Violence, Trauma, and Trauma Surgery

Ethical Issues, Interventions, and Innovations

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Chapter 5
Violence Is a Contagious Disease: Theory and Practice in the USA and Abroad

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Introduction

The data show that violence should be fundamentally redefined as primarily a health issue. In addition, health approaches need to be much more broadly utilized to understand and explain why violence occurs and used by community-based workers to detect, interrupt, and prevent violent events and outbreaks, reduce the spread of violence, and maintain safe and healthy communities. Relatively standard, well-tested, and highly effective public health approaches are being increasingly applied to the problem of violence and show strong evidence of impact among individuals and whole communities. The active involvement of the health sector in the management and treatment of violence is long overdue, specifically through more operational and vigorous implementation of the means of prevention and epidemic control that the health sector knows well and applies effectively for so many other problems.

Understanding Violence as a Health Issue

Violence is a health issue because there is a specific scientific health lens that helps us to better understand and effectively prevent violence. The health perspective means viewing violent behavior from the perspective of epidemiology, physiology, biology, neuroscience, psychology, and sociology. This health perspective recognizes that people doing violence, as well as those who have been affected by violence through injury and exposure, essentially have a personal health problem—a problem of exposure, contagion, and trauma or pain. Violence is also more specifically a

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public health problem because it poses a serious threat to the health of populations and because public health techniques can be effectively utilized to reduce the prevalence and incidence of violence and make communities safer and healthier.

Additionally, the health perspective on violence automatically follows from the fact that violence fulfills the criteria of a contagious disease. A disease is defined as "any deviation or interruption of structure or function of a part, organ, or system of the body, as manifested by characteristic symptoms and signs (causing morbidity and mortality)" (Dorland, 2010). Violence affects the structure and function of the brain, has characteristic signs and symptoms, and causes morbidity and mortality. It also demonstrates the population characteristics of a *contagious* or *epidemic* type of disease, specifically through its clustering, spread, and transmission (Fig. 5.1) (Slutkin, 2013). The transmission of violence between *people* has been well documented for child abuse (Widom, 1989), community violence (Bingenheimer, Brennan, & Earls, 2005), and intimate partner violence (Ehrensaft et al., 2003); it has also been shown between *syndromes*, for example, community violence exposure was found to increase the risk of perpetrating domestic violence (Mullins, Wright, & Jacobs, 2004).

In recent years, much progress has been made in understanding *how* violent behavior is transmitted—both in terms of social psychology and the underlying brain mechanisms (Fig. 5.2). At the individual level, violence is transmitted through

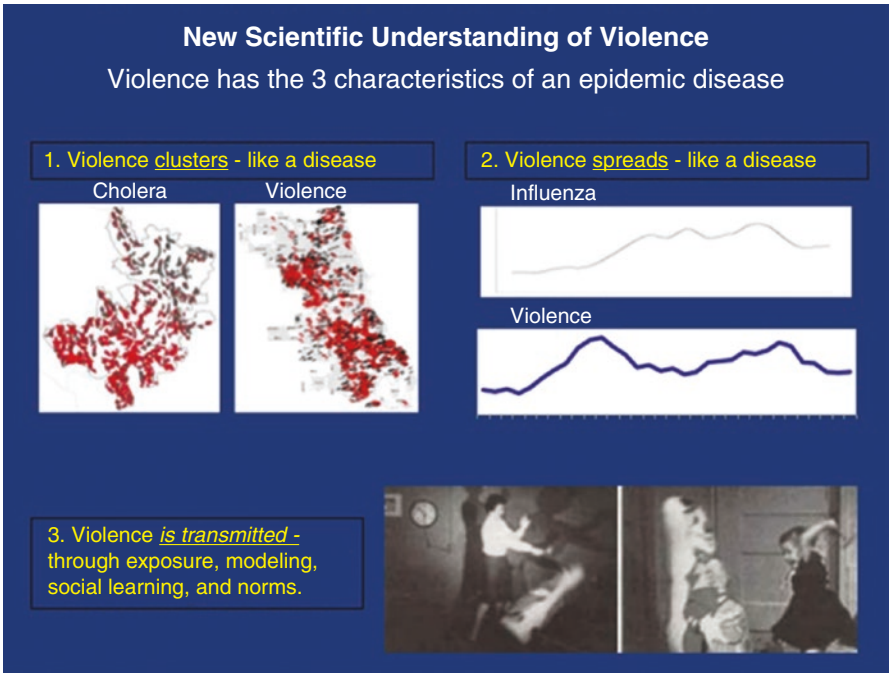

Fig. 5.1 Violence meets the criteria for a contagious problem

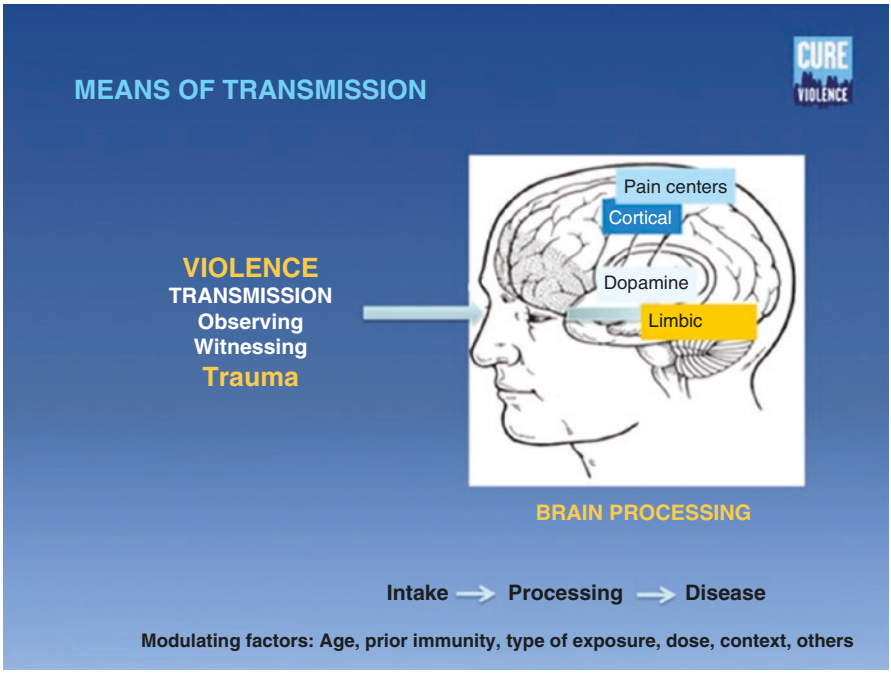

Fig. 5.2 Means of transmission for violence

social learning or modeling (Bandura, Ross, & Ross, 1961; Slutkin, 2013) and, at the group level, through social norms and scripts. For example, in a climate of chronic community violence, violence becomes the accepted or even expected response to conflict, including small disputes, perceived slights, or insults. Such street codes emphasize toughness and quick, violent retribution for transgressions against one's sense of self or insults to one's reputation. Failure to respond can be perceived as or thought to be perceived as a sign of weakness, with a possible ensuing loss of status that can predispose the victim to further victimization (Anderson, 2000). Similar norms and expectations also play a significant role in perpetuating other types of violence, including child abuse (Spinetta & Rigler, 1972) and intimate partner violence (Ahmad, Riaz, Barata, & Stewart, 2004).

Violence has the added effect of being a traumatic experience; such experiences can have a profound mental impact and physiological effects. Exposure to violence can lead to several adaptive responses, including aggression, impulsivity, depression, stress, and exaggerated startle responses (Mead, Beauchaine, & Shannon, 2010; Singer, Anglin, Song, & Lunghofer, 1995), and those with chronic exposure have shown a more than 30 times greater risk of future violent behavior than those with low exposure (Spano, Rivera, & Bolland, 2010).

The Health Approach to Reducing Violence

The health perspective on violence is based on science and allows us to move away from a moralistic perspective that understands violence as caused by "bad" people and "evil." Thinking about good and bad people is replaced by a focus on good and bad outcomes, with people viewed under contextual, biological, environmental, and social influences. From a health perspective, the preferred outcome is to maintain and improve the physical, mental, psychological, and emotional well-being of each individual and of the community. Health approaches avoid harm at all costs and instead provide care, guidance, and education. There is no role for punishment in health-based solutions. Health approaches are neutral with regard to ethnicity, culture, race, gender, class, and sexual orientation, although they still take different influences and manifestations into account.

Care is the fundamental guiding principle of health and health systems, and prevention is a way of providing care before medical problems occur. By understanding the effects of exposure to violence, the symptoms (and latency) of violent ideation, and the effectiveness of particular methods of behavior change, care, or treatment, we can identify and successfully treat people before they become violent. Furthermore, understanding and trying to reduce additional risk factors and enhancing protective factors can and should be used to help persons become less susceptible to violence and increase resistance to the transmission and progression of violence.

Many programs, models, and system changes are already being used in health approaches to violence, although some people may not identify their approach as a *health* approach. Health approaches for preventing violence are those that:

- Are based on an understanding of how violent behaviors are formed and of the effects of exposure to violence
- Apply a preventative approach
- Use evidence-based or evidence-informed approaches
- Are nonjudgmental
- Have a commitment to do no harm
- Approach people through the lens of care.

Health approaches to violence typically fall into four categories, which can be implemented in combination or individually:

1. *Stopping the transmission of violence* by detecting situations in the community where the risk of future violence is high and preventing these situations from becoming lethal
2. *Identifying and treating those at highest risk for violent behavior*, in the same way that health Outreach Workers identify and treat those suspected of having tuberculosis, syphilis, gonorrhea, HIV/AIDS, or even Ebola—all of which also are not obvious and are frequently hidden from persons with authority

3. *Addressing environmental factors,* such as community norms and social determinants of health, to reduce the *community's* susceptibility or increase its resistance to the violence epidemic
4. *Addressing risk factors* (and protective factors) that affect an *individual's* susceptibility or resistance to the violence epidemic, such as mental health issues and alcohol and drug use.

All of these approaches address violence as a behavior and implement health methods that reduce the likelihood of that behavior occurring. Multiple approaches should have a cumulative effect, and all approaches should be carefully monitored and adjusted as needed. All these approaches are important in preventing violence. As with other transmitted diseases, however, the ongoing transmission of violence is the most urgent risk.

Beyond individual approaches, these health approaches can be more systematically implemented across multiple sectors to more effectively prevent violence. What is needed was identified 30 years ago by the US Surgeon General C. Everett Koop's "Workshop on Violence and Public Health": "[E]ducation of the public on the causes and effects of violence, education of health professionals as to better care for victims and better approaches to violence prevention, improved reporting and data-gathering, some additional research, and increased cooperation and coordination—networking if you will—among health and health-related professions and institutions" (Cron, 1986, p.12). In essence, Dr. Koop saw the need for a health system to respond to violence as a health problem in a much more energized and comprehensive way.

Health approaches do not only come from the health sector. Other sectors can take the principles of health approaches and apply them in different settings. For example, schools and educators can learn methods of screening students to determine whether they have had exposure to violence and are at risk for becoming violent and then make appropriate referrals for treatment. Law enforcement is currently being trained in—and could benefit from even further training in—peaceful mediation and de-escalation of conflict. Further, many law enforcement departments are also providing real-time information to health and related professionals and referring people to them; this information can be used to detect conflicts and prevent violence and can help in the treatment of trauma.

The entire justice system, including prisons and jails, probation and parole, prosecutors, defense attorneys, and attorneys general, can adopt a perspective that recognizes both violence as a behavior and the impacts of exposure to violence. This perspective can result in an increased use of treatment services for trauma and mental health care, behavior change, and interruption of conflicts, leading to less violence.

Many other agencies that come into contact with people traumatized by violence, such as child welfare agencies, are also important in detecting ongoing violence and identifying those exposed to violence or who are at risk of violence. Likewise, any agency or organization that is involved in planning or maintaining the built environ-

ment, such as parks and public areas, should consider a health perspective to reduce risk of violence, and many do. These parties, and others, have been working toward preventing violence and have already been incorporating many health-based and related principles and approaches; hopefully, they will continue this trend.

The Epidemic Control Approach to Reducing Violence

Epidemic control is a subspecialty of public health that has specific considerations, concerns, and methods. The epidemic control method specifically combines all of the above-outlined elements of a health approach to preventing violence. One prominent example of the epidemic control method of violence prevention is the Cure Violence Health Model. This model outlines its main components as follows:

1. *Detect and interrupt the transmission of violence* by anticipating where violence may occur and intervening before it erupts.
2. *Change the behavior of the highest potential transmitters* by identifying those at highest risk for violence and working to change their behavior.
3. *Change community norms* by influencing social norms to discourage the use of violence.

These three main components are discussed in more detail below.

Detect and Interrupt the Transmission of Violence

The Cure Violence model deploys Violence Interrupters, who use specific methods to locate potentially lethal, ongoing conflicts and respond with a variety of conflict mediation techniques, both to prevent imminent violence and to change the norms around the need to use violence. Violence Interrupters formulate and regularly update a plan of action that lays out a strategy for gathering information and assessing its accuracy and use. Part of this plan includes establishing and maintaining relationships with key individuals in the program area who are likely to have knowledge of or involvement in conflicts, shootings, or plans for retaliation to previous events. Additionally, program sites receive information from local law enforcement on shootings and killings. Some programs have partnerships with local hospitals and are notified immediately when gunshot wound victims are admitted to emergency rooms.

Before acting on sensitive information, Violence Interrupters consult multiple sources to sift through the information, validate facts, and assist each other in the detection and prevention of potential events and conflicts. Violence Interrupters then gather more information about a specific potential conflict, find out who was involved, and determine which team members are best positioned to respond to the situation. Intervention may take place by talking over the phone or one-on-one with

key players or "influentials"; by hosting a small group "sit-down" or peace-keeping session; or by taking other steps to foster diplomacy between groups, including bringing in a respected third party to negotiate. Violence Interrupters use various methods of interruption, such as creating cognitive dissonance, demonstrating contradictory thinking, and changing the required response. A Violence Interrupter who has a relationship with an individual involved in the conflict will often "shadow" that person to ensure that the conflict does not reignite. For programs with hospital partnerships, Hospital Responders meet in the emergency room with the highest-risk individuals and their families and friends, in addition to coordinating with Violence Interrupters in the field, to prevent further violence and monitor the situation.

Change the Behavior of the Highest Potential Transmitters

Cure Violence employs Outreach Workers as behavior change agents. Outreach Workers work with the highest-risk individuals in the community to convey a message of rejecting the use of violence and assist them in obtaining needed services, such as job training and drug abuse counseling. They build relationships in the community through canvassing the target area, organizing community activities, holding shooting responses, and conducting community walks; then they use these relationships to identify who is at highest risk for involvement in violence. The level of risk for an individual is determined by a set of criteria that was established during preimplementation and is used to determine whether an individual is a candidate for the intervention.

Each Outreach Worker builds a caseload of high-risk participants who agree to take part in the program. Within the first 3 months, each Outreach Worker should have 10 to 20 high-risk participants who have been cleared by the outreach supervisor as being at high enough risk to qualify for the program. Outreach Workers then begin a dialogue, create buy-in, and build rapport with those at highest risk by explaining the program and the potential role the Outreach Worker and others within the community can play in their lives.

Outreach Workers start work with the participants by using some basic principles, including maintaining confidentiality, adopting a nonjudgmental approach, and meeting the participant "where they are." Outreach Workers create a risk reduction plan for each participant that maps out the issues that the participant faces and the steps that will be taken to reduce his or her risk and uses specific messages and specific resources in the community that can help the participant with their issues. Outreach Workers meet with participants several times a week, including at critical times of need, to develop a relationship, address issues, and work on changing behaviors.

The behavior change work is centered in cognitive behavioral interventions, which target both thought and behavior for change. Underlying this work is the understanding that thoughts, feelings, and behavior are interrelated—thoughts affect behavior and experiences shape thoughts. Using this understanding, Outreach

Workers challenge violent thoughts one by one. Outreach Workers also help participants in other areas of their lives, such as education, employment, drug treatment, housing assistance, leaving a gang, and family counseling. Although dealing with these issues is separate from behavior change, such issues are very much connected to risk for violent behavior.

Change Community Norms

To create lasting change, communities much change the norms that accept and encourage violence. The Cure Violence model uses multiple messengers of the same new norms so that messages are consistently and abundantly heard. Canvassing efforts bring messages about rejecting violence directly to community members' doors, where workers spread the word about the campaign and recruit persons to work with local coalitions. Workers also establish relationships with service providers to educate them about the unique challenges faced by program participants and urge providers to accept referrals. Shooting responses are held at the site of a shooting or killing within 72 hours of its occurrence, with the goal of changing norms through public statements that shootings are an unacceptable behavior that can and must be changed. Community activities bring residents together to show their support for and interest in a safe, nonviolent community.

Cure Violence deploys a public education campaign that uses the media, messaging, and other organized communication activities to discourage the use of violence. The specific materials for these communications and the methods for dissemination are provided through the Cure Violence technical assistance team and are modifiable such that local programs can include local information. Materials are disseminated during canvassing, responses, and activities, as well as through local churches, businesses, and organizations.

Cure Violence also uses small group sessions to address norms. These sessions involve discussion with the intent of disposing of negative norms and creating new positive norms to replace them. The Cure Violence team performs an assessment of the community to determine which groups of people will need to be involved in these small group sessions, but typically they include significant others and families of participants, elderly residents, and key stakeholders. The sessions can also include skill-building components that seek to give participants basic skills in de-escalation and in changing the norms of others in their community.

Data and Monitoring

Data and monitoring are used with each of the components of the Cure Violence model to measure and provide constant feedback to the system. Violence Interrupters record information on all mediations and keep daily logs that report on other

activity. Outreach Workers record information on their participants, including the assessment at intake, the risk reduction plan, and general case notes that record their work on changing behaviors. For the norm change component, reports are kept for all community activities, shooting responses, and the dissemination of public education materials. Additionally, programs obtain information on violence in the community from local law enforcement and hospitals, so that a site can determine the progress of its work and make any needed adjustments. All of the data are used at weekly staff meetings to evaluate and update the strategy and to coordinate workers.

Maintaining an Effective Program

A central characteristic of the Cure Violence model is the use of credible messengers as workers. Credible messengers are individuals from the community in which the program is located who are trusted and have access to the people who are most at risk of perpetrating violence. This type of credibility allows access to individuals and communities that can lead to the types of conversation and participation needed to achieve positive outcomes. Because Cure Violence workers have access and trust, they are able to talk about violent behavior credibly and persuade high-risk individuals to resist behaving violently. Intensive and very specific training is required, but hiring the right workers is essential to get the access, trust, and credibility required for the job—as for all health workers attempting to access hard-to-reach populations of any type. The approach should also be implemented by a credible partner organization in the target community that has a proven track record for positive work and well-established relationships with key organizations and local leaders.

Although the credible workers and organizations are essential, it is equally important that the model is implemented as designed and that the workers are trained in the specific techniques of the model. To ensure that the program stays on model and responds appropriately to problems, Cure Violence provides extensive technical assistance, including weekly calls, quarterly booster trainings, site visits, sustainability and scaling planning, and, potentially, embedded technical assistance staff at the site when needed.

The Applications of the Cure Violence Health Approach

Cities around the world have turned to the Cure Violence Health Model to prevent many types of violence—from community violence to sectarian violence to prison violence. As of the writing of this paper, the Cure Violence approach has been implemented in more than 100 communities across 16 countries. At the local level,

all Cure Violence programs are implemented by local organizations that have been carefully trained by Cure Violence.

In the United States, the program is currently implemented in 25 cities. In New York City, an extensive program has been implemented across 20 communities and includes hospital response programs and comprehensive support services for clients and workers. In Chicago, where the Cure Violence model was first implemented in 2000, the program has been implemented in as many as 18 community areas. Recent budget cutbacks in 2015 that extended through most of 2017 resulted in all but one program site closing down and coincided with an epidemic increase in violence that nearly doubled the rate of shootings and killings. Funding has recently been restored, and the model is now being implemented in ten community areas and four hospitals. Programs are also being implemented in Baltimore, Camden, Durham, New Orleans, San Antonio, Kansas City, Philadelphia, and several cities across the state of New York.

Outside the United States, the Cure Violence approach has expanded into several areas of Latin America, the Middle East, and Africa. In Latin America, early success in Juarez and Chihuahua in Mexico, with a 50% reductions in killings in sites in Juarez, has led to plans being made for expansion of the model in both cities, as well as for possible expansion to Mexico City. Programs in Honduras and El Salvador continue to show strong results, with a recent study showing 88% reductions in shootings and killings in communities in San Pedro Sula, Honduras (Ransford et al., 2017). Additionally, the program is being implemented in communities in El Salvador, Trinidad, Jamaica, Columbia, and Argentina, and initial work to implement the model is being done in Guatemala and Brazil.

In the Middle East, Cure Violence partnered in Israel with the Salam Institute to create a network of 25 trainers and Violence Interrupters from the cities of Hebron, Bethlehem, Nablus, Tulkarem, Qalqiliya, Jenin, and Jerusalem. These individuals were trained in the Cure Violence approach to interrupting violence and in skills related to nonviolent communication. In addition, the trainees implemented projects designed to put into practice what they had learned. Combined, they interrupted over 100 incidents during a period of less than 1 month and trained an additional 200 youth and adults in the Cure Violence approach.

Other efforts in the Middle East include implementation of a reintegration program in Morocco to prevent violence among individuals returning from fighting in wars in the Middle East, as well as trainings on Cure Violence methods in the region to enable those trained to proactively mediate conflict and promote peace building in their localities. Previously, from 2008 to 2013, the Cure Violence program was implemented in Basra and Sadr City in Iraq, in partnership with the American Islamic Congress (AIC) in Iraq, and resulted in close to 1000 interruptions, and over 14,000 people reached through outreach activities.

In Africa, since 2012 the Cure Violence program has been implemented in the Hanover Park community in Cape Town, South Africa, with the local partner

Violence Prevention through Urban Upgrade. Data from the program site have shown reductions in violence that are much greater than in surrounding communities. Trainings have also occurred in Nigeria and Kenya.

Evidence of Impact of Cure Violence Approach

The Cure Violence model has been independently evaluated multiple times, with each evaluation showing large, statistically significant reductions in gun violence. In New York City, the John Jay College of Criminal Justice Research and Evaluation Center conducted an extensive, independent evaluation of the Cure Violence program that showed a reduction in violence, a shift in norms, and an improvement in police-community relations. The evaluation found a 37% to 50% reduction in gun injuries in the two communities examined. Additionally, the study found a 14% reduction in attitudes supporting violence (with no change in controls) and an increased confidence in police and increased willingness to contact police (Butts & Delgado, 2017).

An independent evaluation of the Chicago intervention sponsored by the US Department of Justice and conducted by Northwestern University concluded that the Cure Violence intervention led to reductions in shootings of 41% to 73%, reductions in shooting hot spots of up to 40%, and the elimination of retaliation killings in five of eight communities. The study additionally found that 84% of the participants met the criteria for being at high risk to be the victim or offender of a gun crime and 87% of participants received the help they needed in terms of finding employment, leaving a gang, getting assistance for drug abuse, obtaining an education, and other needs. Participants ranked Cure Violence Outreach Workers second only to parents as important adults in their lives upon whom they could rely (Skogan, Harnett, Bump, & DuBois, 2009).

An independent evaluation of the Baltimore intervention by Johns Hopkins University showed significant reductions of 34% to 56% in shootings or homicides across four communities, as well as evidence of norm change. The Baltimore study also demonstrated that communities that implement the model with greater fidelity are able to achieve greater reductions (Webster, Whitehill, Vernick, & Parker, 2012). An evaluation of the program from 2012 to 2013 in Chicago found a 31% reduction in killings in the two target districts (Henry, Knoblauch, & Sigurvinsdottir, 2014). Other studies have been conducted, as summarized in Table 5.1, and several others will be released soon, including studies of programs in Philadelphia and Port of Spain, Trinidad. Additionally, beyond the impact of the Cure Violence approach on levels of violence, the approach has also been shown to help the highest-risk persons in the community with employment, education, parenting, and many other areas of their lives and to have positive effects on children in the communities served, as summarized in Table 5.2.

Table 5.1 Findings on the impact of the Cure Violence Health Model on violence

Location	Statistical findings	Reference/data
North America[a]		
Baltimore (USA)	Up to 56% reduction in killings up to 44% reduction in shootings evidence of norm change on violence	Webster et al. (2012) Police data and surveys
Baltimore (USA)	25% reduction in shootings across five sites (highest reduction, 43%)	Webster (2016) Police data
Baltimore (USA)	43% of the attitudes on violence improved	Milam et al. (2016) Survey
Chicago (USA)	41%–73% reduction in shootings and killings 100% reduction in retaliations	Skogan et al. (2009) Police data
Chicago (USA)	31% reduction in killings 19% reduction in shootings	Henry et al. (2014) Police data
Chicago (USA)	50% reduction in reinjury	Salzman et al. (2010) Hospital data
Chicago (USA)	48% reduction in shootings	University of Chicago (2015) Police data
Chicago (USA)	67% reduction in shootings in first community Average 42% reduction in shootings across first five communities	Ransford, Kane, Metzger, and Quintana (2010)
Halifax (Canada)	Reductions in shootings and violent crimes (not quantified)	Ungar and Brisson (2016) Unpublished police data and interviews
Kansas City (USA)	52.6% reduction in killings 5% reduction in shootings	Watson-Thompson, Jones, and Taylor (2014) Police data
Kansas City (USA)	16% reduction in total violent incidents 42.1% reduction in killings 4% reduction in shootings	Watson-Thompson, Jones, and Taylor (2015) Police data
New Orleans (USA)	47% reduction in shootings victims 85% reduction in retaliations/ argument motive 44% reduction in shooting reinjury	City of New Orleans (2016) Progress Report Police and hospital data
New York City (USA)	37% to 50% reduction in gun injuries 63% reduction in shootings evidence of norm change on violence	Delgado et al. (2017) Hospital data High-risk survey
New York City (USA)	Increased confidence in and willingness to contact law enforcement	Butts and Delgado et al. (2017) High-risk survey
New York City (USA)	20% lower rates of shooting > 100 mediations involving >1000 people	Picard-Fritsche and Cerniglia (2013) Police data

Table 5.1 (continued)

Location	Statistical findings	Reference/data
New York City (USA)	18% reduction in killings vs. 69% increase in control	Butts, Wolff, Misshula, and Delgado (2015) Police data
Philadelphia (USA)	30% reduction in shootings	Roman, Klein, Wolff, Bellamy, and Reeves (2017) Police data
Latin America/Caribbean (LAC)		
Juarez (Mexico)	50% or more reduction in killings in 2016 in most areas, with overall reductions in killings in 2015 and 2016	Mesa de Seguridad y Justicia de Ciudad Juarez (2017) Official unpublished data
Juarez (Mexico)	Reduction in perceived number of disputes and conflicts	Del Barrio a la Comunidad (2016) Surveys and observatory unpublished data
Kingston and Montego Bay (Jamaica)	60 workers trained, results forthcoming	Cure Violence (2018) Unpublished data
Loiza (Puerto Rico, USA)	53% reduction in killings	Cure Violence (2018) Unpublished police data
Port of Spain (Trinidad)	67% in woundings and attempted murders33% in calls for persons armed with firearms	Maguire (2017) Police data
Quezaltepeque, Nejapa, Los Novillos, La Divina, La Taqueria (El Salvador)	20 workers trained, results forthcoming	Cure Violence (2018) Unpublished data
San Pedro Sula (Honduras)	88% reduction in shootings and killings1 site, 17 months without any shootings, Over 1000 conflicts mediated	Ransford et al. (2018) Site reported data
Middle East/North Africa (MENA)		
Basra and Sadr City (Iraq)	Almost 1000 interruptions More than 14,000 people reached through outreach	Cure Violence (2018) Unpublished data
Bethlehem, E. Jerusalem, Hebron, Nablus/Jenin	25 workers implementing projects and spreading the methods in 4 communities	Cure Violence (2018) Unpublished data
Syria	133 Syrians trained70% reported interrupting violence in first 3 months	Cure Violence (2018) Unpublished data
Africa		
Cape Town (South Africa)	14% reduction in killings 29% reduction in attempted killings 10% reduction in serious assaults	Ransford et al. (2018) Police data

(continued)

Table 5.1 (continued)

Location	Statistical findings	Reference/data
Kenya [election violence]	Low levels of election violence (2013; compared with all other elections)	Cure Violence (2018) Unpublished data
Morocco [reintegration program]	3 trainings conducted	Cure Violence (2018) Unpublished data
Nigeria	1 training conducted	Cure Violence (2018) Unpublished data
Europe		
County of Kent (UK) [prison program]	51% reduction in overall violence 95% reduction in group attacks 44% reduction in adjudications (discipline)	Ransford et al. (2018) Unpublished prison data

[a]Caribbean and Latin American countries are listed separately from North America

Table 5.2 Other impacts of the cure violence health model

Area	Impact summary	References
Children	Peaceful mediation of conflicts with children present (18% of conflicts)	Cure Violence (2018) Unpublished data
	87% of clients report home visits, 53% assistance to family members	Skogan et al. (2009)
	Assistance to younger siblings and children of clients	Ransford, Cruz, Decker, and Slutkin (2015)
	New norms to protect children; improvement of behavior toward children	Ransford et al. (2015)
School	45% of clients helped to complete school/GED	Cure Violence (2018) Unpublished data
	Students less likely to fight	Ransford et al. (2015)
	Assistance in managing conflicts	Ransford et al. (2015)
Employment	Assistance for job preparedness (resumes, applications, practice interviews)	Skogan et al. (2009)
	Assistance with job readiness: 87% helped to prepare for a job interview; 86% helped to find a job opening; 82% helped to prepare a resume	Skogan et al. (2009)
	72% of workers connected clients to job programs at least once a month	Skogan et al. (2009)
	63% of workers helped clients get state IDs at least once a month	Skogan et al. (2009)
	Among clients receiving assistance, 52% were later working	Skogan et al. (2009)
	64% of workers connected clients to job interviews at least once a month	Skogan et al. (2009)

Table 5.2 (continued)

Area	Impact summary	References
Parenting	27% of clients needed help with family conflict and 15% of clients needed parenting help; over 90% reported that their needs were met	Skogan et al. (2009)
	95% of clients thought that cure violence made them a better parent	Ransford et al. (2015)
Mentoring	"One striking finding of the interviews was how important [cure violence] loomed in their lives; after their parents, their outreach worker was typically rated the most important adult in their lives"	Skogan et al. (2009)
	"Many of these clients emphasized the importance of being able to get in touch with their outreach workers at critical moments in their lives—Times when they are tempted to go back on drugs, get involved in illegal forms of employment, or when they felt that violence was imminent"	Skogan et al. (2009)
Other assistance provided to highest risk	89% to 99% of clients got help with a variety of personal problems (dealing with emotions, enrolling in rehab for drug or alcohol problems, getting tested and treated for STDs, finding a place to live, leaving a gang, resolving family conflict, and getting an education)	Skogan et al. (2009)
	31% of participants mediated their own conflict because of cure violence	Cure Violence (2018) Unpublished data
Norms	Community norms changed to reject use of violence	Delgado et al. (2017)
	High-risk individuals report being more likely to call and feel they can count on police	Butts and Delgado et al. (2017)
	Changed attitudes on use of violence among highest-risk individuals	Webster et al. (2012)

Conclusion

Violence is one of the most pressing global issues. It not only causes injury and death but also erodes the physical, psychological, social, and economic health and development of nearly everyone in affected communities, reducing life expectancy, inflicting trauma, limiting opportunity and achievement, and further entrenching inequities. These extensive effects make it absolutely necessary to address violence as a *first* step toward global progress. As we do with all other epidemics, we must immediately support investments in effective preventive methods.

When we acknowledge violence as an epidemic health problem that is transmitted through exposure and mediated by the brain and social processes, we understand that it can be effectively prevented and treated with health methods. This scientifically grounded understanding of violence holds potential for a fundamental shift in how violence and persons who show symptoms of violence are treated. Recognition

and treatment of violence as a health crisis is long overdue. To date, the health sector and health professionals have been highly underutilized for the prevention, treatment, and control of violence.

The issue of lethal violent behavior is much broader, deeper, and more specific than the current law enforcement, gun control, and mental health debates allow. If these areas represent the limit of our response, that response will be ineffective, because these areas fall short of conveying to the public how violence is formed, maintained, and changed. Violence can be successfully diagnosed, criteria can be developed and refined to predict it, and people can be successfully and humanely treated to become less violent. Effective solutions must be based on this scientifically grounded understanding of the violent behavior of an individual as an acquired and preventable event, which society has the *responsibility* to prevent. That prevention includes reducing the exposure, transmission, and progression of violence in individuals' brains and in communities through the use of community-based and health system-based outreach methods that are also used for epidemics and diseases that spread. This approach has been shown to be effective for several types of violence and has the potential to be effective for many other types of violence (Table 5.3).

The Cure Violence Health Model has shown strong and consistent evidence of effectively reducing violence in communities around the world. The model is a health approach with guidance from health professionals, but by employing workers from the same populations that are being served, the model is centered in the community, for the community, and by the community. This structure elevates the community as the main actor in preventing violence. The community is empowered by the health sector through the provision of a curriculum and skills, tools, and protocols that help to ensure effectiveness.

Beyond health approaches implemented in communities and hospitals, many other components of the system play a critical role, including teachers, law enforcement, several parts of the youth and social sector, and the media. These other stakeholders have key roles in spreading the health understanding of violence and its causes, providing effective solutions, and—to the extent they are able—screening and providing appropriate referral for treatment of people heavily exposed to vio-

Table 5.3 Syndromes of violence where the health approach is (or could be) helpful

Syndrome of violence	Shown to be contagious	Shown to be prevented using health approach
Community	+	+
Cartel	+	+
Tribal/sectarian	+	+
Partner	+	(+)
Child	+	(+)
Ideologically inspired	+	(+)
Mass shootings	+	(+)
Suicide	+	+
War	+	(+)

lence. In many instances, each of these stakeholders and others have already been incorporating health-based principles and approaches, and our hope is that this discussion further encourages collaboration and even more use and adaptations of health approaches by all sectors to help produce an even healthier and safer society.

Massive reductions in other serious behaviors and problems have been achieved with public health methods. Violence can be reduced to much lower levels in our communities—perhaps even to rare events—when we take the time to understand, explain, and treat it as a health issue by activating and organizing the health lens, sector, system, and partners to better prevent it.

Clinical Pearls

- Violence fulfills the criteria of a contagious disease—it spreads, clusters, and transmits between individuals.
- The health perspective of violence recognizes that people doing violence, as well as those who have been affected through injury and exposure, essentially have a personal health problem—a problem of exposure, contagion, and trauma or pain.
- The Cure Violence Health Model addresses violence by detecting and interrupting the transmission of violence, changing the behavior of the highest potential transmitters and changing community norms.
- A central characteristic of the Cure Violence model is the use of credible messengers as workers—individuals from the same communities who are trusted and have access to the people who are most at risk of perpetrating violence.

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