Pursuing Violence-Prevention Strategies: A Case for Individual vs. Social Policy Interventions

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This narrative reflects on the author's experiences over the past fifteen years of attempting to integrate a personal and professional agenda that has focused on the prevention of violence. The traditional distinction made between casework and social policy is not an issue of focus, for the target of both is the individual and/or family. Rather, the difference is the set of tools one employs to effect change.

I hadn't been at the Medical Center but for a short time, when one of the physicians, whom I had come to know, asked me to come downstairs to the Emergency Room—he had something he wanted to show me. He took me into the isolation room that was used to constrain patients who were acting out and, in those days, it usually meant under the influence of PCP. Instead, there was the shape of a small figure, covered with a white sheet. Without saying a word, he pulled back the sheet to reveal the body of a 12-year-old Latino male with a through-and-through gunshot wound to the neck. He had been brought in two days before as a John Doe and remained there, his body still unclaimed. The image was haunting and, in retrospect, I suppose was perhaps the defining moment in my professional career, the significance of which, however, I wasn't to fully recognize until years later. In this isolation room, I had come face to face with the effects of violence. And looking at this young boy lying there, dead, I realized that, but for the grace of God it could have been me, or my child, or anyone else. To me this young boy was a clear sign that violence is not "just" a gang or a drug problem: it is a societal problem. Seeing this young dead boy, gave violence a face; it was no longer just an academic concern. I knew I had to do something about it.

I came to the King/Drew Medical Center in 1985 to pursue my personal and professional goals of working to improve the conditions for underserved populations. When I first came to Drew, I was told there were six areas that had a disproportionate

negative impact on the health of minority populations: cancer, cardio-vascular disease, diabetes, infant mortality, intentional injury, and substance abuse. I chose to work in the area of intentional injury. It may have had something to do with my previous work with juvenile offenders, but violence was an issue I saw as both a daunting challenge and an incredible opportunity for making a difference. I suppose it was the sort of big picture challenge I had set out in search of when I decided to leave the comforts of my job as a middle-school counselor—something, at the time, I had thought I wanted to do for the rest of my life—in order to return to get my doctorate in social policy. At that time, I had no idea the direction my career would take, only hoping that it was something through which I could really make a difference. At that time I was feeling that working with individuals and families wasn't enough. With little guidance, lots of energy, and a heady dose of naiveté, I set out on a personal mission to accomplish what I had

identified in my high school yearbook as my personal goal: to make lots of money and to save the world. Well, in hindsight, they were pretty lofty goals—in particular, the one about making lots of money—for someone committed to a career in the helping professions!

When I first started working at the King/Drew Medical Center, I had no specific expertise in medicine, health care, or violence, and certainly didn't know the first thing about teaching in a medical school. I mean, what was I going to teach a physician? Me, a young Mexican-American man from the Yakima Valley in eastern Washington state by way of a state college and before that, gasp, a community college. But the sheer act of having recently completed a doctoral program, I guess, makes you feel like you can accomplish just about anything and even if you can't certainly to be able to convince others that you can. Yet even with a graduate degree in social policy, I don't think I really understood how an individual goes about promoting social change. In retrospect, however, I can trace the elements of social policy change through the activities in which I was involved

When I first arrived at the medical center, I used to talk to physicians and nurses and support staff at the hospital, telling them that I was going to be working in the area of violence and how totally supportive everyone at the Medical Center seemed to be. Even in the mid-80's, everyone I talked to recognized violence as the defining and perhaps most perplexing social problem facing our inner city communities. From those initial efforts, I helped to establish an institutional Committee on Intentional Injury, composed of the Chairs of all the Departments and any other interested persons. We talked about whether there was anything we could do as health care professionals to minimize the prevalence and/or impact of violence in the community. What I didn't realize, and perhaps couldn't appreciate at the time, was that we were participating in the first steps of the process of social change - increasing our own knowledge and understanding of an issue. At that time, I didn't really think about it in terms of changing social policy but of identifying a common goal. Developing a common body of knowledge among different constituents is the key first critical step of changing social policy. While changing knowledge and understanding of an issue can occur in many different ways, it requires the pursuit of processes through which persons become engaged in a discourse about a social problem or issue to develop a common understanding of the problem and strategies for affecting change.

Initially, there was little consensus among the Intentional Injury committee members about what the problem was. So after unsuccessful efforts to define the nature of the problem, we decided to conduct a series of studies to better inform our conceptualization of the problem. We found that, while everyone thought they knew about the causes of violence, the truth was everyone's perceptions of violence was shaped by the constant media drumbeat of gangs and drugs, gangs and drugs, gangs and drugs. And the profile of patients seen in the Trauma Center certainly appeared to fit that explanation: young black and brown men shot, stabbed, and beaten up. So as we progressed with our discussions about violence, we unanimously decided that we would undertake a research project, interviewing patients who were admitted for trauma to find out how much of it was intentionally inflicted and what led to the altercations.

To begin the research, I applied for and was awarded a small institutional research grant, which paid for a group of rising second-year medical students whom I trained to interview patients, one summer, with the help of our Hospital Social Services Department. So every day, with the assistance of the Trauma Nurse Coordinator, we reviewed medical records, approached patients for consent to participate in a research project, and asked them about the nature of their injury and personal life experiences. With limited resources, we

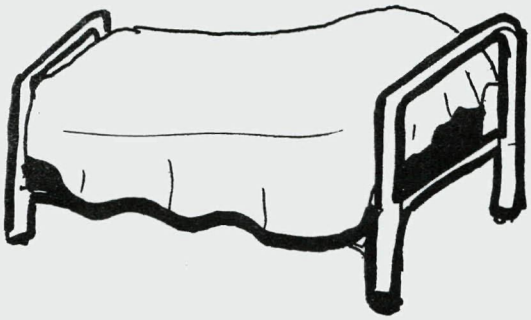
interviewed approximately 100 patients to find out more about how violence affected their lives. What we found through our research was that violence affects all ages, genders, and race/ethnicities, and that gangs and drugs accounted for only a small percentage of intentional injury admissions. Specifically, we found that over 50% of trauma center admissions, at the time of the study, were due to intentional injuries; and that firearms were the leading cause of injury, followed by cutting instruments and blunt trauma. Further results showed a very different profile from what the media had led us to expect. Far from being gang-and-drug-caused or related, most of the violence we saw was the result of an altercation between acquaintances: an argument, something offensive somebody said, a fight at the park or bar, a domestic dispute, etc. Only a small percentage of the trauma admissions were actually gang-or-drug (other than alcohol) related. We also found, as a direct result of the research process, that few individuals had been asked about the incident and that most of the patients admitted for intentional injuries were very open, almost eager, to talk about the incident that led to their admission, what for some had been a near-death experience. It wasn't that they didn't want to talk about their personal situations; it was that nobody had even bothered to ask.

At the conclusion of the research our understanding of the acts of violence that had led to hospitalization was clearer. However, there still was no consensus that we (i.e. health care professionals) were in a position to do anything about it. One day a senior research faculty member was providing a visitor from NIH a tour of the facility and was explaining what research different faculty members were doing. When he stopped in front of my office, not knowing I was inside, he informed the visitor that my interest was in preventing violence, and he made an off-handed comment that I thought that we were going to stop "them" from killing each other and being so violent. They both walked off laughing and making jokes about it. It was clear, however, they didn't understand! While my initial reaction was anger, this situation helped me understand two important points. First, it was evident that while health care professionals are in a position to identify and intervene with victims of violence and those at risk of victimization, there was no consensus that this was the role of the health care provider. Second, it also helped me understand the importance of keeping key decision-makers informed and to continually disseminate information through various means.

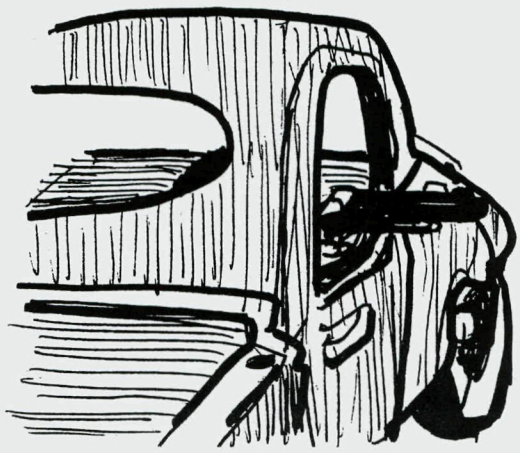
As part of carrying out the research project, I used to review the Trauma Registry in the Trauma Office on a daily basis. We did our daily identification of records and kept track of how many patients were admitted for the previous reporting period. Some days there would be as many as ten admissions and on weekends there could be more than twenty. One Monday morning around 8 a.m., I had gone straight to the Trauma Office to see how many victims of intentional injuries had been admitted over the weekend. What I experienced was a lesson not soon to be forgotten. When I got upstairs to the third floor, it was already crowded, something I hadn't seen before. Entire families were sitting up against the walls up and down the halls, some of them still asleep. I thought it peculiar that so many people were there in this condition on a Monday morning, so I asked the social worker what was going on. She looked at me and said, "It was a bad weekend...they're waiting." Silly me. I looked at her and asked, "Waiting for what?" She looked up and said,"This is overflow from the surgical ICU waiting room and they're all waiting to see if their loved ones are going to survive!" I was dumbfounded and embarrassed. I had

forgotten the humanity behind the numbers. But it was a lesson I learned well. I finally got it: the 12-year old Latino boy, these families, each of the numbers represented not only the loss of a human life but the shattering impact on families, communities, and our society. This was violence. It is an epidemic. This is what violence does. I went back to my office. I knew I had to do something more.

A few days later, after I had gotten over my initial embarrassment, I called the social worker to talk more about what I had witnessed. I asked her what she does when somebody doesn't survive. She told me there's not much her department can do because they were so understaffed and their primary responsibility was discharge planning. She further explained that if individual patients don't need assistance with their discharge (or if they don't leave the hospital—and by definition the deceased



don't), and/or if family members don't "fall out," then hospital social services doesn't usually get involved. I supposed I wasn't prepared for that answer either. I was speechless. Surely social workers would offer help. Not even. But as we talked, the social worker told me she did volunteer work in the community with a support group for the survivors of homicide victims. They met weekly at a church and invited me to visit one Saturday. Even though I thought I would be prepared for what I would see and hear, I wasn't. The grief was heart wrenching. But at the same time, the love and support offered to each other by those who



had experienced such a devastating loss was even more overwhelming.

I guess I had never really thought through the full scope of losing a loved one to homicide. First, there is the shock and grief of a sudden, unexplainable, and tragic loss: a parent, a son or daughter, an aunt or uncle, a close friend. Why? And in such a terrible violent manner. Some had witnessed their loved one being murdered. Some were horrific acts: a gunshot wound to the head, multiple gunshot wounds, internal bleeding, dying in their loved one's arms, multiple stab wounds to the body after being raped, perhaps in front of the children, and then there were the drive-by shootings. The pain, the guilt, the overwhelming grief one is left with: "If only I had...." replaying the scenario that led to the event in one's mind, over and over again. There was a mother who had asked her son to take the garbage out; another who had asked her daughter to run to the store to get something for her.

In the aftermath of the homicide are the burial, funeral arrangements, arrest, no arrest, trial, and so on. There's not enough evidence to charge him. He's going to get away with murder? Then there is the day-to-day impact. How are we going to make ends meet? I can't pay the rent, the car note, tuition. There are no groceries. I have three children and have never worked outside of the home. I only have a fourth grade education. I don't speak English. Will I get deported? What am I going to do? What about my other children? Where are we

going to live? And on and on. Lives turned upside down in a moment, for a lifetime. The pain never goes away; you just have to learn to live with it. Holidays, birthdays, special events, they all bring back a flood of emotions. The newest members of the support group are consoled by those whose loss has been tempered with time and by counseling and the support and compassion of those who truly understand what they were going through.

What do I do? I decided to get involved with two women with whom I now shared a common calling to do something to help those who had had a loved one murdered. We formed a non-profit agency to help, giving birth to the community-based agency: Loved Ones of Homicide Victims. We incorporated the efforts of a group of volunteers — including therapists and mothers who had experienced the tragedy of homicide to a loved one — wrote some grants, and started an agency that was born of the grief and the hopes of those who cared. As time went on, the agency expanded to provide a broad range of services including crisis intervention, emergency assistance, support groups, individual and family therapy, assistance with funeral and burial arrangements, court accompaniment, and in-service training for law enforcement, educators, and therapists. In addition, services now are provided both in English and Spanish and target different age groups including children, teens, and adults.

After several years of working with Loved Ones of Homicide Victims, though, I decided I needed to do more to help prevent the violence from occurring in the first place. One day, while having lunch with two public health colleagues, one from the Public Health Services of the Los Angeles County, Department of Health Services, and the other from the UCLA School of Public Health, we started talking about applying a public health approach to violence prevention. From that meeting we concurred that we could do something about violence. We each agreed to call a couple of friends/ colleagues and meet to talk further about it. This is how the Violence Prevention Coalition of Greater Los Angeles (VPCLA) was formed: people wanting to do something, no plan, no big picture, just a shared concern and belief that something could be done.

At each meeting of this emerging Coalition, attendees were asked to bring others who were concerned about interpersonal violence: child abuse, domestic violence, elder abuse, gang violence, firearm violence, rape/sexual assault. Lively discussions ensued. Are all types of violence alike? What are the commonalities? The differences? It took us an entire year to agree on a common definition of violence! For the record, we identified violence as intentional, interpersonal, and physically injurious. We recognized that our definition was not all encompassing and that it excluded emotional outcomes of violence and self-destructive behavior and other social acts that can be construed as violence against entire populations. I fondly tell the story of a meeting where we were telling each other what our interests were and of our interest in violence. The public health official told the group that one of her roles with the Health Department was to do surveillance...and the representative from the District Attorney's office jumped up and down yelling: "You can't do surveillance...we do surveillance!" I knew then that there was a lot of work to be done.

By applying a public health model to violence, we were able to accomplish several tasks. First, we were able to break down a complex social issue into several smaller components of injury: agent (vector or mechanism of injury), host (victim or recipient of injury), and environment (physical and social). The public health approach provided a different way for identifying risk factors and conceptualizing interventions that target each of the three areas. Second, the public health approach relies on working collaboratively with various entities within a community. Establishing the VPCLA provided both the necessary structure and the flexibility to engage various agencies and individuals

with different organizational missions and funding streams to address the piece of the violence puzzle consistent with their own institutional mission and goals without being seen as a threat or competitor for scarce resources. Coalition partners were not asked to undertake activities that were not already within their scope of services and target populations. Instead, they were asked to work together on common challenges by sharing information and resources to help provide more comprehensive and coordinated services to individuals, families, and communities. Third, over the course of a few years, the Coalition has grown to serve as a clearinghouse to the community for distributing information about what agencies and communities are doing to prevent violence, linking agencies together, and linking communities with resources.

Operating since 1982, the VPCLA is now recognized locally, statewide, and nationally as a model Coalition, representative of a diverse, knowledgeable, and committed constituency. The Coalition, made up of individuals who volunteer their time and efforts, is now composed of over 500 persons from across the county and serves as the regional nexus on issues relating to violence prevention. The Coalition provides the structure for coordinating many community-wide activities that reach across categorical authorities, geographic regions, and target populations served by most agencies. Broad activities coordinated by the VPCLA include maintaining an updated Calendar of Events; hosting bi-annual violence prevention conferences; distributing a regular violence prevention newsletter; maintaining a VPCLA web site with current job announcements, training sessions, etc.; sponsoring and co-sponsoring Violence Prevention marches; and conducting an annual Angel of Peace award ceremony, which recognizes the contributions of local and national leaders and youth who have contributed to the prevention of violence. In addition, it provides its members with information on legislative initiatives and policy analyses of the potential impact of those measures. Its countywide focus also has helped to expand the reach and influence of member agencies that may have local missions but have a lot to teach others about working with a specific population.

However, the public health model has a limited capacity for addressing complex social problems. Based on an infectious disease medical model, it is not as dynamic as the open systems model used in social work, which looks at the context and interactions of individuals, family, community, and society. Other challenges to collaboration across agencies include differences in theoretical/conceptual paradigms used, language used to describe the phenomenon observed, and organizational structures and hierarchies for addressing the identified problems. Integrating the public health model with an open systems model provides a conceptual approach for explaining the complex interactions between individuals, families, communities, and society. It provides us with a more effective approach in understanding the complexity of violence and the need for comprehensive theoretical explanations and dynamic interventions.

In addition, the process of educating different communities has required the establishment of mechanisms to maintain ongoing and iterative structures and processes, both within the community and among Coalition partners. We can thus further understand the dynamic relationships

of bio-psycho-social–economic-political forces that enable violence to occur, disseminate information about best practices, perform values clarification activities, and help others understand the importance of participating in strategies to effect social change through social policy. To accomplish this, we have fully embraced community education as a fundamental task of the Coalition and to create and maintain different forums.

The Coalition promotes community education among its membership by regularly bringing together an array of professional and lay communities to facilitate the pursuit of common objectives and shared values. For instance, the Coalition maintains an organizational structure that supports five standing committees, each of which focuses on broad, cross-cutting issues rather than narrow categories such as age, types of services offered, type of victims, etc. Decisions are made by an Executive Committee that is comprised of the chair and co-chair of each of the standing Committees and key others identified in the bylaws. The standing committees are community mobilization, health, education, policy, and data collection. Each committee is composed of diverse persons from different personal and professional backgrounds, geographic areas of the community, and interests and skills. In addition, the Coalition provides a "keynote" speaker at each of its quarterly Coalition meetings to foster common knowledge of different issues of interest to the membership. The bi-annual Violence Prevention Conference is attended by over 500 persons, including a significant number of attendees who are provided scholarships to cover expenses. It also hosts regular youth forums across the county to engage young people in a discourse on violence, seeks their ideas about what can be done to prevent it, and funds proposals submitted by youth groups to engage in violence-prevention activities.

The educational process about violence prevention also has been maintained at a community level. Changes in attitudes on these issues were necessary before elected officials were even willing to allow these issues onto the agenda for public debate. Thus the Coalition has engaged in various community-education activities over time: sponsoring/co-sponsoring a violence prevention campaign utilizing billboards; public service announcements; publishing and distributing a series of fact sheets; participating on talk and news shows; sending letters to the editors of local newspapers on different issues relating to firearms; and meeting regularly with elected officials and their staff to discuss issues such as banning the sale of Saturday night Specials and semi-automatic weapons, promoting firearm safety devices such as trigger locks and smart gun technology, restricting the purchase of firearms to one gun per month, and preventing the sale of firearms on county property.

These policy changes have only been made possible, however, as the result of sustained efforts to change traditional public attitudes, values, and beliefs on a range of issues: the sacrosanct status of "a man's home is his castle"; the role of children and women as subservient to the man of the house; the notion that the regulation of firearms is somehow unconstitutional; and attitudes towards homosexuality. These long-held cultural attitudes and beliefs had to be challenged and overcome in order to promote social policy changes that target child abuse, domestic violence, firearms, and hate crimes.

The constant pull between intervening at an individual/ family level vs. community/ social policy level still remains within me. To a large extent, the VPCLA has now become institutionalized, with a legitimate office in the Health Department, paid staff, and independent funding. As such, it has taken on a life of its own. I am, therefore, feeling the need to return to the unfinished challenges in my personal and professional life: working directly with troubled youth and young adults. Perhaps my involvement with a new community-based organization called Save Our Future will enable me the

opportunity to integrate my counseling/case-work skills with my policy skills in addressing the needs of young ex-offenders. As I take on this new challenge, I can now draw upon the skills that I learned as a high school counselor, the knowledge of adolescent development and human behavior that I learned as a "houseparent" in a group home with juvenile offenders, the administrative and management skills that I learned in helping to establish a non-profit organization, and the organizational and policy skills that I learned working as part of a community-based coalition.

My involvement with Save Our Future has its roots back in the early 1990's when I was volunteering at Loved Ones of Homicide Victims. At that time, I met a couple of mothers, both of whom had lost children to homicide, who were true inspirations to me and to the many others who had the opportunity to work with them. One of these mothers had a second child who was murdered subsequently. I can't even let myself imagine the pain and heartache she has experienced. But she is an angel of peace. Instead of focusing on her own situation, or becoming angry with the world, this woman dedicated herself to working with juvenile offenders—likely the same individuals who may have been responsible for the death of her two children. She began to pour her energy into a group she started with the help of her husband and others dedicated to a similar cause: Save our Future. She recognized what many of us give lip service to but are not swayed from our day to day routines to do anything about: that our future is truly our youth. We can't cast them aside, or lock them up as many would have us do, or take away their dreams. They need us, just as we need them. The goal of Save Our Future is to help parolees prepare to find jobs using computers and internet technology. By teaching these young men and women how to develop an effective resume, to use email, and to do job searches, we hope to give them a stake and a vested interest in the computer/digital age and provide them with the means to define their own futures.

I suppose I've come full circle now as I become more involved working at an individual level with Save our Future. I once believed I had to choose how I wanted to devote my energies and focus my career - being involved at either an individual or a policy level. I now recognize that they are truly inseparable: that while you can make changes in policy, it still comes down to making changes at the individual level. An understanding of how the processes relate and when to pursue one avenue vs. the other, however, is a skill that has taken me twenty years to discover. So as I start again to help provide opportunities for individual growth and development to a population that has been long neglected by our society, I recognize that helping individuals and families occurs both through direct intervention and through changing social policy. And this time I'm better prepared as I have a fuller set of tools with which to work. ❑