Report on Healing Hurt People – Chicago

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John A. Rich, MD, MPH, is a Professor at the Drexel University School of Public Health. He has been a leader in the field of public health, and his work has focused on serving one of the nation’s most ignored and underserved populations – African-American men in urban settings. In 2006, Dr. Rich was granted a MacArthur Foundation Fellowship. In awarding this distinction, the Foundation cited his work to design “new models of health care that stretch across the boundaries of public health, education, social service, and justice systems to engage young men in caring for themselves and their peers.”

Prior to Drexel University, Rich served as the medical director of the Boston Public Health Commission. As a primary care doctor at Boston Medical Center, Rich created the Young Men’s Health Clinic and initiated the Boston Health CREW, a program to train inner city young men to become peer health educators who focus on the health of men and boys in their communities.

He earned his Dartmouth A.B. degree in English, his M.D. from Duke University Medical School, and his Master’s from the Harvard School of Public Health. He completed his internship and residency at the Massachusetts General Hospital and was a fellow in general internal medicine at Harvard Medical School. He received an honorary Doctor of Science degree from Dartmouth in 2007 and now serves on its Board of Trustees. In 2009, Dr. Rich was inducted into the Institute of Medicine of the National Academy of Sciences. His recently published book about urban violence Wrong Place, Wrong Time: Trauma and Violence in the Lives of Young Black Men has drawn critical acclaim.
Healing Hurt People (HHP) is a trauma informed violence intervention program for survivors of urban intentional violence. Chicago Beyond funded a learning collaborative among HHP’s founders and Healing Hurt People-Chicago, to better understand the program and support its growth; for the founders to provide specific trainings and technical assistance; and to enable two urban settings to learn from one another’s local adaptations. This report is one product of that collaboration.

History

Healing Hurt People was founded in Philadelphia in 2007 by Theodore Corbin, MD, MPP and John Rich, MD, MPH as a hospital-based trauma informed violence intervention program for survivors of urban intentional violence. The impetus to launch an intervention to address the physical and psychological trauma of young men and women drew from Dr. Corbin’s and Dr. Rich’s experiences as urban health care providers. Having seen many young survivors of violence as patients, Drs. Corbin and Rich realized that psychological trauma was driving the cycle of violence, fueled by the structural violence of racism and stigma which posed barriers to effective access to care. A stated goal of HHP has been to heal the wounds of trauma among young people as a way to ease their psychological and physical stress, while helping them connect with needed resources.

Healing Hurt People Chicago (HHP-C) was founded in 2013 by Brad Stolbach, Ph.D. and Rev. Carol Reese, LCSW and was modeled on HHP Philadelphia (HHP-P). Dr. Stolbach, a pediatric trauma clinical psychologist and Rev. Reese, a licensed clinical social worker and chaplain saw the need to attend to the deep trauma affecting survivors of trauma in Chicago. HHP-C began by serving pediatric clients at the University of Chicago Comer Children’s Hospital and John H. Stroger, Jr. Hospital of Cook County. Recently with increasing success, HHP Chicago has now expanded to serve adults who suffer trauma in Chicago at University of Chicago Medical Center and John H. Stroger, Jr. Hospital of Cook County.

Since the founding, both programs have worked together to advance the HHP model while also adapting it to local and regional contexts. As the prevalence of violence continues to devastate the health of communities in Chicago and in Philadelphia, HHP is poised to pursue new opportunities for innovation in trauma-informed, culturally responsive and evidence-based intervention, while also designing paths to sustainability and greater impact.

Rationale

Survivors of interpersonal violence seen in typical hospital settings receive treatment for their physical wounds, but their mental and emotional wounds are left unattended. A body of research now tells us that trauma drives the cycle of violence and that these survivors are at high
risk for reinjury, retaliation, posttraumatic stress disorder, depression and other physical and mental health consequences.

The fundamental concepts behind HHP include the following:

1. Interpersonal violence is a major public health and behavioral health issue in the United States, and hospitals present a unique opportunity to reach patients at the highest risk.
2. Violent injury presents a “teachable moment” in which the patient may have an increased interest in intervention, support, and/or change.
3. Violence is a cyclical problem, and the cycle must be interrupted in order to improve the life course trajectories of victims of violence and to decrease re-injury, retaliation, and premature death.
4. Trauma and adversity cause significant harm to the mind and body.
5. Trauma Informed Care is essential: past trauma, stress, and adversity have powerful impacts on physical health, mental health, and behavior, and therefore trauma informed strategies must be a part of all intervention methods.
6. Individuals who have experienced trauma are injured and in need of healing. Without addressing the experience of trauma for individuals impacted by violence, we will not be able to successfully promote healing and recovery.

HHP, a trauma-informed, hospital-based violence intervention program allows for young people that have sustained interpersonal injuries to have the opportunity to receive high quality trauma-informed services to support their healing and recovery, and to allow them to return to productive lives with their families and in their communities.

Interpersonal violence disproportionately affects African Americans, especially young African American males. Violence is the leading cause of death for young African American males between the ages of 10 and 24, and the second leading cause of death for young Latino males. By contrast, violence ranks as the fifth leading cause of death among white males in the same age group. During 2018 in Chicago, 561 people were victims of homicide. There were 2,948 shooting victims in 2018.

Often survivors of violence are seen in hospital emergency departments multiple times for violence related injuries. A survey of 48 violently injured youth (median age 14.5 years) participating in HHP-P found that 23% reported previously sustaining a violent injury requiring medical treatment. A review of needs-assessment data collected for 78 violently injured youth participating in HHP-P found that 40% do not feel safe in their neighborhoods and 49% do not feel safe in school.

The obvious physical consequences of nonfatal violent injury, including disability, pose a significant burden for these survivors. However, beyond the physical impact of violence, the psychological consequences, including depression, symptoms of posttraumatic stress and posttraumatic stress disorder, and substance abuse are seldom taken into account by programs attempting to address violence. Lack of access to health insurance, high rates of poverty and a lack of marketable job skills further complicate the lives of these survivors of violence. In the
absence of intervention and an opportunity to understand the potential after-effects of their experience, survivors of violence are at risk for violent reinjury after they leave the hospital. IV, V

Published research shows that 75% of HHP clients meet full criteria for post-traumatic stress disorder (PTSD) and 50% of clients experienced more than four adverse childhood experiences. VI HHP’s skilled Trauma Intervention Specialists (TIS) have the opportunity to meet young people where they are and to focus on supporting both physical and emotional healing from their violent injury. Survivors of violence served by HHP often also suffer related mental health consequences, including difficulty readjusting to their daily lives and routine, anxiety, as well as posttraumatic stress disorder (PTSD).

Male survivors of violence, particularly young male survivors of color, face persistent barriers to finding and accessing services that meet their needs, in part because of their own exposure to significant trauma and in part because institutions and programs designed to serve them often lack relevant, culturally competent services and, therefore, the capacity to fully engage them. Often, because of trauma, the culture of masculinity, and the persistent adversity and threats to basic safety that these male survivors of violence face, they do not identify as victims and therefore do not seek out and engage with traditional services. They are also disconnected from other types of resources, such as health insurance and adaptive modifications for homes, that hinder their ability to focus on their physical, emotional and behavioral health. A relatively small proportion of survivors of violence apply for, and obtain, victims’ compensation and assistance services. VII, VIII In 2011, the U.S. Department of Justice’s (DOJ) Office of Justice Programs (OJP) issued a report documenting trends in the utilization of victim assistance services. Using data from the National Crime Victimization Survey, OJP found that only 8% of victims of aggravated assault received services, and that this proportion had not changed significantly between 1993 and 2009. This proportion was significantly lower among those who did not report victimization to police compared to those who did (4% vs. 14%), a common occurrence among male survivors of violence, especially those of color.

Interpersonal violence is a major public health problem in the United States—and hospitals stand on the front lines of the epidemic. According to the Centers for Disease Control and Prevention, homicide was responsible for 16,799 deaths in 2009, translating to over 540,536 potential life years lost and more than $25.3 billion in medical costs and lost productivity. IX While the social and economic costs of homicide are immense, non-fatal violent injuries outnumber fatal violent injuries by more than one hundred-to-one. In 2010, an estimated 1.7 million incidents of non-sexual violent assault were treated in hospitals across the country. Young men of color suffer the highest rates of nonfatal and fatal violence. X

Violence is a cyclical problem—being the victim of a non-fatal violent injury increases risk of re-injury, retaliation, premature death, and incarceration. In urban settings, it is estimated that up to 45 percent of patients treated for violent injury are re-injured within five years. XI One survey of victims of violence at five years follow-up found that 20 percent had died. XII The risk of re-injury has been found to be greatest within 30 days of the initial incident. XIII
It is widely recognized among experts who serve the needs of males of color that they frequently avoid involvement with systems because these systems that are supposed to help them have often traumatized or stigmatized them. For this reason, we now recognize that extraordinary efforts are needed to engage males of color in care. This is especially important because of the many survivors of urban interpersonal violence who do not seek help in hospitals but rather suffer silently in their communities.

Many of the clients served by HHP-C have experienced multiple traumas over the course of their young lives. For many, the violent injury which brought them to the hospital is merely another accumulated blow which mounts upon significant childhood adversity, witnessing community violence, losing friends and family members to violence, ineffective schooling, housing and food insecurity and the weight of structural violence and racism. The narratives of young survivors of intentional violence are powerful because they demonstrate both the challenges and the unrecognized potential/resilience inherent in each HHP-C client despite these accumulated life stresses. HHP-C engages, enrolls and provides support to some of the most difficult to reach and engage young people, who have been repeated failed and retraumatized by the systems which are assigned to help them. The data which follow clearly demonstrate that as a voluntary program, HHP-C engages youth at a stage of readiness for change, and the program does not select those who have the greatest possibility and discard those typically regarded as “too difficult” to reach. Rather, HHP-C intentionally focuses on serving those youth with the greatest challenges, and often the greatest potential.

The goal of HHP is to engage these clients after their injury in order to help them heal from their trauma, and to focus on recovery and strength-based approaches to not only reduce symptomatology but increase positive connections, supports, and quality of life. For individuals progressing through HHP who require a higher level of care or longer term treatment to address issues of complex trauma that may emerge while working with the program, HHP serves as a “bridge” to longer term care that is trauma-informed and culturally competent.

Healing Hurt People's mission is to promote healing, reduce reinjury and stem retaliation among youth who are survivors of violence through trauma-informed practices. HHP provides trauma-informed services that are individualized, community focused, and that seek to help violently injured young people manage their lives with a focus on Safety, Emotional Management, Loss and Letting Go, and Future. The services of HHP emphasize self-determination, individual strengths, and the possibility for change and recognize the importance of the person in environment, the social determinants of health, and the need for care that recognizes the individual’s holistic needs and promotes systems collaboration. The ultimate goals are to engage survivors of interpersonal violence in HHP in order to:

- Decrease reinjury and retaliation among the population of survivors seen in these settings, most of whom are young males of color.
- Improve the healing trajectory of survivors of violence by addressing both physical and emotional responses to their violent experiences.
• Decrease the development of long-term posttraumatic stress symptoms (including PTSD), depression, sleep disturbance and other mental health consequences of violence in this population.

What HHP-C Does

HHP-C has been intentionally designed to take best advantage of its locations at Stroger, the hospital that sees the majority of Chicago’s trauma survivors, and at the new University of Chicago trauma center, which predominantly serves Chicago’s South Side. Realizing that connecting with a trauma survivor in the most trauma informed and timely manner was is essential to successfully engaging that survivor as an HHP-C client, HHP-C has a social worker embedded with the team in the Trauma Unit at Stroger who focuses specifically on those survivors who meet HHP-C’s eligibility criteria. A key goal of this focus in the days after injury is to leverage the window of opportunity that is opened in the mind of a trauma survivor when he/she comes to grips with the seriousness of the violent event. The trauma unit social worker also has the opportunity to build a rapport with the young person and establish a base of trust. As a result, from admission through discharge, the client is educated about trauma and about the potential to engage with HHP-C. While not all trauma survivors have reached a point of readiness for HHP-C, for those who are ready, the social worker in the Trauma unit is able to facilitate a meeting with a community-based TIS to achieve a “warm handoff.” This in-person introduction serves to transfer the trust that has been established in the trauma unit to the expanded set of services offered through HHP-C.

Over the 6-12 month trajectory of HHP-C participation, the TIS engages with the client in his/her community, sharing conversations about safety, healing and change as mutual concerns. In this way, HHP-C breaks the traditional and ineffective model of paternalistic caregiving because the TIS walks with the client through the healing process, which begins by helping the client meet his/her basic needs – such as medical care, education, identification, insurance, court support, behavioral health care – while progressing toward the most appropriate therapeutic intervention to meet the unique needs of each client.

To better serve victims of violence, HHP-C engages them in a trauma-informed and culturally competent manner, and provides trauma informed services. Through HHP-C, victims will also have access to culturally-responsive trauma specific therapies – such as glass-blowing through Project FIRE - to allow them to return to productive lives with their families in their communities.

Specific services that HHP-C provides are described below:

Supportive case management, mentoring, and systems navigation
Licensed Mental Health Professionals (MHPs) in Trauma Intervention Specialists positions will provide trauma-informed supportive case management, and peer support services (including family and collateral support). Case management service planning and implementation will be performed using clinical techniques such a SELF, Child Family
Traumatic Stress Intervention (CFTSI), Cognitive Behavioral Therapy (CBT) informed change strategies, and Motivational Interviewing. These techniques will help to engage clients in behavioral change while also addressing clients’ concrete case management needs. Through this process, TISs also develop relationships and build rapport with clients, which provides a natural opportunity to role model effective communication and follow-through, to present information on trauma and healing, and helps clients to understand and complete complex processes to obtain needed services and benefits. Supportive case management generally focuses on educational support, housing, legal and court, doctors and medical, afterschool, substance use, employment/training, and other levels of mental health care, as needed and willing.

**Individual therapeutic sessions**
Licensed MHPs in the Trauma Intervention Specialist position will offer clinical sessions to individuals willing to participate. These sessions will be multi-modality, and will draw from relational therapy, SELF, motivational interviewing, CFTSI, CBT-based, mindfulness and other techniques. This component of HHP-C often helps individuals who are resistant to the idea of therapy or distrustful of systems of care to develop an understanding of the benefits of therapeutic work in their lives, and aims to reduce trauma symptoms and increase coping skills and safety, while also helping bridge individuals as needed to longer term therapeutic care.

**Family and collateral therapeutic session**
Licensed MHPs in the Trauma Intervention Specialist position will offer clinical sessions to related family members and caregivers willing to participate. These sessions will be multi-modality, and will draw from relational therapy, SELF, motivational interviewing, CFTSI, CBT-based, mindfulness and other techniques. HHP-C views the family and other natural supports as key players in healing and long-term stability. As a result, HHP-C engages family and natural support as early and often as possible.

**Trauma-focused interventions**
Licensed MHPs in the Trauma Intervention Specialist position offer discrete trauma focused interventions to clients, and will provide services when they relate to a client’s goals and needs. These interventions include but are not limited to the CFTSI, CBT and Trauma Art Narrative Therapy.

**SELF groups**
SELF group emerged out of the Sanctuary Model of trauma-informed care, and focuses on issues of Safety, Emotional Management, Loss and Letting Go, and Future. These concepts are interwoven with trauma education and coping skills related to the group member’s injury as well as lifetime adversity. SELF group is offered to all clients, as clinically appropriate and as capacity permits, and meets once weekly. SELF groups are co-facilitated by a minimum of one licensed clinician (Trauma Intervention Specialist) and a co-facilitator. In some instances, SELF groups are paired with a culturally responsive healing practice of glass-blowing—Project FIRE. This partnership allows clients to learn how to blow glass
while also offering a safe place to connect with peers facing similar struggles, and providing protective, positive, safe relationships with older youth and adults.

Services are offered both in the hospital offices as well as in the home/community, determined by the client needs. This allows for flexibility to support safety concerns that may have resulted from the injury, transportation challenges, and resistance to traditional systems of care. The majority of initial visits post-discharge occur in the home/community. SELF groups will occur onsite or at Project FIRE. As needed, staff will also make visits to other institutions/systems in order to ensure continuity and coordination of care.

The duration, frequency, and intensity of services are individualized in order to provide relevant and effective treatment that spans a wide range of needs, strengths, and barriers. Average frequency of services is projected at 1-2 times a week for 1-2 hours per day for 6-12 months, with the goal of completing in 9 months. This projection reflects a combination of individual, family, and group services. Need for services will be evaluated every 3-4 months, and will include a reassessment of goals/needs as well as a re-administration of scales.

Personal goal setting/recovery planning is developed in a collaborative effort between the individual client and the Trauma Intervention Specialist. This plan is informed by clinical assessments, the client’s identified goals, and available resources. Goal setting strives to be:

- Realistic and obtainable
- Based off of the individual’s strengths, desires, and needs
- Comprehensive—covering both short term and long term needs and goals, as they relate to the client’s recovery and stability
- Holistic—taking into consideration physical, social, interpersonal, emotional and other needs
- Trauma-informed.

**Who HPP-C Serves**

HHP-C serves survivors of interpersonal violence from birth through age-30, a population with high rates of nonfatal violent injury. HHP-C service encompasses the full spectrum from offering support and psychoeducation in the hours and days following injury to ensure that the survivor is safe, to full involvement in case management, SELF groups, individual and/or family trauma specific therapy, and finally to connection to ongoing services as needed. This array of services is significant since in most trauma centers, which lack the services provided by HHP-C, these patients would receive little or no attention for their trauma and case management needs.

Since its inception, HHP-C has served more than 1000 clients. The range of services provided by HHP-C to these clients ranged from initial engagement, safety assessment and meeting basic short-term needs for some clients to full engagement with all elements of the program over a period of a year or more. This range of services is intentional, as services are tailored to the identified and prioritized needs of each client.
Most HHP-C clients have suffered an injury serious enough to bring them to a level 1 trauma center due to community violence – typically a firearm injury, but also including knife stab wounds and assaults. A study of 138 HHP-C clients under the age of 19 found that 77% suffered gunshot wounds and 9% suffered blunt trauma, 3% had been stabbed and 14% had suffered another type of injury or had witnessed violence. Ninety-six percent reported a history of prior exposure to at least 1 traumatic stressor. In addition, 57% reported a history of a prior violent injury.

In addition to their physical recovery needs, this population has high levels of need around behavioral health and case management. For example, 66% of HHP-C patients under age 19 screened positive for posttraumatic stress disorder (PTSD). This proportion of survivors with PTSD is more than four times the current PTSD prevalence among Vietnam Veterans (15.2%). These high levels of PTSD contribute to the cycle of violence including retaliation, depression, incarceration, disability, and premature death.

HHP-C clients also have significant case management needs. Data from HHP-C reveal a range of self-identified client needs at intake, many of which are likely underestimates of the actual need given under-reporting of street-involvement and criminal justice involvement.

- 29% requiring assistance with getting back into school
- 20% requiring assistance finding work
- 30% who are street-involved and/or criminal justice involved, many starting at ages as young as 11.

A typical HHP-C client has numerous life challenges, including:
- Single parent homes
- Family members incarcerated
- Family members and friends who have been murdered
- Poverty
- Un- or Under-employed
- Not in school
- Lacking Insurance
- Lacking Identification
- Homeless or living with relatives
- Food insecurity
- Multiple Adverse Childhood Experiences (ACEs)
- Street involved
- Criminal Justice involved.
With regard to violence, HHP clients have a significant burden of past injury and trauma as shown in the following table:

<table>
<thead>
<tr>
<th>Profile of HHP Clients – Trauma-Exposure (Data from 138 Patients Under 19 Identified by HHP-C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age = 15 yrs, 7 mos</td>
</tr>
<tr>
<td>• 106 (77%) Shot</td>
</tr>
<tr>
<td>• 12 (9%) Other Level 1 Trauma</td>
</tr>
<tr>
<td>• 20 (14%) Other Injury or Witnessed Only</td>
</tr>
<tr>
<td>• 96% report history of prior exposure to at least 1 traumatic stressor.</td>
</tr>
<tr>
<td>• 57% report history of prior violent injury.</td>
</tr>
<tr>
<td>• Heard Gunshots in Neighborhood</td>
</tr>
<tr>
<td>• Lost Family Member(s) or Close Friend(s) to Homicide</td>
</tr>
<tr>
<td>• Witnessed Shooting or Stabbing</td>
</tr>
<tr>
<td>• Physically Assaulted/Severe Fight(s)</td>
</tr>
<tr>
<td>• Witnessed Physical Assault(s)/Severe Fights</td>
</tr>
<tr>
<td>• Witnessed Domestic Violence</td>
</tr>
<tr>
<td>• Witnessed Homicide(s)</td>
</tr>
</tbody>
</table>

In addition to these challenges, it is well documented that the systems designed to help these young people – schools, social services, workplaces, health care systems and behavioral health systems – frequently stigmatize and retraumatize them, by blaming them for their injuries and dehumanizing them by denying their very real manifestations of traumatic stress. While community-based violence intervention and interruption programs are important, trauma-informed and culturally responsive interventions like HHP-C are distinct and critical to holding a therapeutic space where young people can heal from the multitude of traumas which have accumulated over their lives.

Data provided in May 2018 data and extracted from the HHP-C QuesGen database paints a picture of clients since the inception of the program.
**Age Distribution**
Participants in the program ranged from age 3 to age 20, with the greatest number of participants ranging between 13 and 20.

**Gender HHP Chicago**

**Gender**
While more than 80% of the participants were male, 17% were female. The impact of violence on girls and young women is often under-appreciated. Especially for girls/young women who face poverty, discrimination and unaddressed trauma, the impact of a violent injury can disrupt healthy adolescent development at a critical stage. HHP-C has been particularly effective at engaging girls/young women who are survivors of acute and chronic trauma, in part because women of color are well representing among the TIS staff. The ability of the TISs to create a space of safety allows them to address the multiple sources of trauma in the lives of these girls and young women, especially for those who may not identify as victims/survivors of violence and abuse.
**Race**
Seventy eight percent of program participants identify as black or African-American, 17% identify as Hispanic, 4% identify as white, and a very small percentage identify as either Asian, American Indian/Alaskan native, or other.

**Ethnicity**
Consistent with the previous slide (where some participants choose Hispanic ethnicity as their race), 13% of the participants identify as Hispanic when asked specifically about their ethnicity.
Mechanism of injury
With regard to mechanism of injury, 74% of participants were shot, 9% suffered an assault and 3% suffered a stab wound. For 14% of participants, no mechanism of injury was recorded in the database.

Mechanism of injury by gender
Among girls, gunshot wound was the most common mechanism of injury, affecting about three quarters of female participants while assaults affected 23% and stab wounds 3%. By comparison, almost 90% of males in the program had suffered a gunshot wound and only 8% had suffered an assault, while 4% suffered a stab wound.

In summary, these data give insights into participant characteristics during the first four years of program implementation. They do not however reflect the expanded population that HHP-C has been serving since the expansion of care to older victims at Stroger and victims at the University of Chicago trauma center.
OPPORTUNITY AND COST

A cost-benefit analysis of hospital-based violence intervention programs like HHP revealed that such programs are likely to produce savings in health care cost and social costs. Most importantly, HHP works to improve health outcomes and promote health equity. While there is a financial cost to providing services to victims of violence, it pales in comparison to the cost of not intervening. Often, without intervention, trauma festers and manifests in PTSD, depression, self-medication, physical disability, difficulty parenting. HHP intervenes in the window of vulnerability after violent injury, shifting it to a window of opportunity.

HHP DISTINGUISHING FEATURES

HHP Philadelphia has demonstrated decrease in trauma symptoms in clients that engage in and are in receipt of services compared to those who are not. Through qualitative interviews, HHP Philadelphia gleaned that clients are “grateful that someone cares.” This was a consistent theme that presented itself.

What distinguishes HHP-C from other models of violence intervention is the keen focus on addressing the young person’s trauma in the context of the larger social environment in which they live. The young people served by HHP-C have multiple reasons to hold mistrust for the systems with which they interact. Often their interactions with health care, social services, police, and school are experienced as dehumanizing and retraumatizing. For this reason, HHP-C was built on a foundation of trauma-informed, culturally responsive and client-centered practice that is designed to counteract dehumanization and engage young people who are regarded as difficult to engage. A culturally responsive approach recognizes that young people of color have a unique experience in the world not only because of their exposure to racial trauma, but because their healing is deeply connected to their communities and to their historical and cultural touch points, including music, movement, creativity and faith. The TISs recognize these ways of healing and both honor and elevate them in their shared work with the client. Because of this personal focus on young people, coupled with a fierce persistence in staying in contact with the young person, HHP-C’s trauma intervention specialists (TISs) are especially successful in winning the client’s trust.

HHP-C CLIENT FLOW

A goal of our project was also to understand how clients flowed through the program, based upon data in the QuesGen database as well as input from program leadership. The diagram below provides some insight into client flow. Based on the diagram, 577 clients were engaged who were eligible for HHP-C. Of those, 419 did not enter the program but may have received some brief assessment, psychoeducation and safety assessment. One hundred fifty-eight (158) clients entered case management. Of these, 53 remained with the program for up to three months, 25 remained for between three months and six months, 29 remained between six months and 12 months, 18 remained between 12 months and 18 months, eight remained for 18
to 24 months and 11 remained for more than 24 months. Of the 158 who entered case management, 14 remained with HHP-C after two years as peer participants. In summary 27% of those who were engaged by HHP-C entered case management, 49% of those who entered case management received less than or equal to six months, 51% received more than six months and 32% received more than a year of involvement with HHP-C.

These data speak to the power of HHP-C to engage with clients with significant trauma and high need. While there are few similar populations against which to benchmark these numbers, national data on enrollment in and completion of substance abuse treatment shows that of those in need of substance abuse treatment, only 11.2% ever enroll in treatment when offered and 31.9% complete the program. Contrast this to HHP-C, where 27.4% of those who are offered the program services enroll in case management and 51% of those who enroll remain with HHP-C for at least 6 months, the length of involvement to which the HHP-C model aspires. While substance abuse treatment populations and injured victims are different populations, they are similar in that they are voluntarily accepting help based on their readiness to engage. The fact that more than half the members of a group that is typically labeled as difficult to reach remains with the program at 6 months speaks to the value that participants derive from involvement with HHP-C.

A key quality of HHP Chicago is that it is an entirely voluntary program. Participants are not mandated by any authority to join HHP-C and because of this they represent young people with some level of readiness to receive support and to heal from their trauma. This readiness however should not be interpreted as a lack of needs, as HHP-C often provide services to young people who lack the most basic resources such as housing, identification, access to food, healthcare and health insurance.
In addition to addressing the physical and behavioral health of clients, TISs actively work to restore their social health and human dignity. Several examples of the dignity maintained by the work of the TIS include:

1. Facilitating a haircut for longtime trauma inpatient in a persistent vegetative state after a gunshot injury to the head and a removal of a portion of his skull. After many months, the haircut helped the mother see him as her son, not just as a patient in a hospital.
2. Advocating for a patient whose surgery was inappropriately delayed by the hospital, facilitating the doctor’s apology to the family.
3. Establishing homebound educational services for a client who had been denied access.
4. Working with a client who previously struggled to help him attend school full-time, work an after-school job, reconnect with his religious roots and feel hopeful for his future.
5. Supporting a client to graduate from high school early, look at colleges and explore signing up for early college courses.
6. Supporting a client to apply for and receive a full scholarship from the Posse Foundation to attend college in Georgia.

TISs also engage clients as co-presenters at Trauma-Informed Care trainings at local universities and at national conferences. One young client was encouraged to compete in the National Association for the Advancement of Colored People (NAACP) arts competition where he was awarded a silver medal. The judge at the competition told the client “You are the artist the world has been waiting for.” These are only a few important examples of the support that TISs provide to clients, many of which stretch far beyond the usual boundaries of social work practice. For this reason, TISs need significant support and trauma-informed supervision to ensure that their physical and mental health are maintained under the weight of such a high impact role.

Further probing of these data potentially with a more robust database will allow for greater understanding about why clients spend differing lengths of time with HHP-C, how that affects the “dose” of program services they receive and what potential benefits accrue from different lengths of involvement.

**How HHP Works**

HHP-C operates out of John H. Stroger, Jr. Hospital of Cook County and Comer Children’s Hospital of University of Chicago, and accepts referrals from other Level I and II Trauma Centers in the Chicago region. HHP-C also accepts referrals from specific community partners, such as physical rehabilitation centers, schools, Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) organizations, and other community-based programs serving children and young adults who have been victims of or witnessed violence in the community. The team consist of eight (8) community-based Trauma Intervention Specialists (TIS) and one TIS who works exclusively with inpatients in the Trauma Unit at Stroger Hospital. Two (2) Co-directors provide administrative leadership, fundraising and grants administration while a full-time Clinical Supervisor provides performance oversight and clinical supervision.
After a person is hospitalized for their injuries, the TIS who is based in the trauma unit reviews hospital admissions at the Emergency Departments (ED) and Trauma Units (TU) and identifies those clients who are appropriate for HHP-C. This TIS establishes a rapport with the client and tells them about HHP-C. If the client is interested, the hospital-based TIS connects them to a community-based TIS for further care (Corbin, T, J, et al., 2011). Ideally this engagement happens at bedside with patients as a “warm handoff” since maintaining a chain of trust is key to ongoing client engagement and follow-through. However, in some cases, patients are reached by follow-up after they have been discharged, particularly if they were mainly treated in the ED and not admitted to the TU. These clients are assigned directly to community-based TISs by the HHP-C Co-director and Clinical Supervisor.

The services’ duration ranges from a single session to several years, depending on each client's level of need and motivation to engage in our services. Nevertheless, HHP-C aims for clients to achieve their goals, and complete the program, at an average of 6-9 months (Corbin, T, J, et al., 2011).

HHP-C’s overarching framework is trauma informed-care (TIC), which states that past and present exposure to potentially traumatic events (PTEs) can have a wide array of negative consequences on our mental (Post Traumatic Stress Disorder (PTSD), acute stress disorder (ASD) and traumatic stress symptoms (TSS), i.e., depression, anxiety, complicated or traumatic grief); and physical (obesity, heart related issues, etc.) health (Corbin, T, J, et al, 2011). Consequently, HHP-C trains its staff in trauma assessment (of both exposure and symptomatology) and trauma-specific interventions such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Child Family Traumatic Stress Intervention (CFTSI). Further, since the majority of its participants are African American and Latinx, HHP-C uses a racial-trauma lens in the provision of its services. This includes the discussion of the impact of racial trauma on the lives of our participants and creates safe and affirming spaces in which youth can voice the pain, helplessness and rage that can result from ongoing exposure to racism.

TISs represent the key point of engagement for HHP-C. All TISs are trained mental health professionals who have experience working in communities where violence and trauma are prevalent health problems. Most come to this work with a deep sense of social justice, and an understanding of the structural barriers faced by clients. In addition, they share the conviction that trauma is at the center of the cycle of violence and that healing is possible for the young people who find themselves injured by violence.
The work of the TIS evolves over the four phases of HHP-C. Throughout each phase, each TIS is working assertively to engage the client and to build on the power of the warm handoff where they were able to make a positive connection with the client around the time of the injury. Throughout the work of the TIS, each is working to establish a rapport and to build trust with the prospective client. The vast majority of this work of building trust occurs in the community where the TIS is engaging with the client at home or at safe and trusted locations in the community. The TIS focuses on the strengths and supports that the client identifies, and these become a focus of the shared work between the client and TIS to establish a set of goals to be accomplished over the course of involvement with HHP-C.

**Phase 1: Screening/Engagement**

During this phase, HHP-C TISs assertively recruit new clients for the program, both by visiting individuals while in the hospital and by extensive outreach and engagement over the phone via voice call and/or text message. Once HHP-C has made a successful contact with potential client either in-person or via the phone, the individual is considered to be in the Screening/Engagement phase. Once the TIS establishes that the client is eligible for HHP-C services and is interested in learning more, the TIS schedules an in-person meeting in the office or the client’s home to provide continued trauma education and more detailed information about services offered. As the engagement phase continues (up to approximately 30 days) the TIS gathers information about the client’s strengths and challenges, and helps to build resources to meet the client’s most immediate needs. A main focus of the TIS’s work in the engagement phase is to begin building a rapport and a trusting relationship. Additionally, TISs work to identify acute needs, provide education about possible symptoms of posttraumatic stress, and discuss
coping strategies to help clients understand, manage, and heal from the impacts of trauma in their lives.

**Phase 2: Active Involvement**
When a client is ready to agree to active involvement in the program (within the first 1-30 days of meeting), the TIS sits with the client to complete a consent to treatment/agreement, which lays out rights/responsibilities that the TIS and the client (and in the case of a client under the age of 18, their legal guardian) will agree to over the course of the client’s time in HHP-C. Once this consent to treatment is signed, the TIS schedules an appointment to complete the comprehensive intake. At this point, the client moves to the Active Involvement Phase.

The intake completed by the TIS is designed to provide a clear assessment of the client’s challenges and strengths with a focus on the traumatic symptoms that persist after the most recent trauma. This intake is trauma-focused and involves extensive history gathering, established scales to assess trauma symptoms (CTSQ, PCL-5) and depressive symptoms (SMFQ, PHQ9). In addition, information is gathered about exposure to community violence and lifelong trauma history (ACEs) to better understand the sustained traumatic stress that preceded the most recent acute injury, but which has exerted and may continue to exert stress on the client.

During this process, the TIS and client work together to craft a trauma-informed needs recovery plan/personal goal plan. Throughout this phase, the TIS provides support for the client’s trauma recovery goals using appropriate therapeutic interventions including SELF groups, individual sessions, as well as supportive case management designed to address concrete needs, barriers to treatment, and readiness for longer term treatment as needed. The active involvement phase lasts from 1 to 3 months (approximately days 31-120) and is guided by individual needs. Service planning addresses critical concrete needs/goals, as identified in full partnership with the client and family, and is individualized based on need.

**Phase 3: Stabilization/Step Down**
Throughout Phase 3, the TIS continues to provide support and early re-intervention for trauma using appropriate therapeutic interventions including SELF groups, individual sessions, as well as supportive case management designed to address concrete needs, barriers to treatment, and readiness for longer term treatment as needed. The stabilization and step-down phase of the program is considered to be approximately 2 months (days 121-180) of care, but is guided by individual clinical needs. This phase is similar to phase 2, but with a goal of increasing clients’ mastery of skills, stabilization and progress in goals identified.

**Phase 4: Discharge**
In Phase 4, the TIS provides discharge planning and long-term care planning. This includes connection to trauma informed community-based resources, long term goal setting and long-term safety planning.
CORE ELEMENTS TO HHP-C IMPACT

In addition to the work described above, a number of additional elements are core to HHP-C’s impact. Because of the stressful and demanding nature of the work that the TISs do in the community, they need ongoing and available clinical support and supervision. This is provided by the clinical supervisor in regular sessions and in as-needed consultations. The Clinical Supervisor is keenly aware of the need to not only provide individual supervision but to create a culture at HHP-C where the TISs are able to support one another in a trauma informed way. Practically this means that each TIS develops an awareness of how the trauma in their clients may trigger or reanimate their own past traumas. The Clinical Supervisor guides the TIS to establish reasonable boundaries that recognize the unique historical and structural challenges that clients face while also maintaining clearly-articulated standards of integrity. For example, each TIS - indeed every member of the staff - has a personalized Safety Plan which identifies ways to stay physically, psychologically, socially and morally safe while doing the difficult work that often takes place in communities which themselves have been marked by violence and trauma.

HHP-C also acknowledges that clients come from communities and families with strong cultural traditions which are sustaining, uplifting and critical for healing. The staff is able to acknowledge that in addition to clinical interventions, community-based interventions that incorporate cultural strengths are critical, such as using one's hands to create art, creating music, movement and physical activity, spirituality and creating narrative through writing or through spoken word. One such example is Project FIRE which invites clients to enter a glass studio owned by a glass artist who is deeply committed to community. Many of HHP-C’s clients have never been exposed to a glass studio and are intrigued by and drawn to the somewhat risky undertaking of manipulating molten glass. Encountering a new environment where young people are encouraged to work as a team both to create beautiful art, but also remain safe, is a deeply healing environment. Project FIRE allows clients to learn new skills and to learn to trust other young people who have a shared experience of trauma. In addition, the work of glassblowing, and many of the other culturally responsive healing methods mentioned above, is also focused on healing from trauma. The work of handling molten glass at a temperature of up to 1200°F requires deep focus and careful movement in the service of creating an object of beauty. When this is carried out in the presence of support and social safety, it mirrors other well-established approaches to treating trauma which utilize focused attention (as opposed to mind clearing meditation or prolonged exposure to the most recent trauma). In addition, HHP-C clients who participate in Project FIRE have the opportunity to sell their glasswork and achieve modest income. The Project FIRE sessions are linked to a mandatory psychoeducational group built on the SELF model and so clients go from this focused creative activity to a peer-led discussion of safety, emotional management, letting go of the past and creating a future.

More generally for HHP-C, being culturally responsive recognizes the vast diversity and intersecting identities of the clients that are served. HHP-C clients are diverse in gender, age, race, ethnicity, sexual identity, disability status and gender identity. In addition, clients may identify closely with street culture or may be emerging from long-term placement in foster care where family connections are defined differently. In order to best serve the needs of the client
population, HHP-C has worked to ensure that staff not only reflect the diversity of our clients, but that they are constantly supported in understanding the impact of structural violence including racial trauma, homophobia, transphobia, xenophobia, ableism and various forms of privilege as they play out in their own lives and the lives of clients.

These are but examples of core elements of HHP-C that are embedded in, with and under the phases described above. In addition to the critical resources needed to hire training and sustain a bold and effective workforce, the ongoing success of HHP-C also requires investment in the infrastructure needed to support and develop frontline staff, engage and equip current and former clients to serve as peer leaders, and support to critical partnerships that provide culturally responsive healing as well as opportunities for youth to succeed through housing, education and job development.

**Journey Mapping: Detailing How HHP-C works**

To better understand points of interaction between HHP-C staff and clients we used a human centered design tool known as a Journey Map as a way of detailing the process of care from the perspective of those who are actually delivering the care as described by Liedtka and Ogilvie in Designing for Growth: A Design Thinking Toolkit for Managers.

Journey mapping is the representation, in a flowchart or other graphic format, of the customer's experience as he or she interacts with your company in receiving its product or service. These maps can depict the customer's actual or ideal journey. Either way, plotting its stages forces you to focus on your customers, rather than on your organization. As you map their journey, you’re walking a mile in their shoes. Along the way, you are looking for the emotional highs and lows and the meaning that the experience holds for the customer. Ogilvie, Tim; Liedtka, Jeanne. Designing for Growth: A Design Thinking Toolkit for Managers (Columbia Business School Publishing). Columbia University Press.

We also find that journey mapping is a valuable tool in laying out processes of care for HHP-C clinical staff. Doing so allows us to understand how staff are constantly designing and redesigning their processes to meet the needs of clients. By intentionally hearing about their processes and the emotional states associated with them, we have the opportunity to identify challenges and opportunities in the client journey. In this case, we did not have direct access to clients for confidentiality reasons. Even without direct conversations with program participants, journey mapping is helpful in capturing both the staff experience and client experience, in this case through the eyes of the TIS/social worker staff. Journey mapping is recognized as a reliable human centered design tool that allows us to identify an experience from the perspective of those who are engaged in it. Journey mapping can help us identify workarounds, which are often opportunities for innovation. Journey mapping also helps us understand whether there are particular high points or low points, sometimes called pain points, in the client experience which should be the focus of quality improvement and innovation activities. Finally, by identifying the emotional state that is associated with each of the steps in the process, we have an opportunity