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Phenomenological Study Identifying Facilitators and Barriers to Black and Latinx Youth's Engagement in Hospital-Based Violence Intervention Programs

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ORIGINAL ARTICLE

A phenomenological study identifying facilitators and barriers to Black and Latinx youth's engagement in hospital-based violence intervention programs

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Abstract

Black and Latinx youth are disproportionately affected by violence in the United States. Hospital-based violence intervention programs (HVIPs) have emerged as an effective response to this epidemic; however, participation rates remain low. This study aimed to identify facilitators and barriers to recruitment and engagement amongst black and Latinx youth from the perspective of HVIP staff. Employing a phenomenological approach, a purposive sample of key informants was recruited. Focus groups and semi-structured interviews lasting approximately 90 min were conducted with representatives ($N = 12$) from five HVIPs in U.S. cities across the Midwest and Northeast, making up 15% of all HVIPs in the United States. Each interview was recorded and transcribed verbatim. The research team employed rigorous content analysis of the data. Three themes and subsequent categories resulted from the analysis: (1) Interpersonal/Relational Facilitators (building rapport; connecting with youth; enhancing the teachable moment; building relational health); (2) Structural/Systemic Barriers (lack of reinforcement; difficulties connecting after discharge from the hospital; hospital workflow; institutional challenges); (3) Structural/Systemic Facilitators (embedding the HVIP; trauma-informed practices and policies). Given the limited research on black and Latinx youth and the disproportionate rate of violent injuries amongst these groups, an evidence-based systematic approach to engage youth is essential to promote health equity. The findings from this study suggest that there are several steps that HVIPs and hospitals can take to enhance their recruitment and engagement of youth and their families.

KEYWORDS
black youth, gunshot wounds, hospital-based intervention program, Latinx youth, paediatric, violence, violence

1 | INTRODUCTION

In the United States, approximately 45% of youth report experiencing one or more adverse childhood experiences (ACEs), with 61% of black and 51% of Latinx youth reporting at least one (Sacks & Murphey, 2018). One major form of trauma disproportionately experienced by youth of colour is gun violence. Black youth account for 43% of youth gunshot wound deaths, despite only making up approximately 14% of the U.S. population (Fowler et al., 2017). Of those who survive, approximately 37% will return to the emergency department with another violent injury within 2 years (Cunningham et al., 2015). To reduce violent injury recidivism, hospital-based violence intervention programs (HVIPs) provide services to violently injured persons starting at the bedside or in the emergency department, followed by long-term intensive case management (The Health Alliance for Violence Intervention, n.d.-a).

Though effective (Zun et al., 2006), HVIPs are plagued by low participation rates (Snider & Lee, 2009). Despite the disproportionate rates of ACEs and gun violence victimisation amongst black and Latinx youth, little research focuses specifically on these populations in the HVIP literature. Given the need for violence intervention programs, it is crucial to identify potential facilitators and barriers to recruitment and retention amongst these youth.

What is known about this topic?

- Black and Latinx youth are disproportionately affected by violence in the United States.
- Hospital-based violence intervention programs effectively reduce future victimisation amongst program participants but are plagued by low participation rates.
- Studying hospital-based violence intervention practices is critical to advancing health equity and ending the cycle of violence experienced by youth of colour.

What this paper adds?

- The interpersonal/relational facilitators converge with current research; however, a novel finding includes the importance of building relational health amongst youth, including investing in communities and caregivers of youth.
- Manifestations of structural racism may impact youth's care in HVIPs.
- Embedding the program into the hospital may ameliorate some of the structural barriers to workflow, sustainability and funding.

2 | LITERATURE REVIEW

Research on facilitators and barriers to HVIP recruitment and retention remains limited, particularly with respect to factors impacting the youth of colour (The Health Alliance for Violence Intervention, n.d.-b). Black males are most commonly represented in the reviewed studies (Bernardin et al., 2021; Decker et al., 2020; Myers et al., 2017; Neufeld et al., 2021; Richardson et al., 2021); however, few studies put their findings in the context of race. Richardson et al. (2021) notably explain focusing on young black men due to their high admittance to hospitals for violent injury and the potential systemic barriers to access services.

Research focusing on youth is critical to illuminate experiences that may be distinct from adult populations. Of the limited number of studies examining facets of recruitment and retention, sample age ranges vary between youth (Bernardin et al., 2021; Myers et al., 2017; Snider et al., 2010), and young adult or adult populations (Decker et al., 2020; Floyd et al., 2021; Jacob et al., 2021; Richardson et al., 2021). Studies focusing on youth of colour have uncovered factors (e.g. perceived discriminatory attitudes from medical personnel) that may negatively impact their hospital experience and engagement in HVIPs (Snider et al., 2010). Challenges to engaging youth upon discharge also exist, such as unstable means of communication (Floyd et al., 2021) or financial barriers (Richardson et al., 2021).

Trauma-informed care (TIC) principles have been proposed as one way to overcome challenges and address youth needs. TIC can help generate referrals and visibility, support HVIP integration into hospitals, and empower youth with voice and choice (McNamara et al., 2021; Myers et al., 2017). The relational quality between HVIP case managers and participants may also serve as a facilitator (Decker et al., 2020; Myers et al., 2017; Richardson et al., 2021; Wical et al., 2020). The initial encounter between HVIP staff and participants (i.e. the 'teachable moment') is identified as an opportunity for program recruitment (Myers et al., 2017). Qualities of the case manager may be important to the participant, such as exhibiting true compassion and care or having shared identities and/or lived experiences (Decker et al., 2020; McNamara et al., 2021; Richardson et al., 2021). Other studies have focused on actions of the case manager, such as the delivery of key promises, validating fear of hospitalisation, an explicit denial of law enforcement affiliation or participant perceptions that the case manager will not give up on them (Decker et al., 2020).

2.1 | Gaps and current study

Whilst new research is emerging daily, there is a dearth of literature examining factors impacting the youth of colour's recruitment and retention in HVIPs. Furthermore, most HVIP studies report on a singular program, limiting the transferability or generalizability of findings. This study aims to identify facilitators and barriers to recruitment and engagement of black and Latinx youth from the perspective of HVIP representatives across five programs.

3 | MATERIALS AND METHODS

This phenomenological study employed a purposive sampling strategy with HVIP key informants. Considering the socio-cultural-political context of adversity and trauma, HVIPs are located in cities with similar demographics (e.g. race), economic settings (e.g. manufacturing capital) and cultural contexts (e.g. segregation)—Chicago, Cleveland, Milwaukee, Philadelphia and Pittsburgh—were recruited and participated.

A recruitment email to programmatic representatives asked for the participation of staff members who had the most knowledge about recruitment and engagement efforts in their program. The first and third authors conducted two focus groups and one semi-structured interview with participants (see Table 1, for example, questions). The semi-structured interview was to accommodate a team member who was unable to join the focus group. The sample ($N = 12$) consisted of seven women and five men, including four program directors, four case managers, one program manager, one president and one vice president of community health and one academic partner. Though programs served youth and adults, participants were asked to focus their answers on youth. See Table 2 for program characteristics. Interviews were conducted using a virtual meeting platform, lasting approximately 1.5 h. All interviews were transcribed verbatim. Dedoose, a qualitative research software, was used for coding, memoing and organisation. For reporting purposes, sites were randomly assigned a letter (Site A–E) and this was appended to staff quotes hailing from their respective sites. To maintain confidentiality, we did not associate quotes with staff roles due to the small size of the sites. All study procedures were IRB-approved.

TABLE 1 Example interview guide questions

Questions	1. Describe how you approach a family/youth when first recruiting them to the program. • What has been your biggest asset when it comes to connecting with them? • What are some of the barriers to connecting with them? 2. Describe how you attempt to keep patients engaged in the program. • What do you think is most effective about what you do? • What are some of the challenges to keeping youth/families engaged? ○. What do you think might help to address these challenges? 3. What have been the program's greatest barriers to recruitment with your target population? • Describe any successes you have had in addressing these barriers 4. What have been the program's greatest barriers to engagement with your target population? • Describe any successes you have had in addressing these barriers 5. How do you navigate the family system with recruitment and engagement? 6. How does your program address the similarities and differences between staff and participants in your program (e.g. race, gender, age)? 7. How do you develop rapport with youth?

Note: Focus group and interview questions were the same.

Content analysis was conducted in four phases. First, two researchers separately completed open coding (i.e. attaching conceptual labels to segments of the data; Thornberg & Charmaz, 2014) and then applied focused coding (i.e. making connections between the open codes to create categories; Thornberg & Charmaz, 2014) resulting in preliminary categories. Second, the principal investigator reviewed these codes for accuracy, and the three researchers revised and organised these categories into preliminary themes using consensus. Third, preliminary themes, categories and codes were vetted by the larger research team, until a final thematic structure was reached. Finally, the results were shared back with all participating HVIPs, and in-depth feedback was provided by one HVIP. Five of the seven research team members have doctoral-level training in qualitative methods; of the two who did not have this level of training, one author has 5 years of experience conducting community-based research and one received hands-on training and supervision from the first and second author. Reflexivity was built into the data analysis process using memos whilst coding and regular reflexivity check-ins during team meetings.

Several steps enhanced study rigour (Johnson et al., 2020). Credibility was enhanced by developing a codebook and documenting the development processes of the codes, categories, and themes. Potential bias was limited by sharing findings and seeking feedback from study participants (HVIP providers), and the use of two coders, one supervisory coder, and a team of seven researchers to vet the thematic structure. Finally, we enhanced transferability by including detailed information about each program, including program, staff and client characteristics. Commonalities identified across five HVIPs also enhanced the transferability of the findings to similarly-situated HVIPs.

4 | FINDINGS

Three themes emerged related to the facilitators and barriers to HVIP recruitment and engagement: (1) Interpersonal/Relational Facilitators; (2) Structural/Systemic Barriers; (3) Structural/Systemic Facilitators.

4.1 | Interpersonal/relational facilitators

Four interpersonal/relational facilitators were identified in the study team's analysis of the HVIP data. No barriers were significant enough to elevate to the level of a theme; however, one HVIP representative acknowledged youth's sense of independence and autonomy, particularly with older adolescence, as a barrier to engagement.

TABLE 2 Hospital-based violence intervention program (HVIP) characteristics: program, staff and client information

	HVIP location				
	Cleveland	**Pittsburgh**	**Milwaukee**	**Philadelphia**	**Chicago**
Program and staff information					
Years in operation	2	5	25	12	7
Length of program (weeks)					
Designed length	52	4	72	36	88
Average participation	59	6	52	36	52
Staff size	13	4	17	13	15
Staff education requirement	Bachelor–Doctorate	Masters–Doctorate	High School Diploma–Doctorate	High School Diploma–Doctorate	Masters
Staff age range	25–65+	35–75	22–65	21–62	26–65
Staff gender (%)					
Women	75	50	50	41	80
Men	25	50	50	59	20
Other	0	0	0	0	0
Staff race (%)					
African American/Black	42	75	45	59	27
Asian	8	0	0	6	0
Latinx/Chicanx	0	25	1	6	20
Native American/American Indian/First Nations	0	0	1	0	0
White	42	25	27	29	53
Other	8	0	1	0	0
Client information					
Age range served	2–17	15–50	Any	8–35	0–30
Approached that consent (%)	31	50	85	60	33
Clients served per year (*N*)	41	70	216	388	150
Client gender (%)					
Girls/women	58	10	59	33	15
Boys/men	42	85	41	67	84
Other	0	0	0	0	1
Client race (%)					
African American/Black	91	–	84	76	85
Asian	0	–	1	1	0
Latinx/Chicanx	0	–	8	12	15
Native American/American Indian/First Nations	0	–	1	0	0
White	2	–	5	9	0
Other	7	–	1	2	0

Note: The authors are aware of inconsistencies and incomplete data in the staff race percentages reported for the programs in Pittsburgh and Milwaukee, respectively, as well as participant gender for the Pittsburgh program, however, the authors were unable to clarify these numbers with the programs.

4.1.1 | Building rapport

Establishing a rapport with families based on mutual trust and respect was an important facilitator. HVIP staff described different strategies that aided their ability to establish rapport with families. One strategy to build rapport was using support-centred language (e.g. 'Our job is to *support* people with violent injuries') rather than therapy-centred language (e.g. 'therapy' or 'counselling') when introducing the program to families.

> [As to the rapport building,] we do not lead with mental health. We don't say anything about therapy or counseling. We use the word support and [make it clear] that our job is to support people after they've been violently injured. [Site A]

> I can help them with their coping skills or whatever it is that they might need to work on. I tell them I'm not in the therapy role but if that's something that their family may need, then I can refer them to that. [Site E]

Representatives also described respecting and centring caregivers in the process, as caregivers serve as important gatekeepers for youth. One HVIP staff described that their respectful interactions with parents in fact counter to dismissive experiences caregivers may experience in the hospital otherwise.

> Respecting that parent as a parent. This doesn't [happen] a lot in the hospital system, it's almost like the parents aren't there or they [hospital staff] want them out of the way. But when we're first meeting them saying "this is your child, this is your family, this is affecting you." … I think engaging with them from a place of respect goes a long way. [Site A]

4.1.2 | Connecting with youth

Caregiver or parent buy-in was necessary, but not sufficient to effectively recruit and engage youth. Additionally, HVIP staff described building a strong connection with youth as another key facilitator. One strategy discussed was to 'get a win' for youth. For example, one participant described getting a win with youth involved with the police.

> In terms of really engaging the young person, it's really about getting a win or a reward for them. Kids respond to rewards and not punishment. [For example,] a police person can put a kid in handcuffs and tell their parents they can't see them in the hospital … So, a simple win or reward was getting that kid out of handcuffs so he could see his mom and dad, and then we worked with them. … It really is about acknowledging the child, trying to get a win or reward for them, and then building on the relationship after that. [Site B]

Centring youth's voice by being attentive to what they say is another important strategy, strengthening trust in the staff and program.

> One of the key points that we share with the staff is to always acknowledge the youth when you're walking in the room and to be attentive to what they are sharing with you, no matter if it's sharing their story or just telling you about their hobbies. That has really helped us to make sure that they're acknowledged, and that they feel important, and they know that you're there for them. [Site C]

Lastly, making direct connections with youth at places they feel comfortable (e.g. home, school, communities) on a regular basis (e.g. once a week or more) also helped HVIP staff build stronger rapport, yielding better engagement.

> We have outreach and connection directly with youth through our programming opportunities and school advocacy, and we're visiting with them in their home or the community where they want us to meet with them, and doing it sometimes on a regular basis—one time a week or sometimes more depending on the need of the family, it's a little bit easier to build rapport with that family group. [Site C]

4.1.3 | Enhancing the teachable moment

Many HVIPs rely on the opportunity of the 'teachable moment' to facilitate recruitment and engagement (Johnson et al., 2007). To capitalise on this opportunity, representatives described that providing something concrete and immediately helpful to families was favourable for initial engagement (e.g. trauma psychoeducation, strategies to manage trauma responses), as they can be 'less threatening' to families than longer, open-ended interventions.

> The first thing really that we're doing is psychoeducation about trauma and maybe some tips about how to manage trauma reactions when they happen, and I find that that can really get people engaged because they feel like you know what you're talking about and it was actually helpful for them. [Site A]

> We use a dyadic intervention for a child and a caregiver for ages 7–18. It's short-term, focused on the immediate reactions to a traumatic event … it's a structured way to engage with the caregiver that is less threatening than this kind of open-ended, 'oh, we're gonna work with your family.' [Site A]

Participants also described a strategy of keeping a line of communication open with families who were not immediately receptive.

> Never underestimate the power of giving them some time, because we have a number of families that … slam the door in your face, tell you they're done, get out, but we always ask permission to do a follow-up call, 'can we just check in with you a little bit later just to see how you're doing?', and sometimes that's our way in. They know that we're still

there and we still care, so that's a way in to offer that support. [Site C]

4.1.4 | Building relational health

Representatives described important aspects of recruitment and engagement that appeared to the research team as building 'relational health', or interpersonal interactions that are growth-fostering or mutually empathetic and empowering (Liang & West, 2011). For example, hosting family events where the entire HVIP staff and other hospital staff joined in helped to establish growth-fostering interactions with families, enhancing families' sense that staff are fully invested and not just 'checking a box'. Participants described the relationship between the intervention specialists and the clients, characterised as supportive, having longevity and holistic, as the most impactful part of the program.

> The most impactful aspect of the program is the relationships that the intervention specialists have with their clients. They do intensive case management that can last years. They're really involved in supporting our clients in every aspect of their lives, from their medical care to court, school, job, you name it, and there are other components of the program, like trauma psychoeducation groups, and we have numerous partnerships, or overlapping programs that provide other services. But, I think really, that relationship and the way that they get to know their clients and work with them to establish what they want for themselves and supporting them in getting there, that's really the key. [Site A]

Furthermore, collaborating with peer community health workers (hired and trained community youth who provide peer support) can enhance the number and quality of prosocial relationships with similar youth.

> [Youth who have prolonged program engagement] are comfortable talking about their experience, they have grown, they have asked for help, they have welcomed help, but they have also been a peer support to others in that group, and wanted to reach out in their community to give back some of the support they've received, whether it be through community organizations or even faith-based groups, and they want to give back by sharing their experience. [Site C]

4.2 | Structural/systemic barriers

4.2.1 | Lack of reinforcement

HVIPs are voluntary programs and the lack of external motivators for participation in HVIPs, particularly amongst caregivers who can be influential to youth, can pose a barrier to recruitment and engagement. Whilst external incentives (such as monetary or mandates) are not alone sufficient to effectively recruit and engage youth, these tools can be salient when caregivers show indifferent reactions to recruitment efforts of staff.

> When we're meeting with [patients], we require a parent there for that initial one to get consent, and when we're meeting with them, sometimes the parents will say 'it's up to them'. So the parent doesn't want any engagement, and that becomes a challenge in itself because then there's no reinforcement or follow through, and because we're voluntary, that poses a barrier. [Site C]

4.2.2 | Difficulties connecting after discharge

Because HVIPs are based in hospitals, recruitment and engagement are difficult when program staff are unable to make initial contact with patients whilst they are hospitalised. Reasons HVIP staff may not be able to make initial contact in the hospital include understaffing (e.g. no coverage during certain hours) and mild injury resulting in quick release. One representative (Site C) stated, 'If we don't get to families in the hospital, we have a harder time connecting with them outside of the hospital … turning into a cold call'. Also, it can be hard for staff to 'stay in touch', posing a barrier to further engagement. One person (Site D) described this, 'Once people are discharged, [they] are pretty much on their own. … It's a little hard to stay in touch with folks and find out if our linkages have done everything we want them to do … that's the challenge of this kind of work'.

4.2.3 | Hospital workflow

Intra-organisational norms, procedures and policies shaping how hospital staff function may pose barriers to recruitment and engagement. Due to the size of the organisation, hospitals have a complex structure and workflow that can complicate service delivery. For example, HVIPs are commonly structured to rely on hospital staff as referral sources, though they are not directly tied to the program (e.g. nurses), leading to 'slippage' or loss of referrals.

> We work with emergency departments, and critical care, and trauma services, and so we're not in the workflow and we have to rely on social workers and nurses to call us when people show up and that slippage has been a perennial problem for us. [Site D]

Additionally, high turnover amongst hospital staff may result in decreased referrals due to lack of awareness and understanding of the HVIPs amongst new staff.

> There is a huge turnover in the hospitals of social workers and nurses … that's the reason that it's important that we do training for new hires that come in. We try to do it on a quarterly basis, but, so if one social worker goes that really understands the program and the new one comes in and don't know nothing about the program, we don't get the referrals. [Site D]

High turnover rates can also lead to a lack of branding within the hospital, exacerbating the issue of slippage amongst referral sources and requiring a heavy burden for HVIPs to educate new employees on a regular basis. One representative (Site C) stated, 'I think that part of the barrier is that … because of turnover [among the hospital staff], sometimes branding is a challenge'. Finally, the capacity of HVIPs is outmatched by the volume of eligible patients, as described when a representative (Site A) stated. 'The biggest barrier for us is volume. We have a huge volume of patients at both of our hospitals, and they end up waiting for services and we lose them during that time. We need about 3 times as many people on our staff to meet the demand'.

4.2.4 | Institutional challenges

Institutional challenges are the embedded conventions of hospitals that do not align with the aims and mission of HVIPs. For example, the HVIP funding sources were almost entirely external to the hospital budget (i.e. local foundations, government grants), and some hospital trauma services (a vital component of HVIPs) do not provide sufficient commitment to community outreach and training. This was described by a representative (Site D), 'I want the hospital to [m]ake more of a commitment to our programs, because right now we are the ones who go out and get money so that we could do this, but there's only four [program staff] and we need more [support] … We need more of the hospitals to be more engaged'. A lack of institutional support from hospitals for gunshot wound victims in contrast to other patient groups who receive care after hospital discharge also posed a barrier.

> One of the biggest barriers that we face is … [that] anything other than a gunshot wound victim, the hospitals do good with their care managers that go to the house and help individuals depending on what their issue is. They don't do the same with gunshot wound victims. … We've always wanted the hospitals to take more initiative in helping us. We go after our own funding to make this happen. [Site D]

One representative (Site B) described how hospital staff judged the 'worthiness' of victims before deciding to refer youth to the HVIP for extended care. There was agreement amongst the group that this lack of support was a manifestation of 'embedded racism'. In some cases, respondents felt that the gunshot wound victims, most of whom are black and Latinx youths from low socioeconomic backgrounds, are treated as 'throw-away' people. One respondent described how the hospital states they care but does not commit the resources to care for gunshot wound victims.

> I believe there's the embedded racism issue in terms of, these [gunshot wound victims] are throw away people, and it burns me up that they take that view, but it's very real. We've been working hard to try to provide some education to the nurses and the physicians and the social workers, we do in-services on the regular to let them know 'look, you know, we can extend the care, we need you to make the referral. It's not who you decide or think is worthy of the services. It's anyone who's been shot, who's been stabbed, who's been assaulted.' … Sadly, I think our institutions, they get the value added but they're not as willing to chip into that value. So, like I said, there's a deep structural issue there that burns me up. [Site B]

4.3 | Structural/systemic facilitators

4.3.1 | Embedding the HVIP

Strategies to embed HVIPs in the community were identified as facilitators. The extension beyond the hospital was emphasised as a critical feature of HVIPs in order to empower families and recover from violent injury. One participant described this as,

> Once they're in the hospital, they get a service, and then they're discharged and they don't have anything. So this program is very critical to the community because we act as advocates of change and we offer support—intervention support—and resources, and try to help them so that they can be better able to help themselves. [Site E]

Other HVIP staff described a deeper layer of embedding the HVIP in the community. For example, some HVIP staff resided in the communities they served or got involved with community organisations to strengthen connections. This connection to the youth's lived experience was critical in order to create a sense of trust between youth and their families. One participant (Site C) describes this, 'The program component that is the most impactful for the population we serve is our ability to connect throughout the community. A lot of our team resides in the community that we serve, and a lot of our team is involved in different community organizations that we partner with on a daily basis, both formally and informally'. Representatives also described that when participants are able to see others who 'look like them', it can provide comfort in the aftermath of traumatic experiences. One participant (Site C) illustrates this, 'I think the ability for our families to see people who look like them is huge. That is extremely

important—building trust especially in the moment of trauma. It's a level of comfort'. 'You're serving these people, so you gotta put yourself in their shoes'. Another HVIP described how the staff must be both culturally competent and diverse, and that these are not substitutes for one another.

> [Our staff] have to be empathetic, have to be knowledgeable, not only culturally competent but diverse because they're two different things … because the population that we actually work with, it can be very complex sometimes. [Site E]

Hiring and training youth or young adult community members as peer community health workers and mentors was another strategy identified to embed HVIPs in the community and foster recruitment.

> …to bring on someone with lived experience to be a part of the team to help establish relationships … around training young people as health educators. We got some support to develop a community health worker peer training academy. [Site B]

Representatives also described strategies to embed HVIPs into the hospital to enhance success. Embedding the HVIP into the hospital provided more financial security and enhance services for HVIPs. HVIP successfully lobbied for the use of Medicaid clinical codes to reimburse peer or community health workers ('certified peer specialist'), who was instrumental in engagement.

> …behavioral health has a credential for certified peer specialist, which allows them, if they were hired by us or hired by any outpatient clinic, they're eligible for reimbursement [through Medicaid clinical codes] for whatever services are provided. … we have a particular identification number that we're able to bill for the services provided. All services provided are billed for one rate. [Site B]

Representatives described how embedding themselves into the existing hospital and community infrastructure allowed them to maximise resources and connect clients to a system of care to serve the specific needs of patients and families (e.g. coordination of mental health services).

> We, as a leadership team across our entire department, have been able to leverage additional resources and staff who have expertise in certain areas. Many of the families are co-managed by other teams to help with making sure that the staff person is really focused on safety planning and care, wound care, mental health services, while other members of the team may focus on social determinants of health. [Site C]

4.3.2 | TIC practices and policies

Trauma-informed care practices and policies in HVIPs were identified to enhance recruitment and engagement by securing the safety and well-being of the youths, families and staff. These refer to practices and procedures that (1) assume clients, families and staff have experienced and are affected by trauma and (2) aim to minimise or resist further activation of those experiences. For example, representatives described policies that emphasised transparency amongst staff, whilst also maintaining patient confidentiality to preserve trust with the family whilst prioritising staff safety, which was salient with youth at risk of retaliation.

> Some of the issues that we've been trying to navigate through is one, retaliation—we see a lot of overlap in the incidents that are happening that are referred to [our program] and because the referrals are sorted out through our 16 staff of crime victim advocates, making sure that everyone is in the loop without giving them the entire story and breaching trust and rapport that the family has with the person that they're working with [is important]. So keeping our team safe, but also keeping the families safe and keeping privacy at the forefront. [Site C]

One representative described matching families with the best-fitting staff to reduce retraumatization (e.g. assigning female staff to families with domestic violence victimisation by a man).

> We triage cases a lot when they come across us, and we discuss as a [team], 'who is the best fit for this family?' because every staff is not the best fit for the family, and we have to acknowledge that going in. Some of the challenges that we've seen, especially with domestic violence or different form of abuse, we know that sometimes we can't send a male staff. So we have to shift, even though that may be the person I'll call. We do that to ensure that we're not causing more trauma to the family or to the staff. We try to balance That. [Site C]

Other strategies included warm handoffs and protocols ensuring patients and families were not asked to recall traumatic memories repeatedly to different staff.

> I think one of the beauties of our team and how we refer [is that] it's a warm handoff … we don't want to re-traumatize a family by having them retell their story. So, we make sure we make that connection prior to getting everything we need to move forward, and most of the time we do have the staff person who was working with the family do the introduction so

> they know it's someone they can trust, because in this space, they are very vulnerable. [Site C]

Lastly, one program described the integration of self-care and professional development for staff to address vicarious trauma (i.e. occupational trauma resulting from empathic engagement with clients; Bell et al., 2003) stemming from challenges inherent in this line of work. This was described as an essential component to recruit and retain HVIP staff.

> One thing that comes to mind in terms of our barriers in recruiting and maintaining employees and working in this space is the ongoing exposure to the vicarious trauma is a real significant risk for our team. *** do a fabulous job of integrating self-care and a lot of professional development and training around self-care and vicarious trauma, and so there are ways to overcome that. [Site C]

5 | DISCUSSION

As the emerging standard of care for violent injury in hospitals, studies advancing HVIP practices are critical to advancing health equity and ending the cycle of violence experienced by youth of colour. This study presents findings on a variety of facilitators and barriers to recruitment and retention of black and Latinx youth from representatives of five HVIPs. Instead of focusing on a single program, this study's sample increases the chance of transferability of findings to other HVIPs in mid-sized, urban locales. Though based in the United States, this study may be applicable for other countries employing HVIPs to interrupt the cycle of violence, particularly amongst marginalised youth because of shared elements across settings including individual elements such as violent injury and environmental elements such as systemic oppression. Furthermore, this study presents a range and depth of findings at two levels of impact: Interpersonal/Relational and Structural/Systemic. Given the focus, sample and range of findings presented, this study advances the field's understanding of unique factors that support or prevent engaging youth of colour, potentially bolstering HVIP effectiveness.

5.1 | Interpersonal/relational

The interpersonal/relational facilitator findings converge with existing literature at several points. For example, building rapport and connecting with youth mirror other research findings of conveying compassion, 'going the extra mile', engaging with family and friends, and delivery on key promises early (Decker et al., 2020) as critical components to success with youth. Adding to the knowledge base, the current study also pointed to using 'support-centered language' as a means to circumvent the documented stigma of therapy and mental health services in black and Latinx communities (DeFreitas et al., 2018). Furthermore, HVIP representatives identified prioritising youth's agency and needs (i.e. getting a win, centring what youth say) and dedicating time with youth (increase outreach, spending time on a regular basis) as key facilitators.

The 'teachable moment' is considered a critical opportunity in the process of recruitment (Decker et al., 2020; Myers et al., 2017), though little research describes how to effectively engage injured youth of colour during this moment. The disproportionate rates of adversity and trauma experienced by youth of colour (Sacks & Murphey, 2018) and the legacy of institutional racism in healthcare (Paul Jr et al., 2020) may be important factors for the 'teachable moment' with these youth. Findings from this study suggest that the success of this moment hinges on strong interpersonal skills (e.g. giving space to those who need it, being attuned to needs) and training in trauma interventions that can be easily taught to families. Additionally, the HVIPs identified the importance of building the relational health of youth, including investing in communities and caregivers of youth. This extends the literature to incorporate a more holistic ecological approach to engaging youth.

5.2 | Structural/systemic

Several novel and critical findings related to structural and systemic issues in HVIPs emerged. Described as 'throw-away children', one participant illuminated the absence of institutional support for low-income, youth of colour who enter EDs with violent injuries. This finding adds to a small body of literature identifying elements of structural racism impacting youth's care in HVIPs; for example, feeling discriminated against based on race, class and gender by hospital workers (Snider et al., 2010). This study's findings parallel research illuminating discrimination and subsequent inequities in the criminal justice system, judging the worthiness of violently-victimised black women (Garcia & McManimon, 2012). In this historical moment of racial reckoning, many institutions have begun to publicly reflect on structural racism and resulting inequities. Paul Jr et al. (2020) stated 'the history of medicine and public health in the United States reveals a pattern of medicalizing the suffering of White communities while ignoring or criminalizing the similar suffering of minority communities, especially Black communities'. (p. 1404) These authors go on to urge medical institutions to do more than voice this reality and instead take action that aligns with some of the facilitators identified in this study. Actions of this kind were articulated by representatives in our sample when they described the importance of training HVIP staff in TIC and developing policies and practices in line with this approach, similar to recommendations in previous research (McNamara et al., 2021; Myers et al., 2017). Pairing this with the recommendation to have hospitals review existing policies and practices in 'dedication to the approach of truth and reconciliation' could be transformative (Paul Jr et al., 2020). Additionally, HVIPs reported that embedding the program into the hospital (both physically and financially) may ameliorate some

TABLE 3 Recommendations for recruitment and engagement in hospital-based violence intervention programs (HVIPs)

Theme	Recommendations
Interpersonal/relational facilitators	
Youth's sense of independence and autonomy	• Tailor recruitment protocols to the age of youth, particularly with adolescents
Building rapport	• Use relatable language ('support-centred'), rather than potentially stigmatising (i.e., 'therapy') language when introducing the program • Respect caregivers through inclusion, good communication and authentic connection
Connecting with youth	• Identify ways to advocate for 'simple wins' for youth whilst in hospital. • Build trust by being attentive to youth • Once recruited, meet youth in their comfort zones • Spend time with youth on a regular basis
Enhancing the teachable moment	• Deliver brief, trauma-focused intervention to alleviate symptoms in the hospital • Provide brief, concrete deliverables as means to not overwhelm family and build trust • Read verbal and non-verbal cues to sense family's readiness to talk, offer the option to check in later if not ready
Building relational health	• Host and/or attend community events where participants reside • Assess and connect caregivers with resources to address social determinants of health • Enhance support of youth through prosocial engagement activities with peers (e.g. peer community health workers)
Structural/systemic barriers	
Lack of reinforcement	• Include incentives for caregivers (e.g. programming support, case management support) • Use motivational interviewing techniques to bolster engagement
Difficulties connecting after discharge	• Review staffing protocols and referral streams to enhance the likelihood of contact before discharge
Hospital workflow	• Embed HVIP introduction materials into mandatory training for new hires (nurses, social workers, residents, medical students) • Develop a flag in the electronic medical record to prompt referral • Build relationships with medical staff to establish champions and improve program branding to bolster referrals • Awareness
Institutional challenges	• Conduct equity review of institutional support (e.g. infrastructure, internal funding support) across areas of care using an antiracist lens • Educational training in implicit bias for all hospital staff and students
Structural/systemic facilitators	
Embedding the HVIP	• Hire staff with lived experience that mirrors the population served, including youth workers or adults stemming from or residing in similar neighbourhoods and circumstances (e.g. community health workers) • Invest in the communities where youth reside • Link to funding mechanisms, such as Medicaid • Capitalise on existing resources in the hospital to provide well-rounded care for youth where gaps exist
Trauma-informed care practices and policies	• Train HVIP staff in trauma-informed care • Conduct trauma-informed organisational assessment (e.g. policies and procedures) • Establish organisational supports (e.g. reflective supervision, self-care days) to address secondary and vicarious trauma of care providers

of the structural barriers to workflow, sustainability and funding. This facilitator aligns with the recommendation of equitable funding between 'traditional disciplines' and those that disproportionately affect black, indigenous, and people of colour, such as violent injuries (Paul Jr et al., 2020).

5.3 | Study limitations

The HVIPs included in the study were based in Midwest and Northeast U.S. cities. It is possible that HVIPs and their participants have unique characteristics relative to their geographical regions and readers should consider the socio-political-cultural context when interpreting and applying these findings. Though our sample consisted of representatives from five HVIPs, it reflects the experience and perspective of approximately 15% of existing U.S. and England HVIPs at the time of the study ($n = 34$). Some findings may be transferable to other HVIPs despite potential differences across contexts. Along those lines, participating programs did not exclusively serve youth and young adults; however, representatives were aware of the paediatric focus and answered questions with this in mind. HVIPs serving solely paediatric populations are relatively rare in the United States. Finally, youth voices were

not included in this study, though many of our findings converged with studies that did include youth. Nevertheless, this study's findings should be validated with youth's perspectives to discern important nuances and expand the scope of facilitators and barriers.

6 | CONCLUSIONS

This study adds to the limited research on youth of colour and disproportionate rates of violent injuries amongst them in the HVIP literature. Critical to recruitment and engagement are HVIP staff's interpersonal skills; however, this study also illuminated programmatic approaches to build 'relational health', potential barriers of structural racism, and opportunities to improve engagement by embedding the HVIP into the hospital. It is essential for HVIPs to effectively engage youth of colour in order to provide equitable access to care. Table 3 identifies multiple steps HVIPs can take to enhance their recruitment and engagement of youth and their families. Follow-up studies should recruit HVIP providers in other regions of the United States and other countries, as well as with youth recruited for HVIPs, to identify points of convergence and divergence. Convergence on themes reported in this and future studies should prompt translational research using quasi-experimental and mixed-method designs to identify which approaches work best for whom.

AUTHOR CONTRIBUTIONS

Study conceptualization and data collection (Voith; Salas Atwell); data analysis (all authors); manuscript writing (all authors); manuscript editing (all authors).

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CONFLICT OF INTEREST

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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