Community and Public Health Nursing:

A Call to Action

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PEER REVIEW STATEMENT

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- Two peer reviewers provided feedback on the whole book.
- Three reviewers provided feedback on three chapters in Unit 1, so that Chapters 1–9 each had an additional reviewer.
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An overview of the VIVA Open Publishing peer review process, including reviewer guidelines and peer review questions, is located at https://bit.ly/publish-with-viva.

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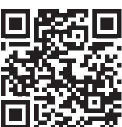

Knowing where and how the OER is used helps VIVA and the authors track its reach and impact and assess the need for updated versions or associated content.

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LIST OF ABBREVIATIONS

AACN: American Association of Colleges of Nursing

ACEs: Adverse childhood experiences

ADHD: Attention-deficit/hyperactivity disorder

ADPIE: Assessment, diagnosis, planning, implementation, and evaluation

AHRQ: Agency for Healthcare Research and Quality

AMP: Action, means, and purposes model

ANA: American Nurses Association

ARPA: American Rescue Plan Act

ASD: Acute stress disorder

CBGVI: Community-based gun violence intervention

CDC: Centers for Disease Control and Prevention

CHANGE: Community health assessment and group evaluation

CHIP: Community Health Improvement Plan

DACA: Deferred Action for Childhood Arrivals

DEI: Diversity, equity, and inclusion

DHHS: U.S. Department of Health and Human Services

EPA: Environmental Protection Agency

FEMA: Federal Emergency Management Agency

GAD: Generalized anxiety disorder

GERD: Gastroesophageal reflux disease

GRASP: Geospatial Research, Analysis, and Services Program

HIV: Human immunodeficiency virus

HOLC: Home Owners Loan Corporation

HRSA: Health Resources & Services Administration

ICS: Incident Command System

INC: In terms of New Cases

INL: Bureau of International Narcotics and Law Enforcement Affairs

IPV: Intimate partner violence

JAMA: Journal of the American Medical Association

KFF: Kaiser Family Foundation

LGBTQIA+: Lesbian, gay, bisexual, transgender, questioning/queer, intersex, and asexual

MAPP: Mobilizing for action through planning and partnerships model

MAT: Medication-assisted treatment

NAADAC: The Association for Addiction Professionals

NASA: National Aeronautics and Space Administration

NCADV: National Coalition Against Domestic Violence

NCAVP: National Coalition of Anti-Violence Programs

NIH: National Institutes of Health

NIAAA: National Institute on Alcohol Abuse and Alcoholism

NIDA: National Institute on Drug Abuse

NIMHD: National Institute on Minority Health and Health Disparities

NOAA: National Oceanic and Atmospheric Administration

NSLP: National School Lunch Program

NQMC: The National Quality Measures Clearinghouse

OASH: Office of the Assistant Secretary for Health

ODPHP: Office of Disease Prevention and Health Promotion

ONDCP: Office of National Drug Control Policy

PTSD: Posttraumatic stress disorder

SAMHSA: Substance Abuse and Mental Health Services Administration

SDOH: Social determinants of health

S.E.L.F: Safety, Emotions, Loss, Future

SNAP: Supplemental Nutrition Assistance Program

STI: Sexually transmitted infection

SUD: Substance use disorder

TEACH: Training in Early Abortion for Comprehensive Healthcare program

UNICEF: United Nations Children's Fund

USDA: United States Department of Agriculture

VNA: Virginia Nurses Association

WHO: World Health Organization

WIC: Women, Infants, and Children program

PREFACE

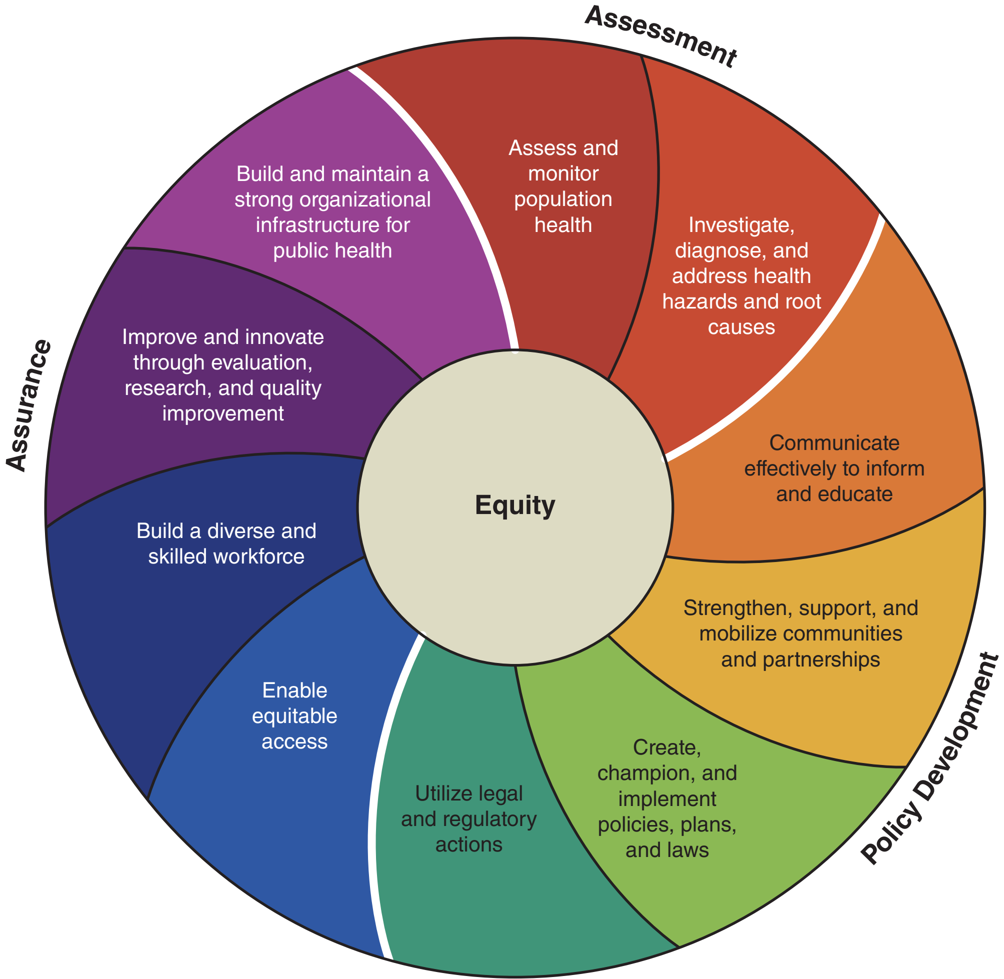

Figure 1: The 10 Essential Public Health Services (CDC, 2024)

Guiding principles for this text focus on community health nursing roles, competencies, challenges, responsibilities, and opportunities for impact that are best considered through the lens of social justice. Social justice promotes the concept that everyone has the right and opportunity to reach their highest level of health and well-being. Quality health care access, education, safe housing, safe living, and safe work environments are the premise for a just society. Our shared belief is that this lens should apply throughout all aspects of professional nursing, including community health. We believe the commitment to social justice is necessary to guide policy, inform actions, and evaluate the allocation of resources to reduce health disparity and level the playing field for all persons when it comes to health. The American Nurses Association Code of Ethics Provision 9 calls special attention to the role of nursing in integrating the principles of social

justice and health policy.[1] Likewise, a core principle supporting the information in this text is an unyielding position that social justice principles should guide all actions necessary to bring about systematic change at all levels of our society and in all domains.

This book responds to the American Nurses Association call and petitions readers to ground their practice in the ethics and values that protect human rights, promote equitable health policy, and reduce disparities.

A NOTE TO STUDENTS

We wrote this book with you in mind. It is imperative that as a future nurse, you recognize your unique opportunity to bring about change to improve the health of individuals, families, communities, and populations. We hope you will use the knowledge gained from this book, the expanse of your nursing education, and your life experiences to do the active work of improving access to care, inclusion, justice, fairness, and equity and will support the rights of all to fully participate in their communities and move toward self-actualization.

Our desire is that as you read this book, you will become enlightened and consider ways you can engage in facilitating change from your current sphere of influence to the level of state and federal policy development. All nurses must be willing to do this and be able to do so. This textbook highlights the strategic role that community and public health nurses have in influencing large-scale change that can revolutionize health care in a way that results in improved health and health care for the state, the nation, and the world. We support you as you continue this critical work for change. Run on!

A NOTE TO EDUCATORS

Our shared goal for this project is to provide a community health open educational resource that supports student access to high-quality free learning materials.

We represent schools from various locations across the state of Virginia that recognize the need for open educational resources for nursing faculty and students.

If you are a nursing educator, you might ask yourself, “Why should I use this book, and why now?” This textbook aims to fill a gap in the equitable distribution of knowledge by providing an up-to-date, free, comprehensive community health textbook to help reduce students’ costs of obtaining a nursing degree. Our belief in social justice extends to our work as educators. Either this text can be used in its entirety or chapters can be separated and used individually or in groups. By providing openly available educational material, we are taking action that makes higher education more accessible to all individuals.

To help educators interested in using this book, we have included Appendix A, which maps the content of this book to the AACN Essentials.[2] You can also access ancillary resources, such as a teaching guide, at https://bit.ly/community-nursing-resources. If you create materials to accompany this text in class, such as slide decks or assessments, we recommend you submit them to vivapub@gmu.edu to be stored alongside the text for future adopters.

1 American Nurses Association. (2016). *The nurse’s role in ethics and human rights: Protecting and promoting individual worth, dignity, and human rights in practice settings.* https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/the-nurses-role-in-ethics-and-human-rights/

2 https://www.aacnnursing.org/essentials

ABOUT OPEN EDUCATIONAL RESOURCES

Information and resources for this collaborative textbook come from a variety of reputable sources, including governmental organizations (e.g., World Health Organization, Centers for Disease Control and Prevention, state health departments), premier health-related journals, health textbooks (as cited), other open educational resources (OERs), and the authors' nursing faculty expertise.

What is an OER? An OER consists of course materials that are made available to students at no cost; OER materials are also available to faculty to use, remix, and alter to best suit the needs of their classrooms. Created under an open license, such as the Creative Commons license we've chosen for this text, OERs invite faculty to achieve their pedagogical goals through materials that their students can access and they can tailor to meet their own needs.

An Introduction to Community and Public Health Nursing

OVERVIEW

The focus of this chapter is to provide an overview of community and public health nursing and highlight its importance in protecting, preserving, and promoting the public's health and safety. The different levels of disease prevention are presented and discussed in consideration of the social determinants of health and health promotion. The chapter provides the common ethical frameworks and theories that guide the work of public and community health nurses.

LEARNING OBJECTIVES

- Define community and public health nursing
- Discuss the roles and settings of public health nurses
- Differentiate between primordial, primary, secondary, tertiary, and quaternary prevention
- Identify the major nursing, social, and public health theories that guide community health education, promotion, and prevention programs
- Identify community health nursing roles and practice settings
- Discuss the ethical principles that guide and influence community health nursing

KEY TERMS

- public health nursing
- community health nursing
- vulnerable populations
- primordial prevention
- primary prevention
- secondary prevention
- tertiary prevention
- quaternary prevention

INTRODUCTION

> *"The success or failure of any government, in the final analysis, must be measured by the well-being of its citizens. Nothing can be more important to a state than its public health; the state's paramount concern should be the health of its people."*
>
> *—Franklin Delano Roosevelt (Quoted in Gostin, 2000).*

Public and community health nursing is a unique aspect of nursing practice. Nurses who work in the community must develop a broad array of knowledge and skills that inform a collaborative approach to improving the health of individuals, families, and whole communities. Community health nurses work directly with community members in roles like home health

and school nursing or through community-based organizations. Public health nurses tend to work with city or state institutions such as the public health department. Though many provide direct care through clinics, many also work to achieve local or statewide population-level health goals. In this chapter, you will learn more about the roles of community and public health nurses, the populations of people they work with, and the overarching approaches to this type of work.

PUBLIC AND COMMUNITY HEALTH NURSING

The American Public Health Association defines *public health nursing* as "the practice of promoting and protecting the health of populations using knowledge from nursing, social and public health sciences" (American Nurses Association [ANA], 2022). Community health nursing is a subset of public health nursing but focuses on specific communities, usually defined in geographic terms. The term *community health nurse* is often used to define a role (e.g., school nurse) more specifically. The public health nurse encompasses the roles of community health nurses but also includes roles that focus on broader interventions that affect whole populations. Throughout this book, the terms *public health nurse* and *community health nurse* are both used. As individuals, nurses directly influence the health and well-being of patients every day. Through frequent contact, nurses are best placed to encourage lifestyle changes in communities and offer education on healthy living, particularly to the most vulnerable in society.

Nurses often work with community partners to address the health of vulnerable populations—those whose health is adversely affected because of their varying access to health care or lack of access to equal social opportunities. This inability to access health care could result from their socioeconomic status, culture, ethnicity, or health status (Waisel, 2013). Some examples of vulnerable populations in the United States are these:

- Racial or ethnic minority members
- Immigrants/refugees/asylees
- Children
- Older adults
- Socioeconomically disadvantaged individuals
- People experiencing homelessness
- Underinsured or uninsured individuals
- Persons who are incarcerated
- Veterans
- LGBTQIA+ population
- Those in certain geographical communities (e.g., Indian reservations, rural)
- Persons who are chronically ill or disabled (Joszt, 2018; Waisel, 2013)

By working collaboratively with community members and key stakeholders, nurses can greatly affect public health as a whole. Nurses can facilitate communication and establish cooperative processes to create inclusive environments. Each community has unique characteristics. Effective community nursing embraces community uniqueness and assists community members to take active leadership roles in determining and addressing needs. During collaborations, community characteristics such as language and cultural preferences may become barriers to effective problem-solving. Nurses can take a lead role as facilitator and advocate

to ensure that high-quality communication between all parties is clear and that the community members' perspectives are centered. Nurses who follow the key principles of community health nursing do the following:

- Emphasize primary prevention
- Work to achieve the greatest good for the largest number of individuals
- Recognize that the client is a partner in health
- Practice cultural humility
- Use resources wisely to promote the best outcomes

PUBLIC HEALTH NURSING ROLES AND SETTINGS

Major Roles

In any setting, the role of public health nurses focuses on the prevention of illness, injury, or disability; the promotion of health; and the maintenance of the health of populations. The community health nurse's role is to integrate public health knowledge into their nursing practice by applying the nursing process of assessment, diagnosis, planning, implementation, and evaluation, commonly referred to as ADPIE (Toney-Butler & Thayer, 2022). Doing this requires incorporating knowledge regarding the social determinants of health (SDOH) in caring for individuals, families, communities, and populations. These determinants of health can be defined as socioeconomic factors with significant direct or indirect impacts on health (Braveman et al., 2011).

Examples of public health nursing activities include the following:

- Evaluating health trends and risk factors of population groups and helping to determine priorities for targeted interventions
- Collaborating with communities or specific population groups within the community to develop public policy and targeted health promotion and disease prevention activities
- Participating in assessing and evaluating health care services to ensure that people are informed of available programs and services and assisted in the utilization of those services
- Providing essential input to interdisciplinary programs that monitor, anticipate, and respond to public health problems in population groups
- Providing health education, care management, and primary care to individuals and families who are members of vulnerable populations and high-risk groups (Missouri Department of Health & Senior Services, 2022)

Community health nurses practice in various settings, including community clinics, government agencies, outpatient clinics, school systems, and nonprofit organizations.

HEALTH DEPARTMENT SERVICES

The Structure of Health Departments

The U.S. Department of Health and Human Services is a federal agency whose aim is to protect all American people. It is the parent agency for many other agencies, including the Centers for

Disease Control and Prevention (CDC). The purpose and function of the CDC reflect the purpose of local health departments.

Public health departments, states, and localities use different governing systems at the local level. There are four main structures for governance:

- Centralized: State employees lead the health units.
- Decentralized: Local (city or county) employees lead the health units.
- Mixed structure: Some local health units are led by employees of the state and some are led by employees of local government. No single structure predominates.
- Shared: Local health units might be led by either state or local employees. If health departments are led by state employees, then the local government has the authority to make financial decisions and/or issue public health orders; if they are led by local employees, then the state has authority (CDC, 2021a).

The Purpose and Function of Health Departments

The key principles of public health nursing work within the framework offered by the CDC's 10 Essential Public Health Services, which protect and promote the health of all people in all communities. To achieve equity, the 10 Essential Public Health Services actively promote policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers resulting in health inequities. Such barriers include poverty, racism, gender discrimination, ableism, and other forms of oppression. The 10 Essential Public Health Services stipulate that public health care providers do the following:

1. Assess and monitor population health status, factors that influence health, and community needs and assets
2. Investigate, diagnose, and address health problems and hazards affecting the population
3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it
4. Strengthen, support, and mobilize communities and partnerships to improve health
5. Create, champion, and implement policies, plans, and laws that affect health
6. Utilize legal and regulatory actions designed to improve and protect the public's health
7. Assure an effective system that enables equitable access to the individual services and care needed to be healthy
8. Build and support a diverse and skilled public health workforce
9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement
10. Build and maintain a strong organizational infrastructure for public health (CDC, 2021b)

The core functions of public health—assessment, policy development, and assurance—provide the structure for assessing public health performance and serve as the basis for these 10 Essential Public Health Services. These services, shown in Figure 2, offer the framework for carrying out the mission of public health nursing and describe the activities that all communities should undertake (CDC, 2021b).

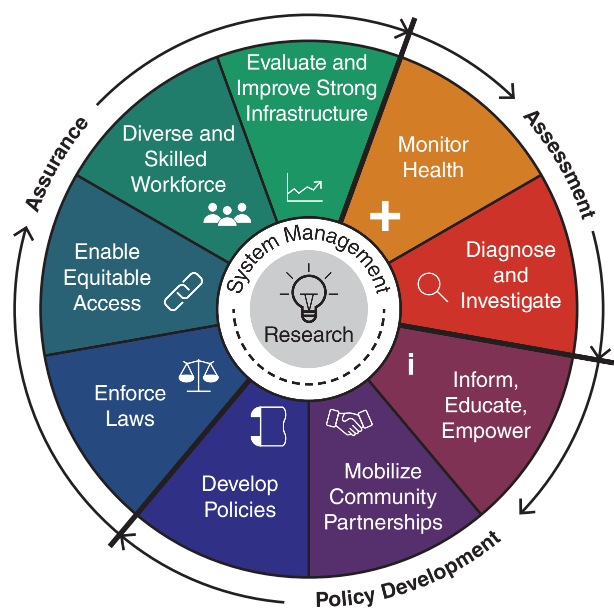

Figure 2: The Core Functions of Public Health (Centers for Disease Control, 2024)

Local public health agencies provide services at the community and individual levels. Local health departments have a fundamental and complex role as the front line for the delivery of basic public health services to most of the communities in this country. Health departments provide services that include emergency preparedness and response, immunizations, environmental health, infectious disease prevention, food safety, maternal and child health, tobacco control, and injury and violence prevention (National Association of County and City Health Officials, 2017). Through primary, secondary, and tertiary prevention strategies, local health departments promote and protect the health of the people and the communities where they live and work (Figure 3).

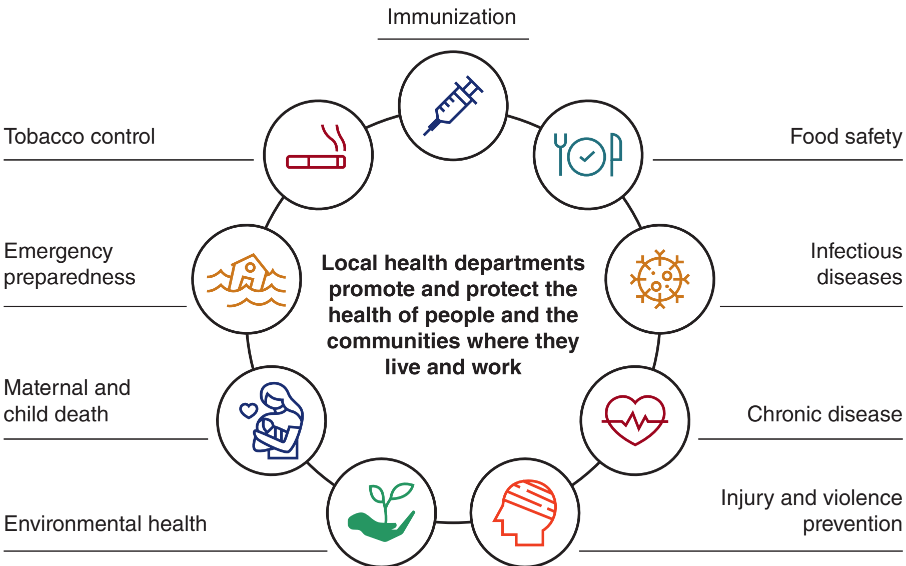

Figure 3: Examples of Health Promotion and Protection by Local Health Departments (Adapted from National Association of County and City Health Officials, 2017)

DISEASE PREVENTION

Primordial, Primary, Secondary, Tertiary, and Quaternary Prevention

Prevention focuses on improving the public's health through avoiding disease, reducing disease severity, and promoting health rather than only treating disease. Prevention strategies address the five distinct stages of illness:

1. Underlying
2. Susceptible
3. Subclinical
4. Clinical
5. Recovery/disability/death (Kisling & M Das, 2022)

Prevention strategies for each stage of illness are divided into four levels: primordial, primary, secondary, and tertiary (Figure 4). These strategies are intended to prevent disease and reduce associated risk and complications from its progression. The health of the American public has improved in some ways over the last decades, but many diseases and illnesses are still increasing in frequency (CDC, 2019). Reasons for these increases are often unknown, making prevention an important element of disease management.

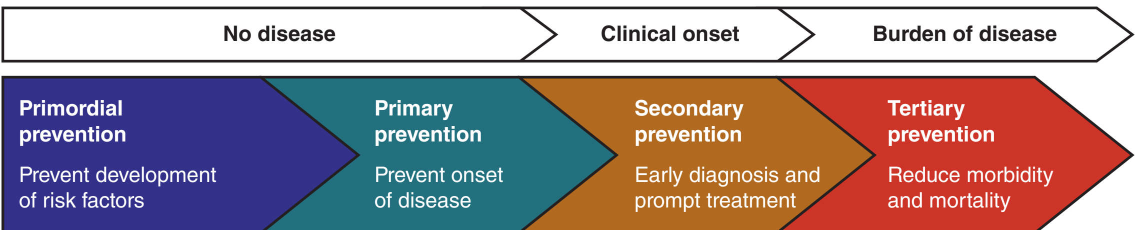

Figure 4: Examples of Stages of Disease and Prevention Levels (Adapted from Martin et al., 2021)

Primordial Prevention

The newest level of prevention, primordial prevention, involves identifying social and environmental variables that can influence the health of entire populations and implementing targeted risk reduction strategies (Kisling & M Das, 2023). These efforts are often advanced by laws and public policy. Primordial prevention is designed to address underlying stages of the disease by considering SDOH. The purpose of primordial prevention is to modify SDOH by addressing factors that are understood to increase the risk of future diseases, such as environmental, economic, social, and behavioral conditions. These strategies seek to inhibit risk factors at a systemic level rather than at the individual, personal level (CDC, 2019).

Examples of primordial prevention include these:

- Government policy—increasing taxes on cigarettes, decreasing advertisement of tobacco
- Built environment—increasing access to safe walking paths, increasing access to stores with healthy food options

- Health promotion—increasing the affordability of programs and activities that maximize health, increasing activity, and promoting weight reduction (CADI Research Foundation, 2012; Kisling & M Das, 2023)

Primordial prevention policies are population-based strategies for prevention. Strategies aimed at lowering risk factors of the entire population are focused on modification of lifestyle with three major lifestyle changes being primarily targeted: smoking cessation, healthy diet, and increased physical activity. Substantial health improvement can result from relatively small costs in these areas. Promoting a healthy lifestyle in the population can be encouraged by helping people seek alternatives and making those alternatives available. Implementing many primordial, evidence-based interventions requires an established long-term policy framework and appropriate institutional support. The goal of primordial prevention is to create future generations who experience fewer health risks and enjoy a greater state of wellness. Public health nurses can participate in primordial prevention by becoming change agents through participating in policy creation and review to protect population health (Villa et al., 2021).

Primary Prevention

Primary prevention strategies are designed to intervene before illness occurs (CDC, 2019). They may include actions to improve health, such as providing information on behavioral and medical health risks, giving guidance, and suggesting measures to decrease health risks at the personal and community level. Primary prevention focuses on measures targeting a susceptible population or individual. The purpose of primary prevention is disease prevention through actions and strategies designed to prevent disease from beginning in the first place. As such, the target population is healthy individuals and communities. Primary prevention is aimed at limiting risk exposure. In addition, primary prevention prioritizes programs and interventions designed to increase the immunity of at-risk individuals in order to prevent a disease from progressing to subclinical disease (Kisling & M Das, 2023).

Primary prevention includes actions targeted at avoiding the manifestation of a disease. This may include any of the following ways to improve health:

- A change in the degree of influence and impact of social and economic determinants on health
- Provision of information and intervention programs on behavioral and medical health risks, in addition to consultation and measures to reduce risk at the personal and community level
- Nutritional and food supplementation programs
- Oral and dental hygiene education
- Clinical preventive services such as immunization and vaccination of children, adults, and the elderly, as well as vaccination or postexposure prophylaxis for people exposed to a communicable disease (World Health Organization [WHO], n.d.)

Public health nurses participate in primary prevention when they participate in vaccination outreach clinics, nutrition education, food access programs, or any other activity designed to prevent the onset of disease at the individual, family, or community level. Nurses also play an essential role in educating people about the adoption of healthy lifestyle choices such as embracing good nutrition, avoiding smoking, engaging in physical activity, and investing in strategies for stress reduction (Vellone, 2016).

Secondary Prevention

Secondary prevention targets early disease detection to improve the chances of positive health outcomes. Secondary prevention aims to detect a disease or condition in an asymptomatic stage and prevent progression to symptomatic disease. Early diagnosis and prompt treatment assist in preserving health. Many diseases found early may be cured without residual complications and pathologies. Often individuals can return to full health (AbdulRaheem, 2023). Secondary prevention also aims to prevent the spread of disease to other individuals and limit the expected disability to prevent potential future inactivity and dependence. While primary prevention activities may be implemented independently of other advances and support structures in other health care services, this is not so for secondary prevention. The benefits of screening and early detection are limited without access to other parts of the health care system. Nurses are the primary caregivers in many diverse and different health care settings and play a significant role in conducting secondary prevention, often serving as a liaison between participants and other professionals. Nurses' perceptions of the barriers to and enablers of secondary prevention help create better understanding of the influencing factors of secondary prevention while contributing to enhanced secondary prevention program design (Ni et al., 2022).

Public health nurses participate in secondary disease prevention services and such activities as:

- Evidence-based screening programs for early detection of congenital malformations
- Blood pressure screening
- Community screening of HGA1C, which can identify prediabetic states
- Hearing screenings for children under age 5 (WHO, 2022)

Tertiary Prevention

Tertiary prevention focuses on both the clinical and outcome stages of a disease. It aims to reduce the severity of disease in symptomatic patients and make living easier with long-term health problems and injuries. Tertiary prevention aims to modify the negative consequences of an already established disease and focuses on measure to restore function through mental, physical, and social restoration and rehabilitation. Tertiary prevention intends to improve the quality of life by reducing disability, limiting or delaying complications, and restoring function. The following are some examples of tertiary prevention:

1. Disease management activities: Disease management activities of chronic conditions such as hypertension, diabetes, asthma, or heart disease are best examples. Strategies focus on lifestyle changes, medication management, and routine physicals. They are implemented by the provision of education, self-care practices, and regular monitoring and are intended to assist persons in controlling their condition, fostering patient compliance, maturing self-efficacy, and avoiding future consequences.
2. Rehabilitation activities: Rehabilitation interventions play a crucial role in supporting individuals who have experienced a significant injury and are designed to help these individuals regain lost functions and skills. These interventions often include physical therapy to restore mobility, occupational therapy to regain independence in daily activities, and speech therapy to enhance communication abilities.

3. Pain management: Pain management strategies are unique tertiary prevention measures designed to help individuals coping with chronic pain conditions. The primary goal of comprehensive pain management is the reduction and/or alleviation of pain in contribution to an overall better quality of life. (AbdulRaheem, 2023)

Nurses participate in many tertiary prevention programs. Among their responsibilities are these:

- Managing outpatient and home-based cardiac or stroke rehabilitation programs
- Leading evidence-based community chronic disease management programs
- Leading support groups that allow members to share strategies for living well

Quaternary Disease Prevention

Quaternary disease prevention includes action taken to identify patients at risk for overtreatment. It is a more recent concept designed to identify persons at risk of excessive medicalization who therefore afford protection from further unnecessary interventions, including avoiding iatrogenic damages. These individuals may be open to suggestions about ethically acceptable alternative measures. Quaternary prevention requires physicians, health professionals, and managers of health systems to critically evaluate themselves and their activity. To be successful, this reflection should include an operational consideration that includes the questioning of technical and ethical limits. The intent is to heighten self-awareness regarding influences that affect decisions. Quaternary prevention is focused on prospective constructs of good practices without cultural, technical, and institutional bias, which can prove harmful to the health of an individual or the health of the population as a whole. The objective of this type of prevention is to influence the action of professionals and health systems (Tesser, 2017). Nurses have the unique opportunity as a function of their patient advocacy role to encourage patients to actively participate in their health care decisions. Nurses practice good advocacy through first establishing an effective and transparent communication and trust relationship with patients and by then becoming and remaining aware of patients' legal rights, with the aim of protecting these rights.

Public health nurses support quaternary prevention strategies by doing the following:

- Completing medication review and reconciliation to prevent unnecessary polypharmacy
- Initiating conversations and assisting in completing advance medical directives
- Empowering individuals, families, and communities to be active and equal participants in their care, seeking second opinions when necessary

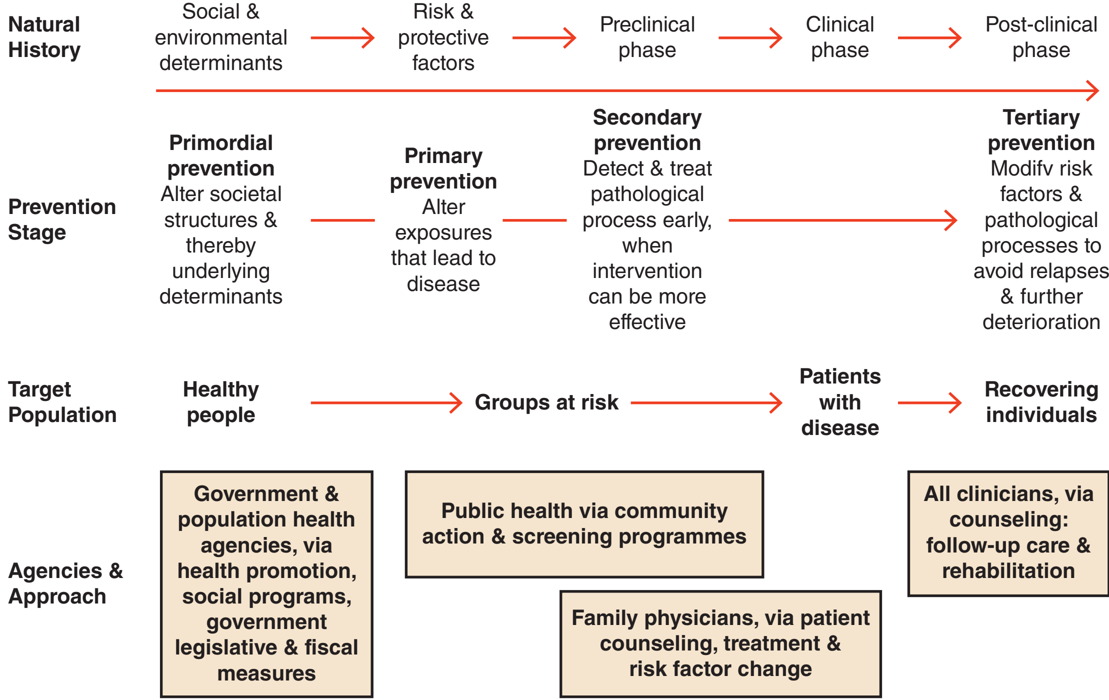

Figure 5: Clinical Course of Disease: Four Prevention Stages (Adapted from Association of Faculties of Medicine of Canada, 2022)

HEALTH PROMOTION

In addition to engaging in prevention strategies to increase the health of communities, public health nurses also engage in health promotion. A working definition for health promotion was presented during the First International Conference of Health Promotion conducted in Ottawa, Canada. *Health promotion* was defined as "the process of enabling people to increase control over, and to improve, their health" (WHO, 1986). Health promotion involves encouraging, guiding, and supporting people in choosing healthy lifestyle behaviors through health literacy. Health promotion applies to individuals, the community-at-large, or vulnerable populations. Examples of public health nursing engaging in health promotion are:

- Building health literacy
- Participating in health campaigns, like knowing the signs of a stroke or performing regular self-exams

Impacts of Prevention Strategies

Prevention strategies and health promotion have an impact beyond the individual. The CDC outlines essential benefits of prevention strategies to communities, including:

- Health status and health disparities. Any intervention that directly or indirectly affects the determinants of health will also affect the community's health, reducing the likelihood of disparity between populations.

- Health care costs. Prevention strategies can also have an impact on health care costs. When a positive change affects an entire community, that community's overall medical care costs go down.
- Non-health impact. Many health prevention interventions have impacts on other sectors of people's lives. Non-health impacts can improve people's ability to increase their "well" days where they can work or enjoy recreational activities that increase their income or sense of well-being. (Miller et al., 2015)

ETHICS

Ethical practice is essential because nurses deal with ethical issues daily. Ethical dilemmas arise as nurses care for patients. These dilemmas may sometimes conflict with the ANA Code of Ethics or the nurse's ethical values. Nurses are advocates for patients and must find a balance while delivering patient care (Haddad & Geiger, 2022).

Ethical considerations in nursing, though challenging, represent a true integration of the art of patient care. Nurses are responsible for themselves, their profession, and their patients to maintain the highest ethical principles. Some organizations have ethics boards in place to review ethical concerns. Public health nurses have an ethical imperative to advocate for patient care, patient rights, and ethical consideration of practice. Ethics inclusion should begin in nursing school and continue in nursing practice.

Community health nurses are guided by the ANA Code of Ethics and other principles and theories, including social justice theories (Pope et al., 2016; ANA, 2016).

Social Justice

Social justice is based on the application and distribution of equity rights, access, and participation within a society focused on countering oppression and powerlessness. In terms of social justice, the role of public health nurses is to support the inclusion of people living on the margins of society, helping empower them to freely participate on an equal footing of respect (Vollman, 2004). Social justice in health care translates to the delivery of high-quality care to all individuals. Achieving social justice is critical to equitable health and health care that ensures all individuals can maintain their highest level of health and wellness (Pope et al., 2016).

Theory and Frameworks

The ANA Code of Ethics for Nurses

The ANA has developed a comprehensive code of ethics that clarifies the profession's primary goals, values, and obligations. The ANA code is an ethical decision-making framework. For all nurses, this code stands as a succinct statement of the ethical obligations and duties of every individual who enters the nursing profession. Nurses should know and demonstrate these principles within their practice (ANA, 2015).

Ethical values are universal rules of conduct that serve as a basis for discerning which actions, intentions, and motives are valued. Ethics are the guiding "moral principles that govern how the person or group will behave or conduct themselves" (Haddad & Geiger, 2022). The focus of ethics is to provide a guide for the right and wrong actions and their consequences when engaging in the decision-making process. Although individuals possess their own set of ethics, morals, and values, many professional organizations have developed a set of ethical principles to guide

competent practice with integrity and good judgment. “Ethics within healthcare are important because workers must recognize healthcare dilemmas, make good judgments and decisions based on their values while keeping within the laws that govern them” (Haddad & Geiger, 2022).

There are currently nine provisions for the ANA Code of Ethics that guide nursing practice. The following is a summary:

Provision 1. The nurse practices with compassion and respect for every person’s inherent dignity, worth, and unique attributes.

> The nurse must provide care to all individuals with demonstrated dignity and respect while valuing their unique attributes. This means that care must be personalized to meet the needs of the individual.

Provision 2. The nurse’s primary commitment is to the patient, whether an individual, family, group, community, or population.

> The nurse should consider the patient as a primary concern while addressing their concerns and encouraging their active participation in their care. Conflicts of interest, at whatever level, should not influence patient care. The nurse must be open to collaborating while maintaining professional boundaries to maximize the level of care provided to the patient.

Provision 3. The nurse promotes, advocates for, and protects patients’ rights, health, and safety.

> The nurse must comprehend and guard all privacy and confidentiality guidelines to protect the patient. The nurse must ensure that informed consent is obtained when needed. The nurse involved in research must ensure that they are well versed in the protection of human subjects and that all safeguards include full disclosure for patients agreeing to participate in research studies and the maintenance of patient privacy and anonymity. The nurse must adhere to all established standards of practice and maintain a high level of competence using current evidence-based interventions.

Provision 4. The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and acts consistent with the obligation to provide optimal patient care.

> The nurse must utilize their authority in an ethical, professional manner. The nurse must responsibly engage in well-thought-out, planned, and purposeful decisions. Delegation of nursing activities or functions must be done with respect for the patient and the actions required to ensure appropriate delegation to one who is qualified and capable of completing the task.

Provision 5. The nurse owes the same duties to themself as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.

> The nurse must demonstrate care for self as well as others. The nurse should be concerned for personal and professional growth and development.

Provision 6. Through individual and collective effort, the nurse establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.

> The nurse is responsible for establishing, maintaining, and improving the ethical, safe, quality work that offers high-quality care.

Provision 7. In all roles and settings, the nurse advances the profession through research and scholarly inquiry, professional standards development, and nursing and health policy generation.

> The nurse must be willing to engage with scholarly inquiry and research and advocacy for and generation of nursing and health policy. The nurse's educational experience should include research principles, and each nurse should understand how to apply scholarly work and inquiry into practice standards.

Provision 8. The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.

> The nurse must collaborate with colleagues in nursing and other disciplines to maximize patient outcomes, promote health diplomacy, protect human rights, and reduce health disparities within their sphere of influence.

Provision 9. The profession of nursing, collectively through its professional organization, must articulate nursing values, maintain the profession's integrity, and integrate principles of social justice into nursing and health policy.

> The nurse is responsible for participating in professional organizations with a willingness to become a voice for social justice and the advancement of the nursing profession. The nurse must maintain political awareness to maintain the integrity of the nursing profession. The nurse should willingly contribute to health policy advocacy, which should be shared among the profession, joining nurses worldwide for a unified voice (Haddad & Geiger, 2022).

Sufficiency of Well-Being

Powers and Faden's (2008) theory of sufficiency of well-being presents social justice as the moral foundation of public health. Their model identifies a six-dimensional theory of well-being that considers ethical issues in public health and health policy development. There are six core dimensions:

- Health
- Personal security
- Reasoning
- Respect
- Attachment
- Self-determination

Ethical Theory of Population-Focused Nursing

Derryl Block and Lavohn Josten, public health educators, proposed the ethical theory of population-focused nursing based on intersecting public health and nursing fields. In their framework, there are three essential elements relevant to public health nursing:

1. An obligation to the population
2. The primacy of prevention
3. The centrality of relationship-based care (Current Nursing, 2020)

Social-Ecological Model

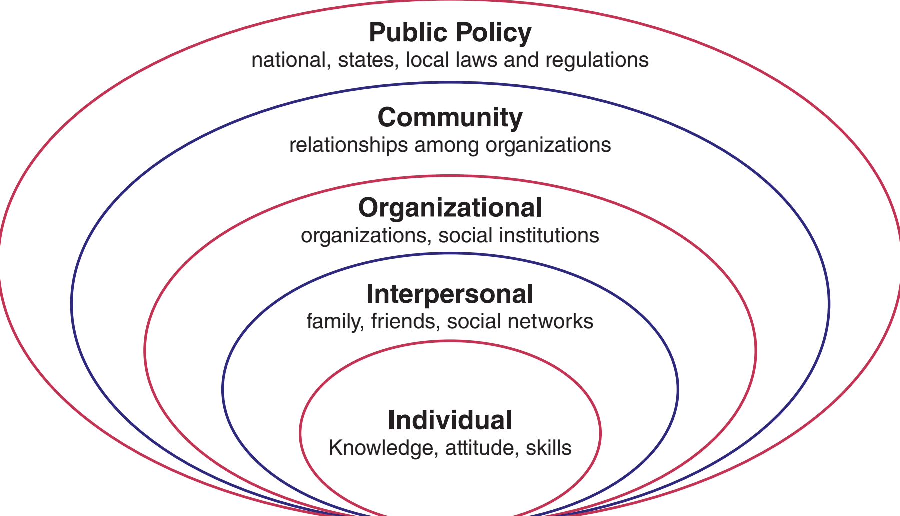

Figure 6: Social-Ecological Model (CDC, 2022)

The social-ecological model considers the complex interrelationships between individuals, relationships, community, and societal factors. The overlapping rings in the model illustrate how factors at one level influence factors at another level (Figure 6). The model suggests a bidirectional relationship between individuals, families, communities, and society (CDC, 2022). Nursing interventions using the social-ecological model must consider all four levels.

Individual: The first level identifies biological and personal history factors that increase the likelihood of becoming a victim or perpetrator of violence. Among these factors are age, education, income, substance use, or history of abuse. Prevention strategies at this level promote attitudes, beliefs, and behaviors that prevent violence. Specific approaches may include conflict resolution and life skills training, social-emotional learning, and safe dating and healthy relationship skill programs.

Relationship: The second level examines close relationships that may increase the risk of experiencing violence as a victim or perpetrator. A person's closest social circle—peers, partners, and family members—influences their behavior and contributes to their experience. Prevention strategies at this level may include parenting or family-focused prevention programs and mentoring and peer programs designed to strengthen parent–child communication and promote positive peer norms, problem-solving skills, and healthy relationships.

Community: The third level explores the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpetrators of violence. Prevention strategies at this level focus on improving the physical and social environment in these settings (e.g., by creating safe places where people live, learn, work, and play) and addressing other conditions that give rise to violence in communities (e.g., neighborhood poverty, residential segregation and instability, high density of alcohol sales and service outlets).

Societal: The fourth level looks at the broad societal factors that help create a climate in which violence is encouraged or inhibited. These factors include social and cultural norms that support violence as an acceptable way to resolve conflicts. Other large societal factors include the health, economic, educational, and social policies that help to maintain economic or social inequalities between groups in society. Prevention strategies at this level include efforts to promote societal norms that protect against violence as well as efforts to strengthen household financial security, provide education and employment opportunities, and foster other policies that affect SDOH (CDC, 2022).

Health Belief Model

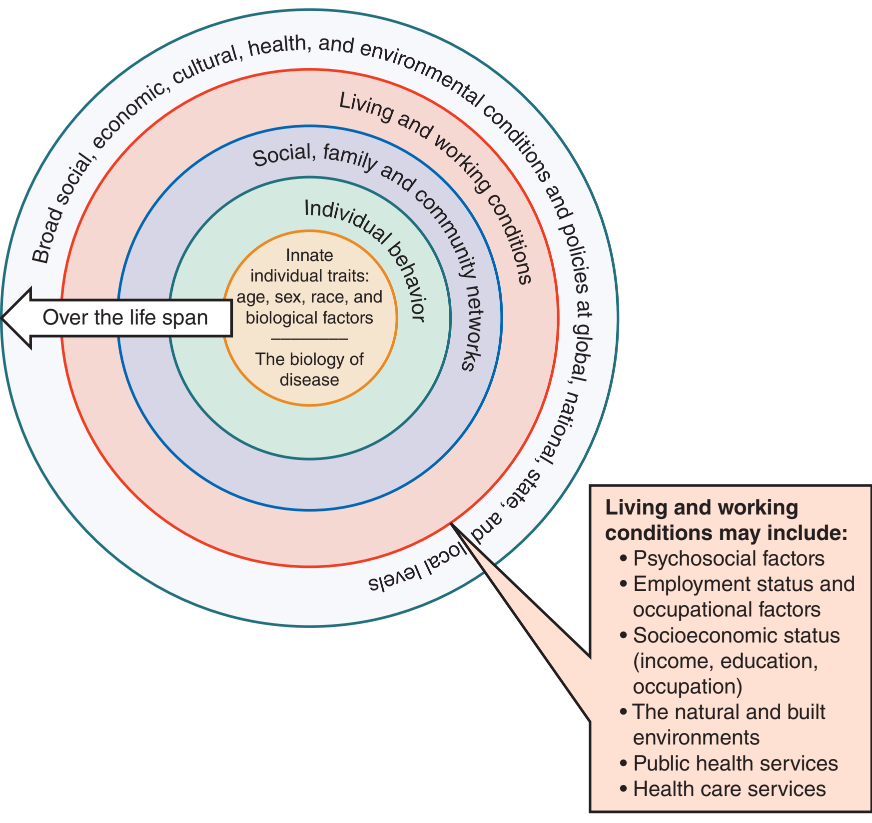

Figure 7: Health belief model (Adapted from U.S. Department of Health & Human Services, 1999)

The health belief model (Figure 7) states that health-related behavior depends on perceptions in four areas:

- The severity of a potential illness
- An individual's susceptibility to that illness
- Benefits of taking preventive action
- The barriers to taking that action (Hochbaum, 1958; Rosenstock, 1960, 1966)

The model also uses the idea of using cues to action. For example, someone might set an alarm to remember to take their medication or to take a walk (Becker, 1976). The health belief model also includes the construct of self-efficacy. *Self-efficacy* means a person's confidence in their ability to successfully perform healthy behavior (Rosenstock, 1990).

Transtheoretical Model

The transtheoretical model of behavior change is a five-stage cycle about readiness to change (Prochaska et al., 1992):

1. Precontemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance (Prochaska & DiClemente, 1982, 1984)

In the transtheoretical model, efficient self-change depends on doing the right thing (processes) at the right time (stages; Prochaska et al., 1992). Nurses can apply this model in the public setting by customizing interventions to match a person's readiness or stage of change (Marcus & Owen, 1992).

Theory of Reasoned Action

Public health nurses continue to use the theory of reasoned action (Ajzen & Fishbein, 1980; Ajzen & Fishbein, 1975) in health promotion programming. This theory presents the idea that individuals' behaviors are determined by their intent to perform that behavior.

Further, that intention is determined by two major factors: first, the person's attitude toward the behavior; and second, the influence of the person's social environment or subjective norm. This means that public health nurses should assess attitudes toward health behavior changes as well as the attitudes of others that may influence the individual. Public health nurses can use this theory when they are working to change attitudes at the community level or helping individuals identify their own health priorities and willingness to make health behavior changes.

Theory of Planned Behavior

The theory of planned behavior (Ajzen, 1985, 1988) builds on the theory of reasoned action to include the concept of perceived control over the opportunities, resources, and skills that are necessary to perform a behavior. Ajzen's perceived behavioral control construct is similar to Bandura's (1977) concept of self-efficacy. Public health nurses can apply this theory to empower clients and communities to identify the elements they feel necessary to succeed in health behavior change.

HEALTHY PEOPLE 2030

Healthy People 2030 is overseen by the Office of Disease Prevention and Health Promotion (ODPHP), Office of the Assistant Secretary for Health, and the Office of the Secretary (ODPHP, 2022a). Healthy People is updated each decade and provides data-driven goals and objectives aimed at improving the health of all. Healthy People 2030 operates on a framework developed by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. The framework aims to provide historical context, locate the current initiatives, and clearly communicate the foundation tenets of the initiatives, principles, context, and rationale for the Healthy People's approach (ODPHP, 2022b).

The Social Determinants of Health

A focus of the Healthy People framework is now on SDOH. Broadly speaking, social determinants are where we are born and where we grow up, go to school, pray, and play. HealthyPeople.gov arranges SDOH into five categories. These are economic stability, education access and stability, health care access and quality, neighborhood and built environment, and social and community context. By shifting focus to include SDOH, we can understand how "upstream" elements like policies and society-level views can affect the health of populations and individuals. What is important to note here is that because of systemic influences, individual health behaviors do not have equal impact across all populations. Figure 8 provides an example of system (upstream) to individual (downstream) social elements that act as health determinants.

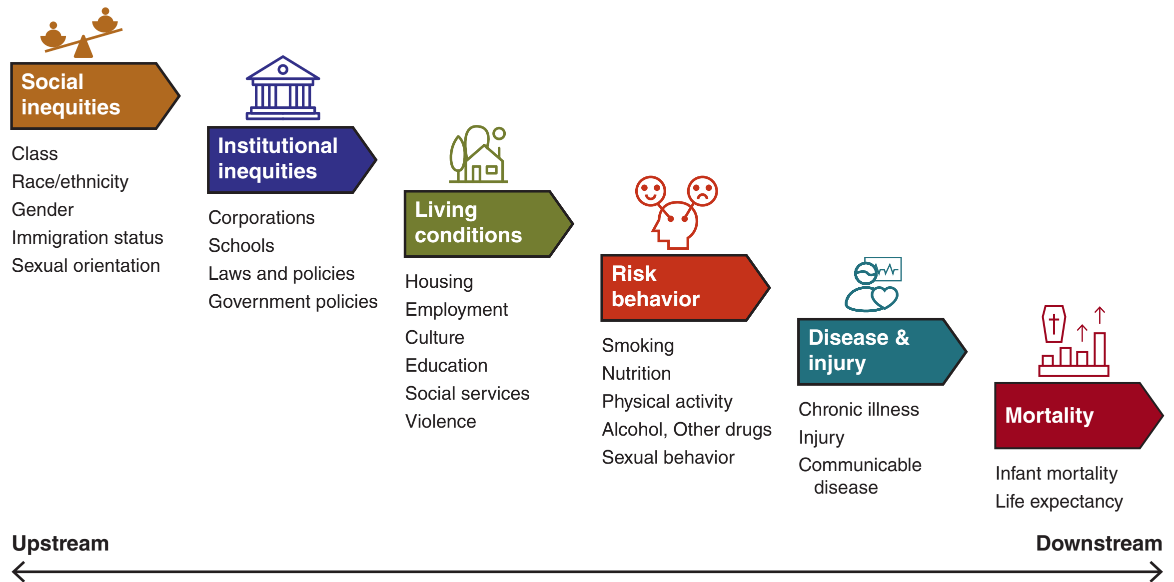

Figure 8: Upstream and Downstream Social Determinants of Health (Adapted from the Bay Area Health Inequities Initiative's conceptual framework with flat icons, https://barhii.org/framework)

PRACTICE APPLICATION

➔ Setting the Scene

As a part of a review of homelessness in the area, the Pleasant City Council has convened a task force to evaluate the need for homeless shelters in the city. Results of the task force's community assessment showed that while more men than women are currently without housing in the city, the percentage of homeless women is steadily rising. Assessment findings also showed that more women with children live in poverty than men. The task force found that many women who are living in poverty are being overlooked and, as a result, are at risk of becoming unhoused.

Pleasant already has a homeless shelter for men. Based on the information gathered from the community assessment, the task force and the Pleasant City Council have decided to open a homeless shelter designed to primarily serve women with children who are unhoused or in poverty.

➔ Think About It

Imagine you are a community health nurse serving on the task force. You and other task force health care professionals are charged with planning health care services for women with children to be provided at the new homeless shelter.

1. What common health problems should you and the task force be aware of when planning which health services to provide at the new shelter?
2. What health determinants influence the health of the residents who will be cared for in the new homeless shelter?
3. What are some suggestions for primordial, primary, secondary, or tertiary disease prevention strategies to support the residents of the new homeless shelter? How might you help these residents participate in these efforts?
4. After the shelter opens, you become one of the nurses who work in the clinic. What strategies are important for you to implement when working with this population?
5. Drawing on the Healthy People 2030 recommendations for health policy advancement, where and how should you become an advocate for change?

ADDITIONAL RESOURCES

American Nursing Association, ANA Code of Ethics

Community Health Nursing [Article]

Watson's Philosophy, Science, and Theory of Human Caring as a Conceptual Framework for Guiding Community Health Nursing Practice [Article]

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UNIT ONE:

Foundations of Community and Public Health Nursing

Chapter One: Community and Public Health Policy

OVERVIEW

This chapter introduces the learner to the foundations of health policy. Policy shapes our experiences at all levels of society. This chapter focuses on the policy's structure, impact, and influence on community and population health. In keeping with the aims of this book, the policy will be discussed through the lens of social justice.

LEARNING OBJECTIVES

- Understand the impact of policies on population outcomes, including social justice and health equity
- Summarize the structural components of legal, regulatory, and policy guidelines for the community and public health
- Analyze system-level and public policy influence on the community and public health overall
- Understand how to advance public health policy through various advocacy strategies
- Identify opportunities to influence policy change

KEY TERMS

- policy
- legal
- regulatory
- advocacy
- vulnerable populations
- stakeholders

INTRODUCTION

Community health nurses are strategically positioned to function as change agents in the community. Actively engaging the understanding of the importance of health policy, navigating the current policy landscape, identifying opportunities to contribute their expertise as health care collaborators, and bridging the gaps in needed services offer community health nurses a unique opportunity to help maximize health potential for all citizens within their sphere of influence. Community nurses can apply knowledge of health policy to advocate for individuals, communities, and populations and enable changes that result in community thriving.

UNDERSTANDING HEALTH POLICY

Health policy is the result of a public decision-making process that makes goal-directed health-related processes (Keller & Ridenour, 2021). Most often, health policy is visible in governmental

policy and legislative decisions at the local, state, and national levels, although policymaking also happens through corporations, institutional boards, and executives. Nurses are critical in advocating for policies that can affect patients and the profession. Nurse advocacy is particularly important to represent vulnerable populations and those who have been historically underrepresented. Policy advocacy can be especially powerful when the nursing profession speaks with a united voice on issues that affect health outcomes. Nurses can influence health policy by understanding and engaging in the policy process on multiple levels, including interpreting, evaluating, and leading policy change.

Health policy, at its best, is meant to promote the health of individuals, communities, and populations. Policy decisions significantly affect health and well-being, and evidence-based health policies can help prevent disease and promote health. For example, smoke-free policies can prevent smoking initiation and increase smoking cessation attempts. Similarly, policies requiring community water systems to provide fluoridated water can improve oral health.

However, health policy is rarely straightforward and often presents complex legal, ethical, and social questions. From a community health viewpoint, it is the responsibility of the government to create a health policy that protects and promotes the health of individuals and the community and to do so in a manner that respects human rights, including the right to self-determination, privacy, and nondiscrimination. Communities must operate within the context of federal and state policies that can affect local government decisions relevant to health through laws and regulations. Widely recognized policies include those that fund or regulate health care delivery services; but policies in all types of areas, from education to land use and housing, the environment, and criminal justice, can be relevant to health and health care disparities within communities.

At the state and federal levels, formal development of health policy is distributed among the three branches of government: the executive, the legislative, and the judicial. Health policy at these levels addresses many issues, such as health care, public health initiatives, and biotechnology. Examples of health care decisions affected by health care policies include reproductive rights, approaches to mental health care, civil rights of differently abled populations, drug pricing, and access to health care, among others (Gostin, 1995). Policies can vary across geographic areas and populations, providing important opportunities or constituting barriers to promoting health equity (Baciu et al., 2017). Other legislative policies are far-reaching.

The Civil Rights Act of 1964 was a sweeping legislative act signed into law by President Johnson on July 2, 1964. This act prohibited discrimination in public places. It provided for the integration of schools and other public facilities and made employment discrimination illegal. Though this act mandated desegregation, institutions have struggled to adequately represent minorities that reflect the geographical populations (Civil Rights Act, 1964). When it comes to health care, large racial disparities continue to persist. For example, people of color are considerably fewer than Whites in medical and nursing schools (Association of American Medical Colleges, 2021; Campaign for Action, n.d.). Yet, diversity of health care teams is linked to improved health outcomes and culturally competent care (Cohen et al., 2002). We can begin to understand, then, how systematic adherence to policy such as the Civil Rights Act of 1964 can contribute to quality education and college preparation, leading to increasing qualified health care applicants and successful graduation. Nurses can inform themselves and others on how policy can directly and indirectly influence health care accessibility and quality.

Underserved, Vulnerable, and Special Needs Populations

The U.S. Department of Health and Human Services (DHHS) characterizes underserved, vulnerable, and special needs populations as communities that include members of minority populations

or individuals who have experienced health disparities. Members of minority populations or individuals who have experienced health disparities include but are not limited to these groups:

- Latino populations
- African American populations
- American Indian/Alaska Native populations
- Refugees
- Individuals with limited English proficiency
- Young adults and postsecondary graduating students who have no health coverage options through a parent's plan, a student plan, or an employer plan
- New mothers and women with children
- Individuals with disabilities
- Consumers not enrolled in Medicaid coverage despite being eligible

The term *vulnerable* is often used interchangeably with *underserved.* Whereas underserved communities have limited access to health care services, vulnerable individuals tend to experience additional barriers to getting care. For example, an individual with limited English proficiency is considered vulnerable but not underserved (e.g., the consumer might have access to high-quality care). However, there can be considerable overlap among vulnerable and underserved populations, with many individuals falling into both categories.

Vulnerable populations include those who share one or more of the following characteristics:

- High risk for multiple health problems and/or preexisting conditions
- Limited life options (e.g., financial, educational, housing)
- Fear and distrust in accessing government programs or disclosing sensitive information about family members
- Limited ability to understand or give informed consent without the assistance of language services (e.g., consumers with limited English proficiency or cognitive impairments)
- Mobility impairments
- No access to transportation services
- Lowered capacity to communicate effectively
- Vulnerability to any type of discrimination

Underserved populations include those who share one or more of the following characteristics:

- Receive fewer health care services
- Encounter barriers to accessing primary health care services (e.g., economic, cultural, and/or linguistic)
- Lack familiarity with the health care delivery system
- Face a shortage of readily available providers

Nursing and Health Policy

The better informed nursing professionals and communities are about the implications of policy changes, the greater their ability to respond, particularly in addressing health disparities and

helping achieve change in the determinants of health. Likewise, the more the needs of communities are considered in policy decision-making, the more effective these policies will be (Baciu et al., 2017). The socioeconomic and political drivers in communities and their political context are highlighted in Figure 1.1, inspired by the National Institutes of Health model for ways to promote health equity presented in *Communities in Action: Pathways to Health Equity Report.* The report provided a conceptual model for community solutions to promote health equity (Baciu et al., 2017). The policy context is highlighted here to convey the focus of this chapter (Baciu et al., 2017).

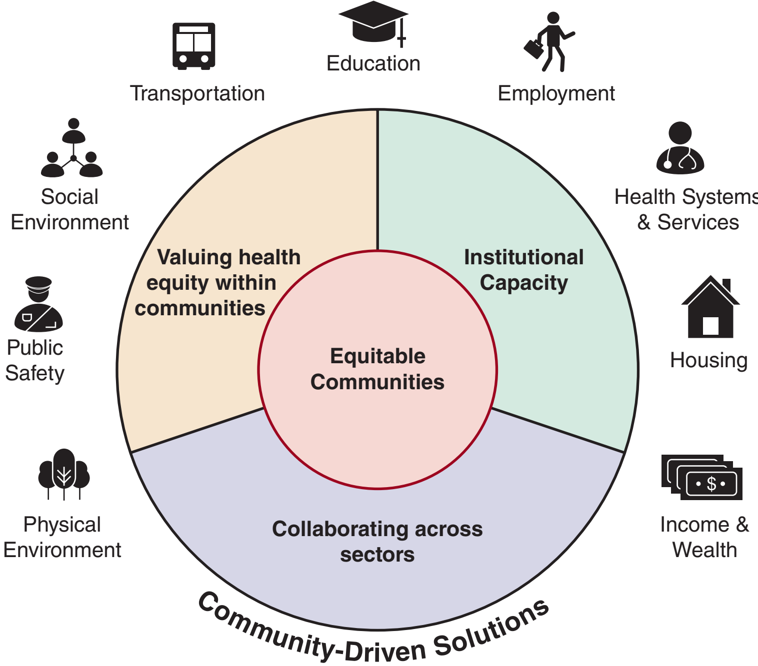

Figure 1.1: Conceptual Model for Community-Driven Solutions to Promote Health Equity

Health policy legislation often represents the competing values of various stakeholders and interest groups and assessments of available data. Interest groups and stakeholders often consider policy questions through a distinct values lens, including individual interpretations of right and wrong, good and bad, necessary and unnecessary.

A number of critical factors influence effective health care policy development:

- Policymakers should be objective.
- Decision-makers should have no conflict of interest.
- Policymakers should understand the data and the arguments presented.
- Health policies should not seriously burden individual rights to liberty, privacy, and nondiscrimination.
- Decision-making bodies should be positioned to receive and evaluate full and objective information on all aspects of a health policy.
- Policymakers should have well-considered criteria for making the decision.
- Policymakers should pursue a fair process to arrive at the decision.

CRITERIA FOR POLICY DEVELOPMENT

Nursing and community health practitioners can play an active role in supporting the development of criteria that decision-makers can use when they are formulating health policy goals. This support may include establishing the scientific, social, and ethical parameters for decision-making, which may help reduce biases that can undermine health policy development. Among criteria to consider are these:

1. Examine the public health interest. Does the proposed policy seek to achieve a compelling health objective? The policymaker should clearly and narrowly define the policy's health purpose(s). This protects against decision-making biases, helps communities understand the policy rationale, and facilitates public debate.
2. Examine the overall effectiveness of the policy. Is the proposed policy likely to be effective in achieving the stated goal(s)? This criterion requires an assessment of whether the policy is an appropriate intervention to achieve the stated objectives and whether it is likely to lead to effective action. The policymaker should gather scientific data and apply logic to analyze whether a policy will be effective.
3. Evaluate whether the policy is well targeted. Is the proposed policy narrowly focused on the health problem? A decision-maker should determine whether a policy is narrowly tailored to address the specific health problem or whether it is over- or underinclusive. Overbroad policies target a population that is much larger than necessary to achieve the health objective.
4. Identify the human rights burdens. Doing this requires an inquiry into the nature of human rights violations, invasiveness, scope, and duration. Does the policy interfere with the right to liberty, autonomy, privacy, or nondiscrimination? For example, a policy that requires women to use contraceptives as a condition of receiving welfare benefits might interfere with the right to reproductive privacy and discriminate against women (because the policy does not apply to men) and persons who are economically disadvantaged (because the policy does not affect higher income women). It may also burden dependent children's social and economic rights if benefits are withdrawn.
5. Examine whether the policy is the least restrictive alternative. A policymaker should assess whether the health objective could be achieved as well, or better, with fewer restrictions on human rights. This approach helps to ensure that a policymaker considers alternatives that may better accommodate societal and individual interests (Gostin, 1995).

IMPACTS OF POLICIES ON COMMUNITY HEALTH

It is clear that health policies at the local, state, and federal levels can influence the health of both individuals and the population-at-large. For example, consider the following:

- Increasing taxes on tobacco sales can improve population health by reducing the number of people using tobacco products.
- The Affordable Care Act, implemented in 2010, significantly increased the number of insured Americans.

- The Health Insurance Portability and Accountability Act protects American workers by allowing them to carry health insurance policies from job to job.
- Along with Medicaid, the Children's Health Insurance Program has created a strong foundation for delivering health coverage to children living in low-income households.

The impact of policies or a lack of policy on non-health domains—economic and environmental domains, for example—can also directly affect community health. Health policies, as well as policies that have an impact on the health of communities, may disproportionately affect vulnerable communities with limited resiliency as a result of socioeconomic barriers. For example, transportation policies, living wage policies, and zoning can dramatically affect health outcomes, particularly in vulnerable communities (Benjamin, 2018; Rieck & Lundin, 2018).

Population Health Outcomes

Researchers, patients, providers, and policymakers have worked to identify, understand, and eliminate the disparities experienced by different racial and ethnic groups across the health care system. In 1985, DHHS published the report of the Secretary's Task Force on Black and Minority Health (Heckler, 1986), marking the U.S. government's first comprehensive study of racial and minority health. Since then, DHHS and other stakeholders have continued this work, including throughout the *National Healthcare Quality and Disparities Report*. The growing evidence base shows that patients of different racial and ethnic groups experience the quality of care inequitably and disparately. For example, although Black, Hispanic, American Indian, and Alaska Native communities have all experienced improvements in health care quality, significant disparities in all domains of health care quality persist. Rates of quality improvement exceeded those White Americans experienced in 11% of all quality measures, but that change has not been enough to eliminate disparities (Agency for Healthcare Research and Quality [AHRQ], 2021).

The *National Healthcare Quality and Disparities Report* notes that a significant disparity persists despite a decrease in HIV death rates, including in Black populations. "From 2000 to 2018, HIV deaths in Black populations decreased from 23.3 deaths to 6.2 deaths per 100,000 population. Still, deaths in Black populations remain more than six times as high as HIV deaths in White populations (0.9 deaths per 100,000 population)" (AHRQ, 2021).

Additionally, "from 2001 to 2018, the incident rates of end-stage renal disease due to diabetes decreased 48% from 526 to 273.1 events per million population in American Indian/Alaska Native communities and decreased 29% from 525.7 to 372.2 per million population in Black communities. Despite these gains, significant disparities persist among non-Hispanic American Indian and Alaska Native, Black, and White populations, with respective incident rates of 273.1, 372.2, and 152.2 events per million population in 2018" (AHRQ, 2021).

The intersections of these variables, race/ethnicity, socioeconomic status, gender, age, and geography, are complex, and health disparities can be partially, yet directly, linked to health policy. Recommended reading includes the full *National Healthcare Quality and Disparities Report* (AHRQ, 2021).

Social Justice and Health Equity

Social justice is the view that everyone deserves equal rights and opportunities, including the right to good health (American Public Health Association, 2021). An avoidable inequity resulting from health policy is unjust.

Health disparity and health inequity play a role in fostering social disadvantage and interfere with social justice within a community. The term *social disadvantage* implies that a person or

group of persons are compromised or marginalized because of their position in society. What follows is a limited or restricted opportunity to fully participate in society and, in turn, a limited opportunity to prosper and contribute. Individuals or persons who are socially disadvantaged through the means of social structures, such as policy, are denied the chance to reach and enjoy their full potential and do not experience the same benefits within society as others do. Social disadvantage is not the same as unavoidable physical disadvantage. For example, when people with disabilities are placed at an avoidable disadvantage in society because they lack necessary support (e.g., accessible public buildings and transportation) or are subject to discrimination in hiring, what results is discriminatory treatment, regardless of intention (Braveman et al., 2011). In these examples, the policy might ensure that public buildings are accessible and that equal employment laws can protect individuals from discrimination in hiring.

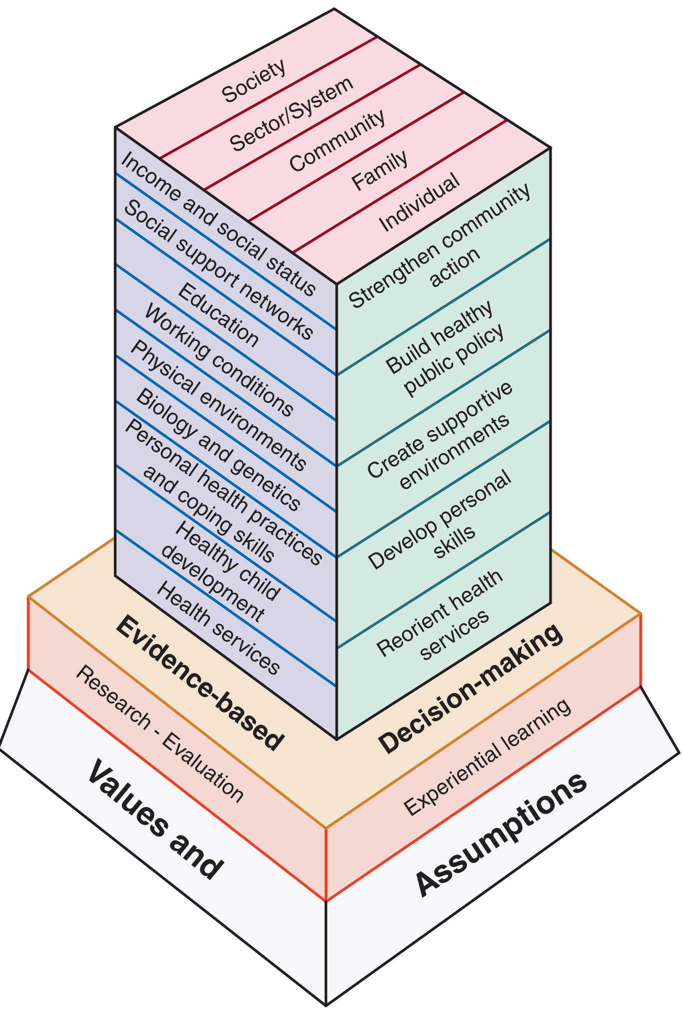

Figure 1.2: Community Health Nursing, Social Determinants of Health, and Health Policy

Social determinants of health (SDOH) are broadly defined by factors such as economic and job stability, education and health care access, social and community context, and neighborhood and built environment (Centers for Disease Control and Prevention, 2021). When individuals are denied opportunities in any of these domains, they may also have limited access to quality health care services and experience greater risk for illness or severity of illness. Impaired health further restricts the opportunity to be fully engaged in society, again intruding on these individuals' rights to be full participants in their community. This is considered unjust.

Figure 1.2 illustrates that community health nurses must reflect on their values and assumptions. Then they can utilize their practice experience and study evidence-based research to address SDOH elements as shown in the blue column with strategies to undertake in the green column, one of which is a policy with the ultimate goal of health and well-being indicated in red.

Healthy People 10-Year Plan

The DHHS initiative Healthy People 2030, referred to as the nation's 10-year plan, sets data-driven national objectives to improve health and well-being and has identified specific objectives aimed at reducing health care disparity and improving the health of vulnerable and underserved

populations (Office of Disease Prevention and Health Promotion, n.d.). The plan focuses on the following SDOH aspects and helps drive the nation's health care policy agenda:

1. Economic Stability

   In the United States, one in 10 people lives in poverty, with many unable to afford things like healthy foods, health care, and housing. While individuals with steady employment are less likely to live in poverty and more likely to be healthy, many people with steady work still do not earn enough to afford the things they need to stay healthy.

   Employment programs, career counseling, and high-quality childcare opportunities can help more people find and keep jobs. In addition, policies to help individuals pay for food, housing, health care, and education can reduce poverty and improve health and well-being.

   Healthy People 2030 goals:

   - Economic Stability
     - Reduce the proportion of people living in poverty (SDOH-01)
     - Increase employment in working-age people (SDOH-02)
   - Housing and Homes
     - Reduce the proportion of families that spend more than 30 percent of income on housing (SDOH-04)
   - Nutrition and Healthy Eating
     - Reduce household food insecurity and hunger (NWS-01)

2. Education Access and Quality

   Living in poverty can have an impact on a child's brain development, leading to classroom challenges. Additionally, children who routinely experience forms of social discrimination like bullying are more likely to struggle with math and reading. Interventions to help children and adolescents do well in school and help families pay for college can have long-term health benefits. Individuals with higher levels of education are more likely to be healthier and live longer.

   Healthy People 2030 goals:

   - Adolescents
     - Increase the proportion of high school students who graduate in 4 years (AH-08)
   - Children
     - Increase the proportion of children who participate in high-quality early childhood education programs (EMC-D03)
   - People with Disabilities
     - Increase the proportion of students with disabilities who are usually in regular education programs (DH-05)
   - Schools
     - Increase the proportion of 4th-graders with math skills at or above the proficient level (AH-06)

3. Health Care Access and Quality

One in 10 people in the United States is uninsured. Individuals without insurance are less likely to have a primary care provider, and they may be unable to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for ensuring that more people get essential health care services, like preventive care and treatment for chronic illnesses.

Healthy People 2030 goals:

- Health Care Access and Quality
  - Increase the proportion of adults who get recommended evidence-based preventive health care (AHS-08)
- Adolescents
  - Increase the proportion of adolescents who speak privately with a provider at a preventive medical visit (AH-02)
- Cancer
  - Increase the proportion of adults who get screened for colorectal cancer (C-07)
- Community
  - Increase the number of community organizations that provide prevention services (ECBP-D07)

4. Neighborhood and Built Environment

The neighborhoods individuals live in significantly affect their health and well-being. Unfortunately, many people in the United States live in neighborhoods with high rates of violence, unsafe air or water, and other health and safety risks. These conditions can be remedied. For example, providing opportunities to walk and bike by adding sidewalks and bike lanes can increase safety and help improve health and quality of life. In addition, many economically vulnerable neighborhoods can be considered food deserts—that is, they areas where people have limited access to a variety of healthy and affordable food. As with other variables that contribute to the health of a community, it is important to understand the characteristics associated with these vulnerable communities, including income, vehicle availability, and access to public transportation. Interventions and policy changes at the local, state, and federal levels can contribute to reducing the risk of these variables to health and safety; at the same time, these policies and strategies can help promote health (United States Department of Agriculture, Economic Research Service, n.d.).

Healthy People 2030 goals:

- Neighborhood and Built Environment—General
  - Increase the proportion of adults with broadband internet (HC/HIT-05)
- Environmental Health
  - Reduce health and environmental risks from hazardous sites (EH-05)
- Health Policy
  - Increase the proportion of people whose water systems have the recommended amount of fluoride (OH-11)

- Housing and Homes
  - Reduce blood lead levels in children aged 1 to 5 years (EH-04)

5. Social and Community Context (Office of Disease Prevention and Health Promotion, 2022)

   Relationships and interactions with family, friends, coworkers, and community members can significantly affect their health and well-being. Many individuals face challenges and dangers they cannot control, like unsafe neighborhoods, discrimination, or trouble affording the things they need.

   Positive relationships at home, at work, and in the community can help reduce these negative impacts. Interventions to help people get the social and community support they need are critical for improving health and well-being.

   Healthy People 2030 goals:

- Social and Community Context—General
  - Reduce anxiety and depression in family caregivers of people with disabilities (DH-D01)
- Adolescents
  - Increase the proportion of adolescents who have an adult they can talk to about serious problems (AH-03)
- Health Communication
  - Increase the proportion of adults who talk to friends or family about their health (HC/HIT-04)
- LGBT
  - Reduce bullying of transgender students (LGBT-D01)

THE NURSE'S ROLE IN COMMUNITY HEALTH ADVOCACY

Nurses are responsible for advocating for policies that advance public health, promote health equity, reduce health disparities, and further social justice. Nurses have an active role to play in understanding the impacts of the policy landscape and in contributing their expertise to the development of policy that affects community health. Targeting SDOH in support of the vulnerable and underserved is advocacy that can significantly promote health. Policy, informed by evidence, can influence improvement in both the social and the economic status of individuals and the community as a whole.

Policy actions in four key social domains have been directly linked with improvements in well-being and reductions in health inequities. These domains comprise child and youth education and development, fair employment and decent work, social protection, and the living environment. Important research has shown that policies can affect health outcomes more than genetic endowment, individual behaviors, or access to health care services can (Carey & Crammond, 2015; Webb, 2014).

The connection between specific SDOH, examples of evidence-based programs and policies, and related nurse advocacy opportunities are essential to understand. Figure 1.3 illustrates this concept. For instance, in an example adapted from Williams et al. (2018), early childhood is a critical period in a child's development of personality, cognition, language, and behavior. Early childhood education can be a determinant of health. Children with delayed early childhood development have been linked to issues with depression, attention deficit, and poor academic achievement in school. Evidence-based programs, including early childhood development programs, can serve as intervention strategies to address this. Nurses have the opportunity to advocate for universal access to quality and affordable childcare education services or support publicly funded center-based programs for children 3–5 years of age, for nurses are advocates and experts on these SDOH factors, having seen their impact on the communities they work with (Aron et al., 2015; Webb, 2014).

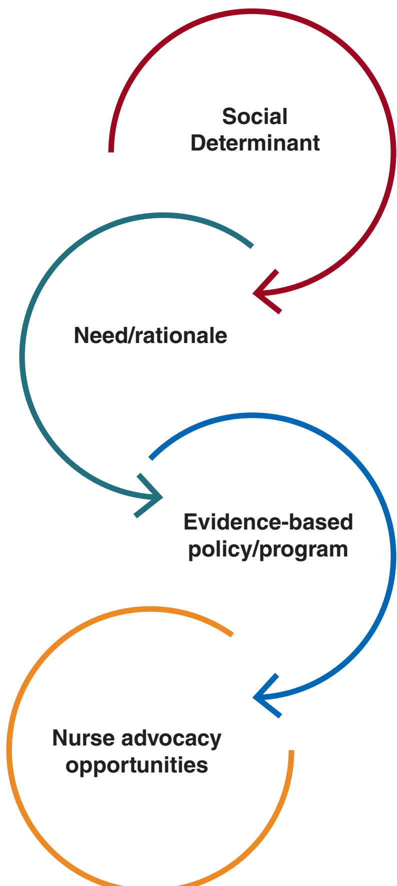

Figure 1.3: Relationship of Social Determinants to Nursing Advocacy Opportunities

PRACTICE APPLICATION

➔ Setting the Scene

Social Determinants of Health

Watch this video by scanning the QR code or visiting
https://youtu.be/u_IoBt7Nicw

➔ Think About It

Imagine you are a community health nurse tasked with supporting the health care of your current community.

1. How would you investigate the health policy agendas of your local legislators?
2. Drawing on your experience living in the community, what health hazards have you noticed? What would you do to advocate for improvement?
3. Develop a set of professional priorities. What social issues would you include?
4. Your supervisor has asked you to organize a program to educate the community about SDOH.
   a. How would you organize this program?
   b. What would be the key aspects of this program?
   c. What considerations would you need to incorporate in their community health program design (e.g., health literacy level, language barriers, social or cultural considerations)?

ADDITIONAL RESOURCES

American Nurses Association Advocacy Resources (Must be a member of ANA to access)

American Association of Colleges of Nursing - Policy and Advocacy

The American Hospital Association - Social Determinants of Health

Healthy People 2030 - Objectives

Health People 2030 - Social Determinants of Health Literature Summaries

National League for Nursing Public Policy Toolkit

Nurse Advocacy: Adopting a Health in All Policies Approach [Article]

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Chapter Two: Health Disparities and Health Equity

OVERVIEW

This chapter introduces the concepts of health inequities, health disparity, and health equity. Inequities are differences in treatment that are unfair or unjust. When applied to health care, the term *inequity* can mean unfair treatment from health providers or unequal access to care or quality health care. Disparities are the differences in outcomes between groups of people. When the term is applied to health, *disparity* means that there are differences in the state of health between populations that are rooted in unequal treatment or social conditions.

LEARNING OBJECTIVES

- Understand the difference between health disparities and health equity
- Discuss health care inequity
- Recognize how history shapes current health care quality and health outcomes
- Identify the impact that health disparities have on individuals and communities
- Discuss the nurse's role in promoting health equity
- Compare and contrast health outcomes between historically excluded aggregates and those with historical social advantage

KEY TERMS

- health equity
- health disparity
- immigrant
- asylum seeker
- refugee
- ableism
- LGBTQIA+

INTRODUCTION

Health disparities and health equity have a profound influence on health and quality of health care received by individuals. Health equity is a fair and just treatment that promotes the prevention or correction of health disparities. Health equity can be achieved through individual actions in providing unbiased, culturally sensitive care and through ensuring equitable access to health care. There are historical, social, economic, and structural (or systemwide) barriers to providing equitable care. These systemic barriers can be remedied through actions that promote health justice.

HEALTH EQUITY, INEQUITIES, AND DISPARITIES

Health equity is achieved when every person has the opportunity to "attain [their] full health potential, [and no one is] disadvantaged from achieving this potential because of social position or other socially determined circumstances" (Centers for Disease Control and Prevention [CDC], 2022b). Health care inequities are the differences in the distribution of health care resources between population groups, arising from the sociopolitical, economic, and structural conditions in which people are born, grow, live, work, and age. The term *health care inequality* is often used interchangeably with *health care inequities*; however, as indicated in Figure 2.1, the two terms are vastly different. Equality means everyone is given the same resources, whereas equity recognizes that each person has different circumstances and needs different resources to reach the same outcome.

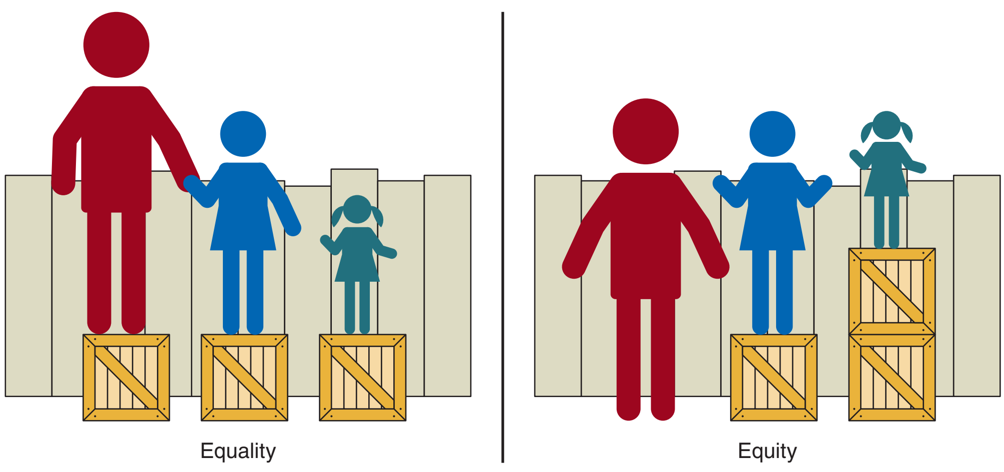

Figure 2.1: Differentiating Between Equality and Equity (Adapted from Achieving Health Equity for All—EveryONE (plos.org))

Health care inequities are the systemic issues that contribute to poor health outcomes and lead to health disparities (World Health Organization, 2022). Health disparities are the differences that exist among specific population groups in the attainment of good health. These differences can be measured by examining health outcomes, including incidence, prevalence, mortality, the burden of disease, and other adverse health conditions (National Academies of Sciences et al., 2017). Working toward health equity means that we must work to reduce health care inequities and health disparities. We need to address why health differences persist, and in so doing, we must evaluate the social-ecological factors that have contributed to the disparities. As health care professionals, we need to expand our perspectives and recognize that issues within our health system and in the health of our patients are reflections of society. This means that we must proactively address discrimination to improve population health.

People are treated differently for many reasons, including racism, sexism, socioeconomic discrimination, and ableism. "Ableism is the discrimination of and social prejudice against people with disabilities based on the belief that typical abilities are superior. At its heart, ableism is rooted in the assumption that disabled people require 'fixing' and defines people by their disability. Like racism and sexism, ableism classifies entire groups of people as 'less than' and includes harmful stereotypes, misconceptions, and generalizations of people with disabilities" (Eisenmenger, 2019).

In addition to being treated differently, these same populations are more likely to experience a lack of patient–provider concordance, contributing to lower quality of care and differences in

health attainment. Health care organizations have a growing responsibility to improve diversity, equity, and inclusion (DEI) in employment to serve patients and their families better. One strategy is to diversify the nursing workforce, which comprises the largest number of health care professions. With nursing strategically positioned to provide care to diverse groups, in addition to diversifying the nursing workforce, measures must also be taken to address bias, stereotyping, and clinical uncertainty (Shen et al., 2018).

Health disparities tend to be persistent and difficult to change for many reasons. The dynamic interrelationships between the physical environment, political landscape, social and cultural environment, and personal attributes play a key role in health, health care, and well-being. Health disparities and substandard public health carry societal, economic, and individual health implications for all citizens, and it is necessary to focus on solutions to decrease health care inequities and health disparities.

Research Framework for Health Disparities

To address health care disparities and inequities and improve patient outcomes for all populations, a research framework was developed by the National Institutes of Health's National Institute on Minority Health and Health Disparities (NIMHD; Table 2.1). This framework is used to help us understand and promote the health of minorities to reduce health disparities. It does this by encouraging researchers to include diverse communities in their research and understand the domains of influence and their impact on health outcomes (Agency for Healthcare Research and Quality, 2021).

Levels of Influence					
		Individual	**Interpersonal**	**Community**	**Societal**
	Biological	Biological vulnerability and mechanisms	Caregiver–child interaction Family microbiome	Community illness Exposure Herd immunity	Sanitation Immunization Pathogen exposure
	Behavioral	Health behaviors Coping strategies	Family functioning School/work functioning	Community functioning	Policies and laws
Domains influence (over the life course)	**Physical/Built Environment**	Personal environment	Household environment School/work environment	Community environment Community resources	Societal structure
	Sociocultural Environment	Sociodemographics Limited English Cultural identity Response to discrimination	Social networks Family/peer norms Interpersonal discrimination	Community norms Local structural discrimination	Social norms Societal structures Discrimination
	Health care system	Insurance coverage Health literacy Treatment preferences	Patient-clinician relationship Medical decision-making	Availability of services Safety net services	Quality of care Health care policies
	Health outcomes				

Table 2.1: Levels of Influence, NIMHD Research Framework (Adapted from Agency for Healthcare Research and Quality, 2021)

Impact of Health Disparities

Racial and Ethnic Minorities

In the United States, the impact of structural racism has continued far beyond the formal end of slavery in 1865. Following the Civil War, discriminatory laws favored majority populations and prevented minority populations from having a full and equal opportunity to participate in the political process that determined the reach of those laws and policies. Segregation ensured that Black and immigrant populations were restricted to living in socioeconomically disadvantaged neighborhoods. Redlining, a process that marked such neighborhoods as too risky for financial investments (including mortgages and small-business loans), limited residents' access to resources to improve their socioeconomic status. With these structural disadvantages came decreased access to health care and overall lower quality of care, because clinics, hospitals, and medical centers were located elsewhere, and the cost of quality care was out of reach for many.

As recently as 2002, the Institute of Medicine reported that even when controlled for lack of health insurance and access to health care, racial and ethnic minorities tend to receive a lower quality of care. Racism and discrimination have been shown to have a negative influence on disease burden within communities, including higher rates of heart disease, cancer, diabetes, obesity, depression, infant mortality, and maternal morbidity (Hawkins et al., 2022). Table 2.2 shows the number of measures for which specific racial or ethnic groups have better, same, or worse care compared with White groups. Compared with White groups, the number of worse measures exceeded the number of measures better for all racial and ethnic minority groups except Asian groups. Some health care disparities, such as those related to HIV outcomes, were common to most racial and ethnic minority groups. Other health care disparities were more prominent for certain groups, reflecting specific contexts and issues experienced by that group. Each racial or ethnic minority group has experienced improving care for many measures, but significant disparities persist because White populations experienced similarly improving care. Since 2000, disparities have narrowed to only about 8% of measures for American Indian and Alaska Native populations, 2% of measures for Asian populations, 3% of measures for Black populations, 4% of measures for Hispanic populations, and 10% of measures of Native Hawaiian/Pacific Islander populations (Agency for Healthcare Research and Quality, 2021).

Race or Ethnic Group	Better	Same	Worse
American	12 (11%)	53 (49%)	43 (40%)
Asian	50 (29%)	75 (43%)	48 (28%)
Black	21 (11%)	90 (46%)	84 (43%)
Hispanic	34 (20%)	76 (44%)	62 (36%)
Native/Hawaiian/Pacific Islander	15 (19%)	43 (53%)	23 (28%)

Table 2.2: Number and Percentage of Quality of Care Measures for Selected Racial/Ethnic Groups Compared With White Groups (Adapted from Agency for Healthcare Research and Quality, 2021)

Women

Women are another group that experiences avoidable disparities. Globally, women have differing levels of freedom, autonomy, and self-determination. The right to vote in the United States was expanded to White women in 1926 and Black women in 1965 (National Archives, 2015). Yet, American women did not have the right to open bank accounts until the Equal Opportunity Credit Act of 1974 (GovTrack, 2022). Societal measures such as these kept women dependent on male family members. Economic disparities and limited access to equitable health care persist for women, in particular for women in historically underserved populations.

Women experience many unique health issues—for example, pregnancy, childbirth, and menopause. Moreover, some health issues that affect both men and women pose unique challenges for women. Healthy People 2030 focuses on addressing these specific needs to improve women's health and safety throughout their lives (U.S. Office of Disease Prevention and Health Promotion [ODPHP], 2022).

Women are also at risk for diseases such as breast and cervical cancer. Screening for these diseases and health issues that disproportionately affect women is key to identifying problems and making sure women get the treatment they need (ODPHP, 2022).

Both pregnancy and childbirth can lead to serious long-term health problems for women. Strategies to decrease unplanned pregnancies and make sure women get high-quality health care before, during, and after pregnancy can help reduce serious health problems and deaths (ODPHP, 2022). Reproductive justice is essential to reducing inequities and ensuring consistent, high-quality care for all women. More information about reproductive health care can be found in Chapter 11.

LGBTQIA+

Another marginalized group comprises members of the lesbian, gay, bisexual, transgender, questioning/queer, intersex, and asexual (LGBTQIA+) community. According to healthypeople.gov, research suggests that LGBTQIA+ individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights. Discrimination against LGBTQIA+ persons has been associated with high rates of psychiatric disorders, substance abuse, and suicide. Experiences of violence and victimization are frequent for LGBTQIA+ individuals and have long-lasting effects on the individual and the community. Personal, family, and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBTQIA+ individuals (ODPHP, n.d.). According to youth.gov, LGBTQIA+ youth are far more likely to experience housing insecurity, which can have a resoundingly negative effect on health and well-being (Youth.gov, n.d.). The perspectives and needs of LGBTQIA+ people should be routinely considered in public health efforts to improve the overall health of every person and eliminate health disparities (CDC, 2022c).

Disability

As of 2016, in the United States an estimated one in four adults, or 61 million people, reported a disability. Individuals with disabilities (such as mobility limitations, deafness, blindness, or intellectual disabilities) face many challenges in achieving optimal health and accessing high-quality health care.

Asylees, Immigrants, Migrants, and Refugees

There is a difference between immigrant, asylee, and refugee status. Although each of these terms applies to people who have left their home country to enter another country, there are similar yet unique health challenges associated with each. An immigrant is any person who is lawfully in the United States who is not a U.S. citizen, U.S. national, or person admitted under a nonimmigrant category as defined by the Immigration and Nationality Act, Section 101 (a) (15), passed by the U.S. House of Representatives (U.S. Code, 2024). With the word *lawfully* placed in the definition provided by Homeland Security, those individuals not lawfully present in the United States are referenced in the literature as "undocumented." This is important to recognize in terms of access to care- and health-seeking behaviors. Undocumented immigrants are often barred access to insurance by law. And though documented immigrants can acquire health insurance, they may nonetheless face barriers in obtaining health care, such as difficulties communicating with a provider or experiencing cultural challenges (Hacker et al., 2015). Migrants are persons who leave their country of origin to seek temporary or permanent residence in another country, specifically with migrant status. An asylee, or asylum seeker, is an immigrant who has been forcibly displaced and might have fled their home country because of war or other factors harming them or their family. Seeking asylum or sanctuary is a legal process. Once a government has accepted an asylum seeker, the seeker's status becomes that of a refugee and hence becomes lawful. Deferred Action for Childhood Arrivals, or DACA, recipients are another group at risk of facing inequities. President Obama created this program in 2012 to protect from deportation people who were brought to the United States as children and who did not have citizenship or legal residency. The protection has to be renewed every 2 years and is not yet a pathway to citizenship. Recipients of DACA can get work permits and obtain health insurance from employers. However, in most states DACA recipients cannot get health insurance through the health care exchange (Jordan, 2022).

Health disparities among immigrants exist for many reasons. A study by the Robert Wood Johnson Foundation (2017) indicated that immigrants have lower rates of health insurance, have lower rates of health care use, and experience lower quality of care than do U.S. citizens and those born in the country. Some immigrants, with or without green card status, experience high levels of long-term stress associated with deportation fears, affecting their physical and mental health (Robert Wood Johnson Foundation, 2017). The effects of toxic stress are more pronounced in children, where it may cause barriers to normal physical and mental growth and development. Fear of deportation also influences associated health-seeking behaviors such as seeking out assistance to prevent food insecurity or housing insecurity (Robert Wood Johnson Foundation, 2017).

Health care professionals can intervene by providing unbiased care, referral to the United Nations High Commissioner for Refugees to establish legal status, and case management services to access services and entitlements, such as SNAP, the Supplemental Nutrition Assistance Program. Nurses should be careful to provide written materials in the patient's native language and to use medical translation services. Nurses should also advocate for funding programs that serve such underserved populations as immigrants. Ensuring workforce diversity and leadership development opportunities for nurses who are from racially and ethnically underrepresented groups must remain a high priority to eliminate health disparities and, ultimately, achieve health equity (Institute of Medicine, 2001).

THE NURSE’S ROLE IN PROMOTING HEALTH EQUITY

The American Nurses Association’s Code of Ethics (2021) obligates nurses to speak up against racism, discrimination, and injustice and to advocate for their patients. Nurses must work to integrate equity into their delivery of care from the individual level to the systems level. Furthermore, nurses must examine their own biases. Addressing social needs in the clinical setting and within the community, working with other disciplines to simultaneously meet a variety of patient needs, and advocating for policy change are all a part of the nurse’s role in promoting health equity (National Academies of Sciences et al., 2021; American Association of Colleges of Nursing, 2024).

The Future of Nursing Report (National Academies of Sciences et al.,2021) calls for nurses to reduce health disparities and prioritize achieving health equity. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities and historical and contemporary injustices and eliminate health and health care disparities. Achieving health equity also involves acknowledging and addressing racism as a threat to public health and the history of unethical practices in public health that lead to inequitable health outcomes (CDC, 2023).

The AACN Essentials (American Association of Colleges of Nursing, 2021) specifically call for nurses to “design policies to impact health equity and structural racism within systems, communities, and populations” and advocate for the promotion of social justice and eradication of structural racism and systematic inequity in nursing and society.”

Nurses play an essential role in addressing health equity by engaging in these important activities:

- Creating inclusive environments that acknowledge and challenge racism in all aspects of nursing education and professional practice
- Advocating for social policies that promote health care equity at the community, state, and national level
- Participating experiential learning opportunities in communities where care is needed
- Prioritizing reducing health disparities among populations disproportionately affected by HIV, viral hepatitis, sexually transmitted infections, tuberculosis, and other related conditions
- Intentionally recruiting, supporting, and mentoring nursing students and nurses from diverse backgrounds to ensure that the next generation of nurses reflects the communities they serve (National Academies of Sciences et al., 2021)

Nurses must be committed to the equitable delivery of care from the individual level to the systems level.

PRACTICE APPLICATION

Setting the Scene

A 37-year-old male comes to a community clinic complaining of unintentional weight loss of 20 pounds over the last 2 months, abdominal bloating, severe fatigue, and persistent gastroesophageal reflux disease (GERD). The provider determines that the patient needs a colonoscopy. The patient is uninsured and, on further discussion with the provider, shared that he is a DACA recipient and is currently unemployed. He states that he tried to get health insurance through the health care exchange but was denied because of his DACA status.

Think About It

Imagine you are the nurse assisting this patient.

1. How would you (or would you not) proceed with offering care to this patient? Why?
2. What other health disparities might this patient experience because of his DACA status?
3. What additional health disparities might this patient experience if he were part of other marginalized groups, such as racial minorities or LBGTQIA+?
4. What effect does being a part of multiple-impacted communities have on the health disparities an individual might experience?
5. How might addressing health disparities among underserved populations of people, like this patient, help promote health equity on a larger scale?

ADDITIONAL RESOURCES

Health Equity

American Planning Association - Plan for Health

American Planning Association - Planners for Health

CDC, Division of Nutrition, Physical Activity, and Obesity - Health Equity Resource

MPHI - Equity in Action Workshops

University of Wisconsin-Madison, Population Health Institute - Health Equity Training Modules

Virginia Department of Health - Health Equity Resources

Support for Specific Populations

Asylum Migration to the Developed World: Persecution, Incentives, and Policy [Article]

Robert Wood Johnson Foundation - Immigration, Health Care and Health

USDA, Food and Nutrition Service - Supplemental Nutrition Assistance Program (SNAP)

USCIS - Green Card Eligibility Categories

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Chapter Three: Social Determinants of Health and Vulnerable Populations

OVERVIEW

This chapter presents foundational information on social determinants of health (SDOH) and vulnerable populations. These determinants are critical to improving health, advancing health equity, and reducing health disparity. Research indicates that health outcomes are a result of multiple variables, including underlying genetics, health behaviors, social and environmental factors, and health care. Vulnerable populations are groups of people and communities at a higher risk for poor health as a result of the barriers they experience, including social, economic, political, and environmental resources, as well as limitations caused by illness or disability (National Collaborating Centre for Determinants of Health, 2022).

LEARNING OBJECTIVES

- Identify the SDOH and how they influence the health status of individuals, communities, and populations
- Recognize the impact of health disparities and SDOH on care outcomes
- Recognize how geospatial determinants of health can make the connection between "place" and health
- Connect SDOH principles with vulnerable populations

KEY TERMS

- social determinants of health
- geospatial determinants of health
- health behaviors
- vulnerable populations

Content in this chapter was adapted from Healthy People 2030.

INTRODUCTION

Public and community health nurses are in an ideal position to integrate a holistic understanding of SDOH and recognize the unique health risks to vulnerable populations. Public health nurses assess, identify, and intervene to improve the health and health outcomes of individuals, families, and populations.

SOCIAL DETERMINANTS OF HEALTH

A significant portion of health can be attributed to social and environmental factors, separate from medical care or a person's individual lifestyle choices. In fact, medical care itself may

account for only 10%–20% of an individual's health outcomes, while approximately 80%-90% of the factors that influence health can be linked with SDOH (Magnan, 2017). *Social determinants of health* comprise the conditions where people are born, work, live, worship, age, and play that affect an individual's health, functioning, quality of life outcomes, and risks (Magnan, 2017; U.S. Office of Disease Prevention and Health Promotion [ODPHP], 2022e; Kaiser Family Foundation, 2018).

Social determinants of health can be broadly grouped into five categories: economic stability, educational access and quality, neighborhood and built environment, health access and quality, and social and community context (ODPHP, 2022k). Nurses should recognize that a person's health consists of a few different factors, and only one of those factors is the individual's health behaviors. As Figure 3.1 demonstrates, socioeconomic factors and physical environment, both SDOH components, are major factors in a person's overall health.

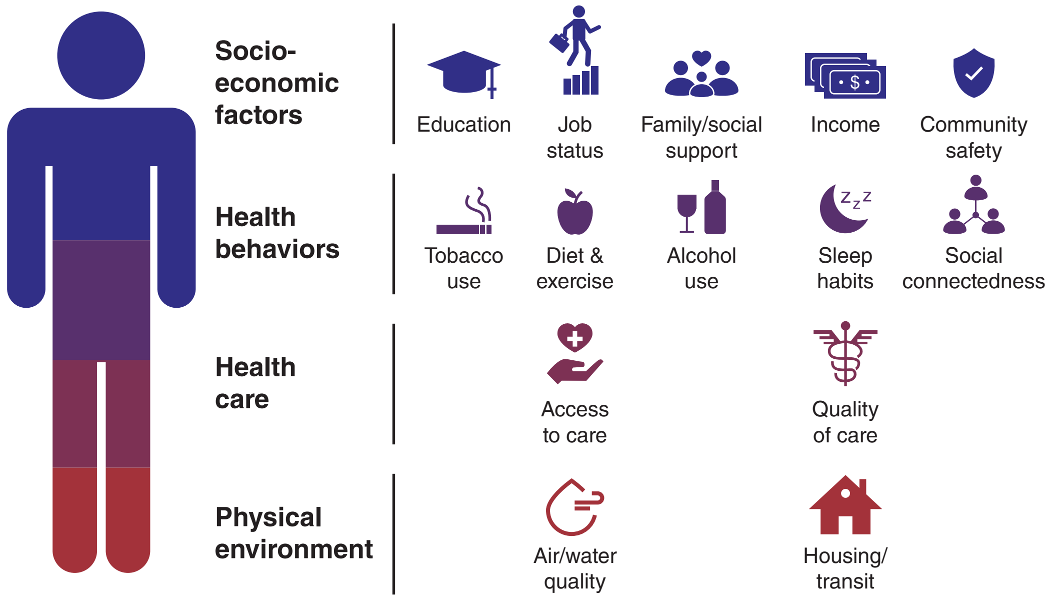


Figure 3.1: Factors in Health

Social determinants contribute to wide health disparities and inequities. For example, people who do not have access to grocery stores with healthy foods are less likely to have good nutrition, raising their risks for health conditions such as heart disease, diabetes, and obesity and lowering life expectancy relative to people who do have access to healthy foods. Nurses then must understand the conditions in which people live, work, play, and pray to understand their patients' barriers to and facilitators of good health. Nurses in the community must realize the impact that social determinants can have on patients' health outcomes and then address those determinants through the alleviation of barriers.

Social determinants can also influence specific health behaviors, such as diet and exercise, which can further drive health outcomes. For example, in terms of education, families with parents who have not completed high school are more likely to live in a neighborhood that poses barriers to health, such as lack of safety, exposed garbage, and substandard housing. They are also less likely to have access to healthy and safe community environments, including sidewalks, parks or playgrounds, recreation centers, or a library. Further, the stress that results from these less than optimal environments is shown to negatively affect health across the lifespan, and these

environmental factors may have multigenerational impacts. Addressing SDOH is not only critical to improving the overall health of individuals, communities, and society as a whole. It is vital to reduce health disparities that are often rooted in social and economic disadvantages.

Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity
- Polluted air and water
- Language and literacy skills (ODPHP, 2022k)

In this chapter, we provide a few selected examples of priorities within each SDOH category, discuss these factors' impact on achieving good health, and provide context for actions that can be taken to help address SDOH.

ECONOMIC STABILITY

Economic security is having stable, sufficient income to meet your basic needs, while economic insecurity is living in a household with incomes below 200% of the federal poverty level. Today one out of every three people in the United States is economically insecure. Economic security for households and residents is essential for the health and well-being of families, neighborhoods, and local and national economies. In 2022, several tax policies enacted by the American Rescue Plan Act (ARPA) in 2021 lapsed, including expanding the earned income tax credit for filers without children and full refundability of the child tax credit and child and dependent care credit. The contraction in federal tax programs led to a substantial decline in real posttax incomes. The U.S. Census Bureau's real median posttax household income in 2022 was 8.8% lower than in 2021.

Economic stability can be described as the ability to access resources essential to one's life and well-being. The federal poverty level is the standard proxy measure to indicate whether individuals or families are poor or unable to meet their basic economic needs. In 2022, the U.S. Census Bureau reported that 11.5% of the population, or 37.9 million people, lived in poverty. Healthy People 2030 has identified unemployment or underemployment, food insecurity, housing instability, and poverty as factors directly influencing economic stability (ODPHP, 2022a).

Food Insecurity

A household experiences food insecurity when facing recurrent barriers to accessing enough food to live a healthy and active life (Feeding America, 2022). In 2020, there were 38.3 million people living with some level of food insecurity, and 584,000 children were living in households with very low food security (United States Department of Agriculture [USDA], Economic Research Service, 2022). The USDA divides food insecurity into two categories:

1. Low food security: "Reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake."
2. Very low food security: "Reports of multiple indications of disrupted eating patterns and reduced food intake."

The type of household a person lives in greatly affects the prevalence of food insecurity. Households with children have higher rates of food insecurity, as also do households that are headed by a single woman, Black non-Hispanic households, and Hispanic households. Some urban and rural neighborhoods have very few full-service supermarkets for residents to frequent. Often, urban neighborhoods have small corner stores with processed food options and limited options for fresh, healthy foods. Additionally, the cost markup for these types of markets tends to be higher than for other grocery stores, effectively limiting the amount of food that local residents can buy. Lack of public transportation also affects a family's ability to obtain food, particularly for families living in rural areas without access to personal vehicles and without public bus routes.

Food insecurity is linked to negative health outcomes in children and adults, and being hungry or malnourished can lead to decreases in school performance. Helping to reduce hunger by addressing unemployment and providing access to nutrition assistance programs can help families achieve better overall health. Food assistance programs—such as the National School Lunch Program (NSLP), the Women, Infants, and Children (WIC) program, and the Supplemental Nutrition Assistance Program (SNAP)—address barriers to accessing healthy food. Nurses can help by making sure the families they care for know about these programs and help families to get signed up for assistance (ODPHP, 2022d).

Housing

There are complex reasons for housing instability that can include many variables, among them having trouble paying rent, overcrowding, moving frequently, or spending the bulk of household income on housing. If more than 30% of a household's income is spent on housing, that household is considered to be cost-burdened; if more than 50%, then the householders are considered to be severely cost-burdened (Bailey et al., 2016). A limited rental market with few affordable vacancies may force people with the lowest incomes to rent substandard housing or force individuals to share housing, resulting in overcrowding. When housing costs are more than a household can reasonably afford, it can lead to foreclosures, which cause a loss of money and possessions and can damage the social fabric of neighborhoods.

Multiple forced moves as a result of housing instability have been associated with negative health outcomes in children. For individuals, housing instability can lead to a greater incidence of poor health outcomes, from mental health issues to heightened stress levels, to relationship injury, and to a greater likelihood of infectious disease transmission (ODPHP, 2022f).

Housing deprivation at its most severe leads to people without homes and with health issues: a study of newly unhoused people "in the New York City shelter system found that 6% had diabetes, 17% had hypertension, 17% had asthma, 35% had major depression, and 53% had a substance use disorder—indicating that chronic disease is more common among people who are newly homeless than among the general population" (Schanzer et al., 2007).

Educational Access and High School Graduation Rates

People with higher levels of education are more likely to be healthier and live longer than those with low levels of education. Providing high-quality educational opportunities for children and adolescents, and helping them do well in school, can ultimately also help them achieve better health. A child who struggles with math and reading could potentially be experiencing a learning disability, living in a low-income situation, or facing social discrimination. These children are less likely to graduate from high school, which limits their ability to secure safe, well-paying jobs. Barriers such as poverty can lead to greater health problems, such as heart disease, depression, and

diabetes. Some children live in areas where the schools are performing poorly, school resources are limited, and attaining the same level of education as someone in a higher-performing school is outside their control. Additionally, if these children live in poverty, they are more likely to be affected by delayed brain development, making it even harder for them to do well in school. Targeted interventions to support educational access and quality, such as taking preventive mental health measures and improving high school graduation rates, can help children have better health in the long term (ODPHP, 2022b).

Higher levels of education are also linked to a lower risk of early death later in life. Many high school students do not graduate, and graduation rates are lower in some racial/ethnic groups. Students from economically disadvantaged families often have less access to resources, and they tend to live in communities with underperforming schools. These factors may contribute to lower academic achievement and higher dropout rates as compared with students from economically advantaged families. In 2015, the number of young people aged 16 to 24 who did not complete high school or were not enrolled in high school was 4.1 times higher in low-income families compared with high-income families (ODPHP, 2022g). High school graduation is important for many reasons, but primarily because the skills learned help support the attainment of a safe, high-paying job or successful college attendance. The ability to secure stable employment and income helps support conditions where people can achieve better health.

Programs that offer vocational training, alternative schools, social-emotional skills training, and/or counseling can help more students graduate from high school. Research shows that high school graduates have better employment prospects and lifelong earning potential than do nongraduates. For every year of high school a student completes, their lifetime wealth increases by 15%. Overall, high school graduation has the potential to improve population health (ODPHP, 2022g).

Preventive Mental Health in Schools

Anxiety and depression are common among children—even more so in the wake of the recent COVID-19 pandemic, when children were suddenly restricted from engaging in their normal social outlets with teachers and friends. For many children, the lengthy distance-learning periods while schools were physically closed meant that students spent a significant amount of time looking at computer screens without the recess, lunch, physical education, and social breaks that are beneficial to mental health. Children who routinely experience forms of social discrimination—like bullying—are more likely to struggle with math and reading and less likely to graduate from high school or go to college (Community Preventive Services Task Force, 2019). Increasing the proportion of children who receive preventive mental health services in school is a high-priority public health issue. Targeted school-based therapy programs are intended to reduce depression and anxiety in school-aged children and adolescents at increased risk for these conditions. Trained school staff or outside mental health professionals deliver these interventions in individual or group settings that helps students build strategies for problem-solving, emotional regulation, and helpful behavior patterns.

NEIGHBORHOOD AND BUILT ENVIRONMENT

In the United States, many people live in neighborhoods with high rates of violence, unsafe air or water, and other health risks, a situation that greatly affects their health and well-being. People with low incomes and members of racial/ethnic minorities are more likely to live in places with these risks. Likewise, individuals may be exposed to conditions at work that can harm their health. There are government interventions and policy changes that can reduce health and safety

risks and promote health, such as providing opportunities for people to walk and bike in their communities by adding sidewalks and bike lanes. These types of interventions can increase safety and help improve health for communities (ODPHP, 2022i).

Geospatial Determinants of Health

The places a life is lived—from home to workplace, schools to parks, and town centers to places of worship—all affect the health of individuals and their communities, directly influencing how people experience disease and well-being. Geospatial science, geographic information systems, and cartographic visualization provide important methods and tools that public health scientists use to analyze the critical relationship between health and the places lives are lived.

The Geospatial Research, Analysis, and Services Program, commonly referred to as GRASP, is developing a framework for the specific geospatial determinants of health to (1) define the geospatial drives of health with an emphasis on factors that vary by place; (2) serve as a catalyst to define, promote, and advance the use of place in research and practice across the public health community; and (3) shape the public health curriculum of schools across the United States to advance geospatial analysis, statistics, and technology in the study of public health (Agency for Toxic Substances and Disease Registry, n.d.).

Environmental Conditions

The quality and state of the environment, or environmental conditions, are part of daily life that can affect health and can vary widely among populations and geographic locations. Although many of the conditions people experience in the environment are naturally occurring, the quality of an environment can be affected by historical, economic, and sociopolitical factors detailed in the literature summarized in Healthy People 2030: Environmental Conditions as a social determinant of health (ODPHP, 2022c).

Populations that may be more susceptible to poor environmental conditions and their associated health disparities include communities of color, persons with low incomes, persons who are unhoused, older adults, pregnant women, and children. The rising temperatures and shifting weather patterns around the globe, a result of climate change, are expected to worsen public health challenges, particularly for disadvantaged communities (ODPHP, 2022c). Policies and programs that can have an impact on environmental conditions have been effective in reducing the harmful effects of pollutants. For example, federal laws, such as the Clean Air Act and Safe Drinking Water Act, regulating air and water quality, have successfully reduced the harmful health effects of pollutants (Weinmeyer et al., 2017; Nethery et al., 2021). As environmental conditions continue to evolve, additional innovative and sustainable interventions are needed to address the effects of environmental conditions on health outcomes and disparities.

Water Quality

As an essential part of human life, water quality is critical to the environment and to health and well-being. The U.S. water supply is generally safe, but water can be contaminated in a variety of ways, such as through certain agricultural practices, sewage leaks, or naturally occurring harmful substances. Water may also be contaminated with pathogens, which cause waterborne diseases, or with chemicals, which cause other negative health issues (Centers for Disease Control and Prevention [CDC], 2022b). There are approximately 7.15 million cases of waterborne illnesses from pathogens alone in the United States each year (CDC, 2020).

The Safe Drinking Water Act was established in 1974 to regulate drinking water by setting national standards for over 90 contaminants (U.S. Environmental Protection Agency, 2015). Water quality may still be affected by several natural, built, and sociopolitical factors, which can lead to health disparities (Balazs & Ray, 2014; Schaider et al., 2019). Many factors can influence the quality of a community's water, from the number of institutions or individuals dedicated to managing a water system to the size of a water source, to city planning decisions (ODPHP, 2022c). Communities with lower incomes and communities of color have been found to have a higher risk of exposure to water quality health violations and water contaminants, such as arsenic and nitrates. Furthermore, the Safe Drinking Water Act does not regulate small, private wells, often putting rural residents, who are more likely to use private well water, at risk, particularly for high levels of nitrates (ODPHP, 2022c). High levels of nitrate or arsenic exposure can cause nausea, vomiting, cardiovascular issues, and death (Agency for Toxic Substances and Disease Registry, 2015, 2017).

Air Quality

Like water, air is a vital condition for life and health. However, air pollution is associated with an estimated 100,000 to 200,000 deaths annually in the United States (Tessum et al., 2019). Particles commonly emitted into the air by motor vehicles, industrial facilities, and fires—such air pollutants as carbon monoxide, ozone, nitrogen and dust, smoke, and drops of liquid—affect air quality (ODPHP, 2022c). Poor air quality is linked to many health problems, including lung cancer and heart disease (Turner et al., 2011). There are also naturally occurring particles, including pollen, that can cause allergic reactions and respiratory concerns that substantially affect community health (Saha et al., 2021).

Urban areas often have more pollution sources, resulting in worse air quality when compared with rural areas. Additionally, as a result of historical, sociopolitical, and discriminatory factors, communities of color encounter air pollution more often than predominantly White communities do. For example, neighborhoods of color are more likely to be located near pollution sources, such as factories and industrial facilities, as a result not only of discriminatory city planning but also of the residents' limited sociopolitical influence (Mikati et al., 2018; Woo et al., 2019).

Climate Change

The impacts of human-induced climate change are rapidly increasing and pose a real and significant threat to the health of the American people. As the U.S. Global Change Research Program (2016) notes, "Rising greenhouse gas concentrations result in increases in temperature, changes in precipitation, increases in the frequency and intensity of some extreme weather events, and rising sea levels." Climate change endangers individuals and population health by affecting food and water sources, the air that people breathe, the weather that people experience, and people's interactions with both built and natural environments. The risks to human health continue to expand as the climate continues to change, with current and future climate changes exposing more people in more places to public health threats.

Already in the United States there are observable climate-related increases in people's exposure to elevated temperatures; more frequent, severe, or longer-lasting extreme events; degraded air quality; diseases transmitted through food, water, and disease vectors (such as ticks and mosquitoes); and stresses to individuals mental health and well-being. These threats are expected to worsen with continued climate change, and while all Americans are at risk, some populations are disproportionately vulnerable, including "those with low income, some communities of color, immigrant groups (including those with limited English proficiency), Indigenous peoples,

children, and pregnant women, older adults, vulnerable occupational groups, persons with disabilities, and persons with preexisting or chronic medical conditions" (U.S. Global Change Research Program, 2016).

For more on climate change, visit The Impacts of Climate Change on Human Health in the United States: A Scientific Assessment (globalchange.gov).

Noise Pollution

Increased exposure to human-made noise, such as traffic, is called noise pollution. Noise pollution has been associated with hearing loss, among other health issues, with some studies finding that noise pollution disproportionately affects communities of color and communities with low incomes (Casey et al., 2017).

Hazardous Waste Threats

There are health concerns for communities living near hazardous waste sites, such as industrial facilities, municipal waste sites, or incinerators; these health concerns include adverse pregnancy outcomes, childhood cancer, and other diseases (Brender et al., 2011; Orr et al., 2002). For example, one study found that adults living in the United States near a coal-burning power plant were more likely to report respiratory, gum, and skin conditions than were adults not living near a power plant (Zierold et al., 2020).

Health Care Access and Quality

Many people in the United States are unable to obtain the health care services they need, either because they have limited access to care or because the quality of care they are receiving is low. Around 10% of people in the United States do not have health insurance (Berchick et al., n.d.), which makes them less likely to have a primary care provider and to afford the health care services and medications they need. For persons who are uninsured or underinsured, the ability to obtain preventive care services and treatment for chronic illness depends on their finances. Increasing insurance coverage for people in the United States means they can get the necessary health care services. Sometimes people do not get recommended health care services, like cancer screenings, because they do not have a primary care provider. Other times, it is because they live too far away from a health care provider who accepts their type of insurance, offers sliding scale services, or specializes in the care they need.

Differences in quality of care contribute to poor health outcomes just as much as limited access to care does (ODPHP, 2022e). In 2002, the Institute of Medicine reported that racial and ethnic minorities tend to receive a lower quality of care. This is true even when issues such as lack of insurance or limited access to health care are controlled (Brummer et al., 2016). Higher rates of heart disease, cancer, diabetes, obesity, depression, infant mortality, and maternal morbidity are just a few examples of health disparities partially resulting from low-quality care. Interventions to increase access to health care professionals and improve care quality can help more people get and stay healthy (ODPHP, 2022e).

Family Planning

Almost half of the pregnancies in the United States are unintended, and unintended pregnancy is linked to negative outcomes for both individuals who are pregnant and infants (CDC, 2021b). With the overturning of *Roe v. Wade* and the changing legislation surrounding access to abortion

services, a community health focus on family planning is as important as ever. Abortion restrictions disproportionately affect people of color and those with low incomes. According to the CDC, Black women are five times more likely to have an abortion than White women, and Latinx women are two times as likely as White women (CDC, 2022a). Of all people who have abortions, 75% are low income or poor. Reproductive health restrictions also affect women's earning potential. Studies indicate that an absence of abortion restrictions would translate to between 1.5% and 2.5% increases in the labor force for Black, Hispanic, and Pacific Islander women. This translates to an estimated $13.4 million in increased earnings at the state level for Black women alone (Winny et al., 2021).

Adolescents are at especially high risk for unintended pregnancy. Close to 200,000 babies are born to teen mothers every year in the United States, and this is a reduction in rates from previous years. Abortion restrictions most negatively affect individuals who can become pregnant and teens who already have other negative SDOH working against them.

Data confirm significantly higher pregnancy-related mortality ratios among Black and American Indian/Alaskan Native women compared with other groups. These gaps did not change over time (Figure 3.2).

Sexually active women who do not want to get pregnant need access to birth control, but many individuals cannot afford effective birth control methods. Interventions such as publicly funded birth control are critical in reducing unintended pregnancies. Linking adolescents to youth-friendly health care services can help prevent pregnancy as well as sexually transmitted

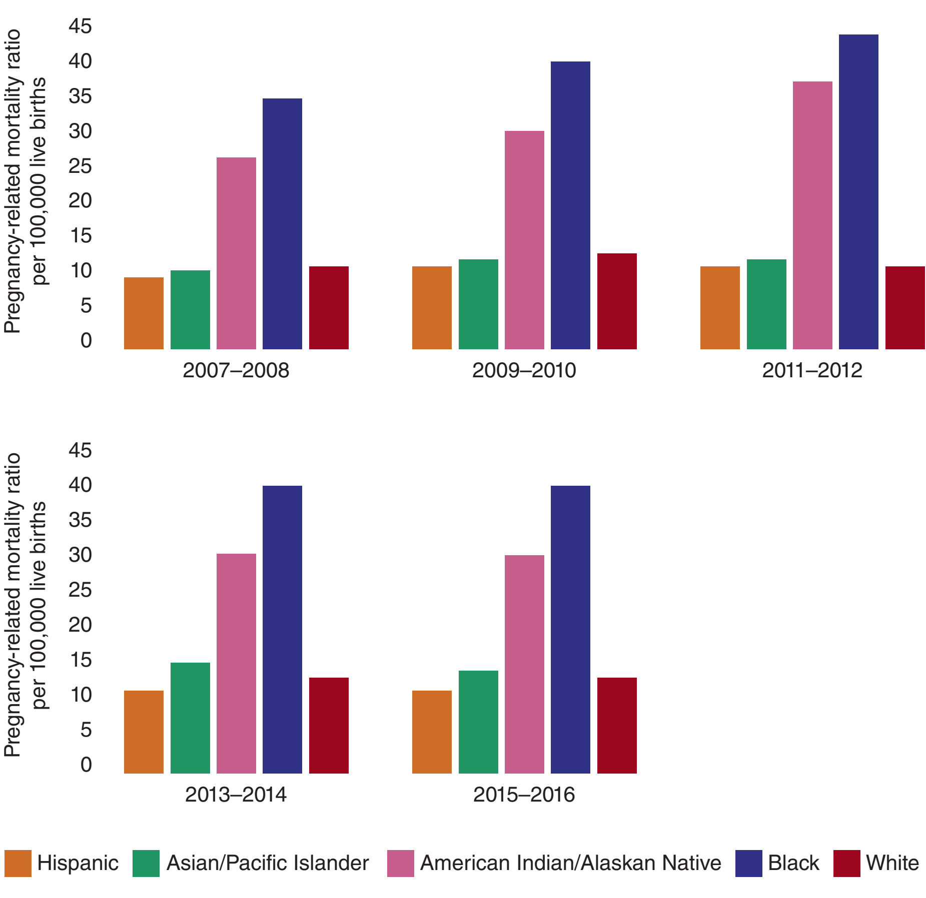


Figure 3.2: Pregnancy-Related Mortality Ratio, 2007–2016 (Adapted from CDC, 2022c)

infections in this age group. Increasing the use of birth control and family planning services may help, in some situations, to reduce the negative health consequences associated with unintended pregnancy. Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression.

Specific interventions suggested by the CDC include examining the need for contraceptive services among women of reproductive age, developing evidence-based strategies to reduce unmet needs for quality family planning services, and building capacity for health care providers, states, communities, and partners to improve quality family planning services.

Social and Community Context

Relationships and interactions with family, friends, coworkers, and community members can significantly affect an individual's health and well-being. Ensuring that people get the social support they need in the places where they live, work, learn, and play is important.

Unsafe neighborhoods, discrimination, and trouble affording the things an individual or family needs are often challenges outside an individual's control and can have a negative impact on health and safety throughout an individual's life. Some individuals do not receive the support they need from loved ones or from others; these individuals may be children whose parents are in jail or bullied adolescents. Positive relationships at home, work, and within the community can help reduce these negative impacts, And interventions to help people access the social and community support they need are critical for improving health and well-being.

Families That Read Together

In 2019, only 55% of children aged 5 and under had a parent or caregiver who read to them at home (ODPHP, 2022h). Studies show that reading to young children improves their language and literacy skills and is linked to better behavior and health. Reading and health go hand in hand throughout life. Children's behavior improves when they are confident in their reading abilities in school. Readers are encouraged to do their best and receive positive feedback, which sets the foundation for their self-esteem. However, children who struggle with reading might be withdrawn in class and lack self-esteem, and consequently when called on to read they may act out to avoid calling attention to their reading problems. Children might also feel headaches, stomach aches, and fatigue, the physical effects of the anxiety and embarrassment associated with reading struggles.

A further complication is that adults with low literacy skills have 3.5 times the health care costs that literate adults have (Nemours Foundation, 2022). So, it is important to consider methods to help children increase language and reading readiness. These methods include reading with a caregiver for at least 10 minutes a day, having a variety of books accessible in the home, and limiting screen time. Parents and children can share routines, build stronger relationships, and have regular positive interactions through reading out loud. Early intervention programs and national initiatives can help raise awareness about the importance of reading to children, but early and consistent reading in individual social circles is the first step toward healthier outcomes.

Bullying

Bullying of youth is a form of violence and is considered an adverse childhood event. It is a serious problem with serious morbidity and mortality consequences in our communities. Bullying can result in physical injury, social and emotional distress, self-harm, and even death. Youth who

bully others are at increased risk for substance misuse, academic problems, and experiencing violence later in adolescence and adulthood. Data from the Youth Risk Behavior Surveillance Survey indicated that almost 20% of students were bullied on school grounds, and 15% had been bullied online (Kann, 2018).

Sexual minority students are at an increased risk of being bullied, especially in conservative or religious districts, where hateful behaviors toward them may often go unchecked by teachers and administrators. Nearly one third of sexual minority (LGBTQIA+) students in grades 9–12 reported that they experienced bullying at school (ODPHP, 2017). High school students who identify as lesbian, gay, or bisexual are almost twice as likely to be bullied as those who identify as heterosexual. Students who are bullied are more likely to have depression, anxiety, and sleep problems—and to drop out of school. As a result of the constant harassment, bullied individuals suffer academically, physically, and emotionally.

School-based programs to reduce violence can help prevent bullying of LGBTQIA+ students. Current bullying prevention efforts include anti-bullying laws and policies at the state, local, and school district levels. Newer efforts toward anti-bullying policies seek to enumerate the specific characteristics of children who are likely to be bullied, among them LGBTQIA+ students, in an effort to create targeted education and campaigns for bullying prevention. Enumerated anti-bullying policies not only define and denounce bullying but also list examples of characteristics that might be the basis of bullying, such as actual (e.g., a student is openly gay) or perceived (e.g., others think that a student is gay) sexual orientation.

Figure 3.3 suggests several protective risk factors and actions nurses can take to help prevent bullying in their communities (CDC, 2021a).

Promote family environments that support healthy development
- Early childhood home visitation
- Parenting skills and family relationships programs

Providing quality education early in life
- Preschool enrichment with family engagement

Strengthen youth's skills
- Universal school-based program

Connect youth to caring adults and activities
- Mentoring programs
- After-school programs

Create protective community environments
- Modify the physical and social environment
- Reduce exposure to community-level risks
- Street outreach and community norm change

Intervene to lessen harms and prevent future risk
- Treatment to lessen the harms of violence exposures
- Treatment to prevent problem behavior and further involvement in violence
- Hospital-community partnerships

Figure 3.3: Protective Risk Factors and Actions Nurses Can Take to Help Prevent Bullying (Adapted from CDC, 2021a)

VULNERABLE POPULATIONS

Many populations are considered vulnerable in the United States, including racial/ethnic groups, the economically disadvantaged, those with chronic health conditions, the LGBTQIA+ community, veterans, the HIV community, refugees and immigrants, the incarcerated, and differently abled populations, among others. Additionally, vulnerable populations may include rural residents, who often face barriers to accessing health care (AJMC, 2006; Joszt, 2018). Significant disparities exist in health care for these vulnerable groups, and health and health care problems can intersect with social factors, such as housing, poverty, and education. The percentage of the population that falls into vulnerable categories is significant. In just one example, Figure 3.4 illustrates the percentage of the adult population in the United States with specific functional disabilities.

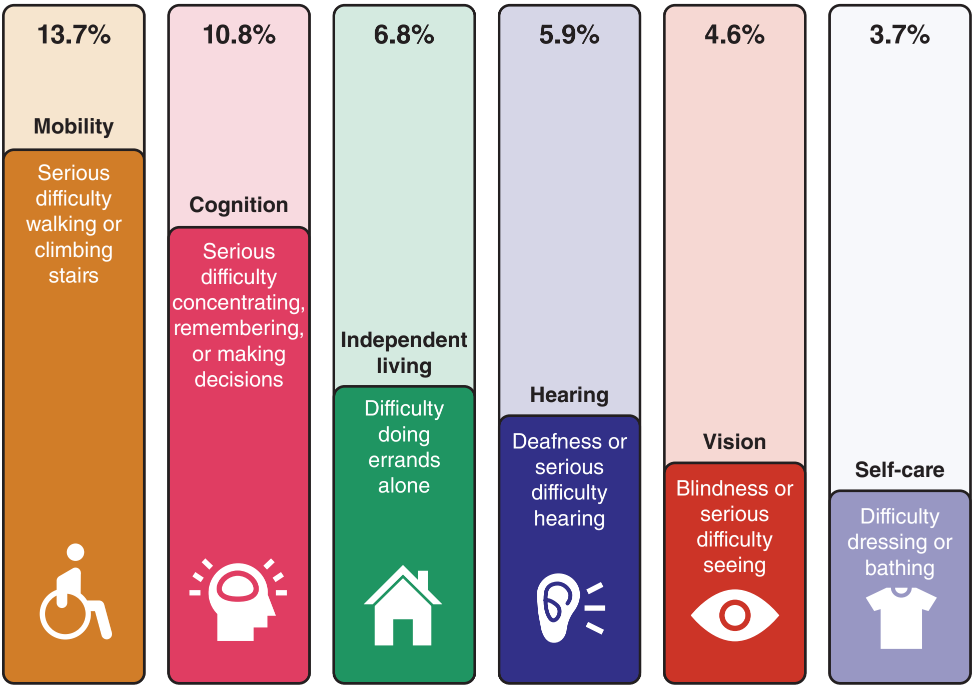


Figure 3.4: Percentage of U.S. Adults With Specific Functional Disabilities (Adapted from CDC, 2019)

Health Domains of Vulnerable Populations

Health domains of vulnerable populations may be divided into several categories, including the physical, psychological, and social. Examples of physical needs could include high-risk mothers and infants and those with chronic medical conditions such as diabetes or heart disease. Among older individuals, there is often more than one chronic condition, with much of this population having two or more chronic illnesses (AJMC, 2006).

Within the psychological domain, chronic mental conditions may include bipolar disorder, attention-deficit/hyperactivity disorder, substance abuse, and schizophrenia. Within the social realm, vulnerable populations can include those living in abusive families, people without homes, immigrants, and refugees (AJMC, 2006).

The health needs of these populations can be debilitating and are often compounded when an individual has issues in multiple domains.

The Need to Focus on Vulnerable Populations

The needs of medically vulnerable populations are serious and can be life-threatening, often requiring extensive nonmedical as well as medical services. Additionally, chronic illnesses are much more prevalent among economically disadvantaged populations. For example, patients with chronic illnesses who have less than a high school education are three times more likely to report being in poor health than those with the same illness who have an advanced degree (Robert Wood Johnson Foundation, 2002; AJMC, 2006).

Multiple risk factors within vulnerable populations intensify problems to make it more likely that health needs will not be adequately addressed. "Low income, no health insurance coverage, and lacking a regular source of care are closely related risk factors that build upon each other to influence the likelihood of having an unmet health need due to cost" (AJMC, 2006).

Vulnerable populations, defined as those at greater risk for poor health status and health care access, also may experience significant disparities in life expectancy, in access to and use of health care services, and in morbidity and mortality. Health needs for these populations are complex and intersect with the social and economic conditions they experience. Interventions are critical not only at the individual level but also at the local, state, and federal levels—where policy and legislation can mitigate the needs of vulnerable populations—because the strain on individuals, their community, and existing health care systems is great (AJMC, 2006).

Figure 3.5 illustrates several examples of vulnerable populations and specific mitigation and intervention measures that nurses working in community health settings may take.

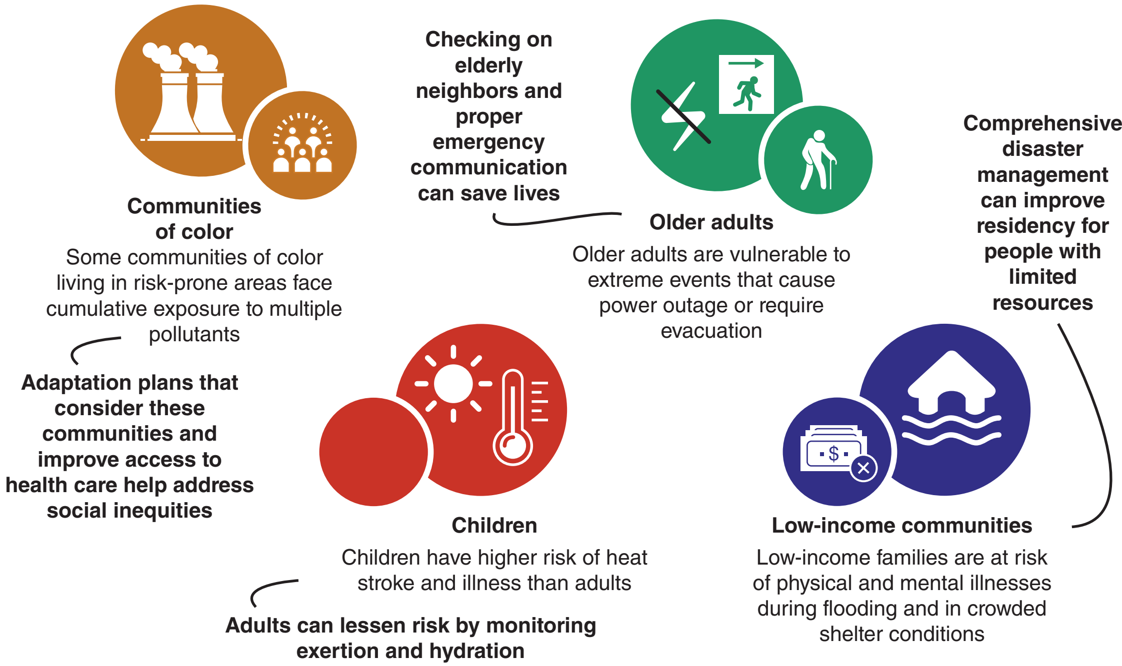


Figure 3.5: Examples of Vulnerable Populations and Mitigation Strategies

THE NURSE'S ROLE IN SOCIAL DETERMINANTS OF HEALTH AND VULNERABLE POPULATIONS

Addressing SDOH differences enables progress toward health equity, a state where every person can attain their highest level of health. Social determinants have been shown to have a greater influence on health than genetic factors or access to health care services. Indeed, SDOH, including the effects of centuries of racism, are key drivers of health inequities within communities of color. The impact is pervasive and deeply embedded in our society, creating inequities in access to various social and economic benefits, such as housing, education, wealth, and employment. These inequities put people at the lower end of the socioeconomic ladder at higher risk of poor health (CDC 2022e).

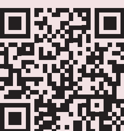
Nurses must focus on working with state and national agencies to ensure that resources reach those in need. Because SDOH constitute a multifaceted public health problem, nurses must collaborate with many sectors (e.g., transportation, education, housing, health care) and types of organizations (e.g., public agencies, private industry, community-based organizations).

PRACTICE APPLICATION

➔ Setting the Scene

Health Care Disparities: Sharlene Adams Goes to Buy a Blood Pressure Cuff

Watch this video by scanning the QR code or visiting
https://youtu.be/d6wH4nQVmhw



➔ Think About It

Consider Sharlene's experience as showcased in the video.

1. What factors did you notice that either contributed to or reduced Sharlene's overall health?
2. Of the factors you identified, how many are considered SDOH?
3. What changes could the physician's office make to make health care more accessible to Sharlene?
4. What were the transportation barriers Sharlene experienced? Do you think this will reduce her health-seeking behaviors in the future? For example, future health screenings?
5. What state or national policies can you identify that would contribute to or present barriers to Sharlene's health if she lived in your neighborhood?

ADDITIONAL RESOURCES

CDC, National Environmental Public Health Tracking – Populations and Vulnerabilities

Center on Budget and Policy Priorities – A Quick Guide to SNAP Eligibility and Benefits

Healthy People 2030 – Environmental Conditions [Literature Summary]

PBS – Unnatural Causes . . . is inequality making us sick?

The State of Health Disparities in the United States [Book Chapter]

USDA, Food and Nutrition Service – A Short History of SNAP

Information on Unique, Vulnerable Populations

Communities of Color: Vulnerability and unmet health care needs. The influence of multiple risk factors [Article]

Persons with Disabilities: WHO – Disability

Older Persons: A framework for understanding old-age vulnerabilities [Article]

The HIV Community: KFF – The Global HIV/AIDS Epidemic

Persons Who Are Homeless: Loma Linda University Health, Institute for Health Policy and Leadership – Disparities in Health Care for the Homeless

Persons Who Are Incarcerated: Healthy People 2030 – Incarceration [Literature Summary]

LGBTQIA+ Community: Health People 2030 – LGBT

Economically Disadvantaged Children: OECD, Changing the Odds for Vulnerable Children: Building Opportunities and Resilience [Report]

Refugees/Immigrants: WHO – Refugee and migrant health

Persons Who Are Uninsured: Health Consequences of Uninsurance among Adults in the United States: Recent Evidence and Implications [Article]

Veterans: George Washington University, Milken Institute of School of Public Health – The Health Risks of a Veteran

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Chapter Four: Epidemiology

OVERVIEW

Epidemiology is the study of the distribution and determinants of health and disease in human populations. It is the principal science of public health, and its use is essential in disease surveillance. The purpose of epidemiology is to:

- Discover the agent, host, and environmental factors that affect health
- Determine the relative importance of causes of illness, disability, and death
- Identify those segments of the population that have the greatest risk from specific causes of ill health
- Evaluate the effectiveness of health programs and services in improving population health

Epidemiology approaches disease surveillance from a public health perspective using questions such as these:

- What is the problem? (surveillance)
- What are the causes? (risk factor identification)
- What is the solution? (intervention evaluation)
- How is the solution used? (implementation)

LEARNING OBJECTIVES

- Define epidemiology
- Describe how epidemiology is used to solve health problems
- Describe basic terminology and concepts of epidemiology
- Differentiate between incidence and prevalence
- Understand epidemiology in terms of levels of prevention

KEY TERMS

- epidemiology
- rate, prevalence, and incidence
- mortality and morbidity
- epidemic, endemic, pandemic, and cluster
- notifiable conditions

Content in this chapter was adapted from the Centers for Disease Control and Prevention (2018) and the HSC Public Health Agency (Arnold et al., 2020).

INTRODUCTION

Nurses use epidemiology to better understand patterns of disease and treatment options for the patients they serve. Knowledge of epidemiology can help health care professionals set priorities for health education programs, use health resources more effectively, and plan strategies to help meet new health needs. Community and public health nurses have played an integral role in identifying diseases and the organisms that have caused them. Nurses must use what they learn during investigation to make recommendations to control disease spread or prevent a future occurrence.

WHAT IS EPIDEMIOLOGY?

Epidemiology is the study of the distribution and determinants of health and disease in human populations. It is the principal science of public health, and its use is essential in disease surveillance. Epidemiology is the method used to find the causes of health outcomes and diseases in populations. In epidemiology, the patient is the community, and individuals are viewed collectively. By definition, epidemiology is the study (scientific, systematic, and data driven) of the distribution (frequency, pattern) and determinants (causes, risk factors) of health-related states and events (not just diseases) in specified populations (neighborhood, school, city, state, country, global).

The purpose of epidemiology is to:

- Discover the agent, host, and environmental factors that affect health
- Determine the relative importance of causes of illness, disability, and death
- Identify those segments of the population that have the greatest risk from specific causes of ill health
- Evaluate the effectiveness of health programs and services in improving population health

As Figure 4.1 demonstrates, epidemiology approaches the study of diseases in human populations from a public health perspective using questions such as these:

- What is the problem?
    - Surveillance
- What is the cause?
    - Risk factor identification
- What works?
    - Intervention evaluation
- How is it used?
    - Implementation

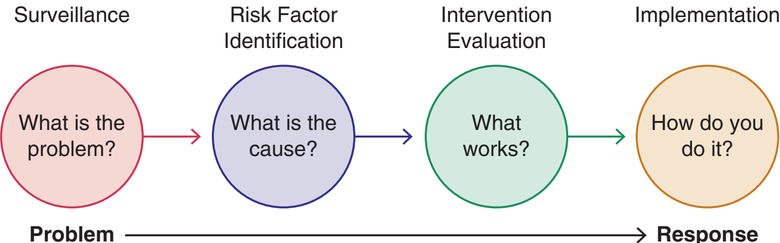

Figure 4.1: A Public Health Approach (Adapted from CDC, 2014)

Like investigators at the scene of a crime, community health nurses will begin by looking for clues. They will systematically gather information, asking questions such as these:

- Who is sick?
- What are their symptoms?
- When did they get sick?
- Where could they have been exposed?

Using statistical analysis, the nurse and other community partners will study answers to these questions to discover how a particular health problem was introduced (Centers for Disease Control and Prevention [CDC], 2016).

The types of public health problems that are scientifically investigated using epidemiological methods include environmental exposures to lead, heavy metals, and air pollutants; infectious diseases from influenza and foodborne illness; injuries from homicides and mass casualties; non-infectious diseases such as birth defects and cancer; chronic diseases such as diabetes; natural disasters such as Hurricane Katrina and the 2010 Haiti earthquake; and the terrorist acts of 9/11.

Epidemiologic data can also help with social justice initiatives to determine if communities or groups of people are at risk for certain diseases or health outcomes and help find ways to bring needed resources to at-risk groups and communities. Epidemiological research can help us to understand measures that will prevent diseases, such as vaccines (primary prevention), and help us to find screening tools and effective early treatment/cures for disease (secondary prevention), or even suggest strategies for the care of patients with chronic advanced disease (tertiary prevention).

Key Epidemiology Terms to Know

There are certain terms to know for understanding epidemiology. An *outbreak* or an *epidemic* exists when there are more cases of a particular disease than expected in a given area or among a specific group of people over a particular period. Another term is *endemic*, used when a population has a high level of the disease all the time. For example, malaria is endemic in parts of Africa. As we know all too well, a *pandemic* is a disease or condition that spreads globally, such as COVID-19. A *cluster* is a group of cases in a specific time and place that exceeds what is expected.

To understand epidemiology, rates also need to be understood. In epidemiology, a *rate* is a measure of the frequency with which an event occurs in a defined population over a specified time. Rates are generally reported as percentages so that disease frequency can be compared in different locations, at different times, or among different groups of people with different-sized populations.

Incidence rate and *prevalence rate* (incidence and prevalence) are important terms. The incidence rate is the rate of occurrences of new cases of a disease in a certain period. The prevalence rate is the number of cases of a disease in the population at a given time. The prevalence rate contains new and existing cases, whereas the incidence rate is looking only at the new cases. (Remember this by thinking that the 'inc" at the beginning of "incidence" stands for In terms of **N**ew **C**ases, or INC.)

The terms *morbidity* and *mortality rates* are also important. Morbidity refers to the rate of illness in a community or population, and mortality rates are the rates of death in a specific community or population.

Understanding Incidence and Prevalence

One way to understand the difference between incidence and prevalence is to think of water entering and leaving a tub (Figure 4.2).

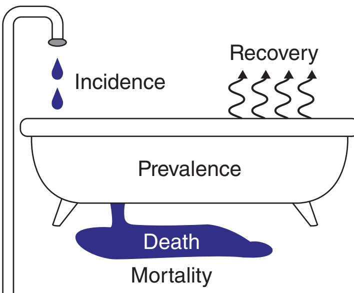

Figure 4.2: Incidence and Prevalence in Epidemiology (Adapted from Arnold et al., 2020)

Incidence

Incidence measures new cases of a disease in the population during a specified period and helps to identify increasing or decreasing transmission rates.

In the bathtub, the incidence is represented by the drops of water entering the bath from the faucet. Think of each drop of water as an increase in the incidence. Understanding a disease's incidence can influence decision-making about public health interventions necessary to slow transmission rates (Arnold et al., 2020).

Prevalence

Prevalence includes both new and existing cases of the disease during a specified period.

In the bathtub, prevalence is represented by the total amount of water at a specific point in time. As we all know, this quantity can change at any time. We can add more water by turning on the faucet. We can also lose water through evaporation or by opening the drain. Therefore, the filled bath represents the total number of cases at a point in time (the prevalence). Arnold et. al. (2020) explain that prevalence is a reflection of a number of issues: "the number of new cases (turning on the tap), the speed of recovery—which is influenced by disease severity, treatment options (evaporation), and the number of people that lose their lives to the disease (releasing the plug)."

Incidence and prevalence are both necessary to better understand a disease process, and both are used to guide public health decisions.

Notifiable Conditions

Content in this section was adapted from Foundations of Epidemiology, *by M. L. Bovbjerg (2020).*

There is a list of conditions—mostly infectious diseases, but a few chronic diseases and injuries also make the list—that must be reported to the CDC whenever they are encountered by clinicians or health department officials. For example, say a patient presents to a primary care clinic

complaining of high fever, cough, and watery eyes followed by a full-body rash. The nurse practitioner who sees the patient diagnoses measles. This clinic must then report the measles case to the local health department, who in turn reports it to the state health department, who in turn reports it to the CDC. This reporting ideally happens quickly, in a matter of days (or within hours for a potentially major threat). The list of nationally notifiable conditions is reviewed every year or so and revised according to current public health threats and priorities.

For instance, the Zika virus and its associated congenital conditions were added to the list in 2016. Some of the conditions on the list are extremely rare (human rabies, plague) or have even been eradicated (smallpox). However, they remain on the notifiable conditions list because in these cases, our expected level (also called the endemic level) is 0, and these conditions are dangerous enough that even one suspected case would be cause for an immediate public health intervention (Bovbjerg, 2020).

WHAT IS THE PROBLEM?

Surveillance and the Epidemiologic Triangle

Content in this section was adapted from Healthy Schools BAM! Body and Mind Classroom Resources for Teachers Program, "Lesson 1: Understanding the Epidemiologic Triangle Through Infectious Disease," from the Centers for Disease Control and Prevention (2015).

The epidemiologic triangle (Figure 4.3) is a model that scientists have developed for studying health problems and conducting surveillance. The triangle has three corners (called vertices):

- **Agent**, or microbe that causes the disease (the "what" of the triangle)
- **Host**, or organism harboring the disease (the "who" of the triangle)
- **Environment**, or those external factors that cause or allow disease transmission (the "where" of the triangle)

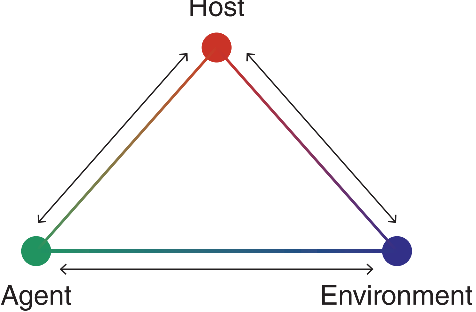

Figure 4.3: Epidemiologic Triangle (Adapted from CDC, 2015)

All three corners need to be present for diseases to occur. The epidemiologist aims to develop a plan that will break at least one of the sides of the triangle, disrupting the connection between the environment, the host, and the agent to stop the continuation of the disease (CDC, 2015).

To break one side of the epidemiologic triangle, information is needed regarding the disease. The process for this is called surveillance, which is an ongoing systematic collection, analysis, and interpretation of health-related data essential to planning, implementation, and evaluation of public health practice (CDC 2022a). The information collected through the process of surveillance is disseminated to those responsible for prevention and control of the identified health problem. Surveillance is foundational for public health practice because it helps us to understand diseases and their spread. The data can be found through local health departments, state health departments, and the CDC.

HEALTHY PEOPLE 2030 AND EPIDEMIOLOGY

Content in this section was adapted from the Office of Disease Prevention and Health Promotion (2022).

Community and public health infrastructure provide the necessary foundation for all public health services, from vaccinations to chronic disease prevention programs to emergency preparedness efforts. Community health nurses must be well versed in collecting and interpreting epidemiological data to ensure a strong public health infrastructure.

A strong public health infrastructure includes a capable and qualified workforce, up-to-date data and information systems, and agencies that can assess and respond to public health needs. While a strong infrastructure depends on many organizations working together, public health departments play a central role in the nation's public health system. Federal agencies rely on solid public health infrastructure in state, tribal, local, and territorial jurisdictions. Community health nurses will play a vital role in meeting Healthy People 2030 goals.

Healthy People 2030 community goals:

- Increase the proportion of local jurisdictions that have a health improvement plan
- Increase the proportion of state and territorial jurisdictions that have a health improvement plan
- Increase the proportion of tribal communities that have a health improvement plan
- Explore the impact of community health assessment and improvement planning efforts
- Explore the impact of public health accreditation and national standards (ODPHP, 2022)

THE NURSE'S ROLE IN EPIDEMIOLOGY

Public health nurses provide a critical linkage between epidemiological data and clinical understanding of health and illness as it is experienced in people's lives. This understanding is translated into action for the public good. An illustration of this role is the surveillance and monitoring of disease trends within the community. Emerging patterns that potentially threaten the public's health are identified and appropriate interventions planned, coordinated, and implemented. This is a role that public health nurses can take in any setting; however, it occurs mainly in the public sector. Public health nurses contribute to systems for monitoring crucial health status indicators such as environmentally caused illnesses, immunization levels, infant mortality rates, and communicable disease occurrence in order to identify problems that threaten the public's health and to develop effective interventions.

Examples of public health nursing activities include the following:

1. Evaluating health trends and risk factors of population groups and helping to determine priorities for targeted interventions
2. Working with communities or specific population groups within the community to develop public policy and targeted health promotion and disease prevention activities
3. Participating in assessing and evaluating health care services to ensure that people are informed of available programs and services and assisted in the utilization of those services

4. Providing essential input to interdisciplinary programs that monitor, anticipate, and respond to public health problems in population groups
5. Providing health education, care management, and primary care to individuals and families who are members of vulnerable population and high-risk groups (Missouri Department of Health and Senior Services, n.d.)

PRACTICE APPLICATION

➔ Setting the Scene

Legionnaires' disease is a type of pneumonia caused by the *Legionella* bacteria. *Legionella* live in nature and rarely cause illness. In a human-made setting, *Legionella* can grow if water is not properly maintained. These water sources become a health problem when small droplets of water that contain the bacteria get into the air and people breathe them in (CDC, 2022b).

Legionnaires' disease is a national reportable condition. In 2015, the New York City Department of Health and Mental Hygiene detected an abnormal number of Legionnaires' cases in the South Bronx via the notifiable conditions public health policy. To better understand how and why this was occurring, the response team within the New York City Department of Health collected more data, including the sampling of many cooling towers within the designated areas within New York City in search of the *Legionella pneumophilia* bacteria. Using the surveillance data and information about the disease, such as where bacteria are commonly found, the health department was able to identify the source (environment) as a cooling tower in the city. Locating this tower led to the destruction of the bacteria within the tower and a new local law to test for *Legionella* as part of the required certification and maintenance inspections (Chamberlain et al., 2017).

➔ Think About It

1. Imagine you were a nurse during this outbreak.
   a. How might you have been involved in the outbreak?
   b. What steps would you take if a patient came in with Legionnaires' disease?
2. Imagine you were a part of the New York City Department of Health and Mental Hygiene when this outbreak took place.
   a. What questions would you ask when the abnormal number of cases first arose?
   b. How would you answer these questions? What data would you need to collect?
   c. What were the three corners/vertices of the epidemiologic triangle for this outbreak?
3. Why might Legionnaires' disease be classified as a notifiable condition?
4. Classify the following diseases as epidemic, pandemic, or cluster. Describe why you selected each classification.
   a. Malaria in Africa, which is present at all times because of the presence of infected mosquitoes
   b. Ebola in parts of Africa where it exceeds what is expected for this region
   c. COVID-19
   d. Measles, as occurring among employees at Factory X in Fort Worth, Texas, in March 1981

ADDITIONAL RESOURCES

CDC - Introduction to Epidemiology

CDC - Solve the Outbreak [Interactive Activity] (Accessible version and mobile app also available)

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Chapter Five: Population Health

OVERVIEW

This chapter will provide an understanding of what population health is as well as what it means in the context of community and public health nursing. Population health focuses on getting available resources to the populations most in need and thus improving health outcomes. An understanding of population health can help nurses better identify issues that affect their patients, connect patients with the appropriate resources in their communities, and promote the health of vulnerable populations.

LEARNING OBJECTIVES

- Apply the concept of population health to nursing practice
- Understand the connections between medical care, population health, and public health strategies
- Differentiate between population health and public health
- Assess population health data and the priorities of a particular community or population
- Ascertain collaborative opportunities for individuals and organizations to improve population health

KEY TERMS

- population health
- public health
- health department
- health policy
- health outcomes

INTRODUCTION

The Centers for Disease Control and Prevention (CDC) defines population health as an interdisciplinary, customizable approach that allows health departments to connect practice to policy for change to happen locally (CDC, 2020). Different sectors of the community—public health, industry, academia, health care, local government entities, and many more—form nontraditional partnerships to achieve positive health outcomes. Population health "brings significant health concerns into focus and addresses ways that resources can be allocated to overcome the problems that drive poor health conditions in the population" (CDC, 2020).

Population health is slightly different from public health because public health works to protect and improve the health of communities through policy recommendations, health education and outreach, and research for disease detection and injury prevention. *Public health* can be defined as what "as a society [we] do collectively to assure the conditions in which people can be healthy" (Institute of Medicine, 1988). *Population health*, in contrast, provides "an opportunity for health care systems, agencies and organizations to work together in order to improve the health outcomes of the communities they serve" (The George Washington University, 2015).

WHAT IS POPULATION HEALTH?

The United States has the costliest health care system in the world, yet many countries consistently outperform the United States in terms of quality of care, health outcomes, and health expenditures. In 2008, researchers and policymakers suggested three aims that would significantly improve health care in the United States. This "Triple Aim" includes the following three goals:

1. Improving the patient experience of care (including quality and satisfaction)
2. Improving the health of populations
3. Reducing the per capita cost of health care (Berwick et al., 2008)

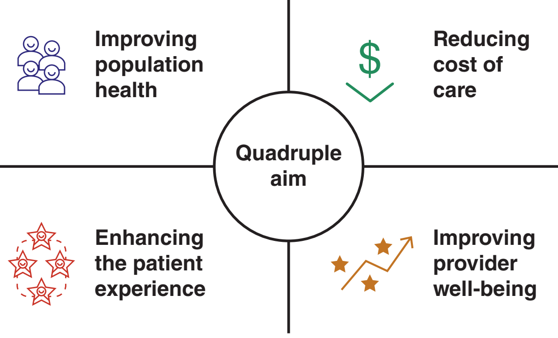

Figure 5.1: Quadruple Aim of Optimizing Health Care System Performance (Adapted from Boehringer Ingelheim Pharmaceuticals, 2021)

In 2014, the "Quadruple Aim"—adapted from the widely accepted Triple Aim—was suggested as a framework to optimize health care system performance (Figure 5.1). The framework encompasses reducing costs and improving population health and patient experience with a new fourth domain: promoting health care team well-being. During this time, researchers began to understand that the performance and quality pressures placed on nurses and other care team members were causing deleterious effects on their physical and mental health as well as reductions in the quality and costs of health care. Therefore, the fourth aim to improve our health system focused on provider well-being, stress reduction, burnout prevention, quality of life, and mindfulness (Arnetz et al., 2020).

Most recently, in 2022, a "Quintuple Aim" was proposed to include advancing health equity as the fifth U.S. health system improvement goal. To read more about the proposed Quintuple Aim, visit this article in the *Journal of the American Medical Association* (*JAMA*): The Quintuple Aim for Health Care Improvement A New Imperative to Advance Health Equity (Nundy et al., 2022).

To learn more about achieving health equity, see Chapter 2.

Population health focuses on preventing and managing costly, prevalent chronic diseases. The specific goals of population health are designed to achieve large-scale health improvements within neighborhoods, cities, counties, regions, or states. Population health measures target fundamental and often multiple determinants of health by addressing chronic diseases at the group level instead of the individual level. Population health evaluates current infrastructure, leverages available resources, mobilizes collective action efforts with multiple stakeholders, and through targeted actions seeks to have an impact on key health metrics such as premature death, air and water quality, tobacco use, and homelessness.

The Agency for Healthcare Research and Quality (AHRQ) defines *population health* as "measures that address health issues of individuals or populations defined by residence in a geographic area or a relationship to organizations that are not primarily organized to deliver or pay for health care services (such as schools or prisons)" (AHRQ, 2018). When we think of a population, we often think of a geographic area. However, in terms of population health, populations can also include people with similar characteristics, such as those who are incarcerated or people who inject drugs. For example, a public health nurse could focus their work on improving health

outcomes for people who inject drugs by working to implement syringe exchanges. Figure 5.2 is a pictorial model of population health. On the left are multiple health factors (or determinants of health), and on the right, health outcomes. What is missing from this picture are people who are living healthy lives and not experiencing morbidity or early death. Also missing from this picture is causality. Causality means that one variable, such as a health factor, causes another variable, such as a health outcome, to occur. It is important to note that in some cases, variables are correlated, but one does *not* necessarily cause the other.

Research to understand the effects of health factors on health outcomes remains ongoing.

Although the responsibility for "performance" typically falls to public officials, public health agencies, or organizations that are not primarily deliverers of care, nurses have direct relationships with patients and communities and are obligated to advocate for the delivery of services.

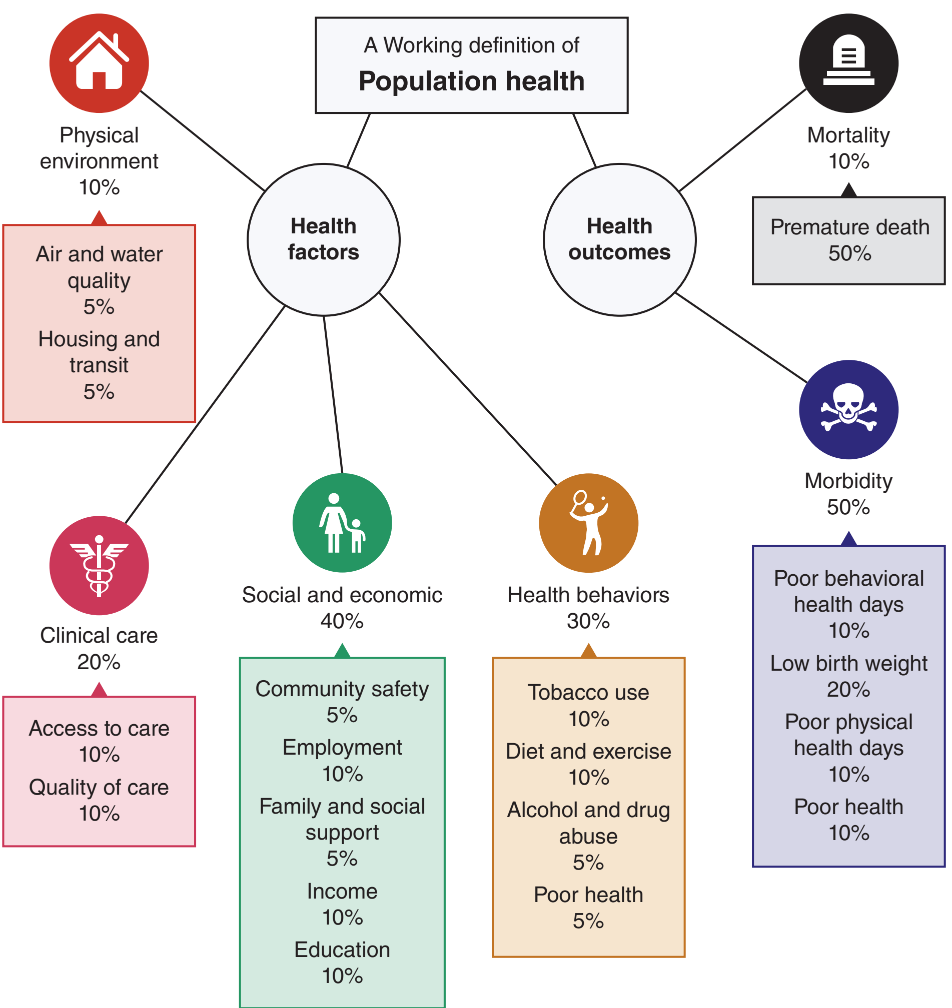

Figure 5.2: A Working Definition of Public Health (Adapted from Virginia Hospital & Healthcare Association, 2015)

Population Health Quality Measures

Content in this section was adapted from the U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality (2018).

Measures are applied to groups of persons identified by geographic location, organizational affiliation, or nonclinical characteristics to assess public health programs, community influences on health, or population-level health characteristics that may not be directly attributable to the care delivery system. These measures are supported by evidence demonstrating that they indicate the better or worse performance of population health activities (Table 5.1).

	Definition	Measures	Example
Population process	A population process of care is a public health–related practice or service performed for, on behalf of, or by a population.	• Population process measures are supported by evidence that the focus of the measure has led to improved outcomes for a population. • These measures are calculated using individuals eligible for a particular public health activity in the denominator, and those who receive the activity in the numerator.	The proportion of adults aged 65 years and older in a county who have received an influenza vaccination in the past year
Population access	Population access to care is the timely and appropriate receipt of a public health intervention by a population.	• Population access measures are supported by evidence that an association exists between the measure and the outcomes of or satisfaction with public health programs among the population.	The percentage of smokers in a county who reported that they were able to access a smoking-cessation program or, in the case of the nurse working to implement the syringe exchange program, the percentage of people accessing the syringe exchange to get clean injection supplies
Population outcome	A population outcome measures the health of a population resulting from a public health intervention.	• Population outcome measures are used to detect the impact of one or more public health interventions. • Measures in this domain are attributable to antecedent public health interventions or services (those meant to prevent or reduce harm) and should include provisions for risk adjustment.	The proportion of children with elevated blood lead levels whose homes undergo lead remediation and whose blood lead levels are subsequently reduced to normal levels. Again, going back to the syringe exchange example, the proportion of people who inject drugs that have contracted hepatitis C since the inception of the syringe exchange program compared with the rate before the establishment of the syringe exchange

	Definition	Measures	Example
Population structure	Population structure of care is a feature of a public health program related to its capacity to provide high-quality public health services to a population.	• Population structure measures are supported by evidence that an association exists between the measure and one of the other population health quality measure domains. • These measures can focus on organizations or individual clinicians working for a public health program.	The number of licensed childcare facilities and slots in a county or how many needle exchange locations are available within the state
Population experience	Population experience is the report of the members of a population concerning observations of and participation in public health programs.	• Population experience measures are supported by evidence that an association exists between the measure and population values and preferences or one of the other population health domains. • These measures may consist of rates or mean scores from population surveys.	The percentage of smokers in a county reporting that they have seen or heard public service announcements promoting a county health department–sponsored smoking-cessation program or the percentage of people who are aware that a syringe is available

Table 5.1: Population Health Quality Measures

Related Population Health Measures

Content in this section was adapted from the U.S. Department of Health and Human Services, Agency for Health-care Research and Quality (2018).

Some population health measures will be applied to a group of people to assess public health programs, community influences on health, or population-level health characteristics that are not related to health care initiatives. These measures are not supported by evidence demonstrating a link to better or worse performance of population health activities (Table 5.2).

	Definition	Measures	Example
Population health state	A population health state is the health status of a population.	• By definition, a population health state is not known to be the result of a public health intervention.	The prevalence rate of asthma in a county
Population management	Population management is a feature of a public health system that is relevant to the system's administration, oversight, or staff.	• Management measures assess administrative activities important to health but not part of the direct interaction between members of a population and the public health system.	Whether a public health department uses competitive bidding to award contracts for social marketing campaigns

	Definition	Measures	Example
Population use of services	Population use of services is the provision of services to, on behalf of, or used by a population.	• Population use of service measures can describe public health program encounters, tests, or interventions that are not linked to evidence of the appropriateness of the service for the population.	The percentage of assisted-living facility beds that are occupied in a county
Population cost	Population costs of care are the monetary or resource units expended to deliver public health interventions to a population. Cost measures are computed from data in monetary or resource units.	• Costs may be reported directly (i.e., actual costs) or estimated based on the volume of resource units provided and the charges for those units.	The average per beneficiary Medicaid expenditures in a county
Population health knowledge	Population health knowledge is the awareness and understanding of health-related information such as risk factors, prevention strategies, or treatment recommendations.		The mean response score to a set of questions about HIV prevention
Social determinants of health	Social determinants of health are characteristics of a population related to social position or economic statuses, such as age, gender, or poverty status, that evidence has shown to be related to health states.		The proportion of families living at or below the poverty level
Environment	Environment represents the conditions outside of the health care delivery system that may influence the health of a population.	• Environment measures can be classified as being related to the physical environment, social environment, or food and water supplies.	The number of days in the past year when the concentration of particulate air pollution in a community exceeds a defined threshold

Table 5.2: Related Population Health Measures

Population Efficiency Measures

Content in this section was adapted from the U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality (2018).

Measures that may be used to assess efficiency directly (e.g., by comparing a measure of quality with a measure of resource use) or indirectly (e.g., by measuring the frequency with which population health processes are implemented that have been demonstrated by evidence to be efficient; Table 5.3).

	Definition	Measures	Example
Population efficiency	Efficiency of population health is the number of resources used to attain a specific level of quality on measures related to maintaining or improving the health of a population.	• Population efficiency measures are linked to evidence supporting one of the five population quality domains: process, access, outcome, structure, and patient experience. • Population efficiency measures typically assess the relationship of the cost of public health programs associated with a specified level of quality. • These measures may address the frequency with which a less resource-intensive intervention is substituted for a more resource-intensive intervention of equal or lesser effectiveness, or a more effective intervention is substituted for a less effective intervention that is equally or more resource intensive. • Measures in this domain may also assess the performance of activities conducted by public health programs to minimize waste (Agency for Healthcare Research and Quality, 2018).	Day case surgery rates, as a percentage of all surgery cases that could be treated in an outpatient setting in a county (based on evidence that day case surgery is equally or more effective and because day case surgery is presumably less costly)

Table 5.3: Population Efficiency Measures

Population Health Strategies

The strategies for population health are as vast and varied as the populations they serve. Strategies for achieving better population health include:

- Understanding indicators and key metrics of health
- Engaging community stakeholders to act
- Assessing the needs and risks within the population or community
- Identifying evidence-based actions to improve health on a population scale
- Developing a shared vision, priorities, and plans amongst stakeholders
- Committing to shared resources and responsibilities
- Coordinating the implementation of health improvement programs
- Evaluating the effectiveness of processes and programs through community-based discussions and reevaluation of key health metrics

Effective population health strategy always begins with an evaluation of the population health data, using reputable sources, to determine the strengths and opportunities for a particular population. This begins with knowledge of where to find relevant sources of data and how to evaluate the data to understand the needs of the populations served. Sources of data typically include government organizations, nongovernmental organizations, research literature, academic centers of excellence, and others.

Benefits of a Population Health Approach

In 2014, Halfon and colleagues described a path for the evolution of the U.S. health care system from an Acute System (episodic, nonintegrated care) to a Coordinated, Seamless Health Care System (outcome-accountable care) to a Community-Integrated Health Care System (Halfon et al., 2014). These stages mirror the three buckets of prevention: traditional clinical prevention, innovative clinical prevention, and total population or community-wide prevention. The portfolios of population health framework (Figure 5.3), adapted from Institute for Healthcare Improvement (2022), builds on this important foundation with several modifications based on experience with supporting health care organizations in their efforts to improve population health.

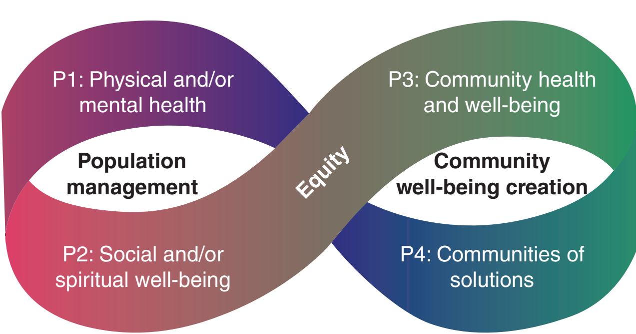

Figure 5.3: Portfolios of Population Health Framework (Adapted from Institute for Healthcare Improvement, 2022)

Two major domains of work emerged: efforts focused on the health and well-being of defined populations for whom health care organizations feel directly responsible, such as patients or employees (population management); and efforts focused on the health and well-being of communities (community well-being creation). These domains were further subdivided into four portfolios of population health on which improvement work is likely to focus (Table 5.4).

	Portfolio 1: Physical and/or Mental Health	Portfolio 2: Social and/ or Spiritual Well-Being	Portfolio 3: Community Health and Well-Being	Portfolio 4: Communities of Solutions
Type of population	Defined	Defined	Place-based and defined	Place-based and defined
Focus of work	Proactively address mental and/or physical health for the population for which an organization is directly responsible (e.g., patients, employees)	Proactively address social and spiritual drivers for the population for which an organization is directly responsible (e.g., employees)	Improvement of health, well-being, and equity focus on specific topics across a place-based or defined population)	Whole community transformation with a focus on long-term structural changes needed for a thriving, equitable community
Example activities	Manage diabetes outcomes for a primary care panel; integrate mental health into primary care	Screen for and address social determinants of health in a partnership with community social-service agencies; establish peer-to-peer supports	Engage in a multisector partnership to address food insecurity in key neighborhoods	Engage in a multisector partnership to create long-term structure, policy, and systems changes (e.g., preferred purchasing from minority-owned local businesses)

Table 5.4: Portfolios of Population Health (Adapted from Saha et al., 2017)

Together, these four interconnected portfolios represent a comprehensive scope of population health–related improvements an organization may pursue. The four portfolios connect to and build on one another and are intended to represent a balanced portfolio of efforts that could be part of a health care organization's overall population health improvement strategy. Consider each portfolio to be a force multiplier—that is, all four portfolios are necessary to achieve maximum impact. If one is missing or weak, the health care organization is likely missing an important part of its optimal population health strategy. In addition, the portfolios are not sequential, and any portfolio can be a starting point. While most health care organizations will likely have a predominance of activities in Portfolio 1, most organizations can identify some existing activity in all four portfolios. Health care organizations would be well served to develop an asset map to identify activities already underway in all four portfolios and then create a plan to develop a balanced portfolio of activities over time (Table 5.5).

	Portfolio 1: Mental and/or Physical Health	**Portfolio 2: Social and/or Spiritual Well-Being**	**Portfolio 3: Community Health and Well-Being**	**Portfolio 4: Communities of Solution**
Roles to leverage	• Care deliverer • Employer • Insurer	Social service and community connector	• Community partner • Community needs and • Assets assessor • Community funder • Community benefit • Community co-improver	Community steward (in partnership with others), leveraging roles as • Purchaser • Employer • Investor • Policymaker • Advocate
Relation-ships	• Partnerships are in place with agencies representing specific patient cohorts (e.g., National Alliance on Mental Illness, American Diabetes Association).	Partnerships are in place with agencies defined by the social service they provide (e.g., Alcoholics Anonymous, food bank, Union Mission).	• Partnerships are in place with community-based organizations needed to effect change in a defined health or well-being topic (e.g., YMCA).	Partnerships are in place with agencies that focus beyond sectarian or defined areas (e.g., United Way, ministerial organizations, mayor's office).
Governance	• Governance model is shifted toward educating and engaging board members to provide input prior to decisions on care redesign and related health care transformation processes. • Shared governance includes patients and families.	• Competencies of the board are developed and adjusted to support the transition from an acute or primary care provider to a community-engaged institution. • Shared governance includes social sector, community, and faith-based agencies.	• A diverse, competency-based committee informs the design and monitors the impact of comprehensive community health improvement strategies. • Shared governance includes partnership in multisector community coalitions.	• Health system commits to being part of an independent governing board focused on health and well-being improvement that supports resource pooling, proactive investment, and shared return on investment.

	Portfolio 1: Mental and/or Physical Health	Portfolio 2: Social and/or Spiritual Well-Being	Portfolio 3: Community Health and Well-Being	Portfolio 4: Communities of Solution
Financing models	• Payment mechanisms are in place that fund or incentivize health care organizations to meet improvement goals for patients under their care. • Examples include pay for performance, bundled payments, shared savings, global budget models, Accountable Care Organizations, and primary care capitation.	• Payment mechanisms are in place that fund or incentivize health care organizations to address social determinants of health and well-being. • Examples include payment for screening for and connecting people with appropriate services, population health goals in payment contracts with insurers, accountable health communities' grants, and philanthropic grants.	• Payment mechanisms are in place that can fund coordinated and collaborative population health improvement efforts between organizations within a community. • Examples include health care organization board investment and community benefits, wellness trusts (funding pools raised to support prevention interventions), braided funds (using multiple funding streams to pay for services or interventions), and shared assets.	• Payment mechanisms are in place that coordinate population health efforts within a community, with an emphasis on cross-sector financing and reinvestment. • Examples include integrated, community-wide social investment and funds set aside by purchasers (including government) to build population health infrastructure.
Policy	• Regulations require insurers to choose consistent, meaningful quality metrics that focus on outcomes (as opposed to process) and increase the amount of health care spending that goes to primary care.	• Policies are in place that make it easier for health care providers to connect patients to needed services outside of health care. • The curriculum of health professional training is mandated to emphasize cross-sector collaboration.	• Policies are in place that make it easier for health systems to share data with public health departments (including addresses, a personal identifier) and other sectors. • Health care organizations advocate for policies to improve community environments.	• Policies are in place that make it easier for community integrators to play the role of data "stewards" for population health improvement.
Data	• Cost and quality data are collected on physical and mental health and used for population health management and performance improvement efforts. • Data might include: no. of emergency department visits, 30-day readmissions, mental health markers • Data are accessible across the continuum of care in the health system.	• Data are collected on financial, social, and spiritual well-being. • Supplemental data are obtained from other sources such as the American Community Survey, including median income, crime rate, and unemployment level in the individual's neighborhood or census block.	• Data are collected at the community level on health and well-being and used to prioritize initiatives, set clear aims, and measure improvement. • Community-level data are shared with partners in the community.	• Data on health and well-being in the community are collected as part of a comprehensive measurement framework and used to set system-level priorities and focus on sustainability.

	Portfolio 1: Mental and/or Physical Health	Portfolio 2: Social and/or Spiritual Well-Being	Portfolio 3: Community Health and Well-Being	Portfolio 4: Communities of Solution
	• Patient data on race, ethnicity, language, and social risk factors are collected and used to reduce disparities in patient care.	• Data are shared across the health system and with social service or referral agencies (e.g., a data field on affiliated congregation is used to support faith–health partnerships). • Patient data on race, ethnicity, language, and social risk factors is collected and used in partnership with social service agencies to reduce disparities in social and spiritual well-being.	• Data on health and well-being are stratified and used to identify opportunities to address inequities in particular populations in the community.	• Community-level data are systematically shared across the community (e.g., with public health departments, community planners, community members, anchor institutions, and other sectors).
Equity	• Health equity is a strategic priority for the health care organization. • Infrastructure is developed to support health equity work that is funded and includes data infrastructure to stratify data by language, race/ethnicity, and other relevant sociodemographic factors (e.g., sexual orientation, gender identity). • The organization is focused on eliminating institutional racism by building staff knowledge and skills in this area through trainings and by assessing and improving organizational policies and practices that disproportionately affect outcomes for communities of color and other marginalized populations.	• Efforts are in place to build awareness and provide education about equity and disparity reduction related to social and spiritual well-being. • The organization actively seeks out community partners that are already working to advance equity and address social determinants of health.	• Community data are stratified based on key sociodemographic factors (including geographic location) and used to close identified equity gaps. • The organization invests in and works alongside community organizations that address equity and social determinants of health.	• The organization advocates for equity-promoting policies as well as changes to local and state policies that may exacerbate inequities.

	Portfolio 1: Mental and/or Physical Health	Portfolio 2: Social and/or Spiritual Well-Being	Portfolio 3: Community Health and Well-Being	Portfolio 4: Communities of Solution
Partner with people with lived experience	• Patients and family members are engaged in identifying, prioritizing, and participating in improvement efforts and are advocating at the leadership level for system change. • The organization learns about the root causes of utilization and the assets that can be leveraged to improve outcomes by understanding the lives of the people served (via patient and family interviews, clinical input, and reviewing all available data on the population of focus).	• Efforts that are meant to address social and/or spiritual drivers of well-being are created in partnership with those who stand to benefit the most. • Peer-to-peer support networks are created and expanded.	• Improvement efforts are conducted to address disparities in partnership with people affected; this requires involving community residents not only in identifying needs but also in designing and implementing solutions and engaging their peers.	• People with lived experience are engaged as senior leaders and champions in community-wide improvement efforts, including design, implementation, and evaluation of community efforts.

Table 5.5: Key Levers for Health Care Organizations to Accelerate Improvements Within and Across Portfolios of Population Health (Adapted from Saha et al., 2017)

Finally, these portfolios are meant to be interconnected and synergistic. The more the activities across portfolios are balanced, the easier it may be to improve population health because each portfolio unlocks a set of relationships, capacities, and levers that a health care organization can use to create change. For meaningful transformation to occur within and across portfolios, factors such as partnering with those with lived experience and addressing equity, payment, and measurement are vital to success.

While describing four portfolios with concomitant activities is a great first step, we must still consider how we operationalize these efforts. The portfolios of population health table (Table 5.4) also outlines actions proposed by the Institute for Healthcare Improvement across a set of key levers deemed vital to accelerating improvements within and across portfolios. The actions are meant to build on each other, with actions described in Portfolio 1 also present in Portfolio 2. For visual clarity, however, these actions are not repeated across portfolios; only those actions that are unique to each portfolio are included in the table.

Examples of Population Health Programs and Initiatives

The Health Impact in 5 Years (HI-5) initiative highlights nonclinical, community-wide approaches that have evidence reporting positive health results within 5 years, and cost-effectiveness and/or cost savings over the lifetime of the population (CDC, 2022).

The health outcomes that HI-5 interventions can prevent or reduce are presented in the following list, which demonstrates the broad health impact that community-wide approaches can have:

- Anxiety and depression
- Asthma
- Blood pressure
- Bronchitis
- Cancer
- Cardiovascular disease
- Child abuse and neglect
- Cognitive development
- Infant mortality
- Liver cirrhosis
- Motor vehicle injuries
- Obesity
- Dental caries
- Pneumonia
- Sexually transmittable infections
- Sexual violence
- Teenage pregnancy
- Traumatic brain injury
- Type II diabetes
- Youth violence (CDC, 2022)

Many programs and initiatives focus on population health at the local, city, state, national, and global levels. Just as many programs exist that focus on specific disease states or metrics across multiple population levels. It is important to recognize that all these programs and initiatives are important drivers of change and that each contributes in small and large ways to improve population health.

The public health impact pyramid in Figure 5.4 highlights the different types of public health interventions, starting with those that have the greatest potential to affect health. The pyramid can be applied to any setting, but this scenario is applied to issues affecting children.

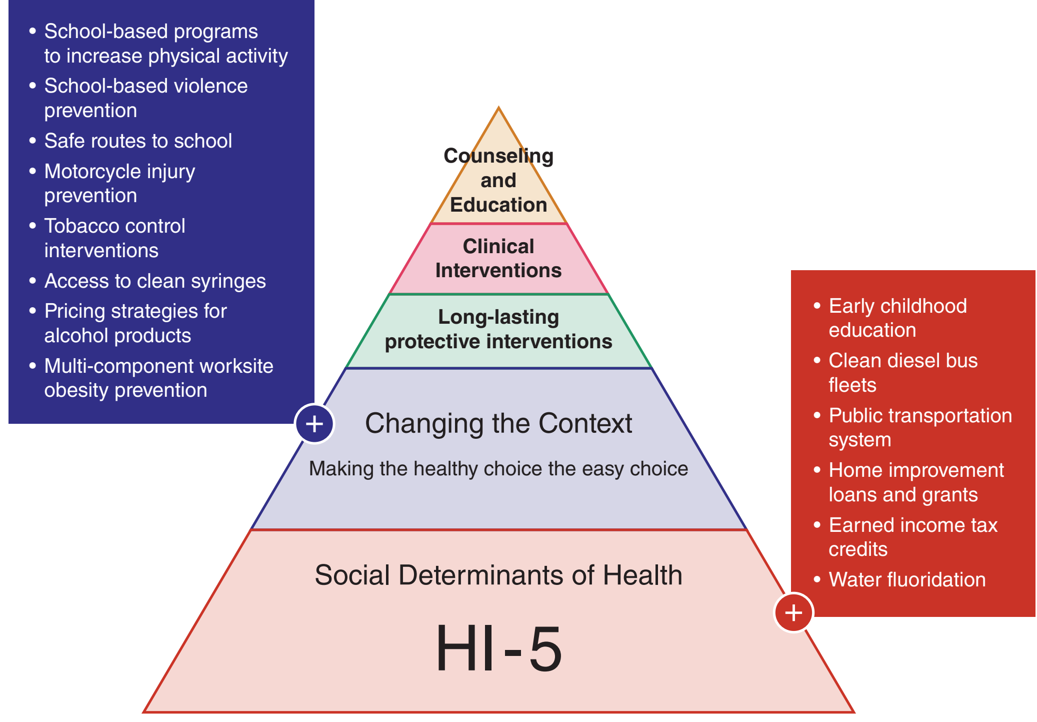

Figure 5.4: Public Health Impact Pyramid (Adapted from CDC, 2022)

THE NURSE'S ROLE IN COMMUNITY AND POPULATION HEALTH

Community health nurses aim to improve the health of community members. Community health nurses work in schools, churches, and government agencies. They focus on vulnerable populations, including socioeconomically disadvantaged families, people living in rural areas, immigrants, and individuals with disabilities. The relationship between community health nurses and their patients is one of shared responsibility for the patient's health outcome (St. Catherine University, 2022).

Although the responsibilities of these nurses differ in each career path, all community health nurses promote healthy living, disease prevention, and access to health care. Community health nurses create programs that promote community health and collect data to identify community needs. The goal is to promote health and prevent disease and disability. Community health nurses' knowledge and skills enable them to contribute significantly to public health. Their clinical knowledge and unique relationships with those they serve allow them to assist in designing and implementing policy-based programs to meet the needs of vulnerable populations. The combination of a clinical nursing background with knowledge from the public health and social sciences provides a sound basis for public health leadership positions (Association of Public Health Nurses, 2022).

Examples of public health nursing activities include the following:

- Evaluating health trends and risk factors of population groups and helping to determine priorities for targeted interventions
- Working with communities or specific population groups within the community to develop public policy and targeted health promotion and disease prevention activities
- Participating in assessing and evaluating health care services to ensure that people are informed of available programs and services and assisted in the utilization of those services

- Providing essential input to interdisciplinary programs that monitor, anticipate, and respond to public health problems in population groups
- Providing health education, care management, and primary care to individuals and families who are members of vulnerable populations and high-risk groups

Public health nurses also provide a critical linkage between epidemiological data and clinical understanding of health and illness as it is experienced in people's lives. This understanding is translated into action for the public good (Association of Public Health Nurses, 2022). It is important to recognize just how essential community health nurses are to bridge the gap between policy and patient-centered care and to ensure that populations have access to the programs they need to improve health outcomes.

PRACTICE APPLICATION

➔ Setting the Scene

As a part of their support for community health, nurses can be involved in initiatives to reduce community tobacco use, increase the use of park spaces for exercise, or reduce childhood asthma attacks in school for a particular population. A nurse may undertake these efforts by doing any of the following:

1. Evaluating the data on the topic for a chosen population using public health data sets and metrics. A full data evaluation may not be required, but the main issues (outcomes) surrounding the topic—such as mortality rates, incidence, prevalence, and years of life lost—need to be considered to gain a good understanding of the impact and burden of this disease or condition within the community.
2. Reaching out to community partners such as a local organization, school, religious center, local government office, or health center to identify potential opportunities for collaboration.
    a. They may already have an existing initiative to become involved with.
    b. If not, they may need incentives for the partnership. What benefits would the partnership bring to the organization? Develop this as a "win-win."

➔ Think About It

Use the Healthy People 2030 website to select a health issue in your community, such as tobacco use, lack of exercise space, or asthma triggers in K–12 schools. Imagine you are a nurse working to build an initiative to combat this issue.

1. What data will be helpful in evaluating this issue? Where can you locate the needed data?
    a. How helpful was Healthy People 2030 in gathering needed information? What was missing from this site?
2. What are the stakeholders for this issue?
3. What work on this issue, if any, is already occurring in each of the four portfolios of population health?
4. Which community organizations will be helpful partners for your initiative?
    a. Do these organizations already have aligned initiatives?
    b. What incentives may be needed to get the organizations to partner?
5. What other information is needed to organize your initiative?

ADDITIONAL RESOURCES

CDC - 6 | 8 Initiative: Accelerating Evidence into Action

CDC - Health Impact in 5 Years

CDC - Preventing Excessive Alcohol Use

CDC - Youth Risk Behavior Survey Report

St. Catherine University - What Is a Community Health Nurse? (Career Overviews)

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Chapter Six: Community Health Assessment and Evaluation

OVERVIEW

The purpose of this chapter is to review two community health assessment tools that can be used to perform a community assessment. Community assessments can help nurses identify community needs, examine elements of the environment where their patients live and work, and provide the data necessary to develop an effective plan for intervention or health promotion.

LEARNING OBJECTIVES

- Understand the purpose of performing a community assessment
- Identify two commonly used frameworks for conducting a community assessment
- Apply different approaches to conduct an assessment (community, population, setting-specific, problem-focused)
- Evaluate quantitative and qualitative data that can be used in the community assessment

KEY TERMS

- community health assessment
- windshield survey
- walking survey
- quantitative data
- qualitative data

INTRODUCTION

Community assessment is a fundamental skill for community and public health nurses. Assessment frameworks are used to identify problems. Nurses and communities work collaboratively to design and implement strategies to alleviate problems as seen and experienced by the community members. Community health frameworks include the evaluation of programs.

COMMUNITY HEALTH ASSESSMENT

A community health assessment, also known as community health needs assessment, refers to a state, tribal, local, or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis. In many ways, community health assessments are similar to patient assessments. As with the nursing process, the first step is assessment. The community health assessment identifies critical health needs and issues through systematic, comprehensive data collection and analysis. This assessment provides organizations with comprehensive information about the community's current health status, needs, and issues.

This information can help health professionals to develop a community health improvement plan by justifying how and where resources should be allocated to best meet community needs (Centers for Disease Control and Prevention [CDC], 2018).

FRAMEWORKS

Content in this section was adapted from the "Community Planning for Health Assessment: Frameworks & Tools" from the Centers for Disease Control and Prevention (2024).

Most community health assessment and planning frameworks include steps or phases similar to those of the nursing process, commonly referred to as ADPIE: assessment, diagnosis, planning, implementation, and evaluation. The first four steps of community health assessment and planning frameworks—organize and plan, engage, develop, and conduct—align with the assessment itself: prioritizing the health issues is the diagnosis, developing the community health plan is the planning aspect of the process, and then implementing and evaluating (Table 6.1).

Community Health Assessment Framework	The Nursing Process
Organize and plan	Assess
Engage the community	
Develop a goal or vision	
Conduct community health assessment	
Prioritize health issues	Diagnose
Develop Community Health Improvement Plan (CHIP)	Plan
Implement and monitor CHIP	Implement
Evaluate process and outcomes	Evaluate

Table 6.1: Community Health Assessment Compared With the Nursing Process ADPIE (Adapted from CDC, 2015)

CHANGE Framework

One commonly used framework for the community health assessment is the CHANGE framework (community health assessment and group evaluation). It is a data collection tool and planning resource developed by the CDC for community members who want to make their community healthier. The CDC's Healthy Communities Program designed the CHANGE tool for all communities interested in creating social and built environments that support healthy living. The purpose of CHANGE is to gather data about the community to determine potential areas for improvement (National Center for Chronic Disease Prevention and Health Promotion, 2010).

The Social-Ecological Model

The social-ecological model (Figure 6.1) provides a valuable framework for showing the multiple influences on community health and barriers to health improvement. Understanding these factors and barriers is essential for developing strong, actionable strategies for the community.

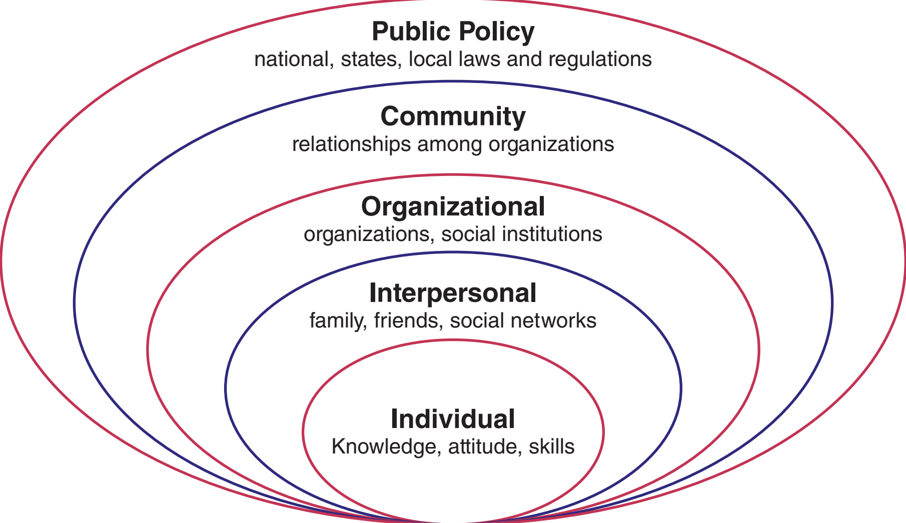

Figure 6.1: Social-Ecological Model (Adapted from CDC, 2022b)

The Mobilizing for Action Through Planning and Partnerships (MAPP) Model

Content in this section was adapted from the Public Health Professionals Gateway: Assessment & Planning Models, Frameworks & Tools from the Centers for Disease Control and Prevention (2015).

The mobilizing for action through planning and partnerships (MAPP) model provides a framework for community health improvement planning at the local level. The focus of this framework emphasizes community engagement and collaboration for system-level planning after identifying assets and needs. The MAPP process has six phases: (1) organizing for success and partnership development, (2) visioning, (3) performing the four assessments, (4) identifying strategic issues, (5) formulating goals and strategies, and (6) moving into the action cycle. Figure 6.2 provides a visualization of the process for this community health assessment plan.

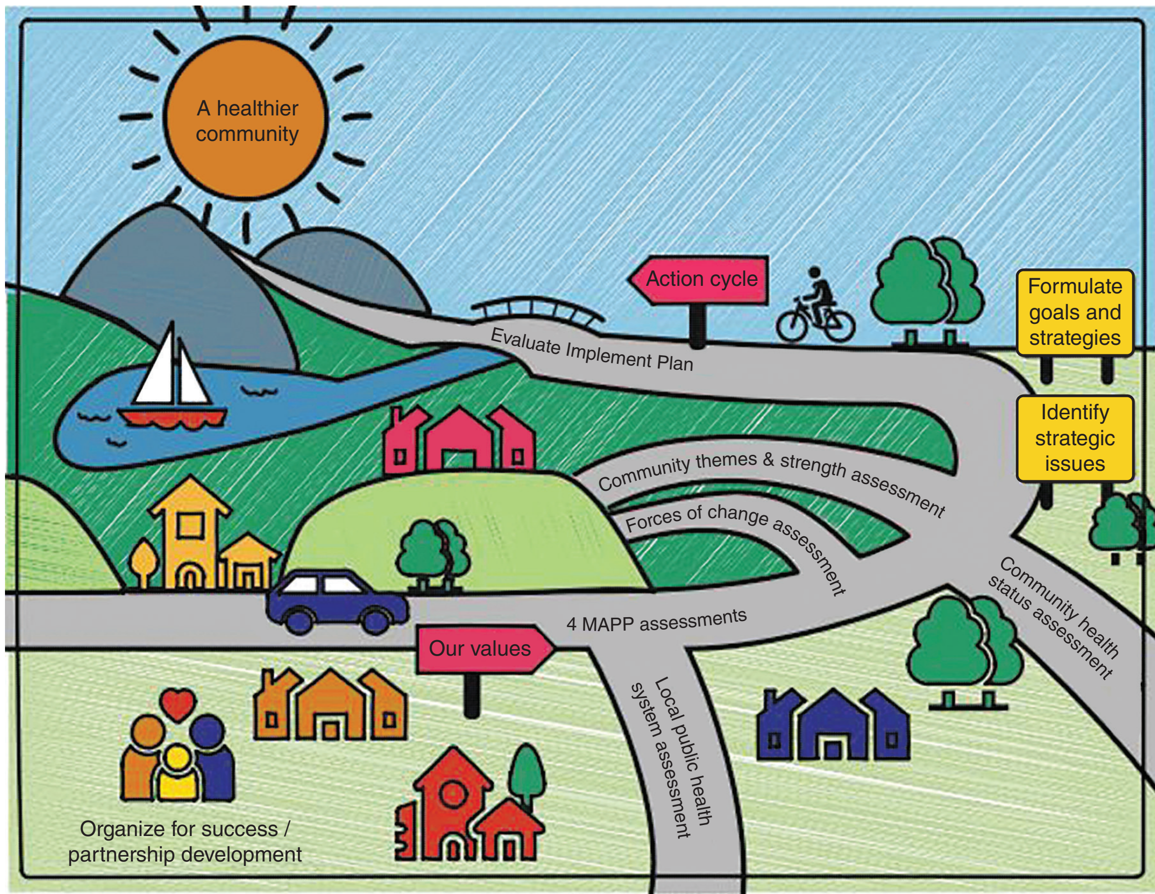

Figure 6.2: Mobilizing for Action Through Planning and Partnerships Framework (Adapted from Marion County, 2015)

APPROACHES TO COMMUNITY HEALTH ASSESSMENT

There are six types of community health assessments. These include comprehensive assessments, rapid needs assessments, problem or health issue assessments, health impact assessments, population-focused assessments, and setting-specific assessments.

A comprehensive assessment is an assessment that includes the assets within a community, such as local health department capacity and identification of problems and issues within the community. It also identifies opportunities for action within the community. As the name implies, the rapid needs assessment is a tool that addresses potential emerging public health concerns and the capacity for emergency response. The problem or health issue–based assessment focuses on addressing a specific problem or concern within a community, such as an outbreak of HIV. A population-focused assessment concerns a specific population of people, such as children with elevated lead levels. A setting-specific health assessment is completed in a specific environment such as a work site with increased injuries or the school setting. According to the World Health Organization (WHO), a health impact assessment is used to evaluate the potential effects of policies (WHO, 2022; Savage, 2019).

What Is a Community Assessment?

Content in this section was adapted from the Public Health Professionals Gateway: Assessment & Planning Models, Frameworks & Tools from the Centers for Disease Control and Prevention (2015).

As noted, a community health assessment is sometimes called a community health needs assessment. Regardless, the fundamental purpose of the assessment is to identify the health needs and issues of the population being evaluated. These are carried out to assess various populations ranging from an entire state or territory to being focused on smaller groups at the local or tribal level. To identify these key needs or issues, systematic, comprehensive methods collect and analyze data. Community health assessments use such principles as:

- Multisector collaborations that support shared ownership of all phases of community health improvement, including assessment, planning, investment, implementation, and evaluation
- Proactive, broad, and diverse community engagement to improve results
- A definition of community that encompasses both a significant enough area to allow for population-wide interventions and measurable results and that includes a targeted focus to address disparities among subpopulations
- Maximum transparency to improve community engagement and accountability
- Use of evidence-based interventions and encouragement of innovative practices with thorough evaluation
- Evaluation to inform a continuous improvement process
- Use of the highest quality data pooled from, and shared among, diverse public and private sources

Comprehensive community statements should be collaborative and involve all stakeholders, including community members.

Community Health Assessment Tools

Content in this section was adapted from "Chapter 3. Assessing Community Needs and Resources, Section 21. Windshield and Walking Surveys," from the University of Kansas Community Toolbox (Rabinowitz, 2022).

One way to get a sense of a community is to drive or walk around it, observing and taking note of its characteristics. Windshield and walking surveys can be an important part of a community assessment. In this section, they are described in more detail, and how to conduct one successfully is discussed.

What Are Windshield and Walking Surveys?

Windshield surveys are systematic observations made from a moving vehicle. Walking surveys are systematic observations made on foot. Either or both can help the observer gain a better understanding of the community in general or its specific condition or aspect.

Windshield surveys are handy when the area to be observed is large and the aspects of interest can be seen from the road. A walking survey might be a better choice when there is a need to understand things that are harder to see from a moving vehicle.

Windshield and walking surveys can be used to assess general community needs—to estimate the poverty level, for example—or to examine more specific facets of the community's physical, social, or economic character. Some possibilities:

- Age, nature, and condition of the community's available housing
- Infrastructure needs (roads, bridges, streetlights, etc.)
- Presence or absence of functioning businesses and industrial facilities
- Location, condition, and use of public spaces
- Amount of activity on the streets at various times of the day, week, or year
- Noise level in various parts of the community
- Amount and movement of traffic at various times of day
- Location and condition of public buildings (the city or town hall, courthouse, etc.)

Why Conduct Windshield and Walking Surveys?

Windshield or walking surveys can be structured to provide an objective view of the community. These are especially adaptable to community-based participatory initiatives. These collaborative interventions can include scientific researchers, health care workers, stakeholders, and members of the community to address diseases and conditions disproportionately affecting populations experiencing health disparities (National Institute on Minority Health and Health Disparities, 2024).

- They can be the easiest and quickest way to get an overview of the entire community.
- They allow clear comparisons among different parts of the community and help determine where to focus.
- They can be beneficial in understanding specific aspects of a community.

Some aspects of the community where one of these surveys could reveal valuable information could be:

- The community's relationship to the environment
- The nature of street life
- Traffic
- Access to food

When Should Windshield and Walking Surveys Be Conducted?

Often in the Community Toolbox the answer to the "When . . .?" question is determined by what is most appropriate or beneficial based on the political or social climate and the logistics of acting. A windshield or walking survey can be conducted whenever it is needed. However, to understand how people use the community, conduct the survey at a time—perhaps several different times—when the community is likely to be engaged in an observable activity. To get the best picture of a community, do surveys at different times of the day, week, and/or year.

Who Should Conduct Windshield and Walking Surveys?

The answer to who should conduct the survey depends on several factors. How large is the area to be surveyed? How many times will surveys be conducted? Is this a participatory research project? Will the survey be conducted in teams or as individuals? A small neighborhood or rural village might be adequately surveyed in a day by a single person, whereas a large city might require several days with several teams of observers. If the survey includes participatory research, organize observers in teams, each of which has representatives of different ages, cultures, ethnicities, income levels, community sectors (business, government, health, and community services, etc.).

One important issue is safety. If there is hostility between races or ethnic groups, it may not be safe for some people to survey particular neighborhoods. Even if there is no real danger but only a perception of danger, the resulting anxiety can affect a survey's accuracy and completeness.

Another difficulty with conducting a windshield or walking survey as a participatory research project is that community members might already have set ideas about many of the questions need to be asked. However, a windshield or walking survey can also serve to open community members' eyes to the realities of their environment.

How Are Windshield and Walking Surveys Conducted?

Windshield and walking surveys are similar in many ways, but some important differences exist. Here we offer guidelines that relate to both and then look at each in turn.

Designing the Survey

- Determine who will conduct the survey.
- The best results are likely if those who will be conducting the survey are involved in its planning. Their observations will be sharper if they understand what they are looking for, which is most likely if they help to develop the survey.
- Whether the survey is conducted driving or walking, the ideal is to use a team or teams for which resources are available. The variety of perspectives will enrich the survey, and each team member can focus on a particular task (observation, recording, etc.), making for a more efficient survey.
- Decide on the questions the survey will answer.
- The questions will determine the scope and structure of the survey. Basic research questions (e.g., "What is the nature of the community?") may require follow-up with secondary questions. Questions with a narrow focus (e.g., "Do most streets in the community have sidewalks?") may not require follow-up. Some questions will have more than one part (e.g., "How, by whom, and how much are public playgrounds used?).

Training the People Who Will Conduct the Survey

- Get well acquainted with the questions, the purpose of the survey, and what it is looking for.
- Make and use a checklist to ensure that all questions have been addressed and observe all the necessary areas.

- Try to be unobtrusive. People not only act differently when they know they are being observed but also may become suspicious or hostile.
- Carry identification.
- Take notes. Take photos or videos with a camera or cell phone to remember and illustrate what has been observed.
- Work in teams and assign roles. A team should have at least one observer and at least one recorder.
- Discuss findings as the survey is conducted.
- Pay attention to safety. Be aware of the neighborhood and situation, especially while walking. If the situation does not feel safe, leave.

What to Examine in a General Community Assessment Survey

- Housing. What is the age and condition of housing in the neighborhoods being surveyed? Are houses and apartment buildings kept up, or are they run-down and in need of repair? Are yards neat or overgrown?
- Other buildings. Are the buildings mostly or fully occupied? Do public and commercial buildings seem accessible to people with disabilities (ramped, street-level entries, etc.)?
- Public spaces. Are there public spaces where people can gather? Are they well kept up? Do they have seating areas, trees, and plants, attractive design, cafes or food vendors, or other features that encourage people to use the space? Who uses these spaces? Is there diversity?
- Parks. Are parks used by a variety of people? Are they well kept up? Are there sports facilities (basketball courts, soccer pitches, baseball fields, cricket pitches, etc.)? Are they used at night?
- Culture and entertainment. Are there museums, theaters, restaurants, clubs, sports stadiums, historic sites, etc.? Are they accessible to all parts of the community (centrally located, reachable by public transportation)? Do they reflect the cultures of community members?
- Streetscape. The streetscape is the environment created by streets and the sidewalks, buildings, trees, etc., that line them. Are there trees and/or plants? Are there sidewalks? Are building facades and storefronts attractive and welcoming? Are the streets and sidewalks relatively clean? Are there trash cans? Is there outdoor seating?
- Pedestrian and bicycle safety. What is the road design, traffic speed, and road/sidewalk quality? How safe is it to walk or ride? What condition are the sidewalks in? What is the physical activity level? Are there pedestrian or bicycle collisions occurring?
- Street use. Are there people on the streets at most times of the day? In the evening? How late? Do they interact with each other? Are streets and sidewalks well lit at night?
- Commercial activity. What kinds of businesses are there? Are there boarded-up or vacant storefronts? Is there a mix of large and small businesses? Are there grocery stores and supermarkets, pharmacies, and other stores that provide necessities in all parts of the community?

- Signs. What languages are business, road, and traffic signs in? Are traffic signs informative? Are there signs directing people to various parts of the community (downtown, museums, highways, etc.)?
- Industry. What kinds of industries exist in the community? Does they seem to be causing pollution?
- Land use. How much open space is there? How are residential, commercial, and industrial areas distributed? Do major roads or railroad tracks divide neighborhoods, or are they on the edges of the community?
- Infrastructure. What is the condition of roads, bridges, sidewalks, etc.? Do these conditions differ from one area of the community to another? Do all parts of the community seem to be equally served by electricity, water, phone, fiber optic, wastewater treatment, waste disposal, and other infrastructure services?
- Public transportation. Is there a functioning public transportation system? Is it well used? By whom? Does it allow relatively easy access to all parts of the community? How easy is it to navigate and use? How much does it cost? Are its vehicles energy-efficient?
- Traffic. How heavy is traffic in the community? Is it mostly commercial and industrial (vans, trucks, etc.) or mostly private cars? Is there ever gridlock? Is there much bicycle traffic? Are there bike lanes? Are there bike racks in many places?
- Environmental quality. How much usable green space is there, and is it scattered throughout the community? Is there smog or haze? Does the air smell of smoke, garbage, car exhaust, chemicals, industrial waste, etc.? Does the water in streams, ponds, lakes, etc. seem reasonably clear?
- Race/ethnicity. Who lives in the community? Are there identifiable racial and ethnic groups? Do particular groups seem to live in particular areas?
- Faith communities. What kinds of religious institutions are there? Do the institutions of one particular religion or sect dominate? Are there separate houses of worship for people of different ethnicities or races, even if they share the same faith?
- Health services. How many hospitals and clinics are there in the community? Where are they located? How big are they? How easy are they to get to?
- Community and public services. Are there identifiable community service providers and organizations in the community (mental health centers, food banks, homeless shelters, welfare offices, etc.)? Are they concentrated in a particular area? Are they easy to reach by public transportation?
- Community safety. Where are police and fire stations located? Are they in good repair? Is the community well lit at night?
- Public schools. Are schools in different neighborhoods in noticeably different states of repair? Are schools well maintained? Or in some developing countries, are there schools in the community?
- Higher education. Are there two- and four-year colleges and/or universities in the community? Where are they located? Do they seem open to the community, or do they seem self-contained and isolated?
- Political activity. Are there signs or other indications of political activity? Is it clear that political activity is allowed and/or encouraged? Are there protests or demonstrations?

- Community organizations. What evidence is there of organizations in the community? Are there service clubs (Lions, Elks, Masons, etc.)? Are there other organizations (groups centered around community issues, the environment, sports or leisure pursuits, socialization, etc.)?
- Media. Are there local media outlets such as radio and TV stations, newspapers, and internet sites devoted to local issues? Are they independent, or are they sponsored or run by governments or corporations? Where are their facilities?
- Food access. Are there markets? Fast-food restaurants? Community gardens?
- Differences among neighborhoods or areas of the community. What are the differences among different parts of the community? Are schools, stores, public and other buildings, streets, etc., in different areas in different conditions? Do some areas seem neglected whereas others are maintained?
- The “feel” of the community. What is the overall impression of the community?

Conducting a Windshield Survey

- Use a map. Google Maps or similar services are an excellent resource.
- Try to use a team of at least two. That way, one person can concentrate on driving while the other navigates and records observations. It is difficult to observe closely and drive safely at the same time.
- Drive at a moderate speed and avoid unexpected actions.
- Drive on both major and minor streets, particularly in residential neighborhoods. Get a sense of different parts of neighborhoods and different streets.
- Pull over at regular intervals to make and compare notes.
- Try to be inconspicuous.

Conducting a Walking Survey

Study a map beforehand or do a drive-through to plan. Try to work in teams of two to three.

- Two or three people walking together is a normal group, but five or six is a crowd and stands out.
- To experience the community, participate in everyday activities. Take public transportation; eat in a local restaurant; or buy something in a drugstore, supermarket, or discount store. Listen to people’s conversations and get a sense of how they interact.
- Go inside public buildings and cultural institutions.
- Sit down in a quiet place to take notes.

In Summary

Sometimes, the best survey can be a combination of walking and driving. Consider some general questions:

- What are the community’s outstanding assets?
- What seem to be the community’s biggest challenges?

- What is the most striking thing about the community?
- What is the most unexpected?
- Does the community have an aesthetic quality, either positive or negative (i.e., is it particularly beautiful or particularly ugly)?

Whether you are starting an all-encompassing campaign to eliminate poverty in the community or simply looking for good places to paint murals to stimulate community pride, a windshield or walking survey can be an excellent way to begin.

ANALYZING DATA AS PART OF THE COMMUNITY HEALTH ASSESSMENT

Content in this section was adapted from Public Health Professionals Gateway: Data & Benchmarks resource from the Centers for Disease Control and Prevention (2021).

Community health assessments typically use primary and secondary data to characterize the community's health. Primary data are collected firsthand through surveys, listening sessions, interviews, and observations. Sometimes the initial observations are done informally via a windshield or walking survey. This entails driving or walking through a community and making observations about the community, such as noting the population makeup, the type of housing, or the number of health care facilities or schools. Note the type and state of buildings and housing in the community. This type of data is qualitative data. Qualitative data cannot be measured or expressed in terms of numbers; rather, such data are descriptive and give a feel of the community.

Secondary data are collected from other sources such as census records or state or county records. This information is quantitative, meaning that it can be expressed in terms of numbers. This information allows nurses to learn more about the community's demographic makeup, median income, housing, and rental costs. Also, look at the prevalence and incidence of diseases. It is important to obtain and review both primary and secondary data when performing a community health assessment. Community health assessment is a valuable tool in understanding and improving the health of communities at both the local and national levels.

THE NURSE'S ROLE IN COMMUNITY HEALTH ASSESSMENT AND EVALUATION

Conducting a community health assessment provides the nurse with comprehensive information about the community's current health status, needs, and issues. This information can help develop a community health improvement plan by justifying how and where resources should be allocated to best meet community needs.

Community health assessments provide a number of important benefits:

- Improved organizational and community coordination and collaboration
- Increased knowledge about public health and the interconnectedness of activities
- Strengthened partnerships within state and local public health systems
- Identified strengths and weaknesses to address in quality improvement efforts
- Baselines on performance to use in preparing for accreditation
- Benchmarks for public health practice improvements (CDC, 2022a)

Identifying key health needs and issues through systematic, comprehensive data collection and analysis enables nurses to deliver care that meets the individual needs of the community.

PRACTICE APPLICATION

➔ Setting the Scene

Local health departments help provide a safe and healthy environment for their communities. They provide these services, among others:

- Planning for emergencies
- Securing resources for disasters, such as first aid equipment and vaccines
- Administering vaccinations
- Managing local disease outbreaks
- Inspecting restaurants, grocery schools, and other community resources for food safety
- Implementing and supporting interventions for drug overdoses

They often work with community partners to ensure a base level of health for the communities they serve (National Association of County and City Health Officials, 2017).

➔ Think About It

Imagine that you are a new member of your local health department. Before you meet with community members, you decide to gather some additional data to help you draw a mental picture of the community. You will need to understand the range of social determinants of health, built environment, and the community's perception of their health and well-being.

1. Describe the benefits, disadvantages, and considerations for each of the following types of assessments.
   a. Census data for the community
   b. Health impact assessment
   c. Windshield survey
   d. MAPP survey
   e. Hospital needs assessment (published every 3 years by nonprofit hospitals)
2. Which assessment type (or combination of assessments) would you pick to help you become quickly familiar with your new community and why?
3. What information will you need to complete a windshield survey?

ADDITIONAL RESOURCES

CDC, National Healthy Worksite Program - Community Partnerships Issue Brief Number 3

CDC, Public Health Professionals Gateway - Community Health Assessment & Health Improvement Planning

Community Health Nursing [Article]

Healthy Communities Foundation

National Institute on Minority Health and Health Disparities - Community-Based Participatory Research Program

Northeastern State University - The Nurse's Role in Community Health

Robert Wood Johnson Foundation - Focus Areas: Healthy Communities

University of Kansas, Center for Community Health and Development - The Community Tool Box: Section 21. Windshield and Walking Surveys

US Department of Housing and Urban Development - Community Engagement Toolkit: Building Purpose and Participation

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Chapter Seven: Community Violence and Violence Prevention

OVERVIEW

The focus of this chapter is violence and violence prevention in the community. Violence is a critical health problem that has become pervasive throughout the United States. The World Health Organization (WHO) Violence Prevention Alliance has defined violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (WHO, 2021).

LEARNING OBJECTIVES

- Define violence
- Recognize the prevalence of violence
- Understand the difference between domestic violence and intimate partner violence (IPV)
- Indicate the consequences that violence has on the health of patients and families
- Identify screening and intervention tools for violence and abuse
- Describe human sex trafficking and implications for health care providers
- Explain the global, national, and regional incidence of gun violence

KEY TERMS

- gender-based violence
- domestic violence
- intimate partner violence
- perpetrate
- violence

Content in this chapter was adapted from "Violence Prevention" from the Centers for Disease Control and Prevention (2021a).

INTRODUCTION

Public health nurses have a role in preventing violence and caring for individuals and families who have experienced violent acts. Violence affects millions of people, and their families, schools, and communities every year. Violence can cause significant physical injuries and mental health conditions such as depression, anxiety, and posttraumatic stress disorder (PTSD). Living in a community experiencing violence is also associated with an increased risk of developing chronic

diseases. Concerns about violence may prevent some people from engaging in healthy behaviors, such as walking, bicycling, using parks and recreational spaces, and accessing healthy food outlets (CDC, 2022e).

VIOLENCE

Violence is not an individual issue but a societal and global concern. Social justice cannot be ensured as long as the threat of violence exists. According to Healthy People 2030, objectives to address crime and violence include reducing:

- The rates of minors and young adults committing violent crimes
- Nonfatal physical assault injuries
- Firearm-related deaths
- Adolescent sexual violence by anyone
- Sexual or physical teen dating violence
- Bullying of lesbian, gay, or bisexual high school students

DOMESTIC AND INTIMATE PARTNER VIOLENCE

The National Coalition Against Domestic Violence (NCADV) defined *domestic violence* as “the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another. It includes physical violence, sexual violence, threats, economic abuse, and emotional/psychological abuse. The frequency and severity of domestic violence vary dramatically” (WHO, 2021). Furthermore, domestic violence does not discriminate (Figure 7.1). More than 80 million people in the United States have experienced IPV in their lifetime (California Firearm Violence Research Center, 2022).

Figure 7.1: Domestic Violence Does Not Discriminate

Although the terms *domestic violence* and *intimate partner violence* are sometimes used interchangeably, the distinction exists in the sense that domestic violence can occur between a parent and child, siblings, or roommates. Intimate partner violence occurs between romantic partners who may or may not be living together in the same household (CDC, 2024e).

Intimate partner violence can exist in all relationships and at every level, including between those who are married or are dating, living together, or encountering each other after the relationship has ended (Kang et al., 2017). Intimate partner violence is a persistent problem (Figure 7.2). Approximately two in five women and nearly one in four men have experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during

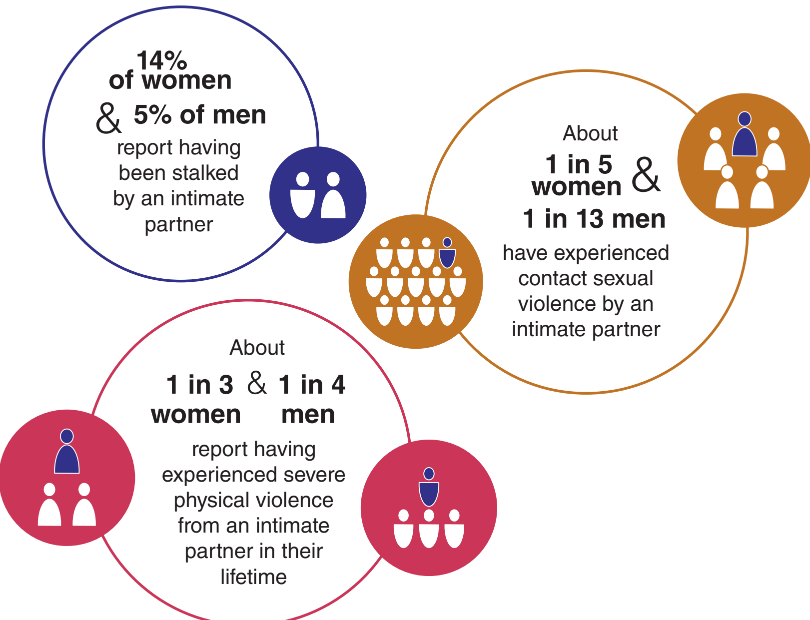

Figure 7.2: Intimate Partner Violence Statistics (Adapted from CDC, 2022b)

their lifetime and have reported some form of IPV-related impact. Over 61 million women and 53 million men have experienced psychological aggression by an intimate partner in their lifetime (CDC, 2024e). Every year, 3–4 million women in the United States. are abused, and 1,500–1,600 are killed by their abusers. In Virginia, 33.6% of women and 28.6% of men experience intimate partner physical violence, intimate partner rape, and/or intimate partner stalking in their lifetimes (Domestic Violence, 2024).

To illustrate a snapshot in time of violence, read the statistics presented in the following paragraphs. Keep in mind that the numbers represent real people experiencing violent acts aimed at harming or killing them.

On just one day in 2020, 84% of the domestic violence programs in Virginia served 1,344 persons who experienced domestic violence and received 606 hotline calls. On that same day, there were 109 requests for services that went unmet because of a lack of resources (NCADV, 2021). Imagine what it is like to experience severe violence and not be able to get help. Nurses should be involved in promoting legislation that protects people against violence and provides avenues for them to seek safety.

In 2020, over half of the 541 homicides in Virginia were committed by an intimate partner. Almost 70% of the Virginia intimate partner homicides involved firearm use. Statistical findings for Virginia reveal that more than 30% of all violent crimes, 11% of forcible sex offenses, and 61% of abductions were committed by an intimate partner (NCADV, 2021).

In the state of Virginia, police estimates indicate that there are nearly 31,000 active protective orders on file at any given time (NCADV, 2021). The statistics are staggering. Because of IPV prevalence, community health nurses must routinely screen for risk factors for perpetrating violence, perceptions of home safety, and relationship characteristics that indicate risk for interpersonal violence. Nurses are in a position to offer resources for counseling, healthy relationship building, and resources for escape if needed.

Risk factors for experiencing IPV are considered from the perspective of an individual in the context of relationship, community, and societal factors. Examples of risk factors include low self-esteem, aggressive or delinquent behavior as a youth, witnessing violence between parents as a child, communities with high unemployment rates, and societal income inequality (CDC, 2024). Intimate partner violence often begins early and continues throughout the lifespan. When IPV occurs in adolescence, it is called teen dating violence. Teen dating violence affects millions of U.S. teens each year. Approximately 11 million women and 5 million men who reported experiencing contact sexual violence, physical violence, or stalking by an intimate partner in their lifetime said that they first experienced these forms of violence before age 18 (CDC, 2024e). Data from CDC's Youth Risk Behavior Survey in 2019 indicated that among U.S. high school students who reported dating during the 12 months before the survey, about one in 12 experienced physical dating violence. About one in 12 of the surveyed high school students experienced sexual dating violence (CDC, 2024e).

Intimate partner violence is preventable. The number of factors may increase or decrease the risk of perpetrating and experiencing IPV. Nurses can play a role in helping to reduce and prevent IPV by doing the following:

- Understanding the risk factors for experiencing violence and identifying protective factors.
- Promoting healthy, respectful, and nonviolent relationships (see Table 7.1). Nurses can model this through therapeutic communication and through sharing resources that help individuals and couples develop healthy and safe relationships (see additional resources at the end of this chapter).
- Seeking additional training to understand the shared risk and protective factors. Since addressing and preventing one form of violence may have an impact on preventing other forms of violence, nurses can significantly influence violence reduction and prevention.
- Referring persons experiencing IPV to the domestic violence website and hotline are among other resources that should be offered to persons in this situation. The domestic violence hotline is a shareable resource for people who are affected by IPV (National Domestic Violence Hotline, 2022).

An in-depth assessment of the person suffering IPV must be undertaken and a safety plan developed. Establishing a plan does not necessarily mean that the person experiencing the violence is willing and able to leave at that time. The goal is to support the patient's decision, offering support, resources, and contact information if desired.

Healthy Relationships	Unhealthy Relationships
Equality You make decisions together.	**Control** One of you makes all the decisions and is demanding.
Honesty You can share your feelings and thoughts with each other.	**Dishonesty** One of you lies and hides things from the other.
Physical safety You feel safe with each other. You are not scared of getting hurt.	**Physical abuse** One of you hits, slaps, grabs, or shoves the other person.

Healthy Relationships	Unhealthy Relationships
Respect You respect each other's opinions, friends, and interests.	**Disrespect** One of you makes fun of the other's feelings, thoughts, and opinions.
Comfort You feel great being yourself, and you are comfortable saying "I am sorry."	**Discomfort** One of you might make threats like "I will break up with you if . . ."
Sexual respectfulness You never force each other to do things you are uncomfortable with.	**Sexual abuse** One of you pressures the other or forces sexual activities the other does not want to do.
Independence You have friends and hobbies outside your relationship.	**Dependence** One of you makes threats to do something drastic if the relationship ends.
Humor You have fun in the relationship.	**Hostility** One of you is mean to the other.

Table 7.1: Characteristics of Healthy Relationships (Adapted from Virginia Department of Health, 2022)

Protective Factors for Intimate Partner Violence Perpetration

Nurses can promote protective factors that prevent IPV by implementing community programs that build healthy relationships and systems of support.

Relationship Factors

The following are relationship factors community and public health nurses need to consider when addressing the needs of individuals at risk for IPV:

- Strong social support networks and stable, positive relationships with others
- Support groups for single, divorced, or separated individuals at risk for IPV
- Screening and referral of individuals acknowledging significant relationship discord
- Screening and referral of individuals expressing impactful relationship satisfaction
- Identification and referral of individuals demonstrating attachment disorders from their adult partners
- Referral of individuals expressing significant emotions of anger and jealousy toward their partner (Capaldi et al., 2012)

Referral resources can be found through Additional Resources | Intimated Partner Violence|Violence Prevention|Injury Center | CDC.

Community Factors

Nurses must be aware of community factors that may help them serve the needs of persons at risk for IVP. Community health nurses should consider these factors:

- Neighborhood collective efficacy (i.e., residents feel connected to each other and are involved in the community)

- Coordination of resources and services among community agencies
- Access to safe, stable housing
- Access to medical care and mental health services
- Access to economic and financial help

LGBTQIA+ VIOLENCE

Homophobia, stigma, and discrimination increase the chance for individuals of the lesbian, gay, bisexual, transgender, questioning/queer, intersex, and asexual (LGBTQIA+) community to experience violence. Violence can include behaviors such as bullying, teasing, harassment, physical assault, IPV, and suicide-related behaviors. Several aspects of IPV can be unique to the LGBTQIA+ community (CDC, 2016). "Outing" or threatening to reveal one partner's sexual orientation or gender identity may be used as a tool of abuse in violent relationships and may also be a barrier that reduces the likelihood of help-seeking for the abuse. Prior experiences of physical or psychological trauma, such as bullying and hate crime, may make persons who are LGBTQIA+ less likely to seek help (NCADV, 2018).

Types of Domestic Violence Affecting the LGBTQIA+ Community

Consider the following statistics:

- 20% of victims have experienced some form of physical violence
- 16% have been victims of threats and intimidation
- 15% have been verbally harassed
- 4% of survivors have experienced sexual violence
- 11% of intimate violence cases reported in the 2015 report by the National Coalition Against Domestic Violence Programs (NCADVP) involved a weapon (NCAVP, 2016)

The 2015 U.S. Transgender Survey found that more than half (54%) of transgender and non-binary respondents experienced IPV in their lifetimes. Nurses must understand that the community of LGBTQIA+ can experience bias from health care and law enforcement (CDC, 2022a). Many times, persons who are not cisgender are discouraged from seeking help for IPV.

For many LGBTQIA+ people, IPV often begins in youth or young adulthood. One in five (19%) lesbian, gay, and bisexual high school–aged students has said they have been forced to have sex, compared with 6% of straight students (CDC, 2019). Another study found that nearly one in four (24%) transgender high school–aged students said they have been forced to have sex, as well as 15% of their cisgender peers. In addition, lesbian, gay, and bisexual high school–aged students report elevated rates of physical (13%) and sexual (16%) dating violence, compared with the rates of physical (7%) and sexual (7%) dating violence reported by their straight peers (CDC, 2019; Johns et al., 2019). Transgender students also report high levels of physical (26%) and sexual (23%) dating violence, compared with the rates of physical (15%) and sexual (16%) dating violence reported by their cisgender peers (Human Rights Campaign Foundation, 2022; Johns et al., 2019).

Nurses must always ensure a safe environment for patients in all settings and provide unbiased trauma-informed care (Santoniccolo et al., 2021). Unfortunately, persons who are LGBTQIA+ experience health inequities and discrimination in the health care system. Nurses can implement

diverse interventions to reduce these disparities (Medina-Martínez et al., 2021). Nursing efforts to improve the health of the LGBTQIA+ population include these initiatives:

- Training health professionals to appropriately inquire and support clients' sexual orientation and gender identity to promote regular use of health care services
- Training health professionals and students regarding culturally competent care
- Providing supportive social services to reduce suicide and homelessness among youth
- Curbing sexually transmitted infections and HIV transmission. (Open RN 2022; HealthyPeople.gov, 2022; National Network to End Domestic Violence, 2021; Quinn et al., 2015; Scheer & Baams, 2021)

VIOLENCE AGAINST CHILDREN

Violence is a major public health and human rights concern. An estimated 1 billion children—half of all the children in the world—are victims of violence every year.

Children who experience violence have higher risks for health and social problems, such as chronic disease, HIV, mental health issues, substance misuse, and reproductive health problems. Violence also leads to continued cycles of violence, because young people who experience violence are more likely to perpetrate violence against others later in life (CDC, 2024a).

Child abuse and neglect are common. At least one in seven children has experienced child abuse or neglect in the past year in the United States. This is likely an underestimate because many cases are unreported. In 2020 in the United States, 1,750 children died of abuse and neglect.

Children living in poverty experience more abuse and neglect than do those in households that are not impoverished. Experiencing poverty can place a lot of stress on families, which may increase the risk for child abuse and neglect. Rates of child abuse and neglect are five times higher for children in families with low socioeconomic status than for those in higher status families.

Child maltreatment is costly. In the United States, the total lifetime economic burden associated with child abuse and neglect was about $592 billion in 2018. This economic burden rivals the cost of other high-profile public health problems, such as heart disease and diabetes (CDC, 2024c).

Long-term behavioral impacts of violence on children include aggressive and antisocial behavior, substance abuse, risky sexual behavior, and criminal behavior. Despite these grave physical and mental health consequences, most children who have been victimized by violent acts never seek or receive help to recover. Children who grow up with violence are more likely to reenact it as young adults and caregivers, creating a new generation of persons who have been abused (UNICEF, 2020).

School violence can seriously affect children's psychological and physical health. Children who are subjected to violence may experience physical injury, sexually transmitted infections, depression, anxiety, posttraumatic stress disorder (PTSD), and suicidal thoughts. They may also begin to exhibit risky, aggressive, and antisocial behavior. Children who grow up around violence, compared with those who do not, have a greater chance of replicating it for a new generation of persons to be victimized. At its most extreme, violence in and around schools can be deadly. School often becomes the front line for the millions of children and adolescents living in conflict-affected areas. Violence in school can reduce school attendance, lower academic performance, and increase dropout rates. This result of school violence has devastating consequences for the success and prosperity of children, their families, and entire communities (UNICEF, 2021).

Strategies to Combat Childhood Violence

Community health nurses promote supportive environments that can, in turn, help children grow up to be healthy and productive citizens so that they can, in turn, build stronger and safer families and communities for their children.

The CDC has recommended Essentials for Childhood to foster the positive development of children and families and, specifically, prevent all forms of child abuse and neglect. While each individual goal is important to community health, the four goals together are more likely to build a comprehensive foundation of safe, stable, nurturing relationships and environments for children. Community health nurse can promote the following strategies:

Goal 1: Raise awareness and commitment to promote safe, stable, nurturing relationships and environments and prevent child abuse and neglect

- Adopt the vision of "assuring safe, stable, nurturing relationships and environments to protect children from child abuse and neglect"
- Raise awareness in support of the vision
- Partner with others to unite behind the vision

Goal 2: Use data to inform actions

- Build a partnership to gather and synthesize relevant data
- Take stock of existing data
- Identify and fill critical data gaps
- Use the data to support other action steps

Goal 3: Create the context for healthy children and families through norms change and programs

- Promote the community norm that we all share responsibility for the well-being of children
- Promote positive community norms about parenting programs and acceptable parenting behaviors
- Implement evidence-based programs for parents and caregivers

Goal 4: Create the context for healthy children and families through policies

- Identify and assess which policies may positively affect the lives of children and families in your community
- Provide decision-makers and community leaders with information on the benefits of evidence-based strategies and rigorous evaluation (CDC, 2021)

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life (Office of Disease Prevention and Health Promotion, 2022). While child abuse and neglect are significant public health problems, they are also preventable (CDC, 2021).

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) include child abuse and neglect but also encompass household events that children may experience as traumatic (Figure 7.3). The CDC–Kaiser Permanente

ACE study is one of the largest investigations of childhood abuse, neglect, and household challenges. The study clearly linked ACEs and later-life health and well-being. The greater the culmination of ACEs, the poorer the health outcomes later in life (Felitti et al., 1998).

The ACE study was conducted at Kaiser Permanente from 1995 to 1997 with two waves of data collection (Kaiser Permanente, 2021). The study indicated that the experience of 10 events before age 18, further classified under three larger categories of abuse, neglect, and household dysfunctions, influence health and well-being throughout the lifespan (Felitti et al., 1998).

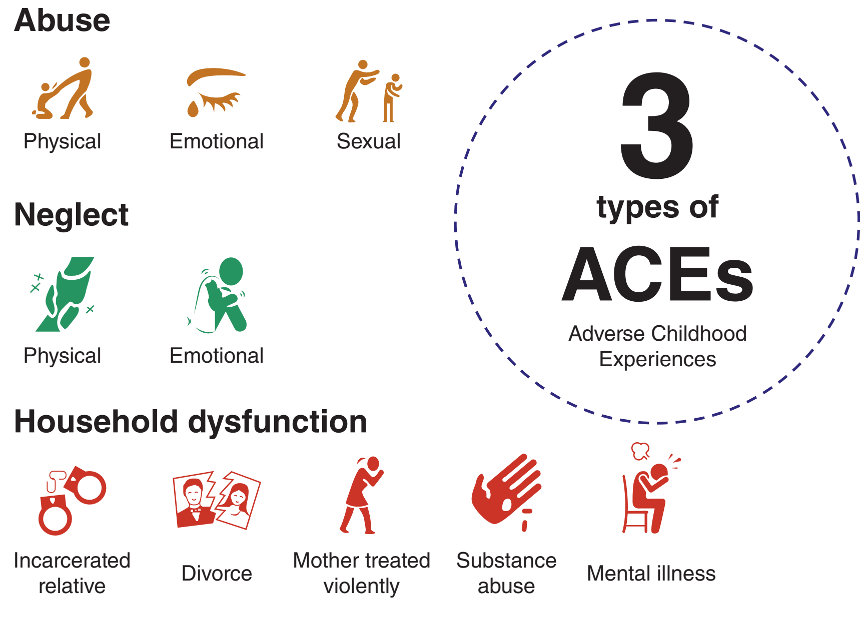

Figure 7.3: Types of Adverse Childhood Experiences

Why Are ACEs a Problem?

Adverse childhood experiences are violations of the safety and well-being of children. They also indicate a family structure in which children and adults are suffering. Moreover, the more ACEs a person experiences, the higher their risk for health-related issues such as these:

- Alcoholism
- Unplanned teen pregnancy
- Depression
- Diabetes
- Heart disease
- IPV
- Suicide
- Eating disorders
- Drug abuse
- Sexually transmitted infections

Since the prevention of ACEs is important to the well-being of a vulnerable population (children) and to families as well as to public health, the CDC has developed some research-based strategies to prevent ACEs and mitigate their impacts. Table 7.2 outlines strategies and approaches that public health nurses can facilitate through working with families and communities.

Preventing Adverse Childhood Experiences	
Strategy	**Approach**
Strengthen economic support to families	• Strengthening of household financial security • Family-friendly work policies
Promote social norms that protect against violence and adversity	• Public education campaigns • Legislative approaches to reduce corporal punishment • Bystander approaches • Men and boys as allies in prevention
Ensure a strong start for children	• Early childhood home visitation • High-quality childcare • Preschool enrichment with family engagement
Teach skills	• Social-emotional learning • Safe dating and healthy relationship skill programs • Parenting skills and family relationship approaches
Connect youth to caring adults and activities	• Mentoring programs • After-school programs
Intervene to lessen immediate and long-term harms	• Enhanced primary care • Victim-centered services • Treatment to lessen the harms of ACEs • Treatment to prevent problem behavior and future involvement in violence • Family-centered treatment for substance use disorders

Table 7.2: Preventing ACEs (Adapted from CDC, 2024b)

HUMAN TRAFFICKING

Human trafficking is also called “modern-day slavery” (U.S. Department of Health and Human Services, 2020). It involves the exploitation of people through force, coercion, threat, and deception and includes human rights abuses. The action, means, and purposes model (AMP) describes the definition of human trafficking in the United States, as outlined by the Victims of Trafficking and Violence Protection Act of 2000 (Figure 7.4). For something to be considered human trafficking, at least one item from each circle shown in Figure 7.4 must be present; however, means is not necessary if the person being trafficked is a minor (National Human Trafficking Hotline, 2014).

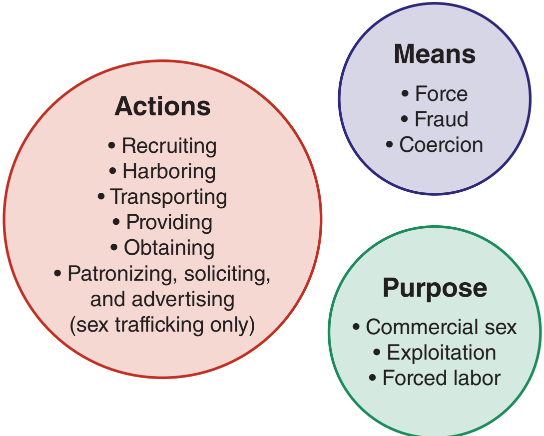

Figure 7.4: Human Trafficking AMP Model

Human trafficking is a human rights violation that denies individuals their basic freedoms and dignity. Human trafficking is underreported, underrecognized, and underprosecuted. Currently, there is no national requirement for nurses to engage in annual or continuing education in assessing or reporting human trafficking. This is extremely concerning because 87% of trafficked persons said that while in captivity they had interactions with a health care professional but their captivity went completely undetected (Farella, 2016). House Bill 2282 (February 24, 2017) mandated that the Department of Education develop guidelines for training school personnel. This bill includes the community health role of school nurses.

Nursing Assessment

Nurses can combat human trafficking through screening, communication, documentation, and protection.

Screening

- Establish rapport through therapeutic communication, trust building, and trauma-informed care
- Ensure comfort
- Use an established short-form screening tool
  - For example, the Vera Institute of Justice screening tool: human-trafficking-identification-tool-and-user-guidelines.pdf (vera.org)
- Remember that trafficked people do not self-identify (Edmonson et al., 2017)

Communication

- Keep the lines of communication open.
- Understand that many trafficked persons believe that they will be prosecuted. However, U.S. law states that any crimes that occur during captivity are not considered criminal acts by the captive, only by the offender.
- Communicate early and often with your colleagues and manager to enlist help.

Documentation

Document all the following in detail about the person who has been trafficked:

- Signs of physical abuse
- Signs of psychological abuse
- The trafficked person's "story"
- Any laboratory results or assessments that support what your patient is telling you

Also document the following behaviors of the offender if they are present:

- Not letting the patient speak for themself
- Holding all currency and important documents
- Not allowing the trafficked person to be alone with the health care provider

Protection

Because one in every three trafficked persons is a child, nurses must understand reporting mandates. Nurses are legally mandated to report any suspicion of trafficking cases involving people under 18. However, there is no reporting mandate for adults who are trafficked. Nonetheless, nurses can still protect their patients by doing the following:

- Establishing an anonymous/protected status in clinics, primary care, and acute care settings
- Contacting local police
- Calling the National Trafficking Hotline at 1-888-373-7888
- Involving case management for after-care resources

GUN VIOLENCE

Gun violence is a serious public health problem that affects the health and safety of Americans. Important gaps remain in our knowledge about the problem and ways to prevent it. Addressing these gaps is an important step toward keeping individuals, families, schools, and communities safe from firearm violence and its consequences.

A firearm injury is a gunshot wound or penetrating injury from a weapon that uses a powder charge to fire a projectile. Weapons that use a power charge include handguns, rifles, and shotguns. Injuries from air- and gas-powered guns, BB guns, and pellet guns are not considered firearm injuries because these types of guns do not use a powder charge to fire a projectile.

Firearm injuries are a serious public health problem. In 2020, there were 45,222 firearm-related deaths in the United States—that is about 124 people dying from a firearm-related injury each day. More than half of firearm-related deaths were suicides, and more than four out of every 10 were firearm homicides.

More people suffer nonfatal firearm-related injuries than die. More than seven out of every 10 medically treated firearm injuries are from firearm-related assaults. Nearly two out of every 10 are from unintentional firearm injuries. There are few intentionally self-inflicted firearm-related injuries seen in hospital emergency departments. Most people who use a firearm in a suicide attempt die from their injury.

Firearm injuries affect people in all stages of life. In 2020, firearm-related injuries were among the five leading causes of death for people aged 1 to 44 in the United States.

Some groups have higher rates of firearm injury than others. Men account for 86% of all victims of firearm death and 87% of nonfatal firearm injuries. Rates of firearm violence also vary by age and race/ethnicity. Firearm homicide rates are highest among teens and young adults 15–34 years of age and among Black or African American, American Indian or Alaska Native, and Hispanic or Latino populations. Firearm suicide rates are highest among adults 75 years of age and older and among American Indian or Alaska Native and non-Hispanic White populations (CDC, 2024d).

Virginia ranked 34th among the states for gun violence deaths, with a rate of 13.4 per 100,000 total population, which equates to 1,174 individuals (CDC, 2022b, 2022d). Figure 7.5 depicts a concentration of gun violence incidents in the eastern region, with Virginia visible as one area affected by this epidemic.

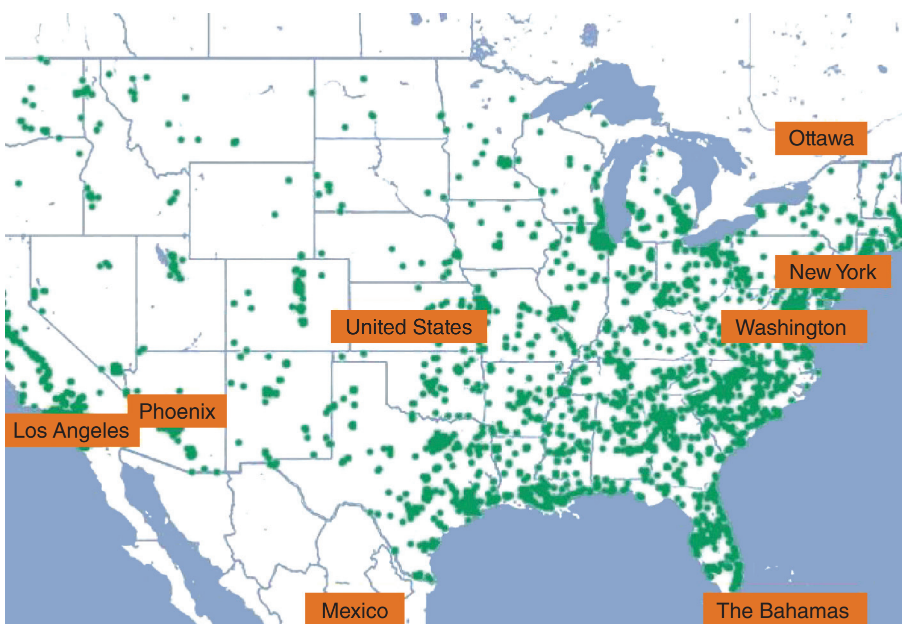

Figure 7.5: Concentration of Gun Deaths in 2022 (Adapted from Gun Violence Archive, 2022)

In contrast to the rising levels of gun violence in America, Europe has seen a decline in the homicide rate by 63% since 2002 and by 38% since 1990. The rate in Asia has fallen by 36% since 1990. There are also indications, however, that homicide is underreported in the official statistics in Pacific countries. Firearm suicide rates continued to remain high in the United States (United Nations Office on Drugs and Crime, 2018).

A comprehensive approach is needed to help reduce firearm-related deaths. Strategies that focus on underlying conditions can reduce disparities and the risk for violence while also strengthening protective factors at the individual, family, and community levels. Some actions can have a more immediate impact on preventing violence, and others can be long-term solutions. Prevention is a primary goal. Working with partners, including policymakers; local, state, territorial, and tribal governments; health, education, justice, and social service agencies; businesses; and community organizations can help ensure that local needs are met (CDC, 2022d; WHO, 2014). Gun violence intervention and prevention programs avert interpersonal

violence by working with a range of community stakeholders to provide support and intervention to those at the highest risk of being persons who have been victimized and/or perpetrators of violence.

As one key effort to address the issue of gun violence in Virginia, the Virginia Department of Criminal Justice Services is stewarding a grant called the Virginia Community-Based Gun Violence Intervention (CBGVI) Grant. The primary purpose of this initiative is to support the implementation of strategies that will result in reducing gun violence and gang activity in Virginia communities.

THE NURSE'S ROLE IN PREVENTING VIOLENCE

There are many types of violence affecting individuals, communities, and populations. Community health nurses play an important role in preventing violence. Regardless of the type of violence, nurses can implement the public health approach to violence prevention, as shown in Figure 7.6. The process begins by identifying the problem, with emphasis placed on the identification of risk and protective factors. If the risk factors are identified early and prevention strategies put in place and communicated to the targeted areas, violence can be prevented (CDC, 2022c).

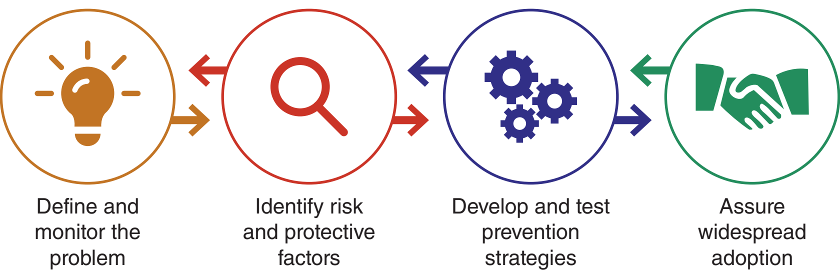

Figure 7.6: The Public Health Approach to Violence Prevention (Adapted from CDC, 2022c)

PRACTICE APPLICATION

➔ Setting the Scene

Mary Lou: Intimate Partner Violence in Later Life

Watch this video by scanning the QR code or visiting
https://youtu.be/B7N8CRorUvg

➔ Think About It

Consider Mary Lou's experience as showcased in the video.

1. Were you surprised that Mary Lou was a victim of domestic violence?
2. What from Mary Lou's experience indicated she was in a domestic violence situation?
3. Was Mary Lou exhibiting any risk factors for domestic violence?
4. If you had a patient like Mary Lou, what would you do if they exhibited clues that they were experiencing domestic violence?
5. What role does a therapist play in treating those who experience domestic violence? How can you, as a nurse, work with therapists in these situations?

➔ Think About It: Other Examples

1. You are working in the sexually transmitted infection (STI) department at the local health department. A 21-year-old transgender man comes in to be treated for syphilis. As a part of the visit, you interview the patient about their current relationship. They confide that their partner can be very controlling and has, on more than one occasion, hit them.
   - **a.** What types of violence might you identify from their story?
   - **b.** What steps would you take after learning about this violence?
   - **c.** How does the patient's transgender status influence your treatment?
2. You are interviewing a 12-year-old at the pediatrician's office, and after reviewing their record, you note that they have a history of being physically abused and neglected by their parents. You also know that their parents are divorced, and their mother is incarcerated.
   - **a.** What types of violence might you identify from their story?
   - **b.** What steps would you take after learning about this violence?
   - **c.** How does the ACE study come into your evaluation?
   - **d.** What adverse impacts might the child experience later in life, based on the ACE study?

ADDITIONAL RESOURCES

CDC - Fast Facts: Preventing Teen Dating Violence

CDC - Injury and Violence Prevention [Video Playlist]

CDC - Preventing Intimate Partner Violence Across the Lifespan : A Technical Package of Programs, Policies, and Practices [PDF]

CDC, VetoViolence (tools and training, prevention information, ACEs resources)

Disarm Domestic Violence (federal and state legislation and data)

Gun Violence Archive

TED Talk - How childhood trauma affects health across a lifetime (Nadine Burke Harris) [Video]

Vera Institute for Justice - Screening for Human Trafficking: Guidelines for Administering the Trafficking Victim Identification Tool (TVIT) [PDF- Manual]

Resources for Patients/the Community

211 (information about local resources and services)

Commonhelp.org (help with applying for assistance or health care)

National Domestic Violence Hotline (also available at 1-800-799-SAFE)

Virginia Department of Housing and Community Development - Housing Assistance

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Chapter Eight: Emergency Preparedness

OVERVIEW

A disaster is an event that can be human-made or environmental (or a combination of both) that causes suffering and demands more resources to manage than the community can provide. Disaster preparedness includes planning and anticipating all forms of hazards and establishing protocols for management in an ever-changing environment. Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health. Such stresses include natural or human-caused disasters or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss.

LEARNING OBJECTIVES

- Discuss the disaster management cycle
- Understand the role of the community health nurse in disaster management
- Identify agents of bioterrorism and their route of delivery

KEY TERMS

- syndromic surveillance
- bioterrorism

Content for this chapter was adapted from "Emergency Preparedness and Response" from the Centers for Disease Control and Prevention (2024).

INTRODUCTION

Emergency preparedness and response is a key role for all nurses (American Nurses Association [ANA], 2022). Many states now require registered nurses to serve as emergency first responders in emergency departments. Public health nurses are involved in helping individuals and communities prepare for emergencies and natural disasters such as hurricanes and floods. Public health nurses also work with cities and states to assist in preparedness and recovery plans. Since public health nurses are familiar with the characteristics of different communities, the principles of preparedness, and person-centered planning for recovery, they are key members of disaster response and recovery teams. Nurses can gain specialization in National Healthcare Disaster Certification through the American Nurses Association (ANA, 2022).

DISASTER MANAGEMENT CYCLE

The terms *emergency* and *disaster* often are used interchangeably. This common use of terms can be confusing. It is easiest to understand an emergency and a disaster as being at two ends of a

scale in which the size of an incident and the resources to deal with the incident are matched to varying degrees.

At one end of the spectrum, emergencies are usually small-scale, localized incidents that are resolved quickly using local resources. However, small-scale emergencies can escalate into disasters when there has been inadequate planning, inadequate resources, or wasteful use of resources. Resource management is one aspect of emergency management.

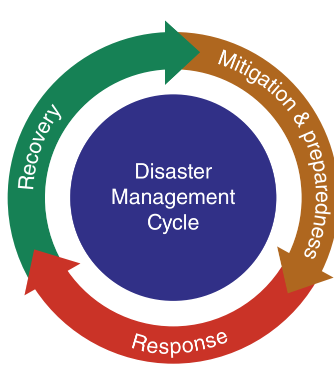

Figure 8.1: Disaster Management Cycle (Adapted from Romão & Pereira, 2022)

At the other end of the spectrum, disasters are typically large-scale and cross geographic, political, and academic boundaries. Disasters require a level of response and recovery greater than local communities can provide (Federal Emergency Management Agency [FEMA], 2022).

Hazard is another term often used interchangeably with disasters. It is important to note that a hazard includes acts of nature as well as human-contrived events, but a hazard cannot become a disaster unless the community or population is left vulnerable.

Protection from hazards includes safety consciousness in addition to disaster preparedness. The "all hazards" approach to disaster preparedness includes proactive measures to help communities plan, prepare, educate, respond, and recover from disasters (Martin et al., 2011). Managing disasters can be organized into mitigation and preparedness, response, and recover, or the disaster management cycle (Figure 8.1).

Disaster Prevention (Mitigation)

The prevention phase includes actions taken to prevent or reduce the cause, impact, and consequences of disasters. Public health nurses work with city and state planners to examine local opportunities for mitigating disasters. Examples of hazard mitigation include:

- Tying down homes or barns with ground anchors to withstand wind damage
- Digging water channels to redirect water and planting vegetation to absorb water
- Constructing levees or permanent barriers to control flooding
- Reinforcing fencing to prevent animal escapes

Disaster Preparedness

The preparedness phase includes planning, preparing, and providing educational activities for events that cannot be mitigated. Public health nurses are involved in all stages of disaster preparedness in the community and with partner agencies. The ANA has issued a position statement on the role of nurses in the event of a disaster. This document guides nurses and employers on how to release nurses to serve in emergency response situations. The entire document is available here: American Nurses Association (2002). *Registered nurses' rights and responsibilities related to work release during a disaster.*

Community-wide disaster preparedness examples include these activities:

- Developing and educating community members on disaster preparedness plans for what to do, where to go, or whom to call for help in a disaster
- Exercising plans through drills, tabletop exercises, and full-scale exercises

- Creating a supply list of items that are useful in a disaster
- Walking around a farm and identifying vulnerabilities to high winds
- Working with agencies like food banks and Meals on Wheels to provide additional emergency provisions to vulnerable populations during months of the year when increased extreme weather is more likely to occur.

Disaster Response

The response phase occurs in the immediate aftermath of a disaster. During the response phase, businesses and other operations do not function normally. Personal safety and well-being in an emergency and the response phase's duration depend on the preparedness level. Examples of response activities include:

- Implementing disaster response plans
- Conducting search and rescue missions
- Taking actions to protect yourself, your family, your animals, and others
- Addressing public perceptions about food safety

Community health nurses may engage in the care of individuals or work with partner agencies to distribute resources.

Public health nurses should be familiarized with FEMA's Incident Command System (ICS), which organizes lines of communications and establishes clear roles and responsibilities during emergency response. Public health nurses should participate in the free educational resources provided through the FEMA website: FEMA, Emergency Management Institute, Independent Study (IS), Course List

Disaster Recovery

Restoration efforts occur concurrently with regular operations and activities during the recovery period. The recovery period from a disaster can be prolonged. Examples of recovery activities include:

- Preventing or reducing stress-related illnesses and excessive financial burdens
- Rebuilding damaged structures based on advanced knowledge obtained from the preceding disaster
- Reducing vulnerability to future disasters

Community nurses can offer trauma-informed care to affected individuals and groups (FEMA, 2022).

SIX PHASES OF A DISASTER

Communities often experience commonalities as they go through disasters. Figure 8.2 depicts the six common phases. Public health nurses need to familiarize themselves with shared responses from community members to improve their ability to provide therapeutic trauma-informed care.

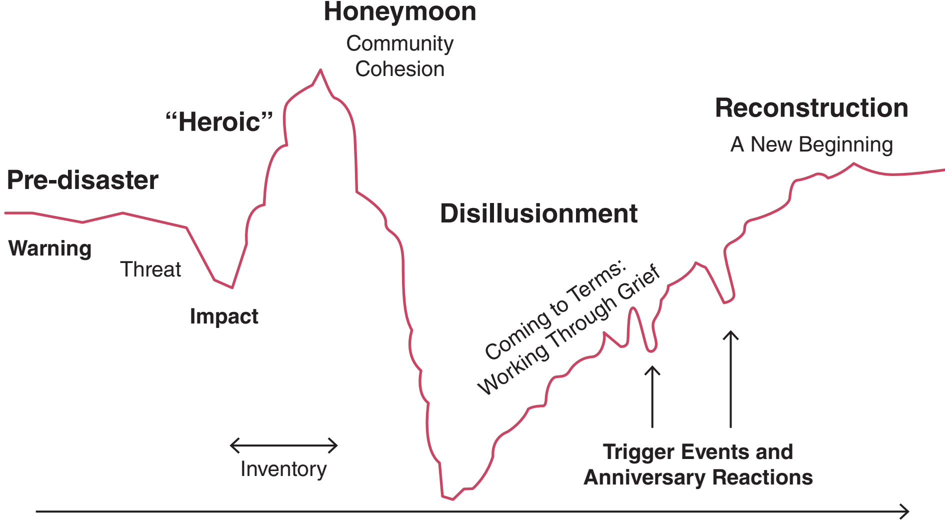

Figure 8.2: Phases of Disaster (Adapted from "Crisis Counseling Assistance and Training Program Guidance," from FEMA, 2023)

BIOTERRORISM

A *biological attack*, or bioterrorism, is the deliberate release of viruses, bacteria, or other germs (agents) used to cause illness or death in people, animals, or plants. These agents are typically found in nature but could be changed to increase their ability to cause disease, make them resistant to current medicines, or increase their ability to be spread into the environment. Biological agents can spread through the air, water, or food. Terrorists may use biological agents because they can be extremely difficult to detect and do not cause illness for several hours to several days. Some bioterrorism agents, like the smallpox virus, can be spread from person to person; some, like anthrax, cannot.

Syndromic Surveillance

In the chapter about epidemiology, the topic of case surveillance was introduced. The methods used in case surveillance were applied to an early detection system called syndromic surveillance. Syndromic surveillance provides public health officials with a timely system for detecting, understanding, and monitoring health events. By tracking symptoms of patients in emergency departments—before a diagnosis is confirmed—public health departments can detect unusual levels of illness to determine whether a response is warranted. Syndromic surveillance was developed as a way to detect potential bioterrorism events early but has been applied to many other conditions (Henning, 2004).

Syndromic data can serve as an early warning system for public health concerns such as influenza outbreaks and has been used in responses to opioid overdoses, lung injury associated with e-cigarette or vaping product use, Zika virus infection, and natural disasters.

The National Syndromic Surveillance Program

The National Syndromic Surveillance Program collects, analyzes, and shares electronic patient encounter data received from emergency departments, urgent and ambulatory care centers,

inpatient health care settings, and laboratories. Data are then integrated into a national shared platform that allows community health departments to further analyze data. Public health officials use these data in a timely and actionable manner to detect, characterize, monitor, and respond to events of public health concern. Data are detected and sent to a "Bio-Sense" platform housed by the Centers for Disease Control and Prevention (CDC). Read more about the Biosense system on the CDC website.

Agents of Bioterrorism

Bioterrorism agents can be separated into three categories, depending on how easily they can be spread and the severity of illness or death they cause. Category A agents are considered the highest risk, and Category C agents are those that are considered emerging threats for disease.

Category A

These high-priority agents include organisms or toxins that pose the highest risk to the public and national security because they can easily be spread or transmitted from person to person. Category A agents:

- Can result in high death rates and have the potential for major public health impact
- Might cause public panic and social disruption
- Require special action for public health preparedness

Examples of Category A agents include:

- Smallpox
- Botulism
- Anthrax
- Tularemia
- Viral hemorrhagic fevers (Ebola, Lassa)
- Bubonic plague

Category B

These agents are the second-highest priority because they are moderately easy to spread. Category B agents:

- Can result in moderate illness rates and low death rates
- Require specific enhancements of CDC's laboratory capacity and enhanced disease monitoring

Examples of Category B agents include:

- Typhus fever
- Ricin toxin
- Diarrheagenic *E. coli*
- West Nile virus

Category C

These third-highest priority agents include emerging pathogens that could be engineered for mass spread in the future because they are easily available.

Category C agents:

- Are easily produced and spread
- Have the potential for high morbidity and mortality rates
- May have major health impact

Examples of Category C agents include:

- Hantavirus
- Influenza virus
- Tuberculosis
- Rabies virus (CDC, 2006)

Delivery Mechanisms for Biological Agents

The delivery of biological agents as a means of bioterrorism can occur in the following ways:

- Direct contact (subcutaneous anthrax)
- Simple dispersal device (airborne, nuclear)
- Water and food contamination
- Droplet or blood contact

Recognition of a Bioterrorism Event

Warnings signs of a bioterrorism event:

- Rapidly increasing disease incidence throughout the community
- A disease that is occurring in an unusual area
- An endemic occurring at an unusual time
- A large number of people dying rapidly with similar presenting manifestations
- An unusual number of dead or dying animals
- The unusual presence of liquids, vapors, or odors

A public health emergency following the deliberate or unintentional release of biological agents will require a coordinated response among public health authorities, health care providers and facilities, veterinarians, and community leaders.

Bioterrorism and Community Health

Community health nurses play a pivotal role in ensuring that state and local public health systems are prepared for public health emergencies. The nurse must be ready to respond effectively, whether it is an infectious, occupational, or environmental incident.

Accurate and timely communication with different audiences will support a successful response to bioterrorism incidents. Along with its federal partners, the CDC will communicate

about national-level efforts and will assist state and local efforts. State and local public health authorities will be responsible for communicating to people within their jurisdictions about the response efforts that affect them.

THE NURSE'S ROLE IN DISASTER MANAGEMENT

Risk Assessment

Community health assessment, also known as community health needs assessment, is a state, tribal, local, or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis.

A community health improvement plan is a long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process.

A community health assessment gives organizations comprehensive information about the community's current health status, needs, and issues. In turn, this information can help with developing a community health improvement plan by justifying how and where resources should be allocated to best meet community needs (CDC, 2018).

Disaster Planning

A community health assessment gives organizations comprehensive information about the community's current health status, needs, and issues. This information can help planners develop a community health improvement plan by justifying how and where resources should be allocated to best meet community needs before disaster strikes.

Community health assessments benefits include:

- Improved organizational and community coordination and collaboration
- Increased knowledge about public health and the interconnectedness of activities
- Strengthened partnerships within state and local public health systems
- Identified strengths and weaknesses to address in quality improvement efforts
- Baselines on performance to use in preparing for accreditation
- Benchmarks for public health practice improvements (CDC, 2019)

Disaster Response and Recovery

Successful response and recovery depend on all disaster response team members having a clear understanding of pre- and postdisaster roles and responsibilities. Clearly defined roles and responsibilities are a foundation for the unity of effort among all recovery partners to jointly identify opportunities, foster partnerships, and optimize resources.

The local government and the public health department play a primary role in planning and managing all aspects of the community's recovery. Individuals, families, and businesses look to local governments to articulate their recovery needs (FEMA, 2020).

Postdisaster nursing roles may include the following:

- Participating in damage and impact assessments with other recovery partners
- Ensuring inclusiveness in the community recovery process, including persons with disabilities and limited English proficiency

- Communicating recovery priorities to state and federal governments and other recovery stakeholders and supporters
- Incorporating critical mitigation, resilience, sustainability, and accessibility-building measures into the recovery plans and efforts
- Working closely with the recovery leadership at all levels to ensure a well-coordinated, timely, and well-executed recovery (FEMA, 2020)

Evaluation of Disaster Response

Evaluation can happen in many forms but should focus on the area, effect, and level of disaster. Ongoing assessments and surveillance reports should be completed and passed along to local governments. Disaster response teams should be evaluated for efficiency and response time. Additionally, the recovery of community services such as electricity and running potable water should be evaluated for the impact and interruption of their services.

PRACTICE APPLICATION

➔ Setting the Scene

Glanders is a disease that usually affects livestock and farm animals and household pets, including these:

- Horses, donkeys, and mules
- Goats
- Dogs
- Cats
- Rabbits
- Guinea pigs
- Hamsters

Of note, cattle, swine, and chickens appear to be resistant to glanders. While the disease still occurs in certain parts of the world, no animal in the United States has gotten sick with glanders since the 1940s. So, it is extremely unlikely that pets or livestock in the United States will get the disease naturally.

Though not common, people have contracted glanders from sick animals. It can be a serious illness, and most people sick with glanders need to be hospitalized for treatment. As many as nine of every 10 people who contract the disease die if they do not receive specific antibiotics, while up to five of 10 people die with the correct antibiotics. Even after they are well enough to go home, people who have had glanders need to take antibiotics for several months to ensure the germs are eradicated in the body and to prevent the disease from coming back.

It can also be difficult to diagnose glanders quickly because its symptoms are the same as more common diseases like community-acquired pneumonia, influenza, or tuberculosis. In the entire world, only a few people are diagnosed with glanders each year. Because glanders in humans is so rare, most doctors are unfamiliar with the disease.

The germs that cause glanders, the bacteria *Burkholderia mallei*, have previously been used as a biological weapon during war, and there remains a possibility that they may again be used for

a similar purpose. The germs that cause glanders are prime candidates for bioterrorism because of the combined severity and rarity of the disease.

A bioterrorism attack that releases glanders germs into the air, water, or food supply might put many people at risk of getting sick. For example, if the germs that cause glanders were released into the air in a crowded place, many people might inhale them. Or, if the germs were put into food, people who eat the contaminated food would eat the germs too. Anyone who comes into contact with these germs is in danger of getting sick with glanders. Discovering that an attack occurred may be delayed because people cannot see, smell, or taste the germs. Instead, an occurrence will likely not be identified until doctors begin to see many people sick with fevers and respiratory illnesses. Once doctors diagnose patients with glanders, they will work with public health authorities to find out how the patients came into contact with the glanders germs.

Public health authorities study glanders and many other germs to be prepared if a bioterrorism attack ever occurs. They develop bioterrorism response plans, which are extremely valuable and key to protection against bioterrorism attacks (CDC, 2017).

➔ Think About It

Nurses' roles in public health emergencies vary depending on the nurses' areas of focus. Select a community or public health nursing role from the following:

- Nurse at a public health department
- Nurse at a hospital internal medicine department
- School nurse at a middle school
- Home visiting nurse at Nurse Family Partnership, with a focus on families with children under 5 years of age

Answer these questions and then discuss your responses with classmates who have selected the same or different roles:

1. What category of agents of bioterrorism is glanders?
2. What is your role in preparing for a disaster like glanders in the community? In the workplace?
3. What steps would you take if you suspect a patient has glanders or another disease that may be used in a bioterrorism attack?
4. What is your role in each step of the disaster management cycle for outbreaks such as the one described in the case study?
5. How willing are you to respond during an outbreak when there are unknown levels of risk?

ADDITIONAL RESOURCES

CDC - Emergency Preparedness and Response

CDC, Emergency Preparedness and Response - Bioterrorism

National Safety Council

Ready (National public service campaign to educate and empower disaster response)

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Chapter Nine: Trauma-Informed Care

OVERVIEW

Trauma is pervasive throughout society, and community-based services play a vital role in creating trauma-informed responses and environments. Key steps include meeting individuals in a safe, collaborative, and compassionate manner; preventing practices that retraumatize individuals who are seeking help or services; recognizing strengths and the resilience of individuals within their environment and community; and fostering trauma-informed principles in all aspects of the care delivery process.

LEARNING OBJECTIVES

- Understand the principles of trauma-informed care in community health
- Identify the range of symptoms associated with complex trauma and its impact on overall health
- Describe grounding techniques
- Analyze various approaches for trauma management
- Identify things and events that can be sources of trauma
- Recognize the impact of trauma on communities

KEY TERMS

- trauma
- retraumatization

Content for this chapter was adapted from "Trauma-Informed Care in Behavioral Health Services," Treatment Improvement Protocol (TIP) Series 57 publication, by the Substance Abuse and Mental Health Services Administration (2014).

INTRODUCTION

Trauma-informed care cannot be discussed without mentioning social justice. In fact, trauma-informed care is social justice. Imagine someone who is visiting a community clinic complaining of genital discharge. The patient is asked to undress and wait in the room for the health provider. The patient waits for 5 minutes and then starts screaming that they need to be seen. When the community health nurse enters the room to speak to the patient, the patient states that they need to leave now. They cannot wait any longer. The nurse speaks to the patient and discovers that the patient was raped years ago, and this experience is bringing back all those memories. The nurse then realizes they should have completed a trauma assessment before asking the patient to undress. The nurse then speaks with the patient and uses some of the grounding techniques learned in this chapter to get the patient to stay and be seen. A Healthy People 2030 goal is to

increase access to high-quality comprehensive health care services (Office of Disease Prevention and Health Promotion, 2022). Providing every patient with trauma-informed care is a step toward achieving this goal.

TRAUMA

According to the Trauma and Justice Strategic Initiative put forth by the Substance Abuse and Mental Health Services Administration, "Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being" (Menschner & Maul, 2016, p. 2). Trauma can affect people of every race, ethnicity, age, sexual orientation, gender, psychosocial background, and geographic region. Trauma can occur at any age or developmental stage, and often, events that occur outside expected life stages are perceived as traumatic (e.g., a child dying before a parent, cancer as a teen, personal illness, job loss before retirement).

It is not just the event itself that determines whether something is traumatic but also the individual's experience of the event.

A traumatic experience can be a single event, a series of events, and/or a chronic condition (e.g., childhood neglect, domestic violence). Traumas can affect individuals, families, groups, communities, specific cultures, and generations. Trauma overwhelms an individual's or community's resources to cope, and it often ignites the "fight, flight, or freeze'' reaction at the time of the event(s). It frequently produces a sense of fear, vulnerability, and helplessness. Often, traumatic events are unexpected. Individuals may experience the traumatic event directly, witness an event, feel threatened, or hear about an event that affects someone they know. Events may be human made, such as a mechanical error that causes a disaster, war, terrorism, sexual abuse, or violence, or they can be the products of nature (e.g., flooding, hurricanes, tornadoes).

Two people may be exposed to the same event or series of events but experience and interpret these events in vastly different ways. Various biopsychosocial factors influence an individual's immediate response and long-term reactions to trauma. For most, regardless of the severity of the trauma, the immediate or enduring effects of trauma are met with resilience—the ability to rise above the circumstances or to meet the challenges with fortitude. For some people, reactions to a traumatic event are temporary, whereas others have prolonged reactions that move from acute symptoms to more severe, prolonged, or enduring mental health consequences (e.g., posttraumatic stress and other anxiety disorders, substance use, mood disorders) and medical problems (e.g., arthritis, headaches, chronic pain). Others do not meet established criteria for posttraumatic stress or other mental disorders but encounter significant trauma-related symptoms or culturally expressed symptoms of trauma (e.g., somatization, in which psychological stress is expressed through physical concerns). For that reason, even if an individual does not meet the diagnostic criteria for trauma-related disorders, it is important to recognize that trauma may still affect their lives in significant ways.

Sources and Types of Trauma

The following section reviews various forms and types of trauma in no particular order. It does not cover every conceivable trauma that an individual, group, or community may encounter. The intent is to give nurses working in the community setting a broad perspective of the various categories and types of trauma. The classification of trauma as natural or caused by humans can significantly influence how people react to it and what types of assistance are mobilized in its aftermath. See Table 9.1 for a longer listing of trauma examples.

Trauma Caused Naturally	Trauma Caused by People	
	Accidents, Technological Catastrophes	Intentional Acts
Tornado	Train derailment	Arson
Lightning strike	Roofing fall	Terrorism
Wildfire	Structural collapse	Sexual assault and abuse
Avalanche	Mountaineering accident	Homicides or suicides
Physical ailment or disease	Aircraft crash	Mob violence or rioting
Fallen tree	Car accident or malfunction	Physical abuse and neglect
Earthquake	Mine collapse or fire	Stabbing or shooting
Dust storm	Radiation leak	Warfare
Volcanic eruption	Crane collapse	Domestic violence
Blizzard	Gas explosion	Poisoned water supply
Hurricane	Electrolocation	Human trafficking
Cyclone	Machinery-related accident	School violence
Typhoon	Oil spill	Torture
Meteorite	Maritime accident	Home invasion
Flood	Accidental gun shooting	Bank robbery
Tsunami	Sports-related death	Genocide
Epidemic		Medical or food tampering
Famine		
Landslide or fallen boulder		

Table 9.1: Trauma Examples

Trauma from Natural Causes

Natural traumatic experiences can directly affect a small number of people, such as a tree falling on a car during a rainstorm, or many people and communities, as with a hurricane. Natural events, often referred to as "acts of God," are typically unavoidable. Human-caused traumas are caused by human failure (e.g., technological catastrophes, accidents, malevolence) or by human design (e.g., war). Although multiple factors contribute to the severity of a natural or human-caused trauma, traumas perceived as intentionally harmful often make the event more traumatic for people and communities. How survivors of natural trauma respond to the experience often depends on the degree of devastation, the extent of individual and community losses, and the amount of time it takes to reestablish daily routines, activities, and services (such as returning to school or work, being able to do laundry, having products to buy in a local store).

The amount, accessibility, and duration of relief services can significantly influence the duration of traumatic stress reactions and recovery. Alongside the disruption of daily routines, the presence of community members or outsiders in affected areas may add significant stress or create traumatic experiences in and of themselves. It is not just the natural disaster or event that can challenge an individual or community; often, the event's consequences and behavioral responses from others within and outside the community push survivors away from effective coping or toward resilience and recovery.

Trauma Caused by Humans

Human-caused traumas are fundamentally different from natural disasters. They are either intentional, such as a convenience store robbery at gunpoint, or unintentional, such as the technological accident of a bridge collapse that occurred in Pittsburgh, Pennsylvania, on January 28, 2022

(Puskar & Scolforo, 2022). The subsequent reactions to these traumas often depend on their intentionality. However, a person or group of people is typically the target of anger and blame from survivors. Survivors of an unintentionally human-caused traumatic event may feel angry and frustrated because of the lack of protection or care offered by the responsible party or government, particularly if there has been a perceived act of omission. After intentional human-caused acts, survivors often struggle to understand the motives for performing the act, the calculated or random nature of the act, and the psychological makeup of the perpetrator(s).

Trauma Affecting Communities and Cultures

Trauma that affects communities and cultures covers a broad range of violence and atrocities that erode the sense of safety within a given community, including neighborhoods, schools, towns, and reservations. These may involve violence in the form of physical or sexual assaults, hate crimes, robberies, workplace or gang-related violence, threats, shootings, or stabbings—for example, the school shooting at Virginia Polytechnic Institute and State University in 2007. They also include actions that attempt to dismantle systemic cultural practices, resources, and identities, such as making boarding school attendance mandatory for Native American children or placing them in non-Native foster homes. Cultural and/or community-based trauma can also occur via indifference or limited responsiveness to specific communities or cultures that are facing a potential catastrophe. Cultural traumas are events that, whether intentionally or not, erode the heritage of culture—as with prejudice, disenfranchisement, and health inequities (e.g., late prenatal care, inability to afford medications, limited access to culturally appropriate health education, vicinity, and quality of affordable medical services), among other examples.

Characteristics of Trauma

Objective Characteristics of Trauma

Trauma can involve a single event, numerous or repeated events, or sustained/chronic experiences. A single trauma is limited to a single point in time. A rape, an automobile accident, or the sudden death of a loved one, these are examples of a single trauma. Some people who experience a single trauma recover without any specific intervention. But for others—especially those with histories of previous trauma or mental or substance use disorders, or those for whom the trauma experience is particularly horrific or overwhelming—a single trauma can result in traumatic stress symptoms and trauma- and stress-related disorders. Single traumas do not necessarily have a lesser psychological impact than repeated traumas.

Some repeated traumas are sustained or chronic. Sustained trauma experiences tend to wear down resilience and the ability to adapt. Some examples include children who endure ongoing sexual abuse, physical neglect, or emotional abuse; people who are in violent relationships; and people who live in chronic poverty. Individuals in chronically stressful, traumatizing environments are particularly susceptible to traumatic stress reactions, substance use, and mental disorders.

Bidirectional relationships exist between trauma and substance use as well as trauma and mental illness. For example, abuse of alcohol and drugs increases the risk of a traumatic experience and creates greater vulnerability to the effects of trauma; substance use reduces a person's ability to take corrective and remedial actions that might reduce the impact of the trauma. Likewise, traumatic stress leads to a greater likelihood of substance use that, in turn, increases the risk of additional exposure to trauma. Paralleling this bidirectional relationship, mental illness increases vulnerability to the effects of trauma and raises the risk of substance use disorders and

additional traumatic events. So too, early exposure to ACEs (adverse childhood experiences) is associated with traumatic stress reactions and subsequent exposure to trauma in adult years.

Subjective Characteristics of Trauma

An important clinical issue in understanding the impact of trauma is the meaning that the survivor has attached to the traumatic experience. Survivors' unique cognitive interpretations of an event—their beliefs and assumptions—contribute to how they process, react to, cope with, and recover from the trauma. Does the event represent retribution for past deeds committed by the individual or their family? How does the individual attach meaning to their survival? Do they believe it signifies a greater purpose not yet revealed?

People interpret traumatic events in vastly different ways, and many variables shape how an individual assigns meaning to the experience (framing the meaning through culture, family beliefs, prior life experiences and learning, personality and other psychological features, etc.). Even in an event that happens in a household, each family member may interpret the experience differently. Likewise, the same type of event can occur at two different times in a person's life, but the person's interpretation of the events may differ considerably because of developmental differences acquired between events, current cognitive and emotional processing skills, availability of and access to environmental resources, and so forth.

Individual Factors

Several factors influence one's ability to deal with trauma effectively and increase one's risk for traumatic stress reactions. Individual factors pertain to the individual's genetic, biological, and psychological makeup and history because they influence the person's experience, interpretation, and reactions to trauma. However, many factors, not just individual characteristics, influence individual responses to trauma. Failing to recognize that multiple factors, aside from individual attributes and history, influence experiences during and after trauma can lead to blaming the victim for having traumatic stress.

Cultural Meanings of Trauma

It is critical that nurses do not presume to understand the meaning of a traumatic experience without considering the client's cultural context. Culture strongly influences the perceptions of trauma. Similarly, the sudden death of a family member or loved one can be less traumatic in a culture with a strong belief in a positive afterlife. Nurses need to recognize that their perceptions of a specific trauma could differ from those of their clients. Be careful not to judge a client's beliefs in light of your own value system.

Understanding the Impact of Trauma

Trauma-informed care involves a broad understanding of traumatic stress reactions and common responses to trauma. Nurses need to understand how trauma can affect treatment presentation, engagement, and the outcome of health services. Trauma affects everyone differently, including one-time, multiple, or long-lasting repetitive events. Some individuals may display criteria associated with posttraumatic stress disorder (PTSD), but many more individuals will exhibit resilient responses or brief subclinical symptoms or consequences that fall outside of diagnostic criteria. The impact of trauma can be subtle, insidious, or outright destructive. How an event affects an individual depends on many factors, including individual characteristics, the type and characteristics of the event(s), developmental processes, the meaning of the trauma, and sociocultural factors.

Trauma Reactions

A variety of reactions are often reported and/or observed after trauma. Most survivors exhibit immediate reactions, yet these typically resolve without severe long-term consequences. This is because most trauma survivors are highly resilient and develop appropriate coping strategies, including the use of social support, to deal with the aftermath and effects of trauma. Most recover with time, show minimal distress, and function effectively across major life areas and developmental stages. Even so, clients who show little impairment may still have subclinical symptoms or symptoms that do not fit the diagnostic criteria for acute stress disorder (ASD) or PTSD. Only a small percentage of people with a history of trauma show impairment and symptoms that meet the criteria for trauma-related stress disorders, including mood and anxiety disorders. See Table 9.2 for common responses to trauma.

	Immediate Reactions to Trauma	**Delayed Reactions to Trauma**
Emotional	• Numbness and detachment • Anxiety or severe fear • Guilt (including survivor guilt) • Exhilaration as a result of surviving • Anger • Sadness • Helplessness • Feeling unreal; depersonalization (e.g., feeling as if you are watching yourself) • Disorientation • Feeling out of control • Denial • Constriction of feelings • Feeling overwhelmed	• Irritability and/or hostility • Depression • Mood swings, instability • Anxiety (e.g., phobia, generalized anxiety) • Fear of trauma recurrence • Grief reactions • Shame • Feelings of fragility and/or vulnerability • Emotional detachment from anything that requires emotional reactions (e.g., significant and/or family relationships, conversations about self, discussion of traumatic events or reactions to them)
Physical	• Nausea and/or gastrointestinal distress • Sweating or shivering • Faintness • Muscle tremors or uncontrollable shaking • Elevated heartbeat, respiration, and blood pressure • Extreme fatigue or exhaustion • Greater startle responses • Depersonalization	• Sleep disturbances, nightmares • Somatization (e.g., increased focus on and worry about body aches and pains) • Appetite and digestive changes • Lowered resistance to colds and infection • Persistent fatigue • Elevated cortisol levels • Hyperarousal • Long-term health effects including heart, liver, autoimmune, and chronic obstructive pulmonary disease
Cognitive	• Difficulty concentrating • Rumination or racing thoughts (e.g., replaying the traumatic event over and over again) • Distortion of time and space (e.g., traumatic event may be perceived as if it was happening in slow motion, or a few seconds can be perceived as a minutes) • Memory problems (e.g., not being able to recall important aspects of the trauma) • Strong identification with victims	• Intrusive memories or flashbacks • Reactivation of previous traumatic events • Self-blame • Preoccupation with event • Difficulty making decisions • Magical thinking: belief that certain behaviors, including avoidant behavior, will protect against future trauma • Belief that feelings or memories are dangerous • Generalization of triggers (e.g., a person who experiences a home invasion during the day may avoid being alone during the day) • Suicidal thinking

	Immediate Reactions to Trauma	Delayed Reactions to Trauma
Behavioral	• Startled reaction • Restlessness • Sleep and appetite disturbances • Difficulty expressing oneself • Argumentative behavior • Increased use of alcohol, drugs, and tobacco • Withdrawal and apathy • Avoidant behaviors	• Avoidance of event reminders • Social relationship disturbances • Decreased activity level • Engagement in high-risk activities • Increased use of alcohol and drugs • Withdrawal
Existential	• Intense use of prayer • Restoration of faith in the goodness of others (e.g., receiving help from others) • Loss of self-efficacy • Despair about humanity, particularly if the event was intentional • Immediate disruption of life assumptions (e.g., fairness, safety, goodness, predictability of life)	• Questioning (e.g., "Why me?") • Increased cynicism, disillusionment • Increased self-confidence (e.g., "If I can survive this, I can survive anything.") • Loss of purpose • Renewed faith • Hopelessness • Reestablishing priorities • Redefining meaning and importance of life • Reworking life's assumptions to accommodate the trauma (e.g., taking a self-defense class to reestablish a sense of safety)

Table 9.2: Common Experiences and Responses to Trauma (Adapted from Briere & Scott 2006; Foa et al., 2006; Pietrzak et al., 2011)

TRAUMA-INFORMED CARE

Screening and Assessment

Screening

Screening begins by determining whether the person has a history of trauma and whether the person has trauma-related symptoms. Screening obtains answers to "yes" or "no" questions: "Has this client experienced a trauma in the past?" and "Does this client at this time warrant further assessment regarding trauma-related symptoms?" If someone acknowledges a trauma history, then further screening is necessary to determine whether trauma-related symptoms are present. However, the presence of such symptoms does not necessarily say anything about their severity, nor does a positive screen indicate that a disorder exists. Positive screens indicate only that assessment or further evaluation is warranted, and negative screens do not necessarily mean that an individual does not have symptoms that warrant intervention.

Figure 9.1: A Trauma-Informed Approach

Screening procedures should always define the steps to take after a positive or negative screening. That is, the screening process establishes precisely how to score responses to screening tools or questions and clearly defines what constitutes a positive score (called a "cutoff score") for a

particular potential problem. The screening procedures detail the actions to take after a client scores in the positive range. Clinical supervision is helpful—and sometimes necessary—in judging how to proceed. Trauma-informed screening is essential to the intake evaluation and treatment planning process, but it is not an end in itself. Screening processes can be developed that allow staff without advanced degrees or graduate-level training to conduct them, whereas assessments for trauma-related disorders require a mental health professional trained in assessment and evaluation processes.

The most important domains to screen among individuals with trauma histories include these:

- Trauma-related symptoms
- Depressive or dissociative symptoms, sleep disturbances, and intrusive experiences
- Past and present mental disorders, including typically trauma-related disorders (e.g., mood disorders)
- Severity or characteristics of a specific trauma type (e.g., forms of interpersonal violence, adverse childhood events, combat experiences)
- Substance use
- Social support and coping styles
- Availability of resources
- Risks for self-harm, suicide, and violence
- Health screenings

Assessment

When a client has substance use disorder, trauma-related symptoms, or mental disorders, the agency or counselor should follow up with an assessment. A positive screening calls for more action—an assessment that determines and defines presenting struggles to develop an appropriate treatment plan and to make an informed and collaborative decision about treatment placement. The assessment determines the nature and extent of the client's problems; it might require the client to respond to written questions, or it could involve a clinical interview by mental health or substance use professionals qualified to assess the client and arrive at a diagnosis. A clinical assessment delves into a client's past and current experiences, psychosocial and cultural history, and assets and resources. Assessment protocols can require more than a single session to complete and should also use multiple avenues to obtain the necessary clinical information, including self-assessment tools, past and present clinical and medical records, structured clinical interviews, assessment measures, and collateral information from significant others, other health professionals, and agencies.

Qualifications for conducting assessments and clinical interviews are more rigorous than for screening. Advanced degrees, licensing or certification, and special training in administration, scoring, and interpretation of specific assessment instruments and interviews are often required. For people with histories of traumatic life events who screen positive for possible trauma-related symptoms and disorders, a thorough assessment gathers all relevant information necessary to understand the role of the trauma in their lives; appropriate treatment objectives, goals, planning, and placement; and any ongoing diagnostic and treatment considerations, including reevaluation or follow-up. Overall, the assessment may indicate symptoms that meet diagnostic criteria for a substance use or mental disorder or a milder form of symptomatology that does not reach a diagnostic level, or it may reveal that the positive screen was false and that there is no significant cause for concern.

Information from an assessment is used to plan the client's treatment. The plan can include such domains as a level of care, acute safety needs, diagnosis, disability, strengths and skills, support network, and cultural context. Assessments should recur throughout treatment. Ongoing assessment during treatment can provide valuable information by revealing further details of trauma history as clients' trust in staff members grows and by gauging clients' progress.

Strategies for Screeening and Assessments

The success of treatment can be enhanced by paying careful attention to the approach to the screening and assessment process by using the following strategies:

- Clarify to the client what to expect in the screening and assessment process
- Approach the client in a matter-of-fact and supportive manner
- Respect the client's personal space
- Adjust tone and speech volume to suit the client's level of engagement and comfort in the interview process
- Provide culturally appropriate symbols of safety in the physical environment
- Be aware of one's own emotional responses to hearing clients' trauma histories
- Overcome linguistic barriers via an interpreter
- Elicit only the information necessary for determining a history of trauma and the possible existence and extent of traumatic stress symptoms and related disorders
- Use self-administered, written checklists rather than interviews (when possible) to assess trauma
- Interview the client if they have trouble reading or writing or cannot complete a checklist
- Allow time for the client to become calm and oriented to the present if the client has very intense emotional responses when recalling or acknowledging a trauma
- Avoid phrases that imply a judgment about the trauma
- Provide feedback about the results of the screening
- Be aware of the possible legal implications of assessment

Barriers to Screening and Assessment

Without screening, it is not necessarily easy or obvious to identify an individual who has survived trauma. Moreover, some clients may deny that they have encountered trauma and its effects even after being screened or asked direct questions to identify the occurrence of traumatic events.

The two main barriers to evaluating trauma and its related disorders in health care settings are clients not reporting trauma and nurses and other health care providers overlooking trauma and its effects. Concerning the first main barrier, some events affect the person's responses to them and the meanings they attach to the event. Certain situations make it more likely the event will be experienced as traumatic by one person but considered nontraumatic by another. A history of trauma encompasses the experience of a potentially traumatic event and the likelihood that the client will not be forthcoming about traumatic events or their responses to those events. Some clients might not have ever thought of a particular event or their response to it as traumatic and thus might not report or even recall the event. Some clients might be reluctant to discuss something that they sense might bring up uncomfortable feelings (especially with a counselor they have met only recently). Clients may avoid openly discussing traumatic events or have difficulty

recognizing or articulating their experience of trauma for other reasons, such as feelings of shame, guilt, or fear of retribution by others associated with the event (e.g., in cases of interpersonal or domestic violence). Others may deny their history because they are tired of being interviewed or asked to fill out forms and may believe it does not matter anyway.

Managing Trauma

Grounding Techniques

Grounding techniques are important skills for assessors and all other behavioral health service providers who interact with traumatized clients (e.g., nurses, security, administrators, clinicians). Even if you do not directly conduct therapy, knowledge of grounding can help defuse an escalating situation or calm a client who is triggered by the assessment process. Grounding strategies help a person who is overwhelmed by memories or strong emotions or is dissociating; they help the person become aware of the here and now. A useful metaphor is an experience of walking out of a movie theater. When the person dissociates or has a flashback, it's like watching a mental movie; grounding techniques help the person step out of the movie theater into the daylight and the present environment. The client's task is not only to hold on to moments from the past but also to acknowledge that what they were experiencing is from the past. Try the following techniques (Melnick & Bassuk, 2000):

1. Ask the client to state what they observe.

   Guide the client through this exercise by using statements like these: "You seem to feel very scared/angry right now. You're probably feeling things related to what happened in the past. Now, you're in a safe situation. Let's try to stay in the present. Take a slow deep breath, relax your shoulders, and put your feet on the floor; let's talk about what day and time it is, notice what's on the wall, . . . What else can you do to feel okay in your body right now?"

2. Help the client decrease the intensity of the effect.

   "Emotion dial": A client imagines turning down the volume on their emotions. Clenching fists can move the energy of emotion into fists, which the client can then release. Guided imagery can be used to visualize a safe place.

   Distraction (see Item 3, next). Use strengths-based questions (e.g., "How did you survive?" or "What strengths did you possess to survive the trauma?").

3. Distract the client from unbearable emotional states.

   Have the client focus on the external environment (e.g., naming red objects in the room).

   Ask the client to focus on recent and future events (e.g., "to do" list for the day). Help the client use self-talk to remind themself of current safety. Use distractions, such as counting, to return the focus to current reality. Somatosensory techniques (e.g., toe-wiggling, touching a chair) can remind clients of current reality.

4. Ask the client to use breathing techniques.

   Ask the client to inhale through the nose and exhale through the mouth. Have the client place their hands on their abdomen and then watch the hands go up and down while the belly expands and contracts.

Psychoeducation

Trauma-informed education informs clients about traumatic stress and trauma-related symptoms and disorders and the consequences of trauma exposure. It focuses on giving information to clients to help normalize presenting symptoms, highlighting potential short- and long-term consequences of trauma and various paths to recovery, and underscoring the message that recovery is possible. Education frequently takes place before or immediately following an initial screening as a way to prepare clients for hearing results or to place the screening and subsequent assessment findings in the proper context.

However, education does not necessarily constitute a stand-alone treatment; rather, it can be conceptualized as a first step and/or component of a more comprehensive treatment. Nonetheless, education may be a prevention and intervention strategy for individuals with histories of trauma without current consequences or symptoms and/or those who have reported a resolution of past trauma(s). For example, some clients may have significantly delayed onset of traumatic stress symptoms. In this scenario, earlier education can enhance the recognition of symptoms and ease the path to seeking treatment. Some clients do not recognize the link between their current difficulties and their trauma histories; education can help them understand the possible origin of their difficulties.

Psychoeducation presents trauma-related symptoms that follow a trauma as normal reactions. Identifying the source of clients' current difficulties and framing them as normal thoughts, emotions, and behaviors in response to trauma helps trauma survivors. Many report a reduction in the intensity of the difficulties or symptoms. Often, a client will express relief that their reactions are normal. The U.S. Department of Veterans Affairs National Center's PTSD educational handouts on traumatic stress reactions may be useful here. Psychoeducation goes beyond identifying traumatic stress symptoms and/or learning about trauma's psychological, cognitive, and physical impacts. Numerous curricula are available that use psychoeducation as a first-line or complementary approach to trauma-specific therapies to enhance coping strategies in key areas, including safety, emotional regulation, help-seeking, avoidant behavior, and so forth. An example is S.E.L.F., a trauma-informed psychoeducational group curriculum with educational components related to trauma recovery in the following areas: creating Safety, regulating Emotions, addressing Loss, and redefining the Future (Bloom et al., 2021).

Normalize Symptoms

Symptoms of trauma can become serious barriers to recovery from substance use and mental disorders, including trauma-related ones. Counselors should know how trauma symptoms can present and how to respond to them when they do appear. A significant step in addressing symptoms is normalizing them. People with traumatic stress symptoms need to know that their symptoms are not unique and that their reactions are common to their experience(s). Often, normalizing symptoms gives considerable relief to clients who may have thought that their symptoms signified some pervasive, untreatable mental disorder.

Identify Triggers and Trauma

Many clients who have traumatic stress are caught off guard by intrusive thoughts, feelings, sensations, or environmental cues of the trauma. This experience can be quite disconcerting, but often, the individual does not draw an immediate connection between the internal or external trigger and their reactions. At other times, the trigger is so potent that the individual is unable to discern the present trigger from the past trauma and begins to respond as if the trauma is

reoccurring. A key step in identifying triggers is to reflect on the situation, surroundings, or sensations before the strong reaction. This step may enable the connections among these cues, the past trauma(s), and the client's reaction to be determined. Once the cue is identified, the next step is to discuss how it is connected to past trauma. For some cues, there will be an obvious and immediate connection (e.g., having someone say "I love you" in a significant relationship as an adult and connecting this to an abuser who said the same thing before a sexual assault). Other cues will not be as obvious. With practice, the client can begin to track back through what occurred immediately before an emotional, physical, or behavioral reaction and then examine how that experience reminds them of their past.

Teach Balance

A thin line is walked when addressing trauma. On the one hand, too much work focused on highly distressing content can turn a desensitization process into a session whereby the client dissociates, shuts down, or becomes emotionally overwhelmed. On the other hand, too little focus by the client or counselor can easily reinforce avoidance and confirm the client's internal belief that it is too dangerous to deal with the aftermath of the trauma.

Several trauma-specific theories offer guidelines on acceptable levels of distress associated with the traumatic content that the therapy addresses. For example, some traditional desensitization processes start at an incredibly low level of subjective distress, gradually working up through a hierarchy of trauma memories and experiences until those experiences produce minimal reactions when paired with some coping strategy, such as relaxation training. Other desensitization processes start at a higher level of intensity to provide more rapid extinction of traumatic associations and to decrease the risk of avoidance—a behavior that reinforces traumatic stress.

Working with trauma is a delicate balancing act between the development and/or use of coping strategies and the need to process the traumatic experiences. Individuals will choose different paths to recovery; it is a myth that every traumatic experience needs to be expressed and every story told. For some individuals, the use of coping skills, support, and spirituality are enough to recover. Regardless of theoretical beliefs, counselors must teach coping strategies as soon as possible. Retraumatization is a risk whenever clients are exposed to their traumatic histories without sufficient tools, support, and safety to manage emotional, behavioral, and physical reactions.

Retraumatization

Retraumatization occurs when clients experience something that makes them feel as though they are undergoing another trauma, as was illustrated in the example at the beginning of this chapter. Unfortunately, treatment settings and clinicians can create retraumatizing experiences, often without being aware of it. Sometimes clients themselves are not consciously aware that a clinical situation has triggered a traumatic stress reaction. Agencies that anticipate the risk for retraumatization and actively work on adjusting program policies and procedures to remain sensitive to the histories and needs of individuals who have undergone past trauma are likely to succeed in providing care, retaining clients, and achieving positive outcomes. A number of staff and agency issues can cause retraumatization:

- Being unaware that the client's traumatic history significantly affects their life
- Failing to screen for trauma history prior to treatment planning

- Challenging or discounting reports of abuse or other traumatic events
- Using isolation or physical restraints
- Using experiential exercises that humiliate the individual
- Endorsing a confrontational approach in counseling
- Allowing the abusive behavior of one client toward another to continue without intervention
- Labeling behavior and/or feelings as pathological
- Failing to provide adequate security and safety within the program
- Limiting the participation of the client in treatment decisions and planning processes
- Minimizing, discrediting, or ignoring client responses
- Disrupting counselor–client relationships by changing counselors' schedules and assignments
- Obtaining urine specimens in a nonprivate setting
- Having clients undress in the presence of others
- Inconsistently enforcing rules and allowing chaos in the treatment environment
- Imposing agency policies or rules without exceptions or an opportunity for clients to question them
- Enforcing new restrictions within the program without staff–client communication
- Limiting access to services for ethnically diverse populations
- Accepting agency dysfunction, including lack of consistent, competent leadership

THE NURSE'S ROLE IN TRAUMA-INFORMED CARE

Many individuals who seek care in community settings have histories of trauma, but they often do not recognize the significant effects of trauma in their lives; either they do not draw connections between their trauma histories and their presenting problems or they avoid the topic altogether. Likewise, community health nurses may not ask questions that elicit a client's history of trauma, may feel unprepared to address trauma-related issues proactively, or may struggle to address traumatic stress effectively within the constraints of their treatment program, the program's clinical orientation, or their agency's directives. By recognizing that traumatic experiences tie closely into behavioral health problems, nurses and community-based programs can begin to build a trauma-informed environment across the continuum of care. Key steps include meeting client needs in a safe, collaborative, and compassionate manner; believing what the patient says about their experience; preventing treatment practices that retraumatize people with histories of trauma who are seeking help or receiving services; building on the strengths and resilience of clients in the context of their environments and communities; and endorsing trauma-informed principles in agencies through support, consultation, and supervision of staff.

PRACTICE APPLICATION

➔ Setting the Scene

Stressful time often denotes being bombarded with many things at one time, perceived or actual, without sufficient time or ability to address them emotionally, cognitively, spiritually, and/or physically. The same goes for trauma: rapid exposure to numerous traumas one after another lessens one's ability to process the event before the next onslaught. This creates a cumulative effect, making it more difficult to heal from any singular trauma.

➔ Think About It

Imagine an event that was particularly stressful (but not traumatic) in your life. Revisit this period as an observer watching the events unfold.

1. What made this event particularly stressful? Was it difficult to manage one situation before another circumstance came along demanding your time?
2. How did you process the event? What were the resources you used? Did you learn anything from processing it?
3. Are there any tools you'd use to process similar situations moving forward?
4. Suppose in your work area you were exposed to multiple poor patient outcomes over several days.
   a. How do you think this situation might affect you and your role as a nurse?
   b. Would you be able to use some of these same resources that you used to process your stressful event? Why or why not?

ADDITIONAL RESOURCES

ACEs Aware - Trauma-Informed Care

Center for Health Care Strategies - Key Ingredients for Successful Trauma-Informed Care Implementation [brief]

The National Child Traumatic Stress Network - Trauma-Informed Care

Virginia Department of Behavioral Health and Developmental Services - Trauma Informed Care

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UNIT TWO:

Current Challenges and Community Issues

Chapter Ten: Mental Health

OVERVIEW

Individuals in the community who have a mental illness frequently experience stigma, marginalization, lack of support, and few treatment options.

LEARNING OBJECTIVES

- Define characteristics of mental health disorders
- Understand specific mental health illnesses frequently found in the community
- Identify factors affecting mental health
- Discuss strategies for improving mental health

KEY TERMS

- anxiety
- depression
- bipolar
- schizophrenia
- suicide

Content for this chapter was adapted from "Mental Health" from the Centers for Disease Control and Prevention (2021).

INTRODUCTION

A mental illness can be defined as a health condition that changes a person's thinking, feelings, or behavior (or all three) and causes the person distress and difficulty in functioning. Mental illness can be mild or severe. Individuals with a mental illness do not necessarily look sick, especially if their illness is mild.

Other individuals may show more explicit symptoms such as confusion, agitation, or withdrawal. Even if you or a family member has not experienced mental illness directly, you likely know someone who has. Estimates are that at least one in four people is directly or indirectly affected by mental illness (National Institutes of Health [NIH], 2007). Consider the following statistics to get an idea of just how widespread the effects of mental illness are in society:

- More than 50% of Americans will be diagnosed with a mental illness or disorder at some point in their lifetime.
- One in five Americans will experience a mental illness in a given year.
- One in five children, either currently or at some point during their life, has had a seriously debilitating mental illness.
- One in 25 Americans lives with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression. (Centers for Disease Control and Prevention [CDC], 2021)

Nurses need to understand the complexities of mental health to recognize, identify, and take care of those at risk.

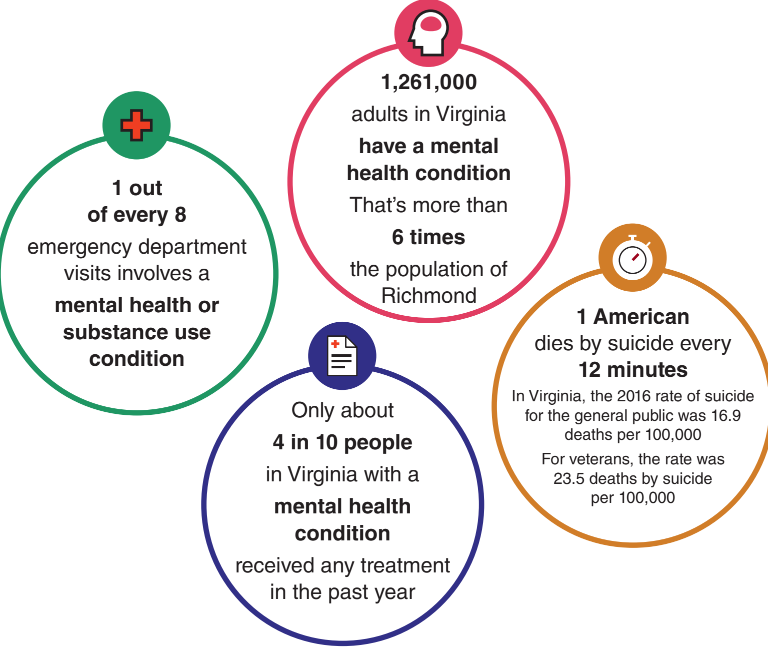

Figure 10.1: Mental Health Statistics

SPECIFIC MENTAL ILLNESS DISORDERS

This section provides an overview of select common mental illness disorders that you may encounter as a nurse. The list is not exhaustive. The National Alliance on Mental Illness provides information on additional disorders, including overviews, possible treatments, and examples of how to support yourself and others with mental illnesses.

Anxiety Disorders

Occasional anxiety is a normal part of life. Many people worry about things such as health, money, or family problems, but anxiety disorders involve more than temporary worry or fear. For people with an anxiety disorder, the anxiety does not go away and can get worse over time. The symptoms can interfere with daily activities such as job performance, schoolwork, and relationships (NIH, 2022). Anxiety disorders are a common mental health problem. Research indicates 19% of adults and 31% of adolescents have an anxiety disorder in the United States (NIH, n.d.). The percentage of adults with an anxiety disorder associated with various levels of anxiety are estimated as mild (43%), moderate (33%), and severe (23%). There are several types of anxiety-related disorders, including generalized anxiety disorder, social anxiety disorder, panic disorder, and phobia-related disorders (Open RN, 2022b).

Generalized Anxiety Disorder

Generalized anxiety disorder (GAD) involves a persistent feeling of anxiety or dread, which can interfere with daily life. It is different from occasionally worrying about things or experiencing anxiety resulting from stressful life events. The *DSM-5* defines *GAD* as "excessive anxiety, and worry, occurring on more days than not for at least six months, about a number of events or

activities such as school or work" (First and Compton, 2022a). People living with GAD experience frequent anxiety for months, if not years.

A person with GAD experiences at least three of the following symptoms:

- Feeling restless, wound up, or on edge
- Being easily fatigued
- Having difficulty concentrating
- Being irritable
- Having headaches, muscle aches, stomachaches, or unexplained pains
- Having difficulty controlling feelings of worry
- Having sleep problems, such as difficulty falling or staying asleep (NIH, 2022)

Panic Disorder

People with panic disorder have frequent and unexpected panic attacks. Panic attacks are sudden periods of intense fear, discomfort, or a sense of losing control even when there is no clear danger or trigger. Not everyone who experiences a panic attack will develop panic disorder (NIH, 2022).

The *DSM-5* defines a panic attack as when a person experiences four or more of the following symptoms:

- Pounding or racing heart
- Sweating
- Trembling or tingling
- Chest pain
- Feelings of impending doom
- Feelings of being out of control (American Psychiatric Association, 2013)

According to the *DSM-5*, to be diagnosed with a panic disorder, at least one of the panic attacks is followed by 1 month (or more) of one or both of the following characteristics:

- Persistent concern or worry about additional panic attacks or their consequences
- A significant maladaptive change in behavior related to the attacks (such as avoiding unfamiliar situations; American Psychiatric Association, 2013)

People with panic disorder often worry about when the next attack will happen and actively try to prevent future attacks by avoiding places, situations, or behaviors they associate with panic attacks. Panic attacks can occur as frequently as several times a day or as rarely as a few times a year (NIH, 2022).

Social Anxiety Disorder

Social anxiety disorder is an intense, persistent fear of being watched and judged by others. For people with social anxiety disorder, the fear of social situations may feel so intense that it seems beyond their control. For some people, this fear may get in the way of going to work, attending school, or doing everyday things (NIH, 2022). The *DSM-5* defines social anxiety as marked fear or anxiety about one or more social situations in which an individual is exposed to possible scrutiny by others (American Psychiatric Association, 2013).

People with a social anxiety disorder may experience the following symptoms:

- Blushing, sweating, or trembling
- Pounding or racing heart
- Stomachaches
- Rigid body posture or speaking with an overly soft voice
- Difficulty making eye contact or being around people they do not know
- Feelings of self-consciousness or fear that people will judge them negatively (NIH, 2022)

Phobia-Related Disorders

A phobia is an intense fear of—or aversion to—specific objects or situations. Although it can be realistic to be anxious in some circumstances, the fear people with phobias feel is out of proportion to the actual danger caused by the situation or object.

People with a phobia:

- May have an irrational or excessive worry about encountering the feared object or situation
- Take active steps to avoid the feared object or situation
- Experience immediate, intense anxiety upon encountering the feared object or situation
- Endure unavoidable objects and situations with intense anxiety (NIH, n.d., 2022)

Three common phobias are social anxiety disorder, discussed in the preceding section, agoraphobia, and separation anxiety disorder. Social anxiety disorder is a type of phobia marked by fear, anxiety, or avoidance that is persistent and typically lasts for 6 months or more. It results in clinically significant impairment in social, occupational, or other important areas of functioning. For someone with a phobia, certain places, events, or objects create powerful reactions of intense, irrational fear, which can lead to panic. Depending on the type and number of triggers, attempts to control fear can take over a person's life.

Agoraphobia

The *DSM-5* defines agoraphobia as an intense fear in two or more of the following situations:

- Using public transportation
- Being in open spaces
- Being in enclosed spaces
- Standing in line or being in a crowd
- Being outside the home alone (First & Compton, 2022)

People with agoraphobia often avoid these situations, in part because they think being able to leave might be difficult or impossible in the event they have paniclike reactions or other embarrassing symptoms. In the most severe form of agoraphobia, an individual can become housebound (NIH, 2022).

Separation Anxiety Disorder

Separation anxiety is often thought of as something that only children deal with. However, adults can also be diagnosed with separation anxiety disorder. People with separation anxiety disorder

have fears about being separated from the people they are attached to. They often worry that some sort of harm or something untoward will happen to their attachment figures while they are separated. This fear leads them to avoid being separated from their attachment figures and to avoid being alone (NIH, 2022). The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and typically 6 months or more in adults, causing significant distress or impairment to social, occupational, or other important areas of functioning (American Psychiatric Association, 2013). People with separation anxiety may have nightmares about being separated from attachment figures or experience physical symptoms when separation occurs or is anticipated (NIH, 2022).

Posttraumatic Stress Disorder

Posttraumatic stress disorder (PTSD) is a disorder that develops in some people who have experienced a shocking, scary, or dangerous event (NIH, 2019).

It is natural to feel afraid during and after a traumatic situation. Fear triggers many split-second changes in the body to help defend against danger or to avoid it. This "fight-or-flight" response is a typical reaction meant to protect a person from harm. Nearly everyone will experience a range of reactions after trauma, yet most people recover from initial symptoms naturally. Those who continue to experience problems may be diagnosed with PTSD. People who have PTSD may feel stressed or frightened, even when they are not in danger (NIH, 2019).

While most traumatized people experience short-term symptoms, the majority do not develop ongoing (chronic) PTSD. Events that may later lead to PTSD can be violent or nonviolent. For example, experiences like the sudden, unexpected death of a loved one can cause PTSD. Symptoms usually begin early, within 3 months of the traumatic incident, but sometimes they begin years afterward. Symptoms must last more than a month and be severe enough to interfere with relationships or work to be considered PTSD. The course of the illness varies. Some people recover within 6 months, whereas others have symptoms that last much longer. In some people, the condition becomes chronic (NIH, 2019).

Figure 10.2: Signs and Symptoms of PTSD

To be diagnosed with PTSD, an adult must have all the following for at least 1 month:

- At least one reexperiencing symptom
- At least one avoidance symptom
- At least two arousal and reactivity symptoms
- At least two cognition and mood symptoms

Reexperiencing symptoms include:

- Flashbacks—reliving the trauma over and over, including physical symptoms like a racing heart or sweating
- Bad dreams
- Frightening thoughts

Reexperiencing symptoms may cause problems in a person's everyday routine. The symptoms can start from the person's thoughts and feelings. Words, objects, or situations that are reminders of the traumatic event can also trigger reexperiencing symptoms.

Avoidance symptoms include:

- Staying away from places, events, or objects that are reminders of the traumatic experience
- Avoiding thoughts or feelings related to the traumatic event

Things that remind a person of the traumatic event can trigger avoidance symptoms. These symptoms may cause a person to change their routine. For example, after a bad car accident, a person who usually drives may avoid driving or riding in a car.

Arousal and reactivity symptoms include:

- Being easily startled
- Feeling tense or on edge
- Having difficulty sleeping
- Having angry outbursts

Arousal symptoms are usually constant, instead of being triggered by things that remind the person of the traumatic events. These symptoms can make the person feel stressed and angry. They may make it hard to do daily tasks, such as sleeping, eating, or concentrating.

Cognition and mood symptoms include:

- Trouble remembering key features of the traumatic event
- Negative thoughts about oneself or the world
- Distorted feelings like guilt or blame
- Loss of interest in enjoyable activities

Cognition and mood symptoms can begin or worsen after the traumatic event but are not the result of injury or substance use. These symptoms can make the person feel alienated or detached from friends or family members.

It is natural to have some of these symptoms for a few weeks after a dangerous event. When the symptoms last more than a month, seriously affect one's ability to function, and are not attributable to substance use, medical illness, or anything except the event itself, they might be

indicators of PTSD. Some people with PTSD do not show any symptoms for weeks or months. Often, PTSD is accompanied by depression, substance abuse, or one or more of the other anxiety disorders (NIH, 2019).

Depression

Depression is more than just feeling down or having a bad day. When a sad mood lasts for a long time and interferes with everyday functioning, the likely cause is depression. Depression can become a serious health condition that affects all aspects of daily life. Symptoms of depression include:

- Feeling sad or anxious often or all the time
- Not wanting to do activities that used to be fun
- Feeling irritable, easily frustrated, or restless
- Having trouble falling asleep or staying asleep
- Waking up too early or sleeping too much
- Eating more or less than usual or having no appetite
- Experiencing aches, pains, headaches, or stomach problems that do not improve with treatment
- Having trouble concentrating, remembering details, or making decisions
- Feeling tired, even after sleeping well
- Feeling guilty, worthless, or helpless
- Thinking about suicide or self-harm

The exact cause of depression is unknown. It may be caused by a combination of genetic, biological, environmental, and psychological factors. Everyone is different, but the following factors may increase a person's chances of becoming depressed:

- Having blood relatives who have had depression
- Experiencing traumatic or stressful events, such as physical or sexual abuse, the death of a loved one, or financial problems
- Going through a major life change, even if it was planned
- Having a medical diagnosis, such as cancer, stroke, or chronic pain
- Taking certain medications
- Using alcohol or drugs

In general, about one out of every six adults will have depression at some time in their life. Depression affects about 16 million American adults every year. Anyone can get depressed, and depression can happen at any age and in any type of person.

Many people who experience depression also have other mental health conditions. Anxiety disorders often go hand in hand with depression. People who have anxiety disorders struggle with intense and uncontrollable feelings of anxiety, fear, worry, and/or panic. These feelings can interfere with daily activities and may last for a long time (CDC, 2022).

According to the *The Diagnostic and Statistical Manual of Mental Disorders (DSM-5),* criteria for Major Depressive Disorder includes the patient experiencing five or more of the following symptoms for a the same 2-week period and represent a change from previous functioning:

- Continual depressed mood
- Markedly diminished interest or pleasure in all, or almost all, activities.
- Significant weight loss when not dieting or weight gain or decrease or increase in appetite
- Insomnia or hypersomnia
- Psychomotor agitation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional)
- Diminished ability to think or concentrate, or indecisiveness,
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

These symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning and are not attributable to the physiological effects of a substance or another medical condition.

According to the *DSM-5*, the types of depressive disorders include the following:

- Major Depressive Disorder: Five or more symptoms are present during the same 2-week period and represent a change from previous functioning and at least one of the symptoms is depressed mood or loss of interest or pleasure.
- Specifiers may be attached to the diagnosis such as:
  - With anxious distress (tense and/or restless)
  - With mixed features (manic symptoms)
  - With psychotic features (delusions and/or hallucinations)
  - With peripartum onset (includes perinatal and postpartum depression)
  - With a seasonal pattern (includes seasonal affective disorder)
- Persistent Depressive Disorder (Dysthymia): Depressed mood for most of the day for at least 2 years.
- Premenstrual Dysphoric Disorder: In the majority of menstrual cycles, at least five symptoms are present in the week before the onset of menses, start to improve after the onset of menses, and become minimal or absent in the week postmenses.
- Substance/Medication-Induced Depressive Disorder: A persistent disturbance in mood that develops during or soon after substance intoxication or during withdrawal from a substance.
- Depressive Disorder Due to Another Medical Condition: A persistent period of depressed mood that is the direct consequence of another medical condition. (Open RN, 2022b)

Bipolar Disorder

Manic Episodes

Bipolar disorders include shifts in mood from abnormal highs (called manic episodes) to abnormal lows (i.e., depressive episodes). A manic episode is a persistently elevated or irritable mood with abnormally increased energy lasting at least 1 week. The severe mood disturbance causes marked impairment in social or occupational function. Severe episodes often require hospitalization to prevent harm to self or others. As the manic episode intensifies, the individual may become psychotic with hallucinations, delusions, and disturbed thoughts. The episode is not caused by the physiological effects of a substance (such as drug abuse, prescribed medication, or other treatment) or another medical condition (Open RN, 2022a).

According to the *DSM-5*, three or more of the following symptoms are present during a manic episode:

- Inflated self-esteem or grandiosity
- Decreased need for sleep (i.e., feels rested after only 3 hours of sleep)
- More talkative than usual or pressure to keep talking
- Flight of ideas or subjective experience that thoughts are racing
- Distractibility (i.e., attention is too easily drawn to unimportant or irrelevant stimuli)
- Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
- Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

People experiencing manic episodes may become physically exhausted. Depressive episodes associated with bipolar disorder can lead to suicide. The mortality ratio attributable to suicide for people with bipolar disorder is 20 times above the general population rate and exceeds rates for other mental health disorders.

Hypomanic episodes have similar symptoms to manic episodes but are less severe and do not cause significant impairment in social or occupational functioning or require hospitalization.

Types of Bipolar Disorders

There are three major types of bipolar and related disorders: Bipolar I, Bipolar II, and Cyclothymia.

Bipolar I

Bipolar I disorder is the most severe bipolar disorder. Individuals with Bipolar 1 disorder have had at least one manic episode and often experience additional hypomanic and depressive episodes. One manic episode in the course of an individual's life can change an individual's diagnosis from depression to bipolar disorder. Manic episodes last at least 1 week and present for most of the day, nearly every day. They can be so severe that the person requires hospitalization. Depressive episodes typically last at least 2 weeks. Episodes of depression with mixed features (having depressive symptoms and manic symptoms at the same time) are also possible.

Bipolar II

Bipolar II disorder is defined by a pattern of depressive episodes and hypomanic episodes, but individuals have never experienced a full-blown manic episode typical of Bipolar I disorder. Individuals with Bipolar II disorder often have higher productivity when they are hypomanic and may exhibit increased irritability.

Cyclothymia

Cyclothymia is defined by periods of hypomanic symptoms and depressive symptoms lasting for at least 2 years (1 year in children and adolescents). However, the symptoms do not meet the diagnostic requirements for hypomanic episodes or depressive episodes. Individuals with cyclothymia do not experience the same severity or impairment in functioning as seen in individuals with bipolar disorder. Individuals with cyclothymia are often able to maintain work and personal relationships.

Some people with Bipolar I or Bipolar II disorders experience rapid cycling with at least four mood change episodes in a 12-month period. These mood episodes can be manic, hypomanic, or major depressive episodes. Cycling can also occur within a month or even a 24-hour period. Rapid cycling is associated with severe symptoms and poorer functioning and is more difficult to treat (Open RN, 2022a).

Schizophrenia

Schizophrenia is a serious mental illness that affects how a person thinks, feels, and behaves. People with schizophrenia may seem as if they have lost touch with reality, which can be distressing for them and their family and friends. The symptoms of schizophrenia can make it difficult to participate in usual, everyday activities, but effective treatments are available. Many people who receive treatment can engage in school or work, achieve independence, and enjoy personal relationships (NIH, 2023).

It is important to recognize the symptoms of schizophrenia, with the intervention being critical to stabilization. People with schizophrenia are usually diagnosed between the ages of 16 and 30, after the first episode of psychosis. The condition is rare in children under age 16. Starting treatment as soon as possible following the first episode of psychosis is an important step toward recovery. However, research shows that gradual changes in thinking, mood, and social functioning often appear before the first episode of psychosis (NIH, 2023).

Schizophrenia symptoms can differ from person to person, but they generally fall into three main categories: psychotic, negative, and cognitive.

Psychotic symptoms include changes in the way a person thinks, acts, and experiences the world. People with psychotic symptoms may lose a shared sense of reality with others and experience the world in a distorted way. For some people, these symptoms come and go. For others, the symptoms become stable over time. Psychotic symptoms include:

- **Hallucinations:** When a person sees, hears, smells, tastes, or feels things that are not there. Hearing voices is common for people with schizophrenia. People who hear voices may hear them for a long time before family or friends notice a problem.
- **Delusions:** When a person has strong beliefs that are not true and may seem irrational to others. For example, individuals experiencing delusions may believe that people on the radio and television are sending special messages that require a certain response, or they may believe that they are in danger or that others are trying to hurt them.

- **Thought disorder:** When a person has ways of thinking that are unusual or illogical. People with thought disorders may have trouble organizing their thoughts and speech. Sometimes a person will stop talking in the middle of a thought, jump from topic to topic, or create words that have no meaning.
- **Movement disorder:** When a person exhibits abnormal body movements. People with a movement disorder may repeat certain motions over and over.

Negative symptoms include loss of motivation, loss of interest or enjoyment in daily activities, withdrawal from social life, difficulty showing emotions, and difficulty functioning normally.

Negative symptoms include:

- Having trouble planning and sticking with activities, such as grocery shopping
- Having trouble anticipating and feeling pleasure in everyday life
- Talking in a dull voice and showing limited facial expression
- Avoiding social interaction or interacting in socially awkward ways
- Having very low energy and spending a lot of time in passive activities. In extreme cases, a person might stop moving or talking for a while, which is a rare condition called catatonia.

These symptoms are sometimes mistaken for symptoms of depression or other mental illnesses.

Cognitive symptoms include problems in attention, concentration, and memory. These symptoms can make it hard to follow a conversation, learn new things, or remember appointments. A person's level of cognitive functioning is one of the best predictors of their day-to-day functioning. Cognitive functioning is evaluated using specific tests. Cognitive symptoms include:

- Having trouble processing information to make decisions
- Having trouble using information immediately after learning it
- Having trouble focusing or paying attention (NIH, 2023)

According to the *DSM-5*, schizophrenia is diagnosed when two (or more) of the following characteristics are present for a significant portion of time during a 1-month period (or less if successfully treated). At least one symptom is delusions, hallucinations, or disorganized speech:

- Delusions
- Hallucinations
- Disorganized speech (i.e., frequent derailment or incoherence)
- Grossly disorganized or catatonic behavior; catatonia is a state of unresponsiveness
- Negative symptoms (i.e., diminished emotional expression or avolition.) Avolition refers to reduced motivation or goal-directed behavior. (First & Compton, 2022b)

Most people with schizophrenia are not violent. Overall, people with schizophrenia are more likely than those without the illness to be harmed by others. For people with schizophrenia, the risk of self-harm and violence to others is greatest when the illness is untreated. It is important to help people who are showing symptoms to get treatment as quickly as possible (NIH, 2023).

Suicide and Self-Harm

Suicide is a major public health concern. In 2019, suicide was the 10th leading cause of death overall in the United States, claiming the lives of over 47,500 people. Suicide is complicated and tragic, but it is often preventable. Knowing the warning signs for suicide and how to get help can help save lives (NIH, 2021).

Suicide is when people harm themselves intending to end their life and they die as a result. A suicide attempt is when people harm themselves with the goal of ending their life, but they do not die. Avoid using expressions such as "committing suicide," "successful suicide," or "failed suicide" when referring to suicide and suicide attempts, as these expressions often carry negative meanings.

Warning signs that someone may be at immediate risk for attempting suicide include:

- Talking about wanting to die or wanting to kill themself
- Talking about feeling empty or hopeless or having no reason to live
- Talking about feeling trapped or feeling that there are no solutions
- Feeling unbearable emotional or physical pain
- Talking about being a burden to others
- Withdrawing from family and friends
- Giving away important possessions
- Saying goodbye to friends and family
- Putting affairs in order, such as making a will
- Taking great risks that could lead to death, such as driving extremely fast
- Talking or thinking about death often

Other serious warning signs that someone may be at risk for attempting suicide include:

- Displaying extreme mood swings, suddenly changing from very sad to very calm or happy
- Planning or looking for ways to kill themself, such as searching for lethal methods online, stockpiling pills, or buying a gun
- Talking about feeling great guilt or shame
- Using alcohol or drugs more often
- Acting anxious or agitated
- Changing eating or sleeping habits
- Showing rage or talking about seeking revenge

It is important to note that suicide is not a normal response to stress. Suicidal thoughts or actions are a sign of extreme distress and should not be ignored. If these warning signs apply to you or someone you know, get help as soon as possible, particularly if the behavior is new or has increased recently (NIH, 2021; Schreiber & Culpepper, 2021).

FACTORS THAT INFLUENCE MENTAL HEALTH

There is no single cause for mental health issues. Several factors that result from interactions between the mind, body, and environment contribute to the development of a condition.

The various and complex factors that influence our mental health and well-being are often defined as either risk factors or protective factors. Risk factors adversely affect a person's mental health, whereas protective factors strengthen a person's mental health and work to improve a person's ability to cope with difficult circumstances. All areas of life influence risk and protective factors—psychological, social, environmental, cultural, and situational.

Similar life events can have very different impacts on different individuals, depending on what else is happening in their lives at that time, their resiliency, and their ability to learn from life's challenges. Over the lifespan, a person may move through different points, from optimal mental health and well-being to being unwell and through to recovery.

Examples of risk factors include:

- Genetic predisposition
- Unhoused condition and/or unemployment
- Alcohol and other drug use
- Discrimination and racial injustice
- Family conflict or family disorganization
- Stressful life events

Examples of protective factors include:

- Personal attributes, including the ability to cope with stress, face adversity, and employ problem-solving skills
- Physical health and healthy behaviors
- Physical activity levels
- Social support and inclusion
- Strong cultural identity and pride

Achieving and maintaining good mental health requires building protective factors, minimizing risk factors, and breaking down barriers to seeking help.

Mental health is not as simple as being well or unwell. It can be viewed as a continuum, where individual optimal mental health is at one end, represented by feeling and functioning well. On the other end of the spectrum are mental health issues, which are characterized by changes in thoughts, feelings, or behaviors that affect an individual's ability to carry out their everyday activities (Government of Western Australia Mental Health Commission, n.d.).

THE STIGMA OF MENTAL HEALTH

Words can hurt. Many derogatory words and phrases are used about mental illness. However, these words maintain the stereotyped image and do not reflect the reality of mental illness. Try not to use these words. It is more appropriate to refer to "a person who has a mental illness" when speaking about someone than saying, "Mentally ill people are nuts, crazy." How often have we heard comments like this or seen portrayals in movies, television shows, or books? We may even

be guilty of making comments like them ourselves. Is there any truth behind these portrayals, or is that negative view based on our ignorance and fear?

Stigmas are negative stereotypes about groups of people. Common stigmas about mentally ill people include:

- Individuals who have a mental illness are dangerous.
- Individuals who have a mental illness are irresponsible and cannot make life decisions for themselves.
- People with a mental illness are childlike and must be cared for by parents or guardians.
- People who have a mental illness should just get over it.

Each of those preconceptions about people who have a mental illness is based on false information. Very few people who have a mental illness are dangerous to society. Most can hold jobs, attend school, and live independently. A person who has a mental illness cannot simply decide to get over it any more than someone who has a different chronic disease such as diabetes, asthma, or heart disease can. A mental illness, like those other diseases, is caused by a physical problem in the body.

Stigmas against individuals who have a mental illness lead to injustices, including discriminatory decisions regarding housing, employment, and education. Overcoming the stigmas commonly associated with mental illness is yet another challenge that people with a mental illness must face. Indeed, many people who successfully manage their mental illness report that the stigma they face is in many ways more disabling than the illness itself. The public's stigmatizing attitudes toward mental illness lead many persons with mental illness to feelings of shame and guilt, loss of self-esteem, social dependence, and a sense of isolation and hopelessness. One of the worst consequences of stigma is that people who are struggling with a mental illness may be reluctant to seek treatment that would, in most cases, significantly relieve their symptoms.

Providing accurate information is one way to reduce stigmas about mental illness. Advocacy groups protest stereotypes imposed on those who are mentally ill. They demand that the media stop presenting inaccurate views of mental illness and that the public stop believing these negative views. A powerful way of countering stereotypes about mental illness occurs when members of the public meet people who are effectively managing a serious mental illness: holding jobs, providing for themselves, and living as good neighbors in a community. Interaction with people who have mental illnesses challenges a person's assumptions and changes a person's attitudes about mental illness (NIH, 2007).

THE NURSE'S ROLE IN MENTAL HEALTH CARE

The World Health Organization (WHO) recommends an "optimal mix of services pyramid," in which mental health care services that cost the least and are the most frequently needed (e.g., self-care and informal community care) form the base of the pyramid and more expensive services needed by a smaller fraction of the mentally ill population (e.g., long-term inpatient care facilities) are at the top of the pyramid. To develop this mix of services, the WHO recommends that countries do the following:

- Limit the number of mental hospitals
- Build community mental health services
- Develop mental health services in general hospitals

- Integrate mental health services into primary health care
- Build informal community mental health services
- Promote self-care (Unite for Sight, 2021)

Advancement and development of healthier communities will continue to require attention to the support of mental health services and a focus on the underserved and vulnerable populations. Some of these strategies will depend on several factors:

- Sufficient planning and investment for mental health care
- Sufficient workforce to provide mental health services
- Consistency of mental health care inputs and processes with best practice and human rights protection
- Improved outcomes for people with mental disorders (Unite for Sight, 2021)

To improve both local and global access to mental health care, the investment in mental health care services must be closely considered, culturally sensitive in its design, informed by extensive research, and afforded adequate funding.

People are intended to thrive in their communities. It is where they should not only live but also prosper. Many mental health services are delivered within the community, and many are managed by community health nurses. The health care delivery system intends to help create and sustain physically and mentally healthy communities. In addition, it is responsible for identifying and caring for individuals who experience a mental health disorder and for supporting these individuals to return to a successful and productive life within their community. Community health nurses work in many mental health settings and assume many responsibilities for the mental health of individuals and the communities they live in. Nurses are often part of an interprofessional team that focuses on prevention, care management, restoration, or recovery.

As noted by Barnett et al. (2018), it is clear that significant differences exist globally as well as domestically between individuals who need mental health care and those who receive it. In low- and middle-income countries, over 75% of individuals who would benefit from care do not receive it (WHO, 2008, 2010). In the United States, ethnic and racial minorities are less likely to receive mental health treatment than are non-Hispanic White individuals (Alegria et al., 2010; Coker et al., 2009; Wells et al., 2001). In both examples, when treatment is available for underserved populations, it is often neither evidence-based nor high quality (Alegria et al., 2010; Dua et al., 2011). Creating evidence-based treatments in vulnerable communities has been a major focus of international and domestic policies (Barry & Huskamp, 2011; Becker & Kleinman, 2013; WHO, 2010). The WHO started the Mental Health Gap Action Programme to scale up evidence-based treatments for individuals with mental health, neurological, and substance use disorders in low- and middle-income countries (Dua et al., 2011; WHO, 2010). Domestically, the Patient Protection and Affordable Care Act emphasizes the provision of evidence-based care (Barry & Huskamp, 2011). It is concerning that even with these efforts to find innovative solutions, a public health model of workforce development is needed to address existing mental health disparities. This workforce will need to comprise physicians, nurses, social workers, community workers, and other health care professionals trained to identify and care for patients with mental health disorders.

Even when services are available, a wide range of factors affect whether individuals access or seek care, including structural barriers (e.g., lack of transportation), low mental health literacy, mental health stigma, and negative perceptions of mental health care providers (Alegria et al., 2010; Chow et al., 2003; Kilbourne et al., 2006; Nadeem et al., 2007). Nurses play an essential role in considering assessing and planning services for patients who face these challenges.

Treatment Settings

Community mental health nurses practice in a range of behavioral health care settings (Kudless & White, 2007). These include:

- Community mental health centers
- Detoxification centers
- Group homes for individuals with mental disorders and serious mental illnesses
- Residential substance abuse treatment programs

In these settings, community mental health nurses have many roles:

- Making nursing diagnoses of the medical and emotional status of patients
- Recommending treatment options
- Consulting with psychiatrists and other behavioral health staff in designing appropriate treatment plans for clients
- Administering and documenting reactions to psychotropic drugs and other medications
- Participating in group or one-to-one therapy sessions individually or with other health professionals
- Providing nursing services to individuals diagnosed with mental illness, alcoholism or substance abuse, and mental disorders or developmental disabilities, as well as providing nursing services to their caretakers or families
- Making referrals to primary care providers (Kennedy et al., 1997)

Public health nurses can work with agencies to take two important steps:

1. Incorporate mental health promotion into chronic disease prevention efforts and conduct surveillance and research to improve the evidence base about mental health in the United States
2. Collaborate with stakeholders to develop comprehensive mental health plans to enhance coordination of care (CDC, 2005)

PRACTICE APPLICATION

➔ Setting the Scene

Stop the Stigma: Why It's Important to Talk About Mental Health (Heather Sarkis)

Watch this video by scanning the QR code or visiting
https://youtu.be/gy1iH_GxnoQ

➔ Think About It

Drawing from Ms. Sarkis's TEDTalk, consider:

1. Did you find any facts she shared surprising?
2. Why do you think mental health is so stigmatized into today's society? What is the impact of such stigmatization?
3. How have you encountered mental illness in your life? How did it influence your experience with others?
4. What is one thing you can do to help reduce or eliminate stigma related to mental illness?
5. As a nurse:
   a. What can you do to help your patients avoid being treated as if "it's all in their heads"?
   b. How can you incorporate acceptance and treatment of mental health into your practice, especially if this is not your area of focus?

ADDITIONAL RESOURCES

CDC - Mental Health

National Alliance on Mental Illness (NAMI)

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA - Trauma-Informed Care

WHO - Mental Health

Resources for Patients/the Community

988 Suicide & Crisis Lifeline (also available by dialing 988)

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Chapter Eleven: Current Topics

OVERVIEW

Community health nurses play a vital role in the communities they serve as advocates for patients and members of the community as they negotiate the health impact of pressing current issues. This chapter provides a brief overview of four of the issues facing nurses and the communities they serve.

KEY TERMS

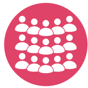
- opioids
- prescription drug monitoring programs
- medication-assisted treatment
- harm reduction
- reproductive justice
- transgender
- gender-affirming
- stigma
- discrimination
- climate justice

OPIOID USE DISORDER

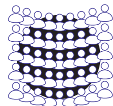
Substance use disorder (SUD) occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. Opioid use disorder is one type of SUD. The terms *opiate* and *opioid* are often used interchangeably, but there are differences between the two. Opiates are a class of drugs naturally found in the opium poppy plant and include the drugs morphine and codeine; these are referred to as "natural opioids." The term *opioid* is a broader term and encompasses all substances natural or synthetic (derived in a laboratory) that bind to the receptors in the brain. This includes the naturally derived opiates (morphine) as well as synthetic (fentanyl) and semi-synthetic (natural and laboratory) opioids like oxycodone. Opioids are used to treat pain because they block pain signals between the brain and the body. Opioids were originally prescribed for cancer pain. Heroin, a street drug, is also a natural opiate. In addition to providing pain relief, opioids make some people feel relaxed and high (Butanis, 2022).

Since 1999, more than 932,000 people have died from a drug overdose. In 2020 alone, nearly 92,000 people died from a drug overdose, and over 68,000 or 75% of these deaths involved an opioid overdose (Centers for Disease Control and Prevention [CDC], 2022f). In 2020, an average of four Virginians died every day from an opioid overdose (Virginia Department of Health, 2021).

The Opioid Epidemic

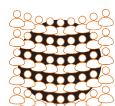


70,630
people died from drug overdose in 2019[2]



1.6 million
people had an opioid use disorder in the past year[1]

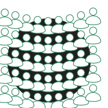
745,000
people used heroin in the past year[1]



1.6 million
people misused prescription pain relievers for the first time[1]

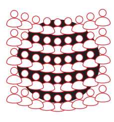
48,006
deaths attributed to overdosing on synthetic opioids other than methadone (in 12-month period ending June 2020)[3]

10.1 million
people misused prescription opioids in the past year[1]



2 million
people used methamphetamine in the past year[1]

50,000
people used heroin for the first time[1]



14,480
deaths attributed to overdosing on heroin (in 12-month period ending June 2020)[3]

Sources
1. 2019 National Survey on Drugs Use and Health, 2020.
2. NCHS Data Brief No. 394, December 2020.
3. NCHS, National Vital Statistics System, Provisional drug overdose death counts

Figure 11.1: The Opioid Epidemic by the Numbers (Adapted from U.S. Department of Health and Human Services Digital Communications Division, 2022)

In the late 1990s, pharmaceutical companies used aggressive marketing to encourage providers to prescribe opioids to patients for pain relief. The companies assured the providers that patients would not become addicted to opioid pain relievers, leading to increased prescribing rates and widespread misuse of prescription and nonprescription opioids. It then became clear that these medications were in fact highly addictive, with dependency leading to an increase in opioid overdose deaths in 1999, primarily related to prescription opioid overdoses (CDC, 2022f; see Figures 11.1 and 11.2).

By 2010, many people who had been prescribed opioids were dependent on them; however, providers were no longer readily prescribing them, so people were turning to heroin to get the same feeling. When people are dependent on or addicted to opioids, they need them to function in everyday life. If they do not take the opioids, they experience withdrawal symptoms that include but are not limited to nausea, vomiting, diarrhea, abdominal cramping, excessive sweating, runny nose, and muscle aches (CDC, 2022f).

By 2013, there was an increase in synthetic opioid overdoses from illicitly manufactured fentanyl. Fentanyl is 50 to 100 times more potent than heroin and is often cut with heroin (CDC, 2022f).

In 2017, the U.S. Department of Health and Human Services declared the opioid crisis a public health emergency (Assistant Secretary of Public Affairs, 2017). In late 2020, Purdue Pharma, one of the drug companies that encouraged providers to prescribe opioids, pleaded guilty to impeding the U.S. drug enforcement efforts to combat the addiction crisis (Mulvihill, 2020).

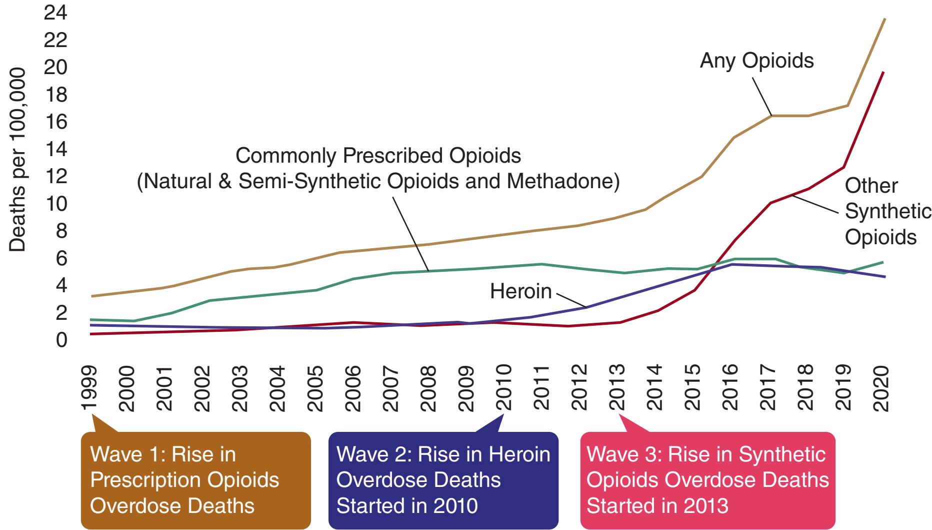


Figure 11.2: Three Waves of Opioid Overdose Deaths (Adapted from CDC, 2022f)

Affected Populations

No part of the United States is unaffected by the opioid epidemic. Additionally, all races, ethnicities, and ages are affected by the opioid epidemic (Table 11.1). This open educational resource focuses on the state of Virginia and the United States. However, the Kaiser Family Foundation (KFF) provides statistics for all states. In the United States and the state of Virginia, KFF found that the majority of opioid overdoses were among White non-Hispanics, followed by Black non-Hispanics. Further, the majority of opioid overdose deaths occurred in people between the ages of 25 and 44 (Figure 11.3).

Location	White Non-Hispanic	Black Non-Hispanic	Hispanic	Other
United States	69%	17%	12%	2%
Virginia	67%	26%	4%	1%

Table 11.1: Opioid Overdose Deaths by Race/Ethnicity | KFF (Adapted from Kaiser Family Foundation, 2022)

Prescription drug monitoring programs are a way for providers to check whether a person has recently received a prescription for a controlled substance. This electronic database tracks controlled substance prescriptions in a state. Prescription drug monitoring programs can provide health authorities with timely information about prescribing and patient behaviors that contribute to the epidemic. This measure was put in place to prevent overprescribing of controlled substances (CDC, 2021b).

The overall national opioid dispensing rate declined from 2012 to 2020. In 2020, the dispensing rate had fallen to the lowest in 15 years, at 43.3 prescriptions per 100 persons. Nevertheless, dispensing rates continued to remain very high in certain areas across the country, and 3.6% of U.S. counties had enough opioid prescriptions dispensed for every person to have one (CDC, 2022e).

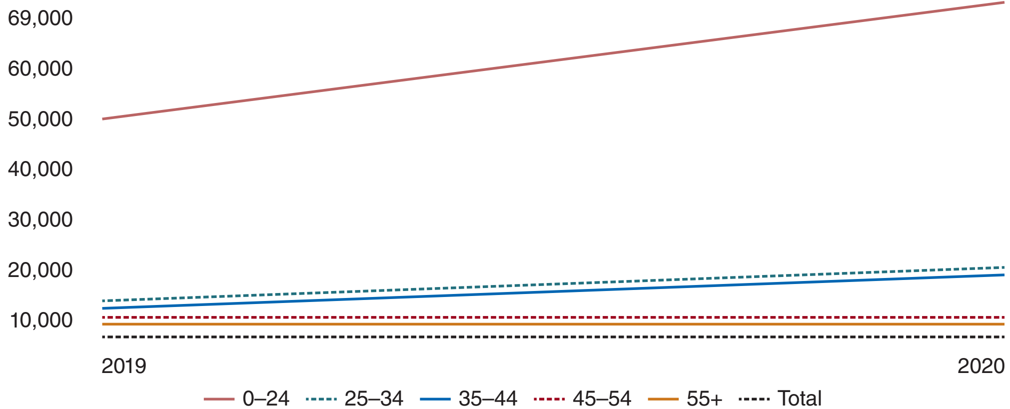


Figure 11.3: Opioid Overdose Deaths by Age Group (Adapted from Kaiser Family Foundation, 2022)

Research indicates that 43% of people being treated for SUD have a diagnosis or symptoms of mental illness, particularly depression and anxiety. Substance use disorder also often occurs with attention-deficit/hyperactivity disorder, psychotic illness, borderline personality disorder, antisocial personality disorder, and posttraumatic stress disorder (PTSD). Additionally, people with schizophrenia have higher rates of alcohol, tobacco, and drug use disorders than the general population (National Institute on Drug Abuse [NIDA], 2020).

There is a lot of stigma surrounding SUD. People with SUD continue to be blamed for their disease. The public, including many in health care and the justice system, continue to view SUD as a moral weakness and flawed character rather than a complex brain disorder with behavioral components. It is important to note that SUD is a chronic, relapsing disease, and stigma on the part of the health care provider can lead to substandard care or discourage people with SUD from seeking care when they need it (CDC, 2022g).

The opioid epidemic does not affect only the person who is using drugs. It also affects families and communities. Foster care placements have risen alongside the opioid epidemic, as has opioid-related neonatal abstinence. Moreover, premature deaths cause family members and communities to lose out on benefits from an individual's lifetime earnings; there are added health care costs from health care complications caused by drug use (e.g., hepatitis) and added costs from criminal justice expenses. Furthermore, there is a loss of productivity and reduced quality of life as a result of drug use (Crowley et al., 2019; Kuehn, 2021).

■ Treatments

According to the CDC, the best way to prevent opioid overdose deaths is to improve opioid prescribing, reduce exposure to opioids, prevent misuse, and treat opioid use disorder (CDC, 2018). Additional treatments are explored in the next section.

■ Medication-Assisted Treatment

Medication-assisted treatment (MAT) is the use of medication in combination with counseling and behavior therapy to treat SUDs. Medication-assisted treatment is primarily used to treat addiction to opioids such as heroin and prescription pain relievers containing opiates. The ultimate goal of MAT is to allow people to live self-directed lives. This treatment approach has been shown to improve survival, increase retention in treatment, increase people's ability to find and

retain work, and improve birth outcomes among pregnant people with SUD. Additionally, MAT can lower a person's risk of contracting HIV and hepatitis C (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022; Kleinman & Sanches, 2023; National Academies of Sciences et al., 2019).

There are a few MAT options.

Methadone

Methadone is prescribed to reduce opioid cravings and withdrawal and blunt or block the effects of opioids. It is a synthetic opioid agonist that eliminates withdrawal symptoms and relieves drug cravings by acting on opioid receptors in the brain—the same receptors that other opioids such as heroin, morphine, and opioid pain medications activate (Figure 11.4). Methadone must be dispensed through specialized opioid treatment programs, and patients usually go to the clinic daily to get their methadone dose. Eventually, stable patients may receive take-home doses if they meet certain criteria, such as a period of time without illicit drug use. However it is important to note that methadone, like other opioids, can be associated with overdose deaths, particularly when misused such as taking it in combination with other substances, such as alcohol or benzodiazepines (NIDA, 2021).

Buprenorphine

Buprenorphine is another MAT option. It suppresses and reduces cravings for opioids. It is a partial opioid agonist, meaning that it binds to those same opioid receptors but activates them less strongly than full agonists do (Figure 11.4). It can be prescribed by more providers, including primary care providers, but there are limits to the number of patients who can be treated (NIDA, 2021).

Naloxone

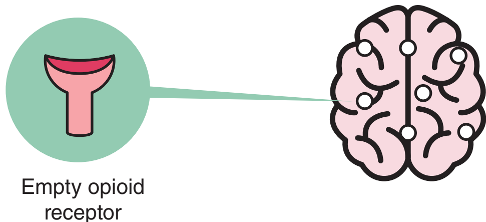
Naloxone (Narcan®) is known as an opioid antagonist or "blocker." It blocks the effects of opioids. When combined with buprenorphine, it is absorbed and activated in the body only if the drug is injected instead of being dissolved in the mouth, as prescribed. This is to discourage people from injecting Suboxone® (a trade name for buprenorphine). Naloxone is used to reverse opioid overdoses (SAMHSA, 2024; Figure 11.5).

Figure 11.4: Nasal Narcan Spray

Naltrexone

Naltrexone blocks the sedative effects of opioids and prevents feelings of euphoria. It is an opioid antagonist, which means that it works by blocking the activation of opioid receptors (Figure 11.4). Instead of controlling withdrawal and cravings, it

treats opioid use disorder by preventing any opioid drug from producing rewarding effects such as euphoria (NIDA, 2021; SAMHSA, 2022).



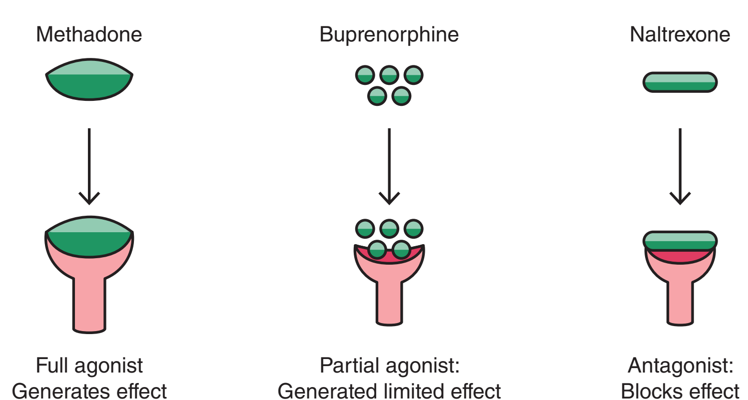


Figure 11.5: Impact of Medication-Assisted Treatments on Receptors (Adapted from Pew Charitable Trusts, 2020)

Harm Reduction

Harm reduction is another strategy that is used to deal with the negative consequences of using drugs. It may or may not include MAT. Harm reduction is a form of social justice built on respect for people who use drugs as well as for the rights of people who use drugs. The social justice window "recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm" (National Harm Reduction Coalition, 2020).

There is no one way to implement a harm reduction program. Generally, providers meet people where they are and determine what can be done to help them. This can include safe injection sites, primary prevention such as access to syringe exchanges to prevent the spread of HIV and hepatitis, access to providers who respect people who use drugs and treat them in a nonjudgmental manner, access to MAT, access to abstinence programs and anything that will help people who use drugs. "Drug use is a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others" (National Harm Reduction Coalition, 2020).

The Nurse's Role in Harm Reduction

Nurses often spend a lot of time with their patients in direct clinical care as well as in education; this time is an opportunity to engage the patient in conversation about how to keep themself safe. As previously mentioned, harm reduction involves nonjudgmental patient-centered engagement.

It is focused on reducing the harm of drug use to the individual and society for patients who are unable or unwilling to stop using drugs at the moment when they are interacting with you as the nurse in the health care setting. Many individuals experiencing SUD have experienced one or more traumas in their lifetime. A systematic review of American Indian and Native Alaskan substance users showed that the lifetime trauma rate varied from 21% to 98% (Herron & Venner, 2022). To learn more about practicing trauma-informed care, see Chapter Nine: Trauma-Informed Care.

As the nurse, you are not minimizing or ignoring the harms associated with drug use but rather working to engage the individual in behaviors that reduce those harms. Patient teaching opportunities include recognizing the signs of an overdose, using fentanyl test strips, giving patients a naloxone kit, discussing safe use strategies (e.g., do not use alone, use sterile water, consider smoking or snorting rather than injecting), and syringe access services (University of Michigan Injury Center, n.d.). Nurses should be able to identify the signs and symptoms of an opioid overdose (Figure 11.6).

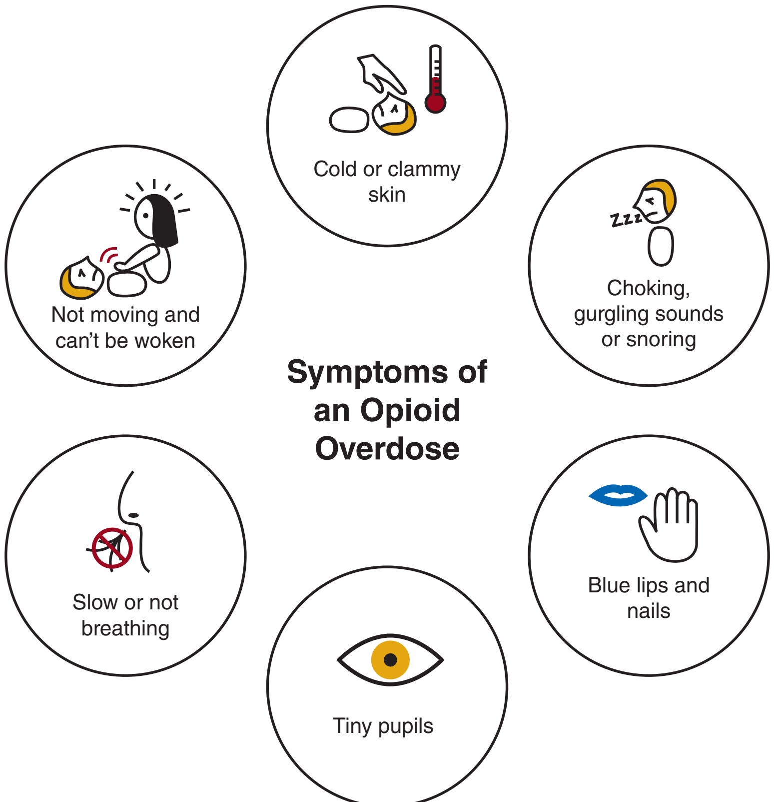


Figure 11.6: Symptoms of an Opioid Overdose

On a broader level, NAADAC, the association for addiction professionals, has the following suggestions for decreasing community-wide SUD (NAADAC, 2022):

Understand the issues. Nurses can learn more about state and federal policies that have an impact on how medications are prescribed and dispensed and laws that determine how and if

illicit substances are controlled and criminalized. You can learn more about policy issues that affect community members and professionals through the following links:

- White House Office of National Drug Control Policy (ONDCP) (whitehouse.gov)
- Bureau of International Narcotics and Law Enforcement Affairs (INL)
- Health Resources & Services Administration (HRSA)
- National Institute on Alcohol Abuse and Alcoholism (NIAAA)
- National Institute on Drug Abuse (NIDA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

Become an advocate. As a nurse, you are a trusted professional. You can:

- Write a letter to your legislature
- Write an informed letter to your local paper aimed at helping the general public understand the issue or a current bill in the legislature
- Seek more information about how to advocate for this issue from your state nurses association like the VNA, Virginia Nurses Association

PRACTICE APPLICATION

➔ Setting the Scene

The opioid epidemic is widespread, affecting every state in the United States. As an independent polling and public policy research company, KFF has a collection of data related to the epidemic, including information on deaths and the prevalence of opioid use disorder. The collection can be accessed at https://www.kff.org/statedata/collection/opioid-epidemic/

➔ Think About It

Using the KFF collection, look up the data for your state.

1. Does the death rate from opioid overdose in your state surprise you? Why or why not?
2. Which of the classifications of data (e.g., death by sex or by age) was the most surprising?
3. Did your state differ from national trends in any categories? What aspects of the community might influence this difference?
4. What do you think is one thing that might lessen the opioid-related death rate in your state?

ADDITIONAL RESOURCES

CDC - Drug Overdose

Virginia Department of Health - Drug Overdose and Related Health Outcomes

Reproductive Health Care

In the United States, a history of systemic inequities and injustices is reflected in the history of reproductive health care. Enslaved and immigrant women were forced to become nonconsenting research subjects for physicians to practice their gynecological techniques. Gynecological abuse continues in family planning services. Currently, threats include forced sterilization, long-acting reversible contraceptives, and threats to individual parenthood. These abuses disproportionately affect individuals who are Black, Indigenous, and people of color, those who are economically disadvantaged, those with disabilities, immigrants, the LGBTQIA+ community, and those who are incarcerated (Center for Reproductive Rights, 2022). Black and Indigenous women continue to bear a disproportionate burden of the maternal mortality rates in the United States.

Many organizations have been formed to address the legacy of these abuses. One such organization, the SisterSong Reproductive Justice Collective, was formed in 1994 in response to the discriminatory past of gynecological care within Black communities. Embracing reproductive justice as a framework, the SisterSong Reproductive Justice Collective conceptualized four basic tenets:

- The individual's right to maintain personal bodily autonomy
- The individual's right to have children
- The individual's right to not have children
- The individual's right to parent children in safe and sustainable communities (SisterSong, n.d.).

Reproductive oppression can be addressed through frameworks that address reproductive health, reproductive rights, and reproductive justice. Reproductive health ideology ensures access to reproductive health services. Reproductive rights are rooted in the concept that everyone has the right to universal legal protections. A reproductive justice framework analyzes the impact of reproductive oppression as the result of multifaceted barriers to social justice and human rights. Individuals may have limited options concerning their pregnancy outcome, which is further influenced by their race, gender, class, sexual orientation, and age. According to the TEACH Abortion Training Curriculum,

> Reproductive experience occurs within a social, structural, political, environmental, and economic context, including insurance, employment, food, safe water and air, and education. Supporting reproductive justice and bodily autonomy requires that we examine, understand, and improve the structural and social context in which people experience reproduction and parenting. (Fleming et al., 2022)

Social justice, intersectionality, and contributions of Black communities are foundational to reproductive justice frameworks. In contrast, the reproductive rights movement has historically focused on the needs of cisgender White heterosexual women regarding their legal right to abortion. Reproductive justice encompasses and embraces transformational and grassroots movements led by Black and Indigenous peoples and people of color to improve institutional policies and create sustainable system changes that enhance and empower the reproductive choices and lives of historically marginalized communities. Health care providers should be aware of the impact of the devaluation of the childbearing of marginalized populations and ensure respectful care that is focused on individual autonomy and honors the patient's preferences and values.

United States Law

In 1973, the U.S. Supreme Court decision in *Roe v. Wade* established that abortion was legal and state laws cannot interfere with a woman's right to end a pregnancy. During the following 50 years, the Supreme Court superseded states as the driving force in crafting abortion policy. On June 24, 2022, the Supreme Court issued *Dobbs v. Jackson Women's Health Organization*, a decision that overturned preexisting protections and sent decision-making on issues of abortion back to the states (Jung et al., 2023). Abortion laws changed quickly thereafter, and they continue to vary widely depending on each state's political climate.[3] The position of the American Nurses Association (ANA) is that women should have full access to reproductive health care (ANA, 2022).

Increasing legislation and the resulting restrictive access to abortion care directly affect overall community health locally and nationally. One in four individuals who is pregnancy capable will seek abortion care in the United States. This includes women and non-binary and transgender individuals who experience an undesired pregnancy. Those living in restricted states with little or no access to abortion services have poorer financial and health outcomes, including higher rates of abortion-related mortality, than their counterparts in states without such restrictions (Jung et al., 2023).

Community Health and Abortion

While laws seek to ban the practice of abortion, individuals will still seek and need abortion care throughout the community. Communities with increased legal restrictions and laws regarding abortion care are associated with increased maternal morbidity and mortality. Decreased access to abortion care is associated with decreased health outcomes. In 2016, the United States had a 45% higher unintended pregnancy rate than the global average (Aztlan-James et al., 2017; Singh et al., 2010; Finer & Zolna, 2016).

Individual patient pregnancy preferences must be addressed and are an essential component within the framework of public health. Primary care and community clinics are well positioned and have an ethical responsibility to provide reproductive health screening, pregnancy options counseling, contraceptive services, miscarriage management, and appropriate referral or provision of abortion services.

The Nurse's Role in Reproductive Health Care

Community health nurses should be committed to supporting policy solutions that ensure all people have access to a full range of preventive, reproductive, and sexual health services.

Abortion is an essential component of reproductive health care. Delivering care may present an ethical challenge to health care providers in communities where the legal status of abortion is uncertain. Stigma regarding abortion is further associated with unethical practices, including "refusal to provide abortion services to patients, alleging conscientious objection or religious directives, and discrimination against patients who may have complications of ectopic pregnancy or abortion, without tending to the obligation of preventing harm to patients for whose care they are responsible" (Fleming et al., 2022). In addition, people who seek or undergo abortion may keep their decision a secret and may not report it in their medical history, which could prove detrimental.

3 This text reflects conditions as of March 2024.

Medical facilities within the community must practice transparency and disclose any religious affiliation and their potential impact on health services in order to ensure that patients and health care providers can make informed decisions. Although most states allow health care professionals to refuse involvement in abortion on the basis of conscientious objection, many abortion providers characterize their provision as conscience based (Advancing New Standards in Reproduction Health, 2022).

PRACTICE APPLICATION

➔ Setting the Scene

Frontline: The Abortion Divide

Watch this video by scanning the QR code or visiting
https://www.pbs.org/wgbh/frontline/documentary/the-abortion-divide/

➔ Think About It

The *Frontline* video provides an overview of the fight of abortion. Drawing on the video and your experiences, answer the following questions:

1. What is the criminalization of abortion?
2. How does abortion access positively affect individuals who can give birth?
3. What are some examples of recent legislation on reproductive rights?
4. How do existing restrictive reproductive rights laws affect community health?
5. How are reproductive rights connected to racial justice?
6. What does it mean for the Supreme Court to overturn reproductive rights?

ADDITIONAL RESOURCES

Center for Reproductive Rights

National Organization for Women - Reproductive Rights and Justice

Planned Parenthood

TEACH Abortion Training Curriculum [Online Curriculum]

Abortion in Perspective [Chapter]

■ Resources for Patients/the Community

text4baby

Virginia Department of Health - Resource Mothers

Gender-Affirming Care

Content for this section was adapted from "Patient-Centered Care for Transgender People: Recommended Practices for Health Care Settings" from the Centers for Disease Control and Prevention (2022c).

Gender-affirming care is a supportive form of health care. It consists of an array of services that may include medical, surgical, mental health, and nonmedical services for transgender and non-binary people (OASH/Office of Population Affairs, 2022). Many transgender people experience stigma and discrimination in their day-to-day lives that can affect access to health care. In particular, many transgender women of color (specifically those who are Black or African American and Hispanic or Latino) have reported being victims of harassment and violence, even in health care settings. Given these challenges, transgender people, especially transgender women of color, may delay seeking medical care because of fear or experience of negative treatment by health care staff.

Concepts

The term *transgender* has varying definitions across cultures and communities. Most describe transgender people as those who have a gender identity that is different from their sex assigned at birth. Sex assignment at birth is based on the external genitalia, whereas gender identity refers to the internal sense of one's gender. Although people use many different terms to describe themselves, in general, a transgender woman is someone who was listed as male on their birth certificate and whose gender identity is female, and a transgender man is someone who was listed as female on their birth certificate and whose gender identity is male. Other people may have a gender identity that is fluid or non-binary; their gender is neither male nor female, nor is it a mix of male and female. Sexual orientation, which relates to emotional and sexual attraction to others, is distinct from gender identity; transgender people may have any sexual orientation regardless of their gender identity. For transgender people, the discordance between their gender identity and their assigned sex at birth can cause great distress, necessitating access to patient-centered, gender-affirming health care (CDC, 2022c).

For transgender and non-binary children and adolescents, early gender-affirming care is crucial to overall health and well-being because it allows the child or adolescent to focus on social transitions and can increase their confidence while navigating the health care system. Nurses can help families navigate resources and provide education that may empower them to have the necessary and sometimes difficult conversations within their own families and with health care providers (OASH/Office of Population Affairs, 2022).

Many but not all transgender people change their physical appearance. This is sometimes called gender affirmation. These changes can include modifications to clothing, hairstyles, and mannerisms. Many will change their first name and may want others to refer to them by pronouns that correspond to their gender identity. It is estimated that about 60%–70% of transgender people take hormones and that about 20%–40% have had one or more gender-affirming surgeries to alter their physical characteristics. Decisions about medical or surgical treatments depend on personal choice and cost. Nurses in all settings need to develop a comfort level by asking individuals to state their gender and their preferred pronouns. Information about the individual's preferences should be integrated throughout the care continuum to ensure patient-centered care (CDC, 2022c).

COMMON TERMS

- **Cisgender:** Describes a person whose gender identity aligns with their sex assigned at birth.
- **Gender-diverse or expansive:** An umbrella term for a person with gender identity and/or expression broader than the male or female binary. *Gender minority* is also used interchangeably with this term.
- **Gender dysphoria:** Clinically significant distress a person may feel when the sex or gender assigned at birth differs from their identity.
- **Gender identity:** One's internal sense of self as man, woman, both, or neither.
- **Non-binary:** Describes a person who does not identify with the man or woman gender binary.
- **Transgender:** Describes a person whose gender identity and/or expression is different from their sex assigned at birth and societal and cultural expectations around sex. (CDC, 2022c)

How Many People Identify as Transgender?

According to recent estimates, between 0.4% and 0.6% of American adults identify as transgender. The new estimates are larger than the previous estimate from roughly a decade ago. The analyses note several reasons that may account for this difference, including a perceived increase in visibility and social acceptance of transgender people, which may increase the number of individuals willing to identify as transgender on a government survey. It is also noted that younger adults aged 18 to 24 years are more likely than older adults to say they are transgender (CDC, 2022c).

Transgender Health Needs

Studies indicate that transgender people experience multiple health disparities as a result of stigma, discrimination, and unique barriers to accessing quality care. A summary of the barriers to achieving positive health outcomes and the consequences of those barriers is presented next. The purpose of identifying these barriers is to build an understanding of the difficulties transgender people face so that health care providers can help break down barriers.

Stigma and Discrimination

The majority of transgender people experience various forms of harassment, victimization, and discrimination in their daily lives (Figure 11.7).

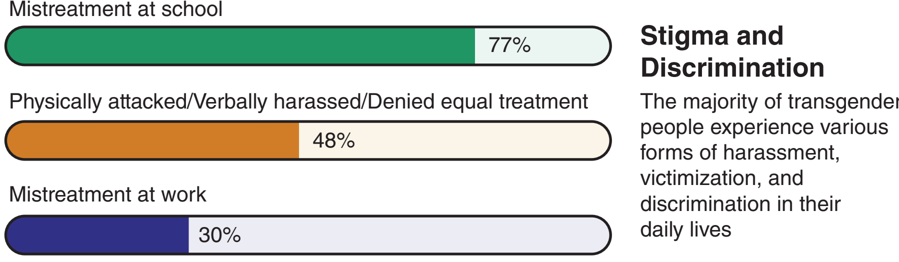


Figure 11.7: Impact of Stigma and Discrimination on Transgender People (Adapted from CDC, 2022c)

In addition to facing discrimination, transgender people are more likely than the general population to be homeless, unemployed or underemployed, and living below the federal poverty level.

The trauma and stress induced by stigma and discrimination, as well as the related effects of underemployment and unemployment, homelessness, lack of access to transition-related care, and lack of insurance, among other issues, can create a great burden on the mental and physical health of transgender people.

Figure 11.8 illustrates research findings from several sources, including the National Academy of Medicine and the U.S. Department of Health and Human Services' Healthy People 2020, which found that, compared with the general population, transgender people experience higher rates of several health concerns.

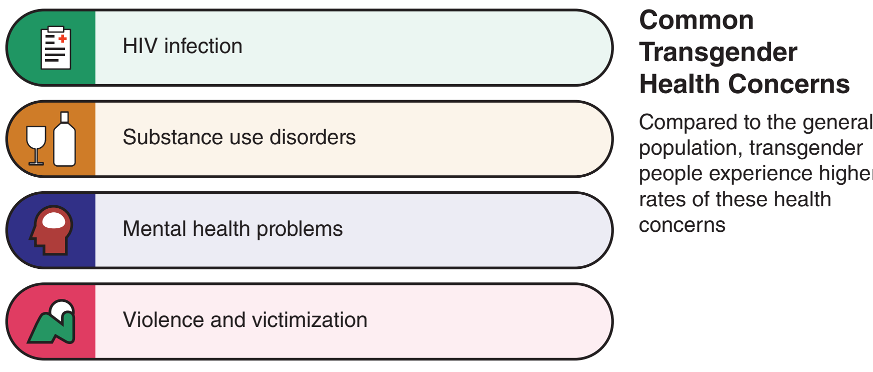


Figure 11.8: Common Transgender Health Concerns (Adapted from CDC, 2022c)

More specifically, studies have found that 41% of transgender people had attempted suicide at some point in their lives and that transgender women have one of the highest prevalence rates of HIV of any group. Survival sex work—or engagement in sex work to access basic necessities such as food and shelter—increases the risk for some. Transgender women, particularly those of color, have to contend with greater vulnerability to violence.

Unfortunately, transgender women of color face bias and discrimination on several fronts. For example, an African American transgender woman may face racism, stigma, and sexism in her daily life, with negative or deadly consequences for her health.

Transgender people have been shown to have higher odds of depression and attempted suicide than nontransgender (cisgender) people. These data suggests the importance of providers screening and treating patients experiencing mental health challenges (CDC, 2022c).

Barriers to Accessing Care

Lack of Trained Providers

Because of expectations of discrimination or misunderstanding in medical settings, many transgender people avoid or delay seeing a health care provider. But even when they do access care, they have difficulty finding a provider or being referred to providers who have expertise in patient-centered care for transgender people. To facilitate care, public health nurses can develop a list of gender-affirming care providers. A national resource such as Health Coverage Guide | National Center for Transgender Equality (transequality.org) is a place to start (National Center for Transgender Equality, n.d.).

Some transgender people may seek unauthorized (sometimes referred to as "underground") care through the internet or through friends and/or other nonmedical individuals in their social circle. They may take nonprescription and potentially dangerous hormones, get silicone injections, or have silicone implants to enhance their appearance. This can lead to a higher risk of illness and injury, further complicating health disparities. For instance, sharing needles to inject silicone or hormones may place transgender people at risk for HIV and hepatitis C.

Consider speaking with the person's health provider about the different types of medical care the person uses, or possibly speak with the person's friend or other nonmedical people. Consider discussing possible options for safer ways to get what the person is looking for in their health care.

Lack of Insurance

Many transgender people lack health insurance, have been denied insurance coverage for transition-related care, or denied coverage of preventive care that is not consistent with the gender their insurer has listed (e.g., coverage for a transgender woman to receive prostate exams may be denied if the patient's gender is listed as female). Federal law does not require health insurance plans to cover transition-related care, although some states have made this a requirement.

Gender-Affirming Care and Young People

Research demonstrates that gender-affirming care improves the mental health and overall well-being of gender-diverse children and adolescents. Because gender-affirming care encompasses many facets of health care needs and support, it has been shown to increase positive outcomes for transgender and non-binary children and adolescents. Gender-affirming care is patient-centered care that treats individuals holistically, aligning their outward physical traits with their gender identity.

Gender-diverse adolescents, in particular, face significant health disparities compared with their cisgender peers. Transgender and gender non-binary adolescents are at increased risk for mental health issues, substance use, and suicide. The Trevor Project's 2021 National Survey on LGBTQIA+ Youth Mental Health found that 52% of LGBTQIA+ youth seriously considered attempting suicide in the past year (The Trevor Project, 2021).

A safe and affirming health care environment is critical in fostering better outcomes for transgender, non-binary, and other gender-expansive children and adolescents. Medical and psychosocial gender-affirming health care practices have been demonstrated to yield lower rates of adverse mental health outcomes, build self-esteem, and improve the overall quality of life for transgender and gender-diverse youth. Familial and peer support are also crucial in fostering similarly positive outcomes for these populations. The presence of affirming support networks is critical for facilitating and arranging gender-affirming care for children and adolescents. Lack of such support can result in rejection, depression and suicide, homelessness, and other negative outcomes.

The Nurse's Role in Gender-Affirming Care

One of the most important steps for the community health nurse in creating a welcoming environment for transgender people (and indeed all people) is to address patients using their preferred names and pronouns. For many reasons, this can be challenging in health care environments. Yet, using the wrong name or pronoun can cause embarrassment and confusion. Imagine how a transgender woman would feel if a medical assistant called into the waiting room asking for

"Mr. Donald Jones" rather than "Denise Jones." To avoid such situations, here are a few suggested systems and practices that can easily be incorporated into practice:

- **Ask about gender identity on registration forms.** In addition to gender identity, include fields for listed sex at birth, preferred name, and pronouns. It may also be helpful to ask for names on insurance and government-issued identification documents, if different. Enter the information into the electronic health record so all staff can access this information. This information will help staff to use proper pronouns, from the front desk staff to the provider's office. If electronic health records are not yet in place, consider using a name-alert sticker to flag patient charts. Never refer to a person as "it." Try to avoid using gender terms or pronouns with new patients until this information is known, whether in-person or over the phone. For example:
  - Instead of "How may I help you, sir?" ask, "How may I help you?"
  - Instead of "Mr. or Ms.," use the (preferred) first and last name. In the case of writing an email, the salutation Mx. is non-binary. Mx. is pronounced like "mix."
  - Instead of "He is here for his appointment," say, "The patient is here in the waiting room," or "Dr. Reed's 11:30 patient is here," or "They are here for their appointment."
- **Ask patients how they would like to be addressed.** When unsure about pronouns and names, it is acceptable to ask privately and politely, "I would like to be respectful. What name and pronouns would you like me to use?" Once a patient has given this information, staff should note it in the chart and use this name in all interactions. If it is not possible to ask what pronouns must be used, choose the pronouns that most closely match the person's gender expression or use "they/them." See Table 11.2 for examples of pronouns that transgender people may use.

Gender Expression	Commonly Accepted Pronouns		
Woman-identifying pronouns	She	Her	Hers
Man-identifying pronouns	He	Him	His
Non-binary pronouns	Ze	Zim	Zirs
	Sie/Zie	Hir	Hirs
Non-binary/Gender-neutral pronouns	They	Them	Theirs

Table 11.2: Commonly Accepted Pronouns

- **Apologize for mistakes.** Sometimes mistakes happen, and simple apologies can go a long way. If a slip occurs, it is fine to say something like, "I apologize for using the wrong pronoun/name. I did not mean to disrespect you."
- **Consider practicing with colleagues and friends.** Making changes to the way one addresses other people can be challenging. It can help to practice with colleagues (CDC, 2022c).

PRACTICE APPLICATION

➔ Setting the Scene

The City of San Francisco has distinguished itself as a national leader in addressing the needs of the transgender community. Under the leadership of Executive Director Theresa Sparks, who is transgender, the San Francisco Human Rights Commission has led various groundbreaking efforts to prevent anti-transgender violence and reduce the vast disparities faced by members of the transgender community.

One of the city's flagship initiatives has been trans-inclusive universal health care for all residents of San Francisco, which includes all medically necessary transition-related care free of cost to transgender people, care that has limited-to-no impact on the city's budget but would be prohibitively expensive for many individuals.

In the last year alone, San Francisco has also allocated $2 million in funding to local service providers for programs working specifically with transgender residents. These programs include an employment program that has provided training and job placement for 200 transgender people in the last couple of years, the creation of a Trans Advisory Council for the city, and an HIV prevention program aimed at eliminating HIV transmission in the transgender community by the year 2020.

The city also has programs to support transgender women of color in prison and help facilitate their reentry into society following incarceration, which, according to Sparks, has cut the recidivism rate among those who have participated in the program to about 20%, compared with a statewide average of more than 50%. San Francisco is also taking direct aim at the issues of anti-transgender street violence and domestic violence. Earlier this year, the Human Rights Commission, along with 15 other community organizations, published an LGBTQIA+ community violence assessment report and has allocated funding for implementing and tracking the report's recommendations. The city has also started a violence prevention program for transgender Latinas, one of the city's most marginalized groups (Human Rights Campaign, 2015).

➔ Think About It

1. Does your area offer similar programs to support the health and well-being of transgender people in employment, health care, or safety? How did you locate these programs?
2. As a nurse, what actions can you take to ensure that you provide safe and supportive care for transgender patients?
3. In your health care practice, you have a colleague who is misgendering a patient. How do you react?

ADDITIONAL RESOURCES

American Civil Liberties Union (ACLU) - Five Things to Know About Gender-Affirming Health Care

Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline [Article]

Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents [Article]

PBS, Frontline - Growing Up Trans [Documentary]

The Trevor Project - Resources About Gender Identity

US Department of Health and Human Services, Office of Civil Rights - Sex Discrimination

US Department of Health and Human Services, Office of Population Affairs - Gender-Affirming Care and Young People [pdf]

World Professional Association for Transgender Health (WPATH) - Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 8 [Book]

Climate and Health

Content in this section was adapted from "Physical Geography and Natural Disasters" by R. Adam Dastrup (2020).

As our Earth continues to warm, climate scientists have warned of the dangers to come from climate change. Communities, including the nurses who support them, must be equipped with the knowledge and the ability to make necessary changes to the way that finite resources are managed in both an ethical and equitable way.

Nurses must recognize that there are communities and populations that bear a disproportionately larger burden of climate change, pollution, and environmental risk as a result of, but not limited to, race, ethnicity, gender, nationality, age, or ability and/or other social and economic determinants of health. These historical and existing inequities influence overall health, well-being, and quality of life.

Changes in Atmospheric Greenhouse Gas Levels

Climatic data from ice core drilling rings within coral reefs and trees, ocean and lake sediments, and other sources indicate that global temperatures rise when greenhouse gases increase in the atmosphere. When greenhouse gases decrease in the atmosphere, global temperatures fall. In 1958, the National Oceanic and Atmospheric Administration (NOAA) began measuring carbon dioxide levels in real time. Direct measurements of carbon dioxide in the atmosphere indicate that every year, the concentration of the gas increases globally every 6 months and decreases 6 months later. This mostly concerns the continents in the Northern Hemisphere, where the landmass and trees are located. During the warmer months, the trees in the Northern Hemisphere begin photosynthesizing by taking carbon dioxide out of the atmosphere and using sunlight to create chlorophyll. This causes global greenhouse gases to decrease for 6 months. When the Northern Hemisphere experiences fall and winter, the trees stop photosynthesizing and become dormant, causing global greenhouse gases to increase. However, even though carbon dioxide levels increase and decrease yearly, the global trend is that carbon dioxide levels are growing yearly. Current measurements from the National Aeronautics and Space Administration (NASA) show that carbon dioxide levels are at 413 parts per million (ppm), the highest the Earth has seen in nearly a million years (NASA, 2024a). Recently, NASA has created ultra-high-resolution computer models giving scientists a data-driven visualization of carbon dioxide as it flows around the world.

Greenhouse gas levels have varied throughout Earth's history. For example, carbon dioxide has been present at concentrations of less than 200 ppm and at higher levels than today. However, for at least 650,000 years, carbon dioxide has never risen above 300 ppm during either glacial or interglacial periods. Natural processes (e.g., volcanic eruptions and the decay or burning of organic matter) add carbon dioxide to the atmosphere and also remove it (e.g., by absorption by plants, animal tissue, and the ocean). When plants become a form of fossil fuel, the carbon dioxide in their tissue is stored with them, removing carbon dioxide from the atmosphere (NASA, 2024a).

Our problem is that fossil fuel use has skyrocketed in the past few decades, with more people driving and industrial products releasing vast quantities of carbon dioxide into the atmosphere. Burning tropical rainforests to clear land for agriculture, a practice called slash-and-burn

agriculture, also increases atmospheric carbon dioxide. Cutting down trees ensures that they can no longer remove carbon dioxide from the atmosphere. Burning the trees releases into the atmosphere all the carbon dioxide stored in the trees.

The atmosphere currently holds over 40% more carbon dioxide than it did during the Industrial Revolution. Approximately 65% of that increase has occurred since the first carbon dioxide measurements were made on Mauna Loa Volcano, Hawaii, in 1958. Carbon dioxide is a critical greenhouse gas that must be monitored because of human activity. However, other greenhouse gases are increasing as well (NASA, 2024b). The primary greenhouse gases include:

- Water vapor (36% to 70% of total): the most abundant and potent greenhouse gas on the planet and part of the hydrologic cycle
- Carbon dioxide (9% to 26% of total): released from burning fossil fuels
- Methane (4% to 9% of total): released from raising livestock, rice production, and the incomplete burning of rainforest plants
- Tropospheric ozone (3% to 7% of total): from vehicle exhaust, more than doubled since 1976. (Dastrup, 2020)

Emissions and the Health Care Industry

The health care sector accounts for approximately 10% of all greenhouse emissions (Introcaso & Vernon, 2021). Hospitals that are reimbursed by Medicare and Medicaid are legally required to meet certain conditions of participation. One of the conditions mandates that hospitals develop and execute a data-driven quality assessment program, including reporting their greenhouse gas emissions. Public health nurses can partner with institutions to help them develop emission reduction plans. Some of these plans are as simple as creating systems for increasing energy efficiency by switching to LED lights, installing automatic movement-detection lighting systems that will turn off when not in use, or unplugging large equipment that is not required to stay on at all times (Introcaso & Vernon, 2021). The ANA Code of Ethics Provision 9.4 explicitly states that promoting social justice in policy extends beyond just human health and well-being. There is an ethical imperative for nurses to advocate for policies and practices that improve the natural environment (ANA, 2015). This call to action for environmental stewardship is steeped in our history as nurses, as reflected in the environmental management writings of Mary Seacole (Britannica, n.d.).

Healthy People 2030

As a direct result of climate change, exposure to harmful pollutants in the air, water, soil, food, and materials in homes and workplaces has become commonplace. More than 12 million people around the world die every year because they live or work in unhealthy environments. The community and public health nurse has an ethical commitment to actively work to achieve the goals laid out in Healthy People 2030 as related to environmental health and climate change.

Environmental pollutants can cause health problems like respiratory diseases, heart disease, and some types of cancer (Figure 11.9). Individuals with low incomes are more likely to live in polluted areas and have unsafe drinking water. Children and pregnant women are at higher risk of pollution-related health problems than are other persons (Office of Disease Prevention and Health Promotion [ODPHP], 2022).

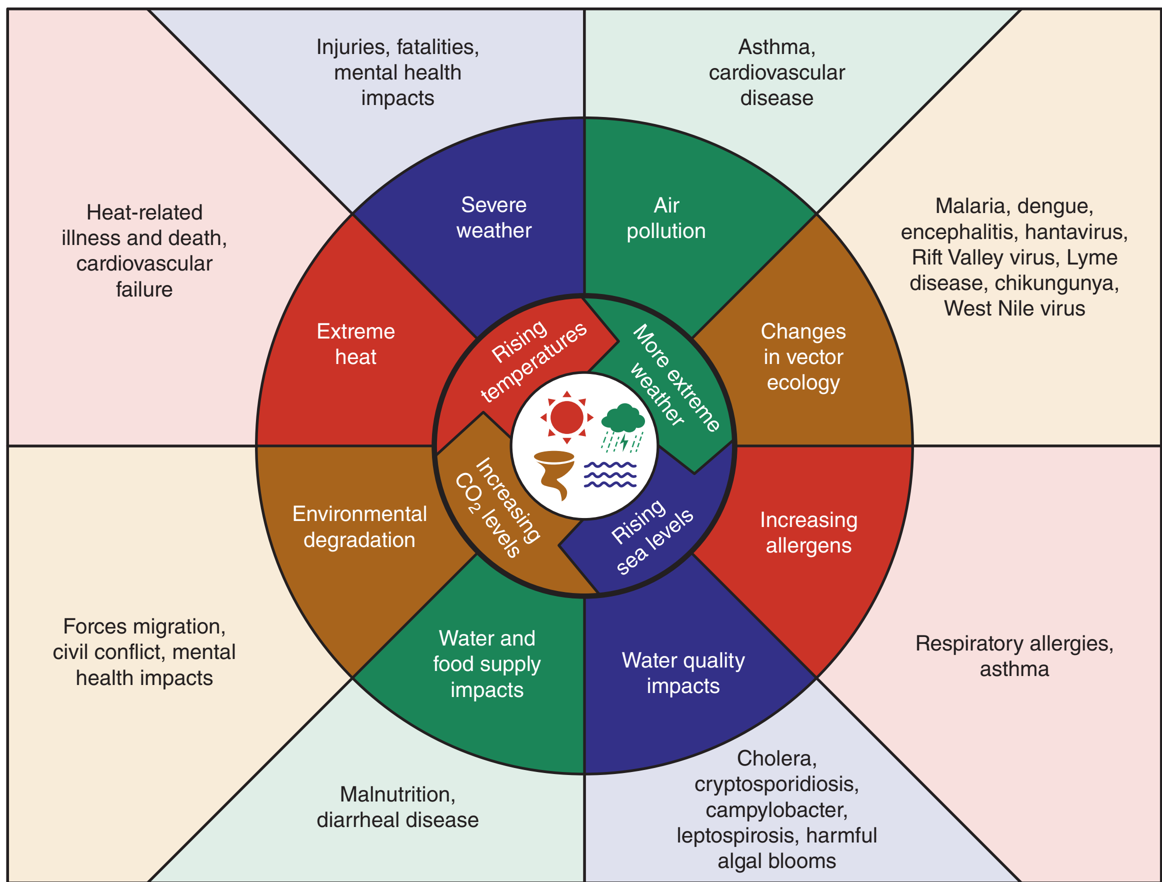


Figure 11.9: Impact of Climate Change on Human Health (Adapted from illustration by George Luber, CDC, National Center for Environmental Health, 2011)

For the community and public health nurse, tracking environmental pollutants is key to figuring out where and how people are exposed to them. Furthermore, nurses must advocate for laws and policies to reduce different types of pollution because these will help prevent many serious health problems and deaths related to global warming.

The environmental goals of Healthy People 2030 focus on reducing people's exposure to harmful pollutants in the air, water, soil, food, and materials in homes and workplaces. Specifically, the goals are to do the following:

- Reduce exposure to arsenic
- Reduce exposure to lead
- Reduce exposure to mercury in children
- Reduce exposure to bisphenol A (better known as BPA)
- Reduce exposure to perchlorate
- Reduce diseases and deaths related to heat
- Increase the proportion of people whose water supply meets Safe Drinking Water Act regulations (ODPHP, 2022)

The Environmental Public Health Tracking Network

This section has been modified from the "National Environmental Public Health Tracking" from the Centers for Disease Control and Prevention (2022).

Through the CDC, the Environmental Public Health Tracking Network gathers data and information needed to make decisions about our environment and health, including personal, community, regulatory, and public health decisions. The Tracking Network allows users to identify demographic factors, environmental burdens, socioeconomic conditions, and public health concerns directly related to environmental justice.

By using Tracking Network data:

- Scientists are better able to assess the connections between the environment and its effect on health.
- Public health professionals can easily assess unusual trends and events to determine which communities may be at risk.
- Elected officials can make more informed policy decisions.
- Everyone can learn more about how the environment may affect their health.

Environmental justice data tools can help users determine communities at risk, help them make informed policy decisions, and help everyone learn more about how the environment affects their health. The Tracking Network presents environmental health data in customizable maps, charts, and tables. Users can add layers to maps, including real-time data (e.g., current radar, surface smoke, active Atlantic cyclones, and transportation noise) and points of interest such as daycare centers, landfills, parks, power plants, public schools, and runways (CDC, 2022a).

What Is Climate Justice?

The nursing community must be committed to the principle that all people, regardless of race, color, national origin, or income, are entitled to equal protection from environmental and health hazards and equal access to the development, implementation, and enforcement of environmental laws, regulations, and policies. A healthy environment is a universal need and a fundamental human right. Nurses have an obligation to address health disparities and environmental injustice. Nurses recognize that climate change directly and negatively affects the most vulnerable—typically those who have done the least to contribute to the problem—and that climate justice:

- Promotes the ideology that those who have benefited the most from using fossil fuels must be dedicated to investing the same amount of success into actively reducing greenhouse gas or carbon emissions.
- Is committed to creating community action plans to address climate change and reduce greenhouse gas emissions fairly and justly.
- Requires holistic thinking. It requires listening carefully to communities that are or will be most affected by extractive industries yet are not receiving an equitable share of benefits. It requires Free, Prior, and Informed Consent before engagement with Indigenous communities. (Frierson, 2022a)

Human Impacts and Inequities

The emphasis on individual footprints has sowed discord within the environmental movement, setting what may seem to be an impossibly high bar of purity and excluding new participants.

Cultural shifts and widespread engagement are essential for enacting the scale of change we need. Projects such as community gardens and mutual aid and sharing networks can be effective at reducing consumption and fossil fuel use while building community resilience. Using less and creating more locally is a great strategy for building the climate justice movement.

When working with climate justice action, consider the hierarchy of responsibility and whether policies could be implemented that solve more than one problem at once. For example:

- How is a renter to blame for high heating emissions when the landlord controls decisions about insulation and efficiency upgrades? Can public investment fix both?
- How are workers in the fossil fuel industry to blame for extraction when they suffer severe health effects from their work? Can we provide a just transition for these laborers?
- How are industrial agricultural emissions the fault of a consumer when inadequate local or fresh food options are available in their community? How can we build food sovereignty around the world?

We also must be aware of the unequal burdens of climate change resulting from policies. One example is the flooding in historically "redlined" neighborhoods that has been documented in communities throughout the United States. Redlining was a policy implemented in the 1930s and 1940s that came out of the Home Owners Loan Corporation (HOLC). Part of the New Deal federal stimulus program, HOLC was established to provide emergency refinancing loans to homeowners, including people of color and immigrants. However, HOLC also created discriminatory housing security maps, which classified neighborhoods on the basis of their supposed "residential security." These maps were color coded, with "A" as green, "B" as blue, "C" as yellow, and "D" as red. The "A" grade was given to wealthy neighborhoods, while the "D" grade was reserved for neighborhoods considered hazardous and home to mostly foreign-born people, socioeconomically disadvantaged White people, and Black people. Banks then used these maps to determine which neighborhoods were safe for financial investment, perpetuating racial and class inequalities. Even after the HOLC emergency funding program ended, banks continued to rely on these maps, neglecting individual borrower information. We must learn from and acknowledge HOLC's discriminatory practices to understand how the practices affect population health even today (Bidadian et al., 2024; Conzelmann et al., 2022; Steinberg-McElroy et al., 2023; Mandal, 2023).

Neighborhoods that were redlined have features that put their residents at greater risk to experience climate change. For example, city money was far less likely to be spent on redlined neighborhoods, which means fewer trees (thus greater heat), few if any sidewalks (thus people are closer to exhaust fumes and are less safe to walk), and few parks or green spaces. These neighborhoods are more likely than others to experience flooding not only because of their location but also because of city planning that paved over areas that could previously absorb water. Compounding the problems is that the built environments are related to higher rates of chronic disease and poorer birth outcomes (Swope et al., 2022; Mandal, 2023).

Justice requires considering past harm when determining paths forward. To have restorative climate justice, it is important to measure the harms done to a given group, the lack of benefit to citizens of the extractive industries, and the parties responsible for the pollution (Frierson, 2022b).

The Nurse's Role in Climate Justice

Climate justice actions demand the fair and meaningful involvement of all voices in addressing environmental threats. Yet, national discussions have traditionally excluded voices from marginalized communities in identifying environmental threats and practices. Nurses are well positioned to ensure that all voices are heard when developing effective, long-term solutions to bolstering human adaptation and health and safeguarding ecosystems for community survival.

Nurses are duty bound to maintain, improve, protect, and promote the health of everyone. All humans have the right to healthy and safe environments, including:

- Clean air, water, and land
- Sustainable, stable shelter
- Safe food and agricultural practices
- Products that are free from harmful chemicals
- A safe climate
- Healthy living and working conditions
- The rights and opportunities to determine the needs of one's community and its future

Community health nurses must recognize that some communities and populations bear a disproportionately larger burden of climate change, pollution, and environmental risk. Nurses must be committed to the following principles in practice:

- Community health nurses must act with integrity, competence, diligence, and respect and in an ethical manner to ensure the equitable distribution of community resources.
- Community health nurses must exercise independent professional judgment when conducting analyses, making recommendations, taking actions, and engaging in community action plans to ensure they are fair and just.
- Community health nurses must acknowledge climate-related risks and opportunities when working with their communities in creating ongoing assessment and surveillance reports.

Without radical changes, we are facing a world of increasing inequality as climate impacts first hit those most vulnerable. Nurses and other radical thinkers can help ensure that the health impact of all the other ecological crises associated with the modern era, such as biodiversity loss, water scarcity, soil degradation, and pollution, are addressed (Frierson, 2022a).

Nurses witness firsthand the impact pollution from the transportation sector has on public health. In an August 2022 letter to the Biden administration and the U.S. Environmental Protection Agency's administrator, Michael Regan, over 300 nurses representing 50 states and the District of Columbia called on the Agency to move forward with the next round of clean car standards for model year 2027 and beyond. The Biden administration promised to advance bold action around emissions and efficiency standards for passenger cars and trucks. According to the executive order, 50% of cars and light truck sales will be zero-emission vehicles by 2030. It is important for nurses not to become complacent but to call for continued action to ensure clean car standards are met (Cook, 2022).

PRACTICE APPLICATION

➔ Setting the Scene

Content in this case study was adapted from the "An Inland City Prepares for a Changing Climate" in the U.S. Climate Resilience Toolkit (n.d.).

Climate adaptation and resilience were not recognized as pressing issues for the community of Blacksburg, Virginia. The current leading climate concern, the rising sea level, did not seem relevant to the city, which is located more than 300 miles from the nearest coastline. However, when Carol Davis was hired as Blacksburg's sustainability manager, she set out to develop the town's 2016 Climate Action Plan (pdf), which led to the town being a leader for climate resilience. The city passed its new Climate Action Plan around the same time as the Global Covenant of Mayors for Climate and Energy, a global alliance dedicated to climate leadership at the local level, was spurring communities to develop mitigation strategies to reduce greenhouse gas emissions and prepare adaptation strategies to make our communities more resilient in a changing climate. Using the plan as a starting point, Blacksburg worked to answer this charge.

Carol quickly found that best practices and tools to assess climate vulnerability, adaptation, and resilience were hard to locate for noncoastal communities. She was able to pull from three sources:

- The Climate Explorer, a visualization tool that provides graphs and maps of historical and projected climate variables for the contiguous United States at the county level
- Key findings from the Fourth National Climate Assessment (U.S. Global Change Research Program, 2018)
- The Temperate tool, which provided a concrete, guided process to help her make sense of the data and evaluate the degree to which each potential climate hazard could have an impact on an array of critical community systems

Using these tools, she determined 13 key temperature and precipitation metrics that would be most relevant to Blacksburg. Each of these metrics pointed to potential areas of vulnerability that Blacksburg might need to address.

To further explore which climate metrics might have the greatest adverse impact on the community and bring a variety of experience and expertise to the project, Carol convened the Climate Vulnerability Advisory Team, comprising experts from a variety of disciplines. The team was primarily composed of faculty from the Blacksburg-located Virginia Tech. Members of the Advisory Team provided input on invasive plants, climate trends and ecological processes, energy systems and society, surface water hydrology, extreme weather conditions, climate modeling, food system resiliency, heat stress and public health, transportation, and land use planning, stormwater engineering, climate adaptation planning, water systems and security, civil engineering, hazard mitigation planning, and forest dynamics. This team:

- Helped Carol interpret the best available climate data and modeling
- Provided critical knowledge on how those changes might specifically affect Blacksburg
- Provided input on potential adaptation policies that could help Blacksburg deal with new conditions

With these tools and the Advisory Team's help, Carol was able to direct the project. The group focused attention on anticipated changes to climate by midcentury and end-of-century

timescales, with both low- and high-emissions scenarios in mind. The group further examined the interplay between local and national geographic scopes for each of the 13 climate metrics under consideration.

In this way, the team was able to identify and prioritize the top three climate hazards of concern for Blacksburg: hotter summers, warmer winters, and increased precipitation anticipated to occur with changing precipitation patterns.

With these top climate hazards in mind, the team turned its attention to how these hazards might affect local community systems. Grouping the systems into four broad categories—People & Climate, Natural Systems, Economy & Employment, and Infrastructure & Basic Services—the team worked to identify the specific elements and systems critical to the community's functioning and the well-being of the residents.

The team's final assessment, the 2020 Climate Vulnerability Assessment (pdf), included plotting potential areas of vulnerability on a risk matrix to consider the degree of risk for each community system from Blacksburg's primary climate hazards. This drew their focus to the areas of highest anticipated risk and helped them focus their efforts on potential adaptation strategies for the greatest threats. The assessment is being integrated into the town's policy documents for future action.

➔ Think About It

1. Why was having an advisory team important to the project? What benefit does having a variety of voices, experiences, and expertise bring to a study?
2. An important outcome of the plan is that Blacksburg's key decision-makers are now aware of potential areas of vulnerability and are also equipped with a list of specific actions they can take to foster short- and long-term community resilience. Imagine you are a nurse in Blacksburg. What impact (direct and indirect) would the plan have on your work? Is there any direct action you would take?
3. Does your local community have a climate action plan, climate vulnerability assessment, or other climate policy? How will this affect your work?
4. Are there any climate issues in your local community that will affect your work as a nurse? What steps can you take to mitigate impact through patient care?

ADDITIONAL RESOURCES

Alliance of Nurses for Healthy Environments (ANHE)

American Red Cross - Working with the Red Cross Before, During & After Disasters [Slides]

Climate for Health

Climate for Health - Climate for Health Ambassador Training

FEMA - Individual Assistance Programs [Slides]

PBS, Frontline - Climate of Doubt [Documentary]

PBS, Frontline - Poisoned Waters | Frontline [Documentary]

TED Talk - A creative solution for the water crisis in Flint, Michigan (LaToya Ruby Frazier) [Video]

TED Talk - It's impossible to have healthy people on a sick planet (Shweta Narayan) [Video]

TED Talk - The link between climate change, health and poverty (Cheryl Holder) [Video]

UNICEF - The impacts of climate change put almost every child at risk

UN Women - Explainer: How gender inequality and climate change are interconnected

US Environmental Protection Agency - PFAS Explained

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APPENDIX A

AACN Essentials Alignment

This appendix maps how each chapter in this textbook aligns with the domains and competencies of the AACN Essentials (2021). We include this mapping to provide a clear roadmap for both nursing students and educators: students can see how the program equips them with these essential skills, while educators gain a framework for ensuring the curriculum effectively covers the AACN requirements.

Chapter	Preface	Intro.	1	2	3	4	5	6	7	8	9	10	11
Domain 1: Knowledge for Nursing Practice													
1.1 Demonstrate an understanding of the discipline of nursing's distinct perspective and where shared perspectives exist with other disciplines.		x	x	x				x	x	x		x	x
1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences.		x		x			x	x			x	x	x
1.3 Demonstrate clinical judgment founded on a broad knowledge base.		x	x	x				x	x	x	x	x	x
Domain 2: Person-Centered Care													
2.1 Engage with the individual in establishing a caring relationship.	x	x							x		x	x	x
2.1 Engage with the individual in establishing a caring relationship.	x	x							x		x	x	x
2.3 Integrate assessment skills in practice.	x				x		x			x	x	x	x
2.4 Diagnose actual or potential health problems and needs.	x				x		x		x	x	x	x	x
2.5 Develop a plan of care.	x	x									x		x
2.6 Demonstrate accountability for care delivery.	x	x								x	x		
2.7 Evaluate outcomes of care.	x	x								x			
2.8 Promote self-care management.	x									x	x		
2.9 Provide care coordination.	x	x											

Chapter	Preface	Intro.	1	2	3	4	5	6	7	8	9	10	11
Domain 3: Population Health													
3.1 Manage population health.	x	x	x	x			x						
3.2 Engage in effective partnerships.	x	x		x			x					x	x
3.3 Consider the socioeconomic impact of the delivery of health care.	x	x	x		x							x	x
3.4 Advance equitable population health policy.	x	x	x	x	x	x	x					x	x
3.5 Demonstrate advocacy strategies.	x	x	x	x							x		
3.6 Advance preparedness to protect population health during disasters and public health emergencies.	x	x	x					x		x			
Domain 4: Scholarship for the Nursing Discipline													
4.1 Advance the scholarship of nursing.		x											
4.2 Integrate best evidence into nursing practice.		x		x									
4.3 Promote the ethical conduct of scholarly activities.													
Domain 5: Quality and Safety													
5.1 Apply quality improvement principles in care delivery.													
5.2 Contribute to a culture of patient safety.										x	x	x	
5.3 Contribute to a culture of provider and work environment safety.										x		x	
Domain 6: Interprofessional Partnerships													
6.1 Communicate in a manner that facilitates a partnership approach to quality care delivery.		x			x						x	x	x
6.2 Perform effectively in different team roles, using principles and values of team dynamics.		x						x		x	x		
6.3 Use knowledge of nursing and other professions to address health care needs.		x			x	x	x	x		x	x	x	x
6.4 Work with other professions to maintain a climate of mutual learning, respect, and shared values.		x						x		x	x		x
Domain 7: Systems-Based Practice													
7.1 Apply knowledge of systems to work effectively across the continuum of care.					x	x	x						
7.2 Incorporate consideration of cost-effectiveness of care.													
7.3 Optimize system effectiveness through application of innovation and evidence-based practice.										x		x	

Chapter	Preface	Intro.	1	2	3	4	5	6	7	8	9	10	11
Domain 8: Informatics and Health Care Technologies													
8.1 Describe the various information and communication technology tools used in the care of patients, communities, and populations.								x			x	x	
8.2 Use information and communication technology to gather data, create information, and generate knowledge.						x	x	x		x	x		
8.3 Use information and communication technologies and informatics processes to deliver safe nursing care to diverse populations in a variety of settings.						x	x			x			
8.4 Use information and communication technology to support documentation of care and communication among providers, patients, and all system levels.										x	x		
8.5 Use information and communication technologies in accordance with ethical, legal, professional, and regulatory standards, and workplace policies in the delivery of care.													
Domain 9: Professionalism													
9.1 Demonstrate an ethical comportment in one's practice reflective of nursing's mission to society.		x	x	x						x	x	x	
9.2 Employ participatory approach to nursing care.					x		x			x	x		
9.3 Demonstrate accountability to the individual, society, and the profession.		x	x	x				x		x	x	x	
9.4 Comply with relevant laws, policies, and regulations.						x				x	x		
9.5 Demonstrate the professional identity of nursing.								x		x	x		
9.6 Integrate diversity, equity, and inclusion as core to one's professional identity.		x	x	x	x								
Domain 10: Personal, Professional, and Leadership Development													
10.1 Demonstrate a commitment to personal health and well-being.													
10.2 Demonstrate a spirit of inquiry that fosters flexibility and professional maturity.													
10.3 Develop capacity for leadership.		x	x	x						x			

APPENDIX B

Additional Resources URLs

This appendix lists the URLs of the additional resources provided at the end of each chapter. A full citation is provided for any resource that is a journal article.

An Introduction to Community and Public Health Nursing

American Nurses Association (ANA). *ANA code of ethics*. https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/

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Chapter One: Community and Public Health Policy

American Nurses Association. *Advocacy resources*. https://www.nursingworld.org/practice-policy/advocacy/ana-advocacy/

American Association of Colleges of Nursing. *Policy and advocacy*. http://www.aacnnursing.org/Policy-Advocacy

American Hospital Association. *Social determinants of health*. https://www.aha.org/social-determinants-health/populationcommunity-health/community-partnerships

Healthy People 2030. *Objectives*. https://health.gov/healthypeople/objectives-and-data/find-objectives

Healthy People 2030. *Social determinants of health literature summaries*. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries

National League for Nursing. *Public policy toolkit*. https://health.gov/healthypeople/objectives-and-data/find-objectives

Williams, S. D., Phillips, J. M., & Koyama, K. (2018, September 30). Nurse advocacy: Adopting a health in all policies approach. *OJIN: The Online Journal of Issues in Nursing*, *23*(3), Manuscript 1. https://doi.org/10.3912/OJIN.Vol23No03Man01

Chapter Two: Health Disparities and Health Equity

American Planning Association. *Plan for health*. https://www.planning.org/nationalcenters/health/psecoalitions/

American Planning Association. *Planners for health*. https://www.planning.org/nationalcenters/health/planners4health/

Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity. *Health equity resource*. https://www.cdc.gov/nccdphp/dnpao/health-equity/health-equity-resources.html

MPHI. Equity in Action Workshop (EAW) series. https://mphi.org/equity-in-action-workshop/University of Wisconsin–Madison, Population Health Institute. *Health equity training modules*. https://uwphi.pophealth.wisc.edu/match/health-equity-training-modules/

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Robert Wood Johnson Foundation. *Immigration, health care and health* [Collection of analyses and research findings]. https://www.rwjf.org/en/insights/our-research/2017/09/immigration-status-and-health.html

United States Department of Agriculture, Food and Nutrition Service. *Supplemental Nutrition Assistance Program (SNAP)*. https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program

U.S. Citizenship and Immigration Service. *Green card eligibility categories*. https://www.uscis.gov/green-card/green-card-eligibility-categories

Chapter Three: Social Determinants of Health and Vulnerable Populations

Centers for Disease Control and Prevention, National Environmental Public Health Tracking. *Populations and vulnerabilities*. https://www.cdc.gov/nceh/tracking/topics/PopulationsVulnerabilities.htm

Center on Budget and Policy Priorities. *A quick guide to SNAP eligibility and benefits*. https://www.cbpp.org/research/food-assistance/a-quick-guide-to-snap-eligibility-and-benefits

Healthy People 2030. *Environmental conditions* [Literature summary]. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/environmental-conditions

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Climate and Health

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APPENDIX C

Additional URLs

This appendix includes URLs that are included as hyperlinks throughout the text. It is meant as an aid for those using the book in print or others who are not able to directly click on hyperlinks.

Front Matter

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VIVA Open Rapid Publishing Program: https://vivalib.org/va/open/grants/publishing

VIVA Open Grant Program: https://vivalib.org/va/open/grants

VIVA, Virginia's Academic Library Consortium: https://vivalib.org/

Chapter One: Community and Public Health Policy

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Increase employment in working-age people (SDOH-02): https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability/increase-employment-working-age-people-sdoh-02

Reduce the proportion of families that spend more than 30 percent of income on housing (SDOH-04): https://health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04

Reduce household food insecurity and hunger (NWS-01): https://health.gov/healthypeople/objectives-and-data/browse-objectives/nutrition-and-healthy-eating/reduce-household-food-insecurity-and-hunger-nws-01

Increase the proportion of high school students who graduate in 4 years (AH-08): https://health.gov/healthypeople/objectives-and-data/browse-objectives/adolescents/increase-proportion-high-school-students-who-graduate-4-years-ah-08

Increase the proportion of children who participate in high-quality early childhood education programs (EMC-D03): https://health.gov/healthypeople/objectives-and-data/browse-objectives220/children/increase-proportion-children-who-participate-high-quality-early-childhood-education-programs-emc-d03

Increase the proportion of students with disabilities who are usually in regular education programs (DH-05): https://health.gov/healthypeople/objectives-and-data/browse-objectives/people-disabilities/increase-proportion-students-disabilities-who-are-usually-regular-education-programs-dh-05

Increase the proportion of 4th-graders with math skills at or above the proficient level (AH-06): https://health.gov/healthypeople/objectives-and-data/browse-objectives/schools/increase-proportion-4th-graders-math-skills-or-above-proficient-level-ah-06

Increase the proportion of adults who get recommended evidence-based preventive health care (AHS-08): https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality/increase-proportion-adults-who-get-recommended-evidence-based-preventive-health-care-ahs-08

Increase the proportion of adolescents who speak privately with a provider at a preventive medical visit (AH-02): https://health.gov/healthypeople/objectives-and-data/browse-objectives/adolescents/increase-proportion-adolescents-who-speak-privately-provider-preventive-medical-visit-ah-02

Increase the proportion of adults who get screened for colorectal cancer (C-07): https://health.gov/healthypeople/objectives-and-data/browse-objectives/cancer/increase-proportion-adults-who-get-screened-colorectal-cancer-c-07

Increase the number of community organizations that provide prevention services (ECBP-D07): https://health.gov/healthypeople/objectives-and-data/browse-objectives/community/increase-number-community-organizations-provide-prevention-services-ecbp-d07

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Reduce health and environmental risks from hazardous sites (EH-05): https://health.gov/healthypeople/objectives-and-data/browse-objectives/environmental-health/reduce-health-and-environmental-risks-hazardous-sites-eh-05

Increase the proportion of people whose water systems have the recommended amount of fluoride (OH-11): https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-policy/increase-proportion-people-whose-water-systems-have-recommended-amount-fluoride-oh-11

Reduce blood lead levels in children aged 1 to 5 years (EH-04): https://health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-blood-lead-levels-children-aged-1-5-years-eh-04

Reduce anxiety and depression in family caregivers of people with disabilities (DH-D01): https://health.gov/healthypeople/objectives-and-data/browse-objectives/parents-or-caregivers/reduce-anxiety-and-depression-family-caregivers-people-disabilities-dh-d01

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Reduce bullying of transgender students (LGBT-D01): https://health.gov/healthypeople/objectives-and-data/browse-objectives/lgbt/reduce-bullying-transgender-students-lgbt-d01

Chapter Two: Health Disparities and Health Equity

Achieving health equity for all: EveryONE (plos.org): https://everyone.plos.org/2019/01/02/achieving-health-equity-for-all/

Chapter Three: Social Determinants of Health and Vulnerable Populations

Healthy People 2030: https://health.gov/healthypeople

Healthy People 2030: Environmental conditions as a social determinant of health: https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/environmental-conditions

The impacts of climate change on human health in the United States: A scientific assessment (globalchange.gov): https://health2016.globalchange.gov/

Chapter Five: Population Health

The Quintuple Aim for health care improvement: A new imperative to advance health equity: https://jamanetwork.com/journals/jama/fullarticle/2788483

Healthy People 2030 website: https://health.gov/healthypeople

Chapter Seven: Community Violence and Violence Prevention

Referral resources related to intimate partner violence, violence prevention, and partner injury can be found on the Centers for Disease Control and Prevention website: https://www.cdc.gov/violenceprevention/intimatepartnerviolence/resources.html

Chapter Eight: Emergency Preparedness

Registered nurses' rights and responsibilities related to work release during a disaster: American Nurses Association (2002). https://www.nursingworld.org/~4af848/globalassets/practiceandpolicy/work-environment/health--safety/disast.pdf

FEMA, Emergency Management Institute, Independent Study (IS), Course List: https://training.fema.gov/is/crslist.aspx?lang=en

The Biosense system on the CDC website: *https://wwwcdcgov/nssp/biosense/onboarding.html*

Chapter Ten: Mental Health

The National Alliance on Mental Illness: https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions

Chapter Eleven: Current Issues

Opioid Use Disorder

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White House Office of National Drug Control Policy (whitehouse.gov): http://www.whitehouse.gov/ondcp

Bureau of International Narcotics and Law Enforcement Affairs: https://www.state.gov/j/inl/ Health Resources & Services Administration: https://www.hrsa.gov/index.html

National Institute on Alcohol Abuse and Alcoholism: http://www.niaaa.nih.gov/ National Institute on Drug Abuse: http://www.drugabuse.gov/

Substance Abuse and Mental Health Services Administration: http://www.samhsa.gov/ Virginia Nurses Association: https://virginianurses.com/

Gender-Affirming Care

National Center for Transgender Equality health coverage guide (transequality.org): https://transequality.org/health-coverage-guide/

Climate and Health

Free, prior, and informed consent: Food and Agriculture Organization of the United Nations: http://www.fao.org/indigenous-peoples/our-pillars/fpic/en/

Climate action plan: https://www.blacksburg.gov/departments/departments-l-z/sustainability/climate-protection/climate-action-plan-and-supporting-documents

Climate explorer: https://crt-climate-explorer.nemac.org/

Fourth national climate assessment: https://nca2018.globalchange.gov/

Temperate: https://www.azavea.com/blog/2019/04/17/turbotax-for-climate-vulnerability-assessements/

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Appendix A: AACN Essentials Alignment

AACN Essentials (2021): https://www.aacnnursing.org/Portals/0/PDFs/Publications/Essentials-2021.pdf

GLOSSARY

Key Terms by Chapter

An Introduction to Public and Community Health Nursing

Public health nursing: the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences

Community health nursing: a subset of public health nursing that is further focused on specific communities, usually defined in geographic terms

Vulnerable populations: groups of people and communities at a higher risk for poor health as a result of the barriers they experience to social, economic, political, and environmental resources, as well as limitations caused by illness or disability

Primordial disease prevention: identifying social and environmental variables that can influence the health of entire populations and implementing targeted risk reduction strategies

Primary disease prevention: aims to prevent disease or injury before it occurs

Secondary disease prevention: focuses on detecting disease early and reducing the impact of disease before it progresses further

Tertiary disease prevention: aims to reduce the severity of disease in symptomatic patients and make it easier to live with long-term health problems and injuries

Quaternary disease prevention: preventing medical interventions likely to cause more harm than good

Chapter One: Community and Public Health Policy

Policy: a course or principle of action adopted or proposed by a government, party, business, or individual

Legal: based on or concerned with the law

Regulatory: relating to the control or direction of an activity by a set of rules, laws, etc.

Advocacy: the act or process of pleading for, supporting, or recommending a cause or course of action

Vulnerable populations: groups of people and communities at a higher risk for poor health as a result of the barriers they experience to social, economic, political, and environmental resources, as well as limitations caused by illness or disability

Stakeholders: persons with an interest or concern in something

Chapter Two: Health Disparities and Health Equity

Health equity: a fair and just treatment that promotes the prevention or correction of health disparities

Health disparity: the differences that exist among specific population groups in the attainment of good health

Immigrant: a person who comes to live permanently in a foreign country

Asylum seeker: an immigrant who has been forcibly displaced and might have fled their home country because of war or other factors harming them or their family (seeking asylum or sanctuary is a legal process)

Refugee: once an asylum seeker has gone through the legal process and the government has accepted them, their status becomes that of a refugee

Ableism: the discrimination of and social prejudice against people with disabilities based on the belief that typical abilities are superior

LGBTQIA+: an inclusive acronym used to include people of all genders and sexualities that stands for lesbian, gay, bisexual, transgender, questioning/queer, intersex, asexual plus others such as pansexual

Chapter Three: Social Determinants of Health and Vulnerable Populations

Social determinants of health: the conditions where people are born, work, live, worship, play, and age, that affect an individual's health, functioning, quality of life outcomes, and risks

Geospatial determinants of health: the places life is lived—from home to workplace, schools to parks, and town centers to places of worship—all affect individuals and a community's health, thereby directly influencing how people experience both disease and well-being

Health behaviors: actions individuals take that affect their health

Vulnerable populations: groups of people and communities at a higher risk for poor health as a result of the barriers they experience to social, economic, political, and environmental resources, as well as limitations caused by illness or disability

Chapter Four: Epidemiology

Epidemiology: the study of the distribution and determinants of health and disease in human populations

Rate: a measure of the frequency with which an event occurs in a defined population over a specified time

Prevalence: the number of cases in the population at a given time

Incidence: the rate of occurrences of new cases in a certain period

Mortality: the rates of death in a specific community or subset of the population

Morbidity: the rate of illness in a community or specific subset of the population

Epidemic: when there are more cases of a particular disease than expected in a given area, or among a specific group of people, over a particular period

Endemic: when a population has a high level of the disease all the time (e.g., malaria is endemic in parts of Africa)

Pandemic: a disease or condition that spreads globally, such as COVID-19

Cluster: a group of cases in a specific time and place that exceeds what is expected

Notifiable conditions: a list of conditions that must be reported to the Centers for Disease Control and Prevention (CDC) whenever they are encountered by clinicians or health department officials

Chapter Five: Population Health

Population health: an interdisciplinary, customizable approach that allows health departments to connect practice to policy for change to happen locally

Public health: what society collectively does to assure the conditions in which people can be healthy

Health department: a division of a local or larger government responsible for the oversight and care of matters relating to public health

Health policy: a course or principle of action adopted or proposed by a government, party, business, or individual to promote wellness

Health outcomes: measure a change in the health status of an individual or a group that can be attributed to the intervention

Chapter Six: Community Assessment and Evaluation

Community health assessment: a state, tribal, local, or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis

Windshield survey: systematic observations made from a moving vehicle

Walking survey: systematic observations made on foot

Quantitative data: information that can be expressed in terms of numbers

Qualitative data: information that cannot be measured or expressed in terms of numbers but instead is descriptive and gives a feel of the community

Chapter Seven: Community Violence and Violence Prevention

Gender-based violence: violence directed against a person because of their gender

Domestic violence: willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another

Intimate partner violence: behavior within an intimate relationship that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors

Perpetrate: carry out or commit

Violence: behavior with the intention to harm someone

Chapter Eight: Emergency Preparedness

Syndromic surveillance: provides public health officials with a timely system for detecting, understanding, and monitoring health events by tracking symptoms of patients before a diagnosis is confirmed (public health can detect unusual levels of illness to determine whether a response is warranted)

Bioterrorism: terrorism involving the release of toxic biological agents

Chapter Nine: Trauma-Informed Care

Trauma: a deeply distressing or disturbing experience

Retraumatization: reliving the event that caused the trauma

Chapter Ten: Mental Health

Anxiety: a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome

Depression: a common mood disorder causing severe symptoms that affect how a person feels, thinks, and handles daily activities, such as sleeping, eating, or working

Bipolar: a mental illness that causes unusual shifts in mood, ranging from extreme highs (mania or "manic" episodes) to lows (depression or "depressive" episode)

Schizophrenia: a serious mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions

Suicide: death caused by injuring oneself with the intent to die

Chapter Eleven: Current Issues

Opioids: a class of drugs that include synthetic opioids such as fentanyl; pain relievers available legally by prescription, such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine; the illegal drug heroin; and many others

Prescription drug monitoring programs: an electronic database that tracks controlled substance prescriptions in a state

Medication-assisted treatment: the use of medications in combination with counseling and behavioral therapies, which is effective in the treatment of opioid use disorders and can help some people to sustain recovery

Harm reduction: a public health approach that focuses on mitigating the harmful consequences of drug use, including transmission of infectious disease and prevention of overdose, through provision of care that is intended to be free of stigma and centered on the needs of people who use drugs

Reproductive justice: the human right to control our sexuality, our gender, our work, and our reproduction

Transgender: denoting or relating to a person whose sense of personal identity and gender does not correspond with their birth sex

Gender-affirming: treating individuals holistically and affirming a person's gender with the name, pronouns, and expressions they use

Stigma: a mark of disgrace associated with a particular circumstance, quality, or person

Discrimination: the unjust or prejudicial treatment of different categories of people or things, especially on the grounds of race, age, or sex

Climate justice: a movement acknowledging that climate change can have differing social, economic, public health, and other adverse impacts on underprivileged populations

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