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[1,2] 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[1,3]
- 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/BH, child welfare, juvenile justice) have had historical implications criminalizing African American youth, and punitive institutional scrutiny of African American mothers.[4]
- 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.
- Violence prevention and intervention efforts that incorporate system of care principles, such as hospital-based violence intervention programs, have shown potential in decreasing rate of subsequent violent reinjury and retaliation.[3,5,6]

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 attempt 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 minoritized populations.

CLINICAL COURSE

Case: 12yo black M with a hx of ADHD admitted to surgery for a pneumothorax sustained during a domestic dispute. CL Psychiatry consulted post-op day 1 s/p thoracostomy, for evaluation of agitation, and recommendations for BH supports after recent trauma.

- Day 0:
  - Pt sustained life-threatening injury, admitted to hospital -> thoracostomy
  - Police investigation initiated, Initial CPS report placed
- Day 1:
  - Psychology initially consulted because no med management question, but deferred to CL psych due to lack of psychologist availability on-site at hospital that day
  - Per primary team: No acute safety or med management concerns. Though team concerned about safe disposition planning, and pt without access to trauma-informed care after life-threatening injury. Told by family that police investigation found pt's 18 yo sister to have stabbed pt out of self-defense due to pt punching mother and sister after pt argued with mother about not wanting to complete chores. Pt will likely be medically cleared in 1-2 days. Disposition plan pending guidance from law enforcement and CPS, though with tentative options including discharge to police custody on assault charges or discharge home to mother and sister. No injuries sustained by, and no charges against sister or mother.

CLINICAL COURSE CONTINUED

- Notable findings per collateral from mom:
  - PPHx:
    - Punches and hits to mom have occurred only in response to being told to do chores, to stop playing video games, or having his phone taken away. Has not resulted in bruises, scars, or injuries requiring medical attention, thought pt has started hitting harder. Since pt was diagnosed with ADHD at 4 yo, had episodes of physically aggression, defiance, hyperactivity, and inattention only when off of ADHD medications. Stopped all BH treatment 2 years ago after moving to a new home due to difficulties obtaining med refills, and losing access to core service agency. Since then, pt noted to be depressed, argumentative and punches mom only when asked to do chores or stop video games. No hx mania, psychosis, substance use, inpatient hospitalization, or suicide attempts.
  - FHx:
    - bipolar disorder, schizophrenia, and substance use
    - Mom, sister and younger brother: "duplication syndrome" – constellation of metabolic syndromes, intellectual disability, emotional dysregulation, ADHD; mom and sister not on medications
    - Younger brother: nonverbal, wheelchair bound, intellectual disability, multiple medical comorbidities, severe emotional dysregulation attempting to place at RTF
  - Social Hx:
    - 7th grade. Honor roll. Accomplished spelling bee champion. Has had in-school suspension for school fights, but no prior law involvement, or other hx of violence other than noted above. 504 for ADHD. Has friends. Single-parent family with low SES. Lives with mom, older sister, and younger brother. No other family, caregiving (other than school), or community supports.
- Notable findings on pt assessment:
  - Pt reported he would retaliate against sister for attempting to murder him if he was forced to return home to mother and sister. He was also told by family that he would be placed in foster care because he was no longer welcome at home. Reported multiple incidents of physical abuse from mom including hitting, choking, and stabbing him. Sister with increased substance use recently.
  - Therapy and medications had been beneficial for ADHD, though able to function adequately at school without BH resources. Declined med management and therapy at this time. Stated therapy did not work because mom didn't follow therapist's recommendations.
- 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 med management at that time. Referred to in-hospital child abuse center for more thorough assessment for child abuse due to concern of repeated and escalating violence in home. Recommended therapy while in-hospital, and outpatient therapy and BH med 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

CLINICAL COURSE CONTINUED

Day 2:

- No CPS investigation from initial CPS report because violence toward a child conducted in self-defense did not meet criteria for child abuse. CPS report placed, CPS investigation officially opened. CFSA CM connected with patient
- Detective contacted CL psych provider regarding patient's HI toward sister; later questioned pt in room without legal representation
- Pt expressed statements concerning for SI. Pt guarded on exam, expressed acute safety concerns related to potentially discharging home, but voluntary for inpatient admission.
- Mother planned for sister to continue to live at home, expressed fear for her and daughter's safety if pt were to return home. Concerned about daughter's mental health. Voluntary for inpatient psychiatric admission of son for elevated risk of harm to self and others.
- CAP-C evaluation

Day 3 & 4 (weekend): await transfer to inpatient psych unit

Day 5: Admitted to inpatient psych

- No family or friends had visited patient since admission
- Pt without therapeutic alliance with any provider
- Pt and family had not been engaged in safe disposition planning

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 retaliation prevention and coordinating safety supports with hospital and community violence organization systems. [3] Their multidisciplinary team can consist of an ER physician, 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 crisis intervention and long-term case management. [5] 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]

HVIP Care Pathway example: [3,5]

- On arrival of violently injured individual in ED/trauma bay:
  - Activate hospital safety protocols to protect person
  - 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 – 1+year

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