Southern California Academic Center of Excellence on Youth Violence Prevention

University of California Riverside

Reinjury Prevention for Youth Presenting with Violence-Related Injuries

A Training Curriculum for Trauma Centers

Editors

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Winter 2008

Acknowledgments

Death due to violent injury is one of the largest and often unacknowledged health disparities. In 2004 more than 5,000 youth ages 15 to 24 were victims of homicide, making it the leading cause of death for African-American males in the United States.

750,000 people ages 10 to 24, throughout the U.S., were admitted to emergency departments and trauma facilities with violence-related injuries in 2004. Subsequently 44% were readmitted due to another assault and 22% died after first admission. Healthcare professionals in emergency departments and trauma centers play a critical role in preventing violent reinjury and incidence of retaliatory violence.

This curriculum was developed by a team of trauma surgeons, emergency physicians, nurses, social service agencies, violence injury prevention research centers, and in conjunction with former victims of violence.

This manual serves as an introduction to youth violence for healthcare professionals working in trauma centers. It identifies methods to reduce the likelihood of youths presenting with violence related injuries from suffering future injuries, or engaging in retaliatory violence upon discharge.

This curriculum represents the collective efforts of the many individuals listed below. We welcome your comments and suggestions and hope this training guide gives healthcare professionals ideas and resources that can help move beyond the common "treat em' and street em'" approach to gang involved youth and others that present with violence-related injuries.

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Youth Violence Resources for Emergency Trauma Personnel

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Module 1:
The Facts About Youth Violence

OBJECTIVE 1:

Role of the ED in Youth Violence Prevention

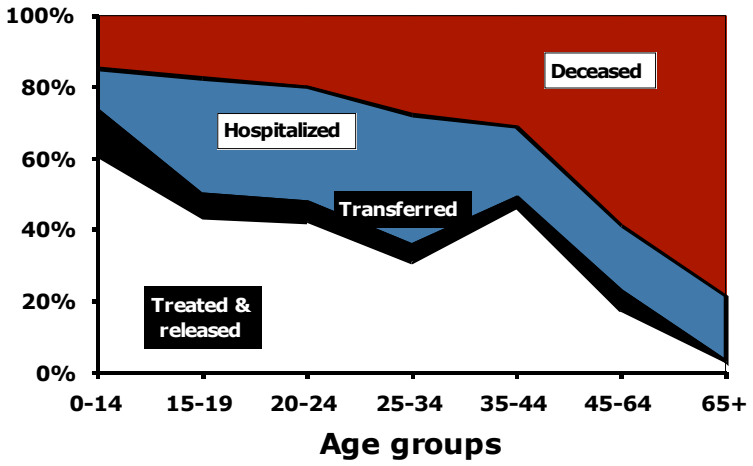
Emergency department (ED) and trauma personnel are gaining recognition as critical participants in youth violence prevention and control. Youth violence interventions based in primary care settings have successfully decreased aggressive behavior, bullying, and fight-related injuries.[1] However, there are several reasons that an ED setting may be more appropriate and effective for such interventions. For one, public health interventions require consistent access to their target populations to be effective. Research shows that many of the groups at highest risk for youth violence utilize the ED as their primary or sole access point to the healthcare system. This is due in large part to lack of a primary care physician, limited insurance coverage, and convenience.[2-5] Second, even if a youth patient utilizes a primary care provider for routine care, it cannot be taken for granted that the provider will address concerns regarding violence related risk factors, such as alcohol use.[6] One recent study found that almost 75% of adolescents did not receive appropriate prevention interventions from their primary care physician.[7] Therefore, while it is ideal and important that youth receive violence prevention messages during routine healthcare visits, the involvement by ED physicians in youth violence prevention is vital to reach many adolescents who may not hear these messages in other healthcare settings and are at high risk for future injury.

Statistics demonstrate the need for interventions in the ED setting. Twenty-five percent of adolescents seen in the ED are treated for violence-related injuries.[8] In 2004 in the US, more than 750,000 youth between the ages of 10 and 24 visited the ED for violence-related injuries.[9] Readmission rates for youth treated for violent injuries in the ED are as high as 44% due to another assault, and 20% for subsequent homicide.[10-14] Furthermore, an analysis of ED discharge disposition shows that the majority of youth sustaining assault-related firearm injuries are treated and released from the ED (Figure 1).[9] These discharged youth will not have the opportunity to interface with resources on the inpatient trauma unit (on the occasions that inpatient resources are available).

Violence-related injuries represent a significant number of emergency department (ED) visits and of those, 25% of adolescents seen in the ED are treated for violence-related injuries.[15] ED visits for attempted suicide and violence represent the most numerous visits among youth. This puts emergency trauma personnel in a unique position to help identify and assess youth at risk for violence. Although many healthcare providers and nurses recognize the importance of identifying, assessing, and intervening with violent youth, most are not currently providing these youth with services that may prevent them from further injury. From a survey conducted among physicians and nurses in emergency departments, Fein and colleagues identified a number of barriers in assessing violent youth.[8] Lack of time, energy, and skills, as well as concern for personal safety and upsetting family members were reasons for not conducting an appropriate risk assessment. However, with a better understanding of techniques and tools available for such interventions ED staff will find it much easier to perform these activities. In this module we will present a review of strategies to encourage communication with victims of violence, effective

youth violence screening tools, an overview of successful youth violence prevention interventions in non-ED settings, and guidelines and examples of successful programs in the ED.

Figure 1. Distribution of ED disposition for firearm-related injuries by age (2001)[9]



The ED should not only be seen as a substitute for the limitations of primary care for youth violence interventions; its strengths support the setting in its own right and emergency and trauma personnel are uniquely positioned for this role. Primarily, there are often lengthy wait times in the ED, providing the time necessary to conduct an assessment and provide an intervention. Second, the majority of violence-related injuries among youth treated in the ED are relatively minor,[16] so that the patient can engage in communication. Third, parents or guardians are often present in the ED when youth are treated for non-life threatening injuries. Family connectedness and parental support have been identified as protective factors for violent behavior among youth.[17-19] Parental involvement is often not easily accessible in other non-medical settings. Fourth, ED and trauma staff already have experience in assessing the risk of future re-injury among patients with other health concerns, including potentially suicidal individuals or those involved in domestic violence. The same skills of screening, intervention, and proper referral apply to violence prevention.

Finally, healthcare encounters in the ED and hospital represent unique "teachable moments" that can be utilized for brief interventions. One study demonstrated the positive impact of a brief intervention designed to decrease alcohol consumption and associated negative behaviors among youth presenting in the ED with an alcohol-related injury.[20] Other studies among injured adults in the ED found an increased willingness to change drinking behavior in the immediate post-injury period, and that this willingness deteriorated over time.[21-23] Taking advantage of teachable moments following violent injuries appears to be especially important in the prevention of assault-specific issues such as re-injury and revenge homicide.[24, 25]

Figure 2. Helpful Resources on Youth Violence and its prevention

HELPFUL RESOURCES

List of Ongoing Evidence Based Violence Prevention Efforts

- http://www.nrepp.samhsa.gov/listofprograms.asp?textsearch=Optional+Search+Terms&ShowHide=1&Sort=1&N11=11

AMA Policy Position

- http://www.ama-assn.org/ama/pub/category/8151.html (Link to download a more detailed description of the AMA policy system at bottom of webpage)

Violence Prevention in the Emergency Room: Clinician Attitudes and Limitations.

- http://www.ncbi.nlm.nih.gov/pubmed/10807302

Youth Violence Statistics Sheet

- http://www.safeyouth.org/scripts/facts/statistics.asp

Project UJIMA: Working Together to Make Things Right.

- http://healthlink.mcw.edu/article/1031002394.html

Connecting the Dots to Prevent Youth Violence - A training and Outreach Guide for Physicians and Other Health Professionals

- http://www.ama-assn.org/ama1/pub/upload/mm/386/youthviolenceguide.pdf

Youth Alive: Closing the Revolving Door of Violence

- http://www.youthalive.org/cinc

OBJECTIVE 2:

The Emergency Department Visit As A "Teachable Moment"

The basic premise of the teachable moment in the context of healthcare is that a sudden change in health status tends to create a state of self-reflection and a tangible sense of an individual's mortality and vulnerability. This "cue" may signify an open window of time during which the individual may be more likely than before to change high-risk behaviors in an effort to prevent future vulnerability and compromise. Critical to the impact a teachable moment can make is the individual's interpretation and judgments of the cues, or health-related event. The interpreted significance, cause, and meaning of an event determine the likelihood that a behavioral change will occur.[26] The concept of the teachable moment has been embraced by healthcare professionals working in fields as diverse as oncology,[27, 28] heart disease,[29, 30] sexually transmitted diseases,[31] alcohol abuse,[32] tobacco cessation,[33-35] and injury prevention.[36] In the acute care setting the teachable moment may be useful in getting the patient and family to take immediate safety actions, and to become engaged in future planned contact for violence prevention activities.

Figure 1: Helpful resource on the ED as an intervention/prevention locale

HELPFUL RESOURCES

Article 1: Characterizing the Teachable Moment: Is an Emergency Department Visit a Teachable Moment for Intervention Among Assault-Injured Youth and Their Parents?

- http://www.ncbi.nlm.nih.gov/pubmed/17726415

Article 2: Understanding The potential of Teachable Moments.

- http://www.ncbi.nlm.nih.gov/pubmed/12729175?dopt=Abstract

OBJECTIVE 3:

What is Youth Violence and What is its Prevalence in the U.S.

Violence is typically defined 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".[37] Youth violence typically refers to any incident in which the victim or perpetrator is between the ages of 10 and 24. Youth violence includes acts such as aggravated assault, robbery, rape, and homicide, as well as aggressive behaviors such as verbal abuse, bullying, hitting, slapping, or fist fighting, which have significant consequences but do not generally result in serious injury or death.[38]

Youth violence is a significant public health problem in the United States. The incidence of violent death throughout the country among adolescents increased dramatically between 1985 and 1991, with homicide rates for 15- to 19-year-olds increasing more than 150%.[17] The incidence of homicide peaked in the mid-1990s, and although it has declined in the past decade the United States retains the highest youth homicide and suicide rates among the 26 wealthiest nations.[39] In 2004, more than 5,000 people ages 15 to 24 were victims of homicide, making it the second leading cause of death overall and the leading cause of death for African-American males in this age group (Figures 2 and 3). The vast majority (79%) of these victims were killed with firearms.[40] Yet despite these statistics, resources and medical training do not adequately prepare medical personnel to participate in preventing and controlling violent injuries.

Figure 1. Leading causes of death among youth ages 15 to 24 in the U.S., 2004[41]

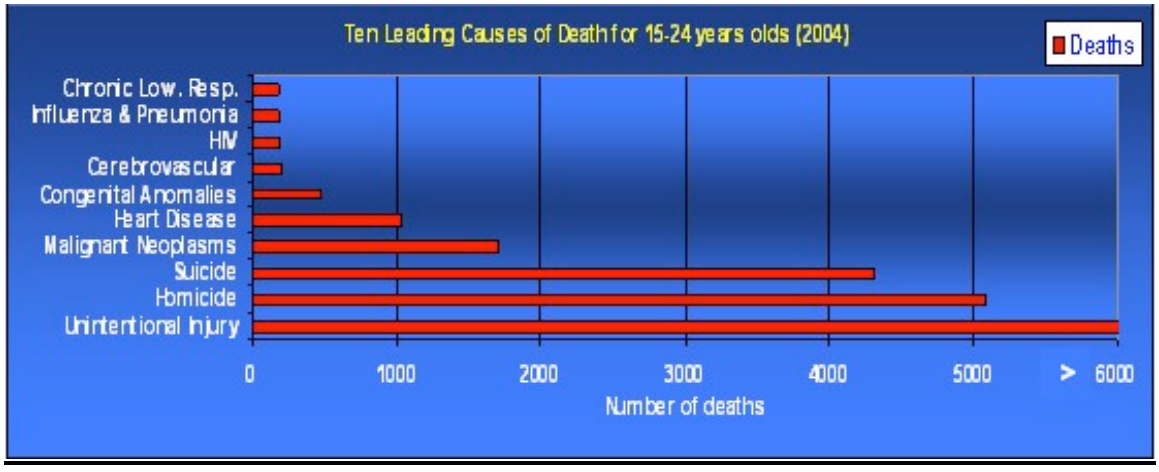


Figure 2. Leading causes of death among youth ages 15 to 24 in the U.S., by gender and race, 2005[9]

	Males Age 15-24		**Females Age 15-24**	
Rank	Black	White	Black	White
1	**Homicide**	Unintentional Injury	Unintentional Injury	Unintentional Injury
2	Unintentional Injury	Suicide	**Homicide**	Suicide
3	Suicide	**Homicide**	Malignant Neoplasms	Malignant Neoplasms
4	Heart Disease	Malignant Neoplasms	Heart Disease	**Homicide**
5	Malignant Neoplasms	Heart Disease	Complicated Pregnancy	Heart Disease

Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). (2005). Available at: www.cdc.gov/ncipc/wisqars. Accessed April 8, 2008.

Youth violence also continues to be a major cause of non-fatal injury in the U.S., as evidenced in studies of healthcare utilization. In 2006, more than 766,000 youth ages 15 to 24 received medical care for non-fatal violent injuries, of which 9% required hospitalization.[9] However, the true burden of youth violence is much higher. The 2003 Youth Risk Behavior Survey, a national survey of students, found that 33% reported being in a physical fight one or more times in the preceding 12 months.[40, 42] The same survey also found that 17% of students reported carrying a weapon on one or more days in the preceding 30 days.[40] Similarly, while national data collected in 2003 document nearly 35,000 injuries due to sexual assault among 10 to 21 year olds[9], research suggests that significant underreporting exists due to missed diagnosis or fear of reprisal among victims.[43]

Figure 3: Helpful resources for Objective 3: Definition and prevalence of youth violence

Helpful Resources

CDC Definition of Youth Violence
- http://www.cdc.gov/ncipc/dvp/YVP/YVP-def.htm

WHO VIP: Homepage
- http://www.who.int/violence_injury_prevention/violence/en/

CDC Database Holds the Leading Causes of Death Reports.
- http://www.cdc.gov/ncipc/wisqars/

Youth Violence Statistics Sheet
- http://www.safeyouth.org/scripts/facts/statistics.asp

OBJECTIVE 4:

Myths and Understanding The Facts about Youth Violence

There are many myths about youth violence that influence public perception about the problem. Possessing adequate information to directly refute these myths is an important part of being an effective advocate. The following list, taken from "Youth Violence: A Report of the Surgeon General," outlines common myths and refuting evidence about groups at increased risk for violence.[44]

Myth: The epidemic of violent behavior that marked the early 1990s is over, and young people—as well as the rest of U.S. society—are much safer today.

Fact: Although key indicators of violence such as arrest and victimization data clearly show significant reductions in violence since the peak of the epidemic in 1993, an equally important indicator warns against concluding that the problem is solved: self-reports by youth reveal that involvement in nonfatal violence has not dropped from the peak years of the epidemic, nor has the proportion of students injured with a weapon at school. For example, in 2005, 36% of students surveyed had been in a physical fight within the past 30 days; 7% had carried a weapon on school property, and 8% had been threatened or injured with a weapon on school property.[45]

Myth: Most future offenders can be identified in early childhood.

Fact: Exhibiting uncontrolled behavior or being diagnosed with conduct disorder as a young child does not predetermine violence in adolescence. A majority of young people who become violent during their adolescent years were not highly aggressive and did not exhibit predisposing violent behaviors in early childhood, and the majority of children with mental and behavioral disorders do not become violent in adolescence.

Myth: Child abuse and neglect inevitably lead to violent behavior later in life.

Fact: Physical abuse and neglect are relatively weak predictors of violence, and sexual abuse does not predict violence. Most children who are abused or neglected will not become violent offenders during adolescence.

Myth: African American and Hispanic youth are more likely to become involved in violence than other racial or ethnic groups.

Fact: Racial minorities are overrepresented in the criminal and juvenile justice systems, as well as in homicide rates. However, this differential may be attributable to law enforcement activity

rather than actual offending.[46] The apparent association between race/ethnicity and youth violence may also be confounded by socioeconomic factors. Furthermore, there are differences in the timing and continuity of violence over the life course, which account in part for the overrepresentation of these groups in U.S. jails and prisons. Data from confidential interviews with youth indicate that race and ethnicity have little bearing on the overall proportion of racial and ethnic groups that engage in nonfatal violent behavior.

Myth: A new violent breed of young super-predators threatens the U.S.

Fact: There is no evidence that young people involved in violence during the peak years of violence in the early 1990s were more frequent or more vicious offenders than youth in earlier years. The increased lethality resulted from gun use, which has since decreased dramatically. There is no scientific evidence to document the claim of increased seriousness or callousness.

Myth: Getting tough with juvenile offenders by trying them in adult criminal courts reduces the likelihood that they will commit more crimes.

Fact: Youth transferred to adult criminal court have significantly higher rates of re-offending and a greater likelihood of committing subsequent felonies than youth who remain in the juvenile justice system. They are also more likely to be victimized, physically and sexually.

Myth: Nothing works with respect to treating or preventing violent behavior.

Fact: A number of prevention and intervention programs that meet very high scientific standards of effectiveness have been identified.

Myth: In the 1990s, school violence affected mostly white students or students who attended suburban or rural schools.

Fact: African American and Hispanic males attending large inner-city schools that serve very poor neighborhoods faced, and still face, the greatest risk of becoming victims or perpetrators of a violent act at school. This is true despite recent shootings in suburban, middle-class, predominantly white schools.

Myth: Weapons-related injuries in schools have increased dramatically in the last five years.

Fact: Weapons-related injuries have not changed significantly in the past 20 years. Compared to neighborhoods and homes, schools are relatively safe places for young people.

Myth: Most violent youth will end up being arrested for a violent crime.

Fact: Most youth involved in violent behavior will never be arrested for a violent crime.

Figure 1: Helpful resources for Objective 4

Helpful Resources

Surgeons General Report on Youth Violence.

- http://www.surgeongeneral.gov/library/youthviolence/default.htm

OBJECTIVE 5:

Theories of Violent Behavior

Social Modeling & Cognitive Theory

Youth learn to be aggressive from modeling behavior, direct experience from achieving desirable outcomes through aggressive behavior, or self-regulation (e.g., rationalizing means as a justification for desired ends). Aggressive behavior is a product of learned cognitive schemas or scripts activated from memory, when one is faced with similar environmental cues to those when the script was learned.[47, 48] For example, a child or adolescent may have observed his family and peers succeed (in his eyes) by using aggressive tactics, and he has achieved a certain social status that protects him if he also uses aggression. These theories help to explain why several researchers have found early childhood family and peer influences to be important in the development of aggressive behaviors.[17, 49-52] Normative beliefs about aggressive behavior are also associated with violent behavior.[49, 53] Although patterns of aggressive behavior emerge during childhood, the social influences of friends, family, and adults can maintain such behavioral patterns during adolescence.[54] Peer influences on aggressive behavior have been well documented.[17, 19, 55, 56] Youth who belong to such groups may reinforce each other's aggressive behavior, and limit exposure to pro-social methods of problem solving [57]. Witnessing violence in the home and neighborhood may also increase the risk for violent behavior among adolescents.[58]

Sociological Theory

Sociological approaches suggest that violence may be part of a more general group of delinquent behaviors. This approach would posit that a child or adolescent's risk-taking behaviors, such as drug or alcohol use, interact with his own experiences with family violence and his views of his community's acceptance of violence as a reasonable tactic. Factors that may predispose a person to violence may include drug and alcohol consumption, weapon possession, or physical or verbal abuse.[59] Similarly, problem behavior may be normative in adolescent development.[60-65] with risk-taking behavior appearing in clusters, including alcohol and drug use as well as delinquent behavior.[66] Another approach suggests that a subculture of violence, particularly in low-income settings, teaches youth that violence is an acceptable way to solve problems.[67, 68] This subculture may be associated with drug dealing and use, gang membership, and the easy availability of guns.

Trauma Theory

From the perspective of trauma theory, an individual's risk for violence is increased as a result of having experienced trauma, whether psychological or physical, earlier in life. The risk for violence may increase with increasing frequency and/or intensity of traumatic events. Trauma theory posits that how the individual's mind and body reacts to the traumatic experience in combination with the unique response of the individual's social group, rather than the traumatic event itself, causes psychological damage.[69] Trauma theory encompasses multiple behaviors that may increase the risk of violence victimization and/or perpetration. One such behavior is

"learned helplessness", whereby repeated exposure accustoms an individual to trauma so that the individual no longer tries to escape from danger. Another is loss of "volume control," whereby an individual loses the ability to modulate the level of response to trauma, and may exhibit increased aggression, impulsivity, and turn to drugs or alcohol for self-modulation. Yet another such behavior is addiction to trauma, whereby individuals who have been exposed to repeatedly high levels of circulating endorphins resulting from the stress of trauma become addicted to their own internal endorphins, and only feel calm when they are feeling that stress.

Figure 1: Helpful resources for Objective 5

Helpful Resources

Social Learning and Violent Behavior

- http://sitemason.vanderbilt.edu/files/l/l3Bguk/slviolrev.pdf

Outline for Parents About Modeling Behavior.

- http://www.ces.purdue.edu/providerparent/PDF%20Links/Modeling%20Behavior.pdf

A New Approach to Violence in Disadvantaged Neighborhoods

- http://www.allacademic.com//meta/p_mla_apa_research_citation/0/2/2/9/3/pages22933/p22933-1.php

Sanctuaryweb.com

- http://www.sanctuaryweb.com/

OBJECTIVE 6:

Identifying Risk and Protective Factors Associated with Youth Violence

Theories for the developmental process of violent behaviors help guide research and assist in the design and evaluation of behavioral interventions. One fundamental result of utilizing developmental models has been the identification of *risk* and *protective* factors for youth violence. Risk factors are not necessarily causes for violent behavior. Rather, risk factors are characteristics of an individual, their family or peer group, neighborhoods, schools, or cultural groups that confer a higher probability that violent behavior will develop. For example, young people who misuse alcohol have odds of violent offending three times higher than those who do not misuse alcohol.[70] Greater access to firearms is also associated with increased violent behavior.[17, 18] In contrast, protective factors help build resilience against negative social pressures on individuals, thereby lowering the probability of a particular harmful behavior.[44, 71] For example, among adolescents higher levels of connectedness with parents and other adults is associated with a lower risk of violence perpetration.[72] It is important to consider that the majority of youth who live in "tough" neighborhoods will not be violent.

Risk and protective factors can have different effects depending on the moment of exposure in the individual's behavioral development. Longitudinal studies have identified two distinct development trajectories for youth violence: early- and late-onset.[44] Early-onset describes youth who have identifiable problem behaviors as young children that progress to serious violent acts before puberty. Late-onset describes youth with no clear behavior problems in childhood who do not become violent until adolescence. These groups also have distinct cumulative violence histories, with early-onset youth committing more serious violent acts and higher rates of violent acts than late-onset youth.[44] However, common to both groups is the fact that violent behaviors often show a developmental progression. Offenders tend to add more serious offenses to their behavioral repertoire over time. The initial behavior is usually a minor form of delinquent behavior or alcohol use.[73] However, approximately 70 percent of the time, such behavior precedes the onset of marijuana and/or poly-drug use.[74] Violence can be stimulated by the presence of risk factors such as substance use, and can escalate based on the presence of other factors such as weapon carriage. Delinquent behaviors such as poor school performance and suspension can increase the risk of entry into the criminal justice system and legal problems, which can then increase the risk of life-threatening violent injuries, the last stage of the continuum. These risk factors are exacerbated by the conditions in which victims and perpetrators of violence live. Community risk factors for violence include high unemployment rates, poor academic achievement rates, easy access to guns, and easy access to drugs and alcohol.[75-77] Table 1 provides a list of some common risk and protective factors.

The individual and community risk factors that lead to high-risk behavior feed a "cycle of violence." Adolescent victims of violence are at increased odds of becoming a perpetrator or victim of various types of violence, such as felony assault or domestic violence, in adulthood.[78]

Exposure to firearm violence approximately doubles the probability that a youth will commit violence within two years.[79] Hospitalization for violence-related injuries is recurrent, with hospital readmission rates for subsequent assaults as high as 44% and subsequent homicide rates as high as 20%.[80]

Figure 1: Examples of risk and protective factors for youth violence [44,71,81]

	Risk Factors	**Protective Factors**
Individual	• Attention deficits/hyperactivity • Antisocial beliefs and attitudes • Early onset of violence, aggression, or delinquency • Involvement with drugs or alcohol • Poor behavioral control • Social cognitive or information-processing deficits	• Intolerant attitude toward deviance • Positive social orientation • Religiosity • Anger control skills
Family	• Authoritarian childrearing • Exposure to violence and family conflict • Child abuse; neglect • Low income; unemployment • Lack of involvement in the child's life • Low emotional attachment to parents or caregivers • Parental substance abuse and criminality • Poor monitoring and supervision of children	• Strong and positive parental presence • Parent-family connectedness • Parental monitoring • Reasonable disciplinary actions
Peer/School	• Association with delinquent peers; involvement in gangs • Social rejection by peers • Lack of involvement in conventional activities • Low commitment to school and school failure	• Commitment to school • Involvement in social activities
Community	• Diminished economic opportunity • High concentration of poor residents • High levels of transiency • High levels of family disruption • Low community participation • Socially disorganized neighborhoods	• Low prevalence of drugs and alcohol • High quality schools and recreational facilities • Organized and cohesive neighborhoods • Economic and employment opportunities • Low levels of poverty
Environmental	• Poverty • Prolonged media exposure to violence • Alienation and disassociation of youth from mainstream society	• Policies that support youth-oriented programs, especially those that support opportunities for youth/adult interaction

Figure 2: Helpful resources for Objective 6

Helpful Resources

Developmental Assets
- http://www.glcyd.org/youthresearch/40developmentalassets.php

Risk & Protective Factors Overview
- http://guide.helpingamericasyouth.gov/programtool-factors.cfm

Developmental Assets Handout
- http://www.search-institute.org/content/40-developmental-assets-adolescents-ages-12-18
-

Developmental Assets for Middle School Children
- http://www.search-institute.org/40-developmental-assets4-6

Contemporary Models of Youth Development and Problem Prevention: Toward an Integration of Terms, Concepts, and Models.
- http://www.uwex.edu/ces/flp/resources/youthdev.pdf

OBJECTIVE 7:

Youth Violence as a Public Health Problem

The conceptualization of injury and violence as public health problems is a fairly recent development. The distinct field of injury science was not established until the mid-1960s. Prior to this advancement, injuries were largely considered accidents or "acts of God" instead of potentially preventable events with identifiable risk and protective factors.[82] Similarly, violence was thought of as an inevitable extension of human nature.

A critical boost for the field of injury and violence prevention came in 1985 with the publication of *Injury in America: A Continuing Public Health Problem* by the National Research Council and the Institute of Medicine.[83] This report highlighted the magnitude of injury as a major cause of morbidity and mortality; more fundamentally it explicitly re-framed injuries from "accidents" to public health problems amenable to systematic study and intervention. The report also changed the operational definition of injury by removing the distinction between unintentional and intentional injuries, while acknowledging that the risk and protective factors may differ. This important advancement identified violence as simply another type of injury that could be systematically reviewed, analyzed, and prevented utilizing the "public health approach". [82]

Module 2 will present an overview of essential components of youth violence assessment and intervention programs; a review of successful programs; and a guide for designing evidence-based programs in the ED setting.

Figure 1: Helpful resources for Objective 7

Helpful Resources

Healthy People 2010 Violence Related Goals.

- http://www.healthypeople.gov/document/html/volume2/15injury.htm

REFERENCES
For Objectives 1 Through 7

1. Borowsky IW, Mozayeny S, Stuenkel K, et al. Effects of a primary care-based intervention on violent behavior and injury in children. *Pediatrics.* 2004;114(4):e392-399.

2. Grumbach K, Keane D, Bindman A. Primary care and public emergency department overcrowding. *Am J Public Health.* Mar 1993;83(3):372-378.

3. Baker DW, Stevens CD, Brook RH. Patients who leave a public hospital emergency department without being seen by a physician. Causes and consequences. *JAMA.* Aug 28 1991;266(8):1085-1090.

4. Bindman AB, Grumbach K, Keane D, et al. Consequences of queuing for care at a public hospital emergency department. *JAMA.* Aug 28 1991;266(8):1091-1096.

5. Pane GA, Farner MC, Salness KA. Health care access problems of medically indigent emergency department walk-in patients. *Ann Emerg Med.* 1991;20(7):730-733.

6. Blum RW, Beuhring T, Wunderlich M, et al. Don't ask, they won't tell: the quality of adolescent health screening in five practice settings. *Am J Public Health.* Dec 1996;86(12):1767-1772.

7. Rosen DS, Elster A, Hedberg V, et al. Clinical preventive services for adolescents: position paper of the Society for Adolescent Medicine. *J Adolesc Health.* Sep 1997;21(3):203-214.

8. Fein JA, Ginsburg KR, McGrath ME, et al. Violence prevention in the emergency department: clinician attitudes and limitations. *Arch Pediatr Adolesc Med.* May 2000;154(5):495-498.

9. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. 2005. Available at: www.cdc.gov/ncipc/wisqars. Accessed April 8, 2008.

10. Goins WA, Thompson J, Simpkins C. Recurrent intentional injury. *J Natl Med Assoc.* May 1992;84(5):431-435.

11. Morrissey TB, Byrd CR, Deitch EA. The incidence of recurrent penetrating trauma in an urban trauma center. *J Trauma.* 1991;31(11):1536-1538.

12. Poole GV, Griswold JA, Thaggard VK, et al. Trauma is a recurrent disease. *Surgery.* Jun 1993;113(6):608-611.

13. Reiner DS, Pastena JA, Swan KG, et al. Trauma recidivism. *The American surgeon.* Sep 1990;56(9):556-560.

14. Sims DW, Bivins BA, Obeid FN, et al. Urban trauma: a chronic recurrent disease. *J Trauma.* 1989;29(7):940-946.

15. Melzer-Lange M, Lye PS. Adolescent health care in a pediatric emergency department. *Ann Emerg Med.* May 1996;27(5):633-637.

16. Sege RD, Kharasch S, Perron C, et al. Pediatric violence-related injuries in Boston: results of a city-wide emergency department surveillance program. *Arch Pediatr Adolesc Med.* Jan 2002;156(1):73-76.

17. Dahlberg LL. Youth violence in the United States. Major trends, risk factors, and prevention approaches. *Am J Prev Med.* May 1998;14(4):259-272.

18. Resnick MD, Bearman PS, Blum RW, et al. Protecting adolescents from harm: Findings from the national longitudinal study on adolescent health. *JAMA.* 1997;278:823-832.

19. Zimmerman MA, Steinman KJ, Rowe KJ. Violence among urban African American adolescents: The protective effects of parental support. In: Arriaga XB, Oskamp S, eds. *Addressing Community Problems: Psychological Support.* Thousand Oaks, CA: Sage; 1998:78-103.

20. Monti PM, Colby SM, Barnett NP, et al. Brief intervention for harm reduction with alcohol-positive older adolescents in a hospital emergency department. *J Consult Clin Psychol.* Dec 1999;67(6):989-994.

21. Becker B, Woolard RE, Nirenberg TD, et al. Alcohol use among sub-critically injured emergency department patients. *Acad Emerg Med.* 1995;2:784-790.

22. Dikmen SS, Machamer JE, Donovan DM, et al. Alcohol use before and after traumatic head injury. *Ann Emerg Med.* 1995;26:167-176.

23. Longabough R, Minugh PA, Nirenberg TD, et al. Injury as a motivator to reduce drinking. *Acad Emerg Med.* 1995;2:817-825.

24. Widom CS. The cycle of violence. *Science.* 1989;244(4901):160-166.

25. Spivak HR, Prothrow-Stith D. Addressing violence in the emergency department. *Clin Pediatr Emerg Med.* 2003;4(2):135-140.

26. Weick K. The collapse of sensemaking in organizations: The Mann Gulch disaster. *Adm Sci Q.* 1993;38:628-652.

27. Carlos RC, Fendrick AM. Improving cancer screening adherence: using the "teachable moment" as a delivery setting for educational interventions. *The American journal of managed care.* Apr 2004;10(4):247-248.

28. Heneghan MK, Hazan C, Halpern AC, et al. Skin cancer coverage in a national newspaper: a teachable moment. *J Cancer Educ.* Summer 2007;22(2):99-104.

29. Williams A, Lindsell C, Rue L, et al. Emergency Department education improves patient knowledge of coronary artery disease risk factors but not the accuracy of their own risk perception. *Prev Med.* Jun 2007;44(6):520-525.

30. Fonarow GC. In-hospital initiation of cardiovascular protective medications for patients undergoing percutaneous coronary intervention: taking advantage of the teachable moment. *The Journal of invasive cardiology.* Nov 2003;15(11):646-652.

31. Fabiano P. Peer-based HIV risk assessment: a step-by-step guide through the teachable moment. *J Am Coll Health.* May 1993;41(6):297-299.

32. Williams S, Brown A, Patton R, et al. The half-life of the 'teachable moment' for alcohol misusing patients in the emergency department. *Drug Alcohol Depend.* Feb 14 2005;77(2):205-208.

33. DePue JD, McCabe B, Kazura A, et al. Assessment of parents' smoking behaviors at a pediatric emergency department. *Nicotine Tob Res.* Jan 2007;9(1):33-41.

34. Taylor KL, Cox LS, Zincke N, et al. Lung cancer screening as a teachable moment for smoking cessation. *Lung cancer (Amsterdam, Netherlands).* Apr 2007;56(1):125-134.

35. Gritz ER, Fingeret MC, Vidrine DJ, et al. Successes and failures of the teachable moment: smoking cessation in cancer patients. *Cancer.* Jan 1 2006;106(1):17-27.

36. Cook BS, Ricketts CD, Brown RL, et al. Effect of safety education on classmates of injured children: a prospective clinical trial. *J Trauma Nurs.* Jul-Sep 2006;13(3):96-101.

37. World Health Organization. *World Report on Violence and Health.* Geneva, Switzerland: World Health Organization; 2002.

38. Centers for Injury Prevention and Control. Youth violence: Overview. *Centers for Disease Control and Prevention Web site*. Available at: http://www.cdc.gov/ncipc/factsheets/yvoverview.htm. Accessed May 31, 2005.

39. Commission for the Prevention of Youth Violence. Youth and violence. Medicine, nursing, and public health: Connecting the dots to prevent violence. *American Medical Association Web site*. Available at: http://www.ama-assn.org/ama/upload/mm/386/fullreport.pdf. . Accessed April 8, 2008.

40. Centers for Injury Prevention and Control. Youth violence: Fact sheet. *Centers for Disease Control and Prevention Web site*. Available at: http://www.cdc.gov/ncipc/factsheets/yvfacts.htm. Accessed April 8, 2008.

41. Heron M. Deaths: leading causes for 2004. *Natl Vital Stat Rep.* Nov 20 2007;56(5):1-95.

42. Centers for Disease Control and Prevention. Youth Risk Behavior Survey. *Center for Disease Control and Prevention*. Available at: www.cdc.gov/yrbss. Accessed November 4, 2007.

43. Stover CS. Domestic violence research: what have we learned and where do we go from here? *J Interpers Violence.* 2005;20(4):448-454.

44. U.S. Department of Health and Human Services. *Youth Violence: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2001.

45. Eaton DK, Kann L, Kinchen S, et al. Youth risk behavior surveillance--United States, 2005. *MMWR Surveill Summ.* Jun 9 2006;55(5):1-108.

46. Peterson D, Esbensen F, Taylor TJ, et al. Youth violence in context: the roles of sex, race, and community in offending. *Youth Violence and Juvenile Justice.* 2007;5(4):385-410.

47. Huesmann LR. An information-processing model for the development of aggression. *Aggr Behav.* 1988;14:13-24.

48. Huesmann LR. The role of social information processing and cognitive schema in the acquisition and maintenance of habitual aggressive behavior. In: Green RG, Donnerstein E, eds. *Human Aggression: Theories, Research & Implications for Policy.* San Diego, CA: Academic Press; 1998.

49. Guerra NG, Huesmann LR, Tolan PH, et al. Stressful events and individual beliefs as correlates of economic disadvantage and aggression: Implications for preventive interventions among inner-city children. *J Consult Clin Psychol* 1995;63:518-528.

50. Huesmann L, Eron L, Lefkowitz M, et al. Stability of aggression over time and generations. *Dev Psychol* 1984;20:1120-1134.

51. Capaldi DM, Patterson GR. The violent adolescent male: Specialist or generalist? Paper presented at: Biennial meeting of the Society for Research in Child Development; March 25-28, 1993; New Orleans, LA.

52. Loeber R, Wung P, Keenan K, et al. Developmental pathways in disruptive childhood behavior. *Dev Psychopathol.* 1993;5:103-133.

53. Huesmann LR, Guerra NG. Children's normative beliefs about aggression and aggressive behavior. *J Pers Soc Psychol* 1997;72:408-419.

54. Eron LD, Huesmann LR. The stability of aggressive behavior--even unto the third generation. In: Lewis M, Miller SM, eds. *Handbook of Developmental Psychology.* New York: Plenum; 1990:147-156.

55. Cairns RB, Cairns BD. The sociogenesis of aggressive and antisocial behaviors. In: McCord J, ed. *Facts, Frameworks, and Forecasts.* New Brunswick, NJ: Transaction Publishers; 1991.

56. Hill HM, Soriano FI, Chen SA, et al. Sociocultural factors in the etiology and prevention of violence among ethnic youth. In: Eron LD, Gentry JH, Schlegel P, eds. *Reason to Hope: A Psychosocial Perspective on Violence and Youth.* Washington, DC: American Psychological Association; 1994:59-97.

57. Parker JG, Asher SR. Peer relations and later personal adjustment: Are low-accepted children at risk? *Psychol Bull* 1987;102:357-389.

58. Thornberry TP, Huizinga D, Loeber R. The prevention of serious delinquency and violence: Implications from the program of research on causes and correlates of delinquency. In: Howell JC, Krisberg B, Hawkins JD, et al., eds. *A Sourcebook: Serious, Violent and Chronic Juvenile Offenders.* Thousand Oaks, CA: Sage Publications; 1995:213-237.

59. Centers for Disease Control and Prevention. *Preventing Violence and Suicide: Enhancing Futures.* Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2000.

60. Baumrind D. A developmental perspective on adolescent risk taking in contemporary America. In: Irwin CE, ed. *Adolescent Social Behavior and Health: New Directions for Child Development.* San Francisco: Jossey Bass; 1987:93-125.

61. Irwin CE, Jr., Millstein SG. Biopsychosocial correlates of risk-taking behaviors during adolescence. Can the physician intervene? *J Adolesc Health Care.* Nov 1986;7(6 Suppl):82S-96S.

62. Irwin CE. *Adolescent Social Behavior and Health: New Directions for Child Development.* Vol 37. San Francisco: Jossey Bass; 1987.

63. Jessor R, Jessor SL. *Problem Behavior and Psychological Development: A Longitudinal Study of Youth*. New York: Academic Press; 1977.

64. Jessor R. Problem behavior and developmental transition in adolescence. *J Sch Health.* May 1982;52(5):295-300.

65. Jessor R. Risk behavior in adolescence: a psychosocial framework for understanding and action. *J Adolesc Health.* Dec 1991;12(8):597-605.

66. Jessor R. Risky driving and adolescent problem behavior: Theoretical and empirical linkage. In: Benjamin T, ed. *Young Drivers Impaired by Alcohol and Other Drugs.* London: Royal Society of Medicine Services Ltd.; 1987:97–110.

67. Berkowitz L. Reason to hope: A psychosocial perspective on violence and youth. In: Eron LD, Gentry JH, Schlegel P, eds. *Guns and Youth.* Washington, DC: American Psychological Association; 1995:251-279.

68. Wolfgang ME. Sociocultural overview of criminal violence. In: Hays JR, Roberts TK, Solway KS, eds. *Violence and the Violent Individual.* New York, NY: S.P. Medical and Scientific Books; 1981.

69. Bloom SL. Trauma theory abbreviated. In: Attorney General of Pennsylvania's Family Violence Task Force, ed. *Final Action Plan: A Coordinated Community-Based Response to Family Violence.* 1999.

70. Fergusson DM, Lynskey MT, Horwood LJ. Alcohol misuse and juvenile offending in adolescence. *Addiction.* Apr 1996;91(4):483-494.

71. Fergus S, Zimmerman MA. Adolescent resilience: a framework for understanding healthy development in the face of risk. *Annu Rev Public Health.* 2005;26:399-419.

72. Resnick MD, Ireland M, Borowsky I. Youth violence perpetration: what protects? what predicts? findings from the national longitudinal study of adolescent health. *J Adolesc Health.* Nov 2004;35(5):424 e421-410.

73. Elliott DS, Hamburg BA, Williams KR. *Violence in American Schools: A New Perspective*. Cambridge, UK: Cambridge University Press; 1998.

74. Menard S, Huizinga D. Age, period, and cohort size effects on self-reported alcohol, marijuana, and polydrug use: results from the national youth survey. *Soc Sci Res.* 1998;18:174-194.

75. Lin N. *Social Capital: A Theory of Social Structure and Action.* Cambridge, United Kingdom: Cambridge University Press; 2001.

76. Edelman P, Holzer H, Offner P. Reconnecting disadvantaged young men. Cited in. *New York Times web site*. Available at: http://www.nytimes.com/2006/03/20/national/20blackmen.html?incamp=article_popular&pagewanted=all. Accessed April 23, 2008.

77. Wilkinson WG. *Unhealthy Societies: the Afflictions of Inequality*. London: Routledge; 1996.

78. Menard S. *Short- and Long-term Consequences of Adolescent Victimization.* Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention; 2002.

79. Bingenheimer JB, Brennan RT, Earls FJ. Firearm violence exposure and serious violent behavior. *Science.* May 27 2005;308(5726):1323-1326.

80. Bonderman J. *Working with Victims of Gun Violence.* Washington, DC: U.S. Department of Justice, Office for Victims of Crime; 2001.

81. National Youth Violence Prevention Resource Center Web site. Risk and protective factors for youth violence fact sheet. *National Youth Violence Prevention Resource*

Center Web site. Available at: http://www.safeyouth.org/scripts/facts/risk.asp. Accessed April 8, 2008.

82. Bonnie RJ, Guyer B. Injury as a field of public health: achievements and controversies. *J Law, Med & Ethics*. 2002;30:267-280.

83. National Research Council and Institute of Medicine. *Injury in America: A Continuing Health Problem.* Washington D.C.: National Academy Press; 1985.

Module 2:

Screening and Intervention Programs for Youth Violence for the Emergency Department

OBJECTIVE 8:

Screening for youth violence risk in the ED

The first step in intervening with youth at risk for violence in the Emergency Department (ED) is identification and assessment. Unfortunately, there are few empirically-based screening tools validated in ED youth to assist this process. The four assessments described below can be used as an introduction and guide.

FISTS

One strategy that has been suggested by the American Academy of Pediatrics is to use the FISTS mnemonic[1] to ask about Fighting, Injuries, Sex, Threats, and Self-Defense. This tool can be used with youth to assess history or risk of violent conflict, although the predictive value of this screening tool has not yet been established.

Figure 1. FISTS: Fighting – Injuries – Sex – Threats – Self-Defense

Fighting	• How many fights have you been in during the past year? • When was your last fight?
Injuries	• Have you ever been injured in a fight? • Have you ever injured someone else in a fight?
Sex	• Has your partner ever hit you? • Have you ever hit (hurt) your partner? • Have you been forced to have sex against your will?
Threats	• Has someone carrying a weapon ever threatened you?
Self-Defense	• What do you do if someone tries to pick a fight with you? • Have you ever carried a weapon in self-defense?

Adolescent and Child Urgent Threat Evaluation (ACUTE)[2]

The Adolescent and Child Urgent Threat Evaluation (ACUTE) is a relatively new assessment that was developed to identify factors such as lethality/threat, predisposing historical impulsiveness, and ideation, all which create a mechanism to measure the level of risk for violence. The ACUTE is a structured assessment composed of 27 items, based on information gathered through patient and family interviews, and medical and school chart reviews. A number of relationships can be examined using the ACUTE assessment: 1) attempt and premeditation, 2) risk for future attempts and late and early onset factors, 3) pre-meditation and suicide and homicide, 4) non-premeditation and suicide and homicide, and 5) neurocognitive functioning and violence. The resulting score provides an overall measure of risk for near-future violence, which can also be broken down into sub-scores representing threat, early and late precipitating factors, predisposing factors, and impulsivity. ACUTE shown to be an effective tool for identifying risk factors for violence in youth ages 13 to 18. The disadvantages of this tool with regard to its application in the ED are that it was not validated strictly in the ED setting, and that it was validated on a sample with a large proportion of coexisting conditions, which may not make the sample representative of patients seen in an ED. Furthermore, the survey is long and may take more than the time available to complete, and it requires data from multiple sources, which may not be possible to secure in a brief ED-based assessment.

Structured Assessment of Violence Risk in Youth (SAVRY)[3]

Structured Assessment of Violence Risk in Youth (SAVRY) was developed to help clinicians and other health professionals identify violence and aggression in youth ages 12-18. It is not a formal or evidence-based screening tool, but a guide to construct ongoing monitoring and intervention planning by helping to identify violent youth. The assessment is also intended to help health professionals make a proper and fair judgment about the level of risk in youth. SAVRY is composed of 6 protective factor items and 24 risk factor items. The risk factors are broken down into historical (history of violence and nonviolent offending; early initiation of violence; poor school achievement, exposure to violence in the home); social and contextual (peer delinquency, peer rejection, stress and poor coping, community disorganization), and clinical and individual (negative attitudes, risk taking and impulsivity, substance use, low empathy).

There are a few advantages of the SAVRY for youth violence screening in the ED setting: administration takes only 15 minutes, and results are easily calculated and interpreted on a qualitative rating structure (low, moderate, or high). Although SAVRY is not validated for the ED setting, it is derived from past research and literature and if developed further could be applied to a number of medical settings.

Fighting, Gender, Hurt, Threatened, Smoker (FIGHTS)

Fighting, Gender, Hurt, Threatened, Smoker (FIGHTS) is a weapon carriage screening tool for adolescents.[4] Its sensitivity and specificity, which were relatively high at 82% and 71% respectively, were derived from the 1999 National Youth Risk Behavior Survey.

Figure 2. FIGHTS score questionnaire to screen youth for weapon carriage

Fighting	During the last 12 months have you been in a physical fight?
Gender	Male
Hurt	During the last 12 months have you been in a fight where you were injured and had to be treated by a doctor or nurse?
Threatened	During the last 12 months have you been threatened with a weapon (knife/ gun) on school property?
Smoker	Have you ever smoked cigarettes regularly (one cigarette/ day for 30 days)?

Figure 3: Helpful resources for Objective 8

Helpful Resources

FISTS Handout

- http://www.vahealth.org/civp/FISTS%20CARDS.pdf

ACUTE (Link to purchasing site)

- http://www3.parinc.com/products/product.aspx?Productid=ACUTE

SAVRY (Link to purchasing site)

- http://www.fmhi.usf.edu/mhlp/savry/statement.htm

FIGHTS Information

- http://news.bio-medicine.org/medicine-news-2/New-emergency-department-program-fights-firearm-carrying-youths-4794-1/

OBJECTIVE 9:

Assessing Risk for Retaliatory Violence

Not only are efficient evidence-based screening tools necessary in order to identify and assess violent youth, but assessments for risk of retaliation and/or re-injury are in need of development as well. ED personnel do not typically inquire about violence history, nor do they ask about the potential for retaliatory violence by patient, family, or friends,[5] although youth homicide and nonfatal assault normally occur between those that know one another, such as family members, classmates, or acquaintances. The ED can provide an ideal setting to assess risk for retaliatory violence among patients, friends, and family members, but a standardized protocol must first be developed in order to achieve this goal. The circumstances surrounding violence-related injuries in the ED can be difficult to characterize; however, prior violence-related injuries is one of the largest risk factors for retaliation. Dowd et al demonstrated that retaliatory injury risk among violent youth victims was 88 times higher than those that were never exposed to violence.[6] Risk for retaliation is presumably the highest in the several weeks following a violence-related injury. For these reasons, youth who appear in an ED with violence-related injuries should be considered at high risk for retaliation and should be subsequently assessed with a comprehensive history.

One study conducted among urban youth at primary care visits found that three short questions regarding performance in school, drug use, and involvement in physical fights predicted violence-related injury in the follow-up period.[7] However, these questions were not validated in the ED setting. Hayes et al developed a screening tool to identify risk factors for adolescent firearms carriage (see **FIGHTS** in previous section).[4] This tool had high sensitivity and specificity among a random sample of high school students, and showed potential for use in a clinical setting.

As part of its Emergency Department Violence Intervention Project, the Children's Hospital of Pennsylvania (CHOP) implemented a violence safety screen for all patients ages 11-24 presenting in the ED with intentional injuries (Table 3). This short, five-question screening tool is used to identify individuals at risk for re-injury, who are then invited to participate in a lengthier assessment that includes questions about safety, retaliation, and contact with authorities or police, as well as other questions regarding risk and protective factors. This assessment stratifies individuals into low, medium, and high-risk categories and can be used to triage patients to appropriate discharge services and follow-up care.

Figure 1. Children's Hospital of Pennsylvania Safety Screen

1. Do you know who the person is that hurt you?
2. Do you think that the conflict that caused this incident is over?
3. Do you plan to hurt anyone because of what happened today?
4. Do you think that any of your friends or family members will hurt anyone because of what happened today?
5. Have you reported the incident to the police or other authority?

The comprehensive CDC publication entitled "Measuring violence-related attitudes, behaviors, and influences among youths: a compendium of assessment tools," is strongly recommended as a guide for choosing ED-based youth violence assessment tools. This document, which can be found at http://www.cdc.gov/ncipc/pub-res/measure.htm,[8] provides a summary of 170 assessment tools that measure the attitudes and beliefs, psychosocial issues and cognition, and behavior and environment of violent youth, and includes a list of 15 screening instruments for aggression and violent behavior. These screening tools can be used in the ED to identify youth who are at greatest risk for violence and should be targeted for further intervention and follow-up care.

Figure 2: Helpful resources for Objective 9

Helpful Resources

Measuring Violence-Related Attitudes, and Behavior

- http://www.cdc.gov/ncipc/pub-res/pdf/YV/YV_Compendium.pdf

Attitude and Belief Assessments capitalize everything

- http://www.cdc.gov/ncipc/pub-res/pdf/YV/CDC_YV_SecI.pdf

Psychosocial and Cognitive Assessments capitalize everything

- http://www.cdc.gov/ncipc/pub-res/pdf/YV/CDC_YV_SecII.pdf

Behavior Assessments

- http://www.cdc.gov/ncipc/pub-res/pdf/YV/CDC_YV_SecIII.pdf

Environmental Assessments

- http://www.cdc.gov/ncipc/pub-res/pdf/YV/CDC_YV_SecIV.pdf

OBJECTIVE 10:

Describing Evidence-Based Youth Violence Prevention Interventions

ED-based youth violence interventions should model what has been effectively accomplished in more traditional settings such as the criminal justice system and schools. Effectiveness criteria for youth violence prevention activities, based on scientific consensus, were published in the Surgeon General's Report on Youth Violence in 2001.[9] Blueprints for Violence Prevention, a national violence prevention initiative administered by the University of Colorado, evaluated and identified several model community-based violence prevention and intervention programs using these effectiveness criteria.[10] This evaluation incorporated both quantitative and qualitative techniques to rate general prevention strategies and programs according to their demonstrated effect on violence, serious delinquency, or their mediators. This rigorous review of existing non-hospital based interventions produced compelling results. For example, a number of programs based on strategies such as scare tactics, boot camps, gun buy-backs, and isolated self-esteem enhancement programs that provide information without skills were ineffective or even harmful.[9, 11-13] Alternatively, the most successful programs were based on strategies such as social skills training, positive youth development, mentoring, parent and family training, and home visitation. A few[9] community-based programs, including the Island Youth Programs in Galveston, TX, and the Boston Strategy to Prevent Youth Violence, were effective in reducing violent injury and behavior, and increasing positive outcomes including school persistence and school to work transition. A list of initiatives meeting criteria for designation as "model programs" by Blueprints for Violence Prevention can be found on their website: http://www.colorado.edu/cspv/index.html.[14, 15]

None of the programs evaluated as "model programs" were implemented in the context of the ED. However, adapting these successful strategies to ED- and hospital-based violence interventions is possible and ongoing. Fortunately, there is precedence for success addressing other injury-related risk behaviors in these settings. ED-based studies have demonstrated the effectiveness of brief counseling at time of care for alcohol use and injury risk in adolescents.[16-22] It is likely that many of the same techniques employed in these interventions can be applied to ED- and hospital-based youth violence prevention. In addition, brief violence-risk screening tools developed for use in primary care settings can be adapted for use in an ED or inpatient setting.[7, 23] A challenge for targeting complex risk behaviors like youth violence in an ED setting is balancing the need for brevity with effective coverage of the complexity of risk factors concomitant with violent behaviors.[24] Potential strategies for overcoming these challenges include the use of trained peer volunteers (as is done for support of many victims of domestic violence), existing or additional funded social workers, and less resources intensive interventions that utilize computer technology.[21, 25, 26]

Figure 1: Helpful resources for Objective 10

Helpful Resources

Blueprints for Violence Prevention Overview

- http://www.colorado.edu/cspv/blueprints/

Model Programs

- http://www.colorado.edu/cspv/blueprints/modelprograms.html

OBJECTIVE 11:

Violence Intervention Programs Based in the Emergency Department

There are a growing number of ED- and hospital-based violence prevention programs already in place and in various stages of evaluation. Many of these interventions focus on identification of at-risk youth and improved linkage to community resource.[27-34] For example, Dicker and colleagues are currently evaluating a hospital-based intervention linking youth injured as a result of interpersonal violence to community mentors and other risk reduction resources.[27] Interventions targeting parents and caregivers have also been evaluated. Kruesi and colleagues demonstrated an increased rate of actions to limit youth access to firearms by parents/caretakers following a ED-based brief intervention by medical personnel.[35] Cooper et al evaluated a hospital-based violence prevention program among adults presenting to the ED with an assault-related injury, who had a history of hospitalization due to violent injury as well as involvement with the criminal justice system.[36] The program appeared to reduce arrests and convictions for violent crime. At the least, the ED can serve as a point of identification and initial contact with youth who are at risk for future violent injury.

Addressing the problem of youth violence can seem like a daunting and futile task. This is especially true for busy trauma and emergency practitioners juggling myriad demands. However, there is precedence for success in addressing complex public health problems through rigorous application of the public health approach. Several emergency department and hospital-based violence prevention programs are already in place and in various stages of evaluation across the country. Three such programs are described below.

Pennsylvania Injury Reporting and Intervention System (PIRIS) is funded by the William Penn Foundation medical centers to develop violence assessment and intervention systems in the Philadelphia emergency departments. PIRIS is a hospital-based injury surveillance and intervention system currently implemented in three large Philadelphia trauma centers.[37] PIRIS provides comprehensive intervention services to 15- to 24-year-old gunshot victims and their families. PIRIS assigns a counselor who helps victims and their families recognize conditions that may have contributed to their exposure to violence, and develops individual plans for victims and their families to prevent further violence. As part of this process, PIRIS provides information and referral services, which include assistance with health insurance, education, job training, transportation, counseling, family needs, legal issues, parenting, and recreational activities.

Caught in the Crossfire is operated by *Youth ALIVE!,* a community-based, non-profit agency with programs in Oakland and Los Angeles, California. In Oakland, the program works in collaboration with the Alameda County Medical Center's Injury Prevention Coordinator to link violently injured youth being treated at the Center's emergency room or trauma unit with intervention specialists or paraprofessional case managers. The Injury Prevention Coordinator screens incoming patients at least once each day, describes the program to each eligible patient, and secures consent for services, as required under HIPAA regulations. Eligible patients are

youth ages 12 to 20 who live in the area and are being treated for a violent injury that is not self-inflicted. A *Caught in the Crossfire* intervention specialist first meets a patient at their hospital bedside, if possible. They focus on developing rapport, preventing immediate and future retaliation, identifying the youth's short-term and long-term needs, developing a plan for staying safe, and setting dates for follow-up contact. Program staff can build a relationship with family members, to demonstrate how they can support the injured family member in living a non-violent lifestyle, and to assist them with getting their social service needs met.

The intervention specialists are young adults who live in and know the neighborhoods where the violently injured patients live. They work with patients for an average of six months post-injury, helping them prepare for discharge and addressing the myriad issues that could contribute to them becoming victims of violence again. They maintain detailed case files including an intake/assessment form, a case plan, a contact log, and relevant materials such as school attendance records.[38]

A quasi-experimental analysis of the program showed significant positive outcomes among those served as opposed to those not receiving services. Those served were 70% less likely to be arrested during the six-month post-injury period than hospitalized youth who did not participate in the program.[29] This is significant because criminal involvement also increases the risk of subsequent homicide victimization, which is clearly a public health concern.[39]

Project Ujima, a collaborative effort of the Children's Hospital of Wisconsin, the Medical College of Wisconsin, Children's Services Society of Wisconsin and the University of Wisconsin-Milwaukee Department of Psychology, targets emergency department/trauma center patients ages 10-18 who are being treated for an intentional injury (excluding self-inflicted or child abuse). The project uses components of *Caught in the Crossfire* as a model. Enrolled patients receive an intervention where a paid community liaison and volunteer peer liaisons meet the patient in the ED, provide support and information about their care, conduct a family and youth psychosocial assessment, and facilitate access to group and family services and community resources to address violence-related issues.

Youth who are admitted to the hospital for their injuries receive ongoing visits from the *Project Ujima* staff. Whether youth are discharged from the ED/trauma center or from the inpatient unit, *Project Ujima* staff visit them in their home within two weeks, if their parent or guardian consents to enrollment in the program. Mental health services to address acute and post-traumatic stress are an important component of the program. These services are provided in community clinics or in-home, depending on the needs of the youth and their family. Intervention effectiveness results are still in the analysis phase.

SaferTeens

A five-year randomized controlled trial focusing on high risk youth seeking ED care is currently underway and to date has screened over 2000 adolescents in the ED (ages 14-18) over 2 years. Teens seeking ED care for any reason (medical or injury) with past year violence & alcohol use were randomly assigned to control group, or 30-min interactive Brief intervention delivered by computer or research therapist containing: review of patients goals, tailored feedback on risk

behaviors including fighting and weapon carriage, role plays for practicing risk reduction, and referrals. This study is ongoing and data collection not complete, however preliminary data analysis is promising, showing universal computerized screening and BI during an ED visit is feasible, well-received and effective at changing violence and alcohol attitudes at post test. Further work will evaluate the effectiveness of the this prevention oriented approach on reducing violent behavior among urban teens in the ED.[40]

Figure 1: Helpful resources for Objective 11

Helpful Resources

Pennsylvania Injury Reporting and Intervention System (PIRIS)

- http://www.piris-pa.org/

Caught in the Crossfire

- http://www.youthalive.org/cinc/

Project Ujima

- http://www.chw.org/display/PPF/DocID/20624/router.asp

REFERENCES

For Objectives 9 Through 11

1. Alpert EJ, Sege RD, Bradshaw YS. Interpersonal violence and the education of physicians. *Acad Med.* Jan 1997;72(1 Suppl):S41-50.

2. Copelan R, Ashley D. *Adolescent and Child Urgent Threat Evaluation.* Lutz, FL: Psychological Assessment Resources, Inc; 2005.

3. Borum R, Bartel P, Forth A. Structured assessment of violence risk in youth (SAVRY). *Psychological Assessment Resources, Inc. web site*. Available at: http://www3.parinc.com/products/product.aspx?Productid=SAVRY. Accessed November 3, 2006.

4. Hayes DN, Sege R. FiGHTS: a preliminary screening tool for adolescent firearms-carrying. *Ann Emerg Med.* Dec 2003;42(6):798-807.

5. Fein JA, Ginsburg KR, McGrath ME, et al. Violence prevention in the emergency department: clinician attitudes and limitations. *Arch Pediatr Adolesc Med.* May 2000;154(5):495-498.

6. Dowd MD. Consequences of violence. Premature death, violence recidivism, and violent criminality. *Pediatric clinics of North America.* Apr 1998;45(2):333-340.

7. Sege R, Stringham P, Short S, et al. Ten years after: examination of adolescent screening questions that predict future violence-related injury. *J Adolesc Health.* Jun 1999;24(6):395-402.

8. Dahlberg LL, Toal SB, Swahn M, et al. *Measuring Violence-Related Attitudes, Behaviors, and Influences among Youths: A Compendium of Assessment Tools*. 2nd ed. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2005.

9. U.S. Department of Health and Human Services. *Youth Violence: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2001.

10. Center for the Study and Prevention of Violence. Blueprints for violence prevention. *University of Colorado at Boulder Web site*. Available at: http://www.colorado.edu/cspv/blueprints/index.html. Accessed July 8, 2005.

11. Commission for the Prevention of Youth Violence. Youth and violence. Medicine, nursing, and public health: Connecting the dots to prevent violence. *American Medical Association Web site*. Available at: http://www.ama-assn.org/ama/upload/mm/386/fullreport.pdf. . Accessed April 8, 2008.

12. Dearing B, Caston RJ, Babin J. The impact of a hospital based educational program on adolescent attitudes toward drinking and driving. *J Drug Educ.* 1991;21(4):349-359.

13. Tucker JB, Barone JE, Stewart J, et al. Violence prevention: reaching adolescents with the message. *Pediatr Emerg Care.* Dec 1999;15(6):436-439.

14. Island Youth Advisory Board. Island youth programs. *Island Youth Advisory Board Web site*. Available at: http://psy.utmb.edu/violence/island/Overview.htm. Accessed April 8, 2008.

15. Boston strategy to prevent youth violence -- Boston, MA. *Office of Juvenile Justice and Delinquency Prevention web site*. Available at: http://ojjdp.ncjrs.org/pubs/gun_violence/profile02.html. Accessed April 24, 2008.

16. Gregor MA, Shope JT, Blow FC, et al. Feasibility of using an interactive laptop program in the emergency department to prevent alcohol misuse among adolescents. *Ann Emerg Med.* Aug 2003;42(2):276-284.

17. Johnston BD, Rivara FP, Droesch RM, et al. Behavior change counseling in the emergency department to reduce injury risk: a randomized, controlled trial. *Pediatrics.* Aug 2002;110(2 Pt 1):267-274.

18. Maio RF. Alcohol and injury in the emergency department: opportunities for intervention. *Ann Emerg Med.* 1995;26(2):221-223.

19. Monti PM, Colby SM, Barnett NP, et al. Brief intervention for harm reduction with alcohol-positive older adolescents in a hospital emergency department. *J Consult Clin Psychol.* Dec 1999;67(6):989-994.

20. Monti PM, Rohsenow DJ, Swift RM, et al. Naltrexone and cue exposure with coping and communication skills training for alcoholics: treatment process and 1-year outcomes. *Alcohol Clin Exp Res.* Nov 2001;25(11):1634-1647.

21. Strecher V, Wang C, Derry H, et al. Tailored interventions for multiple risk behaviors. *Health Educ Res.* Oct 2002;17(5):619-626.

22. Webb PM, Zimet GD, Fortenberry JD, et al. Comparability of a computer-assisted versus written method for collecting health behavior information from adolescent patients. *J Adolesc Health.* Jun 1999;24(6):383-388.

23. Borowsky IW, Mozayeny S, Stuenkel K, et al. Effects of a primary care-based intervention on violent behavior and injury in children. *Pediatrics.* 2004;114(4):e392-399.

24. Prothrow-Stith DB. The epidemic of youth violence in America: using public health prevention strategies to prevent violence. *J Health Care Poor Underserved.* 1995;6(2):95-101.

25. Strecher VJ, Kreuter M, Den Boer DJ, et al. The effects of computer-tailored smoking cessation messages in family practice settings. *J Fam Pract.* Sep 1994;39(3):262-270.

26. Skinner HA. *Promoting Health through Organizational Change.* San Francisco: Benjamin Cummings; 2001.

27. Dicker R. Violence prevention for trauma centers: A feasible start [Poster 2901]. Paper presented at: Injury and Violence In America; May 11, 2005; Denver, CO.

28. Cunningham RM, Vaidya RS, Walton M, et al. Training emergency medicine nurses and physicians in youth violence prevention. *Am J Prev Med.* Dec 2005;29(5 Suppl 2):220-225.

29. Becker MG, Hall JS, Ursic CM, et al. Caught in the crossfire: the effects of a peer-based intervention program for violently injured youth. *J Adolesc Health.* 2004;34(3):177-183.

30. Mitka M. Hospital study offers hope of changing lives prone to violence. *Jama.* Feb 6 2002;287(5):576-577.

31. Marcelle DR, Melzer-Lange MD. Project UJIMA: working together to make things right. *WMJ.* 2001;100(2):22-25.

32. Zun LS, Downey LV, Rosen J. Violence prevention in the ED: linkage of the ED to a social service agency. *Am J Emerg Med.* Oct 2003;21(6):454-457.

33. Fein JA, Shofer FS, Gavin M, et al. Telephone follow-up for victims of youth violence: is it possible? *Acad Emerg Med.* May 1, 2001 2001;8(5):459.

34. Datner E, Fein J, McGrath M. Violence intervention project: Linking healthcare facilities with community-based resources. *Acad Emerg Med.* 1999;6:511.

35. Kruesi MJ, Grossman J, Pennington JM, et al. Suicide and violence prevention: parent education in the emergency department. *J Am Acad Child Adolesc Psychiatry.* 1999;38:250-255.

36. Cooper C, Eslinger DM, Stolley PD. Hospital-based violence intervention programs work. *J Trauma.* Sep 2006;61(3):534-540.

37. Mollen CJ, Fein JA, Vu TN, et al. Characterization of nonfatal events and injuries resulting from youth violence in patients presenting to an emergency department. *Pediatr Emerg Care.* Dec 2003;19(6):379-384.

38. Youth Alive Web site. Available at: http://www.youthalive.org. Accessed April 24, 2008.

39. Dobrin A, Brusk JJ. The risk of offending on homicide victimization: a public health concern. *Am J Health Behav.* Nov-Dec 2003;27(6):603-612.

40. Cunningham R, Walton MA, Zimmerman MA. SafERTeens: Computerized screening and brief intervention for teens at-risk for youth violence. [abstract #264]. Paper presented at: 2007 Annual Meeting Society for Academic Emergency Medicine 2007; Chicago, IL.

Module 3:
Preventing Future Injury

OBJECTIVE 12:

Key Components Of Successful Transition in High Risk populations

The most effective violence prevention approaches, short of massive social and economic reform, build resilience and enhance protective factors to overcome social and environmental stressors.[1-4] These include encouraging participation in peer groups, schools, and communities that emphasize positive social norms, facilitating concomitant involvement in safe activities, providing supportive relationships with adults, and enhancing competence in cognitive, social, and emotional skills. An effective Emergency Department (ED)-based violence prevention program must incorporate these effectiveness criteria.

Programs based on best practices (or program models that have demonstrated positive outcomes) can effectively reduce re-institutionalization for many high-risk populations. These models use a collaborative process that requires input and support from many players including patients, their support system such as family and friends, medical staff, and community-based human services providers. Best practices identify at least four key components to promoting successful transition from an institution or hospital to the community for youth at high risk for violence:[5]

1. Assessment of the patient's psychosocial needs and the risks they pose to public health and safety.
2. Planning for the treatment and services required to address these needs.
3. Identifying required programs responsible for post-discharge services.
4. Coordinating the aftercare plan to ensure appropriate service delivery and mitigate gaps in care.

ED and hospital interventions for victims of violence can be provided at various levels of intensity, depending on the ability of the hospital and community to commit and sustain the necessary resources. In the simplest form ED discharge planning involves assessing youth for risk of retaliation and providing the needed community support to prevent the immediate threat. In a more advanced form this discharge planning involves the creation of an individualized aftercare plan or case management. The next section will detail these components or steps to aid the transition from ED/ Hospital for youth at risk for future violence.

Figure 1: Helpful resources for Objective 12 (General)

Helpful Resources

Benefits of a Hospital-Based Peer Intervention Program for Violently Injured Youth

- http://www.phi.org/pdf-library/youth_alive.pdf

Ceasefire Violence Prevention Outreach Program

- http://ceasefirechicago.org/Hospital%20Pilot%20Proposal%202.htm

Operation Ceasefire

- http://ojjdp.ncjrs.org/pubs/gun_violence/profile21.html

Reducing Gun Violence – Operation Ceasefire Boston

- http://www.ncjrs.gov/pdffiles1/nij/188741.pdf

Reducing Gun Violence – Operation Ceasefire LA

- http://www.ncjrs.gov/pdffiles1/nij/192378.pdf

Step 1:

Needs Assessment Prior to Discharge

Victims of violence treated in the emergency rooms and trauma units must overcome psychosocial challenges that can lead to an increased risk of recidivism if not addressed. Adolescent victims of violence frequently exhibit consequences such as depression, stress, aggression, and self-destructive behaviors, all of which can lead to re-victimization and re-injury.[6] Guidelines for treatment of violently injured adolescents, developed by the American Academy of Pediatrics, call for an emotional assessment to be conducted by a social worker upon discharge from the ED.[7] Discharge planning should incorporate a psychosocial assessment either in the ED or hospital or shortly after discharge that evaluates the patient's situation, their personal strengths and needs, and resources available in the community to which the patient will return. Among youth violence prevention professionals, these strengths, needs, and community resources are called "risk factors" and "protective factors." (See Module 1 for a discussion of risk and protective factors.)

The psychosocial assessment can serve as an effective tool to support program staff in gathering essential information about the patient's health conditions, potential housing arrangements, probation status, school status, financial resources, and family situation. It can also help staff determine potential risk facing the patient upon release.

Discharge planning could also incorporate counseling at discharge for all young patients and their families, and provide them with a list of local services that may help them develop the protective factors needed to overcome risk factors associated with violence. Research shows that recidivism or re-injury can be significantly decreased if patients receive counseling and referral information at discharge, though some studies suggest that the impact is even greater if patients are provided case-managed aftercare.[8]

Step 2:

Planning for Treatment and Services

If the resources to provide case-managed aftercare are not available, the program staff responsible for preparing the patient for discharge can develop a plan that the patient and the significant others in that patient's life will be responsible for managing. The major issues facing this population include:

- Substance abuse
- Educational, including school dropout and unsafe school setting
- Family, including domestic violence, childcare, and fathering
- Occupational, such as job readiness and prior felony convictions
- Housing
- Financial, including lack of employment and access to government assistance

- Healthcare access
- Legal, such as criminal justice system involvement
- Mental health, including anger management and post-traumatic stress disorder
- Gang involvement

Community services lists are often available through the local United Way, city and county human services agencies, and community-based organizations. Those responsible for discharge planning can improve patient outcomes by tailoring a community-specific list of the services that are most appropriate for this population. Outcomes improve when staff members who conduct assessments and provide counseling are able to develop and sustain rapport with these patients.

Figure 2: Helpful resources Objective 12 (Planning for treatment and services)

Helpful Resources

United way LA

- http://www.unitedwayla.org/Pages/default.aspx

Discharge Protocols for Community Services Boards and State Mental Health Facilities

- http://www.dmhmrsas.virginia.gov/documents/OMH-DischargeProtocols.pdf

Needs Assessment for Victims of Domestic Violence

- http://endabuse.org/programs/healthcare/files/trainersmanual/Chapter2.pdf

Impact of Violence and the Emergency Department

- http://linkinghub.elsevier.com/retrieve/pii/S0031395505700195

Step 3:

Identifying Resources for Youth and Families in the Community

Community institutions can provide valuable support for these patients after discharge. This includes schools, places of worship, faith-based organizations, YMCAs, police departments, public defenders offices, city or county council members, and community-based organizations (CBOs) that work with the people who live in the communities where the violently injured patient lives. While most local organizations are under-resourced, they can usually help find the services a patient needs to increase his or her protective factors. Public defenders, for example, often know about the substance abuse treatment programs in the area that work best with specific types of clients. Boys and Girls Clubs, YMCAs, and other community-based agencies often provide a range of services for this population, or can connect with organizations that have similar missions. Local community organization staff members often know who to call in the local school district to most efficiently enroll a student in a school where he or she can feel safer, or how to complete the paperwork needed to secure emergency housing.

Hospital trauma administrators and staff can locate these organizations by calling the local YMCA or a faith-based institution in the neighborhood where the violently injured patient lives and asking a staff member about what they provide and if they know of other agencies providing services to this population. The Internet or local Yellow Pages usually list substance abuse treatment, family counseling, emergency housing, and other human service programs. The local United Way often maintains a list of service providers. It may be useful to house in the ED a list of service organizations categorized by neighborhood, to facilitate the process of aftercare referral.

Step 4:

Case-Managed Aftercare

Providing case-managed aftercare for at least six months for injured youth may reduce post-discharge injury. This approach produces significantly better outcomes than when patients only receive a list of resources that they can contact on their own.[8] Hospital counseling, discharge planning and case-managed aftercare can also significantly decrease arrest rates for these patients.[9] This is significant because criminal involvement increases the risk of subsequent homicide victimization, which is clearly a public health concern.[10]

Professional social workers or paraprofessional case managers can provide effective case-managed aftercare. They may be staff of the hospital or of a contracting agency. If a contracting agency is responsible for aftercare, the contracting agency staff should, wherever possible, work closely with the hospital staff in all phases of discharge planning to ensure a transition that is as

smooth as possible.

Regardless of which agency provides the case management services, aftercare should be a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet each patient's health and human service needs.

The National Association of Social Workers defines case management as follows[11] :

> *Social work case management is a method of providing services whereby a professional social worker assesses the needs of the client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex needs. A professional social worker is the primary provider of social work case management. Distinct from other forms of case management, social work case management addresses both the individual client's biopsychosocial status as well as the state of the social system in which case management operates. Social work case management is both micro and macro in nature: intervention occurs at both the client and system levels. It requires the social worker to develop and maintain a therapeutic relationship with the client, which may include linking the client with systems that provide him or her with needed services, resources, and opportunities. Services provided under the rubric of social work case management practice may be located in a single agency or may be spread across numerous agencies or organizations.*

The staff responsible for the case-managed aftercare should develop and manage the discharge and aftercare plan throughout the transition period in collaboration with the patient, the patient's family and other significant others in the patient's life as well as the community-based services that the patient needs to reduce recidivism.

It is important that the aftercare plan first address the patient's safety in their neighborhood, at home and, for school-aged patients, at school. This may involve arranging for temporary housing with a friend or family member in a safer neighborhood or securing a place in a clean and sober housing facility. It may also involve negotiating with the local public housing authority or a domestic violence program for emergency shelter.

It is important that the aftercare plan also address issues related to the patient's physical recovery, such as follow-up wound care and physical therapy if needed. The plan should also include some or all of the following:

- Gang involvement counseling
- School enrollment support and tutoring or GED preparation
- Job readiness training and employment placement
- Domestic violence counseling
- Childcare and fathering support
- Financial assistance such as access to government assistance (including Victims of Crime funds)

- Legal assistance with victim support and criminal justice system involvement
- Mental health counseling including anger management and post-traumatic stress disorder treatment
- Substance abuse treatment, either inpatient or outpatient

Outcomes improve when program staff members regularly reassess a patient's coping skills and emotional well being. It is also important that the aftercare include working with the patient to periodically revise short- and long-term goals, and ensuring that the youth maintain participation in services to which they are referred, even taking them to appointments, if needed. The aftercare plan should establish a network of support that can continue beyond the transition period. This network may include community-based agencies, such as Boys and Girls Clubs or local YMCAs, faith-based institutions, or individuals who will guide or mentor the patient over the long-term. This is not in the domain of the ED, but ED staff can help to ensure that the patient is directed to aftercare services that provide such support.

Figure 3: Helpful resources Objective 12 (Case Managed Aftercare)

Helpful Resources

Social Worker Case Management

- http://www.socialworkers.org/practice/standards/sw_case_mgmt.asp

Violence Prevention in the ED (Link to abstract)

- http://www.ncbi.nlm.nih.gov/pubmed/14574650

REFERENCES

for Objective 12

1. Catalano RF, Loeber R, McKinney KC. *School and Community Interventions to Prevent Serious and Violent Offending*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention; 1999.

2. Catalano RF, Arthur MW, Hawkins JD, et al. Comprehensive community- and school-based interventions to prevent antisocial behavior. In: Loeber R, Farrington DP, eds. *Serious and Violent Juvenile Offenders: Risk Factors and Successful Interventions*. Thousand Oaks, CA: Sage Publications; 1998:248-283.

3. Masten AS, Coatsworth JD. The development of competence in favorable and unfavorable environments. Lessons from research on successful children. *Am Psychol*. Feb 1998;53(2):205-220.

4. Catalano RF, Hawkins JD. *Communities That Care: Risk-Focused Prevention Using the Social Development Strategy*. Seattle, WA: Developmental Research and Programs, Inc.; 1995.

5. Travis J, Solomon AJ, Waul M. *From Prison to Home: The Dimensions and Consequences of Prisoner Reentry*. Washington, DC: The Urban Institute; 2001.

6. Singer MI, Anglin TM, Song LY, et al. Adolescents' exposure to violence and associated symptoms of psychological trauma. *JAMA*. Feb 8 1995;273(6):477-482.

7. American Academy of Pediatrics Task Force on Adolescent Assault Victim Needs. Adolescent assault victim needs: a review of issues and a model protocol. *Pediatrics*. Nov 1996;98(5):991-1001.

8. Zun LS, Downey LV, Rosen J. Violence prevention in the ED: linkage of the ED to a social service agency. *Am J Emerg Med*. Oct 2003;21(6):454-457.

9. Becker MG, Hall JS, Ursic CM, et al. Caught in the crossfire: the effects of a peer-based intervention program for violently injured youth. *J Adolesc Health*. 2004;34(3):177-183.

10. Dobrin A, Brusk JJ. The risk of offending on homicide victimization: a public health concern. *Am J Health Behav*. Nov-Dec 2003;27(6):603-612.

11. National Association of Social Workers Case Management Standards Work Group. NASW standards for social work case management. *National Association of Social Workers Web site*. Available at: http://www.socialworkers.org/practice/standards/sw_case_mgmt.asp#def. Accessed April 24, 2008.

Module 4

Funding and Evaluating Emergency Department Based Youth Violence Prevention Programs

OBJECTIVE 13:

Funding an Emergency Department Based Youth Violence Prevention Program, The Basics.

How Much Will it Cost?

Conducting a cost-benefit analysis can increase the probability of securing the human and financial resources needed to provide the most comprehensive discharge planning and aftercare strategy possible. Hospital administrators may be able to secure the resources needed to conduct an analysis by working with a local college or university. Hospitalization for gunshot injury can cost from $15,000 to $32,000 per episode.[1] Most comprehensive discharge planning and aftercare for violently injured patients costs an average of $2,000 to $3,500 per patient. In the face of these challenges, hospital administrators can seek funding through state victim assistance funds, private foundations, hospital foundation and corporations such as insurance companies for multi-year program start-up costs. They can also develop collaborations with local community-based agencies.

Sharing The Cost.

For example, one ED-based violence intervention program, *Caught in the Crossfire,* operates as a successful collaboration between the local county trauma center and *Youth ALIVE!*, a community-based agency in Oakland, California.[2] Another discharge planning and aftercare program, *Project Ujima,* operates as a collaborative effort of several medical and youth service institutions in Milwaukee, Wisconsin, to serve young patients being treated for an intentional injury (excluding self-inflicted or child abuse) at the Children's Hospital of Wisconsin, Emergency Department/Trauma Center.[3] *Within Our Reach,* a discharge planning and aftercare program in Chicago operates effectively as a collaboration between Mount Sinai Hospital and the Boys and Girls Clubs.[4] (See descriptions of these programs in Module 3.) In each of these models, community-based agencies hire, train, and supervise community liaisons or case managers and the hospital medical or social work staff identify patients needing more comprehensive discharge planning and aftercare, secure consent from patients, and link them within hours to the community liaisons or case managers.

Long-Term Sustainability

Resources to sustain the program may be generated by cost-savings from reduced recidivism. This approach has been used successfully in the development of Children's Systems of Care, promoted by the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA).[5] Another approach might involve adopting

community liaisons or case managers as part of the hospital social work staff and drawing on Early and Periodic Screening, Diagnosis, and Treatment Program funding (EPSDT), a part of the federal Medicare program. Another potential funding source is the victim of crime assistance funds, federal monies that are managed at the state level. In most states, these funds currently support programs that help victims of domestic violence or child abuse.[6]

Figure 1: Helpful resources for Objective 13

Helpful Resources

US Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA)

- http://systemsofcare.samhsa.gov/

Early and Periodic Screening and Treatment Program Funding (ESPDT)

- http://health.nv.gov/index.php?option=com_content&task=view&id=469&Itemid=787

OBJECTIVE 14:

Evaluating Your ED-Based Intervention

Program evaluation is a tool used to assess and improve programs. Almost all funders routinely require evaluation as a component of program proposals. Evaluation is often perceived as a research or academic endeavor. However it is a useful and necessary process in the success of interventions and can be carried out in a variety of settings by a variety of individuals. Program evaluation is concerned with five broad questions:

1. Is the intervention reaching the target population?
2. Is it being implemented in the ways specified?
3. Is it effective?
4. How much does it cost?
5. What are the costs relative to its effectiveness?

People often think of program evaluation as measuring effectiveness, but there are several different types of evaluation that can be beneficial during all stages of program design and implementation. These include the following:

- *Formative Evaluation* can be thought of as pre-test or a pilot test of a program on a small scale, which allows you to refine a program's implementation before a full-scale roll-out. Information is collected through focus groups and in-depth interviews to ascertain whether the program and its materials are appropriate, acceptable, and appeal to the intended audience. Program developers use this information to help modify or enhance the program prior to full implementation. Formative evaluation is important and plays a role in whether or not the program has an impact. If the intended audience does not respond to the program, favorable outcomes will not likely be achieved.

- *Process Evaluation*, sometimes thought of as quality assurance, can determine whether a program is being implemented as planned. This is an assessment of whether the program was carried out as planned, as opposed to an outcomes assessment. Process evaluation should be conducted throughout the duration of the program, and can focus on the amount of services delivered, to whom services are delivered, consistency of delivery of services, and quality of interaction between staff and clients. Process evaluation is usually conducted through careful record keeping during implementation. Process evaluation is often overlooked, but it can provide valuable information about why the program did or did not achieve established outcomes.

- *Impact or Outcome Evaluation* measures the ultimate effectiveness of the program. Impact evaluation measures the change in knowledge, attitudes and behaviors based upon the intervention among the intended audience, and is often measured through self-report, pre-post surveys, or observed behavior. Outcome evaluation measures whether participants adopted behaviors have resulted in the intended health outcome (i.e. change in health status, reduced injury rates). Outcome evaluation generally measures long-term indicators of success such as reduced morbidity and mortality. It is very difficult to see change in long-term outcomes based on short intervention and evaluation time periods; therefore defining short-term and intermediate outcomes measured through impact evaluation will be important and can speak to the success of a program.

Figure 1: Helpful resources for Objective 14

Helpful Resources

Basic Guide To Program Evaluation

- http://www.managementhelp.org/evaluatn/fnl_eval.htm

Planning a Program Evaluation

- http://learningstore.uwex.edu/pdf/G3658-1.pdf

OBJECTIVE 15:

Using Logic Models to Identify Expected Outcomes

In considering how to evaluate the effectiveness of an ED or hospital program, there are two important questions to ask: (1) What is the purpose of evaluating the program?, and (2) Who will use the information? Bearing in mind the answers to these questions, while developing the evaluation will maintain focus on program goals.

A useful tool to guide the evaluation of your program is the development of a logic model. Defining all of the elements included in a logic model effectively answers the questions about project activities and outcomes. Logic models include the following elements:

- *Inputs* are resources a program uses to achieve program objectives. Examples are staff, volunteers, facilities, equipment, curricula and money. A program uses its inputs to support its activities.

- *Activities* are what a program does with its inputs—the services it provides—to fulfill its mission. Examples are sheltering homeless families, educating the public about the signs of child abuse, and providing adult mentors for youth. A program's activities produce outcomes.

- *Outcomes (short-term, intermediate and long-term)* are products of the program's activities in the short-term like participants attending a program and benefits to those participants in the short, intermediate and long term. Examples of benefits include greater knowledge, skills and attitudes about nutrition, improved reading skills, more effective responses to conflict, and reduced injury burden.

There are several different ways to graphically depict a logic model. Below is an example with a fictional program:

Figure 1. Example: logic model for hypothetical ED-based violence-related injury recidivism prevention program

Inputs	Activities	Outcomes		
		Short-term	**Intermediate**	**Long-term**
Screener / interviewer Case manager Counseling materials Outside service referrals	Program screens youth presenting to ED with violence-related injury for risk of recidivism. The patient is referred to a case manager, who briefly counsels the individual. The youth completes a questionnaire designed to assess his/her understanding of risks of recidivism. The case manager provides linkages to external social services.	Youth understands risk of injury recidivism. Youth contacts outside social services.	Youth reduces involvement in violence. Youth stops carrying weapons.	Reduced rate of violence-related injury recidivism in the ED.

Once the outcomes of your program have been defined, indicators that will be used to track the success towards the program's outcomes must be identified. Indicators describe observable, measurable characteristics or changes that represent achievement of an outcome. Deciding on the right indicators to measure outcomes is critical. Several indicators may be necessary to measure one outcome. Indicators should be specific as possible in the number or percentages they are measuring and referring to a timeframe for measurement. Following are examples of measurable indicators for the violence recidivism example above.

Figure 2. Example: Indicators for evaluating a hypothetical ED-based violence-related injury recidivism prevention program

Outcome	Indicator(s)
Youth participates in intervention.	Number of eligible youth presenting to the ED who participate in intervention.
Youth contacts outside services.	Number of participants who contact outside social services, and length of time used service.
Youth reduces participation in violence.	Number and percent of youth who report reduced involvement in violent incidents in the follow-up period, compared to the period prior to index ED visit (or compared to injured peers who did not enter program).
Youth reduces weapon carriage.	Number and percent of youth who report fewer days carrying weapons in the follow-up period, compared to the period prior to the index ED visit (or compared to injured peers who did not enter program).
Reduced levels of violence-related injury recidivism in the ED.	Reduced rates of repeat violence-related ED visits among participants, compared with control group, after the index ED visit.

After indicators have been selected, data sources for the indicators need to be identified, and the data must be collected and analyzed in a standardized fashion. Following that, the data is analyzed, results should be reported in a variety of venues and then used to advocate for future programs and funding.

Figure 3: Helpful Resources for Objective 15

Helpful Resources

Evaluation Logic Models

- http://www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html

Basic Logic Model Guidelines

- http://www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html

OBJECTIVE 16:

How To Use Evaluation Results Productively

It is generally accepted that 10-20% of the program budget should be set aside for evaluation. Using your advocacy skills to emphasize the importance of program evaluation and to advocate for future resource allocation based upon the evaluation results is entirely appropriate. Following are applications for the evaluation results.

Internal applications

- Use what is learned from evaluation to guide future resources at the hospital
- Provide direction for program staff
- Identify training needs
- Identify program improvement needs and strategies
- Support strategic planning processes
- Draw attention of hospital board members and volunteers to the program

External applications

- Share what is learned broadly to local, state and national policymakers, the media and other health professionals to help inform better public health interventions
- Recruit staff and volunteers
- Promote program to potential participants and referral sources
- Retain and increase funding
- Enhance program's public image
- Identify partners for collaboration

Figure 1: Helpful Resources for Objective 16

Helpful Resources

Office for the Victims of Crime

- http://www.ojp.usdoj.gov/ovc/welcovc/welcome.html

Government Grant Applications

- http://www.grants.gov/

References

For Objectives 13 Through 16

1. Bonderman J. *Working with Victims of Gun Violence.* Washington, DC: U.S. Department of Justice, Office for Victims of Crime; 2001.

2. Becker MG, Hall JS, Ursic CM, et al. Caught in the crossfire: the effects of a peer-based intervention program for violently injured youth. *J Adolesc Health.* 2004;34(3):177-183.

3. Marcelle DR, Melzer-Lange MD. Project UJIMA: working together to make things right. *WMJ.* 2001;100(2):22-25.

4. Zun LS, Downey LV, Rosen J. Violence prevention in the ED: linkage of the ED to a social service agency. *Am J Emerg Med.* Oct 2003;21(6):454-457.

5. Substance Abuse and Mental Health Services Administration. SAMHSA Systems of Care Web site. *U.S. Department of Health and Human Services*. Available at: http://systemsofcare.samhsa.gov/. Accessed April 24, 2008.

6. US Department of Justice, Office for Victims of Crime Web site. Available at: http://www.ojp.usdoj.gov/ovc/fund/welcome.html. Accessed April 24, 2008.

Module 5:
Cultural Competence and Communication Skills

OBJECTIVE 17:

The Importance of Cultural Competence and Youth Violence Interventions.

In the healthcare context, cultural competence is a way of establishing rapport between health and human services providers and those they serve. Health and human service providers practice cultural competency when they "demonstrate respect for and build on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community."[1] Experts in the field recognize that:

- Cultural competence is a process of developing skills and knowledge for both individuals and organizations;
- With appropriate support, individuals can enhance their cultural awareness, knowledge, and skills over time; and
- Cultural competencies exist within organizations or networks of professionals but often go unnoticed and untapped.

In order to improve culturally competency, health practitioners can build on their own knowledge and integrate an awareness of cultural elements into their service provision. These cultural elements include the following[2]:

- The values and belief systems for culturally diverse groups
- The dietary choices/patterns of individuals in various groups
- The exercise or physical activity choices/patterns
- The influence of spirituality or religiosity on perceptions of health and well being
- The authority or credibility attributed to various types of healers
- The impact of family dynamics on healthcare decisions, e.g., high value placed on decisions made by elders, differing gender roles, and the role of extended family
- The strengths and resiliency of diverse individuals, families and communities

When a health practitioner provides culturally competent services, patients are more likely to follow advice provided and ask for help as unanticipated issues arise.

Communication Pitfalls

Many violently injured young people are unable to articulate their needs and strengths and many others find it difficult to accept assistance from people they do not know. Caregivers can differentiate non-receptiveness from lack of articulation in violently injured young patients by listening carefully to their verbal and non-verbal communication and refraining from intervening until sufficient rapport is developed. Some common signals of non-receptiveness are verbal denial of needs for help, use of flippant language in response to questions, and unwillingness to talk at all. Inarticulation, on the other hand, is evident when a young person is not dismissive, but is unable to find the words to describe a need or other condition, or neither declines nor accepts what is being offered.

Figure 1: Helpful Resources for objective 17

Helpful Resources

Cultural Competence

- http://cecp.air.org/cultural/

Office of Minority Health

- http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3

Cultural Competence in Health Care

- http://www.commonwealthfund.org/usr_doc/betancourt_culturalcompetence_576.pdf?section=4039

OBJECTVE 18:

Understanding Community Characteristics

Staff involved in youth violence intervention programs should know the demographics, characteristics, and realities of the community to which the violently injured youth will return, in order to be able to provide linkage to services that will most significantly reduce re-injury and re-admission. Most violently injured youth come from communities that have high unemployment rates, poor academic achievement rates, easy access to guns, and easy access to drugs and alcohol.[3] These communities often lack "social capital," the networks that enable a community's inhabitants to gather the information they need to escape their immediate circumstances.[4] Therefore these young people often require substantial help accessing and making use of the resources that would help them make the changes required to avoid re-injury.

Program staff can be creative in finding and assembling resources, connecting victims with those resources, and adjusting plans as needed. For example, if the victim was injured because of his or her involvement in gang activity, the victim cannot attend school in an area that is controlled by a rival gang or travel through an area controlled by a rival gang when going to and from a job training program or other service. The program staff can either help the victim enroll in a school, job training program, or other service that is more safely accessible or figure out a way of ensure safety under the existing circumstances. Although this is outside of the purview of ED staff, it is possible to establish relationships with external organizations and services that can facilitate this process.

An understanding of the violently injured youth's reality will facilitate the rapport needed to effectively guide the victim to secure the help he or she needs to overcome the risk factors associated with violence. One victim's reality may include a home in a neighborhood where violence between rival gangs is common, but a family in which the relationships between the adults and children are respectful and supportive. Another victim's reality may include persistent family conflict, gang involvement, and a history of arrests and convictions, but also the opportunity for attendance at a community college art program where the victim's artistic abilities and leadership skills could be nurtured and channeled into helping produce the student newspaper.

Protective factors are needed to temper the impact of the environmental and social factors that promote violent re-injury.[5] Adolescents are at a phase of development where peers and community factors have much greater impact than do family members. Many violently injured youth distrust people in authority or people who judge them without knowing their culture or the specific circumstances that led to the violent injury. Thus many are reluctant to accept help. For many of these youth, the significant adults in their lives disappointed and sometimes even abandoned them by taking paths that resulted in drug or alcohol abuse, imprisonment, or premature death. Some parents and caretakers are unable to manage the stresses associated with chronic unemployment or underemployment, racism, single parenthood, or neighborhoods torn by crime and violence. These youth are often unable to identify positive adult role models in their homes, schools, or neighborhood organizations, and will often turn to formal or informal

peer groups that play a substantial role in shaping his or her behavior. Healthcare professionals working to prevent future violence-related injury among youth must understand these realities, recognize the distrust they potentially engender, and work to communicate in a way that conveys that understanding.

Figure 1: Helpful Resources for Objective 18

Helpful Resources

Cultural Competence and Communication

- http://www.medscape.com/viewarticle/508410

Doctor Patient Communication

- http://abs.sagepub.com/cgi/content/abstract/49/6/835

Improving Patient Relations

- http://www.aafp.org/fpm/990500fm/23.html

Adolescent Patient Communication

- http://www.popline.org/docs/0821/048250.html

Communication Skills Workshop

- http://www.msr.org.il/Courses_Medical_Simulation_Center/195.htm

OBJECTIVE 19:

Creating a Safe Place for Interaction with the Patient

Engaging youth with their families and physicians can be especially challenging during the process of identifying youth with violence-related injuries, and assessing the risk of future involvement in violence. It is important to understand that adolescents and family members' reactions to violent trauma is based on many factors, including their prior experiences, coping styles, and natural reactive tendencies. In all cases, it is important to create a physically and emotionally safe place for the initial evaluation by ensuring confidentiality and providing the patient and family with a step-by-step guide regarding the evaluation process.[6] To achieve this, the healthcare professional must assure the patient that it is policy that all information is "just between you, me and the medical team here at the hospital" unless they plan on hurting themselves, another person, or want protection from someone else who plans to hurt them.

Conducting the evaluation and assessment alone with the patient may help to establish rapport, and interactions may be influenced significantly based on expectations of others in the room. It should have been explained to the patient and family members previously that it is the medical policy to conduct a one-on-one meeting with all youth in the care of the ED, and an attempt should be made to find time alone with the patient. Injured youth often have many visitors, which may make it difficult to conduct the evaluation alone with the patient; alternatively, communication with the patient can often be more difficult than communication with the family, depending on the magnitude of the patient's involvement with the violence-related event that led to injury. Furthermore, young patients may respond very poorly to being left alone, and their perception of safety may be strengthened by having family members present. Whether the assessment and evaluation is conducted alone with the patient or with others present, the patient's support network, when appropriate, should be incorporated into follow-up interactions.

Interaction with violently injured youth calls for a clear demonstration of respect and confidentiality on the part of the provider towards the individual. The first interaction is critical in conveying a commitment to the individual. Demonstrating cultural sensitivity and an ability to be non-judgmental is crucial in developing trust (see Module 4 for a discussion of cultural competence). Good interview skills play a major role in facilitating the comfort of the patient. The NSW Centre for the Advancement of Adolescent Health offers a few suggestions to ease communication with an adolescent patient[7]:

- Allow the patient to express their own feelings and ideas of the problem at hand; let them know what your own ideas are as well
- Remain empathetic and unbiased
- Respond to verbal and nonverbal cues
- Speak to the patient in an understandable way; he/she may not be familiar with complex medical terms, etc.
- Always ask permission before exploring sensitive issues
- Use positive reinforcement in response to information revealed by the patient

With regard to whom should conduct the assessment, case managers who have experienced violent injury or who have personal experience with urban violence may have successful interactions with violently injured youth. However, social workers, nurses, and physicians can certainly conduct the assessment and evaluation. Denninghoff et al[8] included interpersonal and communication skills as a fundamental competency of emergency medicine practitioners working in youth violence prevention; these skills can be used as a model for training staff.

OBJECTIVE 20:

Understanding Documentation Issues Around Violent Injury

In order to properly assess, evaluate, and refer violently injured youth, it is important to document the information gleaned from patient interviews. In addition to formal assessment, information such as circumstances leading up to the violent event, the victim's relationship to the aggressor, and weapon use (what was used and how it was used) can be particularly helpful when referring the patient to aftercare services.[9] However, potential negative impacts may result from such documentation on the patient, the patient's family, and the patient's access to care. Documentation of a violently injured individual's social history is extremely sensitive information. This information, if placed in the wrong hands, could put individuals and even providers at risk. According to the NSW Centre for the Advancement of Adolescent Health, "*data on illegal violent behaviors are often held by agencies involved in the investigation and prosecution of the illegal behavior, and releasing information could compromise investigations or violate protections provided to individuals under the law. Some data on violent behavior are attached to child abuse data within social service agencies or to academic data within schools. The costs and the time required to strip data of identifiers are often beyond the capacity or budget restrictions of the agency holding the data."*[7] Providers should adhere to strict confidentiality regulations via HIPAA guidelines.

As a result of HIPAA regulations, patients involved in high-risk activity who are hospitalized are afforded a degree of protection and privacy. To the extent that these regulations are enforceable in any given institution, some comfort may be gleaned by these patients; it is often a concern, on the part of the violently injured patient, that he/she may be at risk of someone finding out where they are located, in an effort to retaliate. Prohibiting the distribution of information as basic as patient location can be life saving with the right measure of regulation, compliance and enforcement.

Disclosure of information by a patient is typically voluntary once confidentiality has been confirmed;[10] therefore, anonymity is necessary to not only protect the patient and/or family, but also to eliminate discrimination of healthcare services based on violence history (i.e. insurance coverage, etc.). Despite these challenges, the development of a standard protocol for documenting violence history or specific involvement in a violence-related event is necessary in order to identify those who are potentially a danger to themselves and others.[11]

Documentation of social history and progress reports from interventions in which a patient may be participating should be kept in a place accessible to those who need to utilize the information on behalf of the patient. Therefore, the medical record may *not* be the most appropriate place for this information. Rather, individuals or departments who are working with the patient can be noted in the medical record, with specific details maintained in a private file only accessible to those for whom the information is relevant. If information is collected for the research purposes,

documentation procedures should follow those specifically outlined in the approved IRB proposal.

Interaction with other services or other hospitals regarding a violently injured individual should be based on two guiding principals: respect for the patient/client and confidentiality. Avoid labels and stereotypes in these communications; they are barriers to sympathetic care and work to destroy the trust between provider and patient. Realties and facts, rather than presumptions and misconceptions should be the backbone of the social information that is exchanged.

Helpful Resources for Objective 20

Helpful Resources

HIPAA Materials

- http://www.hhs.gov/ocr/hipaa/

References

For Objectives 17 Through 20

1. Bruns EJ, Walker JS, Adams J, et al. *Ten Principles of the Wraparound Process*. Portland, Oregon: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University; 2004.

2. National Center for Cultural Competence Web site. Cultural competence health practitioner assessment (CCHPA). *National Center for Cultural Competence Web site*. Available at: http://gucchd.georgetown.edu/nccc/. Accessed April 24, 2008.

3. Youth Alive Web site. Available at: http://www.youthalive.org. Accessed April 24, 2008.

4. Lin N. *Social Capital: A Theory of Social Structure and Action.* Cambridge, United Kingdom: Cambridge University Press; 2001.

5. Fergus S, Zimmerman MA. Adolescent resilience: a framework for understanding healthy development in the face of risk. *Annu Rev Public Health.* 2005;26:399-419.

6. Bailey S. Violent children: a framework for assessment. *Advances in Psychiatric Treatment.* 2002;8:97-106.

7. Kang M, Chown P. Conducting a youth-friendly consultation. In: Unknown, ed. *General Practitioners Resource Kit: Enhancing the Skills of General Practitioners in Caring for Young People from Culturally Diverse Backgrounds* Westmead, Australia; 2004:1-26.

8. Denninghoff KR, Knox L, Cunningham R, et al. Emergency medicine: competencies for youth violence prevention and control. *Acad Emerg Med.* Sep 2002;9(9):947-956.

9. Dowd MD. Consequences of violence. Premature death, violence recidivism, and violent criminality. *Pediatric clinics of North America.* Apr 1998;45(2):333-340.

10. HIPAA Advisory Web site. HIPAA primer. *HIPAA Advisory Web site*. July 2005. Available at: http://www.hipaadvisory.com/REGS/HIPAAprimer.htm. Accessed April 24, 2008.

11. Chalk R, P.A. K, eds. *Violence in Families: Assessing Prevention and Treatment Programs.* Washington, D.C.: National Academic Press; 1998.

Module 6:
Advocacy & Youth Violence Prevention

OBJECTIVE 21:

The Role And Influence of Health Care Professionals In Advocacy and Public Policy

The notion of what constitutes news is based on a complex interaction of human interest, drama, and events that affect people directly. Reporting is a business, one that is based on creating headlines. Unfortunately, reports of crime and violence notoriously distort a clear picture of the facts and can cause readers to be fearful of the world. In addition, this may lead to ambivalence in the general public towards prevention efforts, allowing a more punitive response to prevail.

The media has a tendency to focus on high-profile violence, and often the least common types of homicide get the most attention. The upper-middle class, White, female homicide victim killed by a stranger garners far more attention compared with the young, poor African American male shot in a neighborhood riddled with gun violence. The fallout from this is a perception that gun violence is normal and expected in some of our neighborhoods. It is only through advocacy that we can reframe gun violence to remind the public that, regardless of the circumstances, it is not normal and never acceptable.

In our world of fast-breaking news, transforming headline-selling drama into opportunities for public health advocacy takes preparedness and strategic planning. Almost all hospitals have specially trained individuals who constitute the media relations department at the institution. However, other appropriate members of the healthcare team who can interact with the media are those who are prepared and armed with the capacity to see media attention as an advocate's platform. Table 1 below can be utilized to familiarize a provider with the type of content that is typically sought when reporting on violence.

Figure 1. Areas of inquiry for reporting on violence from a public health perspective

Table 2. Areas of Inquiry for Reporting on Violence From a Public Health Perspective (distributed as a handout at newspaper workshops on violence reporting)

Victim or Suspect	Victim's or Suspect's Family	Weapon	Social Environment	Physical Environment
Age	Effects on family members	Type	Economic level	Location of violent incident: street, house, apartment
Race	Effects on children—whom they live with, number of people living per room	Where obtained	Unemployment level	Alcohol outlet density
Sex	Economic effects	Cost	Job opportunities	Number of people living per room
Income/job	Retention of home	How often used in this type of violence	Youth employment	Lighting
Relationship		How many produced	Population concentration	Healthy community: services (parks, transportation), schools, libraries, supermarkets, entertainment centers, churches, mix of businesses, ratio of abandoned buildings
Residence		How many sold	Crime level	
How often this incident occurs			Alcohol mores	
Injuries			Alcohol advertising	
Rehabilitation			Welfare	
Death			Costs of court, hospital, rehabilitation, convalescence	
Incarceration			Foster care	
Trial				
Health insurance				

Adapted from these sources:

Community Tool Box (2006). Organizing for Effective Advocacy. Available online at: http://ctb.ku.edu/en/

Christoffel KK. Public health advocacy: Process and product. Am J Public Health 2000;90:722-726.

OBJECTIVE 22:

Advocacy: The Role and Influence of Healthcare Professionals

"…Advocacy seeks to increase power of people and groups and to make institutions more responsive to human needs. It attempts to enlarge the range of choices that people can have by increasing their power to define problems and solutions and participate in the broader social and policy arena."

--Lawrence Wallack, DrPH, Dean, College of Urban and Public Affairs Professor of Community Health, Portland State University

According to Webster's Dictionary, an advocate is "one that defends or maintains a cause or proposal," or "one that supports or promotes the interests of another." Physicians, nurses and healthcare providers are primarily advocates for their patients and have the professional expertise to become advocates on other levels as well. This module will focus on advocating for health improvements through public policy change. For the purpose of this module a germane definition of advocacy is "…**the application of information and resources (including finances, effort and votes) to effect systemic change that shape the way people in a community live**."

To better the health of individuals, physicians, nurses, and other healthcare providers employ patient advocacy. Patient advocacy is inherent in the education, training, and everyday lives of physicians and other healthcare providers. Advocacy for a patient can then extend outward to include advocacy for all patients, for the practice or hospital, extending out to international advocacy efforts.

Population-wide advances in health take place beyond the level of advocacy for individual patients and are often a result of changes in public policy. Effecting change in how to access health services, prevention of disease and injuries in high-risk populations, and other population health issues requires skilled physicians, nurses, and other healthcare providers to be prepared to serve as community and public health leaders. Health professionals are in a critical position to impact health policy and effect large scale change in the public's health. There is a growing call for physicians and other health professionals to take on a more public role in advocating policies that improve the health of both individuals and communities. The need to advocate for public policy change doesn't negate the need for or importance of advocating for patients. Rather, in advocating for policy change one looks upstream to prevent or minimize the conditions that placed patients in the ED in the first place. Table 1 provides examples of patient advocacy versus policy advocacy.

Table 1. Differing patient advocacy from policy advocacy

Case	Patient Advocacy	Policy Advocacy
A child presents to the emergency room a victim of abuse and neglect	ED personnel treat child and contact Child Protective Services	ED staff join with child welfare advocates in support of increased funding for Child Protective Service caseworkers
A young man presents to the emergency room with a gun shot wound	ED personnel treat young man and connect patient with appropriate psychological and violence prevention services	ED staff organize a coalition of medical providers interested in limiting access to handguns in the State
A married mother presents to the emergency room a victim of domestic violence	ED personnel treat woman and make referrals to domestic violence programs and shelters	ED staff join with other organizations interested in stronger enforcement of laws governing restraining orders

Some examples may help clarify the difference between providing direct service to patients/individuals and engaging in advocacy:

- You join a group of physicians to provide free medical care for uninsured individuals – this is service, not advocacy.
- You work with a group of concerned physicians to organize a coalition in support of a new health insurance program to expand coverage to low-income families – this is advocacy.
- You spend your Saturdays volunteering at a youth development center for teens who have been involved with violence – this is service.
- You join a group of concerned citizens to work toward increased city funding for after-school and weekend programs to provide activities and alternatives for youth – this is advocacy.

Adapted from these sources:

Vernick JS. Lobbying and Advocacy for the Public's Health: What are the limits for Non-Profit Organizations? Am J Public Health. 1999;89:1425-1429.

Figure 2: Helpful Resources for Objective 22

Helpful Resources

Legal Community Against Violence

- http://www.lcav.org/

OBJECTIVE 23:

How Public Policy Change Can Reduce Youth Violence

Public policies that affect youth, injury and violence are determined at all levels of government, including the national, state, county, and city or municipal levels. At the national and state levels, there are many opportunities within the legislative process for targeting advocacy efforts, including the following:

- During the time of the initial proposal of new legislation, advocates can propose ideas and serve as useful resources.
- When the bill is being introduced and referred to the appropriate committee(s), advocates can call, write and visit legislators to share opinions on the legislation.
- When the bill reaches committee, advocates can provide verbal or written testimony before the committee and/or send letters to committee members supporting or opposing the bill.
- When the bill is scheduled for floor action, advocates should contact their legislators by phone, fax or in person to indicate support or opposition to the legislation.

Please refer to Appendix A for a list of websites for all state legislatures

County governments function in all states except Connecticut and Rhode Island (which are divided geographically by county but don't have functioning governments). County governments typically focus on state-mandated duties including tax assessments, road maintenance, vital records, judicial functions, and election administration. Counties have recently expanded their policymaking functions into other areas including child welfare, consumer protection and water quality, and can be appropriate venues for advocacy. City governments should also not be overlooked as a venue for potential policy change to benefit the health and lives of youth. Cities have authority to keep the public healthy and safe through its public health functions. For information regarding your specific local government structure and functioning, see the following websites:

Local Government Directory: http://www.statelocalgov.net/local.cfm

National Association of Counties: http://www.naco.org

US Conference of Mayors: http://www.usmayors.org/uscm/home.asp

Policies that affect the public can also be developed by private entities like corporations or community organizations. It is appropriate to use advocacy strategies to influence the policy decisions of these groups as well.

Adapted from these sources:

Community Tool Box (2006). Organizing for Effective Advocacy. Available online at: http://ctb.ku.edu/en/

National Association of Counties. Available at: http://www.naco.org

Physicians' Guide to State Legislation. American College of Emergency Physicians. 1997.

Figure 1: Helpful Resources for Objective 23

Helpful Resources

Center For Gun Policy and Research

- http://www.jhsph.edu/gunpolicy/resources_advocacy.html

Gun Violence Legislation

- http://www.wagv.org/legislation.php

OBJECTIVE 24:

How to Develop an Advocacy Plan

In order to effect policy change and influence the legislative process, it is helpful to work with others to clarify the issue, define the message, and develop a communications strategy that is consonant with available resources. There are many ways to influence policy, and it is always important to voice your opinions and educate colleagues as well as policymakers about an issue that is important to you. Following is a stepwise approach to organizing advocacy efforts.

Steps to organizing advocacy efforts

1. *Gather your allies.* Take the time to assess who agrees with your position and enlist their support, including legislators, beneficiaries of the policy for which you are advocating, service professionals, professional organizations, business and church leaders, and recognized experts.

2. *Organize a coalition.* Formalize your allies with a commitment that everyone agrees on the same position and advocacy plan. Either form a coalition with a defined structure for decision making or agree on the plan for working together. It is essential that someone in your group takes the lead as the central coordinator for disseminating information and activating the coalition.

3. *Do your homework.* Know your issue well and all the research and positions both supporting and opposing it. Take the time to learn about the legislators, their districts and voting records on related issues.

4. *Define your message.* Develop a simple and clear message to explain your issue and ensure that your allies are all speaking with one voice.

5. *Activate the coalition.* During critical stages in the legislative process activate your allies through your established communication network (i.e. phone tree, email list, fax alerts).

6. *Engage the media.* Please refer to the separate section in this module on media advocacy.

Remember that real change doesn't happen overnight. Be prepared and prepare your allies to keep at it for a long time. If you are successful, remember to stay vigilant to ensure that the legislation is being implemented in the way it was intended and advocate for evaluation of its impact.

Adapted from these sources:

Community Tool Box (2006). Organizing for Effective Advocacy. Available online at: http://ctb.ku.edu/en/

Figure 1: Helpful Resources for Objective 24:

Helpful Resources

Grassroots Advocacy for Gun Violence Prevention

- http://www.ncbi.nlm.nih.gov/pubmed/15015868

The Advocacy Project

- http://www.advocacynet.org/page/home

OBJECTIVE 25:

Identifying Ways to Reduce Youth Violence Through Policy Change

Policy Opportunities to Reduce Youth Violence

There is no easy answer for the problem of youth violence. The best public health approaches to violence prevention are concerned with improving the pervasive and chronic life influences that lead to violence (poverty, disease, drug addiction, interpersonal violence, unemployment, teen pregnancy, poor housing) rather than only short-term interventions designed to stop violence immediately. Combinations of programs and policies that include both short-term (i.e. immediate policing efforts) and long-term strategy (i.e. home visitation programs for new mothers) have the best chance of success. Following are some examples of policy opportunities to reduce youth violence, focused primarily on gun violence.

Environmental

- Restrict permit zones where licensed gun sellers can do business (not within certain distances from school and residential neighborhoods).
- Limit the number of businesses permitted to sell firearms and ammunition.
- Increase licensing fees for gun store owners and require increased security measures to prevent theft.
- Decrease access to alcohol and other drugs through licensing policy and sale location.

Product

- Require that all handguns sold include safety features to prevent unauthorized or accidental firing.
- Ban the sale of certain types of firearms and ammunition.
- Restrict gun sales by strengthening background check requirements.

Adapted from these sources:

Media Advocacy Workbook. The Health Communications Unit at the Centre for Health Promotion, University of Toronto. February 2000. Available at: http://www.thcu.ca/infoandresources/publications/ma%20workbook%20v104.pdf. Accessed February 1, 2006.

Media Advocacy and Public Health: Power for Prevention; by Lawrence Wallack, Lori Dorfman and Makani Themba, Sage Publications, Inc 1993.

Figure 1: Helpful Resources for Figure 25

Helpful Resources

Brady Center to Prevent Gun Violence

- http://www.bradycenter.org/programs/

Anti-Gun Violence Initiative

- http://www.allsoulsnyc.org/outreach/groups/guncontrol.htm

Building Relationships, Changing Policy

Building relationships with policymakers is a key to success. There are several ways to initiate and maintain ongoing communication with your legislators, including meetings, letter writing, and phone calls.

Meetings

Meeting with your legislator is the best way to establish a relationship and communicate your position. To request a meeting with your Representative and Senator (or his/her staff), phone or email the office for an appointment. It is important to follow up any email correspondence with a phone call. Let them know what you would like to speak with them about, that you are a constituent and any other important information about you (your profession or personal experience with the issue) and the dates that you will be available. Once the meeting is scheduled make a note of the time, location and who you will be meeting with. Confirm the meeting on the day prior.

Tips for a successful meeting

- Be prepared. Bring materials with you that you can leave with your elected officials concerning your issue. Keep your information simple and to one page.
- Combine both local data and anecdotes from your professional experience to make your case.
- Leave behind a *one-page* information sheet with your contact information.
- Ask for your legislator's support for your issue. If there is a piece of legislation that you are asking him or her to support or sponsor, be specific.
- After the meeting send a thank you note and any additional information that was requested in a timely fashion.

Letter writing

Written communication through a letter to your legislator can be delivered through email, fax or regular mail. If you are going to send a letter via regular mail it is a good idea to fax a copy as well – increased security measures can slow down receipt of envelopes in political offices. As a general rule, address only one issue in your letter and keep the length to one page. Identify yourself and your profession (including relevant degrees) and briefly describe why you are writing, how the issue affects you and others, your position or solution and the relevant data to support your position. When applicable reference a particular bill number.

Phone calls

When time doesn't allow for written or in-person communication, calling the legislator's office is perfectly acceptable. In order to make the best use of your call, prepare your talking points in advance. When you call the office, state that you would like to leave a message regarding your issue. Give your name, profession and contact information. Briefly state your position.

Whatever communication method you choose, maintain a dialogue with your legislator and his/her staff. Becoming a reliable and informative source on one issue will build the trust necessary for you to be influential in other policy debates.

Adapted from these sources:

Media Advocacy Manual, American Public Health Association. Available at: http://www.apha.org/NR/rdonlyres/A5A9C4ED-1C0C-4D0C-A56C-C33DEC7F5A49/0/Media_Advocacy_Manual.pdf Accessed January 18, 2006.

News for Change: An Advocates Guide to Working with the Media; by Lawrence Wallack, Katie Woodruff, Lori Dorfman, and Iris Diaz, Sage Publications, Inc 1999.

OBJECTIVE 26:

The Basics of Media Advocacy

"If you don't exist in the media, for all practical purposes you don't exist"

--Daniel Schorr, Senior News Analyst, National Public Radio

Media advocacy in public health is the process of disseminating health-related information through the media. It involves strategic use of the media (usually the news media) to shape public opinion, mobilize community activists, and influence decision makers to create a change in health policy. Traditionally public health has utilized the media to educate and persuade individuals with the goal of convincing them to change a behavior and make better health choices. These education campaigns focus on individual-level responsibility and behavior change to achieve a health outcome. Media advocacy, alternatively, shifts the focus from individual responsibility to social and environmental causes for health problems. Media advocacy is also different from educational campaigns in that it primarily uses earned news media rather than paid advertising. Media coverage is an important way to gain the attention of decision makers at all levels of government, as all monitor the media. Media advocacy is an additional tool for garnering support to change policy.

Developing Clear and Unified Messages

Media advocacy cannot be successful without an overall advocacy strategy for addressing youth violence. Once you have decided upon an overall strategy, your specific media message, target audience and methods for reaching the media will be more easily delineated. Devoting time with your partners to develop this overall strategy is a very important component of media advocacy and will save time and energy later with your media efforts. In order to develop an overall strategy there are several important questions to consider.

1. What is the problem you are addressing?

The problem of youth violence should be broken down into pieces that can be addressed with specific solutions. How the problem is defined also impacts the potential solutions, targets for change, and those who have the power for change. Figure 1 provides an example of defining the problem and solution.

Figure 1. Defining the problem of youth gun violence

	Approach 1	**Approach 2**
If you define the problem as…	Lack of information about the lethality of guns	Lack of alternatives for youth
The solution becomes…	Increase education campaigns about risks of guns	Increase social resources (after school programs, mentors)
The target for change is…	Youth	Policymakers and others who control resources
And the group mobilized is…	Parents, physicians, law enforcement and media to deliver and reinforce messages	Anyone interested in promoting policy change

(Adapted from: News for Change: An Advocates Guide to Working with the Media; by Lawrence Wallack, Katie Woodruff, Lori Dorfman, and Iris Diaz, Sage Publications, Inc 1999)

2. What is the solution?

Often so much emphasis is placed on defining the problem that the solution is lost. Public health issues in general and youth violence in particular are accompanied by a complex set of long-term solutions. However, it is important to define a specific solution that you would like to advance. Having a specific action is more newsworthy than calling for broad societal changes.

3. Who has the power to make the solution possible?

In taking an individualist approach to youth violence the person with the problem should change the problem. Therefore those with the power would be youth and parents. However media advocacy shifts this focus from individuals to social and environmental causes. In the case of changing laws or ordinances those with power would include elected officials, and in the case of changing school policy the power may rest with school boards or even school principals.

4. Who must be mobilized to apply pressure for the solution?

It is important to build a strong partnership or coalition with groups or individuals who are committed to applying the pressure necessary for those in power to make change. Identify the key individuals or organizations that can contribute to your overall strategy, be it community organizers, researchers, or spokespeople. Applying consistent pressure to decision makers for change is the only way to counter the entrenched response of the status quo.

5. What do you need to do or say to get the attention of those who can make the solution happen?

Formulating a message that is persuasive and compelling requires that you keep in mind a few basic principles. First, different messages appeal to different audiences. Second, your message can change over time depending on the evaluation of your problem and solution. Third, pay considerable attention in selecting a spokesperson to deliver the message. In forming the message, it is important to understand what the general public and decision makers think about the issue currently. In the case of youth violence if the public and decision makers don't think guns are a problem, they certainly aren't going to think that restrictions on gun ownership are appropriate solutions.

Once you work through these questions, design a message that is simple and clear. Your message should define the problem, point out why your intended audience should be concerned with this problem, and what solution you are recommending to address the problem. Make your message compelling and persuasive by using both appropriate statistics and humanizing the problem through examples from your professional experience. For a more in-depth treatment of message development refer to the resources listed at the end of this module.

Engaging Media Personnel

Media advocacy strategies rely primarily upon the use of earned media rather than paid advertising. In order to implement a media advocacy plan you will need a system in place to contact the media and methods for engaging and informing media personnel.

1. Preparation for Media Contact

Monitor the media

Before you begin contacting the media you need to familiarize yourself with the sources of media upon which your target audience relies. Be it local or national, print or broadcast, watch and read media reports daily to get a sense about if and how youth violence is being covered. Following is a checklist for monitoring the media:

- Is your issue being covered?
- If not, are other issues being covered that relate to your issue?
- What are the main themes and arguments presented on various sides of the issue?
- Who is reporting on your issue or stories related to it?
- Who are appearing as spokespeople on your issue?
- Who is writing op-ed pieces or letters to the editor on your issue?
- Are any solutions presented to the problem?
- Who is named or implied as having responsibility for solving the problem? Is your target named in the coverage?
- What stories, facts or perspectives could help improve the care for your side?
- What's missing from the news coverage of your issue?

Create a media list

With the names of reporters you identify from monitoring the media, begin a media list. This will serve as an important tool in your efforts. Collect names, affiliations, addresses, phones, faxes, emails and the method of preference for being contacted for all local and some regional and national journalists covering your issue or related issues. This list will require constant attention and may change and expand often. You can gather this information by calling papers or stations and asking who covers a certain "beat" (a reporter's "beat" is the issue area he or she covers on a regular basis). You can also consult media directories found in your local library or other organizations who share a similar mission. Some relevant public health reporter beats include health, medicine, health economics, public policy, health business, children's issues and healthcare.

Develop relationships with journalists

Similar to cultivating relationships with your elected officials and their staff, doing so with journalists is an important component of your advocacy plan. Your objective again is to be a trusted and reliable source of information for journalists as they are developing stories. Start by sending an introductory letter to all journalists on your contact list. Enclose fact sheets and business cards and let them know that you can serve as a resource on particular issues. You can invite journalists to lunch or to tour your hospital. Providing feedback on stories that have aired is also a way to maintain your relationship. Positive reinforcement could be sent through email, voicemail or post, and can include comments that the story was fair or balanced – not that the story helped you out in a particular way. Journalists are not in the business of viewing their stories as favors for organizations. If you aren't happy with a story, suggest ways a future story could be covered and provide examples or resources the journalist can use to develop a future story.

2. Methods for making contact

News release (press releases)

News releases tell the "who, what, when, where, and why" of a news story. They are used to report news and make announcements, publicize an event, or announce the results of an event. Reporters often gather information for stories from news releases they receive. However, reporters receive so many news releases that in order to get yours noticed you need write it effectively in the standard format. News releases are written in the inverted pyramid style in which the conclusion or most important information goes first followed by the supporting facts in decreasing order of significance. They should be brief, at one or two pages. A format for writing a news release is as follows:

- **Organization's name.** If possible the release should be printed on letterhead; otherwise the name of your organization should run across the top of the release.
- **Contact information.** This is located in the upper right hand corner and should include the name and phone/fax number and/or email address of the person the press should contact to get more information.

- **Release date.** This is located at the top left hand corner and tells the reporter when the information can be published or broadcast.
- **Headline.** Located under the contact information and above the body of the release, the headline is very critical and should be a short phrase summarizing the most important point of the release.
- **Body.** This is where you convey the "who, what, where, when and why" of your story. This should be brief, and written as if it will be the basis of a news story. Only first-hand information should be used, and quotes should be employed when possible.
- **Tag.** Finish your release with a tag, which is a one-paragraph "boiler plate" information about your organization.
- **End.** End your release with ### to indicate to reporters that there is no more information.

Letter to the Editor

Letters to the editor provide you with an opportunity to convey your opinion to the general public. Letters to the editor can be used to respond to a previously published story or promote an issue. Surveys have shown that letters to the editor are the most widely read part of any newspaper. The chances of having your letter printed are better in local or regional papers than in national publications. To increase the chances of having your letter published, respond quickly to something you see in the paper. Try to send your letter no later than the next day. Your letter should take a strong position but be brief and punchy. Check the letters section of the paper for word limits but most target 200-250 words.

The letter should be typed on letterhead and should include your name, title, and contact information. Don't forget to sign the letter; editors won't publish anonymous letters. A compelling first sentence will capture the editor's attention. Personal anecdotes and local examples should be used, and medical jargon should be avoided. The letter should be brief, restricted to one or two talking points.

Opinion editorials (Op-ed)

Opinion editorials are pieces written by non-journalists and published on the editorial page. They are longer than letters to the editor and allow you to present an extended and persuasive argument for your issue. They can effectively influence public opinion and policymakers, but are difficult to get published so planning is important.

The newspaper should be consulted for guidelines such as length and type of transmission. Talking with the editor prior to submission is important; try to arrange a meeting or phone call with the editorial staff to discuss your qualifications for writing an op-ed piece. You should read the op-ed pieces the paper publishes to get a sense of the style they like, and format your op-ed in a similar style. Your op-ed should contribute something unique and different to the issue – a new perspective, new data, new and compelling anecdote. The writing should focus on one concept that should be carried out through the entire piece, supported by examples. Within one week of submitting an op-ed, follow up with the editor to ensure it arrived and to answer any questions the editorial staff may have.

Editorial board meetings

Editorial boards, comprised of various editors from the newspaper, make decisions regarding which issues should be covered in the paper's editorials and what position the newspaper should take. By meeting with the editorial board you can try to persuade the group to do an editorial on your issue. Regardless of whether the newspaper writes an editorial on your issue, by holding the meeting you have educated the editors about your issue and established yourself as a source of information. This provides the opportunity for increased coverage of your issue in the future.

Arranging and carrying out a successful meeting with an editorial board is more time consuming than writing a letter but it is an important tool in media advocacy. If you decide to request a meeting with the editorial board of your local paper, there are a few important points to consider. Only 3-4 people should attend, preferably those already influential in the community or those with extensive experience with the issue. Agree on a maximum of three talking points in advance, and arm yourself with counter-arguments that may arise during the meeting. Prior to the meeting, make sure you are aware of previous editorials on the issue, to make sure you are familiar with positions taken and how the issue has been covered in the past. It is a good idea to leave the board with materials explaining your position, including statistics and research that support your argument.

Interviews

Interviews are another way of working with the media. You can give interviews for print or broadcast (radio and television) journalists, which can be initiated either by you or by journalists. If you decide to pitch your story, it is best to contact journalists with whom you have developed a relationship. Make sure to incorporate the newsworthiness and timeliness of your story into your pitch, and include a short summary and argument. You may need to pitch the story to many people. If a journalist contacts you, find out what the story is about, how the reporter got your name, who else the reporter has talked to, what the reporter needs from you, and the reporter's deadline. Answers to these questions will help you frame your responses or provide the name of a more appropriate expert for the reporter. It is also prudent to involve the public relations personnel at the hospital first, before providing an interview or answering questions. After an interview, you should follow up with a note to the reporter or producer. Watch a taped copy or review a transcript of your interview to learn how to improve your performance for your next interview experience.

Media events

Media events are another way to disseminate information. There are two types of media event you can hold: press briefings and news conferences. Press briefings are held to provide reporters with background information on your issue. Often informal, they are a good way to cultivate relationships with the press. News releases are held to announce a major story such as the release of a report, a major new initiative or a new policy. Holding media events requires a lot of preparation and planning but can be worthwhile if you have an important story to announce. You can create opportunities for media events by piggybacking on a current news story or holding an event on the anniversary of a past relevant story to highlight your issue (for example focusing on gun-related deaths on the anniversary of the JFK's assassination).

For a more in-depth treatment of media advocacy and examples of interviewing techniques, news releases, letters to the editor or op-eds refer to the resources listed at the end of this module.

Adapted from these sources:

Media Advocacy Manual, American Public Health Association. Available at: http://www.apha.org/NR/rdonlyres/A5A9C4ED-1C0C-4D0C-A56C-C33DEC7F5A49/0/Media_Advocacy_Manual.pdf Accessed January 18, 2006.

Media Advocacy Toolkit, American College of Emergency Physicians. Available at: http://www.acep.org/advocacy.aspx?id=22254&coll=1&collid=90 Accessed January 31, 2006.

News for Change: An Advocates Guide to Working with the Media; by Lawrence Wallack, Katie Woodruff, Lori Dorfman, and Iris Diaz, Sage Publications, Inc 1999.

Media Advocacy Action Pack, The Marin Institute. Available at: http://www.marininstitute.org/action_packs/media_advocacy.htm Accessed January 18, 2006.

Module 7:
Self-Care: Healthcare Providers on the Front Lines

OBJECTIVE 27:

The Impact of Trauma Care on Medical Staff

Most emergency personnel will experience some degree of acute or delayed stress reaction resulting from their occupation, that is manifested by cognitive, emotional, physical, or behavioral side-effects.[1] This may be particularly relevant for healthcare providers working with youth involved in violence. For most individuals, effects of these experiences will resolve over time. However, there are occasions in which the incident is so devastating that physicians may suffer trauma from the event. Trauma can be described as an emotional wound or shock that creates substantial, lasting damage to the psychological development of a person. Secondary trauma can occur when one does not directly experience, but sees or hears about a traumatic event, such as when a healthcare provider witnesses the impact of violent injuries. Two typical responses to either primary or secondary trauma environments are Post-Traumatic Stress Disorder (PTSD) and chemical dependence, which can both lead to other responses such as depression and change of profession due to career dissatisfaction.

Post-Traumatic Stress Disorder (PTSD)

PTSD is an anxiety condition that develops subsequent to traumatic events.[2] The effects of PTSD lead to feelings of detachment and estrangement from others, difficulty concentrating, loss of sleep, and ultimately places patients in danger. The first step in dealing with the disorder is to identify the symptoms. Primary characteristics of PTSD include:

- Exposure to a sufficiently disturbing event
- A continual re-experiencing of the event in thoughts, dreams, or daily life
- An avoidance of any stimuli associated with the event
- A sense of numbness of one's own emotions
- Cognitive, emotional, physical, or behavioral signs and symptoms that were not present before the event and that have lasted longer than one month

It is important for professionals in this industry to periodically self-assess the frequency and severity of PTSD symptoms. The Davidson Trauma Scale (DTS) is a self-rated scale that is customized to the symptom definitions of the *Diagnostic and Statistical Manual of Mental Disorders*, *4th edition* (DSM-IV) (American Psychiatric Association, 1994).[3] The DTS, which can be taken and scored online,[4] is designed to evaluate symptoms of PTSD in individuals with a history of trauma. Its primary purposes are to measure symptom frequency and severity and to evaluate treatment. The test consists of 17 items that are rated on a five-point scale for both frequency and severity during the previous week. Responses are categorized into intrusive re-experiencing, avoidance and numbness, and hyperarousal. It is important to note that the failure to meet threshold diagnostic criteria of PTSD does not necessarily mean an absence of PTSD. Significant single-category post-traumatic symptoms that cause functional impairment for the care provider may warrant further evaluation and treatment.

Chemical Dependence

Over the last 40 years, chemical dependence has been recognized as the primary disease among medical professionals, and ED doctors and nurses in a high risk specialty.[5] In physicians, the disease is almost always in an advanced state before signs and symptoms become obvious in the workplace, making it easier for them to mask the disease. Luckily the likelihood for successful recovery in physicians with chemical dependence is very high.

There are no well-defined reasons as to why ED physicians have a higher prevalence of chemical dependence. However, it has been hypothesized that the sleep stresses of night duty, the risk-taking personality of the emergency physician, the emotional stress of dealing with sick and dying patients, and easy access to drugs may all contribute. Regardless of the reasons, physicians should be aware of key symptoms of chemical dependence to help themselves or their colleagues if these signs appear. These signs include denial, compulsion, progression, and relapse.

Physicians suffering from chemical dependence have had successful outcomes especially when treated by programs geared specifically for health professionals, such as International Doctors in Alcoholics (www.idaa.org), the American Society of Addiction Medicine (www.asam.org), and Alcoholics Anonymous (http://www.alcoholics-anonymous.org/).

Figure 1: Resources for Objective 27

Helpful Resources

National Institute of Mental Health

- http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml

PTSD Resources

- http://www.ptsdinfo.org/

Workplace Violence

Safety issues both in the ED and hospital setting and after discharge may be present for those working with violently injured youth. For all patients and their family members, but particularly those injured by violence, the major risk factors for violence in the ED or trauma center include[6]:

- Long waits in overcrowded and uncomfortable waiting rooms
- Access to firearms
- Drug and alcohol abuse

To reduce the rate of injury from assaults among hospital workers, the National Institute of Occupational Safety and Health (NIOSH) recommends the following strategies[7]:

- Watch for signals that may be associated with impending violence:
  - Verbally expressed anger and frustration
  - Body language such as threatening gestures
  - Signs of drug or alcohol use
  - Presence of a weapon

- Maintain behavior that helps diffuse anger:
  - Present a calm, caring, attitude and listen
  - Don't match the threats
  - Don't give orders
  - Acknowledge the person's feelings (for example, "I know you are frustrated")
  - Avoid any behavior that may be interpreted as aggressive (for example, moving rapidly, getting too close, touching, or speaking loudly)

- Take these steps if you can't defuse the situation quickly:
  - Remove yourself from the situation
  - Call security for help
  - Report any violent incidents to management

Another effective approach to managing impending violence is to identify and involve a family member such as a grandmother or aunt to calm the parties involved (Caught in the Crossfire Coordinator, Emilio Mena at (510) 594-2588, personal communication, May 2006).

The Occupational Safety and Health Administration (OSHA) committee on workplace violence added that hospitals and social service agencies should provide information on multicultural diversity to increase staff sensitivity to racial and ethnic issues and differences.[8] Formal diversity training can help staff strengthen skills to be able to work more effectively with violently injured youth.[9]

Understanding risks involved in workplace hazards is critical for prevention. Risks in the context of caring for violently injured individuals and interacting with their acquaintances include[10]:

- Working directly with volatile people, especially if they are under the influence of drugs, have a history of violence, or a psychotic diagnosis
- Working when understaffed, especially at meal times and visiting hours
- Transporting patients
- Long waits for services
- Working alone
- Poor environmental design
- Inadequate security
- Lack of staff training for dealing with crisis situations
- Access to firearms
- Unrestricted movement of the public
- Poor lighting

Emergency departments are recognized as one of the highest risk areas, often manifesting many of the above risk factors. One study found that 100% of nurses recorded verbal threats in the emergency department and 82% reported physical assault.[11]

OSHA has developed violence prevention guidelines as a result of a four-year collaborative effort. The basic components appear below[6]:

- There must be a *commitment from high-level management personnel* who are involved in and support a written workplace violence prevention policy and its implementation.

- Meaningful *employee involvement* in policy development, joint management-worker violence prevention committees, post-assault counseling and debriefing, and follow-up are all critical program components.

- *Worksite analysis* includes regular walk-through surveys of all patient care areas and the collection and review of all reports of worker assault. A successful job hazard analysis must include strategies and policies for encouraging the reporting of all incidents of workplace violence, including verbal threats that do not result in physical injury.

- *Hazard prevention and control* includes the installation and maintenance of alarm systems in high-risk areas. It may also include the training and posting of security personnel in emergency departments. Adequate staffing is an essential hazard prevention measure, as is adequate lighting and control of access to staff offices and secluded work areas.

- *Training and education* must include pre-placement and periodic, educationally-appropriate training regarding the risk factors for violence in the healthcare environment and control measures available to prevent violent incidents. Training should include skills in aggressive behavior identification and management, especially for staff working in the mental health and emergency departments.

Figure 2: Helpful Resources for Objective 27

Helpful Resources

Caught in The Crossfire

- http://www.caughtinthecrossfire.com/

US Department of Labor

- http://www.osha.gov/SLTC/workplaceviolence/index.html

OBJECTIVE 28:

How to Recognize and Prevent Staff Burnout

Dealing with victims of youth violence can take a strong emotional toll on physicians. Professional burnout is a prolonged response to chronic physical, emotional and interpersonal stressors in the work environment.[12] Among medical professionals, the most popular theories of burnout include exhaustion, cynicism and inefficacy.[1] Some symptoms of job burnout include the following[13, 14]:

- Experiencing difficulties balancing work and personal life
- Feeling emotionally detached from patients and their families
- Cynical disregard towards patients, resulting in less time spent with the patient
- Easily angry or irritated
- Impaired job performance (expressing negative attitudes, finding excuses to be absent, tardiness, inability to concentrate)
- Stress-related health problems (headaches, hyptertension, sleep disturbances, irritability, fatigue, anxiety, gastrointestinal complaints, depression)
- Contemplating resignation
- Diminished sense of personal accomplishment
- High self-expectations
- Low-self esteem
- Abusing drugs, alcohol, or food
- Hopelessness
- Blaming
- Workaholism
- Inability to maintain balance of empathy and objectivity

Healthcare providers often do not receive training in self-care during their professional education. Because of this, they can lack the self-awareness and self-management skills needed to identify and cope effectively with professional burnout.[15]

Figure 1: Helpful Resources for Objective 28

Helpful Resources

Burnout Self-Tests

- http://www.friedsocialworker.com/selfassessment.htm

How to Prevent Burnout

- http://www.mindtools.com/burnout.html

OBJECTIVE 29:

Creating a Self-Care Plan

It is important to remember that for a healthcare provider to care of others, they must also care for themselves. The opposite of job burnout is job engagement. Dr. Richard G. Petty has identified some key methods that healthcare providers can do to reduce burnout.[12]

Prevention of job burnout at a personal level:

- Influence happiness through personal values and choices
    - Involve yourself in humor, volunteer/mission work, academia, exercise
- Evaluate your personal goals and priorities
    - What do you really want to get out of life?
    - What do you want to put into life?
- Surround yourself with supportive family and friends
- Talk to colleagues you can trust who are involved in similar work
- Engage in religious or spiritual activity
- Attend to your own health through good exercise and nutrition
- Recognize there is an issue, know the warning signs of burnout and seek help
- Learn stress reduction methods
- Keep a personal file with success stories or positive impact stories you can review periodically
- Gain and maintain a sense of personal accomplishment
- Sustain your doctor-patient connection which creates a healthy relationship

On-the-job prevention:

- Control over environment
    - Workload – don't overwhelm yourself with work you can't handle
- Finding meaning in work and setting limits
- Having a mentor
- Having adequate administrative support systems
    - Hospital physician wellness committee
    - Renew (http://www.renewnow.org/), a non-profit organization that helps healthcare professionals prevent or deal with burnout through panel and group discussions, conferences, retreats

If you find that you are experiencing job burnout, there are three things that can speed your recovery:

1. **Spend plenty of quiet time alone.** Learning mindfulness meditation is an excellent way to ground yourself in the moment and keep your thoughts from pulling you in different directions. The ability to reconnect with a spiritual source will also help you achieve inner balance and can produce an almost miraculous turnaround, even when your world seems its blackest.

2. **Recharge your batteries daily.** Something as simple as committing to eat better and stopping all other activities while eating can have an exponential benefit on both your psyche and your physical body. A regular exercise regimen can reduce stress, help you achieve outer balance and re-energize you for time with family and friends.

3. **Hold one focused, connected and meaningful conversation each day.** This will jump start even the most depleted batteries. Time with family and close friends feeds the soul like nothing else and sadly seems to be the first thing to go when time is scarce.

Learning to have the proper balance of work and life outside of work are critical to preventing burnout and maintaining a healthy lifestyle. To assist in assessing and monitoring your personal wellness status, please refer to the Adult APGAR, a brief, self-scoring instrument designed specifically to assist healthcare providers.[16]

Figure 1:. The Adult Apgar

	Almost always Score = 2	**Some of the time** Score = 1	**Hardly ever** Score = 0
1. I am satisfied with the **Access** I have to my emotions – to laugh, to be sad, to feel pleasure or even anger.			
2. I am satisfied that my life's **Priorities** are mine and clearly reflect my values.			
3. I am satisfied with my commitment to personal **Growth**, to initiate and embrace change.			
4. I am satisfied with the way I ask for **Assistance** from others, professionally and personally, when in trouble.			
5. I am satisfied with the **Responsibility** I take for my well-being – physically, emotionally, and spiritually.			
TOTAL SCORE = 0-10			

If a healthcare provider's total score is 9-10, their wellness status is superior. If the score is 6-8 it is assumed that there are some imbalances and stresses that need attention, and the individual likely knows what he or she needs to change. A score of 5 or less indicates that the individual is in significant trouble or pain and needs to make significant changes to bring his or her life back to wellness focus.

References

For Objectives 27 Through 29

1. Goldberg R. Critical incident stress debriefing. In: Bintliff S, Kaplan J, Meredith JM, eds. *Wellness Book for Emergency Physicians.* 1st ed. Dallas, TX: American College of Emergency Physicians; 2004:46-47.

2. Laposa JM, Alden LE, Fullerton LM. Work stress and posttraumatic stress disorder in ED nurses/personnel. *J Emerg Nurs.* Feb 2003;29(1):23-28.

3. Davidson JR, Book SW, Colket JT, et al. Assessment of a new self-rating scale for post-traumatic stress disorder. *Psychological Medicine.* 1997 27(1):153-160.

4. Davidson JR. Davidson trauma scale. *Multi-Health Systems Inc. Web site* Available at: https://www.mhs.com. Accessed April 22, 2008.

5. Pollack M, Schrading W. Physician impairment. In: Bintliff S, Kaplan J, Meredith JM, eds. *Wellness Book for Emergency Physicians.* Dallas, TX: American College of Emergency Physicians; 2004:37-42.

6. Occupational Safety and Health Administration, U.S. Department of Labor. Guidelines for preventing workplace violence for healthcare and social service workers. Available at: http://www.osha.gov/Publications/OSHA3148/osha3148.html. Accessed April 25, 2008.

7. Department of Health and Human Services, National Institute of Occupational Safety and Health. Violence: Occupational hazards in hospitals. Available at: http://www.cdc.gov/niosh/pdfs/2002-101.pdf. Accessed April 24, 2008.

8. U. S. Department of Labor, Occupational Safety and Health Administration. Hospital eTool - healthcare wide hazards module. Workplace violence. Available at: http://www.osha.gov/SLTC/etools/hospital/hazards/workplaceviolence/viol.html. Accessed April 25, 2008.

9. National Center for Cultural Competence Web site. Available at: http://gucchd.georgetown.edu/nccc/. Accessed April 25, 2008.

10. Centers for Disease Control and Prevention/NIOSH. The changing organization of work and the safety and health of working people - knowledge gaps and research directions. *Department of Health and Human Services, National Institute for Occupational Safety and Health (NIOSH)*. Available at: http://www.cdc.gov/niosh/pdfs/02-116.pdf. Accessed April 24, 2008.

11. May DD, Grubbs LM. The extent, nature, and precipitating factors of nurse assault among three groups of registered nurses in a regional medical center. *J Emerg Nurs.* Feb 2002;28(1):11-17.

12. Petty R. Avoiding clinician burnout. *Mental Health Provider Occupational Issues.* 2006.

13. Pfifferling J. Overcoming compassion fatigue when practicing medicine feels more like labor than a labor of love, take steps to heal the healer. *Fam Pract Manage.* 2000;7(4):39.

14. Spickard A., SG G, JF C. Mid-career burnout in generalist and specialist physicians. *JAMA.* 2005;288:1447-1450.

15. Gunderson L. Physician burnout. *Ann Intern Med.* 2001;135:145-148.

16. Bintliff SS. The adult APGAR: an instrument to monitor wellness. In: Bintliff SS, Kaplan JA, Meredith III JM, eds. *Wellness Book for Emergency Physicians.* Dallas, TX: American College of Emergency Physicians; 2004.