Hospital-based violence intervention: Rochester’s Victims Intervention Coalition

Michael A. Scharf, M.D.
Assistant Professor of Psychiatry and Pediatrics
University of Rochester School of Medicine

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Outline

• Violence
  – Understand injury in terms of disease
• Upstate NY/ Rochester Experience
• Youth violence
  – Risk factors
  – Argument for intervention
• Anatomy of an intervention program
  – Structure and process
  – Initial observations

M.N.

• Shot in flank at age 15
• Shot in leg at age 16
• Shot dead at age 17
• Known gang member
• Seen at Strong each time

Initial symptom of a bigger problem

• Chest pain
• Palpable mass
• Unexplained weight loss
  
• Gunshot wound… Stab wound
  – Obvious clinical injury
  – Symptom of larger disease process
  – Ability to affect outcome

Violence as a disease process

Further work-up warranted.
Youth violence

- In 2004, more than 750,000 young people ages 10-24 were treated for violent injury.
- Direct and indirect costs of youth violence exceed $158 billion per year.
- Affects communities by increasing cost of health care, reducing property values, disrupting social services and schools.

Why focus on youth violence?

- Responsibility to protect children
- Vulnerable population
  - Predictable “trauma trajectory”
- Victim vs. perpetrator
  - Risk factors similar

When does violent behavior begin?

- Proportion of persons who initiate serious violence at a given age.
  - Serious violence begins mostly between the ages of 12 and 20. (85%) Peak age of onset is 16.

Myths and truths

**Myths**

1. Adolescent victims of violence are all bad kids.
2. It is dangerous to treat adolescent victims of violence.
3. It is hopeless to treat adolescent victims of violence.

**Truths**

1. Circumstances vary and may involve some risk factors, all or none.
2. Not greatly different than cases of patients with mental illness or abuse/domestic violence.
4. No single system can stop the violence.
### Upstate New York Homicide Rates

- Rochester
- Buffalo
- Syracuse
- New York State

(Per 100,000 population)

### Rochester: A Tale of Two Cities
- Ranked #1 in the country for best quality of life in 2007.
- Ranked #7 as best place in the country to buy a home.
- Ranked #6 among US metro areas for quality of life.


### Rochester: A Tale of Two Cities

- Highest per-capita murder rate of any city in New York State for eight of the last 11 years.
- “Homicide Capital of NYS”
- Ranked 30th most dangerous city in the US, 2007.
- Zip code matters.

1. Democrat and Chronicle, 11/06
2. City Crime Rankings: Crime in Metropolitan America. CQ Press

### Gunshots Treated at Strong vs. Homicides

**Source:** Trauma Registry, SRTC / RIT Criminal Justice Statistics

### Gunshot Injury in Rochester

*Through 9/30/08

**Source:** Trauma Registry, SRTC / Democrat & Chronicle 1/07

### Penetrating Trauma at Strong

*Through 9/30/08
Penetrating trauma at Strong by age

Risk factors

- Previous weapon injury
- Witnessing weapon injury
- Multiple fights
- Black male
- Drug/alcohol use
- Conflict with parents
- Accessibility of guns

- Single parent home
- Mental health history
- Poverty
- School/disconnectedness/failure
- Gang involvement
- Probation
- Family violence

Recidivism

- Individual recidivists with penetrating injuries are more likely to return with the same injury pattern.
  - Second injury ….. 58%
  - Third injury………68%

- Increased risk of death with each subsequent visit.
  - Likelihood of mortality increased over twofold for each subsequent penetrating trauma visit.

Recidivism in the youth population

- Youth assault injuries often occur as part of a “trauma trajectory”.
  - Prior injury is a significant risk factor for subsequent assault injury. 1,2
  - Assault victim’s risk of recurrent injury may reach 80 times that of unexposed individuals. 3
  - Mortality rates as high as 20% within 5 years. 4

Recidivism in the youth population

- Recurrence rate for repeat violence has been reported from 6 - 44% with a 5 year mortality rate of 20%. 1

- Gun-injured youth reported a greater frequency of violent injury over the past three years, consistent with research suggesting that prior injury is a risk factor for later violent injury. 2

Exposure to violence

- 88% of preadolescents in an urban middle school had witnessed a robbery, beating, stabbing, shooting or murder.

References:

Substance Abuse/Legal System Involvement

- Recent substance abuse and/or involvement in criminal offenses in 82% of the victims.1
- For most of the juvenile offenders (88%), court involvement preceded their injuries.2


Psychiatric care and violence

- Frequency of assessments in Emergency Dept.
  - 93 % of youthful suicide attempters
    - 61% scheduled follow-up
  - 49 % of youthful victims of violence
    - 10% scheduled follow-up
    - Less frequent in injured boys
- Adolescent victims of violence
  - Real incidence of undiagnosed/untreated mental illness
  - High-risk for repeat injury
  - Deserve more consistent psychological attention

Poverty/SES

Location, location, location

“Virtually all gang members and virtually all of the perpetrators and victims of violence in Rochester, come from an area of 20 census tracts where the poverty rate is at or above 40%. In fact, the majority of all violent crime in the city and the entire 5-county Rochester region takes place in these 20 inner-city census tracts where poverty is highly concentrated.”

(Rochester is made up of 83 census tracts)

Testimony of Rochester Mayor William Johnson, To the N.Y.S. Commission of Investigation, 10/25/2005.

Education

Graduation rates for the largest four school districts

- Yonkers: 51%
- Buffalo: 56%
- Syracuse: 56%
- Rochester: 49%

*NOTE: The Rochester School District attracts the students related to the state.
SOURCE: N.Y. Education Department

Project Safe Neighborhoods, Rochester 2008

Gangs

- No longer just an urban problem.
  - Rochester1
    - 70 documented gangs
    - 45 where majority is active
    - 790 active gang members
    - 805 associates
  - Members/victims getting younger.2
  - Increasing number of girls.3


Indicators of potential gang involvement

- Withdrawing from family activities
- Developing a bad attitude towards family, school and authorities.
- Staying out later than usual
- Unexplained money or possessions
- Purchasing or desiring to buy only one color or style of clothing.
- Changing friends; spending time with undesirable people.
Indicators of potential gang involvement

- Changing appearance with special haircuts, eyebrow markings or tattoos.

Indicators of potential gang involvement

- Displaying gang graffiti on folders, desks, walls and buildings.

Indicators of potential gang involvement

- Using hand signs.

Indicators of potential gang involvement

- Carrying weapons
  - May be part of “virtual” image
  - Finding a weapon is never ok!

Youth violence and firearms

- Firearm and non-firearm related homicides by youths.

  - By 1994, 82% of homicides by young people were committed with firearms.

No snitch culture

September 29th, 2007:
- 36 year old mother of 4
- Long time U of R employee
- Attacked by mob of mostly women and teenage girls
- Multiple witnesses
- Died from stab wound

December 19, 2007:
- We continue to battle the “no snitching” culture.

1. Democrat and Chronicle, 2007
2. Chief David Moore, Rochester Police
Schools Availability of weapons
Lack of proper role models
Undiagnosed/untreated psych problems
Poor ability to control rage/anger
Availability of weapons
Violence commonplace
Gangs
Drugs
Poverty
Culture

“There is no justification for pessimism about reaching young people who already may be involved in serious violence”.
David Satcher, MD PhD
U.S. Surgeon General
1998-2002


Hospital-Based Youth Violence Intervention:

The Strong Hospital experience

Committee on trauma

• Injury ≠ accident
  ➢ Accident: An unexpected occurrence, happening by chance.
  ➢ Injury: A definable, correctable event, with specific risks for occurrence.
  ➢ “A result of risk poorly managed”.

Basis for concept of injury prevention

Prevention vs. intervention

• Prevention
  – Deliver message to all at risk.
  – Try to prevent injury.

• Intervention
  – Screens out/targets those at highest risk.
  – Survival to intervention is not controllable
    • Bullet trajectory/Injury severity
    • Lousy prevention strategy

• NEED Both!!

Pick the time- “Teachable moment”

• Hospital-based interventions may offer unique opportunity to reach young assault victims.
  – Youth and parents can be vulnerable and introspective after an injury.
  – May be more receptive to intervention.
• “Teachable moment” is an event that motivates individuals to adopt risk-reducing behaviors or makes them more receptive to behavior change interventions.
Given the cyclic nature of youth assault injuries, it is critical that intervention efforts focus on interrupting the cycle of violent victimization and perpetration.

Hospital-based efforts can work

- **Baltimore 1999-2001**:
  - Non-intervention group:
    - 3x more likely to be arrested for a violent crime.
    - 2x more likely to be convicted of any crime.
    - 4x more likely to be convicted of a violent crime.
  - Intervention had a positive effect on recidivism.
    - Intervention group 5% recidivism rate.
    - Non-intervention group 36% recidivism rate.

Developing an intervention program

- **Why hospital-based?**
  - Right time/place
  - Controlled environment
  - Resource rich

- **Why target adolescents?**
  - “At-risk” population
  - Violent behavior patterns
  - Responsibility to protect kids

Local experience - Strong

<table>
<thead>
<tr>
<th>Year</th>
<th>Stab wounds</th>
<th>Gunshot injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>61</td>
<td>60</td>
</tr>
<tr>
<td>2005</td>
<td>44</td>
<td>50</td>
</tr>
</tbody>
</table>

What we did

- Recognized that these kids were frequently slipping through the system.
- Changed institutional mindset regarding these cases.
- Enlisted broad-based community and governmental support.
  - “Community problem needs community solution”
- Worked within “existing systems” to develop a functional program.
Where we started

• Began with a few simple assumptions.
  – Establish essential structure of program
• Focus on existing hospital and community resources.
• Initial emphasis on collaboration and coordination of existing resources.
  – Coordinate existing resources rather than develop new ones.

The assumptions

• No kid should get shot or stabbed ..........Ever!

The assumptions

• Simple presence of a gunshot or stab wound is the result of “high-risk” injury mechanism.
• Kids are generally not injured this way by accident.

The assumptions

• Kids under 18 have a guardian who is responsible for keeping them safe.

Child protection and the law

• Physician obligation to report suspected child abuse/neglect.
  – Legal responsibility
  – Moral obligation
• Civilized society must protect its children.

• Trauma center cannot ignore this disease process. It isn’t going away.
The law

- Abused child:
  - Child less than 18 year of age whose parent or other person legally responsible for his/her care inflicts or allows to be inflicted upon such a child physical injury by other than accidental means that causes or creates a substantial risk of death.

New York Social Service Law § 371

Our interpretation of the law

- Getting shot or stabbed is not an accident.
- Getting shot or stabbed constitutes serious harm or imminent risk of death.
- We have a responsibility to do something.
- Parent or guardian needs to step up.

*Provides opportunity to get involved !!!*

The law

- Neglected child:
  - Child less than 18 years of age whose physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of his/her parent or other person legally responsible for his/her care to exercise a minimum degree of care in providing the child with proper supervision and guardianship.

New York Social Service Law § 371

What we do

- Identify “at-risk” kids on arrival to the hospital
  - All gunshot and stab wounds
- Standardized risk assessment for ALL kids
- Immediate intervention as needed
- Hold the ones we need to hold
- Expect participation of parent/guardian
  - Voluntary
  - Not Voluntary: Work with CPS

Why all wounds?

- The difference between a superficial wound and a life-threatening injury is based on luck more than good aim.
- Does not reflect intent

  *Risk equal in both cases*

Initial evaluation

- Trauma team/Pediatric Emergency Medicine
  - Primary injury identification and management
  - Intervention team notified for ALL patients
    - Initial screen and risk assessment
    - Informed consent for intervention
    - CPS involved if intervention is refused
Initial evaluation

- Pediatric social work (now available 24/7)
  - Comprehensive/standardized screening
  - Assure safe discharge plan
  - Admission/observation of kids felt to be at risk
- Psychiatric care
  - Automatic psych evaluation for all inpatients
  - Outpatient referral/ MCT for those discharged from ED

Disposition from ED

- Admit to hospital:
  - Medically unstable
  - Unsafe discharge
  - Safest choice in many cases
- Discharge:
  - Home with guardian
  - Correctional facility
- Pathways To Peace referral for all.

Interventions

- Standardized approach to evaluation
  - Standardized screening tools
    - Social work screening form
    - Psychiatry screening form
    - Document of understanding
  - Agency review (PD, Probation, etc)
  - Targeted video presentation
    - In development
- Safe discharge plan
- Ongoing case review and follow-up

The goal

- Identify adolescents at risk of violent death.
- Provide immediate protection from harm.
- Provide individualized, targeted interventions.
- Involve/engage responsible guardian.
- Break the chain of violence

The hospital team

- Trauma surgery
- Pediatric social work
- Pediatric psychiatry
- Pediatric surgery
- Pediatric emergency medicine
- Pediatric nursing
- Chaplin service
- Security

Contract

- Clearly written.
- Documents what was discussed during hospitalization.
- Clear offer for ongoing assistance.
- Signed by kid and parent.
- They take copy.
The partners

Beyond our doors - Pathways

• Vital link to community
• Integrated component of hospital-based response
  – Immediate response
    • Respond to hospital-family/staff support
    • Respond to scene-direct intervention to prevent further violence
  – Referral made on all patients
    • Conduct site visits.
    • Help victims/families stay engaged with follow-up.
    • Link to many valuable resources

Child Protection Services

• Initial resistance
• Change in mindset
  – Intervention in the best interest of the child
  – Many families already known to CPS
  – Injury may add to existing case
• Provides the “teeth”
  – Vital partner

Why involve CPS?

• Need to focus on family, particularly role of parent/guardian currently and historically that may have led up to injury.
  – Were parents aware of where patient was at time of injury?
  – Was patient in violation of local curfew?
  – Has patient engaged in previous high risk behaviors? If so, what was done?
  – Did parents do anything that led to injury?

Probation

• Many injured children already exposed to criminal justice system.
  – Injury not always reported
  – Injury sometimes evidence of violation
    • Can be used for leverage
    • Protection comes in many forms
• Communication significantly improved
  – Part of routine screen

Project Exile

• Local partnership with federal law enforcement.
• Goal to reduce gun violence through deterrence and incapacitation.
• Gun offenses tried in federal court
  – MINIMUM 5 years without option for parole
  – Exiled to distant federal prison
• Also support education, intervention and prevention
• Provided significant support in recruitment of community partners.
Project Exile

- US Attorney’s office
- District Attorney
- FBI
- ATF
- State Police
- County Police
- Rochester Police
- County Probation
- Pathways to Peace
- City/County Executive
- PAVE
- Many others

Program Development Timeline

In-House
Concept/Implementation
2/06 12/06

Regional
Presentation to Exile Advisory Board
4/06

National
PSN Presentation- DOJ
Atlanta 9/07

Citywide effort

- Currently in place at Strong and RGH.
- Police Department is key to citywide participation.

Developing Statewide approach

- Interest in Albany, Buffalo and Syracuse.
- Possibility for more organized expansion.

What makes this program different?

- Working relationship with CPS
  - Very unique
  - Allows us to “force” participation
  - Get guardian involved
  - Teeth
- Zero Budget
  - Each partner brings own resources to table

Observations and preliminary results
Observations

- Consent for participation requested on admission
  - One refusal (Parent involved in criminal activity)
  - CPS referral
- Quality of information improved after first 24h
  - Significant benefit of prolonged observation period
- Significant proportion of victims known to “system”
  - Pathways to Peace
  - CPS
  - Probation/ PINS/ Police

Observations

- Significant number with pre-existing psych history
  - Mood disorder, depression, bipolar disorder
  - ADHD
  - Adjustment disorder
  - Few receiving mental health treatment at time of injury!
- Significant number reading well below grade level
- Drug use
  - Cannabis use common
- Drug dependence (clinically significant drug use)
  - About half have confirmed abuse/dependence

Adolescent penetrating trauma

J.W.

- Shot in flank at age 15
- Shot in leg at age 16
- Shot dead at age 17
- Known gang member
- Seen at Strong each time

Predictable?

- Yes

Preventable?

- Maybe

Conclusions

- Youth violence is complex
  - Absolute reality in Rochester.
- We CAN make an impact.
  - Get arms around the problem on a case-by-case basis.
- We must engage the community.
  - Can’t do it alone, but they need us to drive.
- We can choose to deal with the problem or the consequences.
  - Not getting better and not going away.