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Hospital-Based Violence Intervention Programs:
A Cursory Examination

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Introduction

Advances in trauma care have allowed many violently victimized individuals to survive their injuries and return to their lives. However, these same advances have done nothing to help reduce the chances of violent revictimization (Nofi et al., 2023). By and large victims are treated and streeted, left to grapple with their physical and mental pain alone, without any constructive outlets or means to do anything but return to the same environment they were victimized in. Hospital-based violence intervention programs (HVIP) are a relatively new means of addressing violence and violent victimization; they seek to provide targeted services to high-risk populations (Purtle et al., 2013; Snyder, 2018). In 1994, Caught in the Crossfire became the first HVIP in the U.S. and shortly thereafter the National Network of Hospital-based Violence Intervention Programs (NNHVIP) was established to encourage the widespread implementation of these types of programs. To date, there are 40 functional programs (Health Alliance for Violence Intervention [HAVI], n.d.).

What Is an HVIP?

A Hospital-based violence intervention program (HVIP) is intended to be a multidisciplinary program that combines the efforts and resources of hospitals/hospital systems with community-based partners who provide invaluable social support and unique resources for violently victimized individuals (HAVI, n.d.). Essentially, HVIPs seek to address the societal and economic costs of violence by accessing individuals at a crucial moment in their life (Affinati et al., 2016). Extant research argues that interventions are most impactful when they engage individuals shortly after their first violent victimization because it is during this time that individuals are the most motivated and receptive to

making positive changes in their life (Juillard et al., 2016; Nofi et al., 2023).[1] Some researchers refer to this as a teachable moment. These programs aim to reduce retaliatory injury and hospital recidivism by providing intensive case management services to high-risk individuals (Bell et al., 2018). These programs generally exclude domestic violence victims, sexual assault/abuse victims, and those with self-inflicted injuries. The sentiment of most in this field is that these kinds of victims are already well supported by hospitals/hospital systems. Typically, participants are offered six to twelve months of cost-free comprehensive and intensive case management services intended to address all aspects of the circumstance which led to their victimization (Mueller et al., 2022). Some programs go beyond the victim and engage the people in their life; for instance, some offer family therapy (Affinati et al., 2016). The overall intention of these programs is to address all needs of an individual (psychosocial, educational, mental/behavioral, financial counseling, legal support, etc.) to reduce violent victimization and revictimization (Affinati et al., 2016; Belle et al., 2018).

Why HVIPs Are Necessary

Minority groups, like Blacks and Hispanics, continue to experience elevated levels of intentional violent injury (Affinati et al., 2016). As a result, many suffer from non-fatal violent injuries. Effects of these injuries can include disability, economic consequences, social consequences and more, which significantly decrease an individual's quality of life; an unfortunately large number of crime victims experience or develop symptoms of PTSD and/or commit suicide (Juillard et al., 2015; Snyder et al.,

[1] Cooper et al. (2006) demonstrate program effectiveness for individuals who are engaged long after they were initially victimized.

2018).[2] Individuals aged 12 to 18 years-old are the most at risk of becoming victims of violent crime, with some research estimating that individuals aged 12 to 24 years-old account for nearly 50% of serious, nonfatal violent victimizations (Snyder, 2018). Not only are adolescents more likely to be violently victimized, but they are also more likely to be violently revictimized (Snyder et al., 2018). This is concerning considering extant research argues that victimization during adolescence often leads to things like aggressive behavior and anxiety to name a few. Additionally, the more adolescents are exposed to violence the more likely they are to engage in behaviors which increase their likelihood of violent revictimization, things like substance abuse or engagement with deviant peers who advocate for a street lifestyle.

Overall, "One of the strongest predictors of future injury is previous violent injury…victims of violent injury are more than twice as likely to die of violent death compared with matched control subjects…"(Juillard et al., 2016, p. 1156). Nearly 50% of patients who are discharged find themselves violently re-victimized (Affinati et al., 2016). Moreover, individuals who have been violently victimized are at an increased likelihood for becoming violent victimizers themselves (Purtle et al., 2013). Individuals chronically exposed to violence become conditioned to accept it and not explore other alternatives, especially if the larger community maintains a violent status quo (Snyder, 2018).

Examples of the Value of HVIPs

[2] "African American and Latino youth that live in urban areas attempt suicide at twice the national rate, which suggests that the high prevalence of suicidality may be attributed to factors associated with living in urban communities" (Snyder, 2018, p. 24).

In 1998, the Violence Intervention Program (VIP) was established at the R Adams Cowley Shock Trauma Center at the University of Maryland School of Medicine (Cooper et al., 2006). In 2006, Cooper et al., endeavored to conduct a prospective randomized control study to evaluate the VIP's effectiveness for repeat victims of violence. Using hospital data, the authors identified those individuals who had been admitted between January 1, 1999, and October 1, 2001, for injury following violent assault with prior hospitalization for violent injury. Participants had to be at least 18 and involved with the criminal justice system in the form of parole or probation. One hundred patients were enrolled in this study, 56 in the treatment group and 44 in the control group. Those in the control group received no additional support beyond the parole/probation officer they were already assigned, whereas those in the treatment group had access to a variety of beneficial resources. They first participated in a meeting with their case manager and probation officer to review their needs assessment and determine a service plan. Service plans could include substance abuse rehabilitation, conflict resolution, employment assistance, supports for families, and educational support. Once individuals were discharged, their case manager and probation officer maintained regular communication and visitation.

Of their sample, the authors found the program to have very promising outcomes. For instance, those in the treatment group were more likely to find gainful employment. Additionally, the difference between projected incarceration time for the treatment group versus the control was 18 years versus 68 years. They also found the control group to be three times more likely to be arrested as compared to the treatment group and two times more likely to be convicted of any crime. Further, the authors reported that the treatment group had a hospital recidivism rate of 5% whereas the control group

had a rate of 36%. The control group was most likely to be re-hospitalized due to another violent injury which generates a new batch of costs for the individual and, if they are uninsured, the health care system. Two participants died during the study; both were in the control group. This study undeniably illustrates the effectiveness of this HVIP and while the findings cannot be generalized, they do offer promise for other programs. Addressing an individual's physical wounds is only one step toward fostering holistic healing.

The Stand Up to Violence (SUV) program implemented at New York City Health + Hospitals / Jacobi in Bronx, NY, provides a similar multidisciplinary approach to recovery outcomes for adolescent victims of violence (Romo et al., 2023). Objectives were to determine if the SUV team's evaluation reduced re-injury rates and improved outpatient follow-up among adolescents admitted for violent trauma. Among 528 patients aged from 15 -24, 291 patients were assigned to the intervention group and 237 to the control group. Approximately 93% were male, 54% of whom identified as Black and 36% as Latino. Most patients suffered from stab wounds, followed by gunshot wounds, and then assaults. The study found that patients seen by the SUV team had significantly higher odds of attending post-discharge follow-up visits and lower odds of subsequent violent re-injury within three months of the initial admission. Similar to the VIP program, The SUV program offers comprehensive services including medical care coordination, social support, and community outreach which emphasizes the importance of sustained post-discharge engagement in reducing recidivism and improving patient outcomes.

In addition to the above-referenced SUV program, the New York State Division of Criminal Justice

Services (DCJS) and the Office of Victim Services (OVS) partnered with researchers from the University at Albany School of Public Health to initiate SNUG (guns spelled backward; a.k.a. Should Never Use Guns) programs. The SNUG program operates with a public health approach aimed at reducing violence through community-based interventions and connecting crime victims with essential services (Division of Criminal Justice Services [DCJS], 2023). In 2018, hospital-based licensed social workers and case managers were assigned to SNUG sites to facilitate this connection. The program model includes the supervision and support of these professionals who ensure that all SNUG staff receive training in trauma-informed care. Hospital-based social workers at major trauma centers work with victims and families after a violent incidents, offering services such as safety planning, trauma education, and can refer victims to SNUG site-based teams. SNUG enhances the accessibility to services for victims by providing a case manager that works alongside a social worker to assist victims with navigating social services and providing trauma-informed care services.

During an evaluation period of the program between March 2019 and September 2022 there was a notable increase in OVS applications submitted and awarded through the efforts of SNUG and social workers (DCJS, 2023). SNUG sites reported that social work staff significantly contributed in coordinating service referrals and provided substantial emotional support to the SNUG team indicating that "hospital-based social workers were an asset to SNUG sites and improved connections with…shooting victims" (p. 3). Consequently, 80% of SNUG sites were positively perceived within their communities. Additionally, from April 2020 to August 2022, SNUG sites reported increase in the average number of participants served, indicating a greater capacity to support at-risk individuals. Lastly, from January 2021 to August 2022, successful referrals from hospitals to SNUG sites almost

doubled, increasing from 40% to 70% demonstrating community-based programs collaborating with hospitals can address broader socio-environmental issues and create safer environments for victims.

The Wrap-around Program based out of San Francisco General Hospital has been operational since 2005 (Juillard et al., 2015). Individuals who are determined to be high risk for hospital recidivism are offered the ability to participate in the program which gets them access to "…intensive, individualized case management services…" which facilitate connections to risk reduction resources (p.1). While the effectiveness of this particular HVIP has been evaluated, the authors noted that its cost-effectiveness has not been so thoroughly evaluated. Using hospital data, the authors analyzed a hypothetical cohort of violently victimized individuals.[3] Some were assigned to the treatment group (HVIP) while others were assigned to the control group (no HVIP programming). The authors reported that the treatment group generated significant financial savings whilst also providing individuals with additional cost and quality adjusted life years. Purtle et al. (2015) conducted a cost-benefit analysis simulation to estimate the savings a hypothetical HVIP might have in health care, criminal justice, and lost productivity costs and they found that across all three sectors the HVIP generated significant cost savings. While their findings cannot be generalized, there is plenty of research that supports their findings (Chong et al., 2015; Juillard et al., 2015; Snyder, 2018).

Key Components

[3] According to the same authors, since 2005, the program has been associated with a four-fold decrease in the hospital recidivism rate as compared to hospital recidivism rates prior to program inception.

HVIPs operate with a trauma informed care approach which appreciates that both the psychological and physical wounds of an individual must be tended to for them to truly recover (Purtle et al., 2013). After all, many violently injured individuals have extensive histories of trauma. With this, it is equally important to provide robust case management to individuals who have been violently victimized because when they are discharged from the hospital, they face a number of challenges and barriers to the activities of daily life (Bell et al., 2018). They may need to find new housing, address legal issues, and need assistance dealing with the trauma associated with their victimization. When individuals do not have assistance managing these challenges, they may revert to behaviors which increase their risk for re-injury (i.e., substance abuse, possession of a weapon).

Moderate and high exposure to intensive case management has been found to be significantly associated with participant engagement (Smith et al., 2013). Therefore, it is incredibly important to hire case managers/victim intervention specialists that can empathize and appreciate the magnitude of what the victim is dealing with (Decker et al., 2020). Many HVIPs are peer based, utilizing victim intervention specialists (VIS) (Affinati et al., 2016). VIS are different than a typical case manager because they often have lived experience. This allows them to connect with individuals in a different, perhaps more meaningful way than a typical case manager whose background is in social work (Foje et al., 2022). Where VIS are not utilized it should be ensured that case managers are culturally competent and have an understanding of the street dynamics that underlie violence (Purtle et al., 2013). These are the kinds of individuals who can express true compassion and care, which fosters strong therapeutic relationships that facilitate participant success. The right case manager/VIS empowers an individual to want to change their life, which is markedly different from forcing change

on an individual without considering their extenuating circumstances.

Challenges & Shortcomings

In their study of Eskenazi Health Prescription for Hope, a HVIP based out of Sidney & Lois Eskenazi Hospital in Indianapolis, IN, Bell et al. (2018) determined the program did lower the rate of violent injury recidivism. However, they also noted that it seemed to neglect participants' self-proclaimed desire for mental/behavioral health programming. Dineen et al. (2022) elucidates this shortfall of HVIPs more broadly. These authors reviewed a number of studies evaluating the effectiveness of HVIPs and found that many of the programs were principally concerned with meeting short-term needs rather than offering psychological and behavioral support which help an individual in the long term. It is not to say that meeting short-term needs does not matter. Foje et al. (2022) reported that meeting a participant's short-term needs is critical to ensuring their long-term engagement. However, they also cautioned that even meeting short-term goals (e.g., finding a job, applying to school) can take time, and so it can be beneficial to engage individuals with mental/behavioral health resources to continue to keep them engaged and connected with programming. While HVIPs are intended to offer holistic support to an individual, it seems they often fall short on this crucial aspect.

Working with youth in an HVIP comes with its own unique set of challenges. Just like adults, youth experience structural barriers to engaging with this type of programming (Voith et al., 2022). They may need to work to help support the household or lack adequate/reliable transportation to get to appointments. When dealing with youth, it is important to engage parents and show them respect (Voith et al., 2022). Parents sometimes act as gatekeepers to their children and what they perceive as

an affront to their parenting may result in their child losing out on valuable programming.

Beyond parents, including community stakeholders is crucial to fostering participant engagement because members of the community are acutely aware of the barriers which prevent individuals from engaging with HVIP programming. For instance, individuals may be unable to take time off work, find childcare, or transportation (Affinati et al., 2016). Others may be too afraid to leave their house. In their relatively extensive review of studies evaluating the effectiveness of HVIPs, Dineen et al. (2020) reported with great concern the fact that many of the programs were not well connected, if connected at all, with community-based groups also seeking to provide violence intervention support. After all, collaboration with community groups creates a bridge between hospital and community, making individuals more likely to engage with the services being offered because they are endorsed by people they respect and trust (Nofi et al., 2023). Collaboration with the community could also lead to increased service availability. For instance, the Wrap-around Program at San Francisco General Hospital collaborates with "…a community-based organization that specializes in post-traumatic stress and other mental health support services…", allowing them to better meet participant mental health needs (Juillard et al., 2016, p. 1160).

The Role of Hospitals/Hospital Systems

Some make the argument that hospitals should provide structural support because they have the administrative and financial resources to do so, permitting case managers/VIS and community stakeholders to focus all their efforts and resources towards supporting their fellow community members (Mueller et al., 2022; Ranjan et al., 2023). Working with a hospital seems logical; however,

hospitals/hospital systems often suffer from a plethora of institutional issues (Voith et al., 2022). Staff may not always be present to meet with potential participants, which leads to individuals falling through the cracks and not getting services that could potentially help them. When staffing is available, they may not be properly trained due to high rates of turnover. In short, patients may lose out on their ability to participate in this valuable programming simply due to institutional fallibility. One could also make the argument that all these shortcomings are compounded by the "…absence of institutional support for low-income, youth of colour who enter EDs [emergency departments] with violent injuries…" (Voith et al., 2022, p. 4881). Paul Jr. et al. (2020) poignantly argued that the suffering of White communities is often medicalized, whereas the same suffering for minority communities, especially Black communities, is ignored, criminalized, or blamed on the people themselves. They make the point that, as it stands currently, hospitals seem to be offering engagement with no follow through. For example, many HVIPs are not funded by their hospitals at all (Voith et al., 2022). If HVIPs are to truly be successful, they need the authentic support of hospitals and hospital systems.

One would think hospitals/hospital systems would be more enthusiastic about implementing HVIPs. After all, many individuals who are violently victimized are uninsured (Affinati et al., 2016; Chong et al., 2015). In 2017, it was estimated that U.S. hospitals/health systems lost $852,000,000 in unreimbursed medical care costs incurred treating victims of violence (Foje et al., 2022). Hospitals are spending money on violently victimized individuals whether they want to or not, and research has shown that the costs associated with the intensive case management HVIPs are usually the same if not less than the costs incurred without them (Bell et al., 2018; Chong et al., 2015). When HVIPs are

present, the rate of hospital recidivism is significantly decreased.[4] With the hospital recidivism rate lowered, hospitals no longer incur the additional costs associated with another admission for a violent victimization or some other malady, usually substance or psychologically based. Chong et al. in their 2015 study asserted that the cost savings associated with HVIPs could range from $750,000 to $1,000,000 million annually.

Conclusion

Gun violence is not something that anyone could reasonably expect to completely control or eliminate. However, we can expect efforts like hospital-based violence intervention programs to be further improved and built upon. With the proper funding and authentic support from hospitals/hospital systems, culturally competent case managers or victim intervention specialists (VIS), and active collaboration with community stakeholders, hospital-based violence intervention programs could continue to positively impact the lives of many violently victimized individuals. While no program is perfect, certain shortcomings of existing programs can be identified and future programs can be modified accordingly. The time has come for solutions that recognize most individuals who experience violent victimization have wounds both physically and psychologically, and they need care that both recognizes their needs and actively supports them in meeting them to change their lives.

[4] Before the Wrap-around program began the hospital saw a 16% hospital recidivism rate, the 6-year period being analyzed had only a 4% hospital recidivism rate (Smith et al., 2013).

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