Op-Ed

Violent Injury as a Preventable Condition

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HOMICIDE AND SUICIDE TOGETHER CLAIM MORE THAN 50,000 lives in the United States each year. The broader base of victims of violence includes 1.2 million people seen in the emergency department annually as a result of assault, according to the National Vital Statistics System. An estimated 10 million Americans suffer physical violence at the hands of an intimate partner.¹ For US children, more than 1 in 7 experience and more than 1 in 4 witness violence annually.² Yet effective responses to violence by the public health and health care systems remain few, far between, and—if they exist at all—underfunded.

A decade ago, when I was the health commissioner of Baltimore, I addressed a group of about 40 Catholic priests. The city was in the midst of a spate of shootings and the priests were, understandably, alarmed. I told them: “You see violence as a moral failure. The police see violence as crime. In public health, we see violence as a contagious but preventable behavior.”

At the time, I was raising funds for an antiviolence program developed by a global public health expert with experience stopping outbreaks of infectious disease. The program hires community members to work late at night to interrupt the cycle of retaliation. The workers mediate disputes, establish community norms against guns, and connect high-risk youth to education, health care, and jobs. An independent evaluation has found that in the initiative’s focus areas, there is markedly less interest in using guns to settle arguments—and there are fewer shootings.³

Despite a track record of results, the program is still struggling for sustainable funding and is operating at a far smaller scale than necessary. So too are successful hospital-based violence intervention programs, which, in a form of secondary prevention, provide a range of services to patients who suffer injuries from violence. These initiatives may reduce the chances of revictimization by as much as fourfold.⁴ Given that half of certain victims of violence experience violence again, and as many as

1 in 5 are killed within 5 years, broad adoption of such programs could have a substantial impact.⁵

What is holding back health-based efforts to prevent violence?

One possible answer is political controversy. There are few areas in American politics more divisive than gun policy, with Congress unable even to pass popular measures to expand background checks. At the state level, gun-rights enthusiasts have blocked or repealed laws shown to reduce homicides and suicides, such as requirements for gun permits. Congress has even directly limited what federal researchers can say about gun violence, with legislative provisions stating that “none of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention may be used to advocate or promote gun control.” This provision and the paucity of federal research grants for scholars to study gun violence have hampered efforts to help the American public to see violence as a health problem.

Yet politics only goes so far to explain this dilemma. Just a subset of antiviolence efforts involves gun policy. Another explanation is that essentially all efforts to turn the tide on violence encroach on the traditional territory of law enforcement.

Local police departments bear primary responsibility for maintaining order and receive the lion's share of resources devoted to public safety. As a consequence, the police occupy the great majority of mental space on violence. Many people in public health and health care have internalized the idea of violence as a matter for law enforcement. Some nurses and doctors are uncomfortable asking too many questions, even about intimate partner violence (where such assessment is already recommended by leading professional organizations such as the American College of Obstetrics and Gynecology, the American Academy of Pediatrics, and the American College of Emergency Physicians). Recent high-profile failures of policing, including unjustified shooting deaths of African Americans and patterns of civil rights violations, may further reinforce the reluctance of health care workers to engage.

Yet law enforcement should not have a monopoly on violence prevention, and timidity in the health sector misreads the moment. The Black Lives Matter movement, Department of Justice reviews of police departments, and ensuing public discussions are creating the space to rethink traditional roles in preventing violence. Many inside and outside of law enforcement are now beginning to question the long-standing

assumption of police omnipotence. With reference to the Dallas police commissioner, President Barack Obama recently said:

What Chief [David] Brown said is true: So much of the tensions between police departments and minority communities that they serve is because we ask the police to do too much and we ask too little of ourselves. As a society, we choose to underinvest in decent schools. We allow poverty to fester so that entire neighborhoods offer no prospect for gainful employment. We refuse to fund drug treatment and mental health programs. We flood communities with so many guns that it is easier for a teenager to buy a Glock than get his hands on a computer or even a book—and then we tell the police “you’re a social worker, you’re the parent, you’re the teacher, you’re the drug counselor.”

The door is open for health-based efforts to prevent violence. In practice, this can mean more psychiatry departments training police officers to avoid tragic interactions with individuals who suffer from serious mental illness, more emergency departments establishing pathways into addiction treatment, and more health systems hiring counselors to recognize and address the impact of trauma.

Emerging value-based payment programs should provide the flexibility to reimburse for these and other similar activities, while measuring violent injuries as preventable health conditions. Policymakers should facilitate partnerships between healthcare facilities and community organizations that can jump in to settle disputes and prevent retaliation. Health departments should develop dashboards to track indicators of violence and use the data with community input to establish new initiatives. A national technical assistance infrastructure would lower the barriers to engagement.

Progress will require new investment. In August, a coalition of health luminaries and organizations led by former Surgeon General David Satcher issued a paper calling for \$1 billion to be spent on evidence-based health approaches to violence prevention each year, a small fraction of what could be saved in return. Success will also require imagination—specifically, the ability to envision a world in which violence prevention is not just the purpose of police but also the province of health.

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