INTERVENTIONS WITH INDIVIDUALS AT HIGH RISK: GROUP & CURE VIOLENCE

Shani Buggs, PhD, MPH

Postdoctoral Fellow, Violence Prevention Research Program, University of California Davis

Affiliated Research Analyst, Center for Gun Policy and Research, Johns Hopkins Bloomberg School of Public Health

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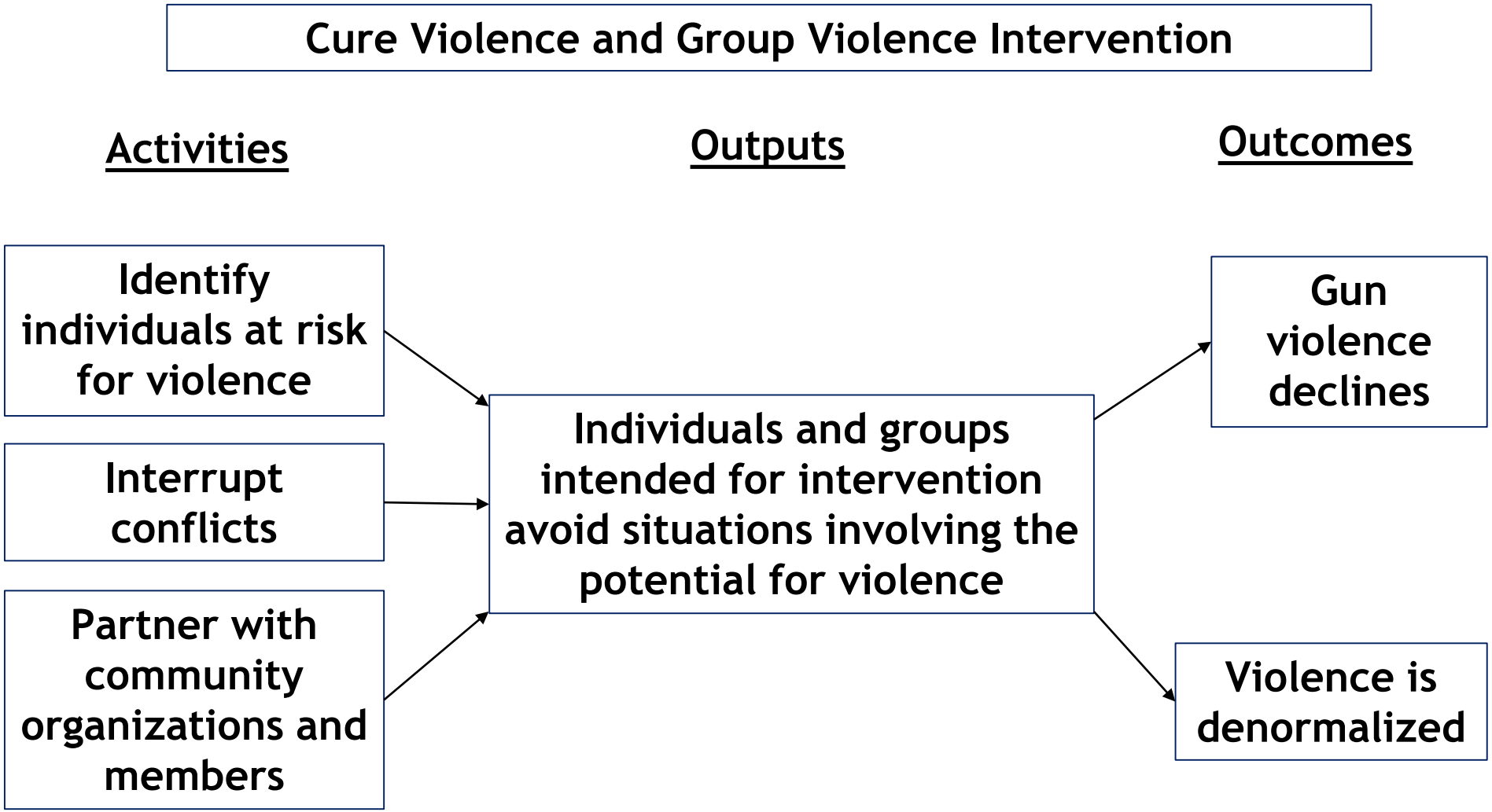


Adapted from C. Roman, 2018

Group Violence Intervention (GVI)

- Also known as “focused deterrence” or “Group Violence Reduction Strategy” or “Ceasefire”
- Key Model Components
  - Cross-agency law enforcement team – local, state, and federal partners
  - Intel from front-line police used to ID group- and violence-involved individuals and develop violence deterrence strategy using all possible legal sanctions
  - “Call-in” or personal notification meeting held to directly communicate intolerance for and consequences of future violence
  - Message from law enforcement accompanied by community member calls to cease violence
  - Services offered to support lifestyle and behavior changes

What We Know: GVI

- Over two dozen evaluations over 20+ years
- 2018 systematic review: 19 of 24 evaluations found strong, statistically significant crime reductions, with greatest impact when model focused on violence (vs. drug dealing or other crime) (Braga, Weisburd and Turchan, 2018)
  - Lowell, MA: -44% gun assaults; no evidence of displacement (Braga et al., 2008)
  - New Orleans, LA: -17% total firearm homicides, -32% group member-involved homicides (Corsaro and Engel, 2015)
  - Indianapolis, IN: -40% homicides, with greatest reductions among group member-involved homicides (McGarrell, 2006)

What We Know: GVI

- Model evolution over time and across places
- Numerous cities have implemented components without evaluation
- Long-term effectiveness unclear
- Great potential for implementation challenges
- Requires fundamental shift in policing and law enforcement engagement with communities that are distrustful of police

Cure Violence (CV)

- Previously also known as “Ceasefire”
- Based on evidence that violence exhibits characteristics similar to infectious disease (IOM, 2013)
- Key Model Components
  - Interrupting transmission of violence by mediating conflicts
  - Identifying those at greatest risk for violence involvement and reducing risk via behavior change, connection to social services
  - Changing community norms around violence through community mobilization and messaging
- Distinction from law enforcement critical to trust-building and conflict mediation

Cure Violence, 2019

What We Know: CV

- Street outreach has existed for decades
- Model replicated in dozens of cities; numerous evaluations
- Impact studies show mixed program results
  - Chicago, IL: -16-28% nonfatal shootings in 4 of 7 communities; variation across sites in impact on group-involved homicides and retaliatory shootings (Skogan et. al, 2008)
  - Philadelphia, PA: -30% nonfatal shootings after 2 years (Roman et. al, 2018)
  - Baltimore, MD: significant reductions in homicides and/or nonfatal shootings in 3 of 4 communities; (Webster et. al, 2013) more recent evaluation shows program effects have attenuated over time (Buggs et. al, forthcoming)

What We Know – CV

- Associated with improved attitudes about using violence in conflict (Delgado et. al, 2017; Milam et. al, 2016) and increased confidence in police (Butts and Delgado, 2017)

- Potential for serious implementation challenges
- Concerns about sustained effect over time
- Difficulties in mediating certain types of conflicts
- Separation between CV and law enforcement can sometimes be problematic

Opportunities

- Most effective citywide gun violence reductions achieved by combining both approaches with greater emphasis on supportive healing, case management, and meaningful community involvement
    - New York City, Oakland, Los Angeles:
        - Less focus on strict application of any particular models
        - Authentic, community-led engagement and feedback
        - Extensive wraparound services for program clients
        - Inclusion of life coaching, restorative justice principles, and community empowerment
        - Prioritization of productive and positive police-community engagement
        - Substantial, dedicated resource allocation to staff and program participants

Recommendations

- Policy makers at every level of government should recognize that public safety starts before – and extends far beyond – police and emergency services.
- Local officials should authentically engage residents in the development of public safety plans for their communities.
- Local and state lawmakers should invest in strategies that concentrate on those at greatest risk for violence, include respected and trusted members of the community in messaging and action, support individuals and families by connecting them to essential services to aid lifestyle change, and foster trust-building between police and the communities they serve.
- Congress should allocate funding and devote resources to spur innovation in gun violence reduction approaches and to evaluate promising interventions for their effectiveness and scalability.

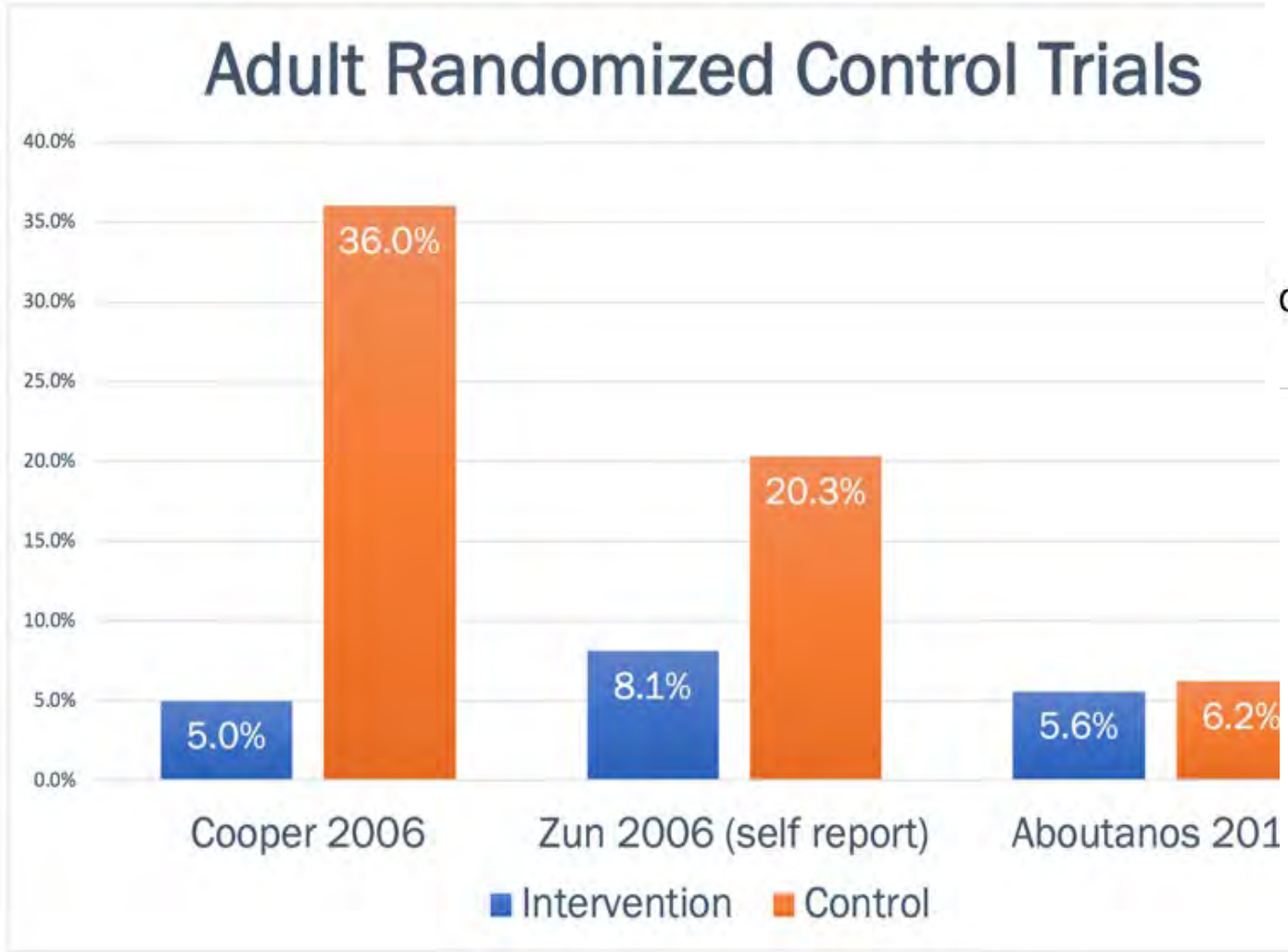
Carnell Cooper, MD

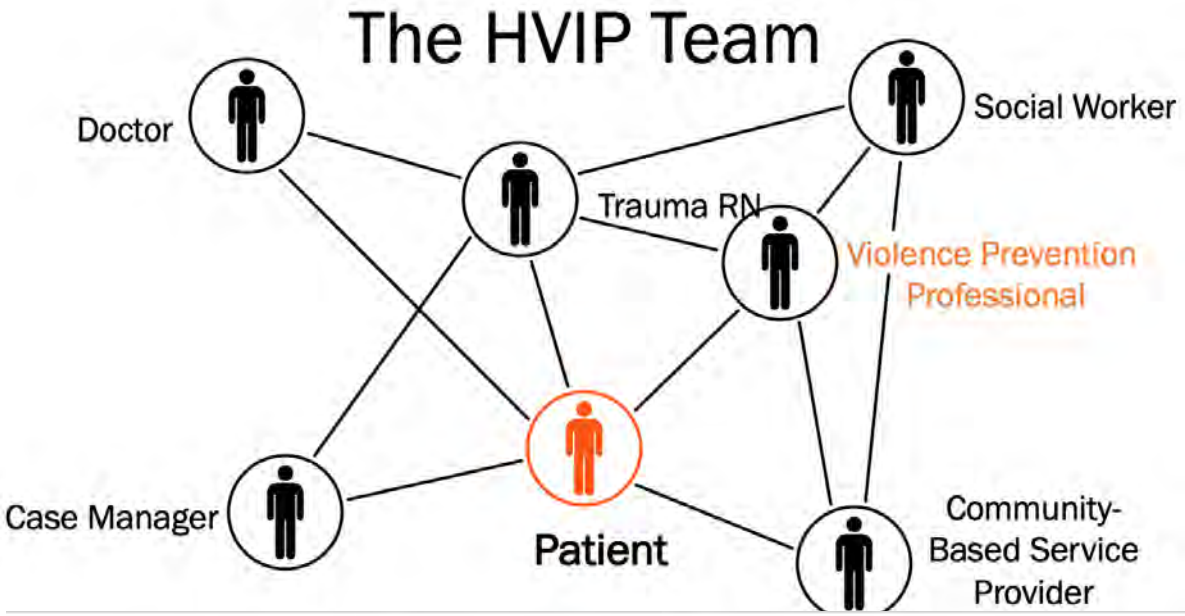
Chief Medical Officer, Northeast Methodist Hospital

THE HEALTH ALLIANCE *for* VIOLENCE INTERVENTION

HOSPITAL-BASED INTERVENTIONS

What We Know





Pediatric Randomized Control Trials

Mentor-Implemented Program for Assault-Injured Youth		
	Intervention *n=56*	Control *n=57*
Fight injuries in last month	5.7%	7.8%

Case Management Program for Assault-Injured Youth		
	Intervention *n=45*	Control *n=43*
Fight or fight injury in 3 months?		
Parental report	0%	14.3%
Youth report	0%	8%

HOSPITAL-BASED INTERVENTIONS

Citations

•Greene MB. (2016). Repeat injuries, variability and recommended research guidelines. Paper presented at the Healing Justice Alliance National Conference, Baltimore, Maryland.

•Bell, TM, Gilyan, D, Moore, BA, et al. (2017). Long-term Evaluation of a Hospital-Based Violence Intervention Program using a Regional Health Information Exchange. *J Trauma Acute Care Surg*. 84(1): 175-182.

•Juillard C, Cooperman L, Allen I, et al. (2016). A Decade of hospital-based violence intervention. *J Trauma Acute Care Surg*. 81(6):1156-61.

•Smith R, Dobbins S, Evans A, Balhotra K, Dicker RA. (2013). Hospital-based violence intervention: Risk reduction resources that are essential for success. *J Trauma Acute Care Surg*. 74:976-982.

•Shibru, D., E. Zahnd, et al. (2007). Benefits of a hospital-based peer intervention program for violently injured youth. *J Am Coll Surg*. 205(5): 684-689.

•Cheng TL, Haynie D, Brenner R, Wright JL, Chung S, Simons-Morton B. (2008). Effectiveness of a mentor-implemented, violence prevention intervention for assault-injured youths presenting to the emergency department: Results of a randomized trial. *Pediatrics*. 122: 938-946.

•Cheng TL, Wright JL, Markakis D, Copeland-Linder N. (2008). Randomized trial of a case management program for assault-injured youth. *Pediatric Emergency Care*. 24(3):130-136.

•Cooper C, Eslinger DM, Stolley P. (2006). Hospital-Based Violence Intervention Programs Work. *J Trauma*. 61:534-540.

•Zun LS, Downey L Rosen J. (2006). The effectiveness of an ED-based violence prevention program. *Am J Emerg Med*. 21:8-13.

•Aboutanos MB, Jordan A, Cohen R et al. (2011). Brief Violence Interventions With Community Case Management Services are Effective for High-Risk Trauma Patients. *J Trauma*. 71: 228-237.

•Coupet E, Karp D, Wiebe DJ, Delgado K. (2018). Shift in U.S. payer responsibility for the acute care of violent injuries after the Affordable Care Act: Implications for prevention. *Am J of Emerg Med*. [Epub ahead of print]

•Fischer, K., Purtle, J., Corbin. (2014). "The Affordable Care Act's Medicaid Expansion Creates Incentives for State Medicaid Agencies to Provide Reimbursement for Hospital-based Violence Intervention Programmes. *Inj Prev*. 20(6): 427-430.

On the Horizon: Opportunities, Partnerships and Recommendations

- **Trauma Centers** - Through The HAVI's partnership with the American College of Surgeons, we seek to increase trauma centers' uptake of HVIP model.
- **Public Education** - Our discussion about violence still focuses almost exclusively on criminal justice actors, not public health approaches.
- **Professionalizing Frontline Workers** - Our 35 hour certification program helps build national professional standards for Violence Prevention Professionals.

Recommendations

- **Any hospital treating over 100 gunshot wounds and other violence-related injuries per year,** both in emergency departments and trauma centers should establish an HVIP.
- **Federal HHS and DOJ and State VOCA** should jointly fund HVIP activities and remove barriers for patient access.
- **Health care payers, such as state Medicaid programs,** should provide reimbursement for violence prevention professional services.

Successes

NJ - S3301 Dept of Health will coordinate HVIP Initiative to achieve impact.

NJ - S3312 Req Level 1 & 2 Trauma Centers to have HVIPs

NJ - S3323 Req VOCA to Partner with Trauma Centers

VA - $2.45M allocated to HVIPs through State VOCA

CA - Law Allows Medicaid to Reimburse for Violence Prevention Services - now on Governor's Desk to Sign

Charles Branas, PhD, MS

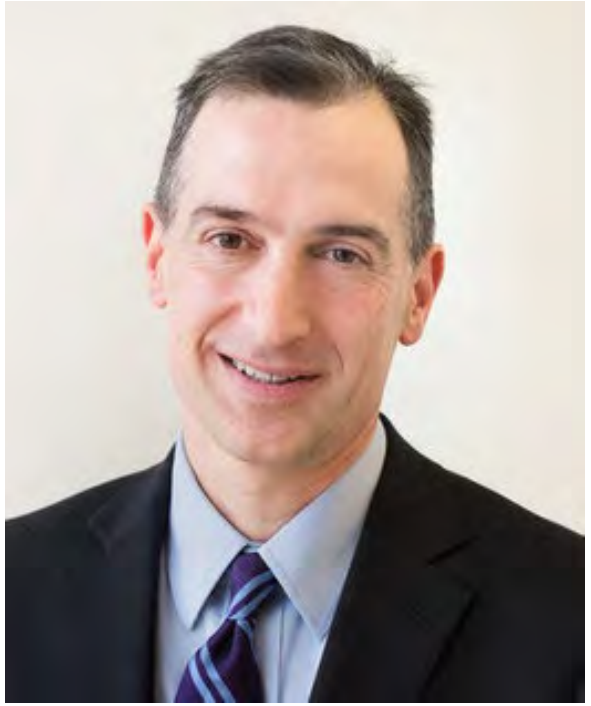
Gelman Endowed Professor and Chair,
Department of Epidemiology

Columbia University, Mailman School of Public Health

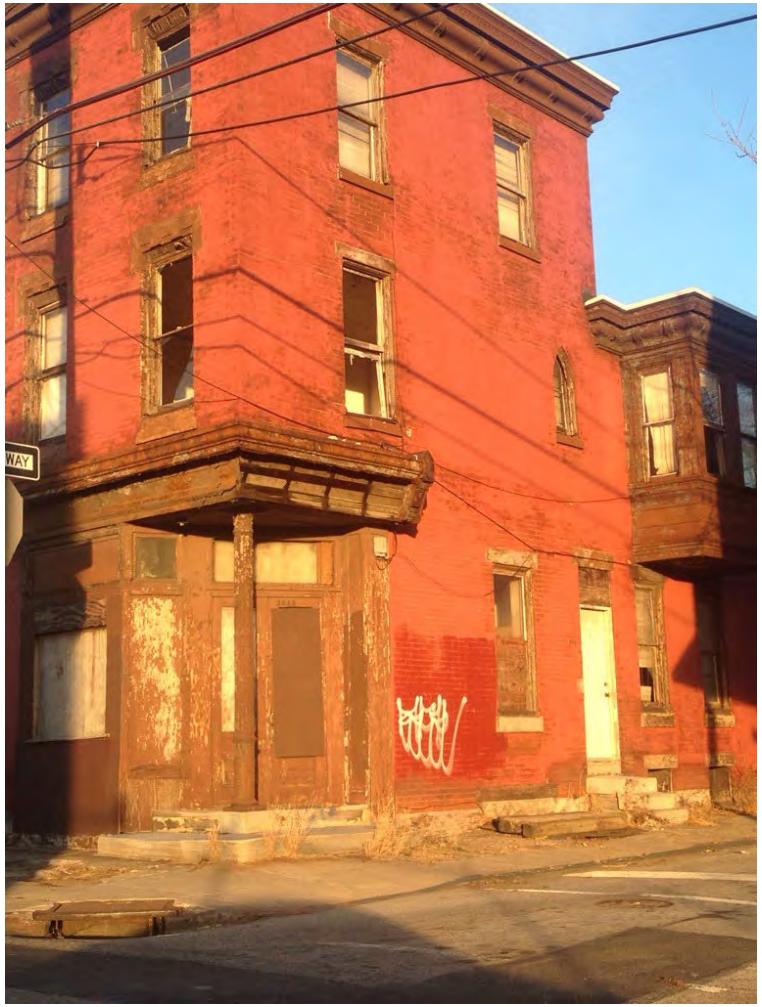
Columbia Center for Injury Science and Prevention

c.branas@columbia.edu

@EpiProfCharlie, @CUEpidemiology



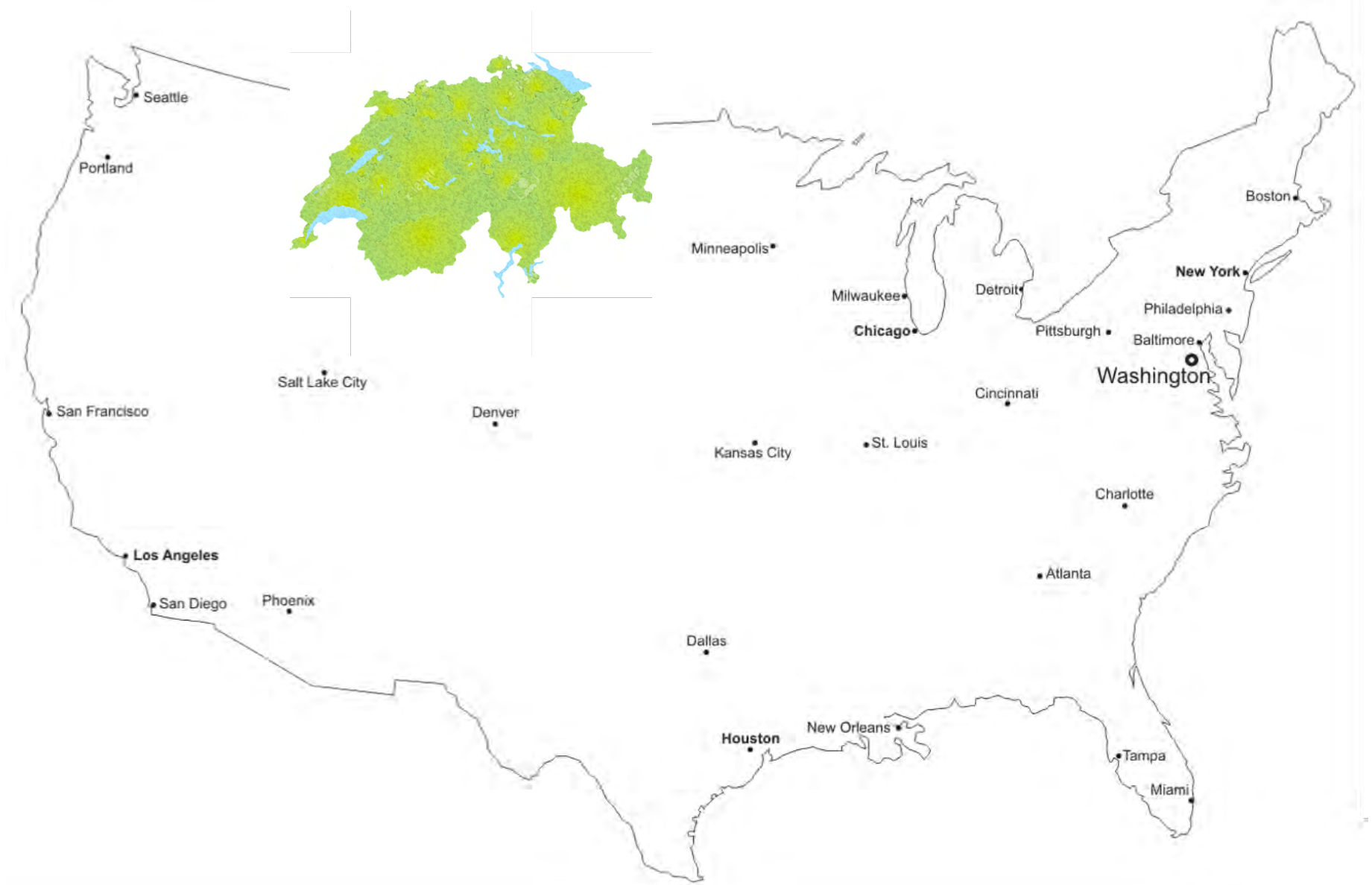
Spiral of disinvestment, crime, and abandonment



REDUCING BLIGHT IN URBAN AREAS

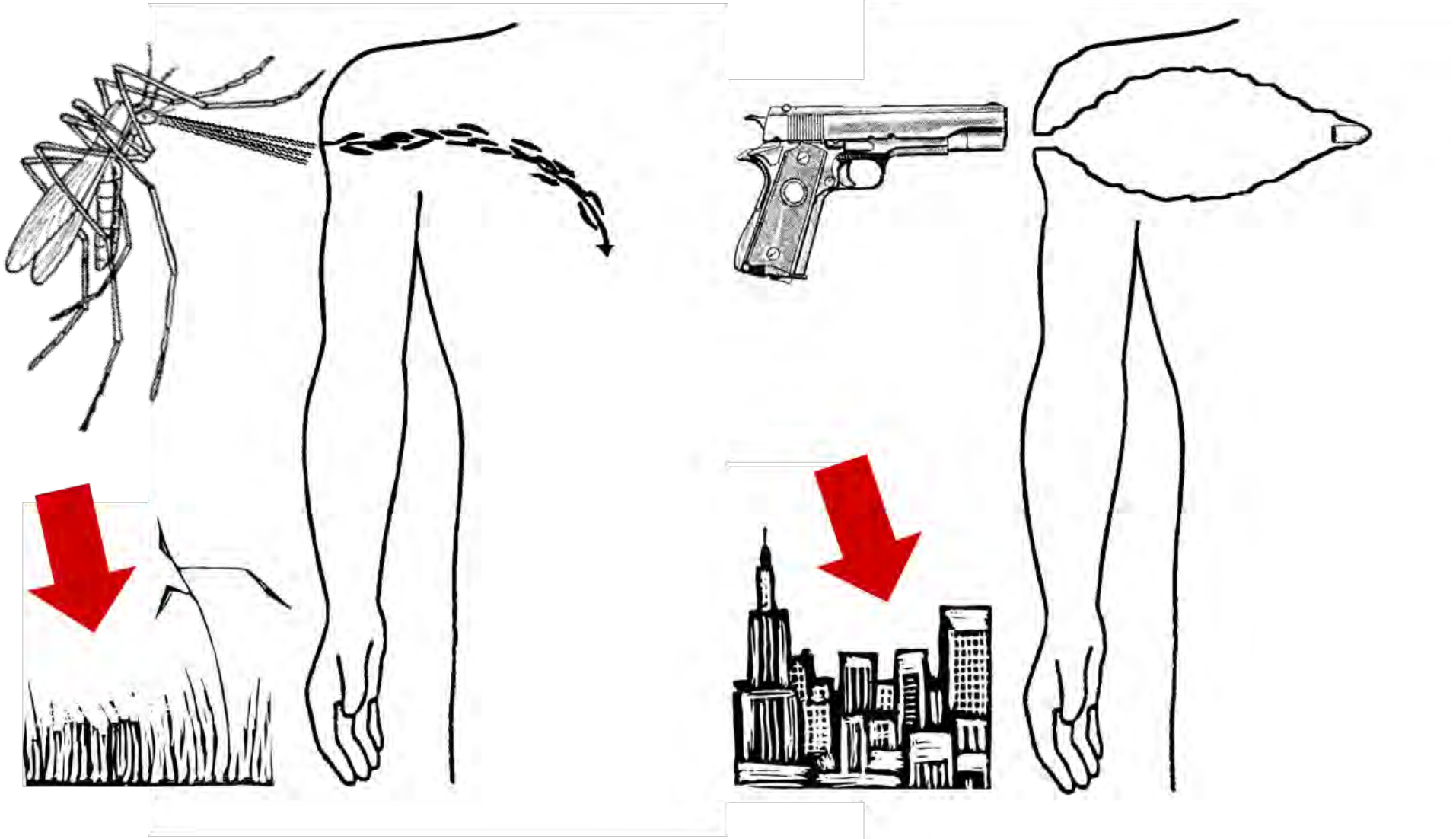
REDUCING BLIGHT IN URBAN AREAS

- Blighted spaces in US cities adds up to an area the size of Switzerland
- Major challenge, but also an opportunity



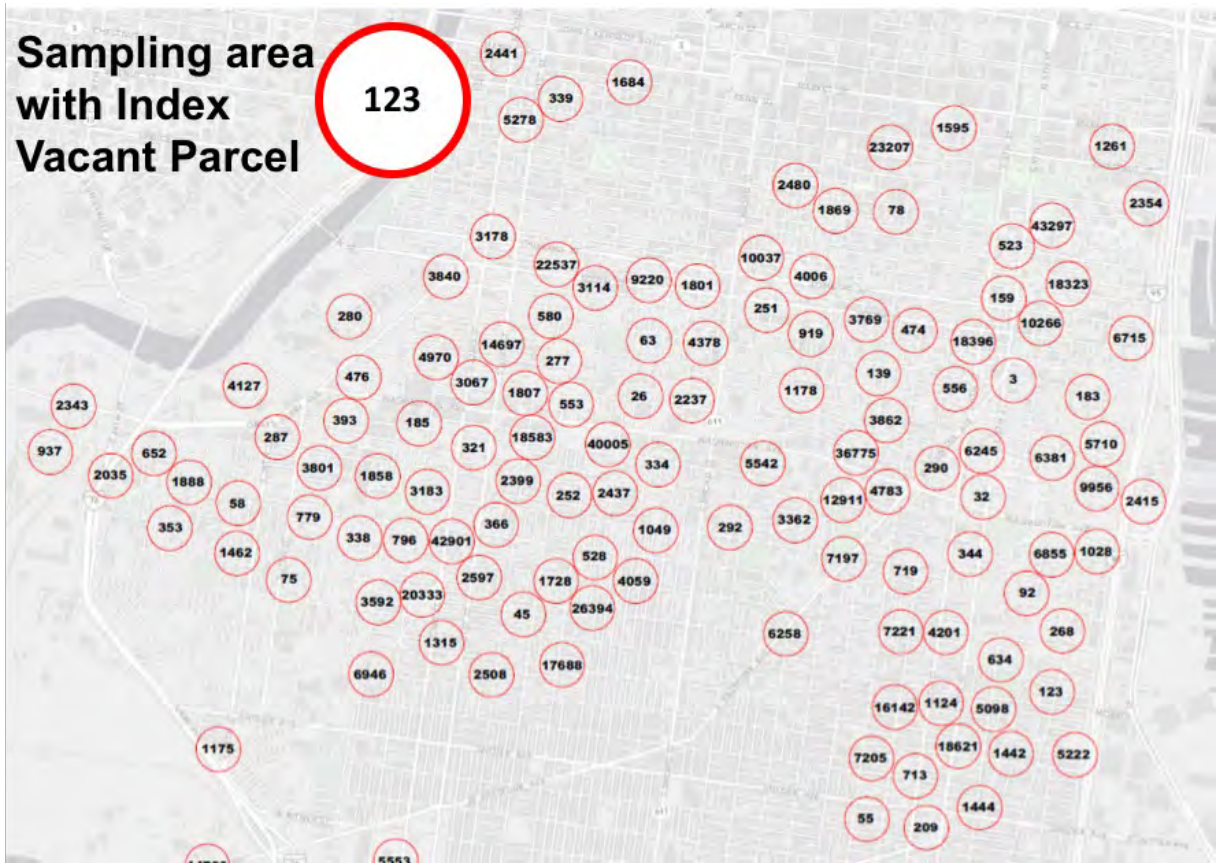
People, pathogens, and places

People, pathogens, and places



Citywide studies and randomized controlled trials

on 10,000s of vacant lots and abandoned buildings



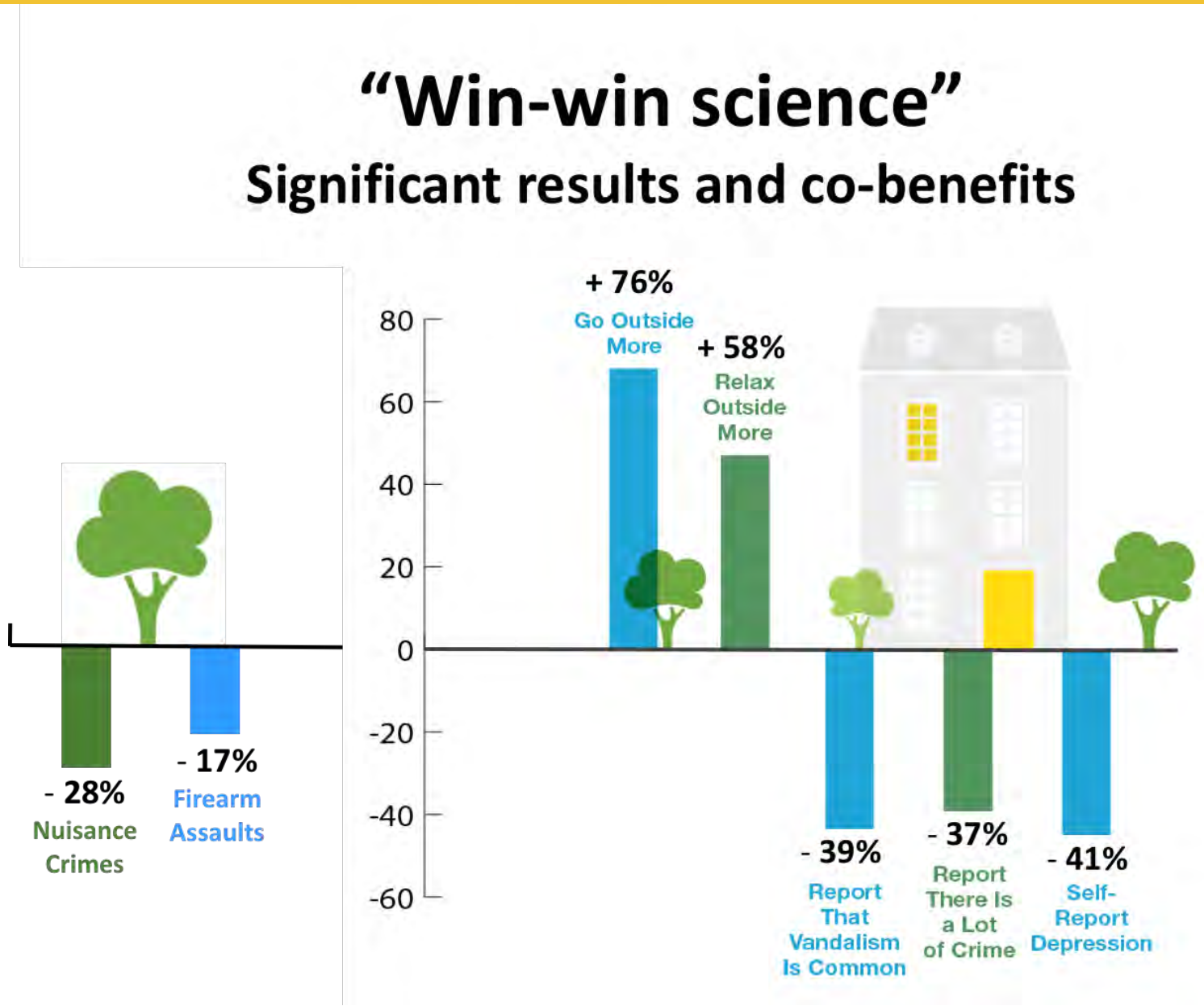
Legend:

- Sampling area
- Index parcel
- Candidate parcel

Greening, Building Fixes, Lighting, Trees

Across studies:

- 6% to 56% less gun violence, vandalism, and crime
- Every $1 invested returns as much as $300 to taxpayers and cities



Why?

- Illegal guns not in blighted spaces
- Informal policing by neighbors
- Connectedness between neighbors

REDUCING BLIGHT IN URBAN AREAS

Recommendations

(1) Population-wide and place-based interventions are long-standing and necessary public health interventions

(1) Gun violence interventions to change blighted, vacant, and abandoned places are:

- well-studied
- effective
- inexpensive
- scalable
- apolitical

(1) City, state, and the federal policymakers can invest in anti-blight ordinances and legislation, and the resources needed to directly address blighted areas

Linda Christine DeGutis, DrPH

Executive Director, Defense Health Horizons

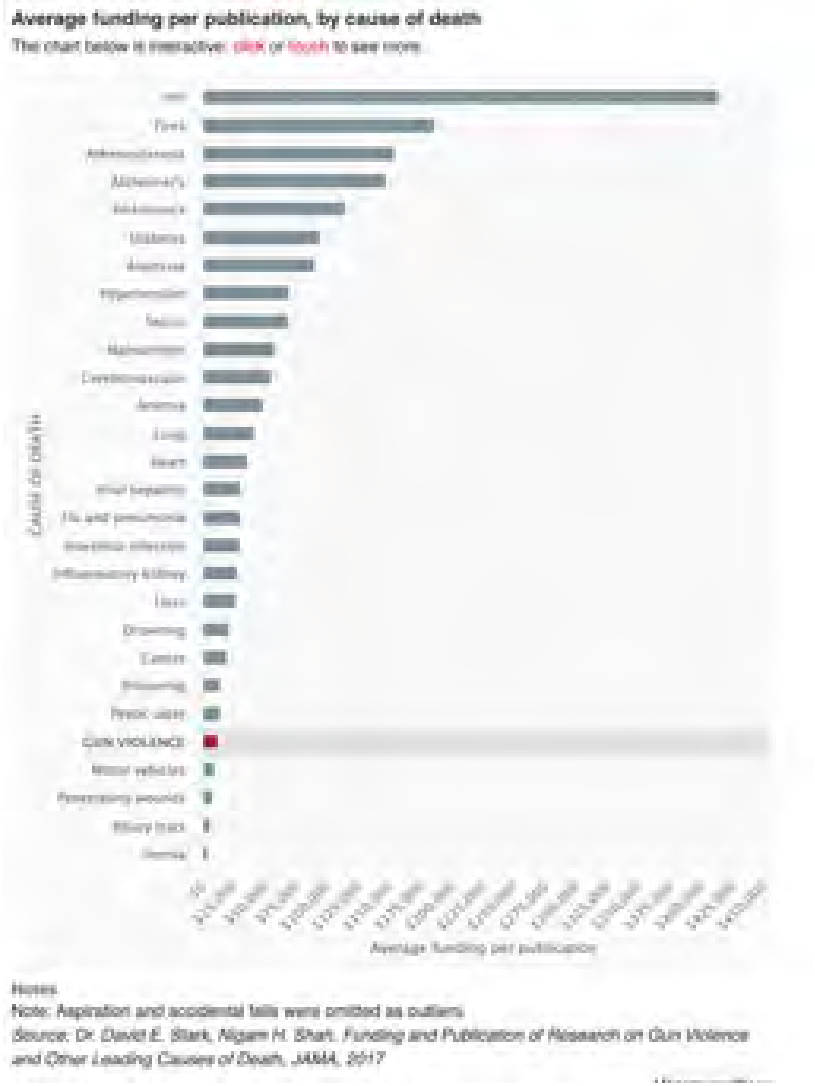
Adjunct Professor, Rollins School of Public Health, Emory University

Policy Introduction

- Federal funding for gun violence research stalled since the Dickey amendment in 1996
- The amendment did NOT prohibit research, but barred using CDC funds to advocate or promote “gun control”
- From 2004 - 2014 Federal funding for gun violence research was just over $20 million dollars
- 2012 - Executive order by President Obama following the Sandy Hook killings
    - Directed CDC to resume funding of gun violence research
    - Directed Congress to appropriate $10 million for gun violence research
    - Directed CDC to develop a public health research agenda for gun violence research
    - Directed federal agencies to:
        - Study the causes of firearm violence
        - Identify interventions that might prevent it
        - Develop strategies to minimize its public health burden

What We Know

- Of the Executive Orders that were issued, the CDC implemented the following:
  - The development of a public health research agenda - Priorities for Research to Reduce the Threat of Firearm-Related Violence: Research Priorities – Institute of Medicine, June 2013
- Research funding for other leading causes of death, illness and disability such as motor vehicle crashes have resulted in implementation of effective policies and interventions that decrease death, illness and disability.



What We Know

- Research funding for other leading causes of death, illness and disability such as motor vehicle crashes have resulted in implementation of effective policies and interventions that decrease death, illness and disability.
- Lack of research limits progress in reducing the number of deaths and injuries that occur each year due to firearms.
- Federal government funding is influenced by appropriations bills and biases on the part of policymakers. Congress can limit specific topics that are addressed using Federal funds.
- Private funding can fill gaps that government funding creates
- Take-up of research is often contingent on political agendas, rather than the societal utility of the research.
- Without the science that demonstrates what works and what doesn't work, we will continue to design, develop and implement strategies that are **reactive**, rather than **proactive**.

Opportunities

- Move from our comfort zone of publishing data to translating data to effect change
- Make science integral to identifying effective policies and programs
- Consider using impact frameworks to encourage collaboration and shared research agendas. They may assume that research generally has a longer-term, incremental impact, often through shaping the framing of policy problems.
- Increase training opportunities for new gun violence researchers
- Ensure that research questions are informed by practice
- Ensure that there are multidisciplinary collaborations to address the issues through research, dissemination, translation and evaluation

Recommendations

- Congress should fund gun violence research at a level that is similar to that provided for other public health epidemics, such as the opioid overdose epidemic, HIV and infectious diseases.
- In order to foster higher quality research, Congress should provide funding that is needed to improve databases and the access that researchers have to them.
- A core group of experts should identify priority topics in gun violence research. This may include revisiting and updating the 2013 IOM report.
- Congress should provide federal funding for the education and mentorship of gun violence researchers similar to what is provided for students and early career researchers in other fields.
- States should fund gun violence research and translation to practice.
- The private sector should fund gun violence research priorities that link to its mission and vision.
- ***Congress, states and the private sector should fund research so that we know what works, not what we think might work.***