



Keys to Collaboration between **Hospital-based Violence Intervention** and **Cure Violence** programs

By any measure, community violence is an epidemic in the United States. The Healing Justice Alliance was formed to spread awareness of effective strategies to reduce violence using a health approach and to help communities seeking to implement best practices. A collaboration of Youth ALIVE!, Cure Violence, Berkeley Media Studies Group and the National Network of Hospital-based Violence Intervention Programs (NNHVIP), our partnership encompasses affiliated programs in over 80 cities, including those implementing the models of hospital-based violence intervention (HVIP) and those following the Cure Violence (CV) strategy of Violence Interruption and Street Outreach. Both of these program models have been the subject of research that demonstrate their effectiveness. Both program models utilize a health approach.

While there are differences between the two models, they are compatible. In fact, they are complementary, reinforcing and, we believe, each an essential component of any community's comprehensive violence prevention strategy. Even when program models are compatible in theory, personalities and organizations are not always compatible in reality. This brief is a response to communities within and beyond the Healing Justice Alliance who are implementing, or are interested in implementing, both HVIP and CV replication sites. The goal of this brief is to help communities, and the personalities and organizations within them, to make this collaboration work. After all, there are lives that depend on it.

Cure Violence and Hospital-based Violence Intervention: Two great models that model great together

- Both are health approaches
- Both are proven effective
- Together, they address primary, secondary and tertiary prevention
- Together, they link communities and institutions in the effort to end violence

In order to deepen our understanding of how communities are actually implementing these models and collaborating on the ground, we interviewed practitioners in Boston, New York, Oakland and San Jose. Their reflections informed this brief, and also inspired the "Notes from the field" sprinkled throughout.

DEFINITIONS

Hospital-based Violence Intervention Programs (HVIPs)

An experience that almost all victims of shootings and stabbings – and many physical assault victims as well – share, is medical treatment at a hospital. The HVIP model recognizes that medical care alone is not sufficient for these survivors, since with medical care alone 44% of patients return with another injury within 5 years. A full 20% of these patients die via homicide.^{1,2} While not the answer by itself, medical treatment presents a unique opportunity for effective intervention.

“ Being trauma-informed means understanding that experiences like violence affect the way someone thinks, feels and behaves in specific ways. ”

The goals of hospital-based violence intervention are to promote healing and to reduce retaliation, re-injury and criminal justice contact by working directly with victims of violent injury treated at local hospitals. In some programs, frontline staff working directly with victims are hospital employees; in many others, the frontline staff are hospital-linked and come from a partner community-based organization, government office or university.

While programs vary in their implementation, there are 4 essential components:

1. Respond as soon as possible after an injury has occurred to take advantage of the “golden moment” when an injured person is open to receiving care
2. Address retaliation explicitly in addition to the other risk factors that a patient faces
3. Continue services post-hospital discharge and into the community for a significant time
4. Employ frontline workers from the community who share, or at least can relate to, the experiences of violence-impacted patients.

A fifth component of HVIPs is actually more of an attitude toward the work. HVIPs must be trauma-informed. Being trauma-informed means understanding that experiences like violence affect the way someone thinks, feels and behaves in specific ways – including hyperarousal and depression – and tailoring their approaches to, at least, not punish or retraumatize someone for exhibiting trauma symptoms. At best, HVIPs and other trauma-informed practices take a healing approach to help people recover emotionally, socially and practically.

Studies show the effectiveness, and cost-effectiveness, of the HVIP model in a number of cities.³ For example, the results of a randomized control trial of a Baltimore HVIP indicated that it dramatically reduced two-year injury recidivism and criminal justice contact, with the control (non-intervention) group seven times more likely to be re-injured and three times more likely to be arrested for a violent crime.⁴ Setting aside for a moment the enormous expense of incarceration, and the savings when it is avoided, the savings for a hospital when it invests in intervention and avoids the cost of subsequent hospitalizations is substantial. A San Francisco study indicated that an HVIP would provide financial benefit to a hospital if that program prevented more than one hospitalization per year.⁵

HVIPs across the country have come together to form the National Network of Hospital-Based Violence Intervention Programs (NNHVIP). NNHVIP is comprised of 34 (and counting) seasoned and effective HVIPs who share best practices, help new and emerging programs develop, and promote the model and policies that support this work and the population they serve. For more information, including free resources, visit NNHVIP.org.

Cure Violence

For nearly 20 years, Cure Violence has successfully worked to reduce violence in communities impacted by violence in the United States and around the world, advancing a new health paradigm on violence and a scientific approach to preventing it. This approach is grounded in an understanding that violence exhibits hallmarks of a health issue. It spreads from person to person: it is acquired and biologically processed, perpetuated through social norms and peer reinforcement, and can be prevented using disease control and behavior change methodology.

The Cure Violence model advances an epidemic-reversal methodology to detect and interrupt potentially violent situations; identify and change the thinking and behavior of the highest risk transmitters; and change group norms that perpetuate violence. This begins with an analysis of violence clusters and transmission dynamics, and uses several new categories of health workers to interrupt transmission and change norms around the use of violence.

“ The Cure Violence approach creates safer and healthier communities. ”

Central to the approach is the use of workers viewed as trustworthy and credible by the population being served. Through community-based partners, carefully-selected individuals with similar background and experiences as individuals most prone to violence are hired as Violence Interrupters and trained by Cure Violence to detect where violence may occur (tapping into their pre-existing networks) and intervene before it erupts. Similarly, Outreach Workers are hired and trained to work with high-risk individuals over 6–24 months, in their homes, on the streets, and in the program’s community-based office, to change thinking and behavior related to violence and connect participants to community resources. In many sites, an additional hospital-based violence intervention component is implemented. Hospital Responders (drawn from similar backgrounds as victims) are deployed to local hospital trauma centers when a gunshot, stabbing, or blunt trauma victim arrives, to intervene during the critical window of opportunity immediately after a violent incident in an effort to prevent retaliation and interrupt the cycle of violence.

In the U.S., the model is being replicated in more than 60 communities and has undergone multiple, rigorous external evaluations. Each evaluation found large, statistically significant reductions in gun violence. Multi-site studies by Northwestern University and Johns Hopkins University showed 41% to 73% reductions in shootings in neighborhoods in Chicago⁶ and 34% and 56% percent decreases in neighborhoods in Baltimore.⁷ In New York, an evaluation by John Jay College found that the Cure Violence approach creates safer and healthier communities. The study states, "New York City neighborhoods operating Cure Violence programs show steeper declines in acts of gun violence and the expression of pro-violence social norms compared with similar neighborhoods not operating Cure Violence programs." The study examined two communities and found reductions across all measures of violence, including a 63% reduction in shootings in one community and a 50% reduction in gun injuries in the other community.⁸

To learn more about Cure Violence visit cureviolence.org.

MODEL COMPATIBILITY: DISTINCTIONS AND OVERLAP

While all program models are tailored to fit the local context where they are implemented, and may include adaptations in terms of the population served, staffing patterns and service delivery, HVIP and CV replication sites are typically comprised of standard characteristics. Each model is uniquely designed, but there are similarities and areas of overlap between the two. In examining the similarities and differences, it is clear that the models not only complement each other, but that collaboration would result in a comprehensive system that allows for improved care, decreased re-injury, decreased recidivism, decreased retaliation and increased healing opportunities for the entire community.

The characteristics identified below represent the standard practices for the majority of HVIPs and CV replication sites, in terms of particular populations served, staff hired, and services provided. We draw particular attention to areas of overlap and specialization. While at the local level, there are some HVIPs that share the characteristics of CV replications, and vice versa, the diagrams below describe what is most typically associated with each model. The goal of this section is to identify general characteristics and to highlight how collaboration would improve systems at local, state and national levels to maximize impact.

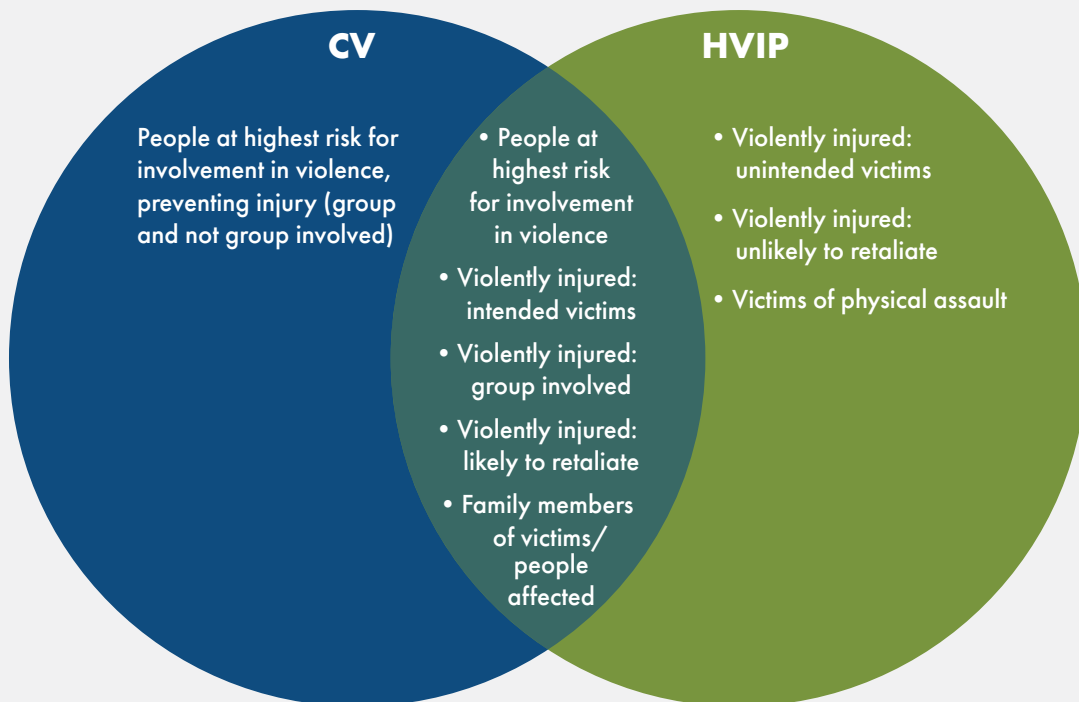


Image from 2017 Healing Justice Alliance Conference,
photo credit: Move Photography

Population Served

HVIPs and CV replication sites both serve individuals involved in violence. This includes those violently injured that were the intended target, group involved,⁹ or likely to retaliate, as well as their families. CV replication sites tend to focus on community based violence prevention and intervention, routinely working with highest risk individuals that are gang/group involved and/or formerly incarcerated, whether or not they have ever experienced a violent injury. Their primary focus is to interrupt violence before it occurs, preventing injury. HIVIPs work with all individuals that are violently injured, including unintended victims and those unlikely to retaliate, and they are more likely to work with individuals who have been physically assaulted, in addition to those shot or stabbed. Their primary focus is to promote healing and to reduce retaliation, re-injury and criminal justice contact by working directly with victims treated at local hospitals.

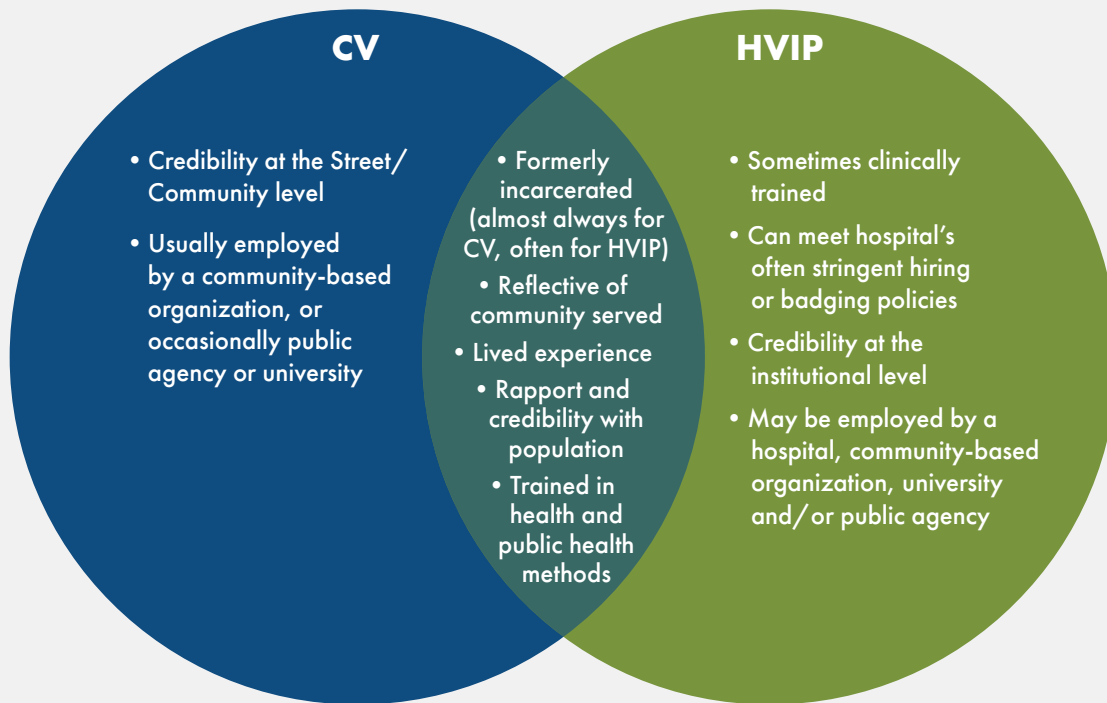
Figure 1: Population Served



Staff

The staff of both models are critical to ensuring the interventions and messages are delivered in ways that can be received by individuals, families and communities. Both HIVIP and CV staff are representative of the communities they serve. They often have had experiences similar to the individuals they are working with. Additionally, they must be able to build and maintain rapport with participants. Often rapport is established through credibility. For CV, staff have street-level, community credibility to work with those at highest risk for involvement in violence. Many are formerly incarcerated and/or formerly gang/group-involved and can share their personal experiences and relate to those with whom they work. Credibility is still required for HIVIP workers to relate to and be trusted by the client population, such as coming from the same community and/or having been involved in violence. HIVIP workers also need to convey credibility at the institutional level, to be perceived as valid health professionals by hospital employees. HIVIP staff must be able to meet the employment qualifications to work within the hospital setting, which in some cases prohibits formerly incarcerated individuals. HIVIP staff may also be clinically trained and degreed, adding additional expertise and skills to strengthen the treatment process.

Figure 2: Staff



Notes from the field

One site we interviewed had all workers – HVIP as well as CV workers based in the community – employed by the hospital. They find that this helped to create support from hospital staff and made it easy for the community-based workers when they did visit the hospital. Having everyone hired through the hospital also helped to avoid problems with HIPAA and encouraged hospital staff to reach out to the program.

Services

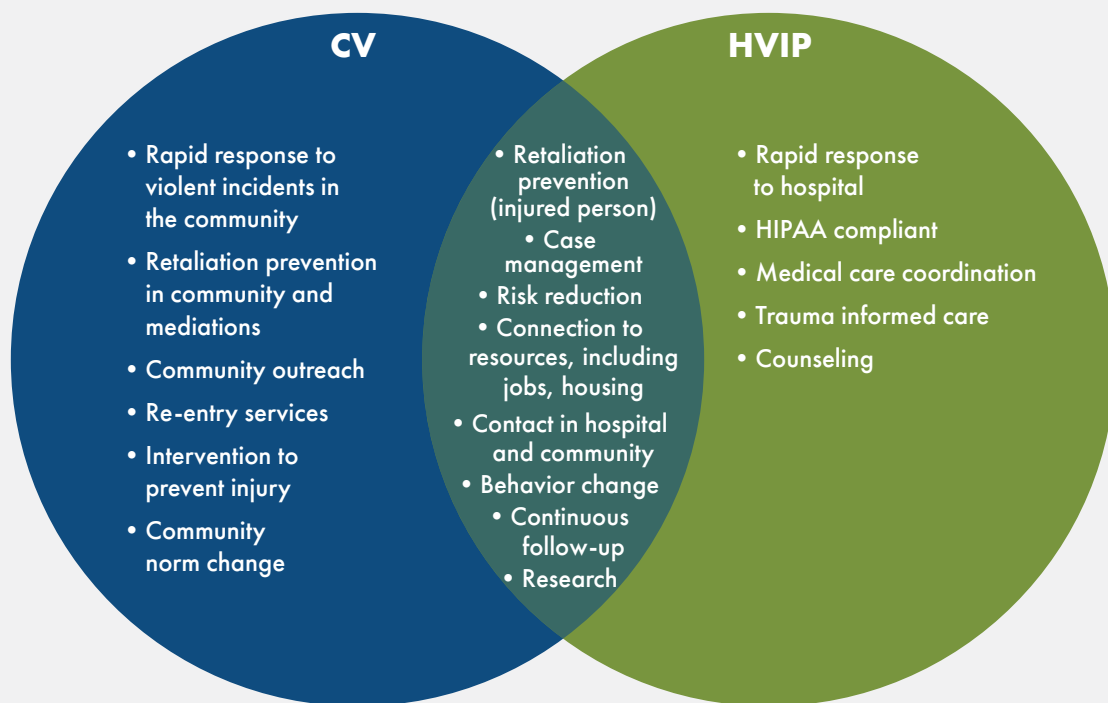
Both models provide assistance and overall case management to those they serve. This includes working to reduce risk for re-injury, re-victimization, and involvement in future violence. Often this involves promoting positive behavior and providing new skills and information so that individuals are able to resolve conflicts peacefully, healthily cope with trauma symptoms and work through their healing process, and successfully adhere to their recovery plan. This work is done within the hospital, as well as the community. Staff provide continuous follow up and work to connect the individual to resources. For both models, individuals who have successfully made significant changes in their lives and are committed to promoting positive alternatives and healing are often recruited and become trained staff.

HVIPs specialize in medical care coordination and navigation, using a trauma-informed care lens, so that clients receive the best possible care for their injury. The model requires HIPAA,¹⁰ training and compliance for medical record confidentiality. The focus is on the victim and providing him/her with counseling and services to promote their physical and emotional healing and prevent re-injury.

They also work with the victim to prevent retaliation and continued involvement in any underlying conflict or issue that may have resulted in their hospitalization. Staff tend to work with clients for a year or longer.

CV replication sites provide community level services, often coordinated by a city agency but implemented by a community based organization. Services include rapid response when violence erupts to prevent retaliation, but also daily efforts to interrupt violence and prevent conflicts from escalating. Staff routinely mediate conflicts between individuals and/or groups and conduct daily follow ups to ensure that those involved remain committed to a peaceful resolution. On a daily basis, these staff members conduct ongoing outreach to those at highest risk for involvement in violence, people with the ability to positively influence individuals and groups, and the community as a whole. CV staff work with community members and partners to change community norms around the acceptance of violence through monthly events, incident responses and public education campaigns. This work builds a community’s capacity to promote social cohesion and sustain the violence reduction long term.

Figure 3: Services



Notes from the field

The sites we spoke with reflected on the difference between community and hospital culture, and how a “very interesting evolution” had to take place for these programs to work. “It takes a long time to change the culture.” One horrific example at a hospital was the experience of a mother being tased because she was deemed “out of control” – something that HVIP and CV staff could have mitigated had hospital staff had trust in, and turned to, those programs. For some HVIPs, it took years for the hospital staff to get used to the HVIP workers being in that space and further adjustment to CV staff if they start coming into the hospital as well. HVIP staff can support CV staff in building relationships at hospitals and CV staff can support HVIP staff in building relationships in the community.

“ When there is an overlap in terms of both models working with a client or people in the same family, communication is imperative. ”

CHALLENGES TO COLLABORATION

There is clear alignment between these two models that have been developed, improved, and replicated independently for decades around the world. In many communities, these programs are the only intervention efforts. In places where both are present, they have rarely been developed and established in tandem. As a result, pre-existing roles and responsibilities can pose a challenge to restructuring the programs to identify points of collaboration.

In a number of cities that are implementing both models, they are working to formalize this partnership and explore solutions to potential challenges, including:

Turf: When there is overlap in terms of population, whose case is it? If it's a shared case, what is the role of each party and how are the roles assigned?

Approach to clients: To prevent retaliation, CV might need to get information immediately from a client, while HVIPs might take a slower approach as a way to build rapport and work towards establishing a longer term relationship.

Funding: Often identifying funding and ensuring sustainability is difficult for one model. Distributing finite resources among two effective models can pose an even greater challenge and result in the programs having to pit themselves against each other for survival.

Cultural/Philosophical: The staffing pattern for HVIPs and CV can be quite different. HVIPs often have a clinician on staff and are focused on caring for the patient and preventing re-injury and/or revictimization. CV staff are often individuals with similar backgrounds and experiences as those they serve. When responding to a violent incident at the hospital their focus is often addressing the potential for immediate violence. As such, HVIPs may sometimes view CV staff as untrained and/or uninterested in the long-term healing process, while CV staff may view HVIP staff

as less connected to the community and/or ineffective at preventing violence. Often these challenges arise simply because CV and HVIP staff do not understand what the other does, potential overlap, and how partnering would benefit the work.

Communication: When there is an overlap in terms of both models working with a client or people in the same family, communication is imperative. HVIPs and CV replication sites need to develop effective communication strategies to report out on the steps each are taking to avoid duplication of services or triangulation by the client.

Politics: Outside forces (funders/government) can have a direct impact on the relationship between HVIPs and CV replication sites. Challenges arise when these outside forces prize one model over the other or give credit for success to one and not the other.

Siloed: Working independently, whether due to communication issues, or inability to understand the role each plays (or can play), can result in an unwillingness or lack of interest in building a larger team. This singular mindset can easily lead to a lack of coordination and weaken the potential of creating a comprehensive team able to provide a multitude of services and support to clients, their families, and the community as a whole.

Moving from program to movement: Due to the challenges of this work and the overwhelming pressure and stress, it is easy to lose site of the big picture. While HVIPs and CV play a huge role in advancing how violence is viewed, treated and ultimately eradicated, the day to day responsibilities can cloud their ability to see themselves in terms of the larger system. This includes not feeling a part of the larger movement to treat violence as a health issue rather than solely a law enforcement one.

Notes from the field

As one site put it, “We have an opportunity. For the most part, people who come in have had terrible experiences with institutions. [We] have the opportunity to do something different for the first time. The window of opportunity is unique to the hospital and it comes and goes so quickly.”

“ HVIP workers are experts in addressing the psychological impact of trauma on an individual. ”

BENEFITS OF COLLABORATION

Because there is alignment and overlap between these models, there is a critical opportunity collaborate across the models, and to provide comprehensive wraparound services that address both upstream violence prevention and downstream violence intervention. The combination of physicians and other staff in the hospital, HVIP workers that straddle the hospital and community settings, and CV workers in the community, establishes a diversity of perspectives and support. This network of support is comprised of multiple messengers, each defined by their own types of credibility and expertise, to increase opportunities and methods for intervention. This larger community of peers and mentors allows for the continual identification and advancement of best practices.

Working in the violence prevention field is inherently taxing for staff due to exposure and continuous contact with those most impacted. Creating this larger network of practitioners is beneficial for all staff. It increases cross-pollination of expertise and relationships that improve personal wellness, reduce risk of burnout, promote a culture of sustainability of the work, and ultimately strengthen the services provided to clients.

Notes from the field

HVIP and CV collaboration “adds another layer of professional support” and “gives everyone a sense of being part of something bigger and something important.” The sites we spoke with found that the environment of having colleagues and interdisciplinary discussions leads to better outcomes.

The highly trained staff of both CV and HVIPs are at the crux of this challenging work. Program and hospital staff across all departments bring a cadre of skills based on their unique perspectives, resources, and experiences. This integrative and collaborative approach, rooted in trauma informed practices, establishes wraparound services to address needs and challenges at the individual and community levels and provide care within and beyond

the four walls of the hospital. Through collaboration and commitment, CV and HVIP staff working in concert reduce re-injury and readmittance, provide more effective follow-up care and planning, and increase community safety.

Establishing collaborative models between Cure Violence and Hospital-based Violence Intervention Programs has additional significant benefits at the individual, community and policy levels as detailed below:

Individual-level

Treatment Plans: When CV replication sites and HVIPs work together, they can tailor more comprehensive treatment plans for clients to meet their needs and respond to their circumstances with input and expertise from all staff working with the individual and their family and community. For example, when they speak with their HVIP worker, a patient in the hospital may not have an accurate picture of whether or not they will be safe when they are discharged to the community, but a CV outreach and violence interrupter team would assist by communicating with their networks in the streets to assess the safety risk. Someone that a CV worker is supporting in the community might be acting in paranoid and anxious ways that have more to do with being traumatized than being in danger, and an HVIP program can help identify that and support their healing.



Photo credit: Cure violence

“ By reframing violence as a health issue, healing becomes a primary focus. ”

Follow-up: Collaboration results in greater likelihood that the client would adhere to both discharge planning and follow-up protocols due to support from staff both in and outside of the hospital walls. For example, sometimes a program loses contact with clients because they move, change phone numbers or stop returning phone calls. Having a different voice or person reach out may re-engage them.

Notes from the field

As one interviewee put it, “resources are wasted when there’s no communication” because partners each have different knowledge of, and relationships with, service providers.

Removal of barriers: Barriers are addressed by bridging communication gaps, providing health care system navigation, and offering long-term direct assistance with connections to follow-up services. Barriers are different for each individual and the collaborative team model ensures flexibility to adapt to each individual’s needs. Many HVIPs have access to health and behavioral health resources that a CV replication site might not; a CV worker might have connections to reentry or employment that an HVIP does not. Together, the programs have twice as many relationships and connections.

Involvement in Violence: There are many reasons why people become involved in violence, and the expertise of CV and HVIP workers mitigate many of these. Both programs provide impactful mentoring and support to create behavior change in clients. In addition, CV staff have expertise in safety assessment and conflict mediation. They are experts in resolving beefs to prevent retaliation and continued violence. HVIP workers are experts in addressing the psychological impact of trauma on an individual, who may engage in risky behaviors like carrying a weapon, using drugs heavily, or joining a gang to cope with the paranoia, stress, depression and hypervigilance caused by their traumatization. Together, both models provide individuals with immediate and long-term support

and intervention services to address past, current, and future conflicts to reduce the likelihood of their involvement in violence.

Community-level

Reducing retaliation, violence, and exposure:

CV and HVIPs work to reduce the potential for retaliation with the understanding that the greatest predictor of violence is a previous violent event. By working with those at highest risk and intervening and mediating conflicts where the potential for violence is imminent, these programs successfully prevent violence. In addition to direct experiences, indirect exposure and fear of violence are known to have serious adverse consequences, especially for children and young adults. Reducing exposure across the entire community promotes positive health outcomes for all.

Changing community norms: Outreach Workers engage leaders in the community as well as community residents, local business owners, faith leaders, service providers, and those at highest risk, conveying the message that the residents, groups, and the community do not support the use of violence. This includes hosting shooting responses, community events, distributing materials to support positive norms.



Image from 2017 Healing Justice Alliance Conference, photo credit: Move Photography

“ Each violently injured patient faces individual and unique risk factors for future involvement in violence. ”

Addressing barriers to health/treatment: At the community-level, CV and HVIP staff work to ease barriers to accessing services related to health, social services, education, and employment. Due to their community-specific knowledge, they are able to identify the unique challenges and ensure that individuals are connected to quality, culturally appropriate resources and highlight gaps in service options.

Health equity: Communities impacted by violence typically have limited access to the necessary resources, services, and environment to ensure healthy outcomes. The compounding effects of violence on all outcomes perpetuates racial and health inequities. CV and HVIP staff are able to call out and begin to address these inequities together by both providing advocacy and working with partners across all sectors. When hospitals take on the responsibility of being an anchor institution in their community, they can bring previously unavailable resources and visibility to the issues of health equity and violence. Despite their critical and unique role in addressing violence, in many communities this role is not fully visible or appreciated, and therefore related opportunities are missed.

Improved community healing and community-based trauma response: By reframing violence as a health issue, healing becomes a primary focus. Traditional trauma informed practices are adapted to the local community context and integrated into the work of changing community norms and addressing the effects of exposure to violence. Ongoing work across the country has demonstrated that community healing reduces the risk for future exposure and subsequent involvement and/or acceptance of violence.

Policy-level

At the policy level, collaboration results in the opportunity for broader advocacy and policy development based on the identification and expansion of best practices. These efforts can be directly linked to increasing the availability of sustainable funding for intervention programming

and incorporating these approaches into other sectors. As policies and practices shift to support health-based intervention strategies, the health sector will be able to take on a larger role in facilitating changes at the city, state, and national levels to effectively treat violence as a health issue.

MODELS FOR COLLABORATION

Existing efforts to implement a collaborative model have taken several approaches and have been adapted to local context. The models below represent the three different approaches that could be taken when working to define roles:

Model 1 – Define roles by location

This model defines the role of CV and HVIP staff based on the location of their work, with CV primarily based in the community and HVIP staff based in the hospital. Within this structure, CV staff do not come to the hospital except when requested by the HVIP staff, working with violently injured clients only upon HVIP invitation. The primary role of the CV staff is to conduct initial assessments of clients referred to them within the community and offer long-term case management, mentoring, and conflict mediation/retaliation prevention to clients enrolled in the program. The HVIP takes the lead on initial assessment of all patients treated at the hospital, even if they are already CV clients. Additionally, the HVIP does not enroll clients referred from the community unless these individuals are first assessed by CV and then referred to the HVIP. For clients first seen in the hospital, the HVIP is responsible for providing the long-term case management and intervention.

Model 2 – Define roles by population risk factor

Each violently injured patient faces individual and unique risk factors for future involvement in violence, but the greatest predictor of future involvement is previous exposure. Within this model of collaboration, screenings of risk factors for violently injured people referred to the program can be conducted by either CV or HVIP staff or even a third party by agreement. This assessment is focused on determining the likelihood that the referred patient is or soon will be engaging in violence. Once the risk level is determined, CV can provide all services to the individuals at highest risk, and HVIP could serve those with lower immediate risks. It is also possible that once the CV staff have successfully reduced the immediate risk factors for the client, they are then passed to the HVIP staff for long-term case management.

“ When we work in violence intervention, we work with traumatized people. ”

Model 3 – Define roles by activities

Each staff position and role is responsible for unique activities based on the expertise and reach of the staff member. This model builds on those assets to structure the work. In this model, CV conducts safety assessments, violent incident intervention, and conflict mediations at the hospital and in the community to prevent exposure to and perpetuation of violence. Meanwhile, the HVIP does long-term case management of patients treated for violent injuries, provides counseling, and offers connections to resources. Initial bedside visits are conducted by CV staff to assess immediate safety and retaliation issues. Once they have established a connection with the patient, they invite HVIP staff to subsequent meetings with the client to enroll them in long-term care and resources. These specified and aligned activities are managed collaboratively through regular – at least weekly – case coordination meetings with all staff.

Notes from the field

One HVIP emphasized the importance of street workers to help establish credibility with the patients and help gain buy-in to facilitate the work that they do with the HVIP case manager. Street outreach workers also assist with follow-up and use their connections to maintain involvement in the program. In a sense, they act as a liaison until the hospital-based program is viewed as trustworthy.

GUIDELINES FOR COLLABORATION

Relationships take effort, even – or especially – the best ones. In order for the two program models to work together effectively, we offer you the following guidelines for collaboration. Many of these practices apply universally to partnerships, but we also offer tips and perspectives on how they particularly apply in collaborations between HVIP and CV replication sites.

Notes from the field

Advice from the sites we interviewed on collaboration include:

- *Scale appropriately. Don't try to do too much too quickly. Understand that it takes time*
- *Collaboration works best when there is an existing relationship. Start with small projects or even just time together not working on a project in order to build that relationship.*
- *Be in the same physical space as often as possible.*
- *Get buy-in from the executive level and involve leadership from the very beginning.*

Agree on shared goals and values

We are all passionate, committed, busy people. Often, people and programs are too busy doing the work to step back and reflect on why we do the work, and operate under the assumption that we all agree. It is critical to agree on some shared goals and values; you do not need to agree on all of your goals for everything you do, but you need to agree for the work you are doing together. If all parties agree on where we are going (Goals) and how we are getting there (Values), then what we are doing flows much more clearly and without misunderstanding. The discussion that leads to this agreement should be done, ideally, in at least one face-to-face meeting to build buy-in. The final agreement should be written down so that partners can reference it and remind each other and themselves.

Assume goodwill

Problems arise. Things go wrong. That is the nature of partnerships and of life. How partners respond to those problems determines the future of the relationship. Before responding to any problem or issue involving a partner, your first reaction and interpretation should assume goodwill and good intent by the other party. Remember, you have already agreed on goals and values. You have established that you both care about this community and are dedicated to addressing violence. So in trying to interpret why a partner did or said something that you do not like, you should, firstly, try not to interpret why. Don't assume anything and ask the partner first. Maybe what you heard happened is not how it actually went down. But secondly, if you must interpret, let your interpretation be based on the assumption that the partner did what they were supposed to do or at least did the best that they could and did so with integrity.

“ We recommend regular, consistent communication, face-to-face when possible. ”

This can be especially important when looking into something that a client said about another provider. When we work in violence intervention, we work with traumatized people. These are people under incredible stress who are often, understandably, desperate to get their needs met and not always aware of how systems work to support them, or trusting that they work. Clients may triangulate service providers, playing them off each other – even subconsciously – in order to get their needs met. Communication between partners that assumes goodwill builds trust and avoids unnecessary drama.

Communicate (and communicate about how you communicate)

All successful relationships are based on good communication. How communication happens with partners working in communities impacted by violence contributes significantly to each program’s success. We recommend regular, consistent communication, face-to-face when possible. This is in addition to unscheduled communications that happen in crisis or in simple problem-solving. Regularly scheduled communication meetings build the trust and comfort to have the unscheduled communication. We recommend that partners meet formally as often as once a week to discuss case coordination, especially if you are working with the same individuals or members of the same family or gang/group. We find that no more than a month should pass between meetings in order to maintain familiarity and mutual understanding.

Notes from the field

Half of the sites we interviewed met every week to communicate and coordinated between hospital-based and community-based partners. This was in addition to what one described as “constant communication.” One interviewee advised partners to “over-communicate” to make sure everyone is on the same page.

Define roles, populations, and processes

The key to communication is clarity. When a partner does not do what you asked or expected them to do, there are only 3 reasons: (1) They refuse to do it, (2) They do not have the expertise or capacity to do it, or (3) They do not know what it is you want or expect them to do. There may be nothing you can do to resolve the first reason, but the latter two can be reduced by defining, in writing, each partner’s role, service population, and processes for referral, engagement and service.

Notes from the field

At two of the sites we spoke with, one way they worked together was when a victim came through the hospital with whom street outreach workers had a prior relationship, they brought that worker in to build that relationship with the family and get buy-in into services.

After reading this brief, you should have some ideas about the different ways that programs that work together can differentiate what they do. When you determine the parameters and definitions of your roles, populations and processes with your partners, put them in writing to make sure everyone is on the same page, literally.



Photo credit: Cure violence

“ Individuals, families and communities benefit when both HVIP and CV replication sites are implemented effectively and in a coordinated fashion. ”

When defining each partner’s role, it is important not just to define what you do, but as much as possible define what you do not do. Try to conceive of it from the client’s perspective. What services do you provide? What services do you not provide or refer out? The hard part is then to stick with what you defined. Partnerships work when all sides stick to their roles when they can, and communicate what and why they do not, when they do not.

Defining populations is critical. Who do you work with? How are they identified? How do you cross-refer someone that you come across who does not fit your service population but fits that of your partner? Even more than the “what” of role and the “who” of population, the “how” of process is important to define in writing. There are many processes to consider defining, but perhaps the most important one is communication. How will regular communication happen – when, where, by phone, text or face-to-face? How will crisis communication happen? And how are those crises defined? How will you document and share information?

Notes from the field

One site discussed their detailed signed partnership MOU (Memorandum of Understanding) that included cross-training for hospital and street outreach staff, joint training on initial risk assessment, plus HIPAA training and certification for street outreach workers who then received formal badges for ease of entry to the hospital.

In addition to communication protocols, partners should define protocols for situations that both programs encounter and activities that both undertake. For example, how do you approach hospital visits? Perhaps the CV staff focus on safety assessment and the HVIP staff focus on financial, psychological and medical needs. How does each program approach case management? Do the local CV replication sites and HVIP have different lengths of service, frequencies of contacts, etc.? An easy path to misunderstanding is to use the same words – like “case management” – to mean different things.

CONCLUSION

Individuals, families and communities benefit when both HVIP and CV replication sites are implemented effectively and in a coordinated fashion. Understanding how the models overlap and differ, and what the strengths are of each, can help partners overcome the challenges and reap the benefits of collaboration. The cities highlighted in this brief are doing just that. By adopting one of the models for collaboration suggested here and following the guidelines for collaboration we suggest, your community can also benefit from these effective health approaches to address violence.

The benefits of collaboration between these two models points to the potential that combining efforts will have a multiplying effect as evidenced by multiple communities where HVIP and CV replication sites co-exist. If brought to scale and streamlined the result can lead to significant reductions in health care costs, significant reductions in costs related to the justice system, significant reductions in trauma imposed on individuals, families, communities and the health sector and most importantly significant amount of lives saved and healed. Moving forward as more communities across the country and around the world replicate these models, there is a unique opportunity to intentionally implement these recommendations.



Image from 2017 Healing Justice Alliance Conference, photo credit: Move Photography

THANK YOU

Special thanks to the following practitioners and programs who contributed to the content of this brief:

Elizabeth Dugan, Clinical Director, Violence Intervention Advocacy Program

Boston, MA

Boston Medical Center's Violence Intervention Advocacy Program (VIAP) assists victims of community violence and their families through physical and emotional trauma recovery by using a trauma-informed care model focused on providing services and opportunities. VIAP provides participants with crisis intervention, support, and advocacy as well as ongoing case management, connections to community resources and family support services. This is all done in an effort to provide immediate and long-term 360 degree care to prevent future injuries and assist with the healing process. VIAP is a Department of Justice, Office for Victims of Crime, Supporting Male Survivors of Violence grantee.

Mario Maciel, Division Manager for the Mayor's Gang Prevention Task Force

San Jose, CA

The San Jose Mayor's Gang Prevention Task Force has been working with the Santa Clara Valley Medical Center to run their Bedside Intervention Program to connect with and provide assistance to victims of gang violence within the first 48 hours following their admission to the hospital. Built upon an existing partnership with the hospital through their Clean Slate Tattoo Removal program, this program works to connect victims between the ages of 13 and 30 and their families to essential services to preventing future incidents of violence and get them the resources they need. The Task Force also has a "Technical Team" comprised of Parks, Recreation & Neighborhood Services staff, police officers, school officials, and direct-service organizations who provide prevention and intervention services in the community to curb gang violence, including street outreach workers.

Erika Mendelsohn, Program Director, Stand Up to Violence

New York, NY

Based out of the Jacobi Medical Center, Stand Up to Violence (SUV) works both in the hospital and in the community to intervene in violence incidents, prevent re-injury, change social norms, and provide essential services to victims of violence. Modeled after Cure Violence, SUV addresses violence as a health issue and employ "credible messengers" from the community as Outreach Workers to connect with victims, their families, and others at highest risk for involvement in violence at the most critical moments for intervention. These immediate services are combined with long-term case management to help participants access needed resources and receive guidance and mentorship.

John Torres, Deputy Director, Youth ALIVE!

Oakland, CA

Youth ALIVE!'s Caught in the Crossfire Program, operating out of three local trauma centers, is a hospital-based violence intervention program operated by Youth ALIVE! The program's Intervention Specialists, young adults from the same communities as the clients who have had similar experiences, respond to the hospital within an hour of being notified that a young person has been admitted to the hospital with a violence related injury. They work with the client, their family members and friends to provide emotional support, work to prevent retaliation, promote alternative strategies for dealing with conflicts, identify short-term needs, and develop a plan for staying safe. This case management and mentorship continues for six months to a year after the patient is discharged from the hospital. Youth ALIVE! is also part of a Cure Violence-based strategy, employing geographically-based violence interrupters who mediate conflicts and address safety issues, in the hospital and in the community, in partnership with street outreach workers who are employed at partner community-based organizations.

ABOUT THE SERIES

The Healing Justice Alliance

The [Healing Justice Alliance](#) is a partnership between Youth ALIVE!, Cure Violence, the National Network of Hospital Based Violence Intervention Programs (NNHVIP) and Berkeley Media Studies Group. HJA has over combined 60 years of experience in training private and public sector agency leadership and staff members that are part of comprehensive, multi-system efforts that respond to crime victims and address violence as a health issue.

Based in Oakland, California, Youth ALIVE! works to help violently wounded people heal themselves and their community. Their overarching mission is to prevent violence and create young leaders through violence prevention, intervention and healing.

Cure Violence stops the spread of violence by using the methods and strategies associated with disease control – detecting and interrupting conflicts, identifying and treating the highest risk individuals, and changing social norms. Cure Violence is guided by clear understandings that violence is a health issue.

With over 30 member programs across the U.S. and beyond, the National Network of Hospital-based Violence Intervention Programs (NNHVIP) seeks to connect and support hospital-based, community-linked violence intervention and prevention programs and promote trauma informed care for communities impacted by violence. Its vision is that all patients and families impacted by violence will receive equitable trauma-informed care through their hospital and within their community.

Berkeley Media Studies Group (BMSG) helps community groups and public health professionals practice media advocacy and the strategic use of mass media to advance policies that improve health. Ultimately, BMSG aims to help reshape how news, entertainment, and advertising present health and social issues.

“ There needs to be a significant shift in the way in which services are provided. ”

The Supporting Male Survivors of Violence initiative In 2015, the Office for Victims of Crime (OVC) awarded the Healing Justice Alliance (HJA) 16 a grant to provide training and technical assistance (TTA) to FY 2015 Supporting Male Survivors of Violence grantees. A collaboration between OVC and the Office of Juvenile Justice and Delinquency Prevention (OJJDP), the grant initiative aims to help improve responses to male survivors of violence and their families. In 2013, OVC released its Vision 21: Transforming Victim Services Final Report. At the core of the report, OVC identified key priorities for providing services to victims of crime.

These priorities include:

- **The need to make services accessible for all victims in all communities.**
- **Development of expansive, flexible, and innovative service models.**
- **And a holistic approach to addressing the historical institutional, geographic, and cultural barriers.**

OVC recognizes that in order for crime victims to gain physical, emotional, and financial recovery from the effects of their victimization, there needs to be a significant shift in the way in which services are provided. This is particularly evident when looking at services available to young men of color who have experienced harm.

Twelve demonstration projects across the country – from Baltimore, Maryland to Santa Cruz, California – were selected to create and implement culturally relevant and trauma informed programs and interventions to engage male survivors of violence, specifically, young men of color (YMOC) and their families impacted by trauma and violence.

The overarching goals of the initiative include:

1. **Creating a multi-disciplinary network of partners to provide coordinated services and support for male survivors of violence and their families.**
2. **Conducting outreach and training to educate stakeholders on the adverse effects of trauma and violence; and, developing methods to overcome barriers that prevent male survivors of violence and their families from accessing services and support.**

1. Goins WA, Thompson J, Simpkins C. Recurrent intentional injury. *J Natl Med Assoc.* 1992;84:431Y435
2. Sims DW, Bivins BA, Obeid FN, Horst HM, Sorensen VJ, Fath JJ. Urban trauma: a chronic recurrent disease. *J Trauma.* 1989;29:940Y947
3. Purtle J, Dicker R, Cooper C, et al. Hospital-based violence intervention programs save lives and money. *J Trauma Acute Care Surg* 2013;75:331–3
4. Cooper C, Eslinger DM, Stolley PD. Hospital-based violence intervention programs work. *J Trauma.* 2006;61:534Y540
5. Juillard C, Smith R, Anaya N, Garcia A, Kahn JG, Dicker RA. Saving lives and saving money: hospital-based violence intervention is cost effective. *J Trauma Acute Care Surg.* 2015;78:252-7. [PMID:25757108] doi:10.1097/TA.0000000000000527
6. Skogan, W., Harnett, S. M., Bump, N., & DuBois, J. (2009). *Evaluation of CeaseFire-Chicago.* Chicago: Northwestern University Institute for Policy Research
7. Webster, D. W., Whitehill, J. M., Vernick, J. S., & Parker, E. M. (2011). *Evaluation of Baltimore's Safe Streets Program: Effects on Attitudes, Participants' Experiences, and Gun Violence.* Baltimore, MD: Johns Hopkins Center for the Prevention of Youth Violence
8. Delgado, Sheyla A., Laila Alsabahi, Kevin Wolff, Nicole Alexander, Patricia Cobar, and Jeffrey A. Butts (2017). The Effects of Cure Violence in the South Bronx and East New York, Brooklyn. In *Denormalizing Violence: A Series of Reports From the John Jay College Evaluation of Cure Violence Programs in New York City.* New York, NY: Research and Evaluation Center, John Jay College of Criminal Justice, City University of New York
9. "Group involved" refers to individuals associated with a larger group who may be involved in high-risk street activity and/or crime, although not necessarily organized or operated as a formal gang. Group involvement increases their risk for violence
10. HIPAA refers to the Health Insurance Portability and Accountability Act of 1996. HIPAA compliance requires data privacy and security provisions for safeguarding medical information that might be shared with outside parties



THANK YOU FOR READING!

For more information: healingjusticealliance.org | [@HJAlliance](https://twitter.com/HJAlliance) | youthalive.org | cureviolence.org | bmsg.org | nnhvip.org

Authors: Anne Marks (Youth ALIVE!/NNHVIP), Lori Toscano (Cure Violence), Matan Zeimer (Cure Violence)

June 2018



This product was produced by the Healing Justice Alliance and was supported by grant number **2015-VF-GX-K025** awarded by the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this product are those of the contributors and do not necessarily represent the official position or policies of the U.S. Department of Justice.