



# TRANSFORMATIVE GUIDANCE

ON VICTIM SERVICES FUNDING  
FOR HOSPITAL-BASED VIOLENCE  
INTERVENTION PROGRAMS



THE  
HEALTH ALLIANCE  
*for* VIOLENCE  
INTERVENTION



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*This product was produced by The Health Alliance for Violence Intervention and was supported by grant number 2018-V3-GX-K039 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.*

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# EXECUTIVE SUMMARY

The United States faces an urgent crisis of violent victimization, with many cities facing high rates of community violence.<sup>1</sup> Homicide, including gun homicide, is concentrated in cities and particularly within racially segregated, economically disadvantaged neighborhoods.<sup>2</sup> Nonfatal violent injuries are over 100 times more frequent than homicide, and repeat victimization is common.<sup>3</sup> In 2019, hospitals across the country treated an estimated 1.4 million incidents of violent assault.<sup>4</sup> Victims of violence face not only physical injuries but also psychological and emotional disturbances associated with post-traumatic stress disorder, depression, and substance use disorder.<sup>5</sup> Homicide accounts for \$280 billion in costs to taxpayers, survivors, families, employers, and communities.<sup>6</sup>



## HVIPS CAN TRANSFORM HEALTH CARE APPROACHES TO COMMUNITY VIOLENCE AND SAVE LIVES.

Hospital-based violence intervention programs (HVIPs) have emerged as an important public health response to the problem of community violence. These programs combine the efforts of medical staff and community-based service providers to intervene with victims of violence in hospital settings, connect them with community-based victim services, and reduce future victimization and violent behaviors.<sup>7</sup> Research has shown that HVIPs are effective at reducing repeat victimization, reducing criminal justice involvement, and reducing health care and other costs associated with violence.<sup>8</sup> HVIPs also address practical realities common to many victims of crime, such as disparities in access to health care, transportation, case management, and a range of social determinants of health.

Victims of Crime Act of 1984 (VOCA) victim assistance funds can play a crucial role in enhancing support for victims of community violence—and other crimes—by partnering with HVIPs. This toolkit provides information and resources to VOCA state administrators and other practitioners seeking to support HVIPs. With support from the Office for Victims of Crime (OVC), the Health Alliance for Violence Intervention (HAVI) gathered lessons from the field, worked with national victim services groups, and interviewed VOCA administrators and grant managers. Based on this research, the HAVI outlines tools for VOCA administrators to support HVIPs in the following ways:

- Take actions to expand access to services for victims of violence who are not currently served.
  - Commit to a more cohesive, victim-centered, and integrated health-systems approach to violence.
  - Play a key role in transforming health systems to serve victims of violence, modeling leadership on racial equity, and stewarding the resources that belong to communities.
  - Promote gold-standard HVIPs that:
    - > use a trauma-informed, healing-centered approach;
    - > support staff power and resiliency for a healthy workplace;
    - > build strong, equitable, and mutually beneficial community partnerships;
    - > integrate lived experience and survivor leadership;
    - > address different forms of violence and social determinants of health;
    - > advocate for equitable policies that benefit patients and staff.
  - Use recent expansions under the 2016 rule change and the 2021 VOCA Fix to better direct VOCA funding to services for victims of community violence.
  - Work directly with communities of color and other underserved communities to increase health equity in funding for HVIP services.
  - Track progress and address challenges.
- With dedicated VOCA administrators and local practitioners, HVIPs can transform health care approaches to community violence and save lives.

# ACKNOWLEDGMENTS

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October 2021

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INTERVENTION**

# INTRODUCTION

The United States faces an urgent crisis of violent victimization. In particular, many U.S. cities struggle with high rates of community violence, or “violence between individuals who are unrelated, and who may or may not know each other, generally taking place outside the home,” as the World Health Organization defines it.<sup>9</sup> This can include fights among gangs and other groups, shootings on streets or at schools, and cycles of violent conflict in neighborhoods.<sup>10</sup>

Homicide and nonfatal injury are among the most pervasive and damaging types of community violence. In 2019, over 16,000 Americans died from homicide.<sup>11</sup> Over 14,400 homicides annually result from guns.<sup>12</sup> Homicide of all kinds, including gun homicide, is concentrated in cities and particularly within racially segregated, economically disadvantaged neighborhoods,<sup>13</sup> where it is the leading cause of death for young Black men and the second leading cause of death for young Latino men.<sup>14</sup> These figures do not account for nonfatal violent injuries, which are over 100 times more frequent than homicide. In 2019, hospitals across the country treated an estimated 1.4 million incidents of violent assault.<sup>15</sup>

Many victims of community violence suffer from repeat victimization. In urban settings, researchers estimate that up to 41 percent of patients treated for violent injury are reinjured within five years.<sup>16</sup> A survey of victims of violence found that 30–40 percent of patients had died by the time of a five-year follow-up contact.<sup>17</sup> This “revolving door” phenomenon of violent victimization is well-documented in the medical literature and has posed major challenges for those in the health care and victim services professions. Victims of violence face not only physical injuries but also psychological and emotional disturbances associated with post-traumatic stress disorder (PTSD), depression, and substance use disorder.<sup>18</sup> An estimated 28 to 45 percent of victims of crime suffer from PTSD, a condition that can cause lasting physical and mental health challenges including fear, hypervigilance, and emotional detachment.<sup>19</sup>

Beyond its effects on victims and their communities, homicide and violent injury present a tremendous cost burden to taxpayers, the health care system, and society at large. Homicide accounts for \$280 billion in costs

MANY VICTIMS OF COMMUNITY VIOLENCE SUFFER FROM REPEAT VICTIMIZATION... 30–40 PERCENT OF PATIENTS HAD DIED BY THE TIME OF A FIVE-YEAR FOLLOW-UP CONTACT.<sup>17</sup>

AN ESTIMATED 28–45 PERCENT OF VICTIMS OF CRIME SUFFER FROM PTSD.<sup>19</sup>

to taxpayers, survivors, families, employers, and communities.<sup>20</sup> The average cost of medical care for an incident of nonfatal violent injury that requires hospitalization is approximately \$29,200.<sup>21</sup>

Because community violence is a public health problem, it demands health care approaches to victim services. Hospital-based violence intervention programs (HVIPs) have emerged as an important public health response to the problem of community violence. Recognizing that hospitals are essential resources for violence reduction, these programs combine the efforts of medical staff and community-based service providers to intervene with victims of violence in hospital settings, connect them with community-based victim services, and reduce future victimization and violent behaviors.<sup>22</sup>

In the mid-1990s, two organizations—Youth ALIVE! in Oakland, California, and Project Ujima at Children’s Hospital of Wisconsin in Milwaukee—developed the nation’s first HVIPs. By 2021, a robust network of 41 established HVIPs had formed, and over 40 other cities had new programs in development. Research has shown that HVIPs are effective at reducing repeat victimization, reducing criminal justice involvement, and reducing health care and other costs associated with violence.<sup>23</sup> (For more on the effectiveness of HVIPs, see “Lead victim services with a public health approach” on p. 12). The model has been supported by the American Society of Pediatrics,<sup>24</sup> the American Hospital Association,<sup>25</sup> the American College of Surgeons,<sup>26</sup> and the U.S. Department of Justice’s Office for Victims of Crime (OVC).<sup>27</sup>

The Crime Victims Fund, established by the Victims of Crime Act of 1984 (VOCA) and administered by OVC, can play a crucial role in enhancing support for victims of community violence and other crimes. Financed by the collection of federal crime fines, forfeitures, and special assessments rather than taxpayer dollars,<sup>28</sup> the fund is a key method for equitably distributing money recovered as restitution for harm to communities. State VOCA administrators are the conduit that ensures this funding is used to serve the populations and communities that need it most. By supporting HVIPs, VOCA administrators move away from narrow funding streams and toward programs that are dynamic and adaptive. Because HVIPs serve a population that disproportionately experiences polyvictimization—meaning they are victims of





multiple and various types of crime, often including domestic and sexual violence<sup>29</sup>—these programs address several VOCA priorities at once. They also address practical realities common to many victims of crime, including disparities in access to health care, transportation, case management, and a range of social determinants of health. In short, funding HVIPs means funding health equity work broadly rather than simply focusing on community violence.

This toolkit is designed to provide information and resources to VOCA administrators and other practitioners seeking to enhance health care approaches to victim services for survivors of community violence. To produce this document, the Health Alliance for Violence Intervention (HAVI), with support from OVC, gathered lessons from its experience providing technical assistance to HVIPs nationally; worked with leaders from groups such as Cure Violence, UC San Francisco Trauma Recovery Center, and Futures Without Violence; and interviewed VOCA administrators and federal and state grant managers. This toolkit provides background information and transformative guidance on enhancing health care approaches to community violence; defines excellence in HVIPs; identifies the role of VOCA in achieving excellence; and outlines a vision for the future. It seeks to broaden the scope of VOCA's current programs and help administrators effectively reach more underserved victims of community violence and other crimes.

While this toolkit was being developed, the country began to experience the effects of Covid-19. The pandemic had negative impacts on social determinants of health nationwide, placing additional strain on survivors of violence and victim services providers, particularly in disadvantaged communities of color. The period of the pandemic also saw a sharp rise in gun homicides and nonfatal shootings in many urban areas.<sup>30</sup> Meanwhile, social distancing restrictions made it more difficult for frontline workers to provide victim services in hospital settings, which were hotbeds of infection.

It will take the nation years to recover from the deep impacts of the pandemic, and addressing increases in violence and racial disparities in health will be an important part of that recovery. These conditions make the services that HVIPs provide more important than ever.

THIS TOOLKIT IS DESIGNED TO PROVIDE INFORMATION AND RESOURCES TO VOCA ADMINISTRATORS AND OTHER PRACTITIONERS SEEKING TO ENHANCE HEALTH CARE APPROACHES TO VICTIM SERVICES FOR SURVIVORS OF COMMUNITY VIOLENCE.

# HEALTH CARE APPROACHES TO VICTIM SERVICES

Using health care approaches to victim services is crucial to addressing the crisis of community violence. Focused actions by VOCA administrators can help expand access to services for those not currently served, provide access for people not covered through victim compensation, and address the disparities between crime victim reporting from law enforcement and health systems. Many VOCA administrators have already made a commitment to work toward a more cohesive, victim-centered, and integrated health systems approach to violence, but the potential for further change is still great. The following outlines the evidence that supports using these approaches.

WORKING TOWARD A MORE COHESIVE,  
VICTIM-CENTERED, AND INTEGRATED HEALTH  
SYSTEMS APPROACH TO VIOLENCE.



## CONSIDER THE LANDSCAPE OF VICTIM SERVICES

Nationally, research shows that although young men of color disproportionately suffer the effects of crime and violence, they often do not get the help they need. Cultural norms around masculinity and victimization mean that many young men of color are reluctant to identify themselves as “victims.”<sup>31</sup> Even when they do report experiencing harm, few victim services exist for the kinds of crimes they face, such as robbery, and those services that exist are often not culturally specific.<sup>32</sup> Data on service uptake reflects this reality: 91 percent of all victims of assault and 92 percent of victims of robbery receive no assistance from victim services agencies.<sup>33</sup> Similarly, despite the psychological trauma of violent injury, many victims of violence do not receive mental health services<sup>34</sup> because of barriers such as perceived stigma about mental illness, distrust of mental health professionals, lack of knowledge about where and how to receive care, cost-prohibitiveness of care, and difficulties obtaining victim compensation to cover the cost.<sup>35</sup>

Research on HVIPs shows that victims of violence served by these programs require a wide range of services beyond traditional medical care. For example, a ten-year review of the San Francisco Wraparound Project shows that 51 percent of patients need culturally appropriate mental health services; 48 percent need victims-of-crime assistance; 36 percent need employment; 30 percent need housing; and 28 percent need education.<sup>36</sup> A study of Philadelphia’s Healing Hurt People program identified a need for PTSD treatment in 75 percent of participants, as well as Adverse Childhood Experiences scores indicating high risk for chronic illness in 50 percent of participants.<sup>37</sup>

VOCA administrators should consider the current landscape of victim services in their jurisdictions, noting what is currently available, barriers to access, and challenges of the current paradigm. Importantly, updates to VOCA in its 2016 Final Rule remove previous prohibitions on VOCA-funded organizations providing rehabilitation and counseling services to victims who are incarcerated or have previous involvement with the criminal justice system, “as the prohibition unnecessarily prevents states and communities from fully leveraging all available resources to provide services to these victims, who have been shown to have a great need for such services.”<sup>38</sup> More recently, Congress passed the VOCA Fix to Sustain the Crime Victims Fund Act of 2021, which is likely to provide more money to VOCA state administering agencies and more flexibility to VOCA administrators in their funding decisions.<sup>39</sup> These developments dramatically widen the array of organizations, services, and clients that VOCA administrators can fund.

Interviews with VOCA practitioners suggest that while VOCA requires states to devote 10 percent of funding to victim services for underserved populations, these funds do not typically prioritize racial equity specifically. VOCA administrators can address this using tools such as needs assessments, asset maps, and surveys. For example, the Massachusetts Office for Victim Assistance plans to conduct a needs assessment with a goal of determining the needs of underserved communities, the services that are available, and ways to direct funding to services the agency is currently missing.<sup>40</sup>



*“One of the key benefits of implementing HVIPs is that you’re capturing a population that you’re not going to see anywhere else, particularly with community violence.... It’s a really unique opportunity to see victims of violence who are often falling through the cracks.”*

ANYA SHAFFER  
VOCA Administrator,  
Virginia Department of Criminal  
Justice Services





# BENEFITS OF HVIPS

## RESEARCH SHOWS THAT HVIPS:

- Save lives and reduce future violent injuries.
- Reduce future criminal justice contact and involvement in violent crime.
- Reduce hospital expenses.
- Connect uninsured patients with Medicaid, SSI, and VOCA programs.
- Help nonprofit hospitals meet community benefit requirements.

More detailed evidence for the effectiveness of HVIPs is available in *Hospital-based Violence Intervention: Practices and Policies to End the Cycle of Violence*, by the HAVI.

## LEAD VICTIM SERVICES WITH A PUBLIC HEALTH APPROACH

Public health service providers and health care professionals are a critical point of connection and intervention. While hospitals have a history of building systems to serve victims of intimate partner violence and sexual assault, systems to serve victims of community violence are less common. Health care practitioners can lead efforts for structural change to deliver important services to victims of community violence—especially boys and men of color—by implementing HVIPs.

HVIPs are an effective approach to reducing violent injury, research shows. Victims of violence who receive HVIP services are significantly less likely to report being victimized again during the six months following their hospital treatment.<sup>41</sup> One study of an HVIP in Chicago showed that only 8 percent reported reinjury compared with 20 percent of victims who did not receive services.<sup>42</sup> Another study of an HVIP in Baltimore showed that 5 percent of participants were rehospitalized compared with 36 percent of victims who did not receive services.<sup>43</sup>

Research has also shown HVIPs to reduce future criminal justice involvement. A study of ten- to fifteen-year-old youth treated for assault in the emergency department in two urban areas found that HVIPs reduced misdemeanor offenses over a six month period.<sup>44</sup> Another study of older, predominantly African American men with a history of previous violent

injury found that those who were randomized to HVIP services were half as likely to be convicted of any crime, four times less likely to be convicted of a violent crime, and six times less likely to be hospitalized for violent injury as those not treated.<sup>45</sup> An HVIP in Oakland was found to significantly reduce risk of involvement with the criminal justice system.<sup>46</sup>

Finally, because HVIPs improve the well-being of violently injured people in multiple ways, they offer significant cost savings for the health care and criminal justice systems. A study of an HVIP in San Francisco found that programs are cost-effective at a scale of approximately 100 young adult patients annually, generating twenty-four quality-adjusted life years (QALY) and producing hospital savings of \$4,100.<sup>47</sup> In Oakland, a study found that HVIPs can achieve one QALY per \$2,941, a far lower figure than accepted values for effective public health interventions for other diseases.<sup>48</sup> The previously cited study of older, predominantly African American men found that HVIP services prevented approximately \$1.25 million in incarceration costs.<sup>49</sup> Economic modeling has also shown that HVIPs have the potential to save money for insurers of high-risk patient populations, including, according to a 2014 study, a savings of approximately \$69 million to the Medicaid program if HVIP services were provided to all violently injured hospitalized patients under the Affordable Care Act.<sup>50</sup>

## EMPHASIZE VOCA ADMINISTRATORS' ROLE IN TRANSFORMATION

VOCA administrators can play a key role in transforming health systems to serve victims of violence, modeling leadership on racial equity, and stewarding the resources that belong to communities. Interviews with VOCA administrators revealed that they are practiced in supporting the implementation of programs to address intimate partner violence and sexual assault, such as Sexual Assault Nurse Examiner programs. However, VOCA administrators could do more to focus on community violence and address racial equity in access to services. Using the evidence for the effectiveness of health care approaches to victims of violence, VOCA administrators can advocate for state support of HVIPs and other health care approaches.

Several states have made commitments through their VOCA offices to fund health services for victims of violence through HVIPs. New Jersey awarded \$20 million in VOCA funding to nine HVIPs, the largest ever VOCA grant for such programs.<sup>51</sup> In Virginia, the Department of Criminal Justice Services awarded \$2.45 million in VOCA funding to the Virginia Hospital and Health care Association Foundation to coordinate the implementation of seven HVIPs across the state.<sup>52</sup> (For more information on statewide support for HVIPs, see Section IV, *The Role of VOCA in Achieving Excellence*, p. 25.)

Other states have used statewide grant programs separate from VOCA to enhance victim services. The California Violence Intervention and Prevention grant program set aside \$200 million in funding for awards to cities and community-based organizations to support evidence-based violence reduction initiatives, including HVIPs, specifically to address people at high risk of homicide, shootings, and assaults.<sup>53</sup> Maryland passed a bill in 2018 to establish the Violence Intervention and Prevention Program, which in part supports HVIPs.<sup>54</sup>

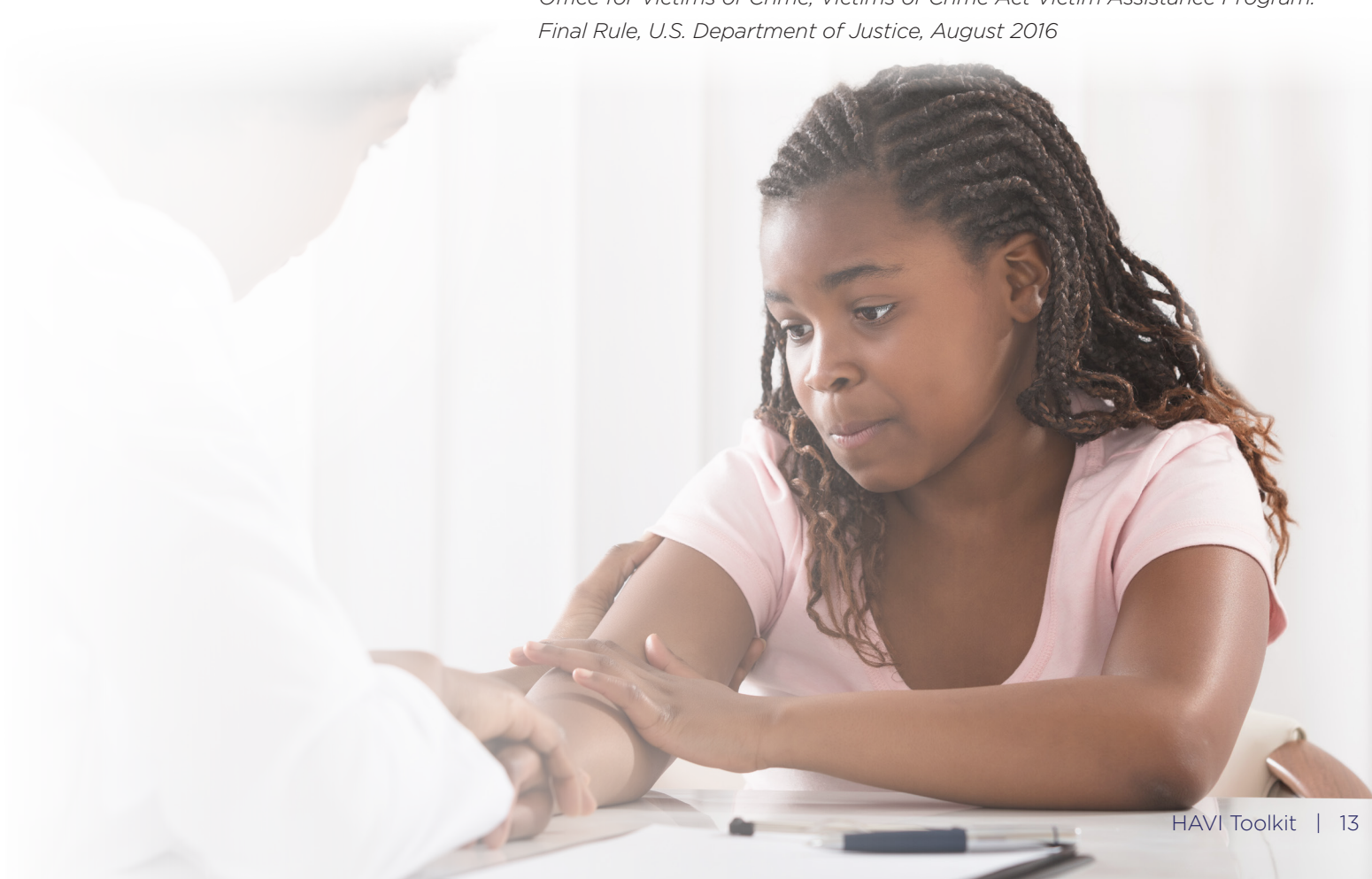
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### Further Readings

*Everytown for Gun Safety (2020), A Fund for Healing: VOCA Grants for Violence Reduction*

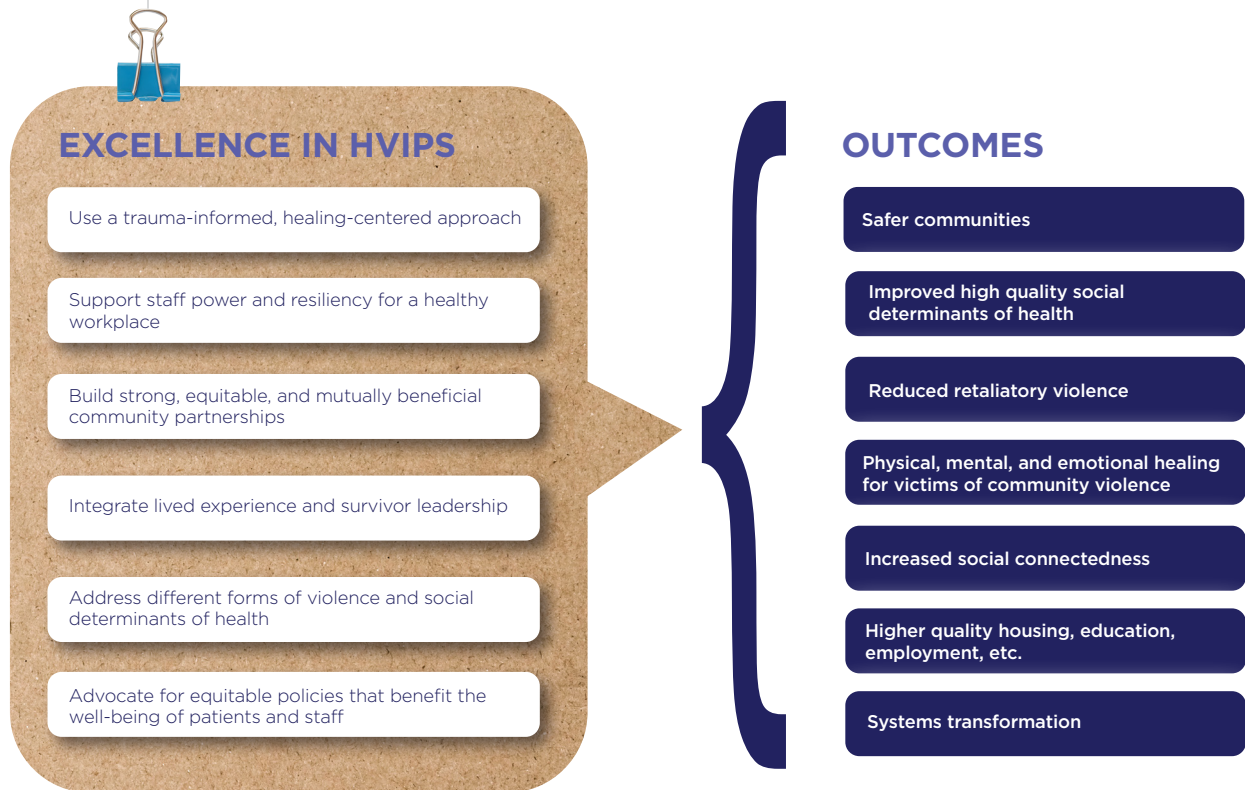
*Office for Victims of Crime (2013), Vision 21: Transforming Victim Services*

*Office for Victims of Crime, Victims of Crime Act Victim Assistance Program: Final Rule, U.S. Department of Justice, August 2016*



# EXCELLENCE IN HOSPITAL-BASED VIOLENCE INTERVENTION PROGRAMS

The best and most effective hospital-based victim services programs share several values and actions. Research and practical experience show that they should use a trauma-informed, healing-centered approach; support staff power and resiliency for a healthy workplace; build strong, equitable, and mutually beneficial community partnerships; integrate lived experience and survivor leadership; address different forms of violence and social determinants of health; and advocate for equitable policies that benefit the well-being of patients and staff. VOCA administrators and hospital stakeholders can help to identify and support gold-standard programs using the following blueprint and tools. When VOCA administrators are seeking to fund HVIPs and other hospital-based victim services programs, they should ensure that they possess these qualities.



## Use a Trauma-informed, Healing-centered Approach

Trauma-informed care is an approach that direct service providers can use to support healing with individual patients, and that institutional leadership can use as a framework to create organizational structures that support staff and patients. Given the prevalence of trauma among victims of community violence, it is a crucial element of any hospital-based victim services program.

Exposure to traumatic events has been shown to have long-term effects on health, including impaired neurodevelopment, weakened immune systems responses, and later health-risk behaviors that can result in chronic physical or behavioral health disorders. However, victims of violence can overcome the effects of trauma, and the way providers deliver treatment has implications for their patients' physical, mental, and emotional well-being.<sup>55</sup>

A trauma-informed approach encourages providers to support and treat patients holistically, rather than focus on treating particular symptoms or behaviors. The Substance Abuse and Mental Health Services Administration identifies six key principles of a trauma-informed approach: (1) safety; (2) trustworthiness and transparency; (3) peer support; (4) collaboration and mutuality; (5) empowerment, voice, and choice; and (6) cultural, historical, and gender issues.<sup>56</sup>

In the context of HVIPs and other hospital-based victim services programs, it is important to structure the organization around these principles. Program leadership should invest in and educate staff on trauma-informed care; draft written policies that make it part of organizational practice; work to create environments that are physically and emotionally safe for patients and staff; employ trauma screening and assessment for patients; and engage survivors of trauma, such as violence prevention professionals and other peers, in making key decisions and evaluating impact of efforts. Clinicians and violence prevention professionals should also use the principles of trauma-informed care when providing direct service to patients, as many HVIPs currently do.<sup>57</sup> This includes recognizing that many patients have long histories of trauma, providing them with education about the symptoms of post-traumatic stress, and connecting them with mental health services that meet their needs. Trauma-informed care acknowledges the ways that a history of trauma affects behaviors. When a patient is not engaging with a clinician as expected, a provider with training in trauma-informed care will seek to understand what has happened to them (versus trying to define what is wrong with them) and how the provider can help them feel safe.

In using a trauma-informed approach, providers should also consider the principles of healing-centered engagement.<sup>58</sup> This more recently developed approach addresses trauma from a strength-based perspective rather than a deficit-based one, views trauma treatment as a partnership with the client rather than a procedure carried out by an expert, employs culturally grounded practices, and acknowledges political and social structures that replicate harm.



## TRAINING OPPORTUNITY

The HAVI offers web-based and in-person training modules on trauma-informed care to provide HVIP staff with concrete skills, a common language, a framework to meet client needs, and guidance on impact evaluation. **More information is available at the HAVI website.**



Several victim services providers demonstrate how practitioners can use a trauma-informed, healing-centered approach. At-Risk Intervention and Mentoring (AIM) is an HVIP at Denver Health Medical Center in Colorado that provides trauma-informed support and victim services to over 200 youth during and after their hospital stays.<sup>59</sup> The program has also received training from the National Compadres Network on its El Joven Noble curriculum, a youth leadership program based on indigenous practices that uses trauma-informed principles and guides youth away from gang violence. Following the training, AIM conducts weekly healing circles with patients and providers in the hospital.<sup>60</sup> Brigham and Women's Hospital, in Boston, Massachusetts, is developing trauma-informed care plans—similar to its acute care plan—under which clinicians work closely with patients to determine what they want and need in their care. Patient preferences, such as, “I don't want to be touched without being told it will happen,” will be included in their electronic medical records. Other Boston hospitals, including Boston Medical Center and Beth Israel Lahey Health, have developed projects to advance trauma-informed care, such as system-wide trainings and simulation labs where clinicians can practice providing trauma-informed care to patients who present with gunshot wounds.<sup>61</sup>

## HELPFUL TOOLS

The National Child Traumatic Stress Network created the Trauma Informed Organizational Assessment as a tool to help organizations evaluate how effectively their practices serve children and families who have experienced trauma and drive organizational change to incorporate trauma-informed approaches. More information is **available at the organization's website.**

*“The Characteristics of White Supremacy Culture,”* from *Dismantling Racism: A Workbook for Social Change Groups*, by Kenneth Jones and Tema Okun, provides guidance for organizations seeking antidotes to the features of white supremacy that pervade many workplaces.





## Support Staff Power and Resiliency for a Healthy Workplace

HVIPs create a safe and healthy workplace by supporting staff power and resiliency. Programs should conduct pay-equity reviews, make living wage commitments, support a work-life balance, and implement flexible work policies. They should be transparent workplaces where decision-making processes are shared and supervisors demonstrate trust of their employees. Programs should also ensure that they include paths for promotion and career development. Importantly, because these programs focus explicitly on violence in disadvantaged communities of color, and often employ workers who come from those communities themselves, they should implement processes for addressing harm and oppression, both structural and interpersonal, within the workplace. They should also address the vicarious trauma that workers may experience as a result of working with victims of violence and their families. Organizations should build self-care practices for staff into their policies and procedures, so that it does not fall to staff to manage on their own. The Office for Victims of Crime has created guidance for hospitals and organizations seeking to improve their policies for addressing vicarious trauma.

Most HVIPs and other victim services programs do not currently possess a comprehensive framework that meets each of these needs. However, some cities, institutions, and individual organizations have implemented measures to support frontline staff. At the institutional level, the HAVI's Violence Prevention Professional certification curriculum provides training on a standard set of competencies for frontline violence intervention workers—an effort to professionalize and validate the field, and thereby build equity for the diverse set of professionals who work in it.<sup>62</sup>

In Los Angeles, violence intervention groups have come together in coalition to call for greater municipal funding that would provide living wages for their work.<sup>63</sup> Individual HVIPs also make efforts to support the frontline workers they employ. DLIVE, an HVIP located at Detroit Medical Center, employs mental health counselors for staff. Youth ALIVE! provides mental health days for staff,<sup>64</sup> while the RYSE Center, which serves disadvantaged youth in Richmond, California, has created healing spaces for staff. Meanwhile, Children's Hospital of Wisconsin is consulting with Project Ujima for guidance about building racial equity and diversity within the institution, a subject on which Project Ujima has become a standard-bearer.



HVIPs SHOULD ADDRESS THE VICARIOUS TRAUMA THAT WORKERS MAY EXPERIENCE AS A RESULT OF WORKING WITH VICTIMS OF VIOLENCE AND THEIR FAMILIES.

## Build Strong, Equitable, and Mutually Beneficial Community Partnerships

HVIPs must form partnerships with and be accountable to community stakeholders, as a matter of both political and practical importance. Beyond providing life-saving services, an important function of HVIPs is to assist disadvantaged communities of color in building power, organizing, and gaining access to the political actors and service providers who can serve their most pressing needs.

Several established and emerging research and action frameworks can assist HVIPs in building strong, equitable, and mutually beneficial community partnerships. Community-based participatory action research is a model that aims to democratize how research and action are conducted in partnership with communities. It is grounded in the needs, issues, and concerns of communities themselves; engages communities directly in the research process; and supports strategic action for community change.<sup>65</sup>

It is also crucially important that HVIPs recognize and avoid perpetuating structural violence, a phenomenon that occurs when institutions themselves, including those devoted to providing health care, do harm to communities and individuals. In a hospital context, this harm may include medical professionals failing to meet patients' needs by limiting their access to health care, or adopting patient-blaming attitudes that ignore patients' lived experiences of racism and lack of access to resources.<sup>66</sup> One emerging model to mitigate such harm is the "healing justice" approach, which aims to respond holistically to the impact of structural violence, intergenerational trauma, and oppression on communities of color and transform harmful structures. It uses practices that HVIPs can incorporate such as healing circles; wellness in movement spaces; education on leadership and organizing skills; education on political advocacy; training on security, including digital security; and development of collective care strategies to address burnout, PTSD, secondary trauma, and emotional and spiritual exhaustion experienced by activists, organizers, survivors, and frontline workers.<sup>67</sup>

At a practical level, it is crucial that HVIPs develop and sustain connections with local community-based organizations to foster coordinated care and referral systems, which allows patients to receive the services they need rapidly. One means of accomplishing this is to integrate services from multiple community providers, using written memoranda of understanding (MOU) to delineate responsibilities and streamline referrals. Some HVIPs have formed links with programs that address intimate partner violence in recognition that victims of gun violence may also suffer unaddressed trauma from intimate partner violence, or may be getting support from partners and family members who themselves suffer from trauma symptoms associated with intimate partner violence.



*"Hospitals often struggle with having meaningful connections with the community that they serve. I think that HVIPs gives them an opportunity to build an actual relationship that is rooted in equity."*

ELIZABETH RUEBMAN  
Special Advisor for Victim Services,  
New Jersey Office of the  
Attorney General



It is also good practice for HVIPs to work with community-based service providers in applying for grants. Pooling resources for the application process and distributing award money equitably among community partners is an important way to build trust, share skills and power, and ensure long-term collaboration to serve violently injured patients. (For more on applying for grants, see “Practical tools for increasing funding to hospital-based services for communities of color and other underserved communities,” on p. 28).

Several organizations exemplify this approach. An HVIP based at the RYSE Center holds a free trauma and healing learning series with local leaders in public health, social services, education, research, and other systems in an effort to gain new insights into trauma-informed community change, explore the impacts of personal and collective trauma on mental health, and strengthen practices for working with trauma-exposed youth and communities. This has led to the development of a network for community learning and resource sharing.<sup>68</sup> At Swedish Covenant Hospital in Chicago, a violence

prevention program has formed a strong partnership with Apna Ghar, a community-based victim services organization that focuses on ending gender-based violence in immigrant communities. The MOU between the hospital and Apna Ghar includes an agreement for one of the organization’s staffers to split their time between the two institutions, fostering interagency collaboration and knowledge-sharing.<sup>69</sup> The Newark Community Street Team in New Jersey is a street outreach and violence intervention organization that has formed a strong partnership with the University Hospital Trauma Center to provide services to violently injured victims.<sup>70</sup> In Washington, D.C., Children’s National Hospital provides a medical home for the city’s trafficked youth; they have many strong partnerships, including with Courtney’s House, a survivor-led support organization for victims of youth trafficking.<sup>71</sup> A clear example of official collaboration, the hospital has granted the executive director of Courtney’s House a hospital badge to visit youth in the emergency department or in hospital rooms if they’ve been admitted.



AT A PRACTICAL LEVEL, IT IS CRUCIAL THAT HVIPs DEVELOP AND SUSTAIN CONNECTIONS WITH LOCAL COMMUNITY-BASED ORGANIZATIONS TO FOSTER COORDINATED CARE AND REFERRAL SYSTEMS, WHICH ALLOWS PATIENTS TO RECEIVE THE SERVICES THEY NEED RAPIDLY.

## Integrate Lived Experience and Survivor Leadership

It is crucial that decision-making power in HVIPs rest with people who have lived experience of victimization. Programs should center on the leadership of the most marginalized victims of violence. Integrating lived experience into HVIPs also means moving away from the “perfect victim” dynamic, wherein authority figures and service providers scrutinize survivors’ pasts and make service provision contingent on never having perpetrated harm. HVIPs should operate with an understanding that most perpetrators of violence have also been victims themselves and need services and treatment. At their best, these programs’ strength is that they provide services to a wider-than-usual range of victims, without respect to their criminal records.

They also practice with the idea that “healed people heal people” and so actively recruit people with lived experiences of violence as candidates for employment and leadership roles.

Several HVIPs and other victim services programs exemplify this approach. Healing Hurt People in Philadelphia has created a training program for certified community health workers and hires survivors into both the program and other open positions at Drexel University, where it is housed.<sup>72</sup> AIM is nested under the Denver’s Gang Rescue and Support Project (GRASP), a community-based intervention program run primarily by people who were formerly gang-involved and work with youth at risk of

gang involvement, help families of gang victims, and serve as youth advocates.<sup>73</sup> The Tundra Women’s Coalition program serves the Yukon-Kuskokwim Delta in Bethel, Alaska, and primarily employs indigenous Yupik people who have passed through the programs to staff their Children’s Advocacy Center. Youth ALIVE! operates a leadership pipeline that creates a clear career path for staff with lived experience of victimization to move into decision-making roles within the organization. DLIVE is run by and employs many violence prevention professionals who have histories as perpetrators and survivors of harm, and Aim4Peace, in Kansas City, Missouri, also hires people with past histories of violence.<sup>74</sup>



## WHAT ARE THE SOCIAL DETERMINANTS OF HEALTH?

Social determinants of health are **the conditions where people are born, live, learn, work, play, worship, and age that affect health, functioning, risks, and quality of life.** These conditions can include policies, systems, and environments. Research also shows that social determinants influence well-being and are associated with health outcomes including gun homicides.<sup>75</sup> Examples of social determinants of health include:<sup>76</sup>

- Socioeconomic conditions (e.g., concentrated poverty)
- Housing
- Healthy food
- Health services, care, and insurance coverage
- Educational and job opportunities
- Transportation options
- Media and technology
- Structural racism (e.g., economic inequality, segregation, police violence)
- Incarceration
- Community violence and social disorder
- Water and sanitation quality

RESEARCH INDICATES THAT THE SOCIAL DETERMINANTS OF HEALTH ARE ASSOCIATED WITH THE FOLLOWING POPULATION TRENDS:<sup>80</sup>

### Social Mobility

Ability to climb the socioeconomic ladder



Increased social mobility is associated with lower gun homicide rates

### Trust in Institutions

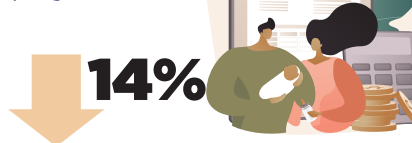
e.g., government, media, corporations



Increased trust in institutions is associated with lower gun homicide rates

### Welfare Spending

e.g., unemployment, public assistance programs



Increased public welfare spending is associated with lower gun homicide rates

### Income Gap

the disparity in income between the rich and the poor



Wider gaps between the rich and poor is associated with higher gun homicide rates

## Address Different Forms of Violence and the Social Determinants of Health

Research shows that most perpetrators of violence have also been victims.<sup>77</sup> HVIPs work to break down the binary distinction between violent offense and victimization by training staff on the overlap between perpetrators and victims; offering support and services to all victims of violence despite their criminal histories; and employing people with lived experience of violence, survivors of violence, and those who may previously have perpetrated harm. HVIPs also recognize that community violence often intersects with other forms of violence, such as intimate partner and family violence.<sup>78</sup> When providing services and treatment for the trauma of violent injury, they are simultaneously treating survivors of other harm, and should develop resources accordingly.

As public health practitioners, HVIPs should also address violently injured victims' social determinants of health, the "conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes."<sup>79</sup> When HVIPs help participants connect with housing, employment, schooling, childcare, legal documentation, primary health care, mental health needs, and treatment for substance use disorder, they are helping them address social determinants of health that are necessary to stabilize and live healthier, happier lives.

This is particularly important in the context of community violence because research shows that in neighborhoods where the social determinants of health are addressed—for example, by building social mobility and trust in institutions—gun homicide rates are lower.<sup>80</sup> HVIPs and related victim service programs meet this need in a variety of ways, without involving law enforcement and the criminal justice system. By applying what we understand about the social determinants of health, the U.S. can improve health, advance equity, and reduce community violence.<sup>81</sup>

To address different forms of violence and the social determinants of health, HVIPs can expand their offerings. Many programs create broader access for underserved participants by providing community-based services through home visits and mobile health clinics to meet patients where they are, especially in cases where participants face challenges to accessing the hospital due to full-time employment, childcare obligations, lack of transportation, or accessibility issues. Many programs also use telehealth services to provide remote patient care, a practice that greatly expanded due to the social distancing requirements of the Covid-19 pandemic.

Another important measure is using harm-reduction practices, a concept developed in the context of substance use treatment. In an HVIP setting, this means meeting participants where they are. This can include continuing to work with participants who remain involved in illicit activity, such as gangs or the street economy, or who use coping strategies deemed unhealthy or maladaptive, such as drug and alcohol use or carrying a weapon for safety. Using harm-reduction practices moves away from a "zero tolerance" mindset among providers that demands complete desistance from maladaptive behaviors in order to receive services. Instead, a harm-reduction approach continues to work with a participant to strategize safe—or safer—ways to cope. For example, this could mean rescheduling



*"One of the key benefits of doing this work in health care settings is that you're capturing a population that you're not going to see anywhere else, particularly with community violence. With a gunshot victim or a victim of assault, they're going to come into the emergency department, get treated, very often get discharged, and you're not going to see them again. They're not reaching out to community services for a variety of reasons. You might see them through other funded programs like housing, but [hospitals] are a really unique opportunity to see victims of violence who are very often falling through the cracks."<sup>82</sup>*

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VOCA Administrator,  
Virginia Department of  
Criminal Justice Services

a therapy session if a participant is under the influence, working together to find times when a participant is less likely to use substances, or ensuring participants have safe travel to meetings so that carrying a weapon does not feel necessary.

Many programs make strong efforts to address different forms of violence, polyvictimization, and the social determinants of health. Some provide a wide range of services under one roof. At the Virginia Commonwealth University in Richmond, Virginia, the Bridging the Gap HIVIP is co-housed in the Trauma Center's Injury and Violence Prevention Program with multiple programs that serve people struggling with substance use, survivors of intimate partner and sexual violence, and youth survivors of violence. Similarly, Brigham and Women's

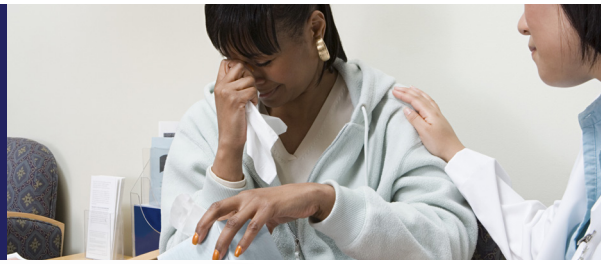
Hospital in Boston, Massachusetts, has brought multiple programs serving survivors of different kinds of violence under one center in order to coordinate services most effectively. Monument Crisis Center in Concord, California, is a family resource center that serves low-income community members, undocumented people, seniors, and victims of violence by providing food, youth programs, free primary health services for uninsured community members, assistance signing up for public benefits, literacy classes, and support for people who need domestic violence restraining orders.<sup>83</sup> DreamCatcher Youth Services, in Oakland, California, connects homeless and trafficked youth in Alameda County to a constellation of services that includes stable housing, further education, employment, and other community and peer supports.<sup>84</sup>

Some programs specifically address polyvictimization. For example, Alliance for Hope, in San Diego, California, provides resources and training to staff on addressing polyvictimization.<sup>85</sup> In New York City, the RISE Project takes an innovative approach to polyvictimization by developing community-based responses to the intersection of gun and intimate partner violence.<sup>86</sup> These programs acknowledge that survivors have myriad needs and strengths, and diverse histories of trauma. People seldom classify themselves by the category of victimization they have experienced, and programs must respond accordingly.

Other programs have made an explicit effort to address the social determinants of health. Boston Medical Center (BMC) has earmarked all of its \$6.5 million in community health funding to



PEOPLE SELDOM CLASSIFY THEMSELVES BY THE CATEGORY OF THE VICTIMIZATION THEY HAVE EXPERIENCED, AND PROGRAMS MUST RESPOND ACCORDINGLY.



combat housing instability and homelessness, an explicit example of health care providers engaging with one social determinant of health at a transformative scale.<sup>87</sup> Using its OVC-funded Supporting Male Survivors of Violence grant, BMC's Boston Violence Intervention Advocacy Program (VIAP) has focused on providing housing for its participants, in recognition that the city's housing crisis is a major obstacle to safety and stability for survivors of violence. Boston VIAP collaborated with a local nonprofit agency to find housing solutions and covered all housing-related expenses. Meanwhile, the program helped participants to overcome common barriers such as low credit scores, unemployment, lack of housing history, and an uncomfortable change of environment.<sup>88</sup>

Because of the close connection that HVIP staff have with their clients and communities, they can be agile in responding to new needs as they arise. During the Covid-19 pandemic, many HVIPs shifted to providing personal protective equipment and food as well as information about the unfolding recommendations on safety, both to their participants and to the broader communities they served.

## SAMPLE MOU

Memorandum of Understanding Between Medical Center and Service Provider

This MOU outlines the responsibilities of the above parties and forms an agreement that they intend to work collaboratively toward the mutual goal of providing supportive services to young patients entering Medical Center as a result of a violent injury [and other criteria such as age, geography, type of injury, etc.].

Under this MOU, Medical Center will:

- Provide the services of the injury prevention coordinator [or other hospital staff member] whose responsibilities will include: managing the hospital-based violence intervention program (HVIP) within Medical Center, training emergency and trauma department staff on the screening and referral of potential program participants, obtaining patient and parental consent when necessary for participation in the program, and referring interested patients to Service Provider immediately after consent is received;
- Screen patients through triage or registration and attempt to identify those who are violently injured and eligible for the HVIP;
- Offer hospital volunteer training and provide ID badges to Service Provider staff;
- Provide Service Provider staff access to patient medical records along with the required training on HIPAA.

Under this MOU, Service Provider will:

- Complete volunteer training [or new employee orientation] and observe hospital protocol, including wearing appropriate badges;
- Arrive at Medical Center within one hour of receiving a referral if the patient is currently in the hospital;
- Contact the patient on the following business day after receiving the referral if patient is discharged at the time of the referral;
- Assign a violence prevention professional to provide a bedside visit, resource information, case management, mentoring, and comprehensive supportive services to participants and their family;
- Maintain clear records of interventions and services provided to each participant;
- Maintain patient confidentiality and uphold HIPAA security requirements;
- Follow participants' progress for up to one year.

Both parties agree to meet as needed to address any issues regarding the quality and success of the HVIP.

## Advocate for Equitable Policies that Benefit Clients and Staff

HVIPs and other victim services organizations should support victims in advocating for federal, state, and local policies that benefit the well-being of clients and staff, as defined by clients and staff themselves. These organizations should focus especially on elevating the voices and demands of victims with lived experience relevant to the policies they are advocating. This work can include supporting policies on the national stage as well as working with local agencies and institutions to implement needed changes.

The Alliance for Safety and Justice supports state campaigns for equitable, inclusive health care policies and provide tools for community organizations seeking to perform local advocacy. The RYSE Center's recently implemented Dynamic Response Fund addressed client needs that arose during the Covid-19 pandemic, including granting \$500 stipends to youth members. A Long Walk Home, a Chicago-based nonprofit that cultivates youth leaders on gender

equity and racial justice, launched the Girl/Friends Leadership Institute, a youth-centered program that provides training to amplify the voices and creative visions of those most vulnerable to violence: girls and women of color.<sup>89</sup> Youth ALIVE! has contributed to writing public safety policy and working on VOCA reform.<sup>90</sup>





# THE ROLE OF VOCA IN ACHIEVING EXCELLENCE

VOCA administrators and hospital stakeholders can play a leadership role in supporting HVIPs to reach underserved patients. This means helping to coordinate funding for both statewide initiatives and individual programs. VOCA victim assistance grants can also be instrumental in supporting historically underrepresented populations.

The VOCA statute articulates that state administering agencies must “allocate a minimum of ten percent of each year’s VOCA grant to underserved victims of violent crime,”<sup>91</sup> and lays out the criteria by which they must identify services for that population. In general, practitioners noted, ten percent is a minimum threshold for funding services to underserved populations, and VOCA administrators can use their discretion to support those populations at higher rates of funding.<sup>92</sup> Many hospital-based and affiliated survivor services, such as those at the heart of HVIPs, are allowable under the original VOCA statute.

The VOCA Victim Assistance Rule change, issued by OVC in 2016, and the VOCA Fix to Sustain the Crime Victims Fund Act, passed by Congress in 2021, both further articulate how VOCA administrators can support these programs.<sup>93</sup> Those updates make key clarifications, remove previous prohibitions, and otherwise broaden the scope of VOCA’s allowable services to include more trauma-informed care. Importantly, the rule change removes prohibitions on services to people who are incarcerated or have histories as perpetrators of harm.<sup>94</sup> It explicitly names exposure to violence as a form of violence within the definition of child abuse, one of the priority categories for funding allocation,<sup>95</sup> and that definition can reasonably be interpreted to include gun violence. It allows greater flexibility for funding mental health counseling and care,<sup>96</sup> and includes peer support as a direct cost.<sup>97</sup> It also removes a previous prohibition on evaluation costs and permits the cost of evaluations for specific projects.<sup>98</sup>

The VOCA Fix creates more flexible rules for VOCA state administering agencies and is widely expected to replenish the Crime Victims Fund, which will result in a larger, more stable fund for victim services. This will apply to both the assistance and compensation funds. The bill also provides VOCA administrators with extra tools to direct the funding. Specifically, it eliminates some limitations on funding availability, so that grant funds are available to states and grantees for a longer period of time. It allows states to waive match requirements, allowing agencies to fund new, smaller



*“In an ideal world, you don’t want VOCA to be your sole source of funding. Diversifying funding sources can be a way of engaging. VOCA administrators can partner with other state agencies, or they can partner with philanthropy. VOCA is a complicated funding mechanism. But if you blend it with another source, it can open opportunities for other collaborations.”*

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Special Advisor for Victim Services,  
New Jersey Office of the  
Attorney General



AS PROGRAMS THAT PROVIDE DIRECT SERVICES TO VICTIMS OF VIOLENT CRIME, HVIPS QUALIFY TO RECEIVE VOCA ASSISTANCE DOLLARS.

service organizations that previously found the fund challenging to access. One provision of the bill will disproportionately assist victims of community violence. Many victims of violent injury, particularly boys and men of color, fear that interactions with law enforcement could increase their risk of reinjury, since it could be construed as “snitching.” In the past, refusing to cooperate with law enforcement excluded this vulnerable population from receiving victim compensation benefits. The new law allows state VOCA agencies to eliminate the requirement for victims to cooperate with law enforcement in order to receive compensation. States should strongly consider this victim-centered approach, which recognizes that most crimes go unreported to the police, especially by those most harmed.

VOCA administrators should look to HVIPs as model programs for reaching underserved victims of violent crime and connecting them with mental health care and peer support, among other critical services intended under the VOCA statute and rule. The following tools will help VOCA administrators make meaningful investments in HVIPs, a powerful way to provide needed services for those impacted by violence while also filling long-standing gaps in support in their states.

## Mechanisms to Direct VOCA Funding to Hospital-based Services

Traditional VOCA grants, at both large and small scales, can fund implementation of HVIPs. In recent years, driven by an expansion of services identified as explicitly allowable under the rule change, VOCA offices have been instrumental in launching statewide initiatives to fund HVIPs and other individual programs. From 2015 to 2018, VOCA saw an expansion of funding that allowed awards to additional programs, followed by a significant decline in VOCA budgets. In July 2021, Congress passed the VOCA Fix to Sustain the Crime Victims Fund Act of 2021, which is expected to replenish the VOCA budget.<sup>99</sup> VOCA funding for HVIPs will continue to be an important mechanism to deliver services to underserved victims of community violence.

VOCA state administering agencies grant funding to hospitals directly. The hospital manages and administers funds for the HVIP, which may be “hospital-based,” meaning that it is situated within the hospital, or “hospital-linked,” meaning that it is an outside community-based organization with which the hospital has established an MOU to provide services. The hospital also establishes the link between patients and violence prevention professionals, whether the program is hospital-based or hospital-linked. VOCA dollars support violence prevention professionals and the infrastructure of the HVIP that allows them to do their work, including roles such as a program manager and administrator. The expectation is that hospitals will help community-based organizations build capacity so that they will eventually be able to secure funding independently. VOCA administrators can require an MOU between hospitals and community-based organizations to codify and sustain the relationship; in addition to the core responsibilities of running the program and serving patients, the hospital can help its partner organization to build management and grant writing capacity.

At the state level, VOCA dollars have been used to fund cohorts of HVIPs in New Jersey and Virginia. While VOCA in New Jersey has long funded well-known entities focused on victims of familiar types of violence such as sexual assault, domestic violence, and human trafficking, Attorney General Gurbir Grewal made it a special priority of his office to fund programs for underserved victims of gun violence. Using \$20 million of VOCA award money, the state simultaneously supported nine HVIPs at once in early 2020, with the HAVI serving as training and technical assistance provider.<sup>100</sup>

Grewal appointed Elizabeth Ruebman special advisor for victim services for the Office of the Attorney General, with a goal of developing the programs.

In Virginia, the Department of Criminal Justice Services (DCJS), the state administering agency for VOCA, granted \$2.45 million in VOCA funding to the Virginia Hospital and Healthcare Association, which coordinates the distribution of funding to seven new HVIPs at partner hospitals statewide.<sup>101</sup> These grants were included in the funding approved

by the Criminal Justice Services Board of DCJS. The HAVI is supporting training and technical assistance for the implementation of the new HVIPs.

Traditional VOCA grants have also worked well for supporting individual HVIPs. As programs that provide direct services to victims of violent crime, HVIPs qualify to receive VOCA assistance dollars. Project Ujima in Milwaukee, Wisconsin has received regular funding from the Wisconsin Department of Justice's Office of Crime Victim

Services, its state administering agency, since 1999. In Michigan, the Crime Victims Services Commission made a one-year VOCA grant of \$270,067 to City Connect Detroit, a nonprofit that supports local community-based organizations, to fund the DLIVE program, Detroit's only HVIP. The grant was funded for one year, with a possible extension to three years. Those dollars paid for two additional violence prevention professionals, as well as training and technical assistance to help DLIVE become more sustainable.<sup>102</sup>



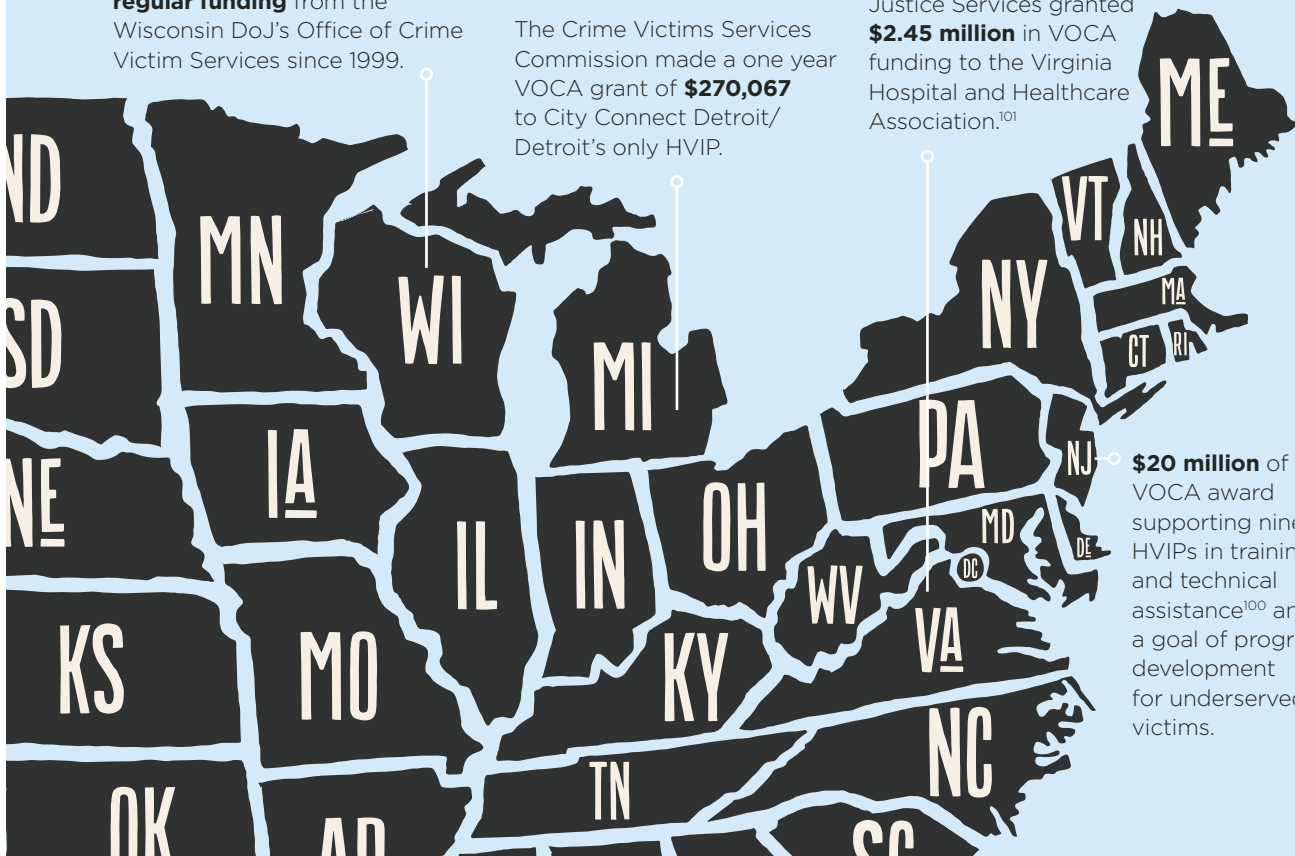
## EXAMPLES OF VOCA FUNDING TO HOSPITAL-BASED SERVICES

Project Ujima has received **regular funding** from the Wisconsin DoJ's Office of Crime Victim Services since 1999.

The Crime Victims Services Commission made a one year VOCA grant of **\$270,067** to City Connect Detroit/ Detroit's only HVIP.

Department of Criminal Justice Services granted **\$2.45 million** in VOCA funding to the Virginia Hospital and Healthcare Association.<sup>101</sup>

**\$20 million** of VOCA award supporting nine HVIPs in training and technical assistance<sup>100</sup> and a goal of program development for underserved victims.





# TRAINING & TECHNICAL ASSISTANCE

A core function of the HAVI is to help launch and support new and emerging HVIPs, as well as to advance established HVIPs and member programs. In addition to the many free resources available to help establish and support programs, the organization offers a range of training and technical assistance services. Training and technical assistance can be onsite or virtual and include guidance on:

- HVIP best practices and implementation
- Frontline staff recruitment and supervision
- Community engagement and partnership development
- Continuity of care and client safety planning
- Working with traumatized populations
- Trauma-informed care and practice in HVIPs
- HVIP fundraising and advocacy

Programs interested in learning how the HAVI can help launch or improve an HVIP can fill out this [online form](#) in order to schedule an informational phone session with a member of the HAVI training and technical assistance team.that pervade many workplaces.

## Use Practical Tools for Increasing Funding to Hospital-based Services for Communities of Color and Other Underserved Communities

States have used a variety of tools to increase funding to services for communities of color and other underserved communities. Practitioners said that expanding funding for HVIPs, which are rooted in a public health approach to victim services, may require a shift in thinking among some VOCA administrators, who are often working within state administering agencies that are part of the criminal justice system.<sup>103</sup> Part of the logic of making this shift is based on inequities in the field and the need to fill longstanding gaps in services. There is good research indicating that communities of color experience the bulk of violent victimization and face the greatest challenges in accessing services (for more information, see Introduction, p. 7). Another part of the logic is economic. It is important to make smart, meaningful investments, especially when resources in the field are limited. Research has shown HVIPs to save public money by reducing repeat hospitalizations among underserved people of color (for more information, see Introduction, p. 7).<sup>104</sup>

State administering agencies often determine their annual priorities for underserved populations in consultation with a state governing board or other collaborative body, or through a set of processes within their jurisdiction. Some practitioners noted that it can require education on HVIPs to get both VOCA staff and governing boards accustomed to the concept of health care approaches to victim services and the rationale for the HVIP model.<sup>105</sup> As a recent report from Everytown for Gun Safety proposes, states could better direct funding to victims of community violence by dedicating at least 10 percent of VOCA funding to victims of gun violence specifically, releasing grant proposals aimed at programs that serve victims of gun violence, and choosing an institution that specializes in gun violence to be the entity that actively selects grant recipients.<sup>106</sup> For example, the state of New York passed a provision in its 2021 budget that commits \$10 million to HVIPs and community-based violence interruption programs, and dedicates 10 percent of the state's VOCA funding to these groups in the future.<sup>107</sup>

In order to ensure that funding goes to the organizations that serve the communities in greatest need, it is important for governing boards to include frontline violence intervention workers and diverse victim services providers. Most states use a competitive application process to fund individual programs. VOCA administrators can share information with potential HVIP applicants in advance of releasing a request for proposals (RFP), or otherwise within an ample time frame, to ensure that they are aware of opportunities for funding and understand the application process.<sup>108</sup> This is especially important for programs and entities unfamiliar with these funding streams—and the complex requirements and processes that applying for and maintaining these funds may entail.

Practitioners said that in order to improve racial equity in service provision for underserved populations, VOCA administrators should do more to reach out directly to community-based organizations run by and for people of color and give them the resources to apply for funding competitively. A promising strategy that multiple jurisdictions have embraced is the By and For Victim Services Initiative. For example, the VOCA state administering agency for Washington state, recognizing that marginalized communities

are disproportionately likely to experience violent victimization and lack of resources, has taken special measures to encourage new funding for organizations run by and serving Black, indigenous, LGBTQ, and other marginalized populations.<sup>109</sup> This includes encouraging small, local organizations to participate in competitive grant opportunities that they have not previously applied for by setting aside funding specifically for this purpose, reaching out continuously to share information about these opportunities, and providing guid-

ance on the application process.<sup>110</sup> The initiative has resulted in VOCA support for programs that use culturally relevant tribal healing practices for victims of violence, help transgender people navigate legal challenges and cope with trauma, and work with immigrant survivors who do not feel comfortable approaching mainstream agencies. In this way, the By and For Victim Services Initiative provides a helpful approach for funding small, nontraditional programs that have not received VOCA support in the past.

THE INITIATIVE HAS RESULTED IN VOCA SUPPORT FOR PROGRAMS THAT USE CULTURALLY RELEVANT TRIBAL HEALING PRACTICES FOR VICTIMS OF VIOLENCE, HELP TRANSGENDER PEOPLE NAVIGATE LEGAL CHALLENGES AND COPE WITH TRAUMA, AND WORK WITH IMMIGRANT SURVIVORS WHO DO NOT FEEL COMFORTABLE APPROACHING MAINSTREAM AGENCIES.



## Promote Excellence in HVIP Services

To expand HVIP services for victims and their communities, VOCA administrators can actively seek to support new or existing HVIPs with excellent characteristics. Part of this support should be providing structure and education to local HVIPs. It is important that VOCA administrators encourage their states to contract with expert training and technical assistance providers, who can help ensure that HVIPs provide services that meet national standards of practice, and ensure that they are not operating in the dark. This should include staff training that emphasizes trauma-informed care, vicarious trauma, and staff wellness. For example, New Jersey works with the HAVI to deliver statewide training and technical assistance to their HVIPs and support local violence prevention professionals. This structure has helped to establish programs with strong connections between hospitals and community advocates who act as conduits to bring in underserved victims. That VOCA office has made an effort to develop culture change, narrative change, and accountability among the HVIPs it funds, allowing programs to work more closely with local communities of color.

The guidance and support of the training and technical assistance experts in the field is vital. For partners starting an HVIP the national experts are the HAVI. For partners starting a trauma recovery center the national experts are the National Association of Trauma

Recovery Centers. “Survivors are some of the most vulnerable people in our communities,” said Elizabeth Ruebman, former special advisor for victim services for the New Jersey Office of the Attorney General. “Many have faced generations of racism and systemic barriers to getting help. It’s our obligation as state administering agencies not to cause more harm, and to get this right. That’s why we need experienced training and technical assistance providers to guide us.”<sup>111</sup>

Another strong measure is hiring an experienced practitioner with an advocate’s background who leads and advises funding efforts within the VOCA state administering agency. In New Jersey, Ruebman—who has focused on the intersection of victim services, public safety strategy, and criminal justice reform, and has managed a statewide chapter of crime survivors—played this role for the Office of the Attorney General, the VOCA state administering agency, until her departure in late 2021. In Massachusetts, Liam Lowney, who previously led victim and witness services for the Office of the Attorney General, serves as executive director for the Massachusetts Office for Victim Assistance, the VOCA state administering agency. Employing leaders like these helps bring needed perspective to VOCA funding practices and promotes a nuanced understanding of the hospital-based programs that best serve victims.



In 2020, the State of New Jersey implemented a network of HVIPs. The state funded training and technical assistance from the HAVI for all new programs. On the value of this assistance, Former Special Advisor for Victim Services ELIZABETH RUEBMAN said:

*“These survivors are some of the most vulnerable people in our communities. Many have faced generations of racism and systemic barriers to getting help. It’s our obligation as state administering agencies not to cause more harm, and to get this right..... we’re not going to DIY it.”*



Promoting strong HVIP services can require a culture shift in VOCA offices that have traditionally drawn a strong dichotomy between victims and perpetrators of violent crime. Research shows that victims and perpetrators are not static, separate groups: the vast majority of perpetrators have been victimized acutely and chronically in their lives.<sup>112</sup> Meaningful trauma-informed approaches have the critical benefit of mitigating the risk that today's victim will harm others, in addition to mitigating the risk of their further victimization. However, the reality is that some victims of crime also have criminal records. Awarding grant money to HVIPs often means funding programs that both serve and hire people with criminal records, sometimes for violent crimes. Hiring people with criminal records is highly constructive: It provides an important opportunity for them to transform histories of trauma into positive action for others. It also helps reduce statutory discrimination against them, thus breaking cycles of violence on multiple levels. Specifically, research shows that employment is a strong protective factor against future use of violence,<sup>113</sup> but a history of incarceration makes gaining employment difficult or impossible for many citizens returning to society.<sup>114</sup> By employing violence prevention professionals with lived experiences of violence, HVIPs break structural barriers for employment among a high-risk population with unique expertise. They also more effectively meet the needs of participants.

Supporting HVIPs that hire people with criminal records is allowable under VOCA rules. While there is nothing that explicitly prohibits using VOCA funding for this purpose at a federal level, challenges may differ from state to state. VOCA offices that have traditionally been uncomfortable with funding programs that employ people with criminal records have sometimes started by making grants on a small scale while governing board members and other stakeholders become accustomed to the idea, and later making larger grants.<sup>115</sup> In Boston, VOCA funds several model HVIPs that work directly with community-based organizations, violence prevention professionals, homicide bereavement programs, and survivors of violence to form a network that responds to different parts of an incident.<sup>116</sup>

Some hospitals have made deliberate efforts to educate their staff on structures and systems that have presented barriers to equity. VOCA makes allowances to direct 5 percent of total funding to administrative purposes, as well as 5 percent to training uses, and VOCA administrators can promote using this funding for education on equity measures.<sup>117</sup> Education of this sort can include training on implicit bias, anti-racism, housing insecurity, food insecurity, or the social determinants of health. Better understanding among hospital staff can help HVIPs that are deliberately trying to reach underserved populations.



BY EMPLOYING VIOLENCE PREVENTION PROFESSIONALS WITH LIVED EXPERIENCES IN VIOLENCE, HVIPs BREAK STRUCTURAL BARRIERS FOR EMPLOYMENT AMONG A HIGH-RISK POPULATION WITH UNIQUE EXPERTISE.

## Track Progress

VOCA administrators should encourage the implementation of HVIPs to include plans to measure indicators of progress. All programs receiving VOCA funding are already required to collect and report data using the Performance Measurement Tool (PMT). Practitioners noted that the PMT is incomplete and lacks important categories of reporting, especially since the 2016 rule change opened the door for funding of HVIPs and other less traditional victim services programs.<sup>118</sup> But because VOCA-funded programs are already spending time and money collecting data, they should use it in ways that help understand important outcomes. VOCA administrators can also consider inserting additional relevant requirements into RFPs.

In practice, HVIPs can track the outcomes of individual program participants. In a study, HVIP administrators and frontline staff identified and prioritized the outcomes that are most important for participants. These include many that are already

commonly researched, such as decreased violent victimization, reduced hospital recidivism due to violent injury, reduced participant mortality, reduced exposure to violence, decreased posttraumatic stress symptoms, and reduced risk for retaliation.<sup>119</sup> A body of research currently exists linking HVIPs to improved outcomes on many such measures.

Other victim-centered outcomes require further tracking and evaluation. Many outcomes that are highly important to participants and staff are currently underused by researchers and funders when evaluating the impact of HVIPs on clients' lives. These include better coping strategies, improved emotional regulation and control, establishing a relationship with a positive adult role model, increased life satisfaction, improved sense of family belonging, improved peer relationships, and improved self-esteem.<sup>120</sup> VOCA administrators can play a role by including such victim-centered outcomes in funding evaluation plans.



*"Hospitals are in the community and allow us an opportunity to get to people who are not showing up to traditional victim services programs."*

LIAM LOWNEY  
Executive Director, Massachusetts  
Office for Victim Assistance





## Address Challenges

Practitioners noted a host of challenges that may arise for VOCA administrators in supporting HVIPs and discussed methods to meet these challenges. One challenge can be securing individual hospital buy-in to form HVIPs. Practitioners noted that when VOCA administrators are proactively seeking to fund the formation of new HVIPs, it is important to have a contact within the hospital who can serve as a liaison and help convince hospital administrators that the program is important and worth the investment of institutional capital to help reduce community violence and its impact on communities of color. This can be a slow process, and it is important to recognize that HVIPs cannot be implemented overnight—or without community support. VOCA administrators must take time to lay groundwork for launching new programs. This means building relationships not only with hospitals but also with community-based organizations that provide a vital connection to community members and survivors, as well as services important to HVIPs, such as mental health counseling, housing assistance, and job placement.

Another challenge is that VOCA administrators have traditionally been wary of programs with high indirect costs. Indirect costs became eligible for VOCA funding under the 2016 rule change, and they are an allowable expense.<sup>121</sup> However, hospital-based programs consume high indirect costs because the hospital itself requires a large amount of funding for administration and supplies. VOCA administrators are often reluctant to grant funding to institutions that use grant money in this way, preferring instead to fund community-based organizations that provide direct services. In cases where local partners have determined that a hospital-based program is the best option, VOCA administrators can make the case that funding HVIPs through hospitals provides outstanding services to victims while also strengthening the capacity of the local community-based programs they work with. Hospitals have a robust infrastructure to administer money and can meet federal reporting requirements while partnering with community-based organizations to serve patients. Hospitals are also well-equipped to bolster community-based organizations, help them build capacity and institutional knowledge, and apply for federal grants that they otherwise would be unable to access.<sup>122</sup> (For more on the distinction between hospital-based and hospital-linked programs, see “Mechanisms to direct VOCA funding to hospital-based services” on p. 16).

An overarching challenge is that the federal government has drastically cut funding to VOCA in recent years. Strapped for cash, the majority of state administering agencies have cut back on grantmaking in an effort to preserve the services they have funded in the five years since VOCA funding was last increased. Fortunately, Congress recently passed the VOCA Fix to Sustain the Crime Victims Fund Act of 2021, which is likely to reverse this trend.<sup>123</sup>

FUNDING HVIPs THROUGH HOSPITALS PROVIDES OUTSTANDING SERVICES TO VICTIMS WHILE ALSO STRENGTHENING THE CAPACITY OF THE LOCAL COMMUNITY-BASED PROGRAMS THEY WORK WITH.

# CONCLUSION: A VISION FOR THE FUTURE

## HOW VOCA AND HOSPITAL-BASED VIOLENCE INTERVENTION PROGRAMS CAN WORK TOGETHER

Addressing community violence requires a paradigm shift in the way violent victimization is viewed and healed in the U.S., such that the way we fund, prioritize, implement, and talk about services is more equitable. Hospital-based violence intervention programs are an effective model for addressing violent victimization, reducing recidivism and reinjury, and treating both individual and community trauma. The future of health care approaches to victim services must include VOCA support for HVIPs that serve a diverse population of victims with gold standards of practice. In the



short term, that may mean moving funding from traditional programs into ones for victims of community violence who have never previously been served. The goal should be equitable distribution of current resources, with a long-term aim of seeing VOCA resourced sufficiently, so that state administering agencies are not forced to reduce funding for one kind of victim services in order to support another.

The future must also incorporate measures for which practices are only just emerging. That includes using VOCA funding for transformative- and restorative-justice practices. Health care approaches to victim services should also take pains to provide support for survivors even if they refuse to cooperate with the criminal justice process or fail to report their victimization to law enforcement. On the national level, a new provision of the VOCA Fix begins to address this problem. On the state level, a new law passed by the Texas legislature, through the advocacy of Alliance for Safety and Justice, protects traumatized victims' eligibility for compensation when they are unable to speak to law enforcement.<sup>124</sup> In general, HVIPs and other victim services must carefully define the role of law enforcement and the criminal justice system as a whole when it comes to serving victims.

VOCA administrators, victim services providers, and health care professionals must come to fully understand the impact of structural racism and generational trauma, such that the language they use to talk and write about community violence avoids further

stigmatizing victims and their communities. For example, how does using terms like “offender,” “perpetrator,” and “felon” limit the provision of services to people who need them? How does describing communities as “crime-infested” shape public understanding of the causes of violence. Asking questions like these is a start to removing the burden of violence and trauma from communities of color and understanding the structural forces—economic exploitation, divestment of social resources, over-policing, and lack of protection—that marginalize them and perpetuate violent victimization.

Some of these measures are aspirational, but with the dedication of VOCA state administering agencies and local practitioners, they stand within reach. Interviews with VOCA administrators across the country revealed numerous ways that states can take steps toward these goals today, placing violently injured victims, their families, and their communities on a path to healing.

### Suggested Citation:

The Health Alliance for Violence Intervention, (2021). Transformative Guidance on Enhancing and Funding Health Care Approaches to Community Violence.

<https://www.thehavi.org/transformational-guidance-on-enhancing-funding-healthcare-approaches-to-community-violence>.



## LANGUAGE MATTERS

The language VOCA administrators use matters, and preferred language is always changing. Many resources exist to provide guidance on language usage around community violence.

Berkeley Media Studies Group.  
*“How can we best educate others about the impact of violence on boys and young men of color?”*

Berkeley Media Studies Group.  
*“Changing the discourse about community violence: To prevent it, we have to talk about it.”*

Healing Justice Alliance. *Communications Toolkit: Tools for Changing the Narrative About Male Survivors of Violence.*

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