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Practice Perspectives

Strength in the City: Assets-Based Violence and Trauma Assessment by Nurses in Urban Environments

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Abstract

Forensic nurses operating in the urban environment frequently find themselves at the intersection of trauma and healing, often providing care in communities disproportionately affected by structural violence, poverty, and systemic inequities. While conventional trauma assessments tend to focus on pathology and risk, this article proposes an *assets-based approach* that centers resilience, cultural knowledge, and community strength. Drawing from frameworks such as Trauma-Informed Care, Strengths-Based Nursing, Resilience Theory, and the Community Cultural Wealth Model, this manuscript outlines how nurses can incorporate patient-identified coping strategies, relational supports, and community resources into violence and trauma assessments. Through illustrative case studies, ranging from school-based care to street outreach, this article demonstrates how assets-based nursing practice affirms patient agency, builds trust, and improves health outcomes. The approach aligns with anti-oppressive and equity-focused principles, reframing trauma narratives through a lens of possibility rather than pathology. Benefits of this model include enhanced therapeutic alliance and culturally responsive care, while limitations include time constraints, institutional barriers, and the potential romanticization of resilience without structural reform. The article concludes with actionable strategies for embedding this model across clinical settings, nursing education, and health policy, advocating for systemic changes that empower nurses to address trauma with cultural humility and justice-

informed care. By shifting the lens from “what is wrong” to “what is strong,” nurses can help transform urban health systems into spaces of recovery and empowerment.

Keywords: assets-based trauma assessment, urban nursing, trauma-informed care, community resilience, health equity

Strength in the City: Assets-Based Violence and Trauma Assessment by Nurses in Urban Environments

Urban environments are dynamic ecosystems that host diverse populations, rich cultural assets, and vibrant community networks. Yet, they also bear a disproportionate burden of violence and trauma exposure. Urban areas, especially those shaped by historical disinvestment and systemic inequality, defined as the entrenched disparities in access to resources, power, and opportunity resulting from discriminatory policies and institutional practices, are uniquely affected by the intersection of community and structural violence. These forms of violence manifest through social and institutional systems that systematically harm or disadvantage certain groups by restricting access to health, safety, and overall well-being (Armstead et al., 2021; Ivey et al., 2025; National Academies of Sciences, 2017; Solomon et al., 2019). These include, but are not limited to, gun violence, domestic and intimate partner violence, housing instability, systemic racism, and chronic poverty (National Academies of Sciences, Engineering, and Medicine, National Academy of Medicine, Committee on the Future of Nursing 2020–2030, 2021; U.S. Department of Health and Human Services [USDHHS], n.d.a). These layered traumas often accumulate across generations, forming what researchers refer to as *social determinants of trauma* (Mikhail et al., 2018).

In the face of such adversity, forensic nurses are essential providers in trauma-informed care delivery. They operate across a spectrum of settings, from emergency departments and urgent care to school clinics, primary care practices, shelters, and community outreach programs. In each of these spaces, forensic nurses provide not only clinical care but also emotional support, resource coordination, and advocacy. Their proximity to individuals and families during critical moments of vulnerability positions them to play a transformative role in healing and prevention (Goddard et al., 2022).

Despite this potential, trauma assessments conducted by forensic nurses, and within healthcare more broadly, often adopt a deficit-oriented lens. Traditional trauma assessments focus heavily on identifying injuries, psychological distress, or risk factors such as prior abuse, mental health conditions, or social instability. While these are important data points, the exclusive focus on deficits can inadvertently pathologize individuals and communities, reinforcing cycles of stigma and marginalization (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023). More concerningly, these assessments often fail to capture protective factors and community strengths that contribute to resilience and recovery, concepts that, as defined by SAMHSA (2019), encompass the capacity of individuals and communities to adapt positively in the face of adversity, maintain or regain well-being, and engage in a continuous process of change toward improved health, self-direction, and social connectedness. By overlooking these dynamic dimensions of strength, many assessment models risk presenting an incomplete understanding of community health, one that emphasizes deficits rather than the inherent capacities that foster healing, empowerment, and sustained wellness.

Rather than viewing people solely through the lens of what has gone wrong, an assets-based approach seeks to identify what is strong; specifically, highlighting individual, familial, and community strengths that foster healing, resistance, and resilience in the face of violence and adversity. This approach aligns with the principles of trauma-informed care (TIC) and equity-centered health frameworks, encouraging nurses to recognize the full complexity of urban trauma while also honoring the agency, creativity, and strength of those who survive and thrive in its wake (SAMHSA, 2017). By shifting the paradigm from *pathology* to *possibility*, this article advocates for forensic nursing practice that not only treats trauma but helps build the conditions for lasting community well-being. Subsequently, the purpose of this article is to describe the integration of assets-based trauma assessment into forensic nursing practice in urban environments.

Theoretical and Conceptual Foundations

Assets-based assessment represents a paradigm shift in health and social care that emphasizes the identification and mobilization of individual, familial, and community strengths rather than focusing solely on deficits or pathology. In contrast to traditional models that prioritize risks, symptoms, and dysfunction, an assets-based approach seeks to uncover protective factors such as emotional coping mechanisms, supportive relationships, spiritual or faith-based practices, and cultural knowledge systems that individuals use to survive and thrive in the face of adversity (Martin-Kerry et al., 2023).

Asset-Based Violence and Trauma Assessment Framework Conceptual Model and Application

Violence-related asset-based assessment in public health emphasizes identifying strengths, capacities, and resources within individuals, families, and communities that can mitigate the impacts of violence and trauma (Martin-Kerry et al., 2023). Unlike deficit-based approaches that focus primarily on risk and pathology, this model seeks to leverage existing assets, such as social support, coping skills, cultural resilience, and institutional resources—to promote recovery and empowerment (Figure 1).

Uses of the Concept

Within forensic and trauma-informed nursing, an asset-based framework broadens assessment beyond symptomatology. It is used to:

1. Identify protective and resilience factors that buffer trauma.
2. Guide interventions toward empowerment and self-efficacy.
3. Foster collaboration between healthcare and community partners to enhance survivors' recovery capital.

This aligns with trauma-informed principles emphasizing safety, empowerment, and collaboration.

Defining Attributes

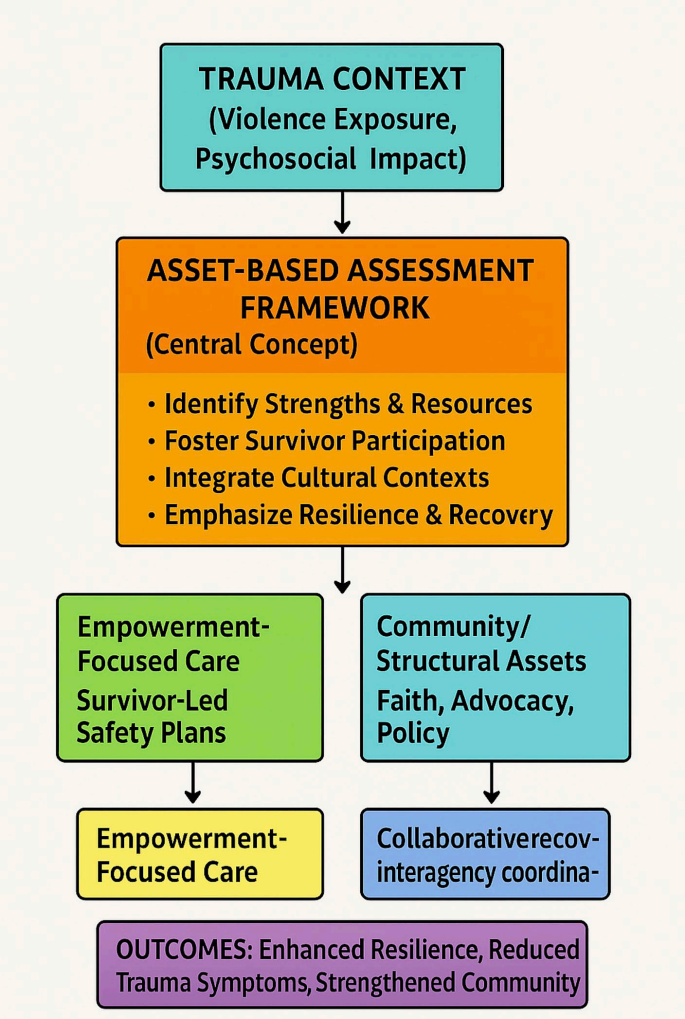
Drawing from Martin-Kerry et al. (2023), defining attributes of asset-based assessment include:

- **Strength orientation:** Emphasis on capacities rather than deficits.

- **Participatory engagement:** Collaboration between clinician and survivor to co-identify strengths.
- **Contextual sensitivity:** Recognition of cultural, social, and environmental determinants.
- **Iterative feedback:** Continuous adaptation as new strengths are discovered.

Figure 1

Asset-Based Violence and Trauma Assessment Framework



Note. Adapted from *"Characterizing asset-based studies in public health: Development of a framework,"* by J. Martin-Kerry et al., 2023, *Health Promotion International, 38*(2), Article daad015 (https://doi.org/10.1093/heapro/daad015).

Model Case

A forensic nurse evaluating an IPV survivor conducts not only lethality and risk screening (Campbell et al., 2008; Johns Hopkins School of Nursing, 2025) but also identifies assets such as strong faith community support and access to advocacy networks. The nurse integrates these strengths into the safety plan, enabling survivor-led decision-making and resilience enhancement.

Antecedents and Consequences

Antecedents include trauma exposure, community disempowerment, and institutional mistrust. *Consequences* include improved engagement in care, reduced retraumatization, and strengthened social recovery pathways.

Empirical Referents

Empirical measures of asset-based approaches include validated tools assessing resilience (e.g., Connor-Davidson Resilience Scale; Riopel, 2019) and community connectedness, which serve as indicators of the concept's operationalization.

An asset-based violence and trauma assessment framework aligns closely with several guiding theories and models relevant to trauma-informed, equity-oriented nursing practice. SAMHSA outlines six core principles of TIC: *safety, trustworthiness, peer support, collaboration, empowerment,* and *cultural, historical, and gender issues*, that align seamlessly with the assets-based approach. Forensic nurses applying TIC are called to shift from asking *What's wrong with you?* to *What happened to you?* and, further still, to *What strengths have helped you endure?* (SAMHSA, 2023).

Strengths-Based Nursing (SBN), developed by Laurie Gottlieb (2014), reinforces this perspective by positioning nurses as facilitators of capacity-building. SBN emphasizes person-centered care, self-efficacy, and the empowerment of patients to be co-participants of their healing processes. In urban settings marked by chronic exposure to violence, SBN encourages forensic nurses to recognize and amplify the skills and wisdom that all persons and communities already possess, particularly those shaped by lived experience and survival.

The **Resilience Theory** further supports this model by framing resilience not as the absence of trauma but as the capacity to adapt and grow in response to it. In the context of urban violence and trauma, resilience can be found in community activism, intergenerational caregiving networks, youth mentorship programs, and cultural storytelling traditions; all of which are integral to recovery and long-term wellness (Ungar, 2013). This theory emphasizes both individual adaptability and the availability of supportive ecological systems.

Adding an explicitly racial and cultural lens, the **Community Cultural Wealth (CCW) Framework**, originally developed by Tara Yosso (2005) and expanded upon in nursing and public health literature, provides a structure for identifying the non-dominant forms of knowledge, resistance, and cultural capital that marginalized communities use to survive oppressive systems. Yosso (2005) identifies forms of wealth such as navigational, linguistic, familial, resistant, and aspirational capital—all of which can be assessed and honored by nurses during trauma evaluations. For example, a person's connection to a mutual aid network or involvement in a cultural advocacy group may serve as both a trauma response and a healing pathway. This integrative framework situates assets-based trauma assessment within a larger commitment to health equity, anti-oppressive practice, and social justice nursing.

In urban environments, where patients may experience structural racism, housing insecurity, and policing-related trauma (Centers for Disease Control Prevention [CDC], 2024; Hirschtick et al., 2019; USDHHS, n.d.b.), forensic nurses have a moral and professional responsibility to adopt approaches that validate lived experience while avoiding pathologization. Assets-based assessments align with anti-oppressive practice (AOP) by resisting deficit-framed narratives and creating space for dignity, cultural affirmation, and patient voice. Moreover, these assessments serve as practical expressions of social justice nursing, reinforcing that healing is not only clinical but social, relational, and contextual (Buettner-Schmidt & Lobo, 2012).

Understanding Violence and Trauma in Urban Settings

Violence and trauma in urban environments are not random or evenly distributed phenomena; they are deeply embedded in structural inequities that disproportionately affect marginalized populations. The epidemiology of urban violence consistently reveals stark disparities along racial, gender, and economic lines. Black and Latin*x* individuals in urban settings experience higher rates of gun violence, police-related harm, and community trauma compared to their white counterparts (Hirschtick et al., 2019; Semenza & Kravitz-Wirtz, 2024). Women, particularly women of color and LGBTQ+ individuals, are at increased risk of intimate partner violence and sexual assault, often exacerbated by economic instability and systemic barriers to protection (Hulley et al., 2023). Youth and low-income residents are similarly overrepresented in exposure to both direct violence and its indirect consequences, such as trauma-related mental health disorders (Gaylord-Harden, 2018).

Moreover, the intersection of early adversity and community violence amplifies vulnerability. Adverse Childhood Experiences (ACEs), including exposure to household violence, neglect, parental substance use, or community-level trauma, serve as cumulative risk factors that shape developmental trajectories and increase the likelihood of both victimization and perpetration of violence in later life. High ACE scores correlate strongly with dysregulated stress responses, impaired attachment, and behavioral maladaptation, reinforcing cycles of trauma that extend across generations (Felitti et al., 1998; Merrick et al., 2019). Recognizing the influence of ACEs thus underscores the need for trauma-informed, resilience-oriented public health interventions that disrupt these pathways and promote recovery capital within high-risk urban populations.

Integrating an understanding of ACEs into violence prevention and trauma intervention strategies requires a paradigm shift from deficit-focused models toward frameworks that recognize and cultivate resilience (Clements et al., 2024). This is where the **asset-based assessment framework** becomes essential. Rather than centering solely on the sequelae of trauma, an asset-based approach identifies protective factors, such as supportive caregivers, community cohesion, spiritual grounding, and access to culturally responsive services, that can moderate the effects of early adversity. By mapping these strengths alongside risk indicators, clinicians and public health professionals can better illuminate the complex interplay between vulnerability and resilience. As Martin-Kerry et al. (2023) emphasize, asset-based models operationalize the concept of *what works well in communities*, transforming assessments from passive data collection tools into active instruments for empowerment and healing. In urban contexts marked by concentrated disadvantage and intergenerational trauma, such an approach provides a pathway for trauma-informed nursing practice to not only recognize the enduring imprint of ACEs but to mobilize the inherent assets that foster recovery, self-efficacy, and long-term well-being.

Urban trauma is multifaceted, often rooted in multiple, intersecting types of violence. Community violence, including shootings, assaults, and gang-related activity, often coexists with domestic and intimate partner violence, especially in settings with limited housing and support services. Police violence and criminalization, particularly of Black and Brown communities, are additional sources of trauma, leading to fear, hypervigilance, and distrust of

systems that should ensure safety (Buchanan et al., 2021). Furthermore, the long-term effects of intergenerational trauma, passed down through families and communities due to historical oppression, forced displacement, and systemic racism, continue to shape how individuals respond to new or ongoing traumatic events (Hankerson et al., 2022).

Environmental and infrastructural features of urban living contribute to the persistence of trauma. Overcrowded housing, inadequate sanitation, neighborhood segregation, and over-policing compound the risk of exposure to violence while limiting opportunities for recovery. For instance, children growing up in communities with limited access to green space, community services, or trauma-informed schools may experience repeated threats to their physical and emotional well-being with few protective buffers (Bikomeye et. al, 2021). In this context, trauma-informed schools are not simply educational institutions with counseling services; rather, they represent systems that acknowledge and respond to the cumulative trauma that students, staff, and communities experience due to structural inequities, racialized violence, and environmental stressors. Specifically, Bikomeye et al. (2021) imply that trauma-informed schools:

1. **Recognize the prevalence of trauma**: understanding that children and educators alike may live with chronic exposure to violence, poverty, racism, and environmental instability.
2. **Integrate safety and belonging**: ensuring that school environments are physically and emotionally safe, predictable, and supportive.
3. **Promote resilience and equity**: through access to green spaces, social supports, and policies that counteract structural determinants of stress and health disparities.
4. **Engage in community healing**: seeing schools as hubs for restorative, culturally responsive, and strength-based interventions that help buffer the effects of adversity.

Similarly, families navigating housing instability, eviction threats, or shelter conditions are at higher risk of chronic stress and exposure to abuse (USDHHS, n.d.b.).

These intersecting conditions give rise to cumulative trauma and chronic toxic stress—physiological and psychological responses to persistent adversity without adequate support or safety. Toxic stress is associated with disrupted neurodevelopment, increased risk for substance use, cardiovascular disease, and mood disorders (Center on the Developing Child at Harvard University, 2025). Importantly, urban residents often experience multiple, layered exposures to trauma over their lifespan, resulting in complex clinical presentations that challenge conventional, pathology-driven models of care (Marris, 2024). For forensic nurses working in these settings, recognizing the contextual and cumulative nature of urban trauma is essential to providing empathetic, effective, and equitable care.

Asset-Based Violence and Trauma Assessment in Practice

Forensic nurses are on the front lines of care across diverse settings, uniquely positioned to identify and respond to trauma in urban environments. Whether in emergency departments, primary care clinics, school-based health centers, public health home visits, or domestic violence shelters, forensic nurses often serve as the first point of contact for individuals who have experienced or are at risk of experiencing violence. Through routine screenings, physical assessments, and therapeutic conversations, forensic nurses have powerful opportunities to shift the lens of trauma assessment; from one focused solely on injury, risk, and dysfunction to one that recognizes the strengths, assets, and resilience of the individuals and

communities they serve (National Academies of Sciences, Engineering, and Medicine, National Academy of Medicine, & Committee on the Future of Nursing 2020-2030, 2021).

An **assets-based approach** to trauma assessment invites nurses to ask not only "What happened to you?" but also "What has helped you get through it?" This dual lens enables clinicians to uncover a range of protective factors that are often invisible in conventional assessments. At the **individual level**, assets may include personal coping strategies such as journaling, prayer, art, physical activity, cultural rituals, or language rooted in ancestral healing traditions. Patients may also draw strength from previous experiences of resilience—times they overcame hardship, reached out for support, or helped others survive (SAMHSA, 2014a).

At the **relational level**, forensic nurses should assess for supportive networks that buffer against trauma. This can include family members, close friends, trusted mentors, chosen family, or community leaders. In many urban communities, informal support systems such as neighborhood elders, youth mentors, or peer counselors may be more impactful than formal services. Recognizing these relational ties as clinical assets can promote deeper engagement, reduce isolation, and inform collaborative safety planning (SAMHSA, 2023).

Finally, at the **community and social level**, forensic nurses should explore broader structural assets that promote healing. Urban environments, despite their challenges, are rich in cultural and social resources—from faith-based organizations, community gardens, and harm reduction programs to spaces like barbershops, salons, and cultural centers that function as hubs of care, conversation, and trust (CDC, 2025). Mapping these community supports into trauma assessments can provide patients with realistic and familiar pathways to recovery.

Trauma narratives and storytelling allow individuals to define their experiences on their own terms, which can be both therapeutic and empowering. These narratives also offer valuable insight into how individuals interpret their trauma and recovery (Center for Trauma and Embodiment, 2025). Additionally, collaborative safety and recovery planning that includes the patient's identified assets ensures that the care plan is both culturally congruent and sustainable. By recognizing and documenting these multilevel assets, forensic nurses become co-creators in trauma recovery, rather than sole providers of care. This shift not only enhances therapeutic alliance and patient outcomes but also helps reframe urban trauma narratives to include resistance, healing, and collective strength.

Illustrative Case Examples

Case 1: Forensic Nurse Consultation Following Alleged Sexual Assault Disclosure

Tiana, a 15-year-old student at a public high school in a densely populated urban neighborhood, was referred to the school nurse after experiencing frequent headaches, panic attacks, and declining academic performance. Her teacher had noted increased irritability, emotional withdrawal, and signs of distress. Initially hesitant to share, Tiana eventually confided in a trusted staff member that she had experienced an incident involving a fellow student—a well-known athlete at the school. While she did not explicitly define the event as sexual assault, her account raised significant concern, prompting a forensic nurse consultation to ensure a trauma-informed and coordinated response.

Rather than relying solely on a symptom-based or deficit-focused assessment, the forensic nurse partnered with the school nurse assigned to the district to conduct a collaborative, asset-

oriented community and school assessment. Together, they identified individual, interpersonal, and community strengths that could serve as protective factors in Tiana's recovery. The school nurse contributed her expertise in community asset mapping, helping the team recognize available neighborhood supports such as youth mentorship programs, accessible family health services, and community centers that hosted safe, structured activities for adolescents.

In a trauma-informed conversation, the forensic nurse invited Tiana into the process, asking open-ended questions such as, *What helps you feel supported when things are difficult?* and *What spaces in your community help you feel most safe or understood?* This inclusive approach positioned Tiana not as a passive recipient of care, but as an active participant in her own healing plan.

Tiana shared that her older cousin, a mentor in a local after-school program, had been a consistent source of support. She also described her passion for spoken-word poetry, which she used to process emotional pain and connect with peers. Building on these strengths, the interprofessional team, which included the school nurse, the school counselor, and the forensic nurse, worked collaboratively to create a comprehensive plan that integrated both clinical and community assets.

The school nurse facilitated a connection between the school and a local youth arts collective offering expressive arts sessions focused on empowerment and healing. She also coordinated with a community-based violence prevention coalition to ensure ongoing mentorship and advocacy opportunities for Tiana and her peers. Simultaneously, the forensic nurse worked closely with the school's trauma-informed counselor to develop a safe peer support group and ensure that Tiana's experience was met with sensitivity and empowerment rather than stigma or retraumatization.

As Tiana engaged in these supportive spaces, she began using her poetry as a platform for healing and community awareness, sharing performances that reflected themes of resilience and justice. The collaboration between the forensic and school nurses exemplified how integrating asset-based assessment, youth participation, and community resource mobilization can transform crisis response into community resilience building.

Ultimately, this case underscores how trauma-informed school systems, when grounded in public health principles and interprofessional collaboration, can shift from a reactive posture to one of empowerment, honoring the voices of youth, fostering connection, and cultivating pathways for long-term recovery and advocacy.

Case 2: Public Health Nurse and Forensic Nurse Collaboration in Intimate Partner Violence Case

Amina, a 42-year-old Somali immigrant and mother of three, was referred to a public health nurse following a hospital visit for injuries consistent with intimate partner violence (IPV). Although physically stable, her presentation raised concerns about ongoing abuse and cultural barriers to seeking help. The complexity of her situation, including linguistic, spiritual, and familial considerations, prompted the public health nurse to request a joint consultation with a forensic nurse specializing in trauma-informed and culturally responsive care**.**

In a deficit-based model, Amina's care might have been confined to medical documentation, safety planning, and referral to a shelter—approaches that, while important, can inadvertently pathologize survivors and overlook cultural assets. Instead, the public health and

forensic nurses collaborated to deliver an assets-based, family-inclusive response grounded in Amina's strengths and community context.

During their joint visit, the forensic nurse initiated trust-building through culturally sensitive inquiry, asking, *Who helps you feel supported during difficult times?* and *What keeps your family strong when challenges arise?* Amina identified her faith, mosque community, and traditional healing practices as vital sources of resilience. She also expressed fears of being misunderstood or judged by community leaders and of her children being stigmatized if her situation became public.

Recognizing the importance of intergenerational healing, the public health nurse conducted a family-centered assessment to explore how the children were experiencing the disruption at home and to identify protective factors. Rather than involving the children in adult disclosure processes, the nurse engaged them through age-appropriate conversation and observation within a trauma-informed framework, acknowledging their needs without exposing them to retraumatizing details.

The assessment revealed that Amina's eldest daughter (age 16) often cared for her younger siblings and sought refuge in school and community youth activities when home life felt unstable. The public health nurse, drawing on her knowledge of community assets, identified a local youth mentorship program affiliated with the mosque that supported girls from East African backgrounds. With Amina's consent, her daughter was connected to a mentor who could provide emotional support, social connection, and leadership development opportunities. Meanwhile, the two younger children were referred to a school-based counselor trained in trauma-informed care to help them process fear and anxiety through play and storytelling.

The forensic nurse, in collaboration with Amina, integrated these family supports into a holistic trauma recovery plan that respected Amina's cultural values. This plan included connecting the family with a community liaison familiar with Somali cultural norms, ensuring safety planning incorporated spiritual practices such as prayer and community supplication. The public health nurse also facilitated access to a faith-sensitive parenting group, helping Amina strengthen parent-child communication in a way that promoted safety and emotional security for all three children.

As Amina's sense of safety and empowerment grew, she gradually resumed her role as a caregiver and community mentor. Drawing on her lived experience, she began leading small women's circles at her mosque, focusing on healthy relationships and nonviolent communication within cultural and faith-based frameworks. Her children, now engaged in community youth programs and peer support activities, mirrored her resilience, demonstrating that trauma-informed interventions can ripple across generations when families are supported as cohesive systems of strength.

Case Study 3: Street Outreach Nurse and Forensic Nurse Collaboration with Gun Violence Survivor

Darnell, a 27-year-old man, was recovering from a gunshot wound when a street outreach nurse encountered him during a mobile clinic visit in his neighborhood. His medical record documented multiple missed appointments and noted possible gang involvement—details that, in a deficit-based model, might have led to stigmatizing labels such as *noncompliant* or *high-risk.* These characterizations risked obscuring Darnell's resilience and the contextual realities of his

environment. Recognizing these complexities, the street outreach nurse partnered with a forensic nurse to conduct a holistic, trauma-informed, and asset-based assessment.

Together, the nurses approached Darnell with empathy and respect, centering his voice in the process. The forensic nurse asked open-ended, affirming questions such as, *Who has helped you navigate your healing?* and *What matters most to you as you move forward?* Darnell revealed that he had been working to disengage from street life, volunteering at a local recreation center where he mentored neighborhood children. He also spoke about reconnecting with a former high school coach who encouraged him to complete his GED and pursue training in community health work.

Recognizing the potential ripple effects of Darnell's mentorship and his existing ties to the recreation center, the public health nurse was invited into the care collaboration. Drawing on her expertise in community assessment and violence prevention resources, she identified a citywide coalition that linked hospital-based violence intervention programs with youth engagement initiatives. Through this partnership, Darnell was connected to a violence interruption program staffed by credible messengers—specifically, community leaders with lived experience who focus on preventing retaliation, supporting survivors, and mentoring at-risk youth.

To expand this community-based support, the public health nurse conducted a neighborhood asset map, identifying safe spaces, after-school programs, and trauma-informed youth organizations where Darnell could continue his mentoring work. She facilitated coordination between the local recreation center, a faith-based youth development nonprofit, and the city's public health department to develop workshops on nonviolence and resilience-building for children exposed to community trauma. Darnell, seeing the value of his own lived experience, agreed to co-facilitate sessions with violence interrupters, transforming his story from one of survival to leadership and advocacy.

Meanwhile, the forensic nurse ensured that Darnell's medical and psychosocial needs were documented through a trauma-informed lens. She provided education on victim compensation, rights, and trauma recovery options, ensuring Darnell felt ownership of his care. The interprofessional team jointly monitored his healing progress and psychosocial stability, recognizing that safety and belonging were essential to long-term recovery.

This collaborative, strengths-based approach redefined Darnell's trajectory. By leveraging community assets and including children in restorative and preventive programs, the nurses helped translate one man's recovery into a broader community-healing initiative. Darnell completed his GED, obtained a community health-worker certification, and continued to mentor youth at the recreation center, helping them build resilience and avoid cycles of violence.

Ultimately, this case illustrates how public health and forensic nurses, working in concert with community partners, can transform trauma-informed care into a platform for empowerment, reframing recovery as both a personal and collective journey toward safety, connection, and leadership.

Benefits and Limitations of Asset-Based Violence and Trauma Assessment

The shift toward an assets-based framework for violence and trauma assessment offers numerous benefits within urban forensic nursing practice. Most importantly, this approach

actively resists pathologizing narratives and invites recognition of patient strengths, community resilience, and cultural knowledge systems (SAMHSA, 2023). Patients are more likely to feel seen, valued, and engaged in their own recovery when assessments prioritize their agency and existing coping strategies. Research has shown that strengths-based models not only enhance patient trust and therapeutic alliance but also improve health outcomes, particularly in marginalized populations who have historically been underserved or misunderstood by deficit-focused systems (Goldstein et al., 2024).

Asset-based assessments foster a deeper level of relational practice, positioning nurses as collaborators in the healing journey rather than as sole authorities (Morgan et al., 2023). In urban environments marked by historical disinvestment and systemic oppression, this collaborative stance is essential for building sustainable pathways to recovery. When patients are invited to identify their own strengths, community supports, and spiritual or cultural assets, the patient is empowered to leverage these resources in pursuit of their wellness goals. This approach aligns with broader public health goals by linking individual healing with community resilience, thereby strengthening the ecological systems that support health equity (National Academies of Sciences, Engineering, and Medicine, 2021).

Despite these critical advantages, assets-based assessment is not without limitations. First, identifying and mobilizing strengths requires time, patience, and relational depth—resources often constrained by institutional demands, high patient volumes, and structural barriers which refer to systemic obstacles embedded within organizational policies, social inequities, or resource distributions that limit equitable access to care and continuity within urban healthcare settings. (SAMHSA, 2023; Yearby et al., 2022). Forensic nurses working under strict productivity metrics or experiencing burnout may struggle to incorporate the reflective, dialogical processes needed for authentic strengths-based inquiry. Additionally, while most patients possess meaningful assets, not all will be readily able to articulate them, especially when facing acute crisis, complex trauma histories, or cultural mistrust of healthcare providers (Goddard et al., 2022).

There is a risk of inadvertently romanticizing resilience, placing the burden of overcoming systemic violence onto individuals and communities without addressing the larger structural forces that perpetuate harm (Hulley et al., 2023). An overemphasis on individual or community strengths must not substitute for systemic reform. Forensic nurses must balance honoring resilience with actively challenging the structural forces that sustain inequities. Lastly, the successful implementation of assets-based assessments hinges on robust training in cultural humility, trauma-informed interviewing, and structural competency, areas where gaps still exist in many nursing curricula (Waite & Hassouneh, 2021). Despite these challenges, integrating an assets-based framework remains a powerful and necessary evolution in trauma assessment. By honoring the full humanity of patients, both their wounds and their wisdom, nurses can play a transformative role in advancing trauma recovery, health equity, and collective healing within urban environments.

Recognizing both the strengths and challenges of assets-based trauma assessment underscores the need for systemic shifts in forensic nursing practice, education, and policy. To fully realize the potential of this approach, forensic nurses must be equipped with the skills, institutional support, and community partnerships necessary to sustain trauma-informed, equity-centered care in urban environments. The following section explores practical strategies for embedding assets-based assessment across clinical, educational, and policy domains, ultimately advancing health equity and community resilience.

Implications for Forensic Nursing Practice, Education, and Policy

The adoption of **assets-based trauma assessment** in urban forensic nursing practice requires intentional changes at the levels of clinical practice, professional education, and health policy. As urban communities continue to face structural inequities and layered trauma, nurses must be empowered with tools and systems that reflect the complexity, resilience, and strength of the populations they serve. Implementing this approach goes beyond changing how questions are asked; it demands a reimagining of care that is culturally grounded, community-centered, and justice-informed.

In **clinical practice**, integrating **assets-based questions into intake and screening tools** is a concrete and immediate step. Standard assessments often focus narrowly on risk and symptoms, overlooking protective factors that can shape healing trajectories. Including prompts such as *What helps you cope when things are difficult?* or *Who do you turn to for support?* can help uncover relational, cultural, and spiritual assets that are vital for recovery (SAMHSA, 2014b). Forensic nurses can document these strengths alongside clinical data to inform care plans that are not only clinically sound but contextually and culturally congruent.

Additionally, forensic nurses should be supported in **fostering partnerships with community-based organizations** that provide critical non-clinical resources such as mentorship programs, mutual aid networks, harm reduction services, and cultural healing spaces. These partnerships enhance the continuum of care and position forensic nurses as connectors between the healthcare system and the community. Such collaborations are especially vital in urban areas where access to traditional mental health services may be limited or culturally mismatched (SAMHSA, 2023). Forensic nurses, by understanding the assets embedded in the communities they serve, can become bridges to healing pathways that extend beyond hospital walls.

In **nursing education**, preparing the next generation to apply assets-based assessment requires the intentional integration and reinforcement of key frameworks such as cultural humility, structural competency, and trauma-informed interviewing, both within the curriculum and throughout clinical practice. Cultural humility, more than a theoretical concept, must be continually reinforced in experiential learning and clinical evaluation so that nurses sustain reflective awareness of power dynamics, approach every patient as the expert of their own lived experience, and remain open to diverse healing traditions and family systems (National Academies of Sciences, Engineering, and Medicine, National Academy of Medicine, & Committee on the Future of Nursing 2020–2030, 2021b). Structural competency further equips nurses to recognize and respond to how broader systems, including housing, policing, education, and economic policy, shape health outcomes, particularly in under-resourced and urban environments (CDC, 2024; Hirschtick et al., 2019; USDHHS, n.d.b.). Trauma-informed interviewing fosters safety, choice, and empowerment during clinical encounters, aligning with the assets-based model's emphasis on resilience and patient agency (Waite & Hassouneh, 2021).

Beyond the classroom, these frameworks should be operationalized through ongoing data collection and participatory feedback loops that adopt a bottom-up approach to evaluating what works in practice. Embedding nurses in policy discussions, community boards, and systems-level initiatives allows them to articulate frontline experiences and advocate for reduction of structural barriers that impede equitable care delivery (Institute of Medicine, 2011; Turale & Kunaviktikul, 2019). Thus, nursing curricula should prioritize these competencies not as electives, but as foundational to ethical, equitable, and systemically engaged nursing practice.

Extending beyond undergraduate education, there is a pressing need to cultivate advanced educational pathways and continuing professional development for nurses specializing in forensic and public health settings, where the principles of assets-based assessment, cultural humility, and structural competency intersect most directly with social justice and population health outcomes. Graduate programs, post-master's certificates, and interprofessional training initiatives can deepen nurses' expertise in navigating complex systems, such as criminal justice interfaces, community health surveillance, and policy advocacy for violence prevention and equity promotion. Specialized education in these domains equips nurses to identify and address structural barriers that perpetuate disparities, while strengthening their ability to collect and interpret data that inform evidence-based reforms at local, state, and national levels. Furthermore, such specialization ensures that nurses positioned in public health or forensic environments serve as vital bridges between clinical practice and systemic advocacy, translating patient narratives into actionable insights for policy and institutional change (Turale & Kunaviktikul, 2019; Williams et. al, 2019).

Moreover, **investing in urban community infrastructure**, from youth centers and art spaces to violence prevention initiatives and community gardens, must be recognized as a form of public health intervention. Forensic nurses can play a pivotal role in policy conversations by highlighting how these resources serve as *social prescriptions* that mitigate the health impacts of trauma and promote resilience (Clements & Solecki, 2025). In doing so, forensic nurses can move from solely treating the consequences of violence to advocating for the conditions that prevent it.

Ultimately, embracing assets-based trauma assessment is a call to transform forensic nursing practice from one of **reaction** to one of **restorative engagement**, affirming the strength of individuals and communities even amidst profound adversity. By embedding this approach across practice, education, and policy, nursing can help reimagine urban health systems as sites of not just survival—but strength, healing, and collective power (Goldstein et al., 2024).

Conclusion

The integration of assets-based violence and trauma assessment into forensic nursing practice represents a critical evolution in how care is delivered to urban populations disproportionately affected by systemic violence, disinvestment, and structural inequities. By moving beyond a deficit-based model that centers on risk and pathology, forensic nurses are uniquely positioned to identify and amplify the strengths, resilience, and cultural assets that patients bring with them to the healing process. This shift in approach not only aligns with trauma-informed and equity-centered frameworks, but also ensures that care is responsive to the lived realities and community contexts of those most impacted by violence and trauma.

To fully realize the transformative potential of assets-based trauma assessment, systemic changes in education, policy, and practice are essential. Forensic nurses must be equipped with structural competency, cultural humility, and trauma-informed communication skills, supported by institutions that value relational depth and community collaboration. As urban communities continue to bear the weight of intergenerational trauma and systemic harm, forensic nursing can lead the way in reframing narratives—from brokenness to resilience, from crisis response to collective healing. In doing so, the profession reaffirms its commitment not just to treating trauma, but to advancing justice, dignity, and the possibility of thriving in every urban neighborhood.

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