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Research Brief

Hospital-Based Violence Intervention Program Retrospective Assessment: Findings From The New Jersey Cohort

Prepared by Health Resources in Action

Background

Black and brown communities bear the brunt of gun and other forms of violence driven by structural racism and inequity. Hospital-based violence intervention programs (HVIPs) are comprehensive, trauma-informed, culturally competent programs that connect at-risk, violently injured individuals to hospital- and community-based services. HVIPs support healing through a holistic approach that goes beyond medical treatment to address the individual's social, emotional, and material needs. These programs are an evidence-based, equity-centered public health approach that disrupts the cycle of violence prevalent in Black and brown communities due to long-standing systemic inequities.

In 2019, the New Jersey Office of the Attorney General (NJOAG) invested $20 million dollars to strengthen HVIPs across New Jersey. The funding was used to launch seven new HVIPs and to expand the services offered by an additional two existing programs (these nine programs are hereafter referred to as the NJ Cohort).[1] NJOAG also awarded funding to the Health Alliance for Violence Intervention (the HAVI) to provide extensive training and technical assistance (TTA) to the NJ cohort.

In 2022, the HAVI and its fiscal sponsor, Health Resources in Action (HRiA), received funding from the Robert Wood Johnson Foundation (RWJF) to conduct a retrospective assessment of the NJ cohort. The goal of the assessment was to support effective replication and implementation of the HVIP model. The specific aims were to:

1) Identify the core components of the HVIP model in the NJ cohort
2) Examine barriers and facilitators to implementing these components
3) Summarize the lessons learned to inform TTA provision

This report summarizes the main findings of the retrospective assessment.

Methods

The HVIP retrospective assessment involved primary qualitative data collection and document review. Grounded in a participatory research approach, the researchers invited HVIP site representatives, community members, and national violence experts to serve as advisors on the New Jersey Cohort Advisory Committee (NJCAC).[2] Committee members provided critical guidance throughout the process, from data collection to interpretation and dissemination of the findings. Between March and June 2022,

[1] The NJ Cohort is comprised of the following HVIP sites: AtlantiCare HVIP, Atlantic County; New Brunswick HVIP, New Brunswick University Hospital HVIP, Newark; Cure4Camden, Camden County; Paterson Healing Collective, Paterson; Project HEAL, Monmouth County; Project H.U.D.S.O.N, Jersey City; Robert Wood Johnson University Hospital Trauma Response, Assessment, and Coordination (TRAC), Elizabeth; and Violence Intervention for the Community Through Outreach Recovery (VICTORY), Trenton.

[2] New Jersey Cohort Advisory Committee Members: Abdul-Maalik Jackson, Center for Family Services, Camden, NJ; Anawilda Matos Mejías, TRAC, Elizabeth, NJ; Arturo Zinny, Healing Hurt People, Philadelphia, PA; Dean Hameda, PRAB, New Brunswick, NJ; Elaine Hewins, Robert Wood Johnson University Hospital New Brunswick HVIP, New Brunswick; Kim Watson, VICTORY, Trenton, NJ; Liza Chowdhury, Reimagining Justice, Paterson, NJ; Marissa Fisher, Project H.U.D.S.O.N, Jersey City, NJ; Michael Ordonez, University Hospital HVIP, Newark; Pam Johnson, Jersey City Anti-Violence Coalition Movement, Jersey City, NJ; Shantia Murphy, AtlantiCare HVIP, Egg Harbor, NJ; and Sheetal Ranjan, Montclair State University, Montclair, NJ.

the research team conducted 18 semi-structured interviews with 32 HVIP staff members. The interviews covered programmatic details, services provided, and individual, interpersonal, and contextual factors associated with HVIP development, launch, and implementation. The information collected from these discussions was complemented by a review of TTA and programmatic documents from the sites.

Findings

The retrospective assessment illuminated the following five components deemed essential to the HVIP model and crucial to implementation:

1) Shared vision, goal, and aims
2) Person-centered participant engagement and service delivery
3) Strong hospital-community partnerships
4) Trained, compassionate violence prevention professionals
5) Availability of flexible and sustainable funding

These five core components and their associated barriers and facilitators are summarized in **Table 1** and described below.

Shared Vision, Goal, and Aims

> *"We look at the root causes of violence and we try to plant ourselves in these areas. We're always at school board meetings, trying to advocate for more funding to go to schools."*
>
> — Interviewee

The HVIPs all viewed violence as a public health problem that can be interrupted by addressing the root causes, which include systemic inequities and discrimination against Black and brown communities. Additionally, the programs all shared a common goal of breaking the cycle of violence by addressing the social determinants of health and promoting racial equity. In the short term, they sought to prevent reinjury and retaliation by meeting clients' immediate social, emotional, and material needs. In the mid-term, they focused on supporting clients' well-being and lifestyle change through goal setting. Over the long-term, their objective was to change the underlying conditions that give rise to violence in Black and brown communities. The capacity of an HVIP to meet this goal and the associated short- mid- and long-term objectives is contingent on the other four areas detailed below.

Person-centered Participant Engagement and Program Delivery

The HVIPs that comprise the NJ Cohort vary in the services offered to participants; however, across all the programs, the approach to participant engagement and program delivery is grounded in a holistic understanding of violence (both experienced and perpetrated) as a public health problem. The care provided by the HVIPs aims to 1) meet clients' immediate housing, food security, and mental and physical care needs; 2) support clients in extracting themselves from risky situations (e.g., through education, employment, and setting change); and 3) address structural inequities through education and advocacy to advance policy change and shift community norms.

Core HVIP strategies include:

- Rapid Post-Injury Support and Relationship Building: Frontline staff engage with clients as soon as possible following their injury to build rapport during what is referred to as the "teachable moment," or the period immediately following a violent assault when they may be more open to changing behaviors that put them at risk of future violence. This initial interaction is also an opportunity to provide immediate support, identify needs, and begin a conversation around safety planning and goal setting.
- Tailored Case Management: In the context of HVIPs, case management is trauma-informed, person-centered, and tailored to the unique needs and risk factors of each client. Often, case management is more intensive at the beginning of the intervention and tapers over time as the client's needs are met. The core principles of case management are to understand the client's needs, help them set goals, locate the resources and services they need to achieve those goals, and support them as they successfully deal with issues that could put them in danger.
- Care Coordination: HVIP staff also provide care coordination to support the injured person in receiving and completing the medical interventions required for physical, mental, and emotional recovery. The primary goal of care coordination is to streamline and guide the client through interactions with the members of their medical care team to increase efficiency, improve communication, facilitate quick hand-offs between medical providers, and support the client in meeting the goals in their health plan. The client also receives support and motivation to advocate for their own needs, increase their health literacy and understanding of medical procedures and instructions, maintain lifestyle changes, and adhere to medications as prescribed.

> *"[In this first interaction is] where I use my lived experience and understanding of how communities deal with community violence... It's instant gratification for them to see someone that went through something like themselves and has success in dealing with and overcoming the impact of trauma."*
>
> — Interviewee

- Trauma-informed Care: Given that recent violence and hospitalizations are the primary catalysts for enrolling clients in HVIPs, HVIP staff highlighted the importance of utilizing a trauma-informed approach when interacting with clients and providing services. Trauma-informed care includes acknowledging the presence of trauma and its role in survivors' mental and physical health as well as considering how a client's prior history of trauma may affect their response to treatment. The interviewees mentioned using a number of trauma-informed strategies, including building trust, rapport, and a shared understanding with clients; listening to the client and centering the care around the client's expressed needs; and offering choices.
- Peer Mentorship: Peer mentorship is used to foster connections and help build the client's support network. Often, mentors are program graduates who can build rapport based on shared lived experiences and provide guidance and counseling as needed.
- Advocacy and Education: HVIP staff engage and partner with community coalitions and leaders, hospital administrators, and policymakers to amplify the voices of those most impacted by violence, educate partners on violence as a public health problem, and advance changes in public policy and community norms to reduce community violence and racism-related disparities.

At the interpersonal level, clients' distrust of institutions and wariness about the stigma around mental health presented barriers to program enrollment and service delivery. Interviewees considered it critical to program success that violence prevention professionals be local, have lived experience of violence so they can build trust and rapport with participants, and be knowledgeable about the hospital and community resources available to meet clients' needs. Another facilitating strategy was to pursue quick wins, such as helping clients obtain financial assistance through Victims of Crime Act funding.

> *"…we train them in electrical, plumbing, HVAC, and carpentry. Now we have something to say, 'I've got a job for you as long as you … graduate'."*
>
> — Interviewee

Multiple violence prevention professionals voiced their frustration that rapport with clients can only go so far if the resources to meet the client's needs are not accessible. Additionally, interviewees mentioned having to overcome institutionalized discrimination and dehumanization of Black and brown violently injured individuals, including by hospital staff. Violence prevention professionals themselves also experienced systemic discrimination, which is evidenced by their inadequate compensation and opportunities for career growth. In terms of material support, the top barriers faced were a dearth of affordable housing to relocate at-risk clients, insufficient employment opportunities, and a lack of culturally competent mental health professionals. Providing support to undocumented immigrants and justice-involved individuals was particularly challenging due to federal and state funding restrictions and discriminatory policies. Having violence prevention professionals on staff who could tap into community resources and enlist local educational institutions, businesses, and potential employers were facilitators to the work of HVIPs. Some examples included partnering with "mom-and-pop" hotels to temporarily house clients and with vocational institutes to assist clients in gaining technical skills and securing employment.

Strong Hospital-Community Partnerships

All HVIP models share three characteristics related to the setting in which they operate: they serve populations of marginalized identities with shared vulnerability factors related to their race/ethnicity and social class; they have a strong hospital-to-community connection; and the program and staff are community-grounded.

The clients served have often experienced adverse childhood experiences, including being exposed to poverty, food insecurity, homelessness, and intergenerational violence. The communities that clients grow up in are also characterized by concentrated poverty, with limited educational and employment opportunities, which contributes to perpetuating the cycle of violence.

All HVIPs are either hospital-based or linked[3] to allow staff to engage with clients soon after they experience a traumatic injury. The NJOAG stipulated that all grantees in the NJ Cohort were required to have two primary partners: a community-based organization (CBO) and a hospital partner. For the HVIPs in this cohort, close coordination between the two partners was essential for effective HVIP operations. Just as important was for HVIPs to be community-grounded, meaning that they are an integral part of the local community violence intervention ecosystem. For HVIPs to be effective, community

[3] Hospital-based programs are those whose core team members are hospital employees, whereas staff at hospital-linked programs are based in the community.

stakeholders—including public safety agencies—must refer clients to the HVIP, and the HVIP must be able to link clients quickly and reliably to community-based services and resources.

"The reason our team is so incredible is because we have different types of people. If it doesn't work for one person, that person gives a warm handoff to someone else on the team that might be able to get to this person."

— Interviewee

Interviewees mentioned a number of barriers that impede HVIP implementation, including a lack of awareness and/or wariness about the program among staff of other hospital departments; incompatibility of hospital-CBO structures, rules, and regulations; hospital regulations around data sharing, client confidentiality, and granting access that made it difficult for partners to share real-time data and for CBO staff to enter the hospital to meet clients; and hospital 'red tape' and procurement barriers that made it difficult to quickly obtain the needed services. To address these issues, the key institutional factors for effective HVIP implementation were: 1) support from the hospital's leadership for the program; 2) trust from hospital staff in other departments—including providers in trauma centers and emergency departments—to facilitate access and referrals; 3) a robust coordination team that developed and implemented clear protocols; 4) a signed memorandum of understanding between partners that detailed data sharing procedures; and 5) hospital administrators who were willing to work around burdensome institutional procedures to enable HVIPs to quickly secure the resources their clients needed.

Trained, Compassionate Violence Prevention Professionals

Violence prevention professionals, or frontline workers, are critical to the effective operation of HVIPs. Staffing varied greatly among the sites, with most programs having between 5 and 15 staff members. Typically, violence prevention professionals have a deep understanding of the community they serve, bring empathy and their own lived experiences of violence to the services they provide, and are driven to be part of the solution to break the cycle of violence. The HVIP administrators sought to build teams that represented the diversity of the community they served because program participants felt more comfortable interacting with someone with whom they could identify.

Among HVIP staff, the necessary skills and required level of formal training varied depending on the role, ranging from no degree or a bachelor's degree for violence prevention professionals to a master's degree and training to fulfill supervisory and clinical responsibilities for administrators and clinicians. It was recommended that staff receive in-service training and continuing education in three areas: 1) to improve and strengthen the individual staff member (e.g., trainings on self-care or vicarious trauma); 2) to improve work-related skills (e.g., trainings on trauma-informed care, restorative justice, case management, or interpersonal skills); and 3) to improve the organization (e.g., trainings in grant writing or program evaluation).

Given that the job duties of a violence prevention professional can take a significant emotional and physical toll, interviewees considered an environment supportive of HVIP staff as critical to program success. Strategies mentioned included supportive supervision, a close-knit team, opportunities for debriefing, and policies that support staff well-being (e.g., paid time off). Additionally, given the risks inherent to the job, it is imperative that HVIPs implement robust safety protocols and ensure staff are trained in and compliant with these protocols.

Despite the essential role of staff to the success of an HVIP, employment conditions and lack of professional growth opportunities emerged as important challenges to staff well-being and retention. This included that the pay for violence prevention professionals was not commensurate with the job demands due to hospital regulations limiting pay for staff without graduate degrees. In fact, several frontline workers mentioned having to work multiple jobs to make ends meet. Additionally, because the HVIPs were grant-funded, job security was not guaranteed. Violence prevention professionals also lacked professional growth opportunities and a clear career path, which impacted their financial and emotional well-being and led to high staff turnover.

"…some of us, our job may be ending, and we know how important this work is. It's not easy, and it kind of says that we're not important. It puts a worry on us… but you have the heart for the people, so you want to stay in the field, but the pay is not great, and sometimes not fair that [the work is] unstable."

- Interviewee

Sustainability and Funding

Funding emerged as a common problem for program operations and sustainability. Staff at many of the HVIPs mentioned that their programs were supported by grant funding and that such a piecemeal approach to funding did not afford long-term planning and stability. Other challenges associated with grant funding were restrictions that did not permit HVIPs to implement funds with sufficient flexibility to meet clients' often unexpected needs, such as to cover legal fees and rent deposits. In addition, because of delays in budget approvals, the HVIPs often had to rely on hospitals to advance the funds without knowing if or when the expenses would be accepted or the donor funding disbursed. These budgetary uncertainties created a barrier to planning and implementation and took a toll on the well-being of staff.

Table 1. HVIP Model Components, Barriers, and Facilitators

<table>
<tr><th>Components</th><th>Characteristics</th><th>Barriers</th><th>Facilitators</th></tr>
<tr><td>A shared vision of violence</td><td>• Community violence is the result of systems of inequity and oppression against communities of color.
• Violence is a public health problem that can be interrupted by addressing its root causes.</td><td></td><td></td></tr>
<tr><td>A shared goal of interrupting the cycle of violence</td><td>• To prevent reinjury and retaliation by meeting violently injured individuals' immediate mental, physical, and social needs
• To promote healing and trauma recovery by supporting violently injured individuals to set & achieve life goals
• To support safe communities of color by transforming the underlying conditions that give rise to violence</td><td></td><td></td></tr>
<tr><td rowspan="2">Person-centered participant engagement and program delivery</td><td rowspan="2">• Rapid post-injury support and relationship-building
• Tailored case management
• Close care coordination with warm hand-offs to trusted partners
• Trauma-informed, healing-centered care
• Peer mentorship
• Advocacy and education
• Engagement and care are provided with empathy, respect, and cultural humility</td><td>Interpersonal factors:
• Mistrust of the system by injured individuals
• Stigma related to mental health among injured individuals</td><td>Interpersonal factors:
• Services provided by trusted violence prevention professionals with lived experience, close ties to the community, and knowledge of available resources
• Engage participants through 'quick wins'</td></tr>
<tr><td>Systemic factors:
• Institutionalized discrimination and dehumanization of violently injured individuals, including by hospital staff
• Limited community resources
• Discriminatory policies impacting undocumented and justice-involved individuals</td><td>Systemic factors:
• Knowing the community resources & having strong partnerships (e.g., with local businesses, employers, & educational institutions)
• Education and advocacy with hospitals, communities, and government for policy change</td></tr>
</table>

Strong hospital and community partnerships	• Services centered on injured individuals in the communities most affected by violence • HVIPs are integral to the community violence intervention ecosystem • Hospital-based or -linked • Community-grounded • Fluid hospital-community coordination	• Lack of awareness and/or wariness about the program • Incompatibility of hospital-CBO structures, rules, regulations • Hospital regulations for data sharing, client confidentiality, granting access • Hospital 'red tape' and procurement barriers	• Careful planning & design: ○ Clear program flow & protocols ○ MoUs/data sharing • Strong hospital-CBO leadership team • Collaboration with local businesses willing to work with the hospital • Willingness of hospital administrators to revisit procedures
Trained, compassionate violence prevention professionals with lived experience	• Local, credible messengers with lived experience • Believe in the mission • Trained in trauma-informed, empathic care • Staff well-being is critical • Close, supportive program teams	• Compensation not commensurate with job demands • Lack of job security, benefits • Limited professional growth opportunities • High-risk/high-stress job • Compassion fatigue • Risk of vicarious trauma/re-traumatization	• Improve compensation package • Consider lived experience as part of compensation • Provide in-service training & education opportunities • Standardize training and curricula across sites/VPP certification • Develop career path • Supportive supervision • Peer-to-peer exchanges • Policies to promote staff well-being (e.g., paid time off) • Implement robust safety protocols & training
Sustainability & Funding	• Sufficient funding and resources to cover operating expenses, services, and staff development and growth • Training and technical assistance	• Funding continuity and stability • Funding cuts, salary limitations, pushback on benefits for staff (e.g., insurance) • Funding restrictions, difficult funders, inability or delayed access to funds	• Develop and maintain 2–3-year budgets, funding plans, and strategic plans • Diversify funding sources • Leverage hospital connections and resources • Move away from grant-funded programs • Data to show impact

Conclusions and Recommendations

The retrospective assessment identified many of the core qualities and strengths of HVIPs, including that they serve the populations most impacted by violence and contribute to the community violence intervention ecosystem. A key finding was that the HVIP model is characterized not just by the types of services provided—such as case management—but also by how these services are provided as well as who provides and receives them. The following conclusions and recommendations focus on two key areas for improvement—staffing and funding/sustainability—to promote program reach and sustainability. For detailed guidance on planning, implementing, and evaluating HVIPs, readers should refer to *HAVI Standards & Indicators for Hospital-based Violence Intervention Programs*.[4]

Staffing

Several strong conclusions and recommendations emerged regarding staffing. These are rooted in the understanding that 1) it is critical to programmatic success that violence prevention professionals have lived experience of violence and be grounded in the community; and 2) this work takes a heavy emotional toll on staff. Staffing recommendations include:

- Provision of competitive and equitable compensation for staff, including salary and benefits appropriate to the individual's expertise and regional cost of living
- Consideration of lived experience when offering compensation packages
- Implementation of regular pay-equity reviews
- Living wage commitments, particularly for frontline staff
- Budget allocation and support for learning and capacity building opportunities

Funding and Sustainability

Given the critical role of HVIPs in the community violence intervention ecosystem, specific activities can be leveraged by all HVIP sites to promote greater sustainability and funding stability. These include:

- Development and maintenance of a 2-3-year budget, including projections and a fundraising plan
- Exploration of the HVIP's ability to leverage hospital resources (e.g., grant seeking teams) and/or integrate into the hospital's budget
- Diversification of funding from multiple sources (e.g., federal, state, foundation)
- Continuous data collection and analysis for quality improvement processes and to report program outcomes and impact

[4] Nappi T & Rivera T. (2022). HAVI Standards & Indicators for Hospital-based Violence Intervention Programs. The HAVI. Available at: The HAVI — HAVI Standards & Indicators | Health Alliance For Violence Intervention.