ANNE ARUNDEL COUNTY
READINESS ASSESSMENT REPORT
10/07/2024, 11/22/2024 REVISION

OBJECTIVE OF READINESS ASSESSMENT PROCESS

The Cure Violence Global (CVG) Training & Technical Assistance Team conducts a readiness assessment process to determine if local political will and capacity exists to implement the CVG model. The readiness assessment process entails a series of meetings conducted to engage governmental agencies, stakeholders, community organizations, and individuals to familiarize them with the CVG model, to review data to determine potential target areas, develop partnerships, meet with possible workers, and develop potential program structures for future implementation. Specifically, the assessment seeks to determine the following:

(1) Is there a governmental or non-governmental agency with the capacity and will to implement the CVG model with fidelity?
(2) Does official and unofficial data exist about violent incidents to determine potential target areas to focus, monitor, and measure the implementation of the model?
(3) Does official and unofficial data exist regarding the nature of violent incidents to determine if the CVG model is appropriate?
(4) Does official and unofficial data exist to create criteria to identify the highest risk target population for focusing implementation?
(5) Do community organizations exist who fit the CVG criteria to serve as partners to implement the model?
(6) Do individuals exist who could fulfill the role of Violence Interrupters and/or Outreach Workers?
(7) Is there sufficient information to determine initial program recommendations for program size, budget, and a training and technical assistance plan from CVG?

In April of 2024, officials from the Anne Arundel County Department of Health (AACDOH) in Anne Arundel County, Maryland contacted CVG and expressed interest in expanding their community violence intervention efforts utilizing CVG's violence prevention model. After further discussion, an agreement between AACDOH and CVG was executed for CVG to conduct a Readiness Assessment for the northern portion of Anne Arundel County. CVG worked closely with the AACDOH to complete the assessment through the four distinct phases which included:

(1) CVG 101 Informational meetings for a broad range of stakeholders including government agencies, hospitals, service providers, and community-based organizations (hybrid: in-person and remote);
(2) Smaller stakeholder meetings with a subset of attendees of the CVG 101 presentations (virtual);
(3) In-person visit which took place in September of 2024; and
(4) Submission of the Readiness Assessment Report with recommendations for next steps.

The schedule of the Anne Arundel County Readiness Assessment is delineated in the table below:

Anne Arundel North County Readiness Assessment Schedule September 11-13, 2024				
September 11				
Day	**Session**	**Time**	**Target Audience**	**Location**
Wednesday, September 11	Introductory Session	10:30am-1pm	- General Public - Potential Partners - County Executive's Office	6670 Roberts Court Glen Burnie, MD
Wednesday, September 11	Stakeholder Session	1pm-1:15pm	Anne Arundel County Police (AACPD) (Captain Jacklyn Davis)	6670 Roberts Court Glen Burnie, MD
Wednesday, September 11	Stakeholder Session	1:15pm-2:30pm	-Partnership for Children, Youth, & Families (PCYF) -Department of Social Services (DSS) -ROCA	6670 Roberts Court Glen Burnie, MD
Wednesday, September 11	Community Visits (Neighborhood Tours)	8:30-10:30am	-Community Residents/Stakeholders organization -Lived-experience	
September 12				
Thursday, September 12	Stakeholder Session	9:00am-9:45am	-General Public	6670 Roberts Court Glen Burnie, MD
Thursday, September 12	Stakeholder Session	10:00am-10:45am	-Community-Based Organization (Lead4Life)	7310 Ritchie Hwy Suite 304, Glen Burnie, MD
Thursday, September 12	Stakeholder Session	11:00am-12:00pm	-Community-Based Organization (Glimpse of Paradise & Kingdom Kare)	1350 Blair Dr Odenton, MD 21113
Thursday, September 12	Stakeholder Session	1:30pm-2:30pm	-Community-Based Organization (Light of the World)	5317 Ritchie Hwy Brooklyn Park, MD 21225
Thursday, September 12	Stakeholder Session	3:00pm-4:00pm	-Community-Based Organizations (Greater Baybrook Alliance & MedStar Harbor Hospital)	3501 7th Street Baltimore, MD
Thursday, September 12	Community Visits (Neighborhood Tours)	4:30pm-5:30pm	-Community Residents/Stakeholders organization -Lived-experience	
September 13				
Friday, September 13	Stakeholder Session	9:00am-9:45am	-Community-Based Organization (We Are Us)	6670 Roberts Court Glen Burnie, MD
Friday, September 13	Stakeholder Session	10:00am-10:45am	-Hospital (MedStar)	3001 S Hanover Streer Baltimore, MD
Friday, September 13	Stakeholder Session	11:00am-11:45am	-Community-Based Organization (New Kingdon Faith Christian Church)	500 McCormick Dr. Suite H, Glen Burnie, MD 21061
Friday, September 13	Stakeholder Session	12:45pm-1:30pm	-Hospital (BWMC)	301 Hospital Drive Glen Burnie, MD
Friday, September 13	Community Visits (Neighborhood Tours)	2:00pm-5:00pm	Community Residents/Stakeholders organization -Lived-experience	

READINESS ASSESSMENT REPORT

This report details the information that was obtained during the Readiness Assessment and CVG's recommendations for moving forward.

CURE VIOLENCE GLOBAL BACKGROUND

CVG History and Experience

During its first 25 years, Cure Violence Global (CVG) served as both a direct implementer of its health approach (primarily in Chicago) and a provider of Training and Technical Assistance (TTA) to replication partners in the US and internationally. In 2020, CVG made the strategic decision to focus solely on the delivery of TTA and public education to diffuse the approach, adapt it to address other forms of violence, and help shift the prevailing discourse and strategy on violence and public safety in the US and globally.

CVG's replication approach calls for the identification of and collaboration with local partner organizations that have the capacity, credibility, and desire to operate a local program, with CVG providing start-up training, ongoing technical assistance, a peer learning network, and process and outcome evaluation to ensure program fidelity and maximal impact. This approach capitalizes on the relative strengths and expertise of both organizations, with local partners bringing a deep familiarity with the community and relationships with other local organizations and institutions and CVG sharing its expertise in health-based violence prevention and the breadth of its implementation experience.

Over the past two decades, CVG has provided an array of TTA to more than 100 communities in over 15 countries. CVG is currently engaged in assessments or the delivery of TTA in 22 cities in the US (e.g., New York City, Charlotte, Philadelphia, Grand Rapids, Wichita) and 13 cities in Mexico, Honduras, Colombia, Trinidad, Jamaica, and Somalia.

Program Model and Evidence of Effectiveness

CVG's health- and community-based intervention model is based on the World Health Organization's epidemic control approach for reversing the spread of infectious diseases such as AIDS, cholera, and tuberculosis. The model applies epidemic-reversal methods to: 1) detect and interrupt (i.e., prevent) potentially violent situations 2) identify and change the thinking and behavior of the highest risk transmitters (i.e., those most likely to engage in violence), and 3) change group norms that support and perpetuate the use of violence.

CVG's method begins with an analysis of violence clusters and transmission dynamics and uses several new categories of paraprofessional health workers to interrupt transmission and change norms around the use of violence. Central to the approach is the use of workers viewed as trustworthy and credible by the population being served. This is best accomplished by hiring members of the community who have had similar life experiences to those at highest risk (often individuals who are former victims and/or perpetrators of violence who have subsequently renounced violence), who are from the same groups as those currently engaging in violence and are thus viewed as "credible messengers." Staff are trained as community health workers and receive extensive education and coaching in evidence-based methods of mediation, persuasion, behavior change, and norm change -- all of which are essential for limiting the spread of outbreaks of violence.

CVG program sites are typically staffed by Violence Interrupters, Outreach Workers, an Outreach Supervisor and Program Manager. **Violence Interrupters** are carefully selected community insiders with similar backgrounds as individuals at high risk for violence, who are trained to detect imminent violence and intervene before it erupts. Interrupters prevent violence by identifying and mediating potentially lethal conflicts in the community and following up to ensure that the conflict does not reignite. Whenever a shooting happens, they immediately mobilize in the community to cool down emotions and prevent retaliations – working with the victims, friends and family of the victim, and anyone else connected with the event. They also identify conflicts by talking to key people in the community about ongoing disputes, recent arrests and prison releases, and other volatile situations, and use mediation techniques to resolve them peacefully. Interrupters follow up with conflicts for as long as needed to ensure that the conflict does not become violent.

Outreach Workers work intensively with a small caseload (15 - 20) of the highest-risk individuals over 6-24 months, in their homes, on the streets, and in the program's community-based office, to change their thinking and behavior related to violence and connect them to community resources. Using tailored communication and behavior change techniques, they establish contact with high-risk youth/young adults, meet them where they are, develop trusting relationships, talk with them about the consequences of engaging in violence, teach them alternative responses to violence triggers, and help them to obtain services and resources they need (e.g., school support, job training, employment, and drug treatment) to shift their trajectory.

The **Outreach Supervisor** and **Program Manager** direct all program operations. The Supervisor oversees the day-to-day work of staff in the field and often carries a small caseload of highest risk participants. The Manager is responsible for resource referral and partnership development, and coordination of public education and community actions (e.g., marches, peace summits, barbecues) that build cohesion and send a unified message that violence is not acceptable. Whenever a shooting occurs, the Manager and Supervisor organize a public response during which dozens of community members voice their objection to the shooting. Additionally, the manager coordinates with existing and establishes new block clubs, tenant councils, and neighborhood associations to foster social cohesion and promote community safety. He/she also organizes the distribution of public education materials and the hosting of events to convey the message that violence should not be viewed as normal but as a behavior that can be changed.

Additionally, some cities choose to implement a Hospital Response Program in conjunction with community-based program sites. In these cities, **trained Hospital Responders** are deployed to local hospital trauma centers when a gunshot, stabbing, or blunt trauma victim arrives to intervene during the critical window after a violent incident to prevent retaliation and interrupt the cycle of violence. A key aspect of retaliation prevention involves connecting the hospital response to violence interruption work in the community. When a patient is ready for discharge, Hospital Responders also offer connections to aftercare services to help victims begin to set a new course.

CVG's model has undergone 11 independent evaluations to date, all of which have reported statistically significant reductions in violence. A 2009 Northwestern University evaluation found that the model was associated with 16-34% reductions in shootings and 46-100% reductions in retaliatory homicides. An evaluation in three Philadelphia Police Service Areas found that the Cure Violence program was associated with a 30% reduction in the rate of shootings. A 2012 Johns Hopkins University evaluation found that Safe Streets, Cure Violence's partner in Baltimore, reduced killings up to 56%, and shootings up to 44%. A John Jay College of Criminal Justice evaluation of two New York City neighborhoods operating Cure Violence programs from 2014 to 2016 found steeper declines in acts of gun violence and increases in the expression of pro- social norms compared with similar neighborhoods not operating Cure Violence programs. The study found reductions across all measures, including a 63% reduction in shootings in one community, a 50% reduction in gunshot wounds in the other, less support for the use of violence, and greater confidence in police. A 2014 evaluation of two Chicago Cure Violence program neighborhoods showed a 31% reduction in homicides and a 19% reduction in shootings in targeted districts. In a study by Arizona State University in 2018, the adaptation of the Cure Violence model in East Port of Spain, Trinidad found "Based on a series of quasi-experimental designs using three independent data sets maintained and updated by different entities…found that the Cure Violence intervention was associated with significant and substantial reductions in violence." Finally, a study by the Inter-American Development Bank in 2019, conducted by the *Universidad ICESI*, found In intervention area 1, Charco Azul, a 47% reduction in homicides and 47% less likely to experience retaliatory homicides within 7 days compared to control areas and in intervention area 2, *Comuneros,* a 30% reduction in homicides and 100% less likely to experience retaliatory homicide within 7 days compared to control areas. **Notably, the approach has been found effective both when CVG was implementing it directly (in Chicago) and when other jurisdictions are implementing it under the guidance of CVG's TTA.**

READINESS ASSESSMENT FINDINGS

Cure Violence Global was able to determine that Anne Arundel County, Maryland has the political will and capacity to implement the CVG model. Below are brief descriptions of the findings of the readiness assessment for each element which is required to implement the CVG model successfully.

(1) Is there a Governmental or Non-Governmental agency with the capacity and will to implement the CVG model with fidelity?

Yes, CVG was able to determine during the assessment process that Anne Arundel County has the capacity and political will to implement the CVG model with fidelity. CVG was able to engage AACDOH, the County Executive's Office, the Anne Arundel County Police Department (AACPD), the Department of Social Services (DSS), Partnership for Children, Youth, & Families (PCYF), and other several other agencies. All demonstrated the necessary capacity and/or the will to implement the CVG model with fidelity or be a standing partner with the implementing agency.

Given the nature of the model, CVG recommends that AACDOH serve as the oversight agency for the Cure Violence program. AACDOH is currently overseeing the Annapolis CVG replication site and has displayed the necessary capacity to do so effectively. AACDOH's oversight will help to ensure proper leveraging of available health and social service resources, ensure proper focus on and evaluation of the violence in communities receiving the Cure Violence program, and synergy. The programs would also be managed by a credible agency that can educate the public about the root causes of violence and why it is a public health issue and a determinant of health.

As the agency responsible for addressing population health issues and implementing evidence-based initiatives to improve health outcomes, involvement of the local public health authority is an essential component of CVG's approach. The local health authority has the expertise necessary to ensure that implementation of the approach is done in a manner that is grounded in health equity, addresses the root causes of the condition (i.e., violence), and incorporates elements necessary to improve the health of the population in a sustainable manner. Thus, AACDOH is well positioned to serve as the system-level convener, bringing together essential stakeholders and obtaining their support to ensure proper leveraging of existing infrastructure and resources to meet the communities' needs, and to effectively integrate the violence prevention programming into the fabric of Anne Arundel County's local public health ecosystem.

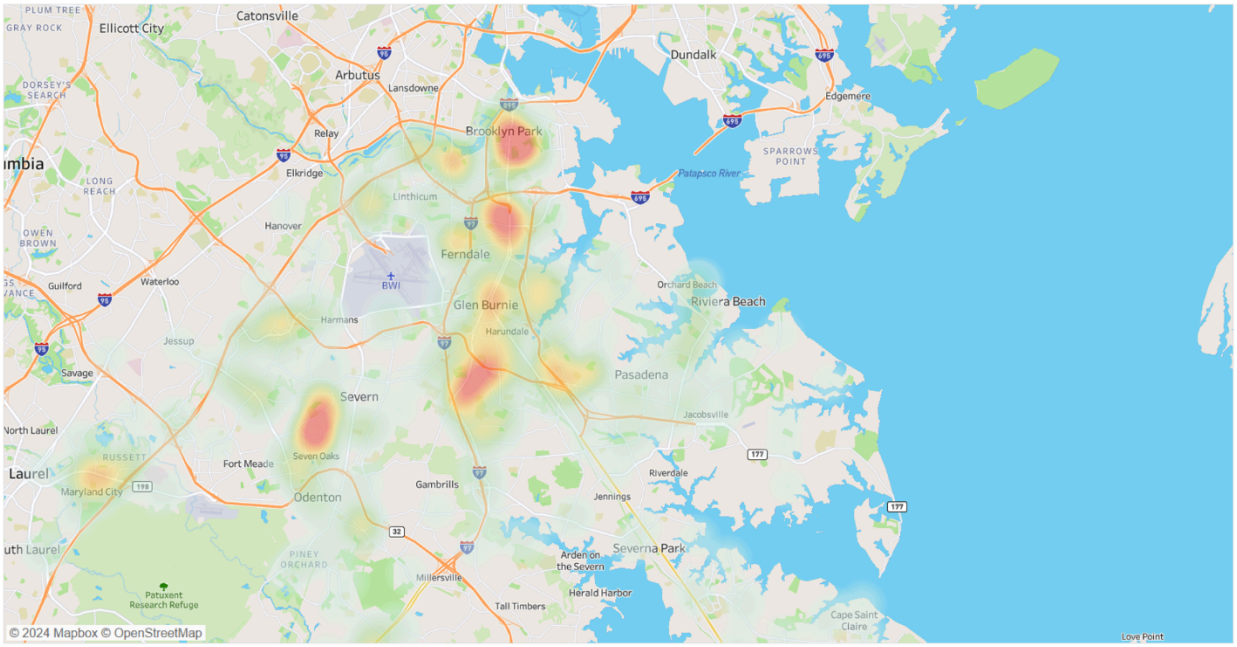
(2) Does official and unofficial data exist about violent incidents to determine potential target areas to focus, monitor, and measure the implementation of the model?

Yes, CVG was able to determine that Anne Arundel County **exceeds** the data requirement for the CVG model to be successful. AACPD, in collaboration with AACDOH, were able to provide data sets for the Readiness Assessment which demonstrated the ability to determine potential target areas to focus on, monitor, measure, and ultimately report on the impact of the CVG model at the community level.

The data provided by AACPD included counts of Aggravated Assaults and Murders (previous last two plus years historical). CVG was able to use GIS to determine which cities contained majority of incidents, analyzed by year and area based on number of Aggravated Assaults and Murders and narrowed down the size of areas based on comparisons with other cities within the county containing similar rates of violence where the program has successfully been implemented.

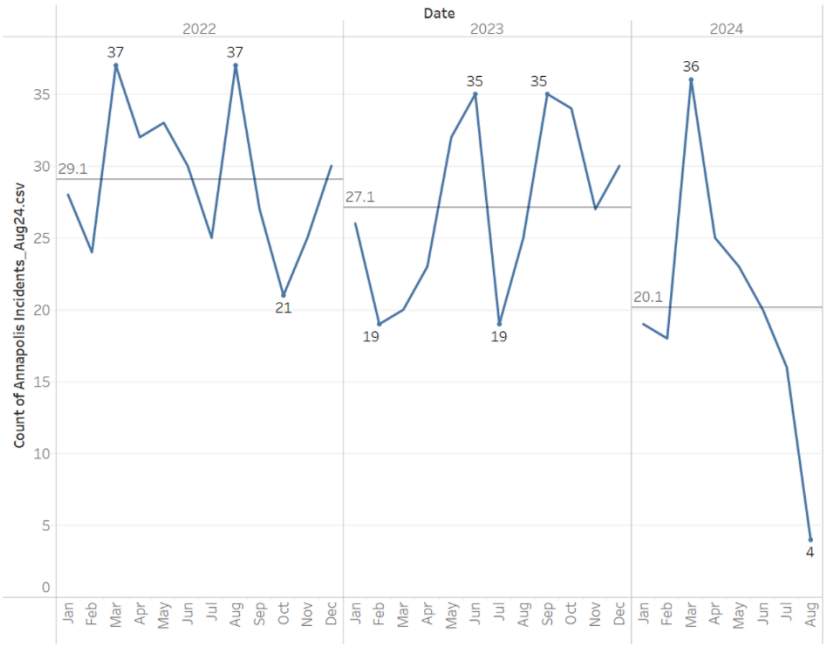
The two recommended Target Areas to expand coverage in the county are (1) Glen Burnie and (2) Brooklyn. The data used to make these recommendations is detailed in the tables below:

Incident Heatmap from 2022-August 2024



Anne Arundel County Incident High-Low Graph

Incident Rate Time-Series - Highs and Lows

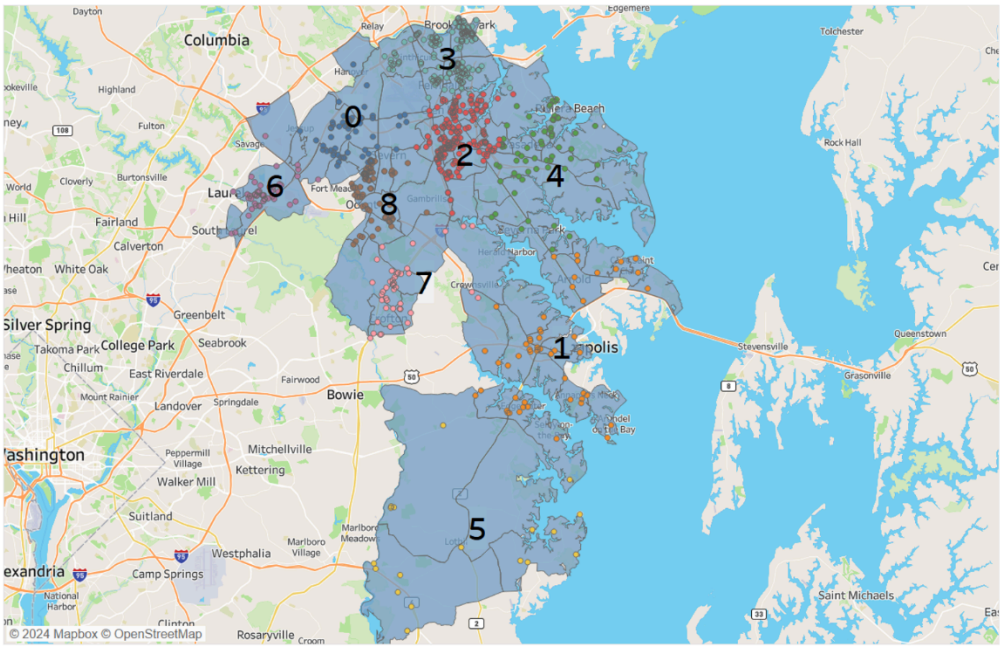


Incident Rates Overtime

Quarter of Date	Month of Date	Date 2022	2023	2024
Q1	January	28	26	19
	February	24	19	18
	March	37	20	36
Q2	April	32	23	25
	May	33	32	23
	June	30	35	20
Q3	July	25	19	16
	August	37	25	4
	September	27	35	
Q4	October	21	34	
	November	25	27	
	December	30	30	
Grand Total		349	325	161

Anne Arundel County Cluster Map

Incident Clusters Mapped



City Counts

City	
glen burnie	268
brooklyn	80
severn	79
pasadena	64
laurel	56
hanover	49
annapolis	46
linthicum heights	39
odenton	36
millersville	21
crofton	19
gambrills	18
edgewater	10
arnold	9
lothian	7
severna park	5
jessup	4
crownsville	3
fort meade	3
harwood	3
shady side	3
annapolis junction	2
curtis bay	2
davidsonville	2
west river	2
baltimore	1
galesville	1
glen burnie e	1
orchard beach	1
stoney beach	1

Anne Arundel County Cluster Count & Directory

Cluster Counts

Cluster ID	Date 2022	2023	2024	Grand Total
0	32	36	17	85
1	24	24	13	61
2	94	90	35	219
3	91	71	35	197
4	23	26	18	67
5	8	6	4	18
6	19	27	15	61
7	18	15	10	43
8	40	30	14	84

Clusters Highlighted by Incident Types Overtime

Incident T (group)	Cluster ID	Date 2022	2023	2024
Agg. Assaults	0	18	19	7
	1	16	11	5
	2	46	54	16
	3	54	32	19
	4	15	19	10
	5	6	4	4
	6	11	12	9
	7	6	9	3
	8	27	18	10
Homicides	0	1	2	1
	1	1	2	
	2	4	3	
	3	1	1	2
	4	2		
	6		1	
	7	1		1
	8	2		1

Clusters Containing Cities and Counts

City	Cluster ID	
glen burnie	2	183
	3	77
	0	3
	4	4
	7	1
brooklyn	3	80
severn	2	3
	0	28
	8	48
pasadena	2	13
	4	51
laurel	6	56
hanover	0	49
annapolis	4	1
	1	44
	6	1
linthicum heights	3	39
odenton	8	34
	7	2
millersville	2	19
	8	1
	7	1
crofton	7	19
gambrills	8	1
	7	17
edgewater	1	9
	5	1
arnold	4	2
	1	7
lothian	5	7
severna park	4	5
jessup	0	3
	6	1
crownsville	7	3
fort meade	0	2
	6	1
harwood	5	3
shady side	5	3
annapolis junction	6	2
curtis bay	4	2
davidsonville	1	1
	5	1
west river	5	2
baltimore	3	1
galesville	5	1
glen burnie e	2	1
orchard beach	4	1
stoney beach	4	1

According to data reviewed; conversations held with the Health Department, county leadership (County Executive), and stakeholders from the areas; and the time spent within the target areas during the readiness assessment process, it has been confirmed that the dynamics of the violence in the target area candidates (Glen Burnie and Brooklyn) are appropriate and consistent with other areas where the CVG model has been implemented. These dynamics included the existence of individuals and groups associated with violence (gangs, crews, cliques, etc.), high levels of social and economic inequity, illegal drug activity, and high levels of robberies and other crimes.

(3-4) Does official and unofficial data exist to determine if the CVG model is appropriate and identify the highest risk target population for focusing implementation?

Yes, the data CVG was able to review provided by AACPD during the assessment process demonstrated that the nature of the violent incidents is consistent with other areas where the CVG model has been successfully implemented. Meaning, that the shootings and homicides take place in mostly public spaces in the community between individuals and groups who are in conflict for various reasons ranging from sale of substances to interpersonal conflicts (often fueled by social media) to other “on the spot” transactional disputes.

Additionally, in speaking with many community stakeholders during the assessment process, the understanding of who is most likely to be involved in the shootings and homicides is consistent with other cities where the CVG model has been implemented successfully. This includes persons who are 16-25 years old (can range from 14-30), have recently been exposed to violence (themselves or someone from their peer/family group, formerly incarcerated (for violent offense), are active in a street organization/crew/clique, have a history of carrying a weapon and, are engaged in high-risk street activity (informal economy).

(5) Do community organizations exist who fit the CVG criteria to serve as partners to implement the model?

Yes, CVG was able to determine during the assessment process that community organizations do exist who fit the majoirty of the criteria to implement the model. Implementation at the community level requires a community-based organization capable of providing oversight of the day-to-day program operations. The criteria for community-based implementation partners are as follows:

- Mission aligned with Cure Violence model and health approach
- Strong ties to the target community
- Viewed as credible, trusted, and neutral by target community and highest risk individuals
- Able to participate in recruitment of potential workers for the target area
- Able and willing to hire and work with individuals with criminal histories and/or whocome from the groups in conflict in target area
- History of direct violence prevention or related work
- Experience of managing grants and contracts
- Experience producing detailed reports on regular basis
- Organizational capacity to support and supervise staff and to provide fiscal oversight

CVG was able to meet with several individuals from organizations who appear to meet criteria to serve as the community-based partner. They have a broad scope of work which included some violence prevention, community engagement, legal services, large and small activities for the community, provision of supportive services, educational programming, mental health services, re-entry work, life skills, sporting activities for youth, mentorship programs, food, and clothing distribution.

CVG did not review the financials of any organizations during the readiness assessment process, however it is not uncommon for organizations who are best positioned to build relationships with the highest risk in the target area to lack the full capacity to provide fiscal oversight. Additional support for administration and fiscal management may be needed to bolster existing candidate organizations. In CVG’s experience this can be achieved through the use of a fiscal agent or housing the program in a larger organization.

If AACDOH decides to move forward with CVG model, CVG will work with them to facilitate the Request for Proposals (RFP) process which can be included in any local procurement procedures for selecting the community-based partner to implement the program.

(6) Do individuals exist who could fulfill the role of Violence Interrupters and/or Outreach Workers?

Yes, CVG was able to determine during the assessment process that individuals do exist who can fulfill the roles of violence interrupter and outreach worker. The best "change agents" for interrupting violence or providing outreach have in many cases lived the same type of life as those who are being affected by violence and are connected to the community where the initiative is being implemented. Characteristics include:

- Has credibility with the highest risk individuals and groups in the target area
- Has relationships (inroads) with the highest risk individuals and groups in the target area
- Has prior ties to gangs or crew, cliques, drug crews, etc., in the target area
- May have been incarcerated for a violent offense
- Resides in or is from the target area
- No longer active in violence, criminal activity, or substance abuse
- Can work as part of a team

During the Readiness Assessment Process, CVG was able to meet with individuals from the communities who either potentially fit the profile to fulfill the role of violence interrupters and outreach workers or who knew individuals in their communities who did. CVG is confident that if the model moves forward, the selected community-based partner will be able to recruit workers who fit the profile to serve as violence interrupters and outreach workers with specific relationships to reach the highest risk in either of the candidate target areas.

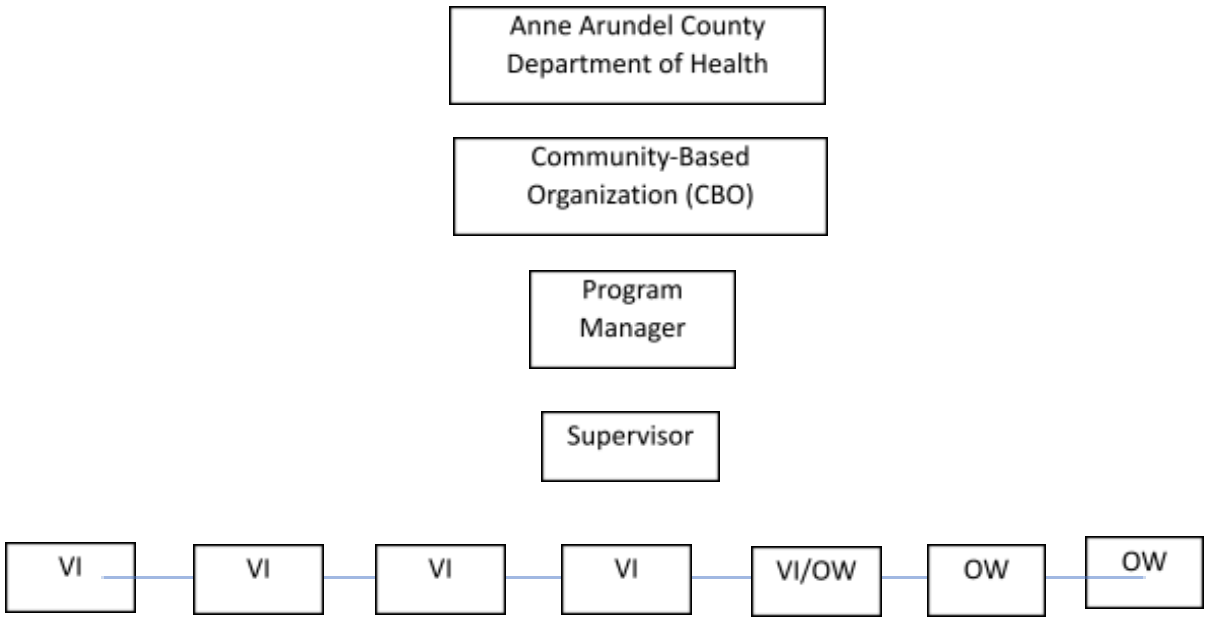
If the program is expanded in Anne Arundel County, CVG has developed specific protocols to ensure the best candidates are selected. This includes a pre-screening and hiring panel process designed to recruit individuals who have the credibility and suitability to best work with the highest risk population in the target areas.

(7) Is there sufficient information to determine initial program recommendations for program size, budget, and ongoing training and technical assistance plan from CVG?

Program Size

Based on the size and the scope of the violence in potential target areas, CVG recommends a program of 8-10 staff to cover either of the candidate target areas. This would be considered a "medium" size program. This staffing pattern would include one program manager, one supervisor, four to six Violence Interrupters (VI), and two to three Outreach Workers (OW).

Staffing Pattern



Program Budget

The estimated budget for setting up a program of this size and scope is $564,750 per year for the first year of implementation depending on where the program is situated. Below is a sample line-item budget based on other programs that have successfully implemented the CVG model at the same estimated staffing level. Local costs and factors will need be considered to finalize the program budgets.

Other Initial Programmatic Recommendations

CVG's violence prevention model is based on proven public health approaches that effectively reduce transmission of diseases. Early iterations of the model solely focused on violence interruption, which effectively reduced killings and shootings. However, the current approach has been modified to improve the environment and health outcomes across the communities implementing the approach. The following are additional initial programmatic recommendations:

1. Create standardized talking points for elected officials, select community-based organizations and other partners who are likely to speak to the media about the implementation of the intervention. This will help increase trust and increase buy-in from community members. Consideration should also be given to issuing a statement that is signed by the essential stakeholders (Mayor, City Manager, Health Department Official, Law Enforcement Official, and others as you deem appropriate)

2. Conduct an environmental scan to identify and map all available health and social service resources for Anne Arundel residents and identify those organizations who are trusted by the community and have a history of providing services in a culturally sensitive and appropriate manner.
    a. This is necessary to ensure the most appropriate service providers are selected to provide services for the jurisdiction's most vulnerable populations.
    b. The following services should be provided:
        i. Housing Assistance
        ii. Food Assistance
        iii. Mortgage/Rental Assistance
        iv. Utility Assistance
        v. Employment Assistance
        vi. Education Assistance
        vii. Job Skills Training
        viii. Identification Assistance
            1. Many individuals may need assistance obtaining a government identification card.
        ix. Preventive Health (Medical and Oral) Services
            1. Many individuals may be uninsured or underinsured. Connecting them with a provider that can provide essential health services and help them navigate health insurance challenges is critical to ensuring individuals are able to achieve their optimal health level. Consider partnering with a local Federally Qualified Health Center that is trusted by community members living in the jurisdiction's most vulnerable areas.
        x. Mental and Behavioral Health Services
            1. Levels of toxic stress are typically higher among those individuals living in the most vulnerable neighborhoods. Connecting them to these support services can give them additional tools to manage stress and ensure any underlying mental health conditions are identified and properly managed.
        xi. Legal Assistance
            1. Assisting individuals with minor infractions to secure record expungement may help them obtain employment.

3. Identify which service providers are willing and able to establish a "fast track protocol" to ensure individuals who are experiencing a crisis can be connected to services within 12-14 hours.
    a. This is necessary to ensure those who are truly the most vulnerable do not resort to violence because they are not able to get the resources they needed in a timely manner.

4. Establish communication protocols for emergency issues that occur at program sites. This should be a simple step-by-step protocol that can be used to ensure timely sharing of information between the sites, community-based organizations, and the oversight agency. The oversight agency will relay critical information to the appropriate government stakeholders.

   Example: Staff Relapse Communications Protocol

   Most sites will not have a worker arrested, but all oversight agencies and sites need to be prepared in case this situation does arise. If a worker gets arrested, there is a high likelihood that a reporter will cover the story. While no one enjoys talking about a negative story, if you are prepared then you can turn this into an opportunity to get your message out and reframe the story.

   You should always respond to a reporter's request for comment

   - *This is an opportunity to talk about the positive work that you do*
   - *It is an opportunity to reframe the story in a more positive light*
   - *The story will run with or without your comment. It is better with your perspective.*

   Before an employee crisis

   - *Your program should ensure all employees undergo training and receive support related to preventing a relapse (not communications, but important for the program-this is in the VIRT)*
   - *Establish a system for staff to immediately notify a supervisor about any situation involving staff and law enforcement, such as an arrest or investigation*
     - *Establish relationship with police for early notification of any employee issue*
   - *Set up a Google alert to be notified of media coverage of your program*

   During an employee crisis

   - *Site Alerts Health Department*
   - *Alert the Cure Violence organization about the crisis immediately*
   - *Alert all relevant staff to refer all media calls to the primary communications point of contact at oversight agency and/or site*
   - *Consult with a human resources person in your organization about what can be said publicly about employment history and status*
   - *Using Cure Violence crisis messaging and statement template, develop a statement to the press for the current situation, and get all necessary approval for its release*
   - *Respond to all press inquiries in a timely fashion*
     - *Ask for their deadline*
     - *Let them know that you will be providing a statement*
     - *If possible, educate them on the work of your organization – credible messenger, access to highest risk, reductions in violence*
   - *Consider notifying board members, funders, or other partners about the situation*

   Tips

   - *Keep the message positive -- No need to acknowledge anything negative*
   - *Be 100% truthful*
   - *Stick to your messages*
   - *When possible, provide a written statement instead of an interview*
   - *Talk about the good work being done by the program and staff*
   - *Be timely – meet the deadline*
   - *Stay broad – avoid commenting on the specifics of the case*
   - *Do not help the story spread*
     - *Avoid posting about it on social media or elsewhere*
     - *Avoid following up after an article has been posted – so as to not encourage additional articles*

5. Establish a communication protocol for ensuring proper authorities and stakeholders receive monthly updates on the impacts the sites are having in the communities. This can be done by emailing reports or creating a public facing dashboard that the oversight agency will update monthly. Typically, the latter option is the most effective and ensures all stakeholders can access the information in a timely manner.

6. Establish internal contract compliance protocols and conduct a contract review with the selected community-based organization.

    a. This is necessary to ensure the selected community-based organizations understand their roles and responsibilities and monthly deliverable completion requirements. This will help ensure compliance throughout the program implementation period and ensure the oversight agency receives the required information in a timely manner.

7. Identify an evaluation partner. This is typically a local tertiary academic institution that has a public health or criminology program that has faculty who have experience conducting mixed methods evaluations and is interested in conducting research on health outcomes related to violence prevention activities.

    a. Ensuring an independent evaluation of the CVG intervention is critical to ensuring the stakeholders have objective information that can help them understand the value of the CVG intervention, its impact on the communities in Anne Arundel County. Furthermore, program evaluation is necessary to advance the field of community violence intervention and help local, state, and national stakeholders understand the importance of implementing a health approach to address violence in communities across the globe.

    b. Evaluations of the approach which can be found http://cvg.org/impact/ have all taken different approaches, study designs, and were conducted at different times (at the beginning of the program, after two or three years of implementation, or when funding was available). It is best practice to allow for one or two years of implementation before an impact evaluation is conducted. This allows the team to be fully training and the model being fully adapted to the local context. CVG would look to AACDOH to determine what would be most beneficial locally in terms of data collected from an independent evaluation.

The intent of these recommendations is to provide communities with guidance that supports the effective integration of CVG's community violence reduction intervention into the fabric of the local public health ecosystem to create safer and healthier communities in a sustainable manner.

Cure Violence Global Training and Technical Assistance Plan

CVG proposes the following training and technical assistance (TTA) to ensure the successful expansion and implementation of the model in Anne Arundel County. TTA will include (1) assistance with the request for proposal process (RFP) to select a community-based partner to implement the CVG model, (2) provision of the "onboarding training" for the community-based partner and governmental agencies, (3) facilitation of panel interviews to recruit and select the best candidates to serve as front line staff, (4) facilitation of program manager/supervisor training for the management of the community based site, (5) facilitation of Violence Interruption and Reduction Training (VIRT) for outreach workers and violence interrupters, (6) access and use of the Database (which includes weekly data reports), (7) participation in weekly monitoring phone calls, (8) three booster trainings/site visits, and 24 hour a day 7 days a week emergency assistance.

A brief description of each is below:

1. Assistance with Request for Proposal (RFP) Process: CVG will provide examples of RFPs used by other cities to select the community-based partner. The sample RFP can be adapted to local procurement laws and processes. The RFP review committee and eventually the hiring panel should include community members and leaders identified during the assessment process.

2. On-Board Training: Two-day onboarding training for community-based partner and governmental oversight agency. The two-day Onboarding Training is designed to equip the governmental oversight agency and community-based partner with the necessary information and skill associated with the successful implementation of the CVG model. All critical implementation issues are addressed, and specific action plans are developed for the first three to six months of programming.

3. Recruitment and Hiring of Staff: To ensure uniform recruitment and hiring practices the CVG model uses hiring panels to hire all violence interrupters and outreach workers which include representatives from the implementing agency (i.e., CVC and representatives from health department), community-based partner organizations (CBO), local faith leaders, community residents, and law enforcement, to ensure that the best candidates are selected for each target area. The following are tools which are used to ensure the best candidates are recruited and selected:
    a. The prescreening checklist to ensure that sufficient background work has been done with the potential candidate to determine that they are suitable to serve as a staff member and have a reliable personal support system.
    b. The panel briefing form to assist in educating all members of the panel on the goals and objectives of the hiring panel and their participation to ensure that the strongest candidates are selected (with the least likelihood of relapse).
    c. The implementation of uniform interview questions and scorecards for each staff position to ensure that the selection of a worker is predicated on their possessing the necessary skillset to implement the model successfully.
    d. The use of a panel tracking form designed to ensure the appropriate individuals and institutions are included in the hiring panels.

4. 40-hour Program Management Training: The Management Training is conducted to impart management-level staff with critical knowledge, skills, strategies, and insights specific to managing a health intervention, frontline staff (violence interrupters & outreach workers), strategic recruitment and deployment of staff, building a strong team, creating a positive work environment, enforcing accountability, mobilizing the community and shifting community norms that perpetuate violence. This training is designed to prepare management for providing oversight of the day-to-day operations, including potential programmatic challenges, strategic planning and the use of data to guide the work and problem solving based upon nearly 20 years of programmatic experience, current staff and community dynamics.

5. 40-hour Violence Interruption and Risk Reduction Training (VIRT): The Violence Interruption and Reduction Training (VIRT) has been developed for outreach workers, violence interrupters, and other administrative staff. It includes a mix of presentation of core concepts and skill development through demonstration and practice. The curriculum is focused on four core areas: 1) Introduction to interruption and outreach, including roles and responsibilities with an emphasis on boundaries and professional conduct; 2) Identifying, engaging and building relationships with participants and prospective participants, assisting participants to change their thinking and behavior as it relates to reducing risk for injury/re-injury and/or involvement in violence; 3) Preventing the initiation of violence or retaliatory acts when violence occurs through mediation and conflict resolution; and 4). Working with key members of the community, including residents, faith leaders and service providers through public education, responses to violence and community building activities.

6. 16-hour Database Training: The database training is designed to equip the site with the necessary skills to use Cure Violence CommCare Database to document all program activities and guide implementation. As a data-driven model, Cure Violence has developed a comprehensive, web-based program database that is used by all implementation sites to track program implementation and participant data. This database provides a robust reporting system which allows for continuous, real-time monitoring of site progress and implementation fidelity. This data is used to monitor and evaluate program progress toward violence reduction and behavior change outcome targets.

7. Weekly Program Monitoring Meetings (with data reports): Ongoing support will be provided through monthly conference calls with the site and representatives of Anne Arundel County, Maryland. These calls will include analysis and review of the weekly data reports. CVG TTA staff will also be available to provide immediate crisis response assistance in addition to the scheduled calls, as needed.

8. Quarterly Booster Training/Site Certification visits: Quarterly site visits will be conducted over the course of the contract period in conjunction with booster trainings. These visits will allow CVG staff to ensure that the lessons from the TTA have been embedded into the local work. Site visits will include observation of daily operations and opportunities to provide onsite feedback as the sites work towards CVG certification.

9. 24/7 Emergency Assistance: CVG staff are available for emergency assistance 24 hours a day, seven days a week.

The cost of the TTA is dependent of local resources and proportional the overall program budget. A scope of work with associated costs of each item and a draft timeline can be provided if the Anne Arundel County Department of Health decides to move forward with the model.

CONCLUSION AND NEXT STEPS

Through the Readiness Assessment process, CVG was able to determine that Anne Arundel County, Maryland has the political will and capacity to expand implementation of the CVG model. The necessary governmental and community infrastructures are all in place to successfully deploy the model and will likely see reductions in shootings and killings in the areas where it is implemented effectively. To conclude the Readiness Assessment, CVG will coordinate with the Anne Arundel County Department of Health to present the findings to the stakeholders who participated in the process.