

**FINN**

THE JOHN F. FINN INSTITUTE  
FOR PUBLIC SAFETY, INC.

## **Hospital-Based Violence Prevention Programs: A Synopsis**

**Robert E. Worden, Ph.D.  
Sarah J. McLean, Ph.D.**

**October, 2008**

423 New Karner Rd  
Suite 5  
Albany, NY 12205  
PH: 518-456-6323  
FAX: 518-456-6312

---

**Robert E. Worden, Ph.D.  
Director**

**Sarah J. McLean, Ph.D.  
Associate Director**

The John F. Finn Institute for Public Safety, Inc., is an independent, not-for-profit and non-partisan corporation, whose work is dedicated to the development of criminal justice strategies, programs, and practices that are effective, lawful, and procedurally fair, through the application of social science findings and methods. The Institute conducts social research on matters of public safety and security – crime, public disorder, and the management of criminal justice agencies and partnerships – in collaboration with municipal, county, state, and federal criminal justice agencies, and for their direct benefit. The findings of the Institute’s research are also disseminated through other media to criminal justice professionals, academicians, elected public officials, and other interested parties, so that those findings may contribute to a broader body of knowledge about criminal justice and to the practical application of those findings in other settings.

The Finn Institute was established in 2007, building on a set of collaborative projects and relationships with criminal justice agencies dating to 1998. The first of those projects, for which we partnered with the Albany Police Department (APD), was initiated by John Finn, who was at that time the sergeant who commanded the APD’s Juvenile Unit. Later promoted to lieutenant and assigned to the department’s Administrative Services Bureau, he spearheaded efforts to implement problem-oriented policing, and to develop an institutional capability for analysis that would support problem-solving. The APD’s capacity for applying social science methods and results thereupon expanded exponentially, based on Lt. Finn’s appreciation for the value of research, his keen aptitude for analysis, and his vision of policing, which entailed the formulation of proactive, data-driven, and – as needed – unconventional strategies to address problems of public safety. Lt. Finn was fatally shot in the line of duty in 2003. The Institute that bears his name honors his life and career by fostering the more effective use of research and analysis within criminal justice agencies, just as Lt. Finn did in the APD.

## Introduction

Some violence prevention programs provide for interventions with victims of violence that commence at the point of their hospitalization. We might call these programs hospital-based, inasmuch as the hospital is the site at which would-be participants are identified and at which the intervention is initiated, even though many of the services that are provided are not delivered by or within the hospital. Research shows that patients admitted with intentionally inflicted injuries are at elevated risk of repeat violence, and one might speculate that they are also at elevated risk of perpetrating violence, in retaliation or more generally, and that in the immediate aftermath of a violent injury, victims would be especially receptive to behavioral change. Estimates of “violence-related recidivism” – that is, the fraction of people once injured as a result of intentional violence who are injured by assault on a second or subsequent occasion – range from 6 percent to as high as 45 percent.<sup>1</sup> Some programs that target this population for intervention have been effective in reducing their risk. Research also shows that such programs vary some in their components. Drawing on studies of several programs, we first describe the principal components of the programs, and we then summarize the evidence on program effectiveness. The programs include these: Boston City Hospital’s Violence Prevention Program; the Violence Intervention Program at the University of Maryland School of Medicine in Baltimore; a program at the Harborview Medical Center in Seattle; a program at a Chicago level 1 trauma center; and a program at an unnamed children’s hospital.<sup>2</sup> In addition, a program of this kind currently operates at Golisano Children’s Hospital at Strong in Rochester, and a hospital-based initiative is part of the CeaseFire program in Chicago; neither of these has been systematically studied, but some descriptive information is available, and some anecdotal evidence about outcomes is available about the latter.<sup>3</sup>

## Program Components

Hospital-based violence-prevention programs vary mainly with respect to two broad components: the target population; and the nature, intensity and duration of the services provided. We would note also that some target populations afford greater leverage on client participation and retention in the program, and insofar as program retention contributes to programmatic success, this leverage may enhance program effectiveness.

---

<sup>1</sup> See Leslie S. Zun, LaVonne Downey, and Jodi Rosen, “The Effectiveness of an ED-Based Violence Prevention Program,” *American Journal of Emergency Medicine* 24 (2006), p. 9, and references therein. We gratefully acknowledge the research assistance of Jennifer Owens in reviewing relevant literature.

<sup>2</sup> On Boston’s program, see Edward De Vos, David A. Stone, Margaret A. Goetz, and Linda L. Dahlberg, “Evaluation of a Hospital-Based Youth Violence Intervention,” *American Journal of Preventive Medicine* 12:5 (suppl, 1996): 101-108. On Baltimore’s program, see Carnell Cooper, Dawn M. Eslinger, and Paul D. Stolley, “Hospital-Based Violence Intervention Programs Work,” *Journal of Trauma Injury, Infection, and Critical Care* 61:3 (2006), pp. 534-540. On Seattle’s program, see Larry M. Gentilello, et al., “Alcohol Interventions in a Trauma Center as a Means of Reducing the Risk of Injury Recurrence,” *Annals of Surgery* 230:4 (1999), pp. 473-480. On Chicago’s program, see Zun, et al., “The Effectiveness of an ED-Based Violence Prevention Program.” On the program in the unnamed children’s hospital, see Tina L. Cheng, et al., “Randomized Trial of a Case Management Program for Assault-Injured Youth,” *Pediatric Emergency Care* 24:3 (2008), pp. 130-136.

<sup>3</sup> On CeaseFire’s emergency room response initiative in Chicago, see [http://www.ceasefirechicago.org/R\\_response.shtml](http://www.ceasefirechicago.org/R_response.shtml) and Advocate Christ Medical Center / CeaseFire Violence Prevention Outreach Program, *A Synopsis of Twelve Test Cases* (<http://www.ceasefirechicago.org/Hospital%20Pilot%20Proposal%202.htm>) (accessed July 2, 2008).

### Target population

The target populations for hospital-based programs all include patients admitted for an injury related to a violent assault, but they vary in terms of subjects' age, substance abuse, criminal justice status, and histories of assault-related injuries. A program might serve both juveniles and adults, as Chicago's program does, or it might serve only juveniles or only adults. Boston's program, for example, treats adolescents aged 12 to 17, and Rochester's program treats juveniles. Baltimore's program, in contrast, treats only adults age 18 and over. In addition, Baltimore's program is limited to victims who are currently under criminal justice supervision, on probation or parole, and who were admitted at least once previously for such an injury. Seattle's program is limited to adult patients who are screened positively for alcohol abuse.

### Services

These programs, in general, provide for moderately or more intensive case management with referrals as needed to a variety of services, including individual and family counseling, support groups, parenting education, tutoring and alternative education, employment training, youth mentoring, anger management, legal aid, recreational and after-school programs, crisis intervention, mental health treatment, substance abuse treatment, community-based violence prevention programs, outpatient child psychiatry, and medical services. Case managers assess the needs of the clients and plan and coordinate service delivery accordingly. The Baltimore program is particularly intensive, providing in addition for bi-weekly (or more frequent) meetings with a social worker or case worker, meetings with probation or parole officers, weekly group encounter sessions, and home visits by the program team. The duration of program involvement ranges from four months to over six months. The CeaseFire-Chicago program provides for responses by "CeaseFire violence interrupters and outreach workers, street-savvy individuals – many of them ex-offenders – who have strong ties in their communities and the ability to connect with the high-risk population"; the program seeks to mediate conflicts and prevent retaliation, as well as facilitate clients' access to needed services.

## **Outcomes**

The effectiveness of these programs has been examined in terms of a number of outcomes, including the incidence of re-injury, arrest, conviction, and incarceration, as well as service utilization, substance use, employment, and (for Seattle's program) alcohol consumption. Only a few program evaluations have been conducted, however, so we can not capitalize on a broad base of research findings in order to draw inferences about the relative efficacy of different program structures and components or about the magnitude of program impacts, and we cannot with confidence estimate the ratio of benefits to costs.<sup>4</sup>

In general, the incidence of re-injury was lower among the patients in treatment groups, compared with that of control groups, in experimental studies with fairly strong research designs. Clients in Baltimore's program, for instance, were one sixth as likely to be hospitalized

---

<sup>4</sup> The report on Boston's program describes the design of an evaluation, and provides baseline data, but it does not include evaluation findings, and we have been unable to locate any other report on that program. The only outcome information on the CeaseFire hospital initiative of which we are aware is anecdotal in nature; the initiative was not examined as a part of the evaluation recently completed by Northwestern University (Wesley G. Skogan, et al., *Evaluation of CeaseFire-Chicago* (Evanston, Ill.: Northwestern University, 2008)).

for a violent injury as the control group over a comparable follow-up period (ranging from less than one year to over two years). Chicago's program was also effective, though somewhat less so: 8 percent of the treatment group, compared with 20 percent of the control group, sustained a (self-reported) assault-related injury (though no difference was found in the prevalence of return visits to the emergency department). The program in the unspecified children's hospital also yielded a lower prevalence of assault-related injuries among the treatment group than among a control group, though with small samples, the difference was not statistically significant at a conventional level.

In addition, the incidence of violence perpetrated by patients in treatment groups was somewhat lower, compared with that of control group subjects, though the findings were not uniformly positive. Participants in Baltimore's program were one third as likely as control group subjects to be arrested for a violent crime during the follow-up period, and one fourth as likely to be convicted of a violent offense. Youth who participated in the children's hospital program were less likely than those in the control group to have been in a physical fight, though they were equally likely to have carried a weapon. And the evaluation of Chicago's program showed no evidence of effects on post-intervention arrests, incarceration, or self-reported offending. In the pilot phase of the CeaseFire-Chicago hospital program, twelve "test cases" were tracked, from which staff surmised that four retaliations were prevented.

Most reported evaluations of programs of this nature have not included information on the costs of the programs, and of course the cost will hinge on the components that comprise the program. But most of these programs, it appears, are operated at a fairly low direct cost inasmuch as they make use of existing service delivery (and payment) mechanisms, e.g., for counseling, substance abuse treatment, youth mentoring, mental health treatment, and the like. The cost of a case manager who coordinates referrals for these services is fairly modest – in Chicago, approximately \$65,000 for a case manager with a caseload of 20.

According to the Centers for Disease Control, a non-fatal assault entails \$57,209 in lost productivity and \$24,353 in medical services.<sup>5</sup> The cost of medical care is subject to variation across hospitals, of course, and so the health-care savings of prevented injuries in any one hospital could be more or less than the average. Cooper, et al., report that "the total cost of hospitalization for the three recidivists from the intervention group [of 56] was \$138,000, compared with \$736,000 for the 16 recidivists from the nonintervention group [of 44]," based on an average cost of \$46,000 for the management of an assault-related injury at that hospital.

### **Program Options**

A hospital-based violence prevention program need not be modeled after any one of the programs reviewed above, but rather could and should be formed to suit the environment of the locale that adopts the program. Youth are disproportionately represented among the victims of violent crime, but a program that focuses exclusively on juveniles would fail to reach many of those at the highest risk of violent victimization and offending. The law affords greater programmatic leverage on juvenile victims of violence, and on their parents or guardians, and conditions of probation or parole afford some leverage on victims who are under criminal justice

---

<sup>5</sup> Phaedra S. Corso, James A. Mercy, Thomas R. Simon, Eric A. Finkelstein, and Ted R. Miller, "Medical Costs and Productivity Losses Due to Interpersonal and Self-Directed Violence in the United States," *American Journal of Preventive Medicine* 32:6 (2007), pp. 474-482.

supervision; a violence prevention intervention might be especially effective on these populations.

If the program will consist of the delivery of services to high-risk individuals, addressing identifiable risk factors, then the program would be appropriately staffed with professional caseworkers. If in addition the program will provide for an intervention that is designed to reduce the immediate potential for retaliation, then staffing might include, in addition or instead, the kind of “street-savvy” outreach workers employed by CeaseFire-Chicago, who have a natural rapport with the highest-risk youth – youth who disproportionately are economically disadvantaged, African-American, and gang-involved.