Developing a Trauma-Informed, Emergency Department–Based Intervention for Victims of Urban Violence

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The Surgeon General's report on youth violence, the Centers for Disease Control and Prevention, and other national organizations are calling for public health approaches to the issue of youth violence. Hospital-based violence intervention programs have shown promise in reducing recurrent violence and decreasing future involvement in the criminal justice system. These programs seldom address trauma-related symptoms. We describe a conceptual framework for emergency department–based and
hospital-based violence intervention programs that intentionally addresses trauma. The intervention described—Healing Hurt People—is a trauma-informed program designed to intervene in the lives of injured patients at the life-changing moment of violent injury. This community-focused program seeks to reduce recurrent violence among 8- to 30-year-olds through opportunities for healing and connection. Healing Hurt People considers the adversity that patients have experienced during their lives and seeks to break the cycle of violence by addressing this trauma.

KEYWORDS emergency medical services, injury prevention/injury control, public health, social issues, trauma

COMMUNITY VIOLENCE AS A PUBLIC HEALTH PROBLEM

According to the Centers for Disease Control and Prevention, homicide is the leading cause of death for young people ages 10 to 24. In 2006, 5,958 in this age group were murdered—an average of 16 each day. Of these youth homicide victims, 87% (5,159) were male, 13% (799) were female, and 84% were killed with a firearm (Centers for Disease Control and Prevention, 2009b). In Philadelphia, where Healing Hurt People is based, homicide is the leading cause of death among African Americans aged 15 to 24 years (Beiser & Wickrama, 2004). In 2007, Philadelphia recorded 392 homicides, 41% of whom were younger than 25. That same year, there were 3,152 nonfatal shootings.

National statistics for nonfatal and school-related violence further show the scale of this crisis. In 2007, more than 668,000 young people aged 10 to 24 years were treated in emergency departments for violent injuries. In a national study of school violence, 4.2% of students in Grades 9 to 12 reported having been in a physical fight one or more times in the previous 12 months that resulted in injuries that needed medical treatment (Centers for Disease Control and Prevention, 2009b). Although patients whose intentional injuries require hospital admission may receive many supports and services, victims who are released often receive nothing beyond the physical care needed to treat their injuries.

Witnessing violence is another layer of the problem. Most young people who suffer intentional injury have witnessed violence prior to their injury and are likely to witness more violence after discharge (Cheng et al., 2003). Witnessing community violence is a risk factor for substance abuse, aggression, anxiety, depression, and antisocial behavior in adolescence (Kilpatrick et al., 2000). Adolescent delinquency and substance use set the stage for a pattern of chronic violent offenses in adulthood (Zinzow et al., 2009). In a study of more than 8,000 sixth-, seventh-, and eighth-grade urban students,
children exposed to a high level of community violence were 7.7 times more likely to carry a handgun, 5.2 times more likely to be involved in a gang, 6.4 times more likely to use marijuana, 5.3 times more likely to binge drink, and 2.8 times more likely to be injured as a result of fighting (Barroso et al., 2008).

Violent injury is also a recurrent problem. Up to 45% of victims who suffer a penetrating injury are re-injured in the 5 years following the first injury, and 20% are dead within those 5 years (Goins, Thompson, & Simkins, 1992; Sims et al., 1989). Exposure to violence and victimization are strongly associated with future acts of violence by victims (American Academy of Pediatrics Task Force on Violence, 1999). This finding was confirmed by research that revealed that young African American male victims of violence believe that if they fail to respond violently to being injured, they will be at further risk for victimization (Rich & Stone, 1996).

Research has revealed a link between past trauma and future violence (Cooper, Eslinger, Nash, al-Zawahri, & Stolley, 2000; Goins et al., 1992; Sims et al., 1989). Research with African American men who are victims of violence has shown that symptoms of trauma combine with the so-called code of the street to compel these men to self-medicate with drugs, carry a weapon, and sometimes seek retaliation, all to reestablish a sense of safety (Rich, 2009; Rich & Grey, 2005). This dynamic also resonates with other men of color who face a limited horizon of life possibilities.

Apart from physical pain and injury, violence causes significant psychological distress for the victim. In the United States, more than 20% of injured trauma survivors have symptoms consistent with a diagnosis of posttraumatic stress disorder 12 months after acute care, in-patient hospitalization (Zatzick et al., 2007). Intentional injuries are among the most costly health problems in the United States, accounting for $75 to $100 billion yearly in disability and lost productivity (Reiner, Pastena, Swan, Lindenthal, & Tischler, 1990).

THE ROLE OF THE EMERGENCY DEPARTMENT IN VIOLENCE INTERVENTION

The Centers for Disease Control and Prevention has outlined a four-step approach to addressing youth violence as a public health issue: (a) defining and monitoring the problem, (b) identifying risk and protective factors, (c) developing and testing prevention strategies, and (d) ensuring widespread adoption of such strategies (Centers for Disease Control and Prevention, 2009a). Although many approaches to violence prevention are based on the assumption that youth must be reached before they become involved in violence, research shows the potential to break the cycle of violence by providing positive supports to youth who have become victims of violence.
According to “Children’s Exposure to Violence: A Comprehensive National Survey” (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009), clearly more needs to be done at all levels of policy and practice to identify children at risk from exposure to violence and to coordinate the delivery of services to these children. This study mentions the need to involve emergency room physicians, nurses, and social workers in responding to the needs of these youth and in connecting with other service providers in young people’s lives to coordinate services. Another study that looked at repeated exposure to violence concluded that the multiplicity of interrelated risk factors mandated a comprehensive approach to violence recidivism and called for hospital-based intervention strategies that address the complex needs of this population (Cooper, Eslinger, & Stolley, 2006). Similarly, a 2001 report from the Surgeon General identified hospital emergency departments as an important source of data about youth violence (Center for Mental Health Services, 2001). We conclude that the emergency departments of community-based urban hospitals are resource-rich settings for identifying young victims of violence, collecting data, and intervening.

KAIT: A HYPOTHETICAL CASE EXAMPLE

The following case is a hypothetical composite example of a typical young person seen in an urban emergency department for violence-related injuries. No human subjects research was conducted in connection with this article.

Kai is a 20-year-old African American man who is brought to the emergency department with gunshot wounds to the back, leg, chest, and arm. He undergoes full resuscitation and is admitted to the surgical intensive care unit. Despite a turbulent initial course, he stabilizes and is transferred to the surgical ward, where he meets a social worker who interviews him about the night he was shot.

Kai was at a birthday party and danced with a young woman he had just met. Unbeknownst to Kai, the woman had a boyfriend who was also at the party. The boyfriend confronted Kai. After a brief scuffle, Kai walked away and left the party. Moments later, Kai was shot from behind by the man who had argued with him.

The social worker learns that 2 years prior, Kai was treated and released from the emergency department for a stab wound. He has also been incarcerated twice and is currently on probation. Kai has a 3-year-old son but is estranged from the child’s mother. The social worker has limited time, and after obtaining the information she needs for the medical record, she writes her notes and leaves. As soon as is medically possible, Kai is discharged from the hospital with follow-up for his wounds but not for his posttrauma psychological or social issues.
This case illustrates how the current assessment of violent injury in the emergency department focuses on the narrow period just before and after injury, with the greatest focus on immediate medical care. Little or no attention is given to psychological or social issues unless the patient presents significant behavioral problems while in the hospital. If any information is obtained outside of medical issues, this inquiry is likely to focus on issues such as involvement with the criminal justice system, past injury, pending legal cases, and child support. Rarely does this assessment include the physical and behavioral consequences of trauma or delve into early childhood adversity and trauma that may affect present and future outcomes. The hospital emergency department is a key setting for violence intervention programs because it is the point of entry for victims and their families. Many of the youth who are most at risk for violent injury use the emergency department as their primary point of access to health care. Studies have shown that following a trauma such as assault, patients in the emergency department are primed for a “teachable moment”—a potentially life-changing window of intervention (Cunningham et al., 2009).

Violence intervention programs have been developed for use in the emergency department using a range of strategies to prevent recurrent violence and to facilitate positive client outcomes (Cunningham et al., 2009); however, because many programs lack an explicit trauma-informed framework, they only measure such distant outcomes as revictimization, death, and involvement with the criminal justice system. More proximate outcomes—such as trauma-related psychological symptoms—are seldom evaluated.

Here we describe an emergency department intervention for victims of intentional injury built on a trauma-informed framework. Based on existing and emerging trauma theory, this model suggests that addressing the effects of childhood adversity as well as the current injury is essential to effective intervention.

HEALING HURT PEOPLE

Early Development

*Healing Hurt People* is a trauma-informed intervention that emphasizes a restorative process to help youth understand the effects of trauma and gain positive coping skills to manage difficult emotions, loss, and stress. It is a community-focused program that seeks to reduce violence among youth ages 8 to 30 by addressing trauma and providing opportunities for healing and connection.

The program grew out of the frustration expressed by emergency department patients and providers alike. Patients were left with no follow-up or support for coping with the effects of their trauma after discharge. Providers were frustrated by the relentless stream of injured and reinjured
youth flowing through the emergency department and the lack of resources
to intervene.

Theodore J. Corbin—an emergency room physician who would go on
to become the director of Healing Hurt People—envisioned a program that
would connect with injured youth in the emergency department at this
potentially life-changing moment with needed supports and services. This
physician was able to secure start-up support for such work through an
academic fellowship. The work resonated with the director of Philadelphia’s
Department of Behavioral Health, who committed to funding implementa-
tion of the program—first at an urban Level 1 trauma center and later at
an urban children’s hospital. This commitment of support is especially
noteworthy in the current context of limited public funds, a depressed economy,
and the lack of reimbursement for violence prevention and outreach.

Healing Hurt People was first implemented at a university hospital as
a partnership between the university’s College of Medicine and School of
Public Health. Support to establish the center from a private behavioral
health foundation, combined with support of Healing Hurt People by the
public sector, converged to launch this multidisciplinary comprehensive
effort.

Several core activities were crucial in designing and implementing the
program:

- a literature review on emergency department–based violence interven-
tions,
- visits to similar model programs in the United States (in particular the
Caught in the Crossfire program in Oakland, CA),
- consultation with experts in the field of violence prevention and trauma,
- focus groups with individuals in the target age range who had experienced
intentional violence,
- focus groups with emergency department personnel, and
- establishment of collaborative relationships with community-based part-
ners to meet the needs of program participants.

Trauma Theory and the Psychobiology of Traumatic Injury

To be “trauma informed,” systems of care must be grounded in a thor-
ough knowledge of the complex biopsychosocial implications of exposure
to toxic stress, adversity, and traumatic life experiences (Harris & Fallot,
2001) A trauma-informed approach to violence intervention recognizes that
trauma feeds the cycle of violence. Our philosophy is guided by a funda-
Evidence in the medical and psychiatric literature supports the conclusion
that trauma is at the center of much physical and psychological pain and
has a direct connection to many significant health, mental health, and social
problems. Most recently, the Adverse Childhood Experiences Study has provided overwhelming evidence that trauma prior to age 18 is strongly related to adverse health outcomes during one’s life (Felitti et al., 1998).

Schnurr and Green (2004) detailed a conceptual model of trauma that demonstrates the multiple effects of violence and adversity (see Figure 1). Their model depicts the psychological, biological, and behavioral risks posed by trauma and adversity. Some of these effects are mediated through biological changes (e.g., obesity, insulin resistance) and others are mediated through behavioral risks (smoking, drug use, violence; Felitti et al., 1998).

Most patients who present to the emergency department with an intentional injury are still suffering the psychological effects of acute stress activated by their trauma. Their systems are biologically awash with stress hormones, and they are often hypervigilant, hyperaroused, and feeling unsafe. Their behavioral response (e.g., obtaining a weapon or assembling friends to retaliate) is often a direct response to the biological and psychological effects of trauma. These effects are heightened in youth who have suffered chronic stress and adversity because of past violence and various forms of abuse and neglect.

In Healing Hurt People, we apply the Schnurr–Green model to the cycle of violence that often characterizes the lives of patients seen in emergency departments for violence-related injuries, as presented in Figure 2.

Sanctuary Model

The organizational framework of the *Healing Hurt People* program is the sanctuary model, a theory-based, evidence-supported method for creating an organizational culture in which healing from psychological and social trauma can be addressed. Based on more than 25 years of clinical experience in responding to the needs of traumatized individuals, sanctuary is not a specific treatment intervention; it is structurally “deeper” than a specific intervention, although many interventions are compatible with it. It is designed to get people from diverse backgrounds speaking a common language; living shared values; and sharing a consistent, practical framework (Bloom, 1997, 2005, 2007; Bloom & Farragher, 2011). The sanctuary model is rated as a “promising practice” of the National Child Traumatic Stress Network (2008) and as showing promising research evidence in the California Evidence-Based Clearinghouse for Child Welfare (2008). Although the sanctuary model is being implemented in a wide range of health, mental health, educational, and social service settings, *Healing Hurt People* is its first adaptation in an emergency department–based intervention.

Program Design

The direct service staff of *Healing Hurt People* includes a trauma-trained social worker and community intervention specialist who engage violently injured youth in the emergency department. The principles of the sanctuary model frame the organizational culture of *Healing Hurt People*, and