Outcome Research on Hospital-Based Violence Prevention Programs: What’s Been Done & Recommendations for Future Research

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Identification of Outcome Studies

Searched: PubMed, PsycINFO, SafetyLit, VioLit, NCJRS, Medline, ERIC, Google Scholar, Review Articles, Academic Emergency Medicine, Network Colleagues

Inclusion Criteria

- Subjects treated in hospital (ED, Trauma Center) for assault-related injury (not sexual / familial assault)
- Initial contact with client in hospital or soon after
- Case management for ≥ 1month after discharge
- Treatment group outcomes compared to statistically valid comparison group
Six Outcome Studies Identified


Program Services

Hospital/ER Services Included:
  Needs Assessment
  Motivational Interviewing
  Establishment of a Service Plan

Post-Release Services Included: (4 to 12 months)
  Mentoring
  Parental Home Visits
  Information & Referral Services
  Case Management (Social Worker and/or Peer Based)
  Linkages with Community-Based Programs
  Primary and Preventive Healthcare
  Home Visits
  Conflict Resolution Skills Training
  Advocacy Services (legal, educational, financial, entitlement, and/or housing)
  Group counseling/support sessions
All 6 programs were operated in urban centers: Chicago, Oakland, Baltimore, Richmond, and Washington, DC.

3 Programs Recruited Patients at Level I Trauma Centers

1 Program Recruited Patients at a Primary Adult Resource Center

2 Programs Recruited Patients the ED of Large Children’s Hospital
5 of the 6 programs targeted adolescents, with upper age ranging from 15 to 24.

1 program focused on adults 18 and over who were on Parole/Probation.

The vast majority of clients in each program were male, ranging from 73 to 95 percent.

The vast majority of clients were African American, ranging from 60 to 95 percent.

The sample sizes were relatively small, ranging from 39 to 96 clients in each treatment group.
<table>
<thead>
<tr>
<th>Program Elements</th>
<th>Study 1</th>
<th>Study 2</th>
<th>Study 3</th>
<th>Study 4</th>
<th>Study 5</th>
<th>Study 6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Motivational Interviewing CM</td>
<td>Mentoring Parental Home Visits</td>
<td>Intensive CM I &amp; R Support Group</td>
<td>CM I &amp; R Support Group</td>
<td>CM</td>
<td>CM Work with primary CBO</td>
</tr>
<tr>
<td>Duration</td>
<td>6 Months</td>
<td>Up to 6 Months</td>
<td>4 Months</td>
<td>Not Reported</td>
<td>12 Months</td>
<td>6 Months</td>
</tr>
<tr>
<td>Prof/Para-Prof</td>
<td>Professional</td>
<td>Both</td>
<td>Professional</td>
<td>Professional</td>
<td>Para</td>
<td>Both</td>
</tr>
</tbody>
</table>
5 of the 6 studies were Randomized Controlled Trials

1 study utilized a Retrospective Comparative Double Cohort Design

5 of the 6 studies utilized an “intent to treat” design

5 of 6 studies compared HBVIP to standard /routine protocol and list of available services; 1 study compared to hospital-based brief intervention with no post-release treatment.
Follow-Up Periods (time for hospital release to outcome assessment) ranged from 6 to 18 months, however, 3 studies did not use uniform follow-up period.

Attrition rates for 5 of the 6 studies were high, ranging from 32 to 57 percent; 1 study, utilizing official records to assess impact, retained nearly all its subjects (95 percent).

3 of the 6 studies reported on dosage of treatment received.

All studies suffered from limited statistical power due to relatively small sample sizes.
Outcome Measures

**Self-Report**

- Attitudes regarding violence
- Aggressive/Delinquent behavior
- Victimization /Injury
- Arrests
- Weapon Carrying
- Family Functioning
- Social competence
- Drug Use
- Employment

**Data Extraction from Official Records**

- Hospital/ER Readmission (nature of medical problem)
- Arrests/Convictions/Incarceration (nature of crime)
- Death
- Compliance with Medical Follow-Up Visits
- Peer Anti-Social Behavior
<table>
<thead>
<tr>
<th>Study</th>
<th>1 6 Months</th>
<th>Study 2 8 Months</th>
<th>Study 3 6-8 Months</th>
<th>Study 4 ≤ 2 Years</th>
<th>Study 5 8 Months</th>
<th>Study 6 12 Months</th>
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</thead>
<tbody>
<tr>
<td>Reduced Reinjury (Self Report)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>NA</td>
<td>NA</td>
<td>Some Yes Some No</td>
</tr>
<tr>
<td>Reduced Reinjury (Official Records)</td>
<td>No</td>
<td>NA</td>
<td>NA</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Reduced Perpetration (Self Report)</td>
<td>NA</td>
<td>Some Yes Some No</td>
<td>No</td>
<td>NA</td>
<td>NA</td>
<td>No</td>
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<tr>
<td>Reduced Perpetration (Official Records)</td>
<td>No</td>
<td>NA</td>
<td>NA</td>
<td>Yes (except for total Number of Arrests)</td>
<td>Some Yes Some No</td>
<td>No</td>
</tr>
<tr>
<td>Other Measures</td>
<td>Accessed Services</td>
<td>Conflict Avoidance</td>
<td>Program Satisfaction</td>
<td>Employment</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>
1. Secure minimal sample sizes of 100 in treatment and comparison groups.

2. Utilize standardized outcome measures that are obtainable from extant records, including, at minimum, hospital and ER subsequent admissions and nature of injury; and number and nature of arrests subsequent to release. This will drastically reduce problems associated with high rates of attrition for purposes of data analysis.

3. Secure participation, if possible, of geographically contiguous hospitals for purposes of collecting follow-up hospital data.

4. Collect common core data elements for characteristics of the population served.

5. Include only assault victims, excluding family and sexual violence victims.
6. Secure measures of fidelity, including, at minimum, dosage of each type of service offered.

7. Describe the nature of the program and the rationale for adopting the program.

8. Secure accurate measures of costs and conduct cost-benefit analyses.

9. Conduct cross-site studies.

10. Utilize RCTs. And “intent to treat” designs.

11. Compute effect sizes (with confidence intervals) in addition to statistical significance.