

# Healing Hurt People: Breaking the Cycle of Violence through Golden Moment Trauma-Informed Interventions

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### Abstract

**Objective:** To determine the feasibility of an intervention to prevent re-traumatization with young males of color who are victims of violence in an emergency room setting.

**Method:** Subjects were selected from a single emergency room after being stabbed, shot or beat up and then referred to peer intervention specialist and injury prevention coordinator who see the patient while in the emergency department and provide intense services during hospitalization and for six months to a year in the community afterwards. Participants were monitored for repeat ER visits, retaliation, repeat injury and re-arrests.

**Results:** Out of 29 participants there were zero repeat ER visits, re-injury, retaliation and reduction in PTSD symptomology with only two arrests for NON-violent offenses.

**Conclusion:** Preliminary results are positive. Additional work with a larger sample and control group is needed. The project has possibilities in the context of residency training and providing an excellent training experience.

### Introduction

As a fourth year resident in training, I developed, implemented and executed a youth violence intervention program called Healing Hurt People (HHP). Healing Hurt People is a trauma-informed, hospital-based, community-focused program that employs a public health lens to treating and preventing violence among African-America male youth. Developing HHP required much proficiency as a future physician-leader [1-3]. These skills include an understanding of systems; change management; collaboration in an interdisciplinary and multidisciplinary setting; familiarity with administrative psychiatry; coaching and collaborative problem solving; and building an innovative consultation model. This project also mandated seamless navigation of various systems and the robust partnership and mentorship of several community psychiatrists and level one trauma physicians. The type of project based work I was allowed to do as a fourth year resident in training may enable trainees to meet and exceed interpersonal/communication, knowledge, skills, attitude and systems-based milestones.

### The building of HHP, the significance of the project and the outcomes

**Case:** A young 12-year old boy of color presents to a level I trauma emergency department in a major city, severely beaten up. Bruises and contusions were expeditiously identified, treated and he was released from the emergency department within eight hours of entering. Two years later, this same young boy, at 14 years of age, re-presented to the same level I trauma center with multiple stab wounds to his legs and shoulders and was again released back into the same violent environment. At the age of 17 this same young man re-presented to the same emergency department, but this time in a body bag. Unfortunately, there are far too many "12 year old boys of color" who've shared a similar path and fate as described in this case [4-7].

While Emergency room physicians did a superb job of treating the physical wounds, interpersonal trauma was left untreated.

Interpersonal trauma can be experienced in different forms, including: child abuse (physical, sexual, and emotional abuse, neglect and witnessing violence), sexual assault/rape, intimate partner violence/domestic violence, war and historical trauma (the pervasive oppression and violence toward a group or culture over years and or generations).

Physiologically, trauma is stored in somatic memory and expressed as changes in the biological stress response. Intense emotions at the time of trauma initiate the long-term conditional responses to reminders of the event, which are associated both with chronic alterations in the physiological stress response and with the amnesias and hyperamnesias characteristic of Posttraumatic Stress Disorder (PTSD).

Animal research suggests that intense emotional memories are processed outside of the hippocampally mediated memory system and are difficult to extinguish. Cortical activity can inhibit the expression of subcortically based emotional memories. The effectiveness of this inhibition depends, in part, on the physiological arousal and neurohormonal activity. These formulations have implications for both the psychotherapy and the pharmacotherapy of PTSD.

Violence is experienced as the failure of “top-down” control systems in the prefrontal cortex to modulate aggressive acts that are triggered by anger provoking stimuli. An imbalance between prefrontal regulatory influences and hyper-responsivity of the amygdala and other limbic regions involved in affective evaluation are implicated. Insufficient serotonergic facilitation of “top-down” control, excessive catecholaminergic stimulation, and subcortical imbalances of glutamatergic/gabaminergic systems may contribute to abnormalities in this circuitry [8-12].

The temporal lobe and hyperactivity of the limbic system, including structures such as the amygdala, in response to negative or provocative stimuli, particularly anger provoking stimuli are also implicated in the susceptibility to violence and aggression. There are specific factors that increase the proclivity for aggression to include cognitive impairment, psychopathy, emotional sensitivity/dysregulation and trauma history.

Pharmacological interventions such as mood stabilizers, which dampen limbic irritability, or Selective Serotonin Reuptake Inhibitors (SSRI's), which may enhance “top-down” control, as well as psychosocial interventions to develop alternative coping skills and reinforce reflective delays may be therapeutic.

Why intervene at the level of the hospital? Several studies in twenty-three major cities have demonstrated the effectiveness of reducing youth violence by intervening at the level of the hospital. Youth violence studies highlight the following:

- 44% of young people hospitalized for violence return with another violent injury within 5 years
- 20% of them eventually die by violence

#### Cooper et al. did a large concurrent case-control study-

- Age >18
- Treatment (intervention): violently injured youth
- Control group (non-intervention): non-violently injured, matched for age & gender
- Previous hospitalization
- Blind randomization
- 3 year follow up

#### Results

- Hospital based interventions do work
- Patients who were not involved in intervention were significantly more likely to be arrested for a violent crime, convicted of a violent crime, involved in repeat violent criminal activity.

## Methods

Young male victim of color between the ages of 10-25 enter the emergency department at Level I Trauma Center

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If above criteria is met: Emergency room chaplain and or Social Worker assesses, identifies and refers to HHP Peer Intervention Specialist (PIS) and Injury Prevention Coordinator (IPC) by emergency page. Both PIS and IPC are Community Behavioral Healthcare Care employees who work 24/7 on rotating call

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PIS - is a young person with lived experience of violence that has overcome (powerful effective model) interacts with young subject of violence

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IPC -is a Masters' trained clinician with extensive experience in family counseling and motivational interviewing, engages the subjects family

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PIS and IPC gain appropriate consent from client to participate in HHP (which is a voluntary program)

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PIS and IPC complete a safety and needs assessment with subject of violence and their identified family while in the hospital

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PIS and IPC work collaboratively with Emergency Room Staff to assist subject of violence and family with in-hospital care and discharge planning

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Upon discharge – in the post discharge period, (average length of stay is with penetrating traumas is 2 weeks – IPC and PIS are engaging the young subject of violence and his family the entire time), IPC and PIS get the young male and his family established with wraparound services at Community Behavioral culturally-specific clinic

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Wraparound services include: family trauma work, individual trauma work; housing; access to health insurance; vocational training; pro-social activities; and educational support to name a few.

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Young male victims and their identified family receive extensive services and support in the community for 6 months to a year

The point of intervention is the emergency department, within a 4 hour window (evidence based, well researched time frame for effective violence intervention deemed “The Golden Moment”).

The “Golden Moment” is that moment in time that subjects of violence are most poised to consider healthier alternatives to retaliation, in this case, they are more willing to move away from

violence and move towards healing. The “Golden Moment” is powerful and must be handled with skill and care - which is why persons working for HHP are well trained in trauma-informed care. Young victims of violence and their families are compassionately engaged in the trauma bay and during their hospital stay. Upon release from the hospital, they are engaged for 6 months to a year, provided with wraparound services and therapy.

## Results

In analyzing data in the first 6 months to one year of HHP- young male victims of color remain free of re-injury, re-arrest, retaliation, repeat emergency room visits and have lower frequency of developing Post Traumatic Stress Disorder.

From June 2013-June 2014: HHP had 29 patients referred

Repeat Emergency Room visits: None (0/29) in the first year of intervention  
Re-injury: None (0/29) in the first year of intervention

- Retaliation: None (0/29) in the first year of intervention
- Re-arrest: Two (2/29) but arrests were for NON-violent offenses
- Measure of PTSD-PCL scores obtained at the beginning and at the end indicated dramatic decreases in PTSD symptomology

## Conclusion

This report began with the case of a young male of color traumatized, living under constant threat and in survival mode. Emergency departments all across the country have traditionally been expert at addressing the physical wounds of trauma, but limited in targeting the psychological wounds.

By employing trauma-informed principles and psychoeducational groups and counseling; providing culturally specific care; employing a peer services model; working with the family as a system of care; coordinating care; treating families and victims with dignity and respect, HHP has been able to realize positive outcomes in a preliminary study.

HHP meets the triple aims as outlined by the Accountable Care Act and Coordinated Care Organizations (ACA and CCO respectively) by reducing overall health care cost (HHP clients did not return to the emergency department during the time they were served by the program);

improving outcomes for specific populations (all of HHP’s participants secured jobs, started school and sought family counseling); and improving care (100% of HHP’s participants had individual and family counseling). The HHP model has been presented to local and state government officials who desired to see the HHP model expand to other emergency departments across the state because HHP “could save untold millions”. The HHP model thus far from “Golden Moment” to In-Hospital Engagement TO Post-Discharge has proven promising.

HHP has implications for Prison reform nationally and locally – in Oregon, House Bill 3194 passed, modifying presumptive sentences for certain individuals convicted of identity theft or robbery, or third degree and eliminates mandatory minimum sentences applicable to certain persons convicted of drug charges. The Department of Corrections (DOC) is tasked with decreasing overall prison cost

by 5% per inmate per year for the next ten years. DOC is looking to community providers to render effective services to the criminal justice involved population in a cost effective, trauma-informed and evidence-based manner. HHP has demonstrated its ability to prevent arrests and re-arrests.

HHP appears to be an effective, trauma-informed, community based model that should be replicated across multiple Emergency Departments.

## Implicates for the Resident in Training and Beyond

- For residents in training, a milestone is a significant point in development and further are competency-based developmental outcomes (e.g, knowledge, skills, attitudes, systems based work and performance) that can be demonstrated progressively by residents and fellows from the beginning of their education through graduation to the unsupervised practice of their specialties.
- Allowing residents in training to get involved in the development of programs and projects in their senior year(s) of training (fourth year and beyond) provides ample opportunity for honing, perfecting and demonstrating their academic acumen, professional development and attainment of developmentally-critical milestones.
- The process of developing HHP facilitated effective cultivation and enhancement of my leadership capacity, consolidation of expertise and establishment of a new community consultation model as a psychiatrist and physician-leader.

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