Addressing Family Violence in the Hospital Setting: Case Report

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INTRODUCTION

- Homicide is the leading cause of death for African American youth.1 African American youth face an elevated risk for violent experiences such as homicide, aggravated assaults, and fights with injuries.1,2 Long-standing systemic inequities and structural racism predispose African American families to socioeconomic risk factors that disproportionately elevate risk of violence among these families.1,2
- The long-standing dynamic between low-income African American single mother families and child-serving systems involved in incidents of family violence (such as medical help, welfare, juvenile justice) have had historical implications criminalizing African American youth and punitive institutional scrutiny of African American mothers.2
- When these dynamics are not considered by entire system of care, it can delay or deter from patient and family-centered collaboration, crucial therapeutic trauma-informed care following a traumatic event can be missed, the family risk assessment may not truly highlight and target the root causes of the family violence, and the safety plan may lack vital community-based supports.2,3 Violence prevention and intervention efforts that incorporate system of care principles, such as trauma-informed care, etc.

Objectives of case report:

- Describe how a family violence case presented to the CAP Consult-Liaison Service (CL) and how psychosocial factors influenced coordination of care by multiple child-serving systems to address family violence.
- Promote discussion on how factors such as structural oppression, stigma, community and system-level limitations, impacted coordination of care with various child-serving systems in a manner that abided by systems of care principles (ie family-driven, youth-guided, strengths-based, and trauma-informed care, etc).
- Illustrate how interventions such as hospital-based violence intervention programs (HVIPs) utilize system of care principles that show potential for addressing family violence among marginalized populations.

Case: 12yo black M with a hx of ADHD admitted to surgery for a pneumonia thorax sustained during a domestic dispute. CL Psychiatry consulted post-op day 1/s/p thoracostomy, for evaluation of agitation, and symptoms of anxiety post violence. HVIP met pt at bedside to build trusting relationship, seek consent, safety plan, and provide education about the hospital setting.

Day 1:

- Pt sustained life-threatening injury, admitted to hospital -> thoracostomy
- Police investigation initiated, Initial CPS report placed
- Day 1:
  - Pt and family had not been engaged in safe disposition planning
  - Pt expressed SI. Pt guarded on exam, expressed acute safety concern
  - HVIP referral
- In-hospital child abuse center deferred evaluation to next day, due to limited provider availability, and all of pt’s physical injuries were already accounted for by primary team
- Notable findings on pt assessment:
  - Assessment in line with primary team collateral: Patient cooperative with all staff members, without notable acute BH symptoms, without any expression of harming self or others, no episodes of agitation or unsafe behaviors towards self or others since admission. No indication for inpatient hospitalization or acute medical management at that time. Referred to in-hospital child abuse center for more thorough assessment of child abuse due to concern of repeated and escalating violence in hospital. Recommended therapy while in hospital, and outpatient therapy and BH management.
- In-hospital child abuse center deferred evaluation to next day, due to limited provider availability, and all of pt’s physical injuries were already accounted for by primary team

REFERENCES


HVIP

HVIP strive to break cycles of violence by integrating trauma-informed care (TIC) pathways within health care system in collaboration with hospital community-based organizations and leaders. They coordinate prevention and coordination safety supports with hospital and community violence organization systems.3 Their multidisciplinary team can consist of a social worker, trauma surgeon, BH provider, CM, SW, and front-line culturally competent violence intervention specialist that is typically from the same or community as the patient and is trained in trauma informed intervention and long-term case management.3 HVIP recognizes community violence as a problem resulting from systemic inequities and structural racism. It integrates racial equity and antiracism principles in its mission and values, recruitment and hiring, and partnerships.3

LVIP Care Pathway example:1,4 On arrival of violently injured individual in ED/trama bay:

- Activate hospital safety protocols to protect patient
- HVIP referral
- If admitted, HVIP meets pt at bedside to build trusting relationship, seek consent, safety plan, prevent retaliation, and offer HVIP enrollment
- Safety plan focused on mitigating risk factors for retaliatory violence
- If pt consents to HVIP participation, intake and comprehensive needs assessment
- In partnership with pt, their family, and medical team, develops plan that addresses immediate safety needs, connects to community-based services to address factors contributing to increased risk of violence, and create goals.
- CM can include assistance with housing, behavioral health, family support, legal support, education assistance, Victims of Crime Act assistance, life skills and job trainings, employment, transportation for medical care
- Engagement and intensive CM for 6mo – 1yr

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