

# Local Health Department Injury and Violence Prevention Infrastructure and Activities



## Introduction

Injury and violence affect everyone regardless of age, gender, race, or socioeconomic status. Injuries are the leading cause of death for Americans ages one to 44, and homicide and suicide are the second and third leading causes of death for persons ages 15 to 34.<sup>1</sup> Mortality rates, however, are only part of the picture. In 2004, approximately 29.6 million people were treated for an injury in U.S. hospital emergency departments.<sup>1</sup>

Injury and violence also put individuals at much higher risk for poor health outcomes. For example, as the Adverse Childhood Experience (ACE) Study suggests, violence and maltreatment in early life are among the major risk factors for the leading causes of illness and death in the U.S.<sup>2</sup> In addition, the ACE Study showed that the children of women who have experienced intimate partner abuse are likely to experience abuse, neglect, and other traumatic experiences.<sup>3</sup> Furthermore, conditions that contribute to the violence that plagues some neighborhoods affect other determinants of health, including whether or not parents will allow their children to be physically active outside or walk to school.

Local health departments (LHDs) are uniquely positioned to plan and implement prevention activities to reduce the health and economic burdens associated with injuries and violence, yet limited information has been collected on injury and violence prevention infrastructure and activities within LHDs. In order to better understand injury and violence prevention activities

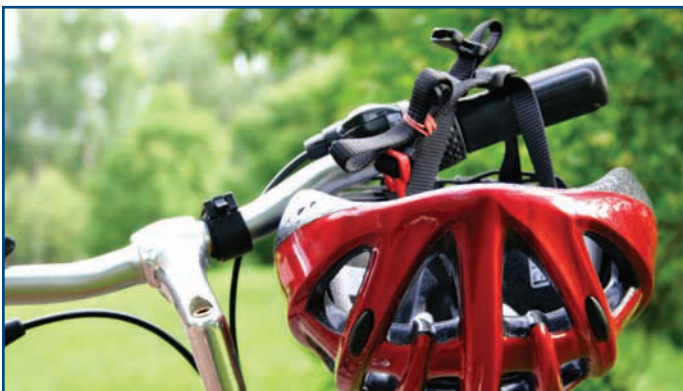
within LHDs, the National Association of County and City Health Officials' (NACCHO's) Injury Prevention Project queried several hundred LHDs through an online questionnaire. This research brief compiles and examines data from this questionnaire. This research brief also characterizes injury and violence prevention efforts within LHDs and highlights the myriad services and innovative injury prevention programs, resources, and activities that LHDs provide.

## Methods

NACCHO used data from the 2005 National Profile of Local Health Departments (Profile) study to create the sample for this study.<sup>4</sup> A random sample of 400 was generated from those LHDs that indicated in the Profile study that they were involved with injury prevention activities. This sample represents approximately 50 percent of the study population (all LHDs who indicated injury prevention in the 2005 Profile). The questionnaire was Web-based and was fielded from July to August 2007. Prior to distributing the questionnaire, NACCHO staff contacted those LHDs selected to participate to verify e-mail addresses. The questionnaire was directed to NACCHO's primary contact at each LHD. During initial contact, NACCHO staff asked the primary contact, usually the health officer, to either complete the questionnaire or forward it to the most appropriate person in the LHD. After eliminating all invalid e-mail addresses, NACCHO staff distributed the questionnaire to 380 LHDs. Through extensive follow-up efforts, the questionnaire yielded a 45 percent overall response rate. The response rates for small, medium, and large LHDs (size of population served) were all similar. In addition to the 171 LHDs that completed the questionnaire, eight LHDs that were not in the original sample completed the questionnaire. These responses are included in the analyses.

## Results

The questionnaire gathered information on the following categories: specific injury and violence prevention activities/topic areas, resources for injury prevention activities (includes funding and staff), internal and external collaboration, access to and use of data, and facilitators and barriers to conducting

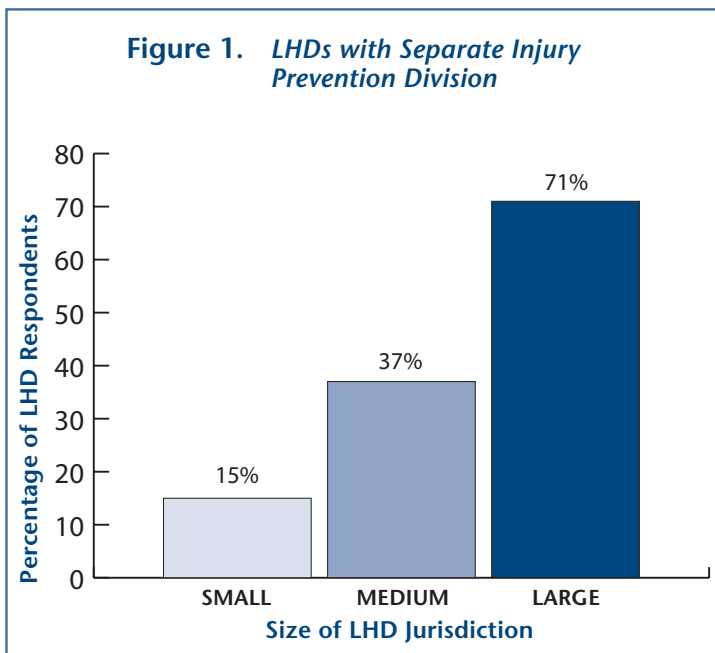


injury and violence prevention activities within the community. It is important to keep in mind that the following results represent a sample from a population of LHDs that reported in 2005 that they were engaged in injury prevention activities.

Eighty percent of LHDs surveyed indicated that they are currently engaged in injury and violence prevention activities. Of those, 32 percent have a separate division or department dedicated to injury prevention. Subgroup analyses were performed on these two questions to determine if jurisdiction size influenced whether the LHD was involved in injury prevention programming or had a stand-alone division or department for injury prevention. Subgroup analysis by population size of LHD jurisdiction used the following three categories:

- Small LHDs: serve populations less than 50,000;
- Medium LHDs: serve populations from 50,000 to 499,999; and
- Large LHDs: serve populations of 500,000 or more.

When analyzed by jurisdiction size, 100 percent of the large LHDs, 86 percent of the medium LHDs, and 69 percent of the small LHDs conducted injury prevention programs. These findings suggest that either many of the smaller LHDs have stopped conducting injury prevention related activities since 2005, or it is possible they reported incorrectly in the 2005 Profile. Large LHDs were more likely to have a separate division or unit within the LHD dedicated to injury and violence prevention than their smaller counterparts. Figure 1 depicts these results.



## Program Activities

Table 1 shows the variety of injury and violence prevention topics that LHDs address. A strong majority of LHD respondents indicated that child passenger safety is an area targeted for prevention activities, particularly in the forms of outreach and education. Additionally, LHDs were asked which topic areas they would like to address but are not currently addressing. The top three responses were suicide prevention, youth violence, and impaired driving.

**Table 1. Topic Areas Addressed by LHDs with Injury or Violence Prevention Programs**

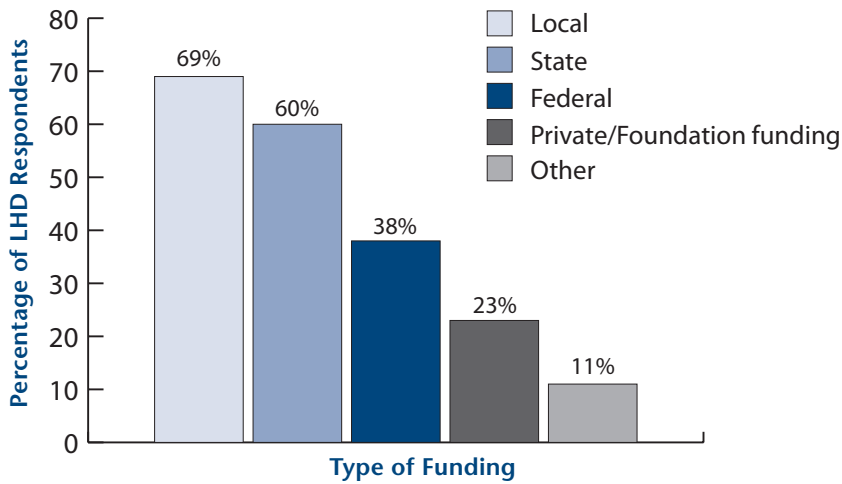
Topic Areas	Percentage of LHDs that Address
Child Passenger Safety	92%
Bike Safety	63%
Child Maltreatment	55%
Falls	49%
Poisoning	47%
Intimate Partner Violence	44%
Pedestrian Safety	33%
Residential Fire Prevention	33%
Drowning	32%
Impaired Driving	27%
Youth Violence	25%
Suicide Prevention	25%
Firearm Safety	24%
Other	19%
Homicide Prevention	7%

## Resources

Funding for injury prevention activities comes from a variety of sources. Questionnaire respondents indicated that injury prevention activities are supported most frequently by local (69% of LHDs) and state (60% of LHDs) funding sources. See Figure 2.

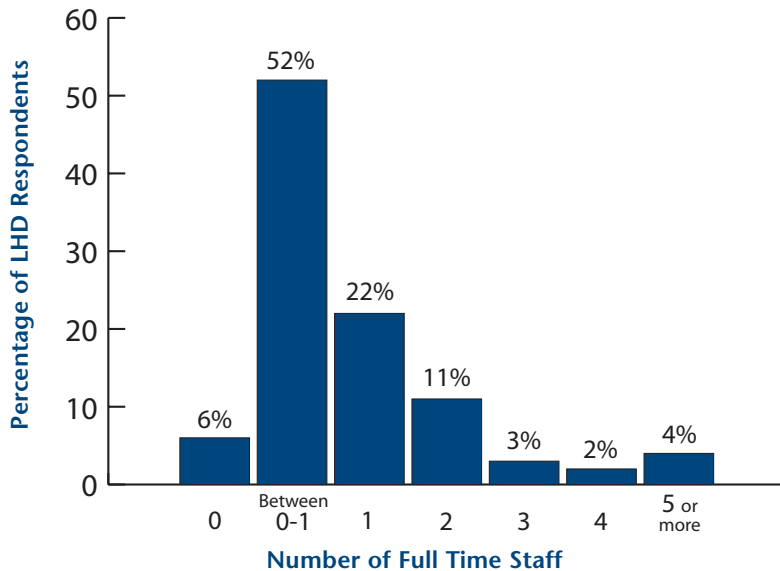
Despite injury being a significant public health concern, injury prevention activities receive relatively modest levels of funding. Eighty-five percent of respondents indicated that five percent

**Figure 2. Funding for Injury Prevention**



or less (majority being less than one percent) of the LHD's total budget is set aside for injury prevention. In addition, few LHDs have one or more FTE staff devoted to injury prevention work. Figure 3 depicts these results.

**Figure 3. Full Time Staff Devoted to Injury Prevention**



## LHDs and Data

The types of data most commonly available to, and accessed by, LHDs are death certificate data and behavioral data (e.g., Behavior Risk Factor Surveillance System or Youth Risk Behavior Survey). LHDs use these data in a variety of ways, including program planning, strategic planning, and seeking funding for sustainability and replication of their prevention activities. Additionally, when asked about facilitators and barriers to

programming, LHDs indicated that local-level data on injury-related topics facilitate program planning and implementation.

## Collaboration

Collaboration, both internally and with external organizations, is vital to the planning and implementation of injury prevention activities. Injury and violence prevention initiatives are often integrated into other program areas within the LHD. Results indicate that the most popular area for integration is maternal and child health (72%). Other responses include emergency preparedness (42%) and chronic disease prevention (40%). Outside the organization, many LHDs convene and lead local coalitions or task forces that focus on injury prevention. Eighty-five percent of LHDs reported partnering with a local coalition. Other community partners include local schools, law enforcement agencies, and hospitals or other healthcare providers.

## Facilitators and Barriers

When asked about factors that influence injury prevention programs, LHDs agree the following facilitate injury and violence prevention programming: a local incident that received widespread publicity, presence of adequate funding, access to locally relevant data, knowledge of proven prevention strategies, and priority given to injury within the LHD and the community. In terms of knowledge or resources that facilitate the implementation of injury prevention programs, the response most frequently given was having knowledge of proven prevention strategies (i.e., best practices).

## Discussion

Although data exist to indicate that injury and violence are issues that affect the health of communities, results from this questionnaire indicate that few resources are allocated to injury and violence prevention. Injury prevention activities are not adequately funded. Many LHDs do not have separate units, or even designated staff, for injury prevention. The LHDs that do have separate divisions tend to be located in large, metropolitan areas. This finding is supported by the information gathered from the 2005 Profile study. Among those surveyed, larger LHDs are more likely to address injury and violence prevention. However, regardless of the size of the LHD, injury and violence prevention are not priority programmatic areas within LHDs.

Among the wide variety of injury-related topics, LHDs report child passenger safety as the most common issue addressed.

This fits well with the finding that many LHDs are collaborating with maternal and child health and chronic disease prevention programs within the LHD. For example, LHDs are working to reduce exposure to violence among children, which has been linked with a greater risk for developing chronic diseases later in life. LHDs are also integrating injury prevention into child obesity prevention efforts by offering health education messages about bicycle helmets, sports safety, and promoting safe routes to school.

In addition to topic areas currently addressed, LHDs were asked to identify emerging issues. Among these responses was youth violence. Although youth violence (which includes homicide, suicide, bullying, and school violence) is a significant public health problem, only 25 percent of the LHDs surveyed are currently addressing it. However, this questionnaire did not assess the barriers LHDs face in addressing youth violence. Youth violence prevention involves a comprehensive public health approach, and this is an area where LHDs can have an impact—if funding and resources are available.

## Conclusion

This questionnaire provided a glimpse into the infrastructure and programmatic activities regarding injury and violence prevention within LHDs. However, the limited data prompt several additional questions. For instance, it would be helpful to learn more about LHDs' capacity for data collection and analysis—in particular, the challenges LHDs experience with access to and use of locally relevant data. Additional information on priority setting and funding sources for injury prevention would be useful in painting a clear picture of injury prevention in LHDs. One more area to focus on may be LHDs' involvement in prevention activities not typically thought of as public health issues (e.g., youth violence). Answers to these questions could provide insight into workforce development issues regarding the skills, capabilities, and training needs of LHD staff.

LHDs face several challenges in implementing injury and violence prevention programs. The major barrier appears to be lack of resources and funding dedicated to injury and violence prevention. Although there are challenges, opportunities do exist to address injury and violence prevention within LHDs; these opportunities involve collaboration across LHD programs to integrate injury and violence prevention messages into existing programs and services.

## NACCHO's Injury Prevention Efforts

NACCHO has a long history in supporting LHDs and communities in their work. For the past seven years, NACCHO has worked with CDC to assist LHDs in meeting the Healthy People 2010 goal of reducing injuries, disabilities, and deaths due to unintentional injuries and violence. Through this relationship, NACCHO, in partnership with the Association of State and Territorial

Health Officials (ASTHO) and the State Injury Prevention Directors Association (STIPDA) has provided education and training to local health officials and agency staff by hosting 25 webcasts on various injury and violence prevention topics and eight sessions during NACCHO's annual conference. In addition, NACCHO has created opportunities for CDC to engage in dialogue with local health officials by establishing an Injury Prevention Workgroup, identified 23 model and promising practices related to injury and violence prevention through NACCHO's Model Practice program, and supported LHDs in their efforts to identify resources to fund injury and violence prevention. NACCHO has also supported local public health efforts by adopting six injury and violence prevention-related policy statements, including those addressing inequities associated with injury and violence, suicide, control of illegal firearms, mandatory motorcycle helmets, and graduated driver licensing.

More information on NACCHO's Injury Prevention Initiative can be found at: <http://www.naccho.org/topics/HPDP/injuryprevention.cfm>.

## References

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# NACCHO

National Association of County & City Health Officials

The National Connection for Local Public Health

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NACCHO is the national organization representing local health departments. NACCHO supports efforts that protect and improve the health of all people and all communities by promoting national policy, developing resources and programs, seeking health equity, and supporting effective local public health practice and systems.

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