentionality with the exception of completed suicides and homicide. Given that intentionality cannot be established, fatal injury rates are most often used as a proxy to describe the epidemiology of injuries in general, and intentional injuries in particular. The cause of an injury is most often described by the

injuries the mechanism of injury ... is or method causing the injury, so that the weapon involved in violence is similar to the vector of disease. Increasingly the vector of violence in the United States is a gun, primarily a handgun (Smith and Laurman, 1988). The importance of firearms, particularly handguns, in the alarmingly high homicide rates in the United States is further emphasized when deaths due to handguns are compared with those in other industrialized nations.

Deaths caused by firearms are classified as intentional, unintentional, and those due to legal intervention. Intentionality is most often determined by a coroner's investigation and/or law enforcement agencies.

The classification of unintended firearm injuries raises the issue of whether a device whose only purpose is to kill can ever be classified as being used unintentionally. During a statistically average day in the United States, one child dies from an unintentional shooting. So-called accidental shootings are the third leading cause of death for 10-29 year olds and the fifth leading cause of death for children from 1-15 years of age. Fifty per cent of all unintentional child shootings occur in the victim's home and an additional 40 per cent occur in the home of a friend or relative (Fingerhut, 1994). In many parts of the United States, suicide rates exceed those for homicides. In 1990, of the 37,184 Americans killed with a firearm, 51 per cent (18,964) committed suicide, and in 1991 48.4 per cent of the 38,235 deaths due to a firearm were classified as suicide (Fingerhut, 1990). In many urban areas however, such as Los Angeles, California, deaths due to interpersonal violence exceed those due to self-inflicted violence. The common element in both types of violence is the availability of a gun, which escalates suicidal thoughts into a fatal reality and, in the case of most homicides, a dispute into a fatal outcome. In order to understand the epidemiology of violent injuries and the magnitude of the escalating epidemic, it is necessary to measure and understand the non-fatal injuries as well. The data regarding non-fatal violent events must rely on a multiplicity of data sources which are not necessarily compatible, such as public health records and criminal justice system records. Non-fatal violence is often under-reported due to difficulties in collecting standardized data. Information on non-fatal domestic violence, child abuse, elder abuse, is often unrepresentative of the levels in the general population, since investigators must rely on studies which do not, and often cannot, select an unbiased sample. Therefore results may not always be applicable to the general population.

Public health records focus on the victim and criminal justice records focus on the perpetrator, and the two are rarely integrated. Available records do not always report intentionality, which may skew the data on intentional violence

to give a false interpretation of the magnitude of the problem. In public health, homicide is used as a surrogate measure for all categories of interpersonal violence, since it is an obvious outcome and reporting is relatively complete. Using homicide as the indicator for monitoring trends and changes in the epidemiology of interpersonal violence permits analysis of trends and comparisons locally, nationally, and internationally.

Victims of homicide

The profile of homicide victims throughout the industrialized world is similar. Worldwide rates are highest for males from 15 to 34 years of age. The United States leads all countries in the industrialized world in homicide rates, by a magnitude of more than 100. In the United States, rates vary by age, gender, racialised and ethnic group. In addition, homicide rates vary by geographic location. Young ethnic minority men aged between 15 and 34 years have rates three times higher than other groups.

Table 5.2
Deaths due to handguns in 1992, by country

Australia	13
Great Britain	33
Sweden	36
Japan	60
Switzerland	97
Canada	128
United States	13,220

Source: Handgun Control Inc., Washington DC

The public health approach to combating violence

The public health approach to violence is a concept that has been developed over the past ten years or so, as it has become increasingly clear that the numbers of deaths and years of potential life lost due to violence is unacceptably high. The epidemic of violence has claimed more lives in Los Angeles than AIDS since 1981, and has required more person-hours of attention from practioners in emergency departments and rehabilitation centers than any other single cause. The public health approach to violence is similar to that used with tobacco use. The ultimate goal of this approach is preventing the occurrence of violence by using primary prevention strategies.

Such an approach involves changing the perception of what is normal or acceptable behaviour. Violence and the injuries that result from violent behaviour are classified as part of the general topic of injury epidemiology and injury prevention.

Despite the fact that most people associate epidemiology with infectious diseases, injury as a public health issue is not new. The public health approach to preventing injuries generally is directed toward interventions that are known to be effective. For example, such an approach to automobile passenger injuries involves the use of passive protection devices, such as seat belts and air bags, and health education to stress the importance of using seat belts and child passenger safety seats. Other examples of the public health model include the use of smoke detectors and the use of barrier fences between house and backyard swimming pool.

It is appropriate to address violence as a public health issue on two counts: it is a measurable phenomenon; and there are appropriate and effective prevention and intervention strategies with which violence has been shown to be preventable. In order to understand the preventive approach it is necessary to understand where primary, secondary, and tertiary prevention fit into the model. Primary prevention is where most public health efforts are directed and aims to prevent exposure to violence and behaviours that lead to violence. Primary prevention may be thought of in the same way as immunization in a medical model. Primary strategies to prevent domestic violence and child abuse would include: provision of parenting training, provision of violence prevention training for pre-school children and their families, teaching conflict resolution skills, mentoring programs and dispute mediation in schools. Secondary prevention focuses on diversion and intervention after exposure to risk factors, for instance, probation programs for those who have been involved in high risk behaviours. Such programs focus on diverting young gang members from engaging in violent gang behaviour, and one of the best examples is the organization of midnight basketball for gang members. In the medical model secondary prevention involves treatment of an illness. Law enforcement is the most common provider of tertiary prevention of violence. It is after the fact and aims to prevent repeated violence. In the medical model, tertiary prevention is the rehabilitative phase of the intervention whose goal is to stop the spread of the disease or the epidemic. Obviously, there are some differences and discrepancies between the medical model and the public health model of violence prevention, but the use of the model provides an example of a measurable, predictable, preventable epidemic, which can be successfully addressed by a comprehensive public health approach. A public health approach has successfully changed behaviour regarding the use of tobacco,

and sexual behaviour has been changed as part of the strategy to prevent the spread of AIDS.

Primary prevention is assumed to be the preferable strategy because of the long term hope for change that it offers. In common with the spread of HIV and widespread tobacco use, the costs of violent behaviour in terms of mortality are high and the secondary and tertiary preventative strategies available are ineffective compared with primary prevention.

Urban versus rural violence

Homicide rates are highest in urban areas, which often leads to the assumption that most violence is the result of random street violence. A study by Fingerhut and Kleinman (1989) compared rates for core counties (containing primary central cities with populations greater than or equal to 1,000,000), fringe counties (primarily suburban counties with populations of at least 1,000,000), medium counties (with populations between 250,000 and 999,999), small counties (with populations of less than 25,000), and non-metropolitan counties. They found that among black male teenagers 72 per cent of the homicides in this group occurred in a metropolitan core county, compared with 6 per cent in non-metropolitan areas. The authors of this study compared death rates for firearm homicides, motor vehicle injury and all natural causes for core counties and non-metropolitan counties in 1988 and computed rate ratios for the urban and rural counties. They found that the firearm homicide rates showed the greatest rate ratios for both black and white teenagers (ratios of 10.8 and 4.9 respectively). Motor vehicle injuries, by contrast, showed a reverse relationship between core and non-metropolitan counties with ratios for both blacks and whites of 0.5. All natural causes of death showed no difference between urban and rural areas (Fingerhut and Kleinman, 1989).

Even in cities, with the highest homicide rates, the majority of homicides and assaults are due to relationships, arguments, and the easy availability of a firearm. The majority of homicides (estimates range from 60 per cent (Weiss, 1994) to 80 per cent (Baker et al., 1992)) occur among people who know each other. Substance abuse, including alcohol and other drugs, play a major contributing role in escalating anger into homicide. The role of firearms, particularly handguns, in escalating the epidemic cannot be overstated. Increasing homicide rates parallel increasing availability of firearms, including handguns (Wintemute, 1994). Handguns are most often associated with urban violence, and long guns such as rifles are more often associated with rural homicide.

Rates of homicide are higher in under-served, impoverished communities (Weiss, 1993). Communities with high rates of poverty and unemployment are also communities with large ethnic minority populations. While minority ethnicity is often identified as a risk factor for violent victimization, minority ethnicity may not be an indicator of risk as much as deprived social class and poverty. Studies that have examined injury rates by ethnicity and poverty have shown that when ethnic group is held constant, the same communities remain at risk from violence, indicating that poverty may play at least as important a role as ethnic group (Chang et al., 1992).

Although rates of homicide are greater in under-served urban areas and fatal outcomes are reported at a lower rate in rural areas, family violence and relationship violence may be nonetheless prevalent in rural settings. Biased reporting and lack of case ascertainment may greatly underestimate the magnitude of the problem in rural settings. Available data suggest that in rural areas rates of self-inflicted violence are higher than that caused by interpersonal relationships. Further investigation is needed to document the variance in rates of violent injury between urban and rural settings.

Youth violence

Youthful street gangs are not a new phenomenon. A brief review of the literature regarding the history of gangs shows that in 19th century London, youthful street gangs terrorized the residents. Prior to the United States Civil War, it was reported that New York City had approximately 30,000 street gang members. At other times Philadelphia and Chicago were proclaimed to be gang capitals. Currently it is thought that Los Angeles is the street gang capital of the world (Garcetti, 1992). In the United States a recorded history of gang activity indicates that second and third generation gang members exist in many urban areas of the country. In Los Angeles, it is estimated that there are more than 100,000 gang members, who belong to more than 1,000 gangs (McBride, 1993). Youth gang behaviour parallels the stages of adolescent development: the need to associate with peers; to fit in; to break away from home; not only typify gang behaviour, but the middle stage of adolescence as well. It is not the gangs themselves that are a menace so much as the violent and criminal behaviour in which they often indulge. The increase in gang violence is traced to the accessibility and availability of firearms, including high-tech automatic and semi-automatic weapons. The easy access to drugs is likely to have increased the lethality of gang violence. Illegal activity is far from the only reason why youths join gangs. Members of gangs commit more types of crime (and more frequently) than non-gang youth, yet many gang members are not involved in crime. Most gang

members are not involved in drug trafficking and most Los Angeles gangs are not organized drug distribution rings. Most gangs are loosely knit, with several members who fill leadership roles, depending on their age and situation. Membership fluctuates and gang members have varying degrees of commitment to the gang. Gang cohesiveness is highest when the gang is challenged by other groups or outsiders (McBride, 1993).

Drive-by shootings and other gun related activities by gang members have increased as guns on the streets have proliferated. Drive-by killings are a direct result of the availability of firearms. People injure people; guns kill people (Genelin, 1992). Gang related homicides in Los Angeles in 1992 were four times higher than the comparable figures for 1978. However, the annual totals for gang related homicides decreased in 1981, 1982, 1984, and 1993.

Table 5.3
Gang related homicides as a percentage of total homicides in Los Angeles County

Year	Total Homicides	Number Gang Related Homicides	Percent Gang Related Homicides
1980	1,825	351	19.2
1981	1,661	292	17.6
1982	1,511	205	13.6
1983	1,480	216	14.6
1984	1,438	212	14.7
1985	1,463	271	18.5
1986	1,542	328	21.3
1987	1,553	387	24.9
1988	1,522	452	29.7
1989	1,766	554	31.4
1990	1,964	690	35.1
1991	2,062	771	37.4
1992	2,209	803	36.4
1993	2,067	724	35.0

There are difficulties in comparing rates of gang activity worldwide or even within the United States, since the definition of a gang member is subject to interpretation. The Los Angeles Police Department defines a gang as a group of three or more persons who have a common identifying sign or symbol and whose members individually or collectively engage in criminal activity, creating an atmosphere of fear and intimidation within the community (Jackson, 1992). The Sheriff's Department uses a similar definition, but

definitions vary by locality and police agency. Gang related crimes are also subject to interpretation by geographic location. The Los Angeles Police Department defines gang related crimes as those in which at least one identified active or associate gang member is the criminal, the victim, or both. Gang reported crimes include assault with a deadly weapon, attempted murder, shooting at an inhabited dwelling, and homicide. Several studies have attempted to test the reliability of reporting methods (Maxson and Kline, 1990; Meehan and O'Carroll, 1992). These studies have affirmed that the Los Angeles Police Department gang related homicide classification was found to be consistent 'between cases, between investigators, between stations, and over time' (Meehan and Kline, 1990). Predominant characteristics of gang related homicide in Los Angeles (1989 to 1991) included disproportionately high numbers of black, male victims. Ninety two per cent of all victims were male and 95 per cent of the victims were either Hispanic or black. This compares with population proportions of Hispanics and blacks at 40 per cent and 13 per cent respectively, so as a proportion of victims of gang violence these figures constitute a considerable over-representation. Eighty-six per cent of the victims were between the ages of 15 and 34 years of age.

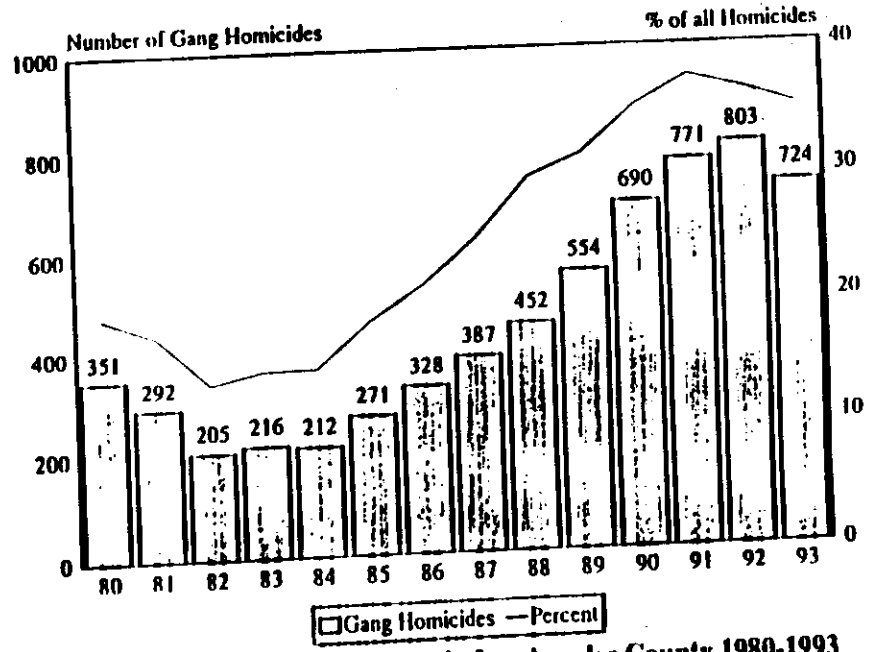

Figure 5.1 Gang related homicides in Los Angeles County 1980-1993
Source: Los Angeles County Department of Health Services Injury and Violence Prevention Program, December 1994

Among the gang homicide victims studied, 58 per cent were gang members killed by other gang members and 42 per cent were non gang members, or innocent bystanders (Gustafson et al., 1992). In Los Angeles approximately two-thirds of all homicides are firearm related (LACDHSIVPP, 1992); among gang homicides, however, 88 per cent of the homicides were firearm related. Eighty-four per cent of the time a handgun was the weapon of choice for the gang related homicides.

As with all homicides, the victim and perpetrators are most often of the same age, ethnicity and gender. It is often assumed that gang related homicide can be tied to drugs and alcohol. However, this is in fact difficult to substantiate for a number of reasons: law enforcement records only report a homicide as gang and drug related if the homicide is the direct result of a 'drug deal'; gang related homicide victims are not consistently tested for drugs and alcohol at autopsy; and finally, suspects are not always apprehended at the scene of the crime and testing for drugs and alcohol at the time of arrest may not reflect conditions at the time of the crime (Weiss and Strassburg, 1992).

The influence of street gangs has spawned a number of high risk behaviours among youth. There is great concern in the increased reporting of children carrying guns to school. In Los Angeles alone, the number of public school children expelled for carrying a firearm to school has increased almost 200 per cent within the past ten years. Approximately two-thirds of the 2,000 children expelled from public schools each year in Los Angeles County are expelled for carrying a gun to school. The Center for Disease Control has estimated that 20 per cent of young people have carried a firearm to school at least once.

Reliance on incarceration to control such activity has glamourized the gang 'life style' and may contribute to the proliferation of youthful street gangs. As law enforcement activity has escalated to control gangs, violence has increased concomitantly. Emphasis on long term solutions is largely ignored in the climate of 'three strikes you're out'. Isn't it about time that we looked at successful prevention models?

The media

In recent years there has been much discussion about the media's role in community violence. Does constant exposure to television violence anaesthetize the population to the horror of violence? Is the media a mirror or an inventor of community lifestyles? The nightly news sensationalizes violence and brings a mythical perception of the amount and type of violence in our communities. The escalating fear factor that has prompted the

increased 'arming' of our homes can be in part, traced to the influence of the [illegible] become increasingly clear that Americans are more likely to respond to the sight of children dying in places such as Somalia, Sarejevo, and Rwanda than they are to the deaths of their own children through violence. This contradiction can be explained in part, by the way in which the media represents violence in foreign countries, compared with their representation of violence in the United States.

Media coverage of children dying by violent means in countries throughout the world focuses on the victims, thus generating sympathy for the victims and their families. Conversely, the nightly news in the United States focuses on the perpetrators of the violence in the United States, thus eroding concern for the victim and enhancing fear of the perpetrators. This focus on the perpetrator instead of the victim has contributed to the 'lock-em up' philosophy so prevalent in the national policy of the United States at the present time. This policy continues despite the fact that the United States incarcerates a larger proportion of the population than any other industrialized country, yet the rate of violence continues to escalate. Incarceration without treatment and rehabilitation thus fails as a preventative measure against violence.

The public health approach to prevention

A public health response to the crisis caused by violent injuries requires a comprehensive public health approach. The public health model includes primary, secondary, and tertiary prevention. Violence and violent behaviour follows a similar pattern to other recent public health epidemics. Its occurrence can be measured and monitored; groups at increased risk and high risk behaviours can be identified. Therefore, the adverse outcomes associated with the epidemic can be predicted and prevented. A public health approach to violence prevention begins with education to increase public awareness about the issue, and about high risk behaviours that can be changed to reduce the risk of becoming a victim of violence. Primary prevention requires a long term commitment and a comprehensive effort from all segments of the community, including the individual.

There have been successful community violence prevention programmes, for instance Jordan High School in the Watts section of Los Angeles. A problem in attempting to replicate these successful community based programs and school curricula is a lack of systematic evaluation for program effectiveness. Such a lack often limits the opportunity to replicate programs. Systematic evaluation allows successful programs to build and expand among vulnerable populations and would encourage funders to provide resources for

long term program support. Evaluation is crucial to demonstrate effectiveness of primary, secondary, and tertiary prevention models. Unfortunately comprehensive evaluation is expensive. Most funding agencies limit access to effective evaluation by funding programs and evaluations for 3 to 5 years. Long term follow-up for evaluation may take 10 to 15 years to determine long term effectiveness.

In addition to discussing the progress of community programs that provide mentoring, tutors and after school activities, teaching parenting skills to adults and youths, and encouraging community input into community program development, professionals must be trained in dispute mediation, conflict resolution, and alternative methods for dealing with anger and cultural sensitivity. Training for medical providers, mental health providers, teachers, and public agencies is crucial to changing community norms to promote the concept that violence is preventable.

Community coalition building for prevention

The public health model requires broad based support from the entire community, including public and private agencies, governmental agencies, the media, schools, university research, medical providers (public and private), law enforcement, probation, the judicial system, emergency medical systems, social services, and the community. A comprehensive community coalition shows the greatest promise for promoting effective violence prevention. A broad based effort requires that we do not address violence by category, but rather by its root causes of poverty, drugs, lack of self empowerment. It seems intuitive that a prevention approach will change the community norm, not just concerning community violence but also domestic violence, child abuse, youth violence, elder abuse, and random violence.

Among the many public health efforts to address the epidemic, the Los Angeles County response is typical of the approach taken by many governmental and private partnerships developed to create a comprehensive effort. In Los Angeles, a Violence Prevention Coalition was formed by the Los Angeles County Department of Health Services in 1991 in response to the public health crisis brought about by the escalating epidemic of violence. This group consists of more than 400 members who are experts in a particular category of violence or violence prevention. Coalition members include representatives from the community, business, medicine, public health, law enforcement, community based organizations, the academic community, schools, the faith community, as well as the State of California Department of Health Services. All work together in a collaborative effort to reduce violence

by measuring the magnitude of the problem, and by developing and promoting effective programs to prevent the injuries caused by violence.

The Coalition was brought together by a mutual belief that the current level of violence and the resulting injuries are unacceptable. Violence can no longer be treated as merely a law enforcement issue but must be addressed as an epidemic affecting every citizen. The Coalition members are in agreement that violence and violence prevention are the concern and responsibility of all segments of the public and private sectors. Moreover, a multi-disciplinary approach using the specific talents and expertise of the various disciplines can call attention to the problem, promote and implement prevention and intervention programs, and evaluate program effectiveness in order to significantly reduce violence and the resultant injuries. In addition, the Coalition provides a forum for influencing public policy regarding public health violence prevention in Los Angeles.

Activities of the Coalition include tracking and sponsoring legislation, investigating the media's role in violence, and advocating for a balanced approach to violence and alternatives to violence in the entertainment and journalistic media. The Coalition also identifies curricula being used by schools, studies the effect of violence on the schools, establishes a comprehensive educational campaign about the effect of violence on the community, explores community resources and programs, and develops interactions between community based organizations. Furthermore, the Coalition is exploring sources of data to quantify the scale of the problem, and drawing up standard definitions and developing linkages between data sets. A resource directory has been compiled, listing all of the resources available in Los Angeles and potential funding sources. The eclectic nature of the Coalition has encouraged the use of public health methods to evaluate the curricula being used by the schools. A series of youth fora are held, bi-monthly, with local youth to obtain their input into the process, and their suggestions for programs and solutions. Training workshops are presented to provide training to the schools. A speakers bureau has been established and the Coalition has facilitated the formation of smaller community coalitions.

Ongoing violence in Los Angeles, including the 1992 Civil Unrest, the high profile murder of the wife of a celebrity, and the subsequent disclosure of a typical domestic violence scenario have shed extended attention on the violence in Los Angeles. During the 1992 Civil Unrest, the violent rage expressed through violence on the streets resulted in more than 2,000 visits to emergency departments. During the three day period of unrest, both victims and perpetrators of street violence were overwhelmingly likely to be ethnic minority males, 15 to 34 years of age. As in the case of homicides and suicides in Los Angeles, most of the injuries in the civil unrest were due to

firearms. The epidemic of violence is far from spent and the public health approach of the Coalition has never been more urgently needed.

Although the public health approach is a long term approach, it shows the greatest promise for reversing the tide of violence in homes, schools and communities. The shift in the perception of tobacco use as normal social behaviour occurred over a period of more than 20 years. Violence as a public health issue has received community attention over the past seven to ten years. It is possible to shift the social paradigm and that is the goal of the public health approach over the next decade. The entire community must be engaged in this effort to promote alternatives to violence, reduce the availability and accessibility of firearms, and to change community norms so that violence is not considered acceptable behaviour.

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