Trauma Surgery & Acute Care Open

Break the cycle Baltimore: proceedings from a summit to unite violence prevention stakeholders

Emily Kemper,[1] Matthew Price,[1] Melissa Hirsch,[1] Insia Zufer,[2] Kathleen Wagner-Kosmakos,[3] Madhu Subramanian ,[1] Joseph Sakran,[1] Nathan Irvin,[1] Katherine Hoops [1,4]

[1]Johns Hopkins University School of Medicine, Baltimore, Maryland, USA
[2]University of Illinois College of Medicine at Chicago, Chicago, Illinois, USA
[3]Johns Hopkins Hospital, Baltimore, Maryland, USA
[4]Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland, USA

Correspondence to
Dr Katherine Hoops; khoops1@jh.edu

EK and MP contributed equally.

Received 2 July 2024
Accepted 22 January 2025

To cite: Kemper E, Price M, Hirsch M, *et al*. *Trauma Surg Acute Care Open* 2025;**10**:e001518.

INTRODUCTION

The city of Baltimore has been ravaged by the epidemic of gun violence for decades and frequently ranks as one of the most violent cities in America. In 2022 alone, 336 people died by firearms in Baltimore and an additional 688 people suffered non-fatal firearm injuries. In 2023, Baltimore experienced the first year in decades with fewer than 300 annual gun violence-related deaths, but 263 lives were still tragically lost in our community.[1] For years, community and faith groups, researchers, clinicians and city and state governments have each worked to reduce violence and the conditions that contribute to it, but often this work occurs in isolated silos. Across the country, there have been evolving initiatives to bring stakeholders together to share information and approaches to develop greater collaboration. In Baltimore, the city government has worked to establish a violence prevention 'ecosystem', a comprehensive approach to violence intervention including hospital-based violence intervention programs (HVIPs), victim service organizations, legal advocacy organizations, community violence prevention and intervention programs, school-based programs and other resources through the Mayor's Office of Neighborhood Safety and Engagement (MONSE).[2]

HVIPs are one of the critical nodes in this robust ecosystem. Created in 2019, our institution's Break the Cycle Hospital-based Violence Intervention Program employs a trauma-informed public health approach to violence and its prevention. Focusing on youth and young adults aged 15–35 who present to the hospital with penetrating assault trauma, the program's violence intervention specialists provide wrap-around case management support to decrease the likelihood of repeated assault-related injuries and to help patients navigate the socio-structural barriers preventing them from living healthier lives. Since its inception, approximately 2% of patients who have participated in the program experienced reinjury, a figure that is far lower than the 15.7% historical reinjury rate that existed before the program started in our institution.[3]

While our HVIP and others around the city have been both passionate about and highly effective in supporting our clients and decreasing the incidence of recurrent injury in the people we serve, many challenges exist to maximizing opportunities for healing and supporting individuals in need across our city. Together with partners in our institution, we sought to convene the dedicated members of the violence prevention ecosystem - bringing together a diverse cohort of community, academic, and policy-making stakeholders to develop collaborative strategies to help break the cycle of violence across our city. Herein, we describe our process for identifying and convening stakeholders. We also share our organizational strategy to inform similar convenings in other cities and summarize the key findings from our discussions.

GOALS FOR CONVENING THE ECOSYSTEM

First, our core team of hospital administrators, physicians, violence intervention specialists, multidisciplinary clinical leaders, and public health researchers converged on a set of goals for the summit. We identified a critical need to:

1. Convene a diverse, intersectional group of stakeholders to share information, highlight best practices, and foster collaboration to build on existing relationships and forge new ones that will fortify the work of the respective organizations.
2. Identify ways to leverage the strengths and talents of the individuals and organizations that constitute the ecosystem in order to maximize the impact of the collective.
3. Bring awareness to the needs of all those affected by firearm injury and violence, their families, and the workforce that supports them.

With those goals in mind, we sought to create an inclusive list of invitees, including groups caring for people harmed by violence and their families, public health researchers and advocates engaged in violence prevention, key hospital administrators, partners in state and local government, and community partners and organizations working to prevent violence or support individuals affected by violence. Invitations to this citywide summit were shared broadly to maximize the inclusivity of the event. In so doing, this summit brought ecosystem partners together to strengthen bonds, highlight best practices, and identify solutions to challenges. Many of the organizations represented are listed in our Acknowledgements section. In addition to area hospital-based programs and local health systems, key contributors included the MONSE, Roca Baltimore (a community-based violence intervention program relentlessly serving youth experiencing trauma), The ROAR Center (a university affiliated program providing legal services and other supports tailored for survivors of crimes), Community Justice

a

b

Figure 1 (a) Panelists discuss community-based initiatives in Baltimore City. (b) Panelist Gregory Jackson, now Deputy Director of the White House Office for Gun Violence Prevention, discusses the need to support those affected by trauma and violence.

(an advocacy organization working to empower marginalized populations to center conversations about violence prevention around affected communities), Marylanders to Prevent Gun Violence (an organization working to promote comprehensive and evidence-based policy to prevent violence in Maryland) and The Johns Hopkins Center for Gun Violence Solutions (home to some of the nation's leading experts on violence prevention).

The full-day summit included an information-sharing morning and an information-gathering afternoon. Lecturers shared information on the impact of violence in our community, historical trends, evidence-based programming and policy and governmental partnerships. The perspectives of survivors, families and community activists were the focus of panel discussions (see figure 1). After these learning and listening opportunities, we then asked participants to self-select into one of several breakout sessions to foster a robust dialogue focused on specific, actionable solutions to address violence in our communities. These breakout sessions focused on four areas: the needs of HVIPs; the role of intersectional educational programming; strategies to unite the Baltimore violence prevention ecosystem and policy strategies for violence prevention.

BREAKOUT SUMMARY: HVIPS

In our HVIP breakout session, we discussed the implementation and challenges of HVIPs, particularly focusing on challenges experienced at the Johns Hopkins Hospital (JHH) and the University of Maryland Medical System (UMMS) as well as three other area HVIPs with members from all these HVIPs present. The discussions highlighted gaps in services, such as limited staffing leading to difficulties in reaching all patients, especially at night. A major factor at JHH was that there are only two specialists on the team, and as such, they do not have the capacity to reach all patients who could benefit from their services. At both JHH and the UMMS, identification of patients who could benefit from the programs has been challenging as many who experience violent injuries come through the emergency department and are discharged before the HVIP team has an opportunity to engage with them. Strategies were explored to improve patient engagement, including involving family members, integrating HVIP members with multidisciplinary clinical teams and providing training for various hospital roles to identify and support patients in need.

Participants highlighted further challenges in pediatric settings. Specifically, minimal funding and low staffing have prevented the expansion of the JHH HVIP to the pediatric emergency setting. Social workers are present during the day to provide support and refer to external resources, but overnight, patients and caregivers receive only a handout with lists of resources to contact.

In addition to the breakout session, a panel discussion featured representatives from various HVIPs. The panel discussion underscored the importance of a relationship-driven approach over a resource-driven one. The emphasis was on treating each patient with dignity and respect, getting to know them individually and building trust, and understanding the impact of victimization on both individuals and communities. The need for ongoing communication, collaboration and shared resources between HVIPs and community organizations was emphasized, along with the vital role of self-care for HVIP team members who routinely encounter trauma in their work.

BREAKOUT SUMMARY: EDUCATIONAL PROGRAM DEVELOPMENT ACROSS SECTORS

This breakout session had participants from many Baltimore community-based organizations (CBOs) (ie, Roca, Safe Streets, Center for Hope and others) as well as healthcare providers. The groups shared similar strategies for engaging and providing services in Baltimore. These included individualizing the approach for each client, identifying personal value systems and motivations and evaluating how service providers can meet client/patient goals. Both CBOs and healthcare providers emphasized employing motivational interviewing to engage young people and meet them 'where they are at'. Key themes emphasized by all participants included delivering on promises made and providing trauma-informed, wraparound support, which includes identifying and targeting a wide variety of needs, from basic resources and mental health needs to educational and financial support as well as mentorship.

Throughout the session, both CBOs and healthcare providers expressed desire for better communication and cross-collaboration between all groups working on violence prevention in the city, specifically emphasizing 'unity, not uniformity'. Specific action items from the session included the development of a centralized registry or referral tool to facilitate collaboration and information sharing across organizations. Additionally, there was a proposal to address gun violence directly in multiple contexts, by incorporating it into educational curricula and discussions as a harm reduction measure alongside existing

initiatives like general education development test preparation and other educational outreach programs.

BREAKOUT SUMMARY: STRATEGIES TO UNITE THE ECOSYSTEM

In this session, participants focused on envisioning what a united ecosystem might look like as well as identifying barriers that prevent patients from full recovery and strategies to overcome those barriers. Two themes emerged: improving the patient's recovery experience and developing fluidity among providers and different services.

The group highlighted that the patient experience can be simplified and eased by ensuring there is no 'wrong door' for a patient to enter the recovery network; rather, multiple entry points should exist in different contexts that funnel towards the existing support systems. There is a need for pathways for prevention of additional violent events, recovery after an event including addressing social determinants of health and other barriers to recovery and re-entry into the job market. Multiple challenges and barriers exist along those pathways, such as finding jobs, housing, educational opportunities, medical care and navigation of the medical system. Particularly vulnerable groups include marginalized communities, formerly incarcerated people and those who feel hopeless or like they have nothing to lose, as they may particularly struggle to engage with the existing pathways and trust in their efficacy. A united ecosystem would help guide all patients through those processes, even as it acknowledged that different patients may have specific priorities at different times.

The group also identified the importance of improving fluidity among providers and services. They acknowledged the need for providers to increase patient trust in institutions by providing consistency and transparency. The group also felt that certain strategies could help medical providers better support their patients, such as developing stronger knowledge of city-wide, rather than institution-specific, resources, and mandating inclusion of stakeholders, including community members, when developing interventions and policies. During the conversation, ideas that gained traction included creating a police liaison to help patients coordinate services and developing an online registry or database of services and providers. Questions for future discussion also arose, such as the role of body cameras in decreasing homicides in Baltimore, consideration of resources directed specifically at female and juvenile offenders as well as older adult men, and how to highlight good news and success stories.

BREAKOUT SUMMARY: POLICY FOR PREVENTION

In this session, participants focused on policy at the hospital-level, local-level and state-level, and how the far-reaching impact of policies might be leveraged to change the current situations, leading to violence and trauma.

At the hospital level, it was identified that there is a need for policies and programming around follow-up for patients impacted by violence, who may lack basic resources and struggle to reintegrate into communities and the workplace. However, lack of financial reimbursement for violence prevention programming can make it difficult for hospital leaders to prioritize such programming in budgeting, even though such programming might prevent costly readmissions and repeat visits. Creation of a system of gathering data in this area might help to highlight the importance of change. The group also discussed the need for proactive universal screening to enable broader identification of needs and the importance of communicating changing policies within the hospital. As an example, recent changes in whether police can talk to or interrogate minors without parents present were not well communicated, leading to confusion in emergency departments.

At the local level, the group noted an overall theme of the challenge in connecting those individuals in need of services and support with organizations capable of providing assistance. Difficulties connecting HVIPs and community organizations, insufficient numbers of community organizations and lack of school-based resources contribute to this deficit. When schools lack resources, both for violence-affected youth and for youth mental health, partnership with community organizations to fill those needs would be ideal, but those partnerships are often difficult to build and to fund. The group discussed the Request for Proposal funding process, and how the tenuousness of funding sources can disincentivize sustainable and data-driven approaches, which may require more time than the guaranteed funding timeframe. At the same time, reallocation of funding to new groups and programs may waste time and resources as the newly funded group needs to start over.

Finally, the group discussed the goal of advocating for policy changes at the state level to prioritize violence prevention. One idea was the creation of a state office of violence prevention, which would organize efforts and address issues in the allocation of funding, which, to participants, felt politically influenced and lacking accountability. The group reflected that reorganization can be an opportunity to build in accordance with values and reimagine new ways to address the problems impacting the communities we serve.

DISCUSSION

The summit illuminated important threats to the viability of the ecosystem. A summary of key recommendations from each session can be found in table 1. A constant refrain among participants across sectors became the primary goal to accomplish following this summit: the need for consistent and close connection, communication among key stakeholders and enhanced awareness of resources available within the ecosystem. Associated challenges included allocation of scarce mental health and rehabilitation resources and overlap in clientele who may enroll in multiple programs after being cared for within multiple institutions throughout the city. All breakout sessions touched on the difficulty of connecting groups and resources aimed at addressing violence with the communities and individuals who would most benefit, while offering important solutions to address these challenges. Multiple sessions raised the idea of a registry or database to help make available resources more accessible, and this also became one of the priorities for future work. The importance of including all voices, such as community members, religious leaders, law enforcement and hospital representatives, in key conversations and decisions was emphasized in each breakout session. All echoed the sentiment by a panel member that 'hurt people hurt people, but healed people heal people', and stressed that healing requires a sustained commitment beyond the hospital setting with continued conversations, partnerships and community engagement to address the complex issue of violence intervention effectively.

CONCLUSIONS

The Break the Cycle Baltimore Summit to Prevent Gun Violence was a transformative opportunity to bring together key stakeholders, to set a course for enhanced collaboration and to

Table 1 Summary of key recommendations

Summary of key recommendations	
Hospital-based violence intervention programs	Develop strategies for building capacity and improving patient engagement
	Improve service availability for pediatric trauma patients
	Ensure implementation of a patient-centered, trauma-informed approach
Educational program development	Use strategies that engage youth and communities
	Develop strategies to improve information-sharing and collaboration among groups
Strategies to unite the ecosystem	Improve patients' recovery experience through collaboration and comprehensive care
	Educate medical team members on local (beyond institutional) resources
Policy for prevention	Policies must center on improving the experience of impacted individuals
	Develop processes to sustain data-driven programs beyond grant funding periods
	State offices for violence prevention may help to improve organization and support for violence prevention efforts

improve our collective efforts to reduce violence, its effects on our community and its root causes within our community. Importantly, our purpose in sharing these proceedings is also to share with other violence prevention researchers and clinical teams that this process was feasible and replicable. Our institution will host an annual summit each June to reconvene these and other stakeholders to hold ourselves accountable to previous years' goals and set new goals as we move forward, together.

Acknowledgements We would like to gratefully acknowledge the following groups for their participation in the Summit: Ascension St. Agnes Health System, Baltimore City Health Department, Baltimore City Police Department, Baltimore Peace Movement, Children's National Medical Center, Community Justice Action Fund, Family Survivor Network, Johns Hopkins University and Health System, LifeBridge Health System and Center for Hope, Maryland Department of Health, Maryland Moms Demand Action, Maryland Network Against Domestic Violence, Marylanders to Prevent Gun Violence, Mayor's Office of Neighborhood Safety and Engagement, MedStar Health System, Mothers on the MoveRoca Baltimore, Safe Streets Baltimore, Sinai Hospital of Baltimore, The Health Alliance for Violence Intervention (HAVI), University of Baltimore School of Law, University of Maryland Baltimore Rebuild, Overcome, and Rise (ROAR), University of Maryland Medical System.

Contributors EK and MP contributed equally to the conceptualization and primary drafting and revising of this manuscript. MH and IZ contributed to the conceptualization and revising of this manuscript. MS, JS, and NI participated in the planning and revising of this manuscript. KW-K contributed to the revising of this manuscript. KH contributed to the conceptualization, planning, drafting, revising of this manuscript, and is responsible for the overall content as guarantor.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; internally peer-reviewed.

Data availability statement There are no data in this work.

ORCID iDs
Madhu Subramanian http://orcid.org/0000-0001-9798-4584
Katherine Hoops http://orcid.org/0000-0002-6404-5422

REFERENCES

1 Data from the baltimore city police department violent crime database. Available: https://app.powerbigov.us/view?r=eyJrIjoiZjcyZDY5NWYtNTBlZS00OTg0LTgyNDQtOWYwMDEyOGI5Y2M1IiwidCI6IjMxMmNiMTI2LWM2YWUtNGZjMi04MDBkLTMxOGU2NzljZTZjNyJ9 [Accessed 16 Apr 2024].
2 City of Baltimore. Mayor's office of neighborhood safety and engagement. 2024. Available: https://monse.baltimorecity.gov
3 Brooke BS, Efron DT, Chang DC, Haut ER, Cornwell EE III. Patterns and outcomes among penetrating trauma recidivists: it only gets worse. *J Trauma* 2006;61:16–9.