Forging a New Era

The American Community Violence Prevention Fund

March 2021

THE HEALTH ALLIANCE *for* VIOLENCE INTERVENTION

A Vision for Trauma-Informed Communities

America stands at a crossroads in its approach to policies affecting young men of color. The misalignment of society's expectations of our police force—coupled with institutional racism and the lack of a clear path forward—has resulted in abhorrent acts of police brutality and increases in health disparities and violence in communities of color.

After weeks of mass protests following the murders of George Floyd, Ahmaud Arbery, and Breonna Taylor, the public's views on the best strategies to keep communities of color safe are shifting quickly. It has become clear that our country must invest in a new vision and a new solution. The most striking example is the recent emergence of a previously fringe idea—defund the police—in mainstream conversation, with proponents frequently pointing to public health approaches like hospital-based violence intervention and street outreach programs as examples of alternatives to policing that work to prevent violence.

Using public health strategies to prevent violence is not a new concept.[1] Numerous evidence-based solutions have been developed, tested, and implemented, and the Health Alliance for Violence Intervention (HAVI) has supported the growth of these programs. Lawmakers have taken notice, creating model legislation at the state and local levels.[2] Now is the time to elevate these solutions to a national scale.

To put this vision into action, the HAVI proposes a plan to address community violence in communities across the United States. This plan will describe not just what should be done, but how

it can be sustainably implemented. If adopted, this plan has the potential to end the cycle of violence in our communities.

Putting Our Values into Action

The HAVI believes that to heal communities, we must mobilize hospitals and communities to end violence together. Hospital and community collaboration is critical to advancing equitable, trauma-informed care and violence intervention and prevention programs.

We uphold standards and practices of care that promote wellness, healing, and health within our network of medical staff and violence prevention professionals in the communities we serve. These practices are trauma-informed and healing-centered.

In order to promote wellness, we strive to build and support interconnected communities so that the actions of those who wish to end the cycle of violence are aligned through collaboration and partnership. We foster community through our relationships among diverse disciplines, perspectives, and lived experiences.

Importantly, these connections are built with continual recognition of the importance of equity. The inequitable distribution of resources unfairly disadvantages individuals and groups, particularly in communities of color. We affirm, amplify, and resource the leadership of those who are most impacted by violence and who are on the frontlines of healing and transformation. Through public health approaches, we work to address root causes and the social determinants of health.

As an organization with experience and expertise on violent victimization, trauma-informed

care, and equity, we reinforce the importance of evidence-based interventions that adhere to program fidelity through standards of practice, peer learning, and targeted mentorship. This includes elevating and supporting the professional development of frontline violence prevention professionals.

In order to truly create a trauma-informed system of care for all Americans, this plan recognizes that hospital-based violence intervention programs alone are insufficient for the challenge we face. Fundamentally, we believe that all people have a right safety and deserve a community that fosters physical and psychological well-being.

Consistent with those values, the HAVI believes that programs should "meet people where they are," to use a common phrase from grassroots public health and anti-violence work. Whether a person seeks safety while they are in the community, in the health system, or within the justice system, all people deserve access to trauma-informed care. In that spirit, this plan advocates for the funding of evidence-based public health approaches across all sectors of society.

The time has passed for half measures or incremental reforms. Our communities have waited for far too long for a truly trauma-informed system.

Overview of the American Community Violence Prevention Fund

The HAVI plan proposes that a significant funding stream of federal dollars be directed to states for investment in communities disproportionately affected by violence. Simply put, the amount of

funding must match the intensity of the problem. Accordingly, the proposed fund is structured to be flexible and able to adapt to the needs of our communities.

In order to accomplish this, the American Community Violence Prevention Fund will be established within the Centers for Disease Control and Prevention (CDC). The annual appropriation for this funding will be determined by the following formula:

Community Violence Prevention Fund = $43,200 x Total Annual U.S. Homicides (3-year average)

Given that each state already has varying levels of support for violence prevention, the federal government's primary roles under this plan are to distribute funds to the states, provide guidance on evidence-based public health interventions, and facilitate high-quality research and program evaluation. Additionally, the CDC will have additional funding reserved to support and promote large-scale evaluation and research of the programs that receive funding.

The dollars within the fund will be distributed to states using a formula that matches the state-level need for community violence interventions:

[State total homicides (3 year average)/ Federal adjusted total homicides (3 year average)] x [Total community violence fund - floor funding]

Upon receipt of the funding, state departments of health will coordinate its distribution to localities through a dedicated Office of Community Violence Prevention. This office will ensure that funding is distributed to the localities disproportionately impacted by community violence.

Disproportionately impacted communities will be targeted for interventions based on the idea that people at risk require interventions that "meet them where they are." For some, this will be in the community; for others, it will be in health care settings; still others may be involved in the justice system. Regardless of where a person resides, targeted interventions must exist to stop the cycle of violence.

The following plan provides a roadmap to determine how much funding is necessary, outlines the logistical aspects of financing the fund, and includes examples of evidence-based, trauma-informed interventions.

Plan Specifics: Administration and Financing

We propose that Congress create the Community Violence Prevention Fund within the CDC. The fund will distribute money to the states, which will in turn administer the funds locally to communities disproportionately affected by violence.

At the state level, funding will be received and distributed through an Office of Community Violence Prevention. As reflected in Maryland's most recent Violence Intervention and Prevention Program Fund legislation,[3] there should be requirements that funds must be directed toward communities at highest risk for gun violence, be used for evidence-based and evidence-informed interventions, and must not be used for suppression activities. We recommend that the legislation mandate that state-level offices be administered through individual departments of health. A grandfather clause could be considered in states that already maintain such a fund.

The Federal Role: The Centers for Disease Control and Prevention

Administration at the Federal Level: The Centers for Disease Control and Prevention

The HAVI proposes that Congress pass legislation creating the Community Violence Prevention Fund and housing it within the CDC. The Department of Health and Human Services (HHS) is the largest governmental payer of health care and biggest spender of public health dollars in the U.S. Within HHS, the CDC has considerable experience and expertise administering funding for public health interventions. Additionally, as the understanding of violence as a public health issue grows, it is most appropriate for the funding to originate from a health-oriented agency.

The CDC's National Center for Injury Prevention and Control (NCIPC) is the best fit for program administration. The Center is already active in suicide prevention and holds broad expertise in violent injury. Additionally, one of the core tenets of the NCIPC is to "provide funding or expert consultation so that communities can replicate these successful strategies."[4] The HAVI plan provides a mechanism to accomplish this.

Some might argue that the Community Violence Prevention Fund should be housed as a subset of the CDC's Prevention and Public Health Fund. However, the scope of this proposal—both in terms of the funding amount and the flexibility of administration—is likely beyond what is intended to be housed within the Prevention Fund. Additionally, the history and structure of the Prevention Fund have created year-to-year

instability as its funding is periodically decreased to offset other funding priorities in the budgetary process.[5]

The HAVI considered a number of possible administering agencies and programs for the Community Violence Prevention Fund. Appendix 1 describes the policy tradeoffs associated with administration through other agencies.

Calculating the Community Violence Prevention Fund

The total amount of funding at the national level will be determined by a formula as written below:

CDC Community Violence Prevention Fund = $43,200 x Total annual U.S. homicides (3-year average)

Several factors guided the creation of this formula. First, the $43,200 reflects the medical costs associated with an intensive care unit hospitalization due to firearm assault injury.[6] One could argue that this number should also account for the broad societal costs of violent injuries across multiple sectors (such as lost productivity in the labor sector, court and policing costs in the justice sector, etc.), but given that this plan is grounded in a health-based approach, it is prudent to tether the funding formula solely to health outcomes.

The decision to use a three-year average of the absolute number of national homicides was made for several reasons. We chose to use the three-year average to add predictability and decrease year-to-year volatility in funding. Total homicides was selected because it is the most reliable data point available to track the need for violence intervention and prevention services at the community level. Some may argue against this choice because homicides account for only a fraction of violent injuries, with non-fatal shootings, stabbings, and beatings greatly outnumbering fatal shootings. However, data on nonfatal shootings is both woefully inadequate and inaccurate.[7] Additionally, while the number of total homicides may encompass other forms of violence—such as intimate partner violence—administrative simplicity is preferable for the topline number as community violence contributes the largest proportion of the total number of homicides.

The CDC's Role in Program Research and Evaluation

Creating the Community Violence Prevention Fund will inherently increase the need for the NCIPC to facilitate research into and disseminate best practices around community violence prevention strategies. For many years, the Dickey Amendment hampered research into effective gun violence prevention.[8] After decades of inaction, the U.S. is now playing catch-up on the depth and breadth of research needed to address the epidemic of community violence. True to public health principles, a responsible approach to programmatic expansion, both scientifically and fiscally, is to pair this effort with robust research.

Recent Congressional action to fund gun violence research through the CDC and NIH is a welcome change.[9] However, the sum total of $25 million split between both agencies is woefully inadequate. Research shows that if federal gun violence research funding were consistent with the level of disease mortality, it would be funded at approximately $1.4 billion dollars annually.[10]

A reasonable approach would be for Congress to appropriate additional funding in an annual amount equal to 10% of the Community Violence Prevention Fund for the NCIPC to facilitate programmatic research. This amount would help close the current research shortfall while still preserving funds for other important issues such as suicide prevention and intimate partner violence. It is critical that Congress ensures equitable research funding for all forms of violence, in addition to fully funding injury surveillance and data monitoring.

The State Role: The Office of Community Violence Prevention

Administration at the State Level: The Office of Community Violence Prevention

In each state, an Office of Community Violence Prevention should be developed to manage and distribute the funding received from the Community Violence Prevention Fund. We recommend that the legislation to create the Community Violence Prevention Fund should mandate that state-level offices be administered through individual departments of health or public health. However, in states that have already established similarly functioning offices (regardless of the agency in which they are housed), those offices may be grandfathered in to avoid disruption and build on existing work.

Importantly, competent administration of the fund will require knowledgeable staff with expertise on both public health approaches to violence prevention and grants management. Therefore,

up to 5% of the state's total allotment should be set aside for administrative costs. Employing full-time, dedicated staff is critically important to ensure that each state's program is both stable and maintains fidelity to the mission of supporting public health approaches to violence prevention. These staff will ensure that the office provides oversight of the fund, conducts public outreach and education, and provides technical assistance and education on best practices for grantees.

Best practices suggest that funding should be guided by an independent Violence Intervention and Prevention Advisory Council. This group's primary role would be to review funding applications, provide technical expertise as it relates to the strength of proposed plans, and provide recommendations on funding distribution. This role is analogous to that of the National Institute of Health's Center for Scientific Review, which provides expert peer review via their study section process.

The Advisory Council should be composed of a variety of stakeholders that represent academic skills, community experience, and governmental roles. An illustrative example comes from the state of Maryland.[11] See Appendix 2 for details of the composition of the Maryland Violence Intervention and Prevention Advisory Council.

Calculating State Funding

Each state will receive funding based on the following formula:

[State total homicides (3 year average)/ Federal adjusted total homicides (3 year average)] x [Total community violence fund - floor funding]

This formula was developed to ensure that states receive consistent, predictable funding from year to year. The use of three year averages are intended to minimize annual variation, which is critical to ensure programs avoid the "boom or bust" funding cycles that violence prevention efforts have often faced.

The benefit of a formula-based approach is that funding will predictably increase when need increases. Additionally, compared to simple block grants, it is an objective measure that can more precisely target states in need. Some may argue that a downside of the formula-based approach is that states running effective prevention programs will experience a decrease in funding. While this is true in the short term, these changes will be gradual given the three-year average, and with time, states will likely reach a "funding homeostasis" that is appropriate for their needs.

As one exception to the formula, an additional mechanism is included to ensure a state is never completely "defunded" and will continue to receive baseline operational funds if violence significantly decreases. States that do not have any municipality with at least 100 homicides per year will receive a set baseline amount of $4.3 million ($43,200 x 100). This ensures that states will always be funded to maintain essential violence prevention infrastructure. Additionally, this will eliminate the possibility of large fluctuations in annual funding due to small year-to-year variations for states with low absolute numbers of homicides. In other words, a set funding floor ensures stability while continuing to fund essential programmatic infrastructure in case rates of violence increase.

Prioritization of Program Funding

Three overarching principles should guide the distribution of funds:

- Communities disproportionately affected by community gun violence are prioritized.

- Funds are utilized for evidence-based and evidence-informed public health and health-based programming.

- Suppression activities and any other activities that may contribute to mass incarceration are ineligible for funding.

The legislative text in Maryland's 2020 Senate Bill 708[12] and House Bill 822[13] reflects these principles, which help ensure that funding is used in the most efficient and effective manner. While policymakers have historically failed to make sufficient investments in communities suffering the most from violence, this framework explicitly directs funding toward those communities. Additional guidelines to promote geographical diversity in funding awards should be included to allow multiple high-risk communities to receive services.

The principles of this framework also incentivize funding for local community programs and promote collaborative efforts between large national groups and small local groups. This is important because large nonprofit groups or academic institutions are often preferentially awarded funding opportunities due to their experience conducting public health programs and research, which can come at the expense of smaller local programs that lack the infrastructure to support grants management or program evaluation.

Both "evidence-based" and "evidence-informed" programming should be included. Historically, the term evidence-based has been used in medicine to describe "conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients."[14] Although it is an intuitively simple definition, in practice, health care providers and public health practitioners continue to have disagreements about what it means. [15] The reality is that for any given practice, there exists a spectrum of evidentiary support,[16] and reasonable people can disagree on the level of evidence necessary to reach the threshold for "evidence-based practice." Therefore, inclusion of the term "evidence-informed" allows for the funding of programs with supportive data—based on public health principles—that would benefit from ongoing evaluation and research.

Program Evaluation

In keeping with a public health approach, it is critically important that violence prevention and intervention programs undergo regular evaluation for effectiveness. This not only ensures that programs are achieving their violence reduction goals but also creates additional evidence for best practices while maintaining the financial integrity of the fund.

In order to ensure strong evaluations, states will be directed to allocate 5 to 10% of their allotment to evaluation activities. Successful program applications should, at a minimum, include a plan for data collection and analysis.

The overall evaluation process should be tailored to the resources and expertise of the applying program. For example, programs with academic affiliations should be both allowed and encouraged to conduct evaluations using existing university infrastructure. It is likely that many academic researchers will already have grant support to facilitate evaluation of programs in their existing research portfolios. In fact, some may receive research funding directly from the CDC as allocated under this plan. The existence of both the federal and state-based research funding opportunities creates incentives for high-quality research at multiple levels.

Many community-based organizations will not have the personnel or financial resources to conduct rigorous evaluations. In these scenarios, the state will facilitate collaboration between these programs and researchers to determine the process and outcome metrics needed to properly assess the effectiveness of the program. At that point, the state can elect to either conduct the evaluation within their agency or contract with local public health departments or external researchers. Each evaluator should be experienced with the particular model they are evaluating, such as hospital-based violence intervention programs or street outreach programs.

Box 1: State Spending Breakdown

Funding Usage at the State Level	
85 - 90%	Direct programmatic support of violence prevention and intervention efforts
5%	Administrative and staffing costs for the Office of Community Violence Prevention
5 - 10%	Program research and evaluation

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Trauma-Informed Solutions to Community Violence

Evidence-based, trauma-informed violence prevention strategies exist in nearly all sectors of society. The remainder of this document serves to inform policymakers of examples of the types of programming that might be funded by each state's Office of Community Violence Prevention. Importantly, this list should not be considered exhaustive. As the science of violence prevention evolves, programmatic funding must evolve in tandem.

Health Care-Based Solutions

Hospital-Based Violence Intervention Programs

Hospital-based violence intervention programs (HVIPs) are multidisciplinary programs that combine the efforts of medical staff and frontline violence prevention professionals with trusted community-based partners to provide safety planning, services, and trauma-informed care to violently injured people, most of whom are boys and men of color. By engaging patients in the hospital during their recovery, HVIPs utilize a golden opportunity to improve patients' lives by addressing symptoms of trauma and the upstream social determinants of health. This support goes beyond hospital walls and continues when patients are discharged, creating a pathway for wraparound services and outpatient care. The end result is a reduction in repeat injuries, improved quality of life, and reduced likelihood of violent retaliation.

Many people who have suffered violent injuries are extremely distrustful of mainstream institutions like the health care and criminal justice systems. Violence prevention professionals are specially trained to use a trauma-informed approach that breaks through this distrust. These highly trained paraprofessionals—who often come from the communities in which they work—can quickly engage violently injured patients and their families in the emergency department, at the hospital bedside, or soon after discharge. After gaining trust and introducing the program, violence prevention professionals work with clients and their families to develop a post-discharge plan that meets their immediate safety needs, provides psychosocial services, and establishes goals. This form of peer mentorship and intensive case management promotes survivors' physical and mental recovery while also improving their social and economic conditions.

Research shows that this model works. One randomized controlled trial in Chicago showed that patients who participate in HVIPs had a 60% decrease in their risk of future injury (8.1% of participants vs. 20.3% of non-participants).[17] A similar program in Baltimore also showed substantial decreases (5% of participants vs. 20.3% of non-participants).[18]

HVIP participation has wide-ranging benefits beyond reducing reinjury. Given that violent injury is a psychologically traumatic event, programs are well equipped to address signs and symptoms of trauma. One program, Philadelphia's Healing Hurt People, has found that patients who enroll in HVIPs experience rates of post-traumatic stress disorder (PTSD) as high as 75%.[19] Additionally, a 10-year review of San Francisco's Wraparound Project found that 51% of participants self-reported mental health needs, and the Wraparound Project was able

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to address 85% of patients' mental health needs.[20] Programs also assist patients in decreasing unhealthy trauma-related coping behaviors such as the use of alcohol, cannabis, and other drugs.[21]

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy (CBT) is a common form of psychotherapy (or talk therapy) utilized by counselors, psychologists, and therapists worldwide. Importantly, it has proven to be effective in multiple phases of the cycle of violence, including decreasing criminal activity, decreasing cannabis dependence, treating PTSD and anxiety disorder, and reducing maladaptive behaviors in response to anger.[22]

CBT is based on the core principle that many psychological problems are rooted in unhelpful ways of thinking and learned patterns of behavior. Underlying CBT is the belief that people can learn better ways to cope with these thoughts and respond in ways that decrease their symptoms and improve their lives.[23]

The use of CBT in patients at risk of violent injury helps them better understand the motivations of others and develop problem-solving skills to cope with difficult situations—critical tools for those seeking to escape the cycle of violence. Randomized controlled trials where CBT was implemented by nonprofit organizations demonstrated a decrease in violent crime arrests of program participants by 45% to 50%.[24]

One advantage to the use of CBT is that it is not location specific. As talk therapy, it can be conducted in a wide variety of settings, including different trauma-informed violence prevention programs. For example, HVIPs can implement

CBT similarly to traditional health programs, while programs such as READI Chicago and Roca, Inc. can utilize the treatment in the community.

Community-Based Solutions

Street Outreach

Community-based street outreach programs use public health approaches to interrupt the spread of violence directly in communities. One pioneer in the field, Cure Violence Global, has been implementing street outreach work for approximately 25 years. The model is based on the World Health Organization's epidemic control approach: the infectious disease model.[25] This model entails interrupting transmission of violence by detecting and de-escalating disputes, intensive engagement with high-risk participants, and changing social norms—techniques similar to those used by public health professionals to interrupt the spread of diseases such as HIV.

This model has been replicated and tested both in the U.S. and internationally. Multiple program evaluations show significant reductions in shootings when street outreach is implemented with fidelity to the model. In New York City, neighborhoods with Cure Violence programs experienced a 63% reduction in shootings.[26] Similarly Baltimore has seen a 44% decrease in shootings,[27] and neighborhoods in Chicago experienced decreases ranging from 41-73%.[28]

Not only do street outreach programs work but they also serve an important role of connecting and amplifying the work of other programs, such as HVIPs.[29] For example, if a person is injured and taken to the hospital, the HVIP can focus on the individual patient and family that has arrived

while simultaneously coordinating with the street outreach program to decrease the risk of immediate retaliatory violence in the aftermath of the shooting. This type of coordination ensures multiple touch points for community safety and healing at all times.

Connecting Social Services and Mental Health Solutions

Trauma Recovery Centers

Trauma recovery centers (TRCs) care for survivors of multiple types of interpersonal violence, including both physical and sexual assaults.[30] The model is predicated on experience and evidence that suggests that, although patients may recover from physical wounds, trauma and psychological injuries such as acute stress disorder and PTSD often take much longer to heal. The model was developed in 2001 at the University of California, San Francisco, and provides safety net services for survivors who otherwise have limited access to mental health and social services.[31]

The TRC model is comprised of ten core components:

1. Assertive outreach and engagement with underserved populations
2. Serving survivors of all types of violent crimes
3. Comprehensive mental health and support services
4. Multidisciplinary team
5. Coordinated care tailored to individual needs
6. Clinical case management
7. Inclusive treatment of clients with complex problems
8. Use of trauma-informed, evidence-based practices
9. Goal-driven
10. Accountable services

Although the TRC model is not specifically focused on community violence, it has demonstrated success in caring for this patient population and is an important component of any comprehensive system of care for trauma victims. Additionally, most patients served by TRCs have a history of multiple forms of trauma, creating complex needs that require a multidisciplinary care team.[32]

A randomized controlled trial of the TRC model found benefits to patients across multiple domains.[33] Patients engaged in services were more than twice as likely to engage in mental health treatment compared to usual care (77% vs. 34%). Additionally, the model has been successful in linkage to critical social services, specifically crime victim compensation benefits.

The Roca Inc. Model: Relentless Outreach and Cognitive-Behavioral Therapy

Roca Inc. is a public health-based approach that combines proven interventions with intervention workers who are both trusted and experienced to reach individuals at high risk for injury. Roca's mission is "to be a relentless force in disrupting incarceration and poverty by engaging the young adults, police, and systems at the center of urban violence in relationships to address trauma, find hope, and drive change."[34]

To accomplish this, Roca engages in what they describe as "relentless outreach" to secure client buy-in. In practice, this means employing trained, credible messengers who engage potential clients persistently. Roca cites an average of ten "relentless efforts" for each patient enrolled. Importantly, this is simply an average, with patients experiencing a wide range of needs. For example, Roca engaged one client in Baltimore 112 times.

Throughout this process, case workers build transformative relationships with clients. The end result is that each client averages two to four years of intensive case management. While engaging in this case management, Roca treats patients' trauma utilizing CBT, which has proven to be effective in multiple phases of the cycle of violence, including decreasing criminal activity, decreasing cannabis dependence, treating PTSD and anxiety disorder, and reducing maladaptive behaviors in response to anger.[35]

Evaluations of the Roca model demonstrate its effectiveness. Despite 85% of clients entering the program with a history of either violent injury or violent behaviors, 80% of program participants are able to escape the cycle of violence.[36] Disentangling which aspects of the program model reap the most benefits (CBT vs. case management) is impossible. Likely, both are synergistic. By addressing the social determinants of health, Roca ensures comprehensive care with effects upstream from violence. Importantly, 70% of participants remained employed for at least six months. Overall, 91% of young men became engaged in employment, education, or life skills programs during their time in the program.[37]

School-Based Solutions

Mentorship Programs

One of the most well-studied interventions delivered in the school setting is mentorship programs. These programs have been broadly adopted over decades and generally focus on enlisting mentors who have specific knowledge and experiences that they can transfer to mentees, but are not in professional or pre-determined relationships such as teacher-student.[38] Perhaps the most well-known is Big Brothers/Big Sisters.[39]

Overall, a systematic review of 46 mentorship programs found positive results across multiple domains.[40] The study found significant improvements in academic achievement and delinquency, and a trend towards decreases in aggressive behaviors and drug use. Importantly, this study focused on students who were perceived as "at-risk" and excluded any study that combined the mentorship program with other interventions such as CBT or other services. This suggests that violence prevention in school-aged children may be enhanced when mentorship is combined with other interventions such as CBT or other programs that address the social determinants of health.

Case Management

Addressing the social determinants of health is a critical component of any trauma-informed intervention for school-aged children. One randomized controlled trial of assault-injured youth offers a roadmap for how this might be implemented in schools.[41] Youths aged 12 to 17 were offered case management services for a period of four months after injury. This resulted in a significant decrease in fights and fight injuries

among those receiving services. None of the 45 children who received case management services were involved in fights, whereas 8 to 14% of the control group were.

While this trial continued case management services after initiation in the hospital, the services were not always continued in schools. Still, it is unlikely that the location of case management delivery (outpatient case management from hospital staff vs. school-initiated case management) would yield different results. One pathway to maintain program fidelity might be a partnership between schools and hospitals to ensure youth receive the comprehensive services necessary to overcome trauma. In fact, the same research team has also demonstrated success with the mentorship model for violence prevention.[42] Given that mentorship models also work in schools, this further suggests that the proven interventions should follow the students, rather than be restricted to a single geographic location.

Second Step

Second Step is a social-emotional learning curriculum that promotes the skills of empathy, emotion management, friendship, and problem solving.[43] It includes games that build executive function, weekly activities, reinforcing activities, and home links so children can continue practicing these skills when not in school. Second Step contains specific lessons for kindergarten through eighth grade. The curriculum was developed by the Committee for Children with the aim to advance violence prevention using a research-based, teacher-friendly approach.

Several studies have found evidence for reductions in problem behaviors such as physical aggression,[44] bullying,[45] and disruptive behaviors,[46] and increases in social competence,[47] prosocial behavior,[48] and empathy.[49] For example, one randomized controlled trial conducted with students in kindergarten to second grade found significant decreases in disruptive behavior and increases in social-emotional skills after two years of receiving the program, with greater gains for those who had the weakest skills in the beginning.[50] This suggests that such a program may be useful for those who require greater skill development in this area.

Further, 36 middle schools in Chicago and Wichita participated in an evaluation of Second Step, with results showing that sixth-graders in schools that implemented the program reported 42% less involvement in physical aggression compared to those who did not implement the program.[51] Taken together, findings show that Second Step is effective in building necessary prosocial skills from a young age, for a wide range of school levels (K-12).

Conflict Resolution Education

Conflict resolution education (CRE) is based on the mission to provide a school environment in which learners can feel both physically and psychologically free from threat, and where the diversity of the school's population is celebrated.[52] The goal of this program is to promote violence prevention through individual behavioral change that builds responsible citizenship and systemic change that ensures an appropriate learning environment. Within this framework, responsible citizenship is characterized as having the ability to resolve conflicts effectively and peacefully, preserving the human dignity of all parties.

CRE can be implemented through four different approaches, and programs typically combine their elements: process curriculum, peer mediation, peaceable classroom, and peaceable school.[53] Process curriculum entails teaching students to engage in negotiation with peers based on their principles and goals in order to achieve peaceful resolution. Peer mediation involves training particular students to facilitate conflict resolution among their peers. In the peaceable classroom approach, CRE is incorporated into core subjects and classroom management strategies. Finally, the peaceable schools approach involves integrating conflict resolution through the whole institution and every member, so as to cause lasting change in the institutional climate.

The most comprehensive review of CRE research—encompassing the program's impact on students, teachers, diverse populations, school climate, and issues of institutionalization—pinpoints several important conclusions.[54] First, CRE has shown positive effects on students' achievement, cooperation, interpersonal relationships, constructive conflict resolution, and self-control. Second, it has contributed to decreases in aggressiveness, suspension and dropout rates, and discipline referrals. However, further study is needed on the effects on diverse and marginalized populations. Therefore, this approach should be combined with a robust evaluation component if funded.

Restorative Justice

Restorative justice is an evidence-informed approach that focuses on righting a wrongful action that one student has done to another in order to repair harm.[55] In this way, it places value on accountability, relationships, and collaborating to resolve the harm that an action may have caused. The approach emerged following the trend toward zero tolerance policies, under the belief that these policies further increase problem behavior and suspensions due to their punitive (as opposed to constructive) nature.[56]

Typical implementation of this program involves students being referred when they have taken an action that does harm to another student.[57] Once they are referred, common practices include circles, where trained facilitators encourage those involved in the conflict to share their feelings and thoughts until a reparative solution is reached. Another common approach is called a peer jury (or peer court), where student volunteers, overseen by an adult, hear cases of minor offenses and offer guidance on how the student needs to repair the harm done. Peer mediation can also be considered a restorative justice practice. After the students undergo the restorative justice practice outlined by the school, admit their responsibility for the incident, acknowledge the harm done, and express remorse, they are reintegrated into the school community.

Research on this approach is promising, but incomplete. For instance, one randomized controlled trial found that implementing restorative justice education reduced suspension rates overall, as well as reduced racial disparities in suspension rates between African-American and white students, and between lower- and higher-income students.[58] However, a different randomized controlled trial showed no significant effects in schools implementing such an approach.[59] Still, the same trial found students' self-reported experiences with restorative practices increased social skills and decreased cyberbullying. Further

research should be conducted, and implementation of restorative justice programs should be accompanied by rigorous evaluation.

Opportunities for the Very Young

While most violence-related deaths do not occur in young children, the experience of trauma unfortunately affects all ages.[60] Because children do not have access to lethal means, fights and fight injuries are often not recognized or intervened in beyond traditional parental or school discipline.

Upstream interventions have been utilized in students as young as pre-school.[61] The Promoting Alternative Thinking Strategies curriculum (PATHS) is a teacher facilitated curriculum that is designed to decrease aggression or classroom disruption, and to improve children's social and emotional wellness. In a study of 20 classrooms, the PATHS program was found to improve children's emotional knowledge, self-regulation, and social skills.[62] However, other programs have shown less promising results.[63] This outcome suggests that PATHS is a program worth attempting on a trial basis with robust evaluation.

Justice System Solutions

Focused Deterrence

Focused deterrence strategies—developed by David Kennedy, executive director of the National Network of Safe Communities, and colleagues—maintain that cities can reduce violence by using data-driven identification of the individuals and groups at highest risk for gun violence; direct and respectful communication to those at high risk; intensive services, supports, and opportunities; and, as a last resort, focused enforcement to reduce violence. In this approach, both community leaders and law enforcement communicate the possibility of sanctions such as prosecution for future violence, as well as services such as job training and drug treatment. This approach seeks to empower the community in setting anti-violence standards and to improve police-community relationships.

Focused deterrence has been advanced by the work of David Muhammad, executive director of the National Institute of Criminal Justice Reform (NICJR). NICJR's Gun Violence Reduction Strategy (GVRS) includes elements of focused deterrence as well as what the organization calls Intensive Life Coaching, a type of culturally responsive, high-touch engagement with participants. The California Partnership for Safe Communities also provides technical assistance, leveraging similar supports for culturally responsive focused deterrence.

An evaluation of GVRS in Oakland found a 46% reduction in homicides and 49% reduction in injury shootings.[64] A systematic review of 24 quasi-experimental studies on focused deterrence also reported a significant, moderate effect of crime reduction.[65] Evidence shows that these reductions in crime and violence can be reduced for up to a year after the intervention period, although more long-term research should be conducted.[66]

Peace Fellowships

Peace fellowships such as Advance Peace function by identifying individuals in a community who are at the very highest risk of violence (and hardest to reach) and providing them with financial resources, personalized mentoring, and supportive relationships.[67] Specifically, the program focuses on young men previously involved in lethal firearm offenses. Individuals enter into an 18-month

fellowships where they receive daily, one-on-one engagements and create a life management action plan with the goal of promoting healthy development. Individual action plans may include components such as life skills classes or travel allowances.

This model is among the newest of the approaches laid out in this plan, and additional data is needed. As such, it should be considered an evidence-informed program and implementation should be paired with robust evaluation. Nevertheless, existing studies show that approximately 80% of those who participate in Advance Peace fellowships report no new firearm-related injuries, charges, or arrests.[68]

Programs to Avoid

Scared Straight

An important part of selecting evidence-based programs is not just knowing which programs to fund but also actively discouraging programs that don't work or are potentially harmful. One such example is Scared Straight and other juvenile awareness programs aimed at preventing juvenile delinquency.

Scared Straight and other similar programs are typically designed with the intent to deter crime and criminal behavior by exposing at-risk children or young people to first-hand experience of correctional institutions. A review of nine experimental studies demonstrates that not only does the program fail in its objective, but it actually increases the odds of criminal involvement among program participants.[69]

Beyond increased criminal involvement, these programs are likely to have additional pernicious effects on youth who are exposed to them. Even before an injury, individuals at risk for violent injury typically carry a significant history of traumatic experiences.[70] This creates a high risk of re-traumatization and is not consistent with the principles of trauma-informed care. For these reasons, fear-based intervention programs in health care settings are discouraged.[71]

Appendix 1

Additional Policy Options for Administration of the Community Violence Fund

Consideration for the Department of Justice

Several programs housed within the Department of Justice (DOJ) could be considered as administrative homes for the Community Violence Prevention Fund, including the Victims of Crime Act (VOCA) Crime Victims Fund and the Bureau of Justice Assistance Edward Byrne Justice Assistance Grant Program. However, from a high-level perspective, funding violence prevention programs through a non-health-oriented agency is not aligned with a public health understanding of violence. Although the DOJ does work serving victims of crime, its numerous roles in crime investigation and prosecution shift the overall focus of the agency, making it less suited for implementing public health programming.

Administering the Community Violence Prevention Fund through the VOCA Crime Victims Fund has certain advantages. First, because victims of gun violence are nearly all victims of crime, the population served is fitting. In fact, VOCA funding has recently been allocated to community violence interventions.[72,73] Additionally, the infrastructure for distribution of large grants already exists. Community violence grants could be added through legislation that newly includes community violence as a mandatory funding priority within the existing structure.

However, the VOCA Crime Victims Fund is, by design, problematic for this purpose. Adding community violence through VOCA assistance grants would likely have significant unintended consequences. First, and most importantly, if the top line funding allocation for VOCA were not increased, community violence funding would be placed in direct competition with funding for other crime victims, particularly those suffering from intimate partner violence. In addition to potentially siphoning off critical resources from other communities, the Crime Victims Fund likely could not sustain this additional funding requirement without significant reforms. The total dollar amount within the fund is largely based upon receipts of criminal fines, rather than tax dollars or a congressional appropriation.[74] Specifically, a significant proportion comes from large dollar corporate fines. Because of this, the funding cap fluctuates annually. This hinders the predictability and sustainability of long-term community violence programming.

While it may be possible to use the VOCA Crime Victims Fund for this purpose, significant reforms would likely need to be paired to the legislation. First, VOCA assistance grants are administered to the state level through a combination of a base rate with increases based on population. This does not account for underlying levels of community violence and would require amendments to match the disbursement plan. Additionally, the state of the VOCA Crime Victims Fund and current congressional budgetary mechanisms is undesirable.

Despite being a non-appropriated fund, a positive fund balance can be scored as a budgetary offset against the DOJ's discretionary spending in any given fiscal year. This is not merely a theoretical concern, as Congress has previously utilized the VOCA fund balance as an offset. If the total size and scope of the program were to be increased, this would inherently increase the perceived opportunity for non-programmatic budgetary purposes.

Administering the Community Violence Prevention Fund through the Bureau of Justice Assistance Edward Byrne Justice Assistance Grant (Byrne JAG) Program is also a possibility. However, to accommodate funding on the scale of the Community Violence Prevention Fund, the Byrne JAG Program would need to significantly expand in size from its current total allotment of $547 million.[75] Additionally, while the Byrne JAG Program does fund community safety initiatives, it also funds other activities ranging from reimbursing cities that provide security for presidential candidates to the Wrongful Conviction Review Program. This broad scope may allow for flexibility but likely diminishes the expertise for delivering evidence-based trauma-informed care. Although the Byrne JAG Program funds Project Safe Neighborhoods,[76] its placement under the DOJ brings a decidedly law enforcement perspective, rather than a health-based one.

Appendix 2

Members of the Maryland Violence Intervention and Prevention Advisory Council

Executive director

Member of Maryland State Senate

Member of Maryland House of Delegates

Individual from academic institution who studies public health

Individual personally affected by gun violence

Four individuals from community or hospital-based violence intervention programs

Two individuals from local or state police departments

Two individuals from local health departments

Appendix 3

Estimated 2020 State Funding Distribution

State	3-Year Average Homicides	Annual Funding
Alabama	571.3	$23,478,431
Alaska	62.7	$4,320,000
Arizona	427.0	$17,547,182
Arkansas	263.3	$10,821,447
California	1995.3	$81,996,435
Colorado	253.0	$10,396,435
Connecticut	96.3	$4,320,000
Delaware	61.0	$4,320,000
Florida	1292.7	$53,120,978
Georgia	803.3	$33,012,263
Hawaii	38.0	$4,320,000
Idaho	40.3	$4,320,000
Illinois	1090.3	$44,806,271
Indiana	469.7	$19,300,531
Iowa	90.0	$4,320,000
Kansas	164.0	$6,739,433
Kentucky	290.0	$11,917,290
Louisiana	633.0	$26,012,568
Maine	19.0	$4,320,000
Maryland	569.0	$23,382,545
Massachusetts	155.3	$6,383,284
Michigan	608.3	$24,998,913
Minnesota	124.3	$5,109,367
Mississippi	362.3	$14,889,764
Missouri	627.7	$25,793,399
Montana	42.0	$4,320,000
Nebraska	48.3	$4,320,000
Nevada	219.0	$8,999,609
New Hampshire	18.7	$4,320,000
New Jersey	352.7	$14,492,521
New Mexico	191.0	$7,848,974
New York	628.0	$25,807,097
North Carolina	687.0	$28,231,649
North Dakota	17.3	$4,320,000
Ohio	769.7	$31,628,762
Oklahoma	301.7	$12,396,721
Oregon	119.3	$4,903,896
Pennsylvania	765.0	$31,436,989
Rhode Island	20.0	$4,320,000
South Carolina	450.3	$18,506,045
South Dakota	34.7	$4,320,000
Tennessee	574.7	$23,615,412
Texas	1626.3	$66,832,711
Utah	75.3	$4,320,000
Vermont	13.3	$4,320,000
Virginia	445.0	$18,286,876
Washington	252.3	$10,369,412
West Virginia	105.7	$4,342,277
Wisconsin	220.7	$9,068,099
Wyoming	19.3	$4,320,000
District of Columbia	129.3	$5,314,837
National	**19234.0**	**$830,908,800**

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Suggested Citation

The Health Alliance for Violence Intervention. Forging a New Era: The American Community Violence Prevention Fund (Philadelphia, PA: The Health Alliance for Violence Intervention, 2021).

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