Good morning. My name is Dr. Theodore Corbin and I am assistant professor in the Department of Emergency Medicine at the Drexel University College of Medicine in Philadelphia. At Drexel University I also direct a trauma-informed violence intervention program called Healing Hurt People. This program focuses on victims of interpersonal injury that were seen in the emergency department and are at risk for recurrent injury or death. The program uses trauma assessment, intensive case management and trauma treatment to address both the physical and psychological wounds of trauma. Today I will be speaking from my experience as an emergency medicine physician in the city with a high rate of violent injury. My goal in this testimony is to put forth, as clearly as possible, my belief that there is a strong link between early childhood adversity and exposure to violence, and this types of violence that we see among young people in the emergency department, most of whom are young men of color.

As you know, homicide is the leading cause of death for black men between the ages of 15 and 24. In 2009, this group suffered almost 92,000 nonfatal injuries. According to CDC data for 2007, this group suffered 2,916 homicides, or 79% of all homicides in this age group.

According to the CDC, in 2005 63,715 individuals under the age of 30 were hospitalized for assault related injuries. The medical cost of these injuries exceeded $1.2 billion, and the work loss cost of these injuries exceeded $4.2 billion. Yet we know that only one in 10 victims of assault who present to the emergency department are hospitalized. In 2005 903,856 persons under the age of 30 were seen in emergency departments and released for assault related injuries. The medical cost of these assaults was $1.39 billion and the work loss cost was $2.78 billion.

We also know that violence is a chronic recurrent problem. Sims and colleagues documented in Chicago that 44% of victims with a penetrating injury suffered a recurrent penetrating injury in the subsequent 5 years. This study also showed that the mortality rate at 5 years from all causes in this cohort was 20%, and in 70% of the deaths substance abuse was listed as a contributing cause on the death certificate.

these services should be reimbursed by Medicaid and private insurers. Effective intervention would not only decrease medical costs but could conceivably decrease costs in the criminal justice system by decreasing retaliation and other illegal behaviors.

While there are many strategies to intervene in the cycle of violence, identification in an emergency department and hospitalization presents a unique opportunity to intervene with a population at highest risk. A 1989 study found hospital readmission rates for youth for recurrent violent injuries are as high as 44% due to assault and 20% due to homicide over a 5-year follow up.[1] Since then, other studies of retrospective chart reviews have noted similar rates.[2] Without intervention, hospitals discharge violently injured patients to the same violent environments where they were injured, without a prescription for how to stay safe and with community pressure to seek revenge. Too often, this results in a revolving door of violence, causing even more injuries, arrests, incarcerations, and, sadly, deaths. In 1996, The American Academy of Pediatrics (AAP) published report pointing out that, while "it has been routine to treat victims of child abuse, suicide attempts, and sexual assault via multidisciplinary care protocols, ... no care guidelines exist that address the unique needs of" violently injured adolescents.[3] Two years later, the U.S. Department of Justice's Office for Victims of Crime took the next step by recommending that hospital-based counseling and prevention programs be established in communities grappling with gang violence.

Emergency departments are resource rich settings for identifying young victims of violence, collecting data to help craft best practices, and intervening. According to "Children's Exposure to Violence: A Comprehensive National Survey," clearly more needs to be done at all levels of policy and practice to identify young people at risk from

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[1] Sims, D. W., B. A. Bivins, (1989). "Urban trauma: a chronic recurrent disease." J Trauma 29(7): 940-946.

[2] Reiner, D. S., J. A. Pastena, (1990). "Trauma recidivism." Am Surg 56(9): 556-60.

Poole, G. V., J. A. Griswold, (1993). "Trauma is a recurrent disease." Surgery 113(6): 608-11.

Morrissey, T. B., C. R. Byrd, (1991). "The incidence of recurrent penetrating trauma in an urban trauma center." J Trauma 31(11): 1536-8.

Goins, W. A., J. Thompson, (1992). "Recurrent intentional injury." J Natl Med Assoc 84(5): 431-5.

Claassen, C. A., G. L. Larkin, (2007). "Criminal correlates of injury-related emergency department recidivism." J Emerg Med 32(2): 141-7.

[3] American Academy of Pediatrics, *Adolescent Assault Victim Needs: A Review of Issues and a Model Protocol*, Pediatrics, Vol.98, No.5, 1996:991- 1001.

profound, affecting mental and physical health and altering their interactions with others. In addition, as experts in the field explain, *"[t]he health and human service systems that serve boys, young men and their families are fragmented, do not share common knowledge or language, compete for limited resources, and are under stress."* When these victims interact with staff in these stressed systems, trauma-related issues can negatively affect service access and success.[10]

In 1998, the U.S. Department of Justice's Office for Victims of Crime (OVC), in response to an American Academy of Pediatrics' report on youth violence, *"recommended that hospital-based counseling and prevention programs be established in medical facilities that provide services to gang violence victims."*[11] The OVC also reported that health care and criminal justice systems respond less sympathetically to violently injured youth, particularly African-American male victims of gun violence, than to other crime victims. They noted that, *"[w]hatever the reason for the disparate treatment of these victims, we must not ignore them. Assumptions about the blameworthiness of young African-Americans and Hispanics shortchange a large segment of the population and perpetuate racial stereotyping."*[12]

Hospital-based programs have started to change the traditional approach to working with this vulnerable population. Today, the National Network of Hospital-based Violence Intervention Programs (NNHVIP), founded in 2009, connects 16 member programs from Boston, Chicago, Oakland, Philadelphia, and other cities across the country to continue improving services.[13] NNHVIP supports the notion that there is a

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[9] Bonderman J. 2001. Working with victims of gun violence. OVC Bulletin, U.S. Department of Justice, Office for Victims of Crime.
http://www.ncjrs.gov/ovc_archives/bulletins/gun_7_2001/welcome.html

[10] Rich, Corbin, Bloom et al. (2009) Healing the hurt: Trauma-informed approaches to the health of boys and young men of color. The Center for Nonviolence and Social Justice, Drexel University.
http://www.calendow.org/uploadedFiles/Publications/BMOC/Drexel%20-%20Healing%20the%20Hurt%20-%20Full%20Report.pdf

[11] *New Directions From the Field: Victims' Rights and Services for the 21st Century* at the Office for Victims of Crime site.

[12] Bonderman J. 2001. Working with victims of gun violence. OVC Bulletin, U.S. Department of Justice, Office for Victims of Crime.
http://www.ncjrs.gov/ovc_archives/bulletins/gun_7_2001/welcome.html

[13] NNHVIP 16 member programs are in these cities: Antioch/Richmond, CA, Baltimore, MD, Boston, MA, Camden, NJ, Chicago, IL, Cincinnati, OH, Davis, CA, Indianapolis, IN, Las Vegas, NV, Milwaukee,

As the Network expanded the decision was made to relocate the NNHVIP headquarters from Youth Alive! to a setting where a more diverse range of shared resources would be able to sustain the work. The NNHVIP Steering Committee solicited proposals from its member organizations and ultimately selected to relocate the leadership to Philadelphia, under a shared collaboration between the Center for Nonviolence and Social Justice (CNSJ) at Drexel University, the Philadelphia Collaborative Violence Prevention Center (PCVPC) at Children's Hospital of Philadelphia (CHOP) and the Firearm Injury Center at the University of Pennsylvania (FICAP). In transferring the leadership of the NNHVIP to this Philadelphia collaborative, the Steering Committee recognized that these three organizations have a proven track record of collaboration in youth violence prevention science, practice, and policy. Each brings independent and complementary strengths to this collaborative.

Existing programs that are part of the NNHVIP have developed a range of best practice interventions to engage victims of interpersonal violence in an array of health, human service, education/ employment training services. Frontline field staff of these hospital-based programs help young victims of violence access, engage in, and navigate health and human services as well as criminal/juvenile justice systems before and after they leave the hospital. Such programs have been found effective in linking violence survivors with community-based services and reducing re-injury and criminal activity.[14]

While each of these programs produces positive outcomes,[15] they have identified barriers both external to and within their own programs to providing more positive outcomes, such as "vicarious trauma" experienced by staff members. Within hospital-based violence intervention programs, lack of knowledge about trauma and

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[14] Liebschultz H et a.. 2010. A chasm between injury and care: Experiences of black male victims of violence. Journal of Trauma 69(6):1372.

[15] Becker MG et al (2004) "Caught in the Crossfire: the Effects of a Peer-based Intervention Program for Violently Injured Youth." *Journal of Adolescent Health:* 2004; 34:177-183.

[16]Cooper, Carnell MD; Eslinger, Dawn M. MS; Stolley, Paul D. MD. "Hospital-Based Violence Intervention Programs Work." *The Journal of Trauma: Injury, Infection, and Critical Care*: September 2006 - Volume 61 - Issue 3 - pp 534-540.

[17]Shibru, Daniel MD, MPH; Zahnd, Elaine PhD, Becker, Marla MPH, Bekaert, Nic MSW, Calhoun, Deane MA, Victorino, Gregory P MD, *Benefits of a Hospital-Based Peer Intervention Program for Violently Injured Youth,* Journal of the American College of Surgeons 2007;205: 684–689.

can often mimic the traumatic experiences that have proven so harmful to the clients served.[19]

Again I fully believe that such interventions are effective and are a critical component of healthcare for this vulnerable population. The greatest challenge to the success of these programs is the lack of funding support. I also fully believe that healing is possible by addressing the trauma that our young men and boys have encountered.

[21]Rich, J, et al (2009). *Healing the Hurt: Trauma-Informed Approaches to the Health of Boys and Youth Men of Color.* Center for Nonviolence and Social Justice at Drexel University Schools of Public Health and Medicine, Philadelphia. (p. 21)