With violence on the rise in many U.S. cities, local public health departments are finding new opportunities to play an important role. One approach is to run case management, substance abuse, or mental health programs for those at high risk for becoming aggressors or victims. Another approach is to analyze crime data to uncover patterns and potential opportunities for intervention. A third promising model is a type of secondary prevention: hospital-based services for victims to de-escalate crises and prevent retaliation. This article describes how a surge in violence led to the development of such a program in Boston. *Local Acts* will provide updates on its evaluation.

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PRESCRIBING PREVENTION TO TREAT URBAN VIOLENCE

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Although Boston was lauded for its success at reducing crime in the early nineties, it, along with many other mid-sized cities, has experienced a disturbing new surge of violence in the past few years. From 2004 to 2005, nonfatal shootings increased 33%, with the highest rates of gunshot and stabbing injuries occurring among males aged 15–19 years and African American residents. [Unpublished data, Weapon-related injuries 2004-2005; available from the Massachusetts Department of Public Health, Weapon-Related Injury Surveillance System.] Recognizing that violence is more than just a criminal justice concern, Mayor Thomas M. Menino convened all city department heads for a weekly Crime Council meeting in January 2006. He encouraged each department to engage community partners in the process with the goal of developing sector-specific strategies that would reduce violence in Boston.

Viewing urban youth violence as a public health issue, the Boston Public Health Commission (BPHC) partnered with the city's health care institutions, providers, consumers, and administrators. The group reviewed the data, the history of violence prevention and intervention, and national and local models for intervention within a variety of clinical settings. As with most other health conditions, the data showed stark disparities for the residents of Boston; by far, residents of color experienced a disproportionate share of the violence. While representing approximately a quarter of Boston's residents, black residents accounted for 71% of the nonfatal gunshot injuries and 55% of the nonfatal stabbing injuries. [Unpublished data, Weapon-related

injuries 2004-2005; available from the Massachusetts Department of Public Health, Weapon-Related Injury Surveillance System.] Along with African Americans, Latinos were disproportionately represented among the victims of stabbing injuries. [Unpublished data, Weapon-related injuries 2004-2005; available from the Massachusetts Department of Public Health, Weapon-Related Injury Surveillance System.] While there was a 28% increase in shootings, the increase in homicides committed with firearms was only 4%. [Unpublished data; Boston Police Department.]

VIOLENCE INTERVENTIONIST ADVOCACY PROGRAM

Boston Medical Center (BMC), considered the city's "safety net" hospital, handles close to two-thirds of the city's nonfatal assault-related gunshot and stabbing injuries every year. [Unpublished data, Weapon-related injuries 2002-2004; available from the Massachusetts Department of Public Health, Weapon-Related Injury Surveillance system.] Staff from the emergency department (ED) were eager to develop a model that allowed them to perform more than "treat and street" medicine. The new project, the Violence Interventionist Advocacy Program (VIAP), was in part based on a program already in existence at the institution—Project ASSERT (Alcohol, Substance abuse, Services, Education, Referral Treatment), an emergency department service developed to facilitate patient access to primary care, clinical preventative services, and, when needed, to the drug and alcohol treatment network. VIAP was also designed to be in keeping with previous research with young men of color seen at BMC; that research (conducted by Dr. John Rich, former Medical Director of the BPHC) suggested that for young black men the feelings of being unsafe after a violent injury can serve as a pathway to recurrent injury,¹ and that the very real circumstances of the "code of the street" need to be

incorporated into models of intervention if they are to be successful. Central to both Project ASSERT and VIAP was the concept of making a connection with the at-risk patient at the moment the patient would be most receptive to change—in the emergency department immediately following a life threatening incident.

The Violence Interventionist Advocacy Program is staffed by two trained patient advocates from 4:00 p.m. to 12:00 a.m., seven days a week. Patients who present with violent injuries are referred to the Violence Interventionist Advocate (VIA), who immediately establishes their role and relationship with the patient, right in the trauma room or exam room. The VIA performs an assessment with each patient and conducts a brief negotiated interview for safety planning. The VIA also acts as a liaison between ED staff and family and friends, a crucial element that is designed to assist in deescalating some of the desire for retaliation that may follow a violent incident. The VIA also helps the family navigate the hospital and criminal justice systems, which can be intimidating and are often perceived as hostile. VIAs engage in rigorous follow-up with patients through consistent contact and reassessment of the patient's needs. Longer-term services focus on the symptoms of trauma, many of which may not immediately appear, but which can have a lasting impact on an individual's ability to recover physically, emotionally, and socially. The VIA makes connections to primary care in neighborhood locations that do not present a safety hazard for the patient and makes referrals to mental health support and job training. This long-term component will continue for up to one year.

These case management services are also directed beyond the individual to the family and community. Issues of retaliation by friends and family can be addressed early and on an ongoing basis to try to contain some of the ripple effect that one incident can have in a community. This work will not only serve the immediate needs of victims of violence, but will also be tied into other relevant public health programs such as the Trauma Project, which works with communities around trauma; the Boston HealthCREW, which educates young men of color to be outreach workers and health educators; and the Father Friendly Program, which provides wraparound services for noncustodial fathers who want to reestablish healthy relationships with their children. VIAs spend a portion of their time formalizing networks of health and social service providers and stimulating collaboration between organizations that serve this population.

The City made an initial funding award to BMC to establish the Violence Interventionist Advocacy Program. Since then, the project has received state funding

via a grant awarded to the City that has allowed for the addition of the second patient advocate. The work of the advocates and other providers in the ED will be enhanced by an additional grant recently received from BPHC through the Disparities Project, which seeks to eliminate racial and ethnic health disparities. The grant will allow BMC emergency department staff to survey all who come to the ED about possible violence in their lives.

OUTCOME AND EVALUATION

The Violence Interventionist Advocacy Program began only recently, so evaluation data are not yet available. Data will be gathered and analyzed on consultations, primary care appointments, referrals to substance use interventions (including tobacco, alcohol, and drug in- and outpatient), mental health support services, and community-based resources. VIAs will also follow up with patients from three to six months and one year after the initial screening to (1) obtain information about violence experiences that followed the original incident, (2) reassess health and social risk factors and variables, (3) determine the patient's successful and problematic experiences with referrals for identified health and social needs, and (4) assist in redirecting individuals to appropriate services. Through the new grant from the BPHC Disparities Project, the program will use an online screening tool to screen both victims of violence and nonvictims from age 15 to 34 who present in the ED for other reasons. This cohort will allow for a noninjured comparison group who will also be followed at three to six month and one year intervals.

LESSONS LEARNED AND NEXT STEPS

The start-up and implementation of this project took much longer than originally anticipated due to the commitment to a partnership model of decision-making as well as the emphasis on finding candidates who possessed relevant professional and personal experience. The process of identifying the two advocates out of 99 applicants who had the ability to work within a large health care institution as well as within the community and who could develop credibility in both settings was a strenuous one.

Next steps include finding new funding opportunities to expand this model and other interventions into additional health care settings—both hospitals and community health centers. We continue to work with our partners in hospitals and health centers to develop new screening practices and referral systems

and with our community-based partners to develop new support systems for victims of violence and survivors of homicide.

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REFERENCES

1. Rich JA, Grey CM. Pathways to recurrent trauma among young black men: traumatic stress, substance use, and the "code of the street." *Am J Public Health* 2005; 95:816-24.