Community Interventions to Prevent Violence
Translation into Public Health Practice

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This supplement to the *American Journal of Preventive Medicine* presents evidence reviews and recommendations from the Task Force on Community Preventive Services (the Task Force) regarding three intervention areas for the prevention of violence: firearms laws, early childhood visitation, and therapeutic foster care.[1–3] Of the interventions evaluated by the Task Force, two are recommended for implementation on the basis of evidence of effectiveness: early childhood home visitation to prevent child maltreatment and program-intensive foster care for chronically delinquent juveniles. With strong evidence of effectiveness (for home visitation) and sufficient evidence (for therapeutic foster care), federal, state, and local policymakers should consider the implementation of these interventions in their specific jurisdictions. The purpose of this commentary is to outline the considerations of translating these recommendations into practice at the state level.

Colorado's experience may present an informative example of the implementation of these types of interventions, in that we have successfully implemented a statewide early childhood visitation program. Our experience may not generalize to each unique state, as there is significant variation in the states in terms of administrative structure, government revenue and tax laws, predominant political ideology, and public health and human services infrastructure. Still, many barriers to implementation are shared, as are potentially enabling factors.

Barriers to creating policy for the implementation of community interventions can be grouped into fiscal, political, structural, and perceptual. Fiscal barriers lead the list, especially in view of the nation's more recent economic challenges. States have differing laws regarding debt and deficit spending, and tax limitation laws requiring voter approval for increases in revenue and spending are in place or being considered in some states. Regardless of the source of revenue, most state governments faced significant challenges with budgets in 2002 and 2003. Adding new programs when faced with continuing budget problems, or when faced with restoring funding levels for critical services, requires novel solutions to fiscal issues. It seems logical that prevention programs with proven cost benefit should be easy to create through legislation. However, when faced with significant budget reductions, legislators are forced to concede investing in the future in order to pay for the core programs in the current year and still balance the budget, even if programs will save state monies in future years.

Intertwined with fiscal barriers are political barriers, which can be much more complex. In general, it seems that prevention programs are a little harder to navigate through the political process, as candidates may have more difficulty building their résumés based on what they prevented—what didn't happen—compared to addressing well-publicized problems. Also, partisan politics can hamper the passage of legislation, as parties are reticent to concede political successes to each other, especially when elections are looming. Ideological differences regarding the role of government, specifically when addressing those issues that straddle the fence between public health and social arenas, also play a role when the creation of a new program is considered.

Structural barriers have to do with how the functions of state and local government are organized, and with the relationships between different agencies and jurisdictions. It is much more difficult to implement programs that require interagency cooperation and collaboration for their success. Requiring agency cooperation in the enabling law certainly gives direction, but can force uncomfortable and inefficient relationships between agencies, having to do with perceptions of control, scope of mission, funding, and basic administration difference. In addition, there is a natural stress in the relationship between state and local (county or parish) governmental agencies, as well as between county and community jurisdictions. Public health services are usually delivered locally but often administered, at least partially, centrally, and this division of authority can produce significant barriers to successful implementation.

Finally, perceptual barriers have to do with the sense of importance of the problem to the community, and these barriers again relate to politics. The community must perceive the issue to be a problem, and prioritize it above other issues competing for their attention. Politicians campaign at least partially on their plans to address the problems of their constituents, and prom-

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ising to enact a program that addresses an issue of little interest to the electorate is a waste of precious campaign resources.

Given all the barriers, how does a statewide community-based prevention program get created? Elements for success include: (1) a strong, experienced, and passionate legislative sponsor; (2) an identified long-term funding source; (3) a sellable problem with broad community support; (4) evidence of value to the citizens; (5) administration and bipartisan general assembly support; (6) strong supporting advocates and experts; (7) available infrastructure to support the program; (8) little organized opposition; and (9) good timing.

In 2000, Colorado passed a law creating the Nurse Home Visitor Program (NHVP), housed in the Colorado Department of Public Health and Environment, with oversight and regulatory authority provided by the state Board of Health. The NHVP provides grants to public or private organizations in Colorado to provide health education and counseling services by specially trained nurse home visitors beginning in pregnancy and up to the child's second birthday for first-time mothers with incomes below 200% of the federal poverty level. Local grantees implement the Nurse-Family Partnership Program as developed by David Olds and his associates at the National Center for Children, Families, and Communities at the University of Colorado Health Sciences Center. This extensively studied intervention provided a good deal of the evidence that the Task Force cited in making the recommendation supporting early childhood home visitation to prevent child maltreatment. For state fiscal year 2002–2003, a total of 18 agencies delivered services in 49 of the state's 64 counties. At the end of the fiscal year, 1384 families with 1019 children were active in the program, and the total funding used for the year was $5,560,660.

The majority of funding for the program comes from the state's tobacco Master Settlement Agreement. Also, the Department of Public Health and Environment and the Department of Healthcare Policy and Finance, which administrates Medicaid, have been directed to collaborate in expanding program funding by using Medicaid dollars to reimburse allowable home visitation services when delivered to Medicaid beneficiaries. The intention of the legislation is that the program be expanded annually so that the services will be available for all eligible mothers who choose to participate in all parts of the state.

This implementation had all of the elements of success. The bill was sponsored by state Senator Norma Anderson, a very experienced and respected legislator. The funding source was not general fund (tax) dollars, and appeared to be very stable at the time. The target of the program was low-income mothers and babies, who had well-documented health problems that had an impact on Medicaid spending, and the intervention had good evidence of broad benefits in multiple areas. There was evidence that this investment would save public dollars in future years. There was broad bipartisan support in the legislature as well as support from Governor Bill Owens. There was an organized group of effective advocates, and a well-known national expert in the field who resided in state, David Olds. Local jurisdictions could choose to participate or not through the grant program, the funding level was appropriate, there were local public health infrastructures to support the program, and nurses available to recruit and train. Given all the support for the program, there was little opposition. And, finally, it was brought forward in primarily a mid-term election year when the revenue forecasts were favorable, the economy was strong, and the Master Settlement money seemed like a windfall for health issues.

Implementing a new program of therapeutic foster care could face a much less certain future. Out of necessity, the funds from the Master Settlement, as in many other states, are being used to help balance the overall state budget, and there are no general fund revenues available to create new programs. The tyranny of immediate need precludes the likelihood of even cost-saving interventions to be funded at this time. Advocacy groups have their priorities elsewhere. The economic benefits of violence reduction from this particular program will accrue across other departments (such as justice, corrections, and K–12 schools) that will not be involved directly with the program, which would likely be housed in human services; benefits may not accrue for perhaps a few years. This is neither a current area of media interest nor a clear community priority. For it to be considered, the funding issue would be paramount, but several other issues would have to be resolved as well.

Translating evidence-based community health interventions into public health practice is a logical role for state government to play. Successful policy creation, even for proven interventions, requires a great deal of work and depends on the successful interaction of many factors and factions. Once programs are implemented, maintenance becomes the next big issue and requires ongoing evidence of benefit and continuing commitment of policymakers. For now, Colorado families are benefiting from the successful implementation of a prevention program with proven effectiveness.

References

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