

## ORIGINAL CONTRIBUTION

# Boston Violence Intervention Advocacy Program: A Qualitative Study of Client Experiences and Perceived Effect

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### Abstract

**Objectives:** This study intended to explore clients' experiences and provide a contextual basis for understanding their perceptions of the effectiveness of the Boston Medical Center (BMC) Violence Intervention Advocacy Program (VIAP).

**Methods:** This was an exploratory, qualitative study conducted in an urban, Level I trauma center from July 1, 2011 to February 24, 2012. Emergency department (ED) patients older than 18 years with penetrating trauma, and who were enrolled in the VIAP, were eligible. Two trained, qualitative interviewers who were not part of the VIAP obtained consent and conducted in-depth, semistructured interviews. Interviews were audiotaped, transcribed, deidentified, coded, and analyzed. Thematic content analysis consistent with grounded theory was used to identify themes related to client experiences with VIAP, life circumstances, challenges to physical and emotional healing postinjury, services provided by VIAP, and perceptions of VIAP's effectiveness.

**Results:** Twenty subjects were interviewed. Most were male, African American, and younger than 30 years of age, reflecting the overall program's clientele. Most subjects perceived their advocates as caring adults in their lives and cited aspects of the peer support model that helped establish trusting relationships. Major challenges to healing were fear and safety, trust, isolation as a coping mechanism, bitterness, and symptoms of posttraumatic stress disorder (PTSD). Every subject noted important services provided by VIAP advocates. Most subjects explicitly stated that they had positive experiences with the VIAP and perceived advocates' roles as a positive influence, providing client-centered advocacy, education, and support.

**Conclusions:** This study provides insight into the lives of 20 BMC VIAP clients and contextualizes their unique challenges. Participants described positive, life-changing behaviors on their journey to healing through connections to caring, supportive adults. Information gained from this study will help the VIAP to further support its clients. However, future research is needed to identify best practices for ED-based violence intervention programs and to measure community-wide efficacy in different settings.

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Violence, particularly among persons younger than 24 years of age, is on the rise in American cities and is a public health problem.<sup>1-3</sup> In 2011, U.S. emergency departments (EDs) treated 707,212 patients aged 12 to 24 years for violent injuries, compared to 668,133 in 2007.<sup>4</sup> Most urban violence occurs in poor communities, and young, African American males are disproportionately affected.<sup>5</sup> Homicide rates in 2010 among non-Hispanic African American males, age 10 to 24 years (51.5 per 100,000), exceeded those of Hispanic males (13.5 per 100,000) and non-Hispanic white males (2.9 per 100,000) in the same age group.<sup>5</sup>

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Up to 40% of injured youth who are under 24 years old and hospitalized sustain subsequent injuries, one-half of whom return as victims of homicide.<sup>6</sup>

Young victims of violence who survive their injuries are often underserved by traditional health care systems and are ill-prepared to address their emotional and social needs, both in the hospital and after discharge.<sup>7,8</sup> The ED presents a unique opportunity for interventions geared specifically to reducing recidivism among vulnerable, violently injured youth. Several cities have responded by establishing effective, peer model-based interventions that use “trauma-informed care” in the ED.<sup>7,9–18</sup> Trauma can cause neurobiologic and psychosocial effects such as hyperarousability, hypervigilance, aggressive responses to fear and threat to safety, loss of empathy for others, withdrawal, anxiety, and depression.<sup>7,19–23</sup> Trauma-informed care is an approach that integrates knowledge about the effects of, and recovery from, trauma in every type of service delivery including medicine, education, juvenile justice systems, and mental health. In trauma-informed care, symptoms are not seen as pathology, but as attempts to cope and survive. Trauma-informed care minimizes revictimization and facilitates recovery and empowerment. In the ED and hospitals, trauma-informed care ensures physical and emotional safety and supports healthy recoveries.<sup>19–23</sup>

The city of Boston has experienced an increase in violent injuries. According to Centers for Disease Control and Prevention data reported from 2003 through 2007 for Massachusetts, homicide was the second leading cause of death among ages 10 to 24 years.<sup>24</sup> In Boston, the majority of victims of intentional shooting and stabbing are sent to Boston Medical Center (BMC). Our ED may be an opportune place to interface with victims of violence at a vulnerable moment in their lives. In June 2006, with support from the mayor and other stakeholders in our city, the BMC Violence Intervention Advocacy Program (VIAP) was created as a response to the resurgence of youth violence in Boston. BMC’s VIAP is an ED-based program designed after other hospital-based violence intervention programs.<sup>7,9</sup> All gunshot and stab wound survivors who are treated in the ED at BMC are VIAP clients.

Our program intervention is targeted toward the physical, emotional, and social needs of violently injured youth. Based on a peer advocate model and trauma-informed care approach, the VIAP’s program goals are to assist in emotional and physical recovery from violent trauma; empower victims of violence with skills, services, and opportunities; facilitate access to continuing health care and local community resources; promote positive role models and alternatives to violence; prevent retaliation and recidivism; and reduce morbidity and mortality from violence. The program employs community residents who are trained as violence intervention advocates (henceforth referred to simply as advocates). Advocates are hospital employees, recruited from communities with the highest rates of violence in Boston and the surrounding areas. Advocates attempt to contact all victims of penetrating trauma older than 15 years of age who enter the BMC ED. For those who participate in the program, advocates provide crisis

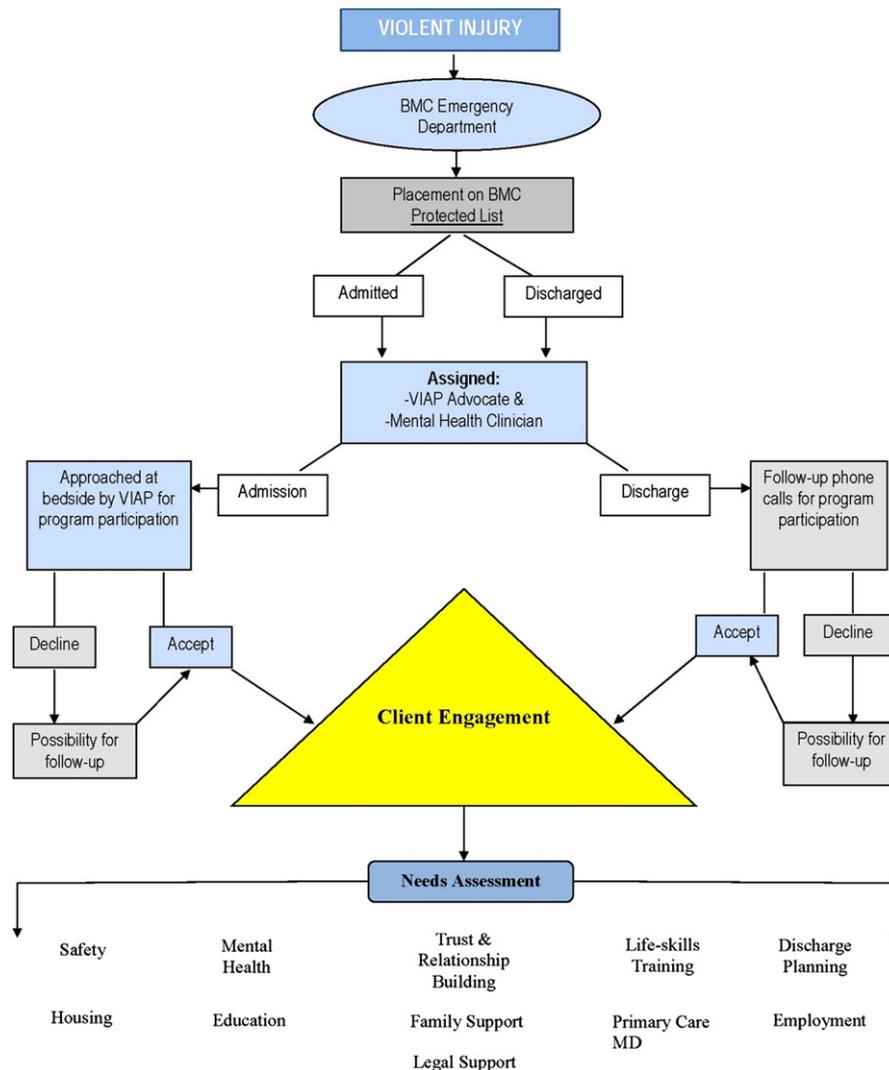
intervention through mentoring, case management, and referrals to other services.

The VIAP office is located across from the ED, where advocates screen the electronic medical record (EMR) system daily for victims of penetrating trauma. Each victim on the EMR list is assigned an advocate. Most gunshot and stab wound victims are admitted to the hospital, enabling advocates to make initial contact and daily visits while they are inpatients. During this time, advocates develop relationships with victims of violence and their families, conduct needs assessments, and begin to create plans to address identified needs. Because victims of intentional violence are at risk of experiencing posttraumatic stress disorder (PTSD), all patients admitted to our hospital for violent trauma are also evaluated by the Department of Trauma Surgery mental health clinicians.<sup>25–28</sup>

If a victim is discharged from the ED, initial outreach is done through follow-up phone calls. Phone numbers and contact information are obtained through medical records; however, due to a number of reasons, such as transience, homelessness, and incarceration, advocates are not able to reach everyone. Once patients are discharged from the hospital, advocates maintain case management relationships with their clients, providing support to address individual needs, and promote trauma recovery and behavior change while incorporating violence prevention messages (see Figure 1). Additionally, the VIAP offers family support services to any family member who is affected by the violent incident. The family support coordinator provides intensive support to family members of VIAP clients, particularly caregivers, by offering information, referrals, and ongoing coordination of any needed services. The VIAP does not limit the amount of time a client can receive services; the work continues as long as a client or family is willing to engage. On average, participation in the program continues for 1 year.

Since its inception in 2006, the VIAP has reached out to more than 3,400 victims of violence who were treated at the BMC ED. Of these, 64% were admitted to the hospital and received a minimum of crisis intervention services, retaliation and safety planning, mental health assessments, and referrals if needed. Of the remaining 36% who were not admitted to the hospital, advocates were able to reach out to 50%. The VIAP typically has between 50 and 75 open cases at a time.

The advocates are given ongoing training and support to optimize their skills, maintain compassion and quality, and manage the stress that comes with the job. Advocates are trained in a variety of evidence-based violence prevention and intervention strategies, including substance abuse screening, brief negotiated interviewing, motivational interviewing, psychological first aid, referral to treatment, and case management skills. Training sessions are also offered on vicarious trauma, recognizing and treating PTSD symptoms, working with family systems, gang mediation, and domestic violence, among other topics. All staff members are also trained on the trauma-informed care approach, as it is central to the clients’ care. Additional services include life skills, mentoring, education, job



**Figure 1.** Boston Medical Center (BMC) Violence Intervention Advocacy Program (VIAP) flow chart.

searching, and family support. In addition to training, advocates receive formal supervision from a licensed clinical social worker, and clinical consultations occur daily.

Previous observational and analytic studies have provided valuable information about the positive, mitigating effects of hospital-based violence interventions.<sup>19,29-44</sup> These studies report statistically significant reductions in violent behavior, retaliation, posttraumatic stress, recidivism, and involvement with the criminal justice system.<sup>9-11,45</sup> However, current literature lacks qualitative, contextual information that is critical for truly effective service provision. We suspected this in-depth information, as told by the clients themselves, would give ED providers a more comprehensive view to enhance their understanding of this young, vulnerable population that too frequently ends up in EDs due to violent injury. This level of insight could not be obtained from quantitative data alone.

This study aimed to explore clients' experiences and provide a contextual basis for understanding their perceptions of the effectiveness of the BMC VIAP.

Specifically, we sought to identify and contextualize VIAP's activities and clients' unique life circumstances.

## METHODS

### Study Design

This was an exploratory, qualitative study. The Boston University Medical Center Institutional Review Board approved the protocol.

### Study Setting and Population

The study was of ED patients who were English speaking, age 18 years or older, who presented to the ED with penetrating trauma and were enrolled in the VIAP. All VIAP clients who were enrolled in the program between July 1, 2010 and June 30, 2011 were eligible to participate ( $n = 204$ ). All interviews were conducted in person from July 1, 2011 and February 24, 2012. Clients who were incarcerated when injured and enrolled in the VIAP were excluded from the study. We identified specific research questions based on a systematic review of the literature conducted in March 2010 of

youth violence, hospital-based violence interventions, and patient advocacy programs.

### Study Protocol

We began with a master list of all patients enrolled in VIAP during the study period. From this list, we randomly selected 30 clients to contact for interviews and the list was divided among the advocates. If a client refused or was unable to be reached, or the current list was exhausted after 10 attempts to reach the clients, a new randomized list was generated from the remaining clients on the master list. This randomization process was repeated five times, until it was determined that data saturation was reached at 20 interviews (i.e., we felt the experiences were well understood).

Advocates were responsible for contacting potential participants for recruitment purposes, but were not involved in the research process beyond initial recruitment. Contact with each subject was made either by phone or in person during a regularly scheduled visit with an advocate who provided a brief introduction to the study. Participation was confidential and voluntary. The interviewer obtained full informed consent with a waiver of documentation from all study participants prior to the start of the interview. Participants were given the opportunity to have all of their questions answered prior to consent. Remuneration of \$50 was given to each participant after completing the interview.

In-depth, semistructured interviews were conducted by two trained qualitative interviewers who were not part of the VIAP team. The interview guide consisted of open-ended questions structured around the following domains: life pre- and postinjury, hospital experience, VIAP experience, retaliation, and general questions relating to family and friend dynamics, accomplishments in life, and goals (see Data Supplement S1, available as supporting information in the online version of this paper). All interviews were recorded with the permission of the participants. Recordings were then transcribed, verbatim, into Word documents by non-VIAP research assistants. All potential identifying information was redacted during the transcription process.

### Data Analysis

As this was a qualitative study, we chose an initial sample size of 30 based on feasibility and the assumption that this number would provide sufficient data to address our study objectives. However, since the interviews and data analysis were conducted concurrently, the decision was made by the investigators to stop data collection once thematic saturation was achieved after 20 interviews (i.e., no new themes emerged from interviews).<sup>46</sup> All interviews were coded and analyzed using QSR International's NVivo 10 qualitative data analysis software. A team of four coders analyzed the data: two trained non-VIAP research assistants, a clinical social worker, and a registered nurse (SB, BKL, ED, PMM). Interview transcripts were read in full by each coder. Fifteen of the 20 interviews were coded by three members of the research team together; differences of opinion regarding the assignment of a code were resolved through discussion. Five remaining interviews were coded independently by two coders. Interrater reliability using Cohen's kappa

was calculated by running a coding comparison query in NVivo, with over 90% agreement on assigned codes.

Data were analyzed using thematic content analysis consistent with grounded theory approach. Grounded theory is a method by which qualitative data are categorized and inductively coded into themes that emerge from in-depth analysis of the text. Participant responses are used to form the theory, as opposed to being used to prove or refute a hypothesis. The constant comparative method based on a grounded theory approach was used to inductively generate codes and highlight common conceptual themes among all responses.<sup>46</sup> Themes were identified by conducting a careful line-by-line analysis of each transcript. Once major themes were identified and agreed on, each theme was further subdivided and organized into separate subthemes and considered separate thematic concepts. Text searches and compound queries were used to further explore the data by examining whether or not linkages existed among particular themes and/or groups. Key themes were identified and data in the form of direct quotes were used to substantiate categories. Due to the nature of this exploratory, qualitative study, results cannot be quantified (i.e., we report only what participants freely described).

## RESULTS

Twenty VIAP clients were interviewed for this study. A descriptive summary of study participants is shown in Table 1. Most participants were male, African

Table 1  
Descriptive Summary of Participants

Characteristic	Study Sample (n = 20)	Total Randomized (n = 150)
Age, yr		
≤21	7 (35)	48 (32)
22–25	6 (30)	39 (26)
26–30	4 (20)	24 (16)
>30	3 (15)	35 (23)
Not documented	—	4 (3)
Sex		
Male	14 (70)	126 (84)
Female	6 (30)	20 (13)
Not documented	—	4 (3)
Race/ethnicity		
Black	14 (70)	105 (70)
Hispanic/other	6 (30)	41 (27)
Not documented	—	4 (3)
Education level		
Some high school (including currently enrolled or GED)	9 (45)	—
High school graduate	3 (15)	—
Some college	5 (25)	—
Not documented	3 (15)	150 (100)*
Previous violent injury		
Yes	5 (25)	25 (17)
No	15 (75)	121 (81)
Not documented	—	4 (3)

Data are reported as n (%).

\*Note: Education level information is not available for all VIAP clients.

GED = general education development; VIAP = Violence Intervention Advocacy Program.

American, and younger than 30 years of age, reflecting the overall VIAP clientele. Education levels ranged from having some high school or GED to having some higher education. Most participants reported they had not suffered prior violent injuries before enrolling in the VIAP.

The final coding structure consisted of six main themes (client program recommendations, effects of violence on community, life domains, other injuries/violent incidents, retaliation, and VIAP experience), 32 sub-themes, and 83 further subdivisions. Themes related to client challenges, life circumstances, and experiences with and perceptions of the VIAP were identified (see Figure 2). For the purpose of this article, we organized our findings into three main domains: challenges to physical and emotional healing, client experience with the VIAP, and effectiveness of the VIAP.

**Challenges to Physical and Emotional Healing**

Major challenges to physical and emotional healing were fear and safety, isolation as a coping mechanism, lack of trust, bitterness, and symptoms of PTSD (intense fear, hypervigilance, estrangement from others, emotional detachment).<sup>47</sup> Fears of going out of the house or being seen on the bus were limiting factors to moving forward. Participants felt unsociable and withdrawn, isolating themselves from friends and family. They described feeling unsafe anywhere in Boston:

Very anti-social, really don't like to go out anymore. I have eliminated a lot of friends now ... People feeling pitiful or sorry for me, I hate that. So, people tend to act like that, I definitely don't want to be around them at all, you know?—ID 20

Now, while I'm in Boston, no I don't feel safe at all. Like, especially like walking at night time, anything—so I try to refrain from that, you know, at all costs.—ID 12

Distrust, toward others or the legal system, presented a challenge to building new, healthy relationships:

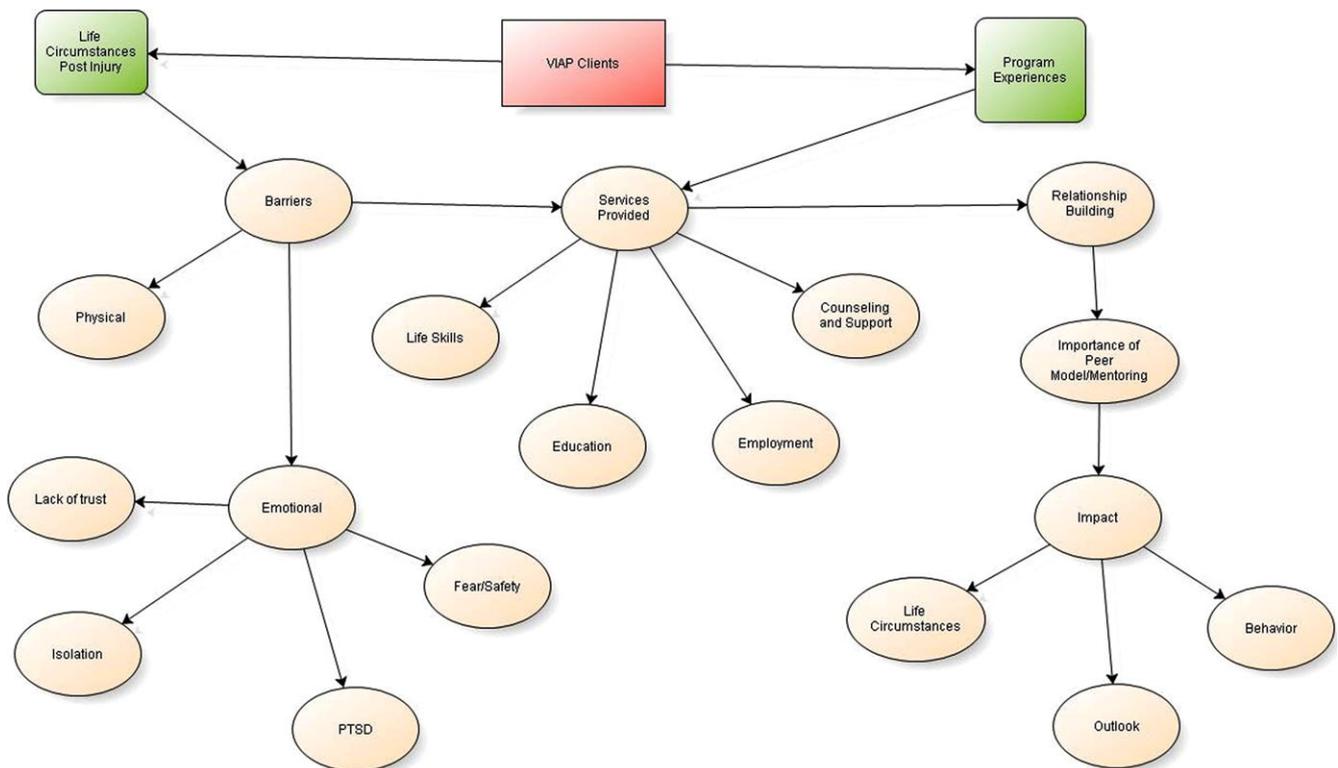
I don't. I can't trust nobody. I don't know who set me up. And everybody feel like it's my fault ... The cops are assholes. I'm sorry. They didn't do anything. They just was like seriously thinking it was all me.—ID 15

Emotions of anger and bitterness were shared:

I don't know, I feel defensive. I feel my life got violated. Let me think ... I feel like they took something from me ... My soul is bitter.—ID 13

You don't f—in' know me. Nobody knows me. Alright—you can't judge a book by its cover. Just cause I look rough and I do rough things—you just see that as rough on the cover and you can't just say that I'm rough. I'm gentle as all can be.—ID 15

Participants described common, interconnected challenges centered on mental health that were a continual part of their recovery. Many feelings described were symptomatic of PTSD (intense fear, hypervigilance, estrangement from others, emotional detachment).<sup>48</sup> Feeling burdened, hopeless, and numb was commonly expressed.



**Figure 2.** Model of coding structure. VIAP = Violence Intervention Advocacy Program.

### Client Experiences With VIAP

Half of participants expressed feelings of distrust or apathy toward their advocates at first contact. The main reason cited was not knowing who their advocates were; a few initially thought their advocates were police officers. Others described that they did not want to talk to anyone at the time. As the relationship progressed, these participants described how their attitudes toward their advocate changed. Many described feeling comfortable with their advocates after seeing how they genuinely cared:

Like I said when I first met him, I was ignorant. I just thought it was a person talking about a bunch of stuff. But after I seen that, you know, they actually did care and following up and still to this day, keeping in touch with me with personal matters, or you know, just playing a positive role, just checking on making sure I was alright. It means a lot to me and I'm—I'm grateful for it—this program to be around.—ID 11

Half trusted their advocates immediately and described some characteristics of peer model in developing connections and mutual trust:

He actually understood. He didn't judge me. When you like—with the other doctors and nurses when you tell them it was because of, you know gang-related—or you tell the police officer that you are like—and they think of you different. You know what I'm saying? So he actually understood what I was talking about cuz he had came from the same situations.—ID 18

When I first met him I thought like this is probably somebody that I can actually talk to because I felt like they could relate.—ID 5

Most participants reported high levels of involvement with their advocates during recovery:

He used to come in every day or like 2–3 times a week—how am I doing—ask me if I'm OK—if I need anything—we would talk. He would bring movies for me to watch.—ID 16

One participant felt the relationship did not last beyond a few months because his advocate did not try:

Yeah it just kinda fell off. Let me see, yeah because I have the same number. Yeah, so I feel like it just—he didn't really push enough. You know, he didn't try hard enough, so.—ID 4

Eight participants described longer-term relationships that went beyond physical recovery. Almost all participants described comfort talking to their advocates while characterizing how the relationships evolved over time. Six mentioned aspects of “listening” or “understanding” in concurrence to describing the relationship progression.

Participants recounted a number of ways advocates supported them postinjury. The following themes describe how the VIAP addressed clients' challenges: counseling and support, help with education, employment, and life skills. Counseling and support was the

most commonly cited service. According to most participants, advocates played a crucial role and filled a gap that is often missing from other service providers; connection to a caring and understanding adult that went beyond the scope of physical recovery from injury. They built meaningful and lasting relationships with their advocates:

He plays a big role. He keeps me level because he talks a lot, about things where I can say—I mean what, what ticks me off. You know maybe he'd call, and I'd be there and it'd be a bad day. You know, he'll call; he'd be like what's wrong man? What's going on? Talk to me! And, you know, we will get to talk. And somehow you know, I'd just let that moment go. And just get to a conversation, just from there. Don't think about it. Like he gives good points to me, you know what I mean? Don't go this way, just talk. Or, just wait and see what turns out with that situation . . . I might just even call him and ask him what he's doing, let's go play basketball.—ID 1

He plays a—he plays a major role. He helped me with a lot of things. If I need any advice, I can just call him. He's always trying to put me to programs and stuff like that.—ID 10

Participants described other ways their advocates supported them:

He has helped me like do my financial aid. He has helped me get myself back in school.—ID 18

You know, he helped me out—he was the first person to help me out with my resumé.—ID 14

Overall, all participants noted positive experiences with their advocates and important services provided; none indicated having had a negative experience. Subjects perceived their advocates' role as a positive influence, providing client-centered advocacy, education, and support. Additional quotes relating to client challenges and experiences with the VIAP are presented in Table 2.

### Effectiveness of the VIAP

The perceived effect of the VIAP was exhibited in a number of ways. Participants indicated positive connections to their advocates, describing ease and familiarity as pivotal in the progression of the relationship; they felt supported by someone who understood them. They felt they could relate to their advocates and that they genuinely cared. This aspect of peer support was commonly cited:

I mean, like I said it was a good thing for me. I don't know how to say it, put it in words. But he did, I mean he came through to me as, like I been all my life. Like he been there, like he came through as a brother.—ID 1

Participants built trusting, enduring relationships with their advocates and discussed current and future roles in their lives:

Table 2  
Themes and Supporting Quotes Related to Client Challenges and Experiences with the VIAP

Challenges	Quote
Fear and safety	"Safety—I mean, I don't know—safety is like—that word really doesn't, that word really doesn't apply to people in my situation."—ID 20
Trust	"So—I don't know, just like I said from the beginning I don't trust a lot of people. Could be my brother and anything. It's just that if I don't trust you, I don't trust you. Jus tryna keep myself on point."—ID 19
Isolation as a coping mechanism	"Ever since I got shot, I've been not trusting about anything—or ANYONE—or any situations. Parties I don't go to. I didn't spend Thanksgiving with my family. I didn't spend Christmas with my family. I just couldn't do it. I don't want to feel that pain. I don't want to go through the grief. I don't want to get killed neither."—ID 15
Bitterness	"I feel defensive. I feel my life got violated. Let me think—(long pause) I feel like they took something from me (long pause) ... My soul is bitter."—ID 13
Symptoms of PTSD	"Emotionally it didn't get me at all ... But then again I never cried at none of my friends' funerals. So I don't know what is wrong with me."—ID 18
VIAP's role	
Counseling and support	"I mean, just, you know, conversating with him ... it changes a lot of things when I had someone to talk to at the time I needed someone to talk to."—ID 1
Providing resources for education	"So yeah we looked for some schools. Actually he did help me look for some GED schools. So then I went. About 10 classes for 2 or 3 months, then I got my GED."—ID 10
Providing resources for employment	"We went to a job fair. Like we do a lot. He does a lot for me ... Again, I went to a job corps—something probably get placed there, get a job."—ID 8
Improving life skills	"Yeah my advocate helped me with everything I'm prepared for today ... Just people skills, better skills at expressing myself. Just sit down here and really think about what I wanna do, you know?"—ID 20

PTSD = posttraumatic stress disorder; VIAP = Violence Intervention Advocacy Program.

Every time I have a problem I reach out to him and he answers.—ID 15

He plays a good role in my life, a positive role. He's the positive role model, like he's the first real positive role model, like as in a person that's not in my family that I have met. You know he's like a bigger—big brother type thing, you know ... Like I have problems with trusting people, I know I can trust him. I know I can trust him.—ID 7

Three participants indicated that the VIAP's roles and effects on their lives were minimal, but described their advocates in a positive light:

Um the impact isn't huge. Like I said I had already made the decision myself, he just helped me to get there. So the impact (short pause) is fair. It's not like—he didn't completely impact my situation but he did help it.—ID 18

I feel like, he can help me, he can say stuff, (but) unless you live the life I live, unless he's from the hood, (he) can't really tell you much, cuz you are not experienced.—ID 4

Half of participants expressed feelings of retaliation initially, but almost all chose not to retaliate after participating in the VIAP for a variety of reasons, including faith in God, not wanting to hurt family, deciding it is not worth it, feeling grateful to be alive, and talking to their advocates. Talking to a caring adult who could relate was an overarching theme throughout the interviews. Improved confidence and desire to follow and

accomplish goals were also commonly expressed among participants:

Like I said we talked about it, and it calmed me down. So with him there, putting out the fire, yeah I came through ... if I did have no one to talk to, I probably would have went out there as soon as I got out of the hospital and got a little better and found my attacker. Boston is not that big ... like said if it weren't for him, I'd be more anger with that today, yeah.—ID 1

You know I really—you know he helped me get into the thought process but once that thought—I see that pin in my head, I had to do it, you know. I had to do it. So yeah we looked for some schools ... So then I went. About 10 classes for 2 or 3 months, then I got my GED.—ID 10

Some discussed how they felt supported and more comfortable going out of the house:

I feel, more comfortable, you know, being, being out. I know before I mentioned to my advocate, I don't feel too comfortable out, in a big space, or crowded places. So, we worked on that. So I feel a little comfortable. I still get little weary sometimes. But I feel a lot more comfortable.—ID 2

Yeah. I probably wouldn't have the courage that I have now because before—before I left the hospital I wasn't thinking that I would be outside anymore. Like he helps me get my motivation back, helps me not to be afraid, and it was just like—I feel like he was my protector.—ID 5

## DISCUSSION

Our findings suggest that BMC's VIAP clients perceive the program as positive and effective. Hospital-based violence intervention programs are growing around the country.<sup>48</sup> These programs witness positive outcomes with patients they serve on a case-by-case basis.<sup>8,11,45,49</sup> These findings help us understand that trauma-informed care and peer model-based interventions that employ staff with similar life circumstances provide opportunities for more in-depth, comprehensive, and effective services. Empowering individuals to return and be productive in their communities requires support, skills, services, and opportunities.

The path to successful, effective services for this poorly understood population involves tiers of full service interventions. Increased representation of these programs in the emergency medicine literature is useful, given that many programs are ED-based. Models of youth violence interventions suggest that despite differences in program structure, there are common themes related to client needs, experiences, and effectiveness. Previous violence intervention studies by Cheng,<sup>11</sup> Zun,<sup>49</sup> Frattaroli,<sup>50</sup> and their colleagues suggest that the needs of victims of violence have been addressed through intense mentorship. A review by Cunningham et al.<sup>9</sup> of hospital-based violence intervention programs corroborates these study findings. Mentors provide support for building skills in communication, conflict resolution, decision-making, safety, crisis management, and self-advocacy for accessing resources. In these studies, mentorship intervention models have been linked to risk reduction.<sup>11,49,50</sup>

In our study, we learned from clients' personal descriptions of their needs and experiences pre- and post trauma, specifically focusing on their experiences with our program. Our findings informed us about whether intense mentorship is an effective model for these clients and why. Clients shed light on specific elements of mentorship, such as a high level of engagement, that have previously been linked to successful outcomes. Our study adds context to earlier study findings by providing insight into how this occurs.<sup>11,49,50</sup> Additionally, this study provides information on the clients' unique life experiences.

Current literature on youth violence interventions lacks information about critical elements determining the acceptability and effectiveness of such a program. Our findings highlight deeper insight into these areas. They reveal important services provided by the VIAP that fill a void of unmet needs where traditional service providers fall short. They indicate the VIAP's positive effects in clients' lives through personal accounts of listening, understanding, and consistent, lasting support. Multiple interrelated challenges were identified that contextualize clients' complex life circumstances and unique experiences, such as lack of trust, fear, and safety; manifestations of PTSD; and isolation. Most importantly, qualitative methods allowed our program participants to tell their stories and share information that helps us to better understand and serve them.

Participants corroborated the crux of mental health in all aspects of violence. Mental health is a key

component in healing for victims of violent injury. Victims of intentional injury suffer psychological sequelae that affect their behavioral responses to the trauma.<sup>7,25</sup> Our findings contextualize these psychological effects (hypervigilant, feeling unsafe, trust issues, isolation) and help us understand how to provide effective support.

Community psychology and youth violence literature suggests the presence of a supportive adult mentor in the life of at-risk youth is an important link to opportunities for success; our findings support this.<sup>51,52</sup> Most study participants expressed feeling comfortable with their advocates. The advocates are able to address and integrate multiple needs simultaneously. Trust, education, insight, brief negotiations, and empowerment life skills are conducted and built through initial and consistent engagement. Almost all participants made conscious decisions not to retaliate. This is compelling, as prior studies show exposure to violence is associated with committing violence.<sup>9,29</sup>

## LIMITATIONS

Our findings are unique to our study participants and are not generalizable to other individuals or settings. Qualitative analysis is subjective by nature. As such, it is possible that findings may reflect personal biases of the investigators. Recruitment of study participants depended on the advocates themselves. This may have affected participants' decisions to participate and willingness to disclose unfavorable views of the VIAP. One interviewer lacked experience and was consequently removed from the study after conducting two interviews. All study participants were involved with their advocates to some degree; therefore, perceptions of those who did not participate in the VIAP were not obtained. This limited our ability to obtain information on mechanisms by which the VIAP may not be effective. Finally, it was beyond the scope of this qualitative study to assess effectiveness of the program through quantitative measures, such as decreased community violence.

## CONCLUSIONS

Victims of violence face multiple challenges that stem from layers of social and economic determinants. Understanding barriers, challenges, and the complexity of healing for victims of violence can help to provide appropriate care. Our findings describe some of these unique challenges that require far-reaching support to address: fear, lack of trust, bitterness, and symptoms of posttraumatic stress disorder. Participants described that they engaged in life-changing behaviors on their journeys to healing through connections to caring, steady, supportive adults who helped them feel trust and hope.

Our study provides important context and insight into the lives of 20 Boston Medical Center Violence Intervention Advocacy Program clients. We have gained valuable information on their perceptions of the effectiveness of this ED-based violence intervention program that will help our violence intervention advocates to further support clients. However, future research is needed to identify best practices for ED-based violence intervention

programs and measure community-wide efficacy in different settings.

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### Supporting Information

The following supporting information is available in the online version of this paper:

**Data Supplement S1.** Violence intervention advocacy program (VIAP) qualitative study interview guide.

# Spanish Abstract

The contents of this page will be used in html only.  
It will not be published as part of main article.

## El Violence Intervention Advocacy Program de Boston: Estudio Cualitativo de las Experiencias y el Efecto Percibido del Usuario

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### Resumen

**Objetivos:** Este estudio pretendió explorar las experiencias de los usuarios y proporcionar una base contextual para comprender sus percepciones de la eficacia del Violence Intervention Advocacy Program (VIAP) del Boston Medical Center (BMC).

**Métodos:** Éste fue un estudio cualitativo exploratorio realizado en un centro urbano de traumatología de nivel 1 del 1 de julio de 2011 al 24 de febrero de 2012. Se seleccionaron los pacientes del servicio de urgencias (SU) mayores de 18 años con traumatismo penetrante y reclutados en el VIAP. Dos entrevistadores formados, que no eran parte del VIAP, obtuvieron el consentimiento y llevaron a cabo las entrevistas semiestructuradas en profundidad. Las entrevistas se grabaron en audio, y fueron transcritas y analizadas, disociadas y codificadas. Se utilizó el análisis de contenido temático coherente con la teoría fundamentada para identificar los temas relacionados con las experiencias de los usuarios del VIAP, las circunstancias vitales, los retos para la curación física y emocional después de la lesión, los servicios prestados por el VIAP y la percepción de la eficacia del VIAP.

**Resultados:** Se entrevistó a 20 sujetos. La mayoría fueron hombres, afroamericanos y menores de 30 años, lo que refleja los usuarios del programa. La mayoría de los sujetos percibieron a sus miembros como cuidadores adultos en sus vidas, y citaron aspectos del modelo de ayuda por iguales que ayudó a establecer relaciones de confianza. Los principales retos para la curación fueron la seguridad y el miedo, la confianza, el aislamiento como mecanismo de defensa, la amargura y los síntomas de trastorno de estrés postraumático (TEPT). Cada sujeto dio cuenta de los importantes servicios prestados por los miembros del VIAP. La mayoría de los sujetos indicaron expresamente que tuvieron experiencias positivas con el VIAP y percibieron los roles de sus miembros como una influencia positiva, que proporcionaron consejo centrado en el cliente, educación y ayuda.

**Conclusiones:** Este estudio proporciona la percepción de las vidas de 20 usuarios del VIAP del BMC y contextualiza sus retos únicos. Los participantes describieron los comportamientos positivos que cambiaron sus vidas en su viaje a la curación a través de sus conexiones para su atención, con los adultos de apoyo. La información obtenida de este estudio contribuirá con el VIAP en la ayuda a sus futuros usuarios. Sin embargo, se necesita investigación futura para identificar las mejores prácticas de los programas de intervención en violencia basados en un SU y medir su eficacia en el contexto comunitario en diferentes escenarios.

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