The Commission on
Women, Children, Seniors, Equity & Opportunity

CWCSEO

Connecticut General Assembly

December 30, 2021

Greetings, Co-Chairs of the Public Health and Human Services Committees of the Connecticut General Assembly:

As Chairman of the Gun Violence Intervention and Prevention Advisory Committee established under Public Act 21-35: S.B. 1, "An Act Equalizing Comprehensive Access to Mental, Behavioral and Physical Health Care in Response to the Pandemic," it is my duty to submit the attached report of Advisory Committee findings and recommendations.

Addressing the five tasks assigned by Section 9 of the statute as *mandates*, the Advisory Committee developed 15 recommendations and 10 areas of detailed, strategic objectives. These are presented in the Executive Summary and further fleshed out in the complete reports of our subcommittees: Evidence-Based Programming and Research; Policy and Funding; and Community Engagement and Public Health.

For this effort, the Advisory Committee drew upon the perspectives of dedicated and seasoned community outreach organizations, victim service providers, public safety professionals, and gun violence policy, public health and youth serving organizations. We also present the extensive public forum testimony delivered in both written submissions and videotaped statements.

It has been an action-packed 90 days! Our inaugural meeting was September 29, 2021 and we officially adjourned today, on December 30, 2021 – after gathering and weighing a great deal of input from community and subject matter experts. Early on, we determined to fulfill the five mandates to the best of our ability. We are proud and honored to have been appointed to serve in this capacity and you can continue to rely on our support to implement the life saving measures that we propose.

The historians among us certainly will remember the 1968 Kerner Commission, which examined the sources of civil unrest in America, at the time of Dr. Martin Luther King Jr.'s assassination. Fifty-three years later, the findings and recommendations of that 1968 national commission – as to urban violence, disparities related to poverty, discriminatory practices and racism – haunt our nation today. The inequities boldly discussed and the recommendations for Congress to seriously consider fell to the wayside of inaction (for details, see the March 2018 *Smithsonian Magazine* article, "The 1968 Kerner Commission Got It Right, But Nobody Listened," online at this link:

https://www.smithsonianmag.com/smithsonian-institution/1968-kerner-commission-got-it-right-nobody-listened-180968318/.

Against this backdrop, Connecticut enters 2022 as a national leader at the crossroads of public trust and public will.

By completing the work of eliminating disparities in public health and society writ large – work that is already under way with the Public Act 21-35 Commission on Racial Equity in Public Health, Connecticut is in a position to solve these vexing problems, not once again shunt them aside.

It is the strong recommendation of this Advisory Committee that evidence-based gun violence prevention and intervention efforts become a permanently coordinated state effort. The intricacies of how it is finally shaped (whether by one or another Commission or by the State Department of Public Health office that now possesses regulatory authority to coordinate prevention and intervention activities) is yet to be determined.

But the important point of this report is that our state is now uniquely poised to lead the nation on implementing coordinated, sustainable gun violence intervention and prevention efforts, subject to evaluation, to reduce street-level violence in the state.

With the potential for real change framed by Public Act 21-35, our state has the opportunity to make good on its promise of equity for all, both in the public health arena and in the hot spots of community violence.

On behalf of this Advisory Committee, I can confidently say that, to a person, we all stand ready to assist you in any way you would deem to be helpful.

Respectfully submitted,

Andrew Woods

Andrew Woods, Chairman
Gun Violence Intervention and Prevention Advisory Committee

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Connecticut General Assembly

Report of the

GUN VIOLENCE INTERVENTION AND PREVENTION ADVISORY COMMITTEE

Submitted to the Connecticut General Assembly
Public Health and Human Services Joint Standing Committees

December 30, 2021

Origins and Scope of the Advisory Committee

Connecticut Public Act 21-35 was signed into law by Governor Ned Lamont in July 2021. The law set in motion this Gun Violence Intervention and Prevention Advisory Committee, charging it with "advising the joint standing committees [Public Health and Human Services] of the General Assembly … on the establishment of a Commission on Gun Violence Intervention and Prevention to coordinate the funding and implementation of evidence-based, community-centric programs and strategies to reduce street-level gun violence in the state."

The Advisory Committee had its inaugural meeting September 29, 2021, and conducted its official business and outreach activities in the fourth quarter of 2021 to fulfill these five mandates explicitly assigned by Public Act 21-35 (in Section 9, pages 10-13):

> **(1) Consult with community outreach organizations, victim service providers, victims of community violence and gun violence, community violence and gun violence researchers, and public safety and law enforcement representatives regarding strategies to reduce community violence and gun violence;**
>
> **(2) Identify effective, evidence-based community violence and gun violence reduction strategies;**
>
> **(3) Identify strategies to align the resources of state agencies to reduce community violence and gun violence;**
>
> **(4) Identify state, federal, and private funding opportunities for community violence and gun violence reduction initiatives; and**
>
> **(5) Develop a public health and community engagement strategy for the Commission on Gun Violence Intervention and Prevention.**

Contents

FOREWORD: It's Time to Save Lives

On average in Connecticut, someone is shot with a gun every day – and every other day, someone is killed from gunfire. Gun violence has gone viral.

Sustained funding for gun violence prevention programs has not been a priority for this highly publicized public health crisis. Risk factors vary greatly by community, family, and even the individual. In our state, prevention efforts have grown organically but without consistent statewide support or coordination. Their strength comes from participation in statewide and national networks that measure outcomes and confirm best practices.

The national data are chilling: More than 100,000 Americans are killed or injured by gunfire every year; in 2019, the leading cause of violence for teens and adults aged 15-34 was firearm homicide. Connecticut's cases have risen during the pandemic, with Bridgeport, Hartford, and New Haven homicides accounting for 70 percent of the statewide total.

Facing these tragedies, the Connecticut General Assembly last summer passed Public Act 21-35, tasking a new Gun Violence Intervention and Prevention Advisory Committee with producing this report. The law called for multi-level perspectives on prevention policy and funding strategies, specifying that community outreach organizations, victim service providers, public safety professionals, and gun violence victims and researchers needed to be heard. Engaging these sources and more, the Advisory Committee in this report offers "feasible and actionable" recommendations.

Key developments in the field warrant this urgent public attention, including:

- Citizen calls for support to prevent and reduce violence, and to support crime survivors.
- Pandemic-era spikes in community violence in Connecticut's cities and nationwide.
- Advocates' demand for sufficient and sustained resources to support violence prevention, intervention, treatment, and recovery initiatives, including training and therapeutic support for frontline workers.

As Public Act 21-35 declares, "racism constitutes a public health crisis in this state." Hence, equity for all must be a priority for Connecticut's violence prevention planning, to address the systemic inequities correlated with violence from the cradle on.

This report emphasizes two worthy priorities for violence prevention planning: Listening to voices from the community and evaluating program effectiveness according to consistent, reliable data. Now the work of planning sustained, well-coordinated gun violence prevention programs really begins, with unusual, federal, state, and local consensus that it is time to save lives.

It is said that history is a race between education and catastrophe. As this informative Advisory Committee report demonstrates, Connecticut is now competing in that race.

State Senator Marilyn Moore, District 22

Advisory Committee Chairman Andrew Woods
Director, CT HVIP Collaborative; Executive Director, Hartford Communities That Care

Executive Director Steven Hernández, Esq.
Commission on Women, Children, Seniors, Equity and Opportunity (CWCSEO)

ADVISORY COMMITTEE MEMBERSHIP AND STAFF

Chair: Andrew Woods, Director, CT HVIP Collaborative; Hartford Communities That Care

Members and Organizational Affiliations:

Deborah Davis, Mothers United Against Violence
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Ebony Epps, Regional Youth Adult Social Action Partnership/StreetSafe Bridgeport
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Leonard Jahad, Connecticut Violence Intervention Program, Inc.
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Steven Hernández, Esq., Executive Director
Thomas Nuccio, Children and Families Policy Analyst
Dr. Pina Violano, Advisory Fellow and Primary Administrator

As Public Act 21-35 states, the administrative staff of the Commission on Women, Children, Seniors, Equity and Opportunity shall serve as administrative staff of the committee.

EXECUTIVE SUMMARY

Introduction

Gun violence is an existential threat in parts of every metro area in America, a crisis now crying out for comprehensive, effective solutions.

In July 2021, the Connecticut General Assembly enacted Public Act 21-35, launching a series of public health research and policy initiatives, including the task of assessing and addressing community gun violence in Connecticut. In specific, the General Assembly sought guidance "on the establishment of a Commission on Gun Violence Intervention and Prevention to coordinate the funding and implementation of evidence-based, community-centric programs and strategies to reduce street-level violence in the state."

To develop this report, the Advisory Committee in Fall 2021 established subcommittees to analyze data and deliberate on three major themes:

- **Evidence-Based Programming and Research.**
- **Policy and Funding.**
- **Community Engagement and Public Health**.

This Executive Summary is designed to report in brief on the subcommittees' work, as approved by the full Advisory Committee. The goal of this document is to highlight the process and steps taken to gather information; note the full set of stakeholder groups engaged; and summarize the recommendations.

The complete reports of the three subcommittees – and the record of full Advisory Committee outreach – are in Appendix A4 of this report.

Throughout this report evidence-based and evidence-informed program examples are presented, and these do not represent a comprehensive list of programs engaged in gun violence prevention. A lack of mention of a specific program does not represent a lack of support for that program.

In sum, the Advisory Committee is reporting on a wide array of pressing developments that warrant sustained community violence prevention programming. In keeping with the lawmakers' call for strategies, the subcommittees discussed a variety of actionable models now under way in many states, including ours, and examined funding options.

The Broad Scope of Public Act 21-35

It is important to note that the scope of Public Act 21-35 is much broader than the gun violence analyses undertaken by this Advisory Committee:

- The law declares that "racism constitutes a public health crisis in this state" and establishes a permanent Commission on Racial Equity in Public Health to develop and periodically update a strategic plan to eliminate health disparities and inequities across sectors.

- Taking a systemic stance, the statute calls for consideration of air and water quality, natural resources and agricultural land, affordable housing, infrastructure systems, public health, access to quality health care, social services, sustainable communities, and the impact of climate change.
- Going further, the law assigns numerous state agency committees, work groups, and task forces to identify policy and research strategies for eliminating health disparities and inequities. Areas of focus range from the macro-level problems of intergenerational poverty and environmental health to micro-level issues such as maternal mortality, breast health and cancer awareness, school-based health services, and peer support services. All warrant attention.
- Moreover, Public Act 21-35 cites the need to plan for future pandemic responses, a responsibility clearly indicated by the ongoing effects of the COVID-19 pandemic.

Among the issues related to racial equity in public health, gun violence was singled out by the lawmakers as a topic on which to gather "grassroots and grass tops" advice from across the stakeholder arena. Indeed, rather than prejudging solutions, the lawmakers tasked the Advisory Committee to report by January 1, 2022, to its joint standing Public Health and Human Services Committees, advising them "on the establishment of a Commission on Gun Violence Intervention and Prevention to coordinate the funding and implementation of evidence-based, community-centric programs and strategies to reduce street-level violence in the state."

In this Executive Summary, the Advisory Committee provides a synopsis of its information-gathering efforts and its recommendations. For the subcommittees' findings, readers are referred to their complete reports in Appendix A4. Appendix B contains written public testimony and subject-matter expert presentations, while Appendix C provides additional information from state agencies as well as other publications.

Process and Steps Taken To Gather Information

Under the membership structure laid out in the law, the appointed Advisory Committee members represent a wide range of medical, government, national, and state policy, professional association, and nonprofit providers – including frontline partners who serve gun violence victims, families, and loved ones. Indeed, Advisory Committee meetings have seen ER doctors arrive at meetings in green hospital scrubs – and frontline staff suddenly leave to lend families assistance when bullets were flying.

In November, the Advisory Committee held public forums, videotaped on the state CT-N Network and on Facebook Live, to glean diverse stakeholder views:

- ✓ **Public Safety Hearing, November 5, 2021**. The Advisory Committee convened 14 public safety and law enforcement leaders on public safety enhancements and violence reduction. Participants also came from the ranks of emergency first responders, criminal justice representatives, and violence prevention professionals, to discuss effective gun violence reduction strategies and programs for enhancing public safety. In addition to the oral testimony on Public Safety (see the video links in Appendix A2), four community leaders provided written testimonies. These written testimonies are in Appendix B1.

- ✓ **Subject Matter Expert Presentations, November 12, 2021.** Three subject matter experts offered details on data and best prevention practices at the full Advisory Committee meeting November 12. These presentations are in Appendix B2 – and were key to the subcommittee findings and recommendations highlighted below.

- ✓ **General Public Hearing, November 17, 2021.** In a Zoom session of more than four hours, the Advisory Committee captured testimony from 47 speakers (and received written testimonies from 26 individuals). Participation reflected a broad cross-section of stakeholders, including many who have lost loved ones, had personal or family experiences with violence, provided services to parents raising children amid the daily stress of being afraid to go outside; or delivered medical, clinical, or other wraparound services for victims of violence seeking to recover from trauma. The list of speakers and written testimonies from November 17th are in Appendix B3.

It is no coincidence that the testimonies on the impact of violence — and the subcommittee analyses — point to the same systemic disparities and inequities that Public Act 21-35 aims to eradicate. A special section at the close of this Executive Summary examines youth perspectives on living with chronic exposure to trauma.

Fulfilling the Legislative Mandates: Recommendations

With multidisciplinary medical and frontline teams, Connecticut is establishing itself as a national leader in the field of community violence prevention. In response to legislators' call for strategies to elevate this progress, this Advisory Committee treated its five assigned tasks as **mandates**. (Appendix A3 lists each subcommittee's members, duties, and the mandates drawing its focus.)

The complete subcommittee reports (in Appendix A4) sought to fulfill these mandates with attention to the physical, psychological, social, and economic costs of street level violence in the State of Connecticut.

First and foremost, the Advisory Committee considered the basic thrust of Public Act 21-35, taking into account how best to maintain momentum and institutional knowledge in 2022 as the contours of any future Commission are developed by the legislature. Both subcommittee and full Advisory Committee discussion touched on the January 1, 2022, sunset of this Advisory Committee and advocated that its members be called on to serve on the Commission as established or to fill a future advisory role. As to the potential formation of such a Commission, the Advisory Committee agreed on this ***overarching recommendation:***

- ***The Advisory Committee recommends that the General Assembly establish a Commission on Gun Violence Intervention and Prevention to coordinate the funding and implementation of evidence-based, evidence-informed, and community-centric programs and strategies to reduce street-level gun violence in the state.***

Going further, the Policy and Funding Subcommittee addressed recommended elements for the new Commission, calling for it to have state-level grant-making authority to determine community-level needs by engaging with communities; secure state, federal, and other monies to provide stable funding; and establish grant criteria, award grants, guide implementation, offer technical expertise, and monitor outcomes.

In addition, the Commission should be staffed with dedicated resources and multi-disciplinary expertise – and receive support from an Advisory Council composed of community stakeholders, public policy experts, gun violence prevention organizations, and others with a stake in the health of Connecticut's urban centers.

Both the Policy and Funding and Evidence-Based Programming and Research Subcommittees presented findings on potential elements for this future Commission, such as its role in monitoring outcomes.

Mandate-Specific Recommendations

For each of the five legislative mandates, here are highlights of the subcommittees' specific recommendations as approved by the full Advisory Committee (the complete subcommittee reports are presented in Appendix A4).

Mandate 1
Consult with community outreach organizations, victim service providers, victims of community violence and gun violence, community violence and gun violence researchers, and public safety and law enforcement representatives regarding strategies to reduce community violence and gun violence.

The Community Engagement and Public Health Subcommittee focused on this mandate, drawing upon testimony, presentations, and deliberations during the four Advisory Committee meetings.

Mandate 1 Recommendations

- ***After weighing the homicide data presented from the Connecticut Violent Death Reporting System and hearing testimony from law enforcement officials, clergy, surviving victims of gun violence, and loved ones left behind by violence, the Community Engagement and Public Health Subcommittee recommends as feasible and actionable the creation of a standing Commission to address gun violence intervention and prevention.***

- ***For the bridging of bureaucratic silos and building of local trust, it will be important to draw upon best practice and technical guidance as well as appropriate representation on the Commission from the full set of state agencies that engage with children and families, including the State Department of Education, as well as from the membership of this Advisory Committee.***

Mandate 2
Identify effective, evidence-based community violence and gun violence reduction strategies.

The Evidence-Based Programming and Research Subcommittee focused on this mandate, drawing upon testimony delivered in the November 5th Public Safety and November 17th General Public Hearings, the November 12th subject matter presentations, and the deliberations of the Advisory Committee.

Mandate 2 Recommendations

- **Emphasize the Implementation and Evaluation of Key Programs:**
  Violence Intervention: Community and Hospital Programs built on established evidence-based frameworks, focused on directly intervening around interpersonal or group conflict and providing intensive case management services to victims or those at elevated risk of violence, as well as negotiating ceasefires and shifting neighborhood cultural norms.

  The programs must utilize a trauma-informed care framework and ensure those at high risk have access to mental health services, such as cognitive behavioral therapy. Examples include:
    - **HVIPs (Hospital-based Violence Intervention Programs)**
    - **Violence Interruption Programs/Cure Violence**
    - **GVI (Group Violence Intervention)**

  Training and Technical Assistance: Community-centric training and technical assistance programs at the national and local levels, respectively, such as, the Health Alliance for Violence Intervention (the HAVI) certification and training of Violence Prevention Professionals (VPPs) and the localized training offered for frontline workers in Connecticut by the Brother Carl Institute.

  Survivor Support Services: Programs focused on providing social services and psychological support for survivors of gun violence, including the community at large.

- **Implement Effective Evidence-Based and Evidenced-Informed Programs:**

  Coordination between programs and services must be a core element of success. Effective violence prevention requires that systems of reporting outcomes and informatics be created, including comprehensive evaluation services and shared resources specifically for community-based organizations on the frontlines.

  Trauma-Informed Care. This framework is for training program providers to engage victims and individuals at elevated risk of violence to improve long-term outcomes. It encourages providers to be knowledgeable about the widespread impact of trauma and treat accordingly.

  Many communities that have experienced high rates of community violence are distrustful of institutions like healthcare and criminal justice systems. Using a trauma-informed approach, violence prevention professionals are specially trained to break through this distrust and value "credible messengers" on their teams, who often come from the communities in which they work and thus can better engage program participants.

  Place-Based Strategies and Coordinated Events. Promising strategies on place-based interventions exist, including vacant lot and green space improvements, and these interventions hold the possibility of coordinated events for multiple programs to raise awareness around community violence prevention. Similarly, gun violence prevention statewide events can be used to leverage fundraising and coordination.

Mandate 3
Identify strategies to align the resources of state agencies to reduce community violence and gun violence.

The Policy and Funding and Evidence-Based Programming and ***Research Subcommittees*** focused on this mandate, drawing upon testimony delivered in the November 12th Public Safety and November 17th General Public Hearings and policy analyses of federal and state initiatives.

Mandate 3 Recommendations

- ***Connecticut must make full use of the federal grant programs it administers, including Medicaid reimbursement for prevention and intervention services by trained and certified violence prevention professionals.***

- ***The State should determine and implement the most expedient vehicle to consolidate existing advisory and oversight authority in order to advance development of a seamless, coordinated, and integrated approach to violence intervention and prevention. This will require rigorous analysis to determine which policy and funding approaches now functioning in Connecticut – and in other states – present the most promising approaches to reduce gun violence.***

- ***Both targeted and competitive state grant programs are needed to address prevention and intervention needs in cities disproportionately impacted by violence.***

Mandate 4
Identify state, federal, and private funding opportunities for community violence and gun violence reduction initiatives.

The Policy and Funding and Evidence-Based Programming **and** ***Research Subcommittees*** focused on this mandate, drawing upon testimony delivered in the November 12th Public Safety and November 17th General Public Hearings and policy analyses of federal and state initiatives.

Mandate 4 Recommendation

- ***Analyses show a wide range of federal funding streams, state opportunities, and private support sources are available. The Commission must ensure these opportunities are fully maximized to sustain prevention and intervention programs that demonstrate a net public benefit.***

Mandate 5
Develop a public health and community engagement strategy for the Commission on Gun Violence Intervention and Prevention.

The Community Engagement and Public Health Subcommittee focused on this mandate, drawing upon testimony delivered in the November 12th Public Safety and November 17th General Public Hearings, as well as the Advisory Committee meetings, including the November 12th subject matter experts' presentations.

Mandate 5 Recommendations

- **The Commission's effort should focus on at least the following objectives:**

✓ **Maximize efforts and resources to effectively reduce the level of risks and increase the protective factors in the community.**
✓ **Provide concrete data and information trends to inform decision making and benchmark progress.**
✓ **Strengthen the ability to track crime prevention program effectiveness.**
✓ **Promote the process of institutionalizing prevention in the community.**
✓ **Place the responsibility for health and behavior problems on identifiable risk factors, not on people.**
✓ **Incorporate strength-based practices designed to empower our youth and develop local solutions.**
✓ **Identify and review systemic impediments which our youth face on a day-to-day basis that are root causes of violence. Specifically, address the systemic community risk factors which have caused racial disparities in the juvenile justice system for Black and Brown youth.**
✓ **Research and identify the geographical areas which are most impacted by gun violence and conduct asset mapping within these communities.**

- ***Public engagement platform strategies should include, but not be limited to:***

✓ ***Listening Sessions and Polling*, *Focus Groups*, *Door to Door/Neighbor to Neighbor Outreach and Polling*, and *the Charrette Work Improvement Protocol* (under which the community is involved in work improvement processes, with neighborhood revitalization groups based upon specific regions or locations).**

✓ **Effective community engagement and partnership will require active participation by community organizations, businesses, and individuals, following best practices for public engagement, including the sharing of evaluation data to promote services and gain support.**

Conclusion

The Advisory Committee recommends that the General Assembly establish a Commission on Gun Violence Intervention and Prevention to coordinate the funding and implementation of evidence-based, evidenced-informed, community-centric programs and strategies to reduce street-level gun violence in the state.

From national and state policy experts, the Advisory Committee received information to construct an overview of effective, "evidence-based" and "evidence-informed" programs currently being implemented in the State of Connecticut and in other states. The Advisory Committee recommendations draw upon that best-practice information and incorporate relevant highlights of pre-eminent local and state-funded violence prevention, intervention, treatment, and recovery efforts under way, as they might be applicable to Connecticut.

Policy and intervention experts at the national and State levels alike recognize Connecticut's leadership in this field, in connection with innovations including but not limited to:

- ***Focus on Proven Practices.*** *The legislature tasked the Gun Violence Intervention and Prevention Advisory Committee by January 1, 2022, to recommend strategies for reducing gun violence, utilizing broad stakeholder outreach. This report fulfills that charge.*
- ***Sustaining the Work.*** *Another law, approved unanimously by both the State House and Senate (Public Act 21-36), will make services by trained and certified Violence Prevention Professionals (VPPs) reimbursable under Medicaid by July 2022. Further measures are needed if prevention efforts are to be sustained.*
- ***The Power of Partnerships.*** *Multi-state and cross-disciplinary approaches enhance public safety, as in the case of the recently solidified, four-state (CT, NJ, NY, and PA) information-sharing agreement to curb illegal gun trafficking. Similarly, teams in Hartford, New Haven, and Bridgeport are connected to the* ***national*** *Health Alliance for Violence Intervention (the HAVI) network and the* ***statewide*** *CT Hospital-Based Violence Intervention Program Collaborative, sharing best prevention practices refined for years among more than three dozen U.S. metro areas. Such vital partnerships must be sustained – and expanded to additional cities and towns needing to develop violence prevention capabilities.*

A Special Focus: Understanding the Youth Experience with Violence

Program Director Ebony Epps of StreetSafe Bridgeport is a member of the Subcommittee on Community Engagement and Public Health as well as a 26-year veteran of the Regional Youth/Adult Social Action Partnership (RYASAP). She provided this special section on youth perspectives related to gun violence, reflecting the Advisory Committee's concern about the chronic stressors that stem from long-term exposure to gun violence. Gun violence not only devastates victims and their families and loved ones, it also negatively affects children's development, mental health, and schooling outcomes. The impact of gun violence on communities is an existential threat not just to individuals, but to the economic health of cities. (Appendix A2 contains video links to the November 17 testimony, which included numerous statements from young people on this issue.)

An alarming number of individuals and families live on and below the poverty line in the United States and around the world. In some cases, poverty has negative outcomes and lasting effects on youth development. Poverty stagnates growth in terms of emotional, mental, and physical development.

Many factors underlie the current achievement gap between students from low socioeconomic backgrounds and those from affluent backgrounds. There are the influences of income; a community's tax base determines their education budget. Take for instance, Bridgeport. Located in one of the richest counties in the world, it's the largest city in Connecticut and its surrounding towns are Stratford, Trumbull, and Fairfield – all of which have better schools. The students enrolled do better academically, socially, and emotionally. Why do students in surrounding communities do better? One answer is, they live in better neighborhoods, with more access to resources and support.

Youth from low socioeconomic backgrounds face juvenile delinquency problems more often than their counterparts from high socioeconomic backgrounds. In part, this is due to their parents often having to work long hours in order to make ends meet. Children are often home alone after school, which affords them more time to get into trouble. Statistics show that youth are more likely to commit offenses between the hours of 3:30 p.m. and 6:00 p.m.

Globally, the United States has the highest prison population and in most instances the prisoners are not receiving any rehabilitation; many do not belong there. Prison is a moneymaking industry with a revolving door.
It is important for us to show urban youth that we value them. We have to find a way to provide them with the same opportunities as their suburban counterparts. Is it fair for us to expect folks living in these conditions to thrive?

In hopes to glean some answers, SafeStreet Bridgeport held a community forum with youth on November 29, 2021. The question below was posed to this group of youth and is followed by their responses.

What are some things that will benefit a young person like yourself?

The Youth Speak:

- ✓ Authority figures respecting us and treating us like human beings
- ✓ Having safe places in our neighborhoods for us to go
- ✓ Opportunities to learn new things for all youth even if you have not discovered their gifts or talents ex: there is always programs available for kids who are good at sports like basketball or do music, but what about us?
- ✓ More educational opportunities
- ✓ Better living conditions
- ✓ Family counseling
- ✓ Family stability
- ✓ Help us with traumas
- ✓ More mentors
- ✓ More teen groups that provide an outlet for us
- ✓ Allowing our voices to be heard
- ✓ Activities available on every side of town
- ✓ Job training & jobs at the end of the training
- ✓ Opportunities to travel out of the community, state, & country to experience life
- ✓ Connect youth & families to viable resources without making us feel poor or like a burden
- ✓ Things will be better if adults stop assuming we are all the same
- ✓ Promote mental health & wellness in our community without being judged

A 12-Year-Old's Forewarning

To underscore how young people view what is at stake in addressing the public health issues related to community gun violence, the Advisory Committee shares the following statement from a 12-year-old, whose identity remains confidential but whose perspective we cannot dismiss:

> ***God has put me in this world to do great things, to help and inspire others. To make people happy and show them my talents. I am not perfect, but I deserve to be treated, fairly, not gunned down in the streets.***
>
> ***Life is a struggle and people will say and do negative things, but God & my mom says to work harder and reach your goals. I can do great things by earning my education in order to make the world a better place.***
>
> ***If my life did not matter, why would I be here?***

Acknowledgements

We would like to express our gratitude to the following esteemed lawmakers and policy makers, who appointed the members of the Advisory Committee:

State Senate President Pro Tempore Martin Looney, 11th District

State Senate Majority Leader Bob Duff, 25th District

State Senate Republican Leader Kevin Kelly, 21st District

Senator Mary Daugherty Abrams, 13th District, Public Health Committee Co-Chair

House Majority Leader Jason Rojas, 9th District

Speaker of the House of Representatives Matt Ritter, 1st District

House Minority Leader Vincent Candelora, 86th District

Commissioner of Connecticut Department of Public Health Dr. Manisha Juthani

Executive Director Steven Hernández, Esq., The Commission on Women, Children, Seniors, Equity and Opportunity (CWCSEO)

We would also like to express our gratitude to Greg Jackson and Aswad Thomas as well as committee members Dr. Kyle Fischer and Michael Makowski for their special presentations to the Advisory Committee. We are extremely grateful to Kent Ashworth for his assistance in writing and editing this report.

We also wish to thank The Commission on Women, Children, Seniors, Equity and Opportunity for serving as the administrative staff, including Denise Drummond and Werner Oyanadel. In recognition of their efforts throughout the process, we especially acknowledge CWCSEO Children and Families Policy Analyst Thomas Nuccio and Advisory Fellow and Primary Administrator Dr. Pina Violano, for providing administrative support and content expertise, and for facilitating the collection of the content used in the preparation of the report.

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Women, Children, Seniors, Equity & Opportunity

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Connecticut General Assembly

Report of the

GUN VIOLENCE INTERVENTION AND PREVENTION ADVISORY COMMITTEE

Submitted to the Connecticut General Assembly
Public Health and Human Services Joint Standing Committees
January 1, 2022

Detailed Table of Contents for the Appendices

APPENDIX A: RECORD OF THE ADVISORY COMMITTEE'S WORK

APPENDIX A1: LINK TO THE COMPLETE TEXT OF SENATE BILL NO. 1, PUBLIC ACT 21-35

This 2021 statute, "AN ACT EQUALIZING COMPREHENSIVE ACCESS TO MENTAL,BEHAVIORAL AND PHYSICAL HEALTH CARE IN RESPONSE TO THE PANDEMIC," passed unanimously in both chambers of the Connecticut General Assembly. The law established this Advisory Committee in Section 9, pp. 10-13.

Link to the complete text of bill:

https://www.cga.ct.gov/2021/ACT/PA/PDF/2021PA-00035-R00SB-00001-PA.PDF

APPENDIX A2: RECORD OF ADVISORY COMMITTEE MEETINGS, PUBLIC HEARINGS, AND SUBJECT MATTER EXPERT PRESENTATIONS

Throughout the fall of 2021, the Advisory Committee engaged a diverse set of stakeholders in public hearings and committee meetings. Written testimonies and subject matter presentations submitted in conjunction with these sessions are included in Appendices B1-B3.

CT-N Live Coverage Links

September 29, 2021, Advisory Committee Meeting:
https://ct-n.com/ondemand.asp?ID=18979

October 15, 2021, Advisory Committee Meeting:
https://ct-n.com/ondemand.asp?ID=19017

November 5, 2021, Public Safety Hearing:
https://ct-n.com/ondemand.asp?ID=19077

November 12, 2021, Advisory Committee Meeting:
https://ct-n.com/ondemand.asp?ID=19097

November 17, 2021, General Public Hearing:
https://ct-n.com/ondemand.asp?ID=19113

November 23, 2021, Advisory Committee Meeting:
https://ct-n.com/ondemand.asp?ID=19134

December 10, 2021, Advisory Committee Meeting:
https://ct-n.com/ondemand.asp?ID=19178

December 22, 2021, Advisory Committee Meeting:
https://ct-n.com/ondemand.asp?ID=19219

December 30, 2021, Advisory Committee Meeting:
https://ct-n.com/ondemand.asp?ID=19223

The Commission on Women, Children, Seniors, Equity & Opportunity
Facebook Live Coverage Links

September 29, 2021, Advisory Committee Meeting:
https://fb.watch/9G8BuQ3U6m/

October 15, 2021, Advisory Committee Meeting:
https://fb.watch/9G8xE8bdC6/

November 5, 2021, Public Safety Hearing:
https://fb.watch/9G8taARiKK/

November 12, 2021, Advisory Committee Meeting:
https://fb.watch/9G8pZbv0Bn/

November 17, 2021, General Public Hearing
https://fb.watch/9G8ot7dGrT/

November 23, 2021, Advisory Committee Meeting:
https://fb.watch/9G8k7X9GpT/

December 10, 2021, Advisory Committee Meeting:
https://fb.watch/9Tu2CZtlgx/

December 22, 2021, Advisory Committee Meeting:
https://fb.watch/abbolxpiv9/

December 30, 2021, Advisory Committee Meeting:
https://fb.watch/adBa3yUrar/

APPENDIX A3: GUN VIOLENCE INTERVENTION & PREVENTION ADVISORY COMMITTEE SUBCOMMITTEES: STRUCTURE, MEMBERS, AND DUTIES

1. The Evidence-Based Programming and Research Subcommittee
2. The Policy and Funding Subcommittee
3. The Community Engagement and Public Health Subcommittee

APPENDIX A4: COMPLETE REPORTS OF THE ADVISORY COMMITTEE SUBCOMMITTEES

1. Evidence-Based Programming and Research
2. Policy and Funding
3. Community Engagement and Public Health

APPENDIX B: HEARING TESTIMONY & SUBJECT MATTER EXPERT PRESENTATIONS

APPENDIX B1: RECORD OF WRITTEN AND ORAL TESTIMONY, PUBLIC SAFETY HEARING, NOVEMBER 5, 2021

Transcripts of written testimony from the following witnesses are included in this appendix:

1. Bishop Jim Curry, Co-Founder, Swords to Plowshares Northeast
2. Hartford Foundation for Public Giving
3. Curt Leng, Mayor of Town of Hamden
4. Michele Voigt, Co-Founder and CEO, Violent Crime Survivors

The following witnesses provided oral testimony:

1. Rev. Dr. Anthony Bennett, Mt. Aery Baptist Church
2. Ed Calderon, Supervisor, RYASAP StreetSafe Bridgeport
3. Aquil Crooks, Outreach Worker, RYASAP StreetSafe Bridgeport
4. Bishop Jim Curry, Co-Founder, Swords to Plowshares Northeast
5. Detective Sean Dolan, Public Information Officer & Major Crimes Unit, Hamden Police Department
6. Brian Foley, Public Information Officer, Connecticut Department of Emergency Services and Public Protection
7. Keisha Gatison, Director of Re-entry Welcome Center, Project MORE, Inc.
8. Lt. Paul Grech, Bridgeport Police Department
9. Assistant Chief Karl Jacobson, New Haven Police Department
10. Judy McBride, Director, Strategic Partnership Investments, Hartford Foundation for Public Giving
11. Latesha Nelson, Career Employment Resource Specialist, Project MORE, Inc.
12. Sean Reeves, Sr., Co-Founder, S.P.O.R.T. Academy
13. Chris Senecal, Senior Public Policy and Media Relations Officer, Hartford Foundation for Public Giving
14. Michele Voigt, Co-Founder and CEO, Violent Crime Survivors

APPENDIX B2: SUBJECT MATTER EXPERT PRESENTATIONS, NOVEMBER 12, 2021

1. Kyle Fischer, MD, MPH, Policy Director, The Health Alliance for Violence Intervention (The HAVI)
2. Greg Jackson, Executive Director, Community Justice Action Fund
3. Aswad Thomas, MSW, National Director, Crime Survivors for Safety and Justice

APPENDIX B3: RECORD OF WRITTEN AND ORAL TESTIMONY, GENERAL PUBLIC HEARING, NOVEMBER 17, 2021

Transcripts of written testimony from the following witnesses are included in this appendix:

1. Rhea Ahuja, Student, Hopkins School; Member, Amnesty International Chapter
2. Shaurice Bacon, Student Engagement Team, Regional Youth Adult Social Action Partnership, Bridgeport
3. Daya Baum, Student, Hopkins School; Member, Amnesty International Chapter
4. Kim Beauregard, President and CEO, InterCommunity Health Care
5. The Rev. Robert Bergner, Co-Founder, Swords to Plowshares Northeast; Priest-in-Charge, Grace & St. Peter's Church, Hamden
6. Dr. Kevin Borrup, Executive Director, Injury Prevention Center, Connecticut Children's Medical Center (joined by Dr. Brendan Campbell, Director of Pediatric Trauma)
7. Connecticut Hospital Association
8. Noa Diarrassouba, Student, Hopkins School; Member, Amnesty International Chapter
9. Dione Dwyer, Parent Advocate, President of Resident Council at PT Barnum Housing Complex, Bridgeport
10. Reginald Eadie, MD, M.B.A., President and CEO, Trinity Health of New England
11. Karen Edwards, MD, MPH, Retired Pediatrician, Professor of Public Health and Adjunct Professor of Pediatrics, Stamford Resident
12. Carolyn Graves, Bridgeport
13. Dr. Charles Johndro, Emergency Department Attending Physician, Hartford Hospital
14. Larry Johnson, Program Director, Hartford Care Response Team, Hartford Communities That Care (with Kent Ashworth, Volunteer Research Assistant)
15. The Rev. Nancy Kingwood, M.S., M.A., Executive Director, Greater Bridgeport Area Prevention Program Inc. (GBAPP)
16. Jennifer Lawlor, Co-Founder, Violent Crime Survivors
17. Peter Murchison, Ridgefield Resident and Member of the Wilton Quaker Meeting
18. Jonathan Perloe, Director of Communications, CT Against Gun Violence
19. Isabel Pizarro, Student, Hopkins School
20. Bob Reilly, Hamden
21. Kate Roschmann, CT Chapter Leader, Moms Demand Action for Gun Sense in America
22. Rabbi Ari Rosenberg, Executive Director, Association of Religious Communities)

23. Ben Simon, Student, Hopkins School, New Haven
24. Dr. Dwayne Smith, CEO, Housatonic Community College
25. John Torres, Executive Director, Bridgeport Caribe Youth Leaders
26. Kelvin Young, Community Health Worker, InterCommunity Health Care

The following witnesses provided oral testimony:

1. Kian Ahmadi, Student, Hopkins School; Student Coordinator, Amnesty International
2. Kent Ashworth, Volunteer Research Assistant, Hartford Communities That Care
3. Cherell Banks, Coordinator, Youth Nonviolence Trainer, CT Center for Nonviolence
4. Thayer Barkley, Founder, Sisters at the Shore
5. Henrietta Beckman, Mothers United Against Violence
6. The Rev. Robert Bergner, Co-Founder, Swords to Plowshares Northeast; Priest-in-Charge, Grace & St. Peter's Church, Hamden
7. Dr. Kevin Borrup, Executive Director, Injury Prevention Center, Connecticut Children's Medical Center
8. Dahmarre Bournes, Greater Hartford Youth Leadership Academy, Hartford Communities That Care
9. Christopher Brechlin, Director of Data & Digital Systems, COMPASS Youth Collaborative
10. Dennis Broadnax, RYASAP StreetSafe Bridgeport
11. Breanna Brown, Greater Hartford Youth Leadership Academy
12. Rev. Henry Brown, Co-Founder and Executive Director, Mothers United Against Violence
13. Sally Connolly, Co-Chairperson, Preventing Gun Violence Task Force, Unitarian Society of New Haven and Hamden
14. Aquil Crooks, Outreach Worker, StreetSafe Bridgeport
15. Deborah Davis, Director of Project Development and Management, Mothers United Against Violence
16. Harold Dimbo, Project Longevity, Bridgeport
17. Carol Dorsey, Mothers United Against Violence
18. Karen Edwards, MD, MPH, Retired Pediatrician, Professor of Public Health and Adjunct Professor of Pediatrics, Stamford Resident
19. Shirley Ellis-West, Executive Director, Urban Community Alliance, Inc
20. Barbara Fair, Community Member
21. Celeste Fulcher, Community Member
22. Freddie Graves, Mothers United Against Violence
23. Dr. Charles Johndro, Emergency Department Attending Physician, Hartford Hospital
24. Dean Jones, Director, COMPASS Youth Collaborative
25. Aki Johnson, Bridgeport Youth
26. Jennifer Lawlor, Co-Founder, Violent Crime Survivors
27. William Love Jr., Leader, Danbury Area Justice Network
28. Anthony Marshal, Founder, Peace in The Streets
29. Ebony McClease, Legislative Coordinator, Amnesty International USA CAGV
30. Da'ee McKnight, Family Reentry, Inc. & Fatherhood Engagement Specialist
31. Rev. Dr. John Morehouse, Senior Minister, Unitarian Church in Westport
32. Peter Murchison, Ridgefield Resident and Member of the Wilton Quaker Meeting
33. Po Murray, Chairwoman, Newtown Action Alliance
34. Jonathan Perloe, Director of Communications, CT Against Gun Violence
35. Logan Phillips, Community Member
36. Elijah Ratner, Student, Hopkins School
37. Carmen Rodriguez, Mothers United Against Violence
38. Kate Roschmann, CT Chapter Leader, Moms Demand Action for Gun Sense in America
39. Dr. Dwayne Smith, CEO, Housatonic Community College
40. Dawn Spearman, You Are Not Alone
41. John Torres, Executive Director, Bridgeport Caribe Youth Leaders
42. Maria Van Gelder, APRN, Nurse Practitioner Trauma, Yale New Haven Hospital
43. Pepe Vega, BA, CPS-T, Violence Prevention Professional, Yale New Haven Hospital
44. Kim Washington, Mothers Demand Action, Hamden Police Commissioner
45. Vanessa Williams, Mothers United Against Violence
46. Pastor Doran Wright, Neighborhood Church Black Rock; CT Coordinator, Straight Ahead Ministries
47. Adam Yagaloff, Staff Attorney, Right Direction: Homeless Youth Advocacy Project

APPENDIX C: SUPPORTING MATERIALS & ADDITIONAL RESOURCES

APPENDIX C1: REQUEST TO AND RESPONSES FROM STATE AGENCIES

The Gun Violence Intervention and Prevention Advisory Committee in November 2021 invited State agencies to share information regarding community violence and gun violence reduction initiatives within their agencies, including an articulation of the sources of funding for these initiatives. The Advisory Committee received the following responses:

1. **State Department of Mental Health and Addiction Services**
   a) ***NICS, Risk Warrants, and VATS in Connecticut,*** prepared by Michael Norko, MD, Director of Forensic Services, Connecticut Department of Mental Health and Addiction Services, 2021
   b) ***Timeline of Gun Legislation & Related Events Pertinent to Connecticut,*** prepared by Michael Norko, MD, Director of Forensic Services, Connecticut Department of Mental Health and Addiction Services, 2021
   c) ***Description of The Mental Health Adjudication Repository (MHAR)***
   d) ***Gun Control Legislation in Connecticut: Effects on Persons with Mental Illness,*** Michael A. Norko and Madelon Baranoski, Connecticut Law Review, May 2014
   e) ***Implementation and Effectiveness of Connecticut's Risk-Based Gun Removal Law: Does It Prevent Suicides?,*** Jeffrey W. Swanson, Ph.D., Michael A. Norko, MD, Mar Hsiu-Ju Lin, PhD, Kelly Alanis-Hirsch, PhD, Linda K. Frisman, PhD, Madelon V. Baranoski, PhD, MSN, Michele M. Easer, PhD, Allison G. Robertson, PhD, MPH, Marvin S. Swartz, MD, and Richard J. Bonnie, LLB, 2017
2. **Office of Legislative Research**
   a) **Response from George L. Miles, Esq., Office of Legislative Research**
3. **CT General Assembly Office of Fiscal Analysis**
   a) **Community Violence and Gun Violence Reduction Initiatives**
4. **State Department of Public Health**
   a) **The Connecticut Violent Death Reporting System and Homicide Victimology in Connecticut 2015 to 2021,** prepared by Michael Makowski, MPH, Connecticut Department of Public Health Epidemiologist, Injury and Violence Surveillance Unit
   b) **The Connecticut Violent Death Reporting System,** prepared by Michael Makowski, MPH, Connecticut Department of Public Health Epidemiologist, Injury and Violence Surveillance Unit
   c) **Background of Homicides in Connecticut 2015 to September 30, 2021,** prepared by Michael Makowski, MPH, Connecticut Department of Public Health Epidemiologist, Injury and Violence Surveillance Unit
5. **Department of Children and Families**
   a) **Response from Commissioner Vannessa L. Dorantes, LMSW**
6. **Police Transparency and Accountability Task Force**
   a) **Connecticut Bar Association Policing Task Force Report and Recommendations**, November 2021
   b) **Police Transparency and Accountability Task Force Infographic**
   c) **Policy Transparency and Accountability Task Force Annual Report,** January 2021

APPENDIX C2: OTHER PUBLICATIONS

1. ***Aligning Systems with Communities to Advance Equity Through Shared Measurement: Guiding Principles***, American Institutes for Research, 2021
2. ***First Generation EV-ROI Model for Hartford Communities That Care's Hartford Crisis Response Team/Hospital-Linked Violence Intervention Program,*** Social Capital Valuations, 2019
3. ***Connecticut Analyses of Evidence-Based Programs,*** *Institute for Municipal and Regional Policy (Results First Connecticut),* Central Connecticut State University, November 2020
4. ***Results First Clearinghouse Database,*** *The Pew Charitable Trusts (link only):* https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database
5. ***On the Front Lines: Elevating the Voices of Violence Intervention Workers (Executive Summary),*** Giffords Law Center to Prevent Gun Violence, 2021
6. ***Age of Gunshot Wound Victims in New Haven, 2003-2015,*** The Policy Lab Working Paper, Institution for Social and Policy Studies, Yale University, 2017.

Journal Articles

1. Dalve, K., Gause, E., Mills, B., Fischer, K.R., Cooper, C., Marks, A., & Slutkin, G. (2020). Prevention Professional for Violence Intervention: A Newly Recognized Health Care Provider for Population Health Programs. *Journal of Health Care for the Poor and Underserved* 31(1), 25-34. DOI: 10.1353/hpu.2020.0005
2. Bonne, S., Hink, A., Violano, P., Allee, L., Duncan, T., Burke, P., Fein, J., Kozyckyj, T., Shapiro, D., Bakes, K., Kuhls, D., Bulger, E., & Dicker, R. (2022). Understanding the makeup of a growing field: A committee on trauma survey of the national network of hospital-based violence intervention programs. *American journal of surgery*, *223*(1), 137–145. DOI: 10.1016/j.amjsurg.2021.07.032
3. Dodington, J. M., & Vaca, F. E. (2021). Why We Need Primary Youth Violence Prevention Through Community-Based Participatory Research. *The Journal of adolescent health:official publication of the Society for Adolescent Medicine*, *68*(2), 231–232. DOI: 10.1016/j.jadohealth.2020.11.003
4. O'Neill, K. M., Vega, C., Saint-Hilaire, S., Jahad, L., Violano, P., Rosenthal, M. S., Maung, A. A., Becher, R. D., & Dodington, J. (2020). Survivors of gun violence and the experience of recovery. *The journal of trauma and acute care surgery*, *89*(1), 29–35. DOI: 10.1097/TA.0000000000002635
5. Wang, E. A., Riley, C., Wood, G., Greene, A., Horton, N., Williams, M., Violano, P., Brase, R. M., Brinkley-Rubinstein, L., Papachristos, A. V., & Roy, B. (2020). Building community resilience to prevent and mitigate community impact of gun violence: conceptual framework and intervention design. *BMJ open*, *10*(10), e040277. DOI: 10.1136/bmjopen-2020-040277
6. Riley, C., Roy, B., Harari, N., Vashi, A., Violano, P., Greene, A., Lucas, G., Smart, J., Hines, T., Spell, S., Taylor, S., Tinney, B., Williams, M., & Wang, E. A. (2017). Preparing for Disaster: a Cross-Sectional Study of Social Connection and Gun Violence. *Journal of urban health : bulletin of the New York Academy of Medicine*, *94*(5), 619–628. DOI: 10.1007/s11524-016-0121-2
7. Floyd, A. S., Rivara, F. P., & Rowhani-Rahbar, A. (2021). Neighborhood disadvantage and firearm injury: does shooting location matter?. *Injury epidemiology*, *8*(1), 10. DOI: 10.1186/s40621-021-00304-2
8. Talley, D., Warner, S., Perry, D., Brissette, E., Consiglio, R., Violano, P., Coker, K. (2021). Understanding situational factors and conditions contributing to suicide among Black youth and young adults, *Aggression and Violent Behavior*, Volume 58, 2021. https://doi.org/10.1016/j.avb.2021.101614

APPENDIX C3: PERSPECTIVES AND VOICES FROM CONNECTICUT YOUTH

1. Comments shared by Sean Reeves, Sr., Co-Founder, S.P.O.R.T. Academy
2. Hartford Communities That Care (HCTC) Youth Leaders' Problem-Solving Framework
3. Letter from Representative Robyn Porter, 94th Assembly District; Member, Juvenile Justice Policy and Oversight Committee

The Commission on
Women, Children, Seniors, Equity & Opportunity

CWCSEO

Connecticut General Assembly

Report of the

GUN VIOLENCE INTERVENTION AND PREVENTION ADVISORY COMMITTEE

Submitted to the Connecticut General Assembly
Public Health and Human Services Joint Standing Committees
January 1, 2022

APPENDICES

APPENDIX A: RECORD OF THE ADVISORY COMMITTEE'S WORK

Appendix A1
Link to the Complete Text of Senate Bill No. 1, Public Act 21-35

Appendix A2
Record of Advisory Committee Meetings, Public Hearings, and Subject Matter Expert Presentations

Appendix A3
Gun Violence Intervention & Prevention Advisory Committee Subcommittees: Structure, Members, and Duties

Appendix A4
Complete Reports of the Advisory Committee Subcommittees

APPENDIX B: HEARING TESTIMONY & SUBJECT MATTER EXPERT PRESENTATIONS

Appendix B1
Record of Written and Oral Testimony, Public Safety Hearing, November 5, 2021

Appendix B2
Subject Matter Expert Presentations, November 12, 2021

Appendix B3
Record of Written and Oral Testimony, General Public Hearing, November 17, 2021

APPENDIX C: SUPPORTING MATERIALS & ADDITIONAL RESOURCES

Appendix C1
Request to and Responses From State Agencies and Task Forces

Appendix C2
Other Publications

Appendix C3
Perspectives and Voices from Connecticut Youth

The Commission on
Women, Children, Seniors, Equity & Opportunity

CWCSEO

Connecticut General Assembly

Report of the

GUN VIOLENCE INTERVENTION AND PREVENTION ADVISORY COMMITTEE

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APPENDIX A:

RECORD OF THE ADVISORY COMMITTEE'S WORK

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Appendix A4

Complete Reports of the Advisory Committee Subcommittees

APPENDIX A1

Link to the Complete Text of Senate Bill No. 1, Public Act 21-35

This 2021 statute, “AN ACT EQUALIZING COMPREHENSIVE ACCESS TO MENTAL,BEHAVIORAL AND PHYSICAL HEALTH CARE IN RESPONSE TO THE PANDEMIC,” passed unanimously in both chambers of the Connecticut General Assembly. The law established this Advisory Committee in Section 9, pp. 10-13.

Link to the complete text of bill:

https://www.cga.ct.gov/2021/ACT/PA/PDF/2021PA-00035-R00SB-00001-PA.PDF

APPENDIX A2

Record of Advisory Committee Meetings, Public Hearings, and Subject Matter Expert Presentations

Throughout the fall of 2021, the Advisory Committee engaged a diverse set of stakeholders in public hearings and committee meetings. Written testimonies and subject matter presentations submitted in conjunction with these sessions are included in Appendices B1-B3.

CT-N Live Coverage Links

September 29, 2021, Advisory Committee Meeting:
https://ct-n.com/ondemand.asp?ID=18979

October 15, 2021, Advisory Committee Meeting:
https://ct-n.com/ondemand.asp?ID=19017

November 5, 2021, Public Safety Hearing:
https://ct-n.com/ondemand.asp?ID=19077

November 12, 2021, Advisory Committee Meeting:
https://ct-n.com/ondemand.asp?ID=19097

November 17, 2021, General Public Hearing:
https://ct-n.com/ondemand.asp?ID=19113

November 23, 2021, Advisory Committee Meeting:
https://ct-n.com/ondemand.asp?ID=19134

December 10, 2021, Advisory Committee Meeting:
https://ct-n.com/ondemand.asp?ID=19178

December 22, 2021, Advisory Committee Meeting:
https://ct-n.com/ondemand.asp?ID=19219

December 30, 2021, Advisory Committee Meeting:
https://ct-n.com/ondemand.asp?ID=19223

The Commission on Women, Children, Seniors, Equity & Opportunity Facebook Live Coverage Links

September 29, 2021, Advisory Committee Meeting:
https://fb.watch/9G8BuQ3U6m/

October 15, 2021, Advisory Committee Meeting:
https://fb.watch/9G8xE8bdC6/

November 5, 2021, Public Safety Hearing:
https://fb.watch/9G8taARiKK/

November 12, 2021, Advisory Committee Meeting:
https://fb.watch/9G8pZbv0Bn/

November 17, 2021, General Public Hearing
https://fb.watch/9G8ot7dGrT/

November 23, 2021, Advisory Committee Meeting:
https://fb.watch/9G8k7X9GpT/

December 10, 2021, Advisory Committee Meeting:
https://fb.watch/9Tu2CZtlgx/

December 22, 2021, Advisory Committee Meeting:
https://fb.watch/abbolxpiv9/

December 30, 2021, Advisory Committee Meeting:
https://fb.watch/adBa3yUrar/

APPENDIX A3

Gun Violence Intervention & Prevention Advisory Committee Subcommittees: Structure, Members, and Duties

Three subcommittees were created to conduct outreach and research activities:

1. **The Evidence-Based Programming and Research Subcommittee**
2. **The Policy and Funding Subcommittee**
3. **The Community Engagement and Public Health Subcommittee**

Each subcommittee was asked to focus on two or more of the five mandates explicitly assigned by Public Act 21-35 (in Section 9, pages 10-13):

1. Consult with community outreach organizations, victim service providers, victims of community violence and gun violence, community violence and gun violence researchers, and public safety and law enforcement representatives regarding strategies to reduce community violence and gun violence.
2. Identify effective, evidence-based community violence and gun violence reduction strategies.
3. Identify strategies to align the resources of state agencies to reduce community violence and gun violence.
4. Identify state, federal, and private funding opportunities for community violence and gun violence reduction initiatives.
5. Develop a public health and community engagement strategy for the Commission on Gun Violence Intervention and Prevention.

The subcommittee members, assignments, and areas of focus were as follows:

1. Evidence-Based Programming & Research Subcommittee

Co-Leads: Dr. James Dodington, Yale New Haven Hospital, and Dr. Kyle Fischer, The Health Alliance for Violence Intervention.

Member: Leonard Jahad, Connecticut Violence Intervention Program.

Duties:

- Facilitate the collection of data on known evidence-based programs and costs to support, sustain and enhance these strategies.
- Identify and elaborate on the role of research and evaluation expertise – including technologies that enhance the comparative and trend data – needed or required to measure the effectiveness of these programs.
- Identify data sources to promote data-driven gun violence intervention and prevention research.
- Identify local, state, and national technical support for community-based programming evaluation.
- Submit a narrative detailing the steps taken to address the mandates, the results of these steps, the gaps uncovered and recommendations.

Primary Mandate Areas of Focus: 2, 3, & 4

2. Policy and Funding Subcommittee

Tri-Leads*:* Carl Schiessl, Connecticut Hospital Association, Jeremy Stein, CT Against Gun Violence, and Jacquelyn Santiago, COMPASS Youth Collaborative.

Duties:

- Inquire and facilitate the collection of known sources of local, state, federal, and foundation funding that support or could support violence prevention, intervention and support crime survivors and their families.
- Inquire and facilitate the collection of known local, state and federal policies and legislation that support or could support violence prevention, intervention and support crime survivors and their families.
- Submit recommendations for the use of policy and funding sources that could support violence prevention, intervention and recovery efforts.

Primary Mandate Areas of Focus: 4 & 5

3. Community Engagement and Public Health Subcommittee

Co-Leads: Deborah Davis, Mothers United Against Violence, and Michael Makowski, State Department of Public Health.

Members: Ebony Epps, Regional Youth Adult Social Action Partnership (RYASAP)/StreetSafe Bridgeport and Dawn Spearman, You Are Not Alone.

Duties:

- Facilitate the collection of community input on the impact of violence and community centered practices known to prevent and reduce violence and support victims of violent crime.
- Facilitate the collection of non-lethal and lethal violence data.
- Recommend community-centered and public health practices, strategies and programs that could prevent and reduce violence and support crime victims.
- Submit a narrative detailing the steps taken to address the mandates, the results of these steps, gaps uncovered and recommendations.

Primary Mandate Areas of Focus: 1 & 5

APPENDIX A4

Complete Reports of the Advisory Committee Subcommittees

1. Evidence-Based Programming and Research
2. Policy and Funding
3. Community Engagement and Public Health

The Gun Violence Intervention and Prevention Advisory Committee

Report of the Evidence-Based Programming & Research Subcommittee

Prepared by: Dr. Kyle Fischer and Dr. James Dodington
with support from Committee Member Mr. Leonard Jahad

Introduction

Public health approaches to reducing gun violence are effective, evidence-based strategies that Connecticut should build upon. The public health approach emphasizes identifying both risk factors and protective factors for injury, intervening to address those factors, and evaluating the results to allow for continuous quality improvement. Community-based intervention programs have successful track records across the country and have been validated repeatedly through independent evaluations and academic research.

The key principle that undergirds all of the highlighted program models is that, even in the cities that suffer from high rates of gun violence, **less than 1%** of the population is responsible for the majority of shootings. Effective community-based programs narrowly focus on the tiny percentage of individuals at the highest risk to shoot or be shot and work to prevent shootings from happening in the first place.

The most effective way to address community violence is to coordinate a comprehensive community-based strategy through a city-wide and state-wide infrastructure. This infrastructure is connected to a broader system of city or county-wide supports that link public health systems, namely hospitals and public health entities, economic development, public safety, and community-based agencies. An example of such a system is New York City's Crisis Management system, which directed and coordinated an expansion of community-based intervention programs, leading to significant declines in violence.[1]

It will be important to ensure equitable distribution of resources to organizations of color, given government tendencies toward politically influenced choices of winners and losers, a form of exclusion that communities of color have observed and objected to for decades.

A central component of many of these intervention programs is frontline violence prevention professionals whose job is to develop close relationships with individuals at high risk of violent injury or violent behaviors. These workers are often referred to by other titles such as "violence interrupters," "violence intervention specialists," or "street outreach workers," etc. Often previously affected by violence themselves, these individuals serve as credible messengers of nonviolence and personal redemption and help steer potential shooters toward a tailored network of wraparound services which might include cognitive behavioral therapy, trauma recovery services, substance use treatment, emergency housing, job training and employment opportunities, and other supports.

These programs approach violence reduction through a public health (rather than criminal justice) framework. Recently, during the COVID crisis, street outreach workers have played

[1] https://www1.nyc.gov/site/peacenyc/interventions/crisis-management.page

critical roles in the hardest-hit neighborhoods, serving not only as violence interrupters, but as public health educators, PPE suppliers, and crisis responders.[2]

Key evidence-based community violence intervention strategies that align with these principles include Hospital-based violence intervention, Street Outreach, Group Violence Intervention/Gun Violence Reduction Strategy, Targeted Trauma-Informed Care, Peace Fellowships, and Survivor and Family Assistance Services and place-based or event-based interventions. Many of these approaches, when adequately resourced and implemented with fidelity (with the support of technical assistance and community accountability), have proven to significantly reduce rates of both fatal and non-fatal gun violence – typically between 30 and 60%. Examples include the work in Oakland which cut shootings and homicides in half.[3] *The importance of a collaborative ecosystem of interventions cannot be emphasized enough.*

Background on the Gun Violence Epidemic in Connecticut & Its Economic Impact

Interpersonal gun violence has a devastating impact in Connecticut. From 2015 to 2019, at least 559 people in Connecticut were victims of homicide, the vast majority by gun violence, while many more survived life-altering gunshot wounds.[4] Like many states, Connecticut has also experienced a sharp increase in violence in recent years, and especially since the pandemic, with 157 homicides in 2020.[5] This violence is disproportionately concentrated in just a few of Connecticut's cities. The vast majority of these murders were committed with a firearm.[6] This toll, like many others, falls disproportionately on communities of color. African Americans make up just over 12% of Connecticut's population but constitute over 65% of the state's gun homicide victims.[7]

Gun violence also has an enormous impact on Connecticut's economy. In recent years, gun-related deaths and injuries have generated an estimated **$430 million** in measurable costs in Connecticut each year, including health care and criminal justice expenses, costs to employers, and lost income; when pain and suffering is taken into account, that figure rises to a staggering $1.2 billion per year.[8] Even this total substantially understates the true economic cost of gun violence in Connecticut because it does not include significant yet difficult to measure costs such as reduced commerce and investment, diminished property values, and reductions in the

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[2] https://www.ipr.northwestern.edu/documents/reports/ipr-n3-rapid-research-reports-multiple-pandemics-17-sept-2020.pdf

[3] https://giffords.org/wp-content/uploads/2019/05/Giffords-Law-Center-A-Case-Study-in-Hope.pdf

[4] CT DPH

[5] CT DPH

[6] CDC WISQARS Fatal Injury Reports show that in 2017, 76% of homicides in Connecticut were committed with a firearm.

[7] Based on CDC WISQARS Fatal Injury Reports for 2017.

[8] Giffords Law Center to Prevent Gun Violence, The Economic Cost of Gun Violence in Connecticut, https://lawcenter.giffords.org/wp-content/uploads/2019/10/Economic-Cost-of-Gun-Violence-in-Connecticut.pdf. Estimates of the cost of gun violence in Connecticut were created by Giffords Law Center to Prevent Gun Violence using a model published in 2012 by economists at the Pacific Institute for Research and Evaluation (PIRE). PIRE is a nonprofit research organization that focuses on using scientific research to inform public policy. This model can be found at www.pire.org/documents/gswcost2010.pdf. All cost estimates were adjusted to 2016 dollars.

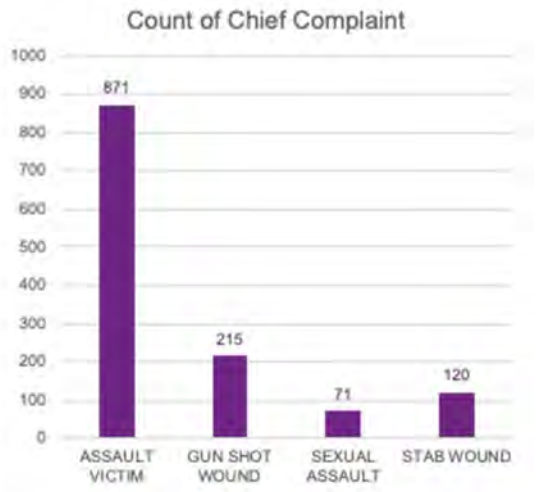
tax base. Of course, these figures also cannot capture violence's enormous personal and moral toll: the lives and loves lost, the generational, cyclical trauma, or the communities torn apart.

Importantly, as referenced above, the majority of the workers involved in community gun violence intervention and prevention are members of the communities they serve. It is critically important that this report takes into account the context in which community gun violence disproportionately impacts communities of color in Connecticut and the history of community and police relations that impacts this work. It is also critical that the perspectives of these frontline staff are centered in this work.

A recent and in-depth discussion of this history and of the organizations directly involved in community gun violence prevention and referenced in the report can be found in: Bernstein, M. (2021), Protecting Black Lives: Ending Community Gun Violence and Police Violence. Sociological Inquiry (https://doi.org/10.1111/soin.12450).

Moreover, Appendix B5 of this report provides two excellent overviews of frontline work: the 2020 *Journal of Health Care for the Poor and Underserved* article, "Professional for Violence Intervention: A Newly Recognized Health Care Provider for Population Health Programs," and the October 2021 Giffords Law Center report, *On the Front Lines: Elevating the Voices of Violence Intervention Workers.*

Because of the enormous cost of gun violence, investments to scale up effective violence reduction strategies have the potential to generate tremendous savings in terms of both lives and taxpayer dollars. Below are representations of actual victims of violence in CT presenting to two Level 1 Trauma Centers between January 1, 2020, and October 30, 2021. It is important to note the larger number of victims of physical assault are at elevated risk of subsequent gun violence. These victims represent a segment of the population actively within the cycle of violence, and moreover, opportunities to save lives.



Evidence-Based Models to Prevent Gun Violence

Hospital-Based Violence Intervention

Hospital-based Violence Intervention Programs (HVIPs) are multidisciplinary programs that combine the efforts of medical staff 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 violent retaliation and repeat injuries.

Many people who have suffered violent injuries are extremely distrustful of mainstream institutions like the health care and criminal justice systems. Using a trauma-informed approach, violence prevention professionals are specially trained to break through this distrust.

These highly trained paraprofessionals, who often come from 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 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 control 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).[9] A similar program in Baltimore showed substantial decreases as well (5% of participants vs. 20.3% of non-participants).[10]

HVIP participation has wide-ranging benefits beyond reinjury. Given that violent injury is a psychologically traumatic event, these programs are well equipped to address signs and symptoms of trauma. In fact, Philadelphia's Healing Hurt People Program has shown that patients who enroll in HVIPs experience exceedingly high rates of post-traumatic stress disorder (PTSD), as high as 75%.[11] Thus, it is not surprising that a 10-year review of San Francisco's Wraparound Project found that 51% of participants self-reported mental health needs—85% of which the program was able to address.[12] Similarly, programs assist patients in decreasing

[9]Zun LS, Downey L, Rosen J. The effectiveness of an ED-based violence prevention program. Am J Emerg Med. 2006;24(1):8-13.

[10]Cooper C, Eslinger DM, Stolley PD. Hospital-based violence intervention programs work. J Trauma. 2006;61(3):534-37.

[11] https://pubmed.ncbi.nlm.nih.gov/23974377/

[12] https://pubmed.ncbi.nlm.nih.gov/27653168/

unhealthy trauma-related coping behaviors such as intake of alcohol, cannabis and other drugs.[13]

Existing HVIPs in Connecticut

- Hartford Communities That Care (St. Francis Hospital)
- Yale New Haven HVIP (CT VIP Partnership)
- Bridgeport RYASAP (StreetSafe Bridgeport [MOU with Bridgeport Hospital and St. Vincent's Medical Center])

Training and Technical Assistance Providers for HVIPs

- The Health Alliance for Violence Intervention (HAVI)

Street Outreach/Violence Interruption

Community-based street outreach programs use public health approaches to interrupt the spread of violence directly in communities. This approach is often referred to by other names, such as "violence interruption" or "Cure Violence." One pioneer in the field, Cure Violence Global, has been implemented for approximately 25 years. The model is based on the World Health Organization's epidemic control approach: the infectious disease model. Because *recent* exposure to violence is one of the largest risk factors for *future* personal injury or retaliation, the cycle of violence spreads similarly to infectious diseases, such as viruses. Thus, the strategy focuses on interrupting the "transmission" of violence by detecting and de-escalating disputes, intensive engagement with high-risk participants, and changing social norms.

The street outreach approach has been replicated and tested both in the United States and internationally. Multiple evaluations of the programs show significant reductions in shootings whenever street outreach is implemented with fidelity to the model. In New York City, neighborhoods with Cure Violence programs experienced a 63% reduction in shootings. Similarly, Baltimore has seen a 44% decrease, and neighborhoods in Chicago decreased ranging from 41-73%.[14]

Not only do street outreach programs work, but they serve an important role of connecting and amplifying the work of other programs, such as hospital-based violence intervention programs. 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.[15]

Existing Street Outreach Programs in Connecticut

- COMPASS Youth Collaborative
- Connecticut VIP

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[13] https://pubmed.ncbi.nlm.nih.gov/21818029/

[14] https://cvg.org/wp-content/uploads/2021/09/Cure-Violence-Evidence-Summary.pdf

[15] https://static1.squarespace.com/static/566b074fbfe87338d2021874/t/5b3df65488251b5631c845a7/1530787437553/Brief_Two_HJA_V6.pdf

- Helping Young People Evolve (HYPE)
- RYASAP StreetSafe Bridgeport

Training and Technical Assistance Providers for Street Outreach

- Brother Carl Institute Intervener Training
- BDO-FMA, LLC (funded by the Dalio Foundation)
- Community-based Public Safety Collaborative
- Cure Violence Global

Group Violence Intervention

The Group Violence Intervention (GVI) Strategy is a law enforcement-based solution that focuses on identifying and intervening with *groups* of individuals at high-risk for violence. This model is often referred to by other names, such as "focused deterrence" or the "gun violence reduction strategy."

GVI operates under the framework that groups of individuals will not engage in violent behaviors when they perceive the costs as outweighing the benefits. Under this model, law enforcement identifies those at high-risk and offers a choice: benefits for nonviolence such as enhanced social services, but prompt legal interventions for any future acts of violence. Operationally, law enforcement must identify high-risk groups, conduct "call-ins" to convene these groups and communicate the choice, and to partner with multiple sectors in society such as social service providers and the faith community to deliver the benefits. In addition to reducing violence, GVI seeks to empower the community in deflecting criminal behavior, as well as improving police-community relationships.

The most effective modern GVI programs also include culturally responsive high-touch engagement with participants, sometimes referred to as intensive life coaching. This type of close peer mentorship is an element commonly seen in many CVI models, such as HVIPs, highlighting its importance for most survivors of violence.

Given the nature of GVI's work, model fidelity is of utmost importance. If programs aren't able to deliver the social services and support promised, this will erode the public's trust in law enforcement and limit success. Additionally, if legal interventions are disproportionate to the crimes committed, it can promote mass incarceration.

An evaluation of GVI in Oakland found a 46% reduction in homicides and 49% reduction in injury shootings.[16] Further, a systematic review of 24 quasi-experimental studies on focused deterrence reported a significant, moderate effect of crime reduction[17]. 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.[18]

[16] NICJR. (2019). Oakland's Successful Gun Violence Reduction Strategy. January 2018.

[17] Braga, A. et al. (2018). Focused Deterrence Strategies and Crime Control. Criminology and Public Policy. https://doi.org/10.1111/1745-9133.12353

[18] NCJRS. (2019). Assessing the Long-Term Impact of Focused Deterrence in New Orleans: A Documentation of Changes in Homicides and Firearm Recoveries. https://www.ncjrs.gov/pdffiles1/nij/grants/254130.pdf

Existing GVI Programs in Connecticut

- Project Longevity

Training and Technical Assistance Providers for GVI

- National Institute for Criminal Justice Reform
- National Network for Safe Communities

Targeted Trauma Informed Care (Roca, Chicago CRED, READI)

Individuals at-risk of violence commonly have a history of multiple prior traumatic experiences. Research shows that even before individuals become a victim of gun violence, over half had already experienced 3 or more physical or psychological traumatic experiences.[19] As a result, traumatic stress disorders, such as PTSD, are common. For this reason, psychological services by providers who understand the cultural perspectives of victims are critical in violence prevention.

The most well studied model of care to prevent violence is cognitive behavioral therapy. Cognitive behavioral therapy (CBT) is a common form of psychotherapy (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 post-traumatic stress disorder and anxiety disorder, and reducing maladaptive behaviors in response to anger.

CBT is based on the core principles that many psychological problems are often rooted in unhelpful ways of thinking and learned patterns of behavior. Underlying these factors 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.

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 control trials where CBT was implemented by non-profit organizations demonstrated a decrease in violent crime arrests by program participants by 45-50%.[20] Importantly, it has proven to be effective in multiple phases of the cycle of violence, including decreasing criminal activity, decreasing cannabis dependence, treating post-traumatic stress disorder and anxiety disorder, and reducing maladaptive behaviors in response to anger.[21]

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, hospital-based violence intervention programs can implement CBT similarly to traditional health programs, while other programs can utilize the treatment in the community.

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

[19] https://muse.jhu.edu/article/519258

[20] https://www.nber.org/papers/w21178

[21] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3584580/

engaging the young adults, police, and systems at the center of urban violence in relationships to address trauma, find hope, and drive change."[22]

To date, numerous programs have implemented CBT into CVI programs. In Chicago, two distinct programs, READI and CRED have been highly successful.[23][24] In Boston and Baltimore, Roca, Inc delivers similar programming.

Roca engages in what they describe as "relentless outreach" to provide services to extremely high-risk individuals. In practice, this means employing trained, credible messengers that engage potential clients with persistent engagement. Roca cites an average of ten "relentless efforts" for each patient enrolled. Importantly, this is simply an average, with a wide range of needs. For example, one client in Baltimore engaged in 112 efforts.

Throughout this process, individuals build transformative relationships with case workers. The end result is that each individual client averages 2-4 years of intensive case management. While engaging in this case management, Roca treats patients' trauma utilizing CBT. Importantly, it is delivered by trained outreach workers, so clients have enhanced access to psychological services beyond the offices of a psychologist or psychiatrist.

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.[25] 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 that looks upstream. Importantly 70% of participants remained employed for at least 6 months. Overall, 91% of young men engaged in employment, education, or life skills programs during their time in the program.[26]

In Connecticut, there are countless Black and Latinx therapists treating and supporting at-risk youth, young adults and their families with evidenced based clinical therapy including CBT. They have been on the front lines for decades as independent licensed clinical social workers, members of clinical group practices, and/or operating within such organizations as My People Clinical Services, A Mind's Journey, the Village for Families and Children, Clifford Beers, InterCommunity Mental Health, Wheeler Clinic, Community Health Resources, and many others throughout Connecticut. There are alternative therapies such as Equine Assisted Therapy offered by such organizations as the Ebony Horsewomen in Hartford. Historically, these organizations, especially the nimbler organizations of color, make themselves available during non-traditional hours, home clinical visits and weekends in neighborhoods where other providers might find it too risky to provide services.

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[22] https://rocainc.org/work/our-intervention-model/

[23] https://urbanlabs.uchicago.edu/attachments/cc07421f48cec7f43282377ffaf1223f7e079b46/store/eb7d1b4c96b0bf0bd7fbf212cd3deeccd1e075d8c7fdf61481b1a2cd4420/READI+Chicago.pdf

[24] https://www.ipr.northwestern.edu/documents/reports/ipr-n3-rapid-research-reports-cred-outreach-jan-22-2021.pdf

[25] https://rocainc.org/wp-content/uploads/2019/10/FY19_MA-Young-Men_Dashboard-FINAL_2019_10.08.pdf

[26] Ibid

The Hartford Communities that Care (HCTC) program of group and individual sessions is an example of CBT implementation in Connecticut. It demonstrated a significant return on investment (ROI). Based on wraparound services that HCTC provided for 82 young men in Hartford in 2017-18, a Social Capital Valuations analysis measured the short-term benefits and costs of this hospital-linked violence intervention program (HVIP) against long-term taxpayer benefits. The ROI, or net public benefit, encompassed a combined hospital plus Medicaid and taxpayer benefit of $3,464,211 at a cost of $290,976. This means there is a net gain to the hospital, Medicaid and taxpayers of $3,173,235. The benefit-cost ratio to these three groups is 11.9 to 1.

Existing Targeted Trauma-informed Care Programs in Connecticut

- Hartford Communities that Care “Becoming a Man Replication”
- Connecticut Center for Nonviolence
- Individual CBT providers
- Violent Crime Survivors (VCS)

Training and Technical Assistance Providers for Targeted Trauma-informed Care Programs

- Targeted Trauma-informed Care Programs

Survivor and Family Assistance

Trauma Recovery Centers (TRCs) care for survivors of multiple types of interpersonal violence, including both physical and sexual assaults.[27] The model itself 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 out of University of California San Francisco in 2001 and provides safety net services for survivors who otherwise had limited access to mental health and social services.[28]

The TRC model comprises 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

[27] http://traumarecoverycenter.org/wp-content/uploads/2020/01/TRCBrief-R3.pdf

[28] http://traumarecoverycenter.org/wp-content/uploads/2020/04/TRC-Manual.pdf

Although the TRC model is not specific to community violence, it has demonstrated success in caring for this patient population and is an important component of any system of comprehensive 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.[29]

A randomized controlled trial of the TRC model found benefits to patients among multiple domains.[30] Specifically, 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.

Importantly survivor assistance programs often utilize aspects of TRCs in their program structure, also incorporating Trauma informed care, and other aspects of the above programs. An example of this approach is the longstanding Mother United Against Violence CT organization.

Existing Survivor and Family Assistance Programs in Connecticut

- Mothers United Against Violence
- New Haven Police Department Office of Victim Services
- Violent Crime Survivors (VCS)
- You Are Not Alone

Training and Technical Assistance Providers for Survivor and Family Assistance Programs

- Alliance for Safety and Justice

Peace Fellowships

Peace Fellowships, such as the “Advance Peace” program in California, function by identifying individuals in a community who are at the very highest risk (and hardest to reach), and providing them with financial resources, personalized mentoring, and supportive relationships.[31] Specifically, the program focuses on young men previously involved in lethal firearm offenses. Individuals enter into 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. As such, it should be considered an evidence-informed program whose implementation should be paired with a robust evaluation. Still, studies to date show that approximately 80% of those who participate in

[29] Boccellari, A., Alvidrez, J., Shumway, M., Kelly, V., Merrill, G., Gelb, M., et al. (2007). Characteristics and psychosocial needs of victims of violent crime identified at a public-sector hospital: Data from a large clinical trial. General Hospital Psychiatry, 29, 236-243.

[30] Alvidrez, J., Shumway, M., Boccellari, A., Green, J. D., Kelly, V., & Merrill, G. (2008). Reduction of state victim compensation disparities in disadvantaged crime victims through active outreach and assistance: A randomized trial. American Journal of Public Health, 98, 882-888.

[31] https://www.advancepeace.org/

Advance Peace Fellowships report no new firearm-related injuries, charges, or arrests.[32] Although additional data is needed, it is an intervention that should be considered.

Existing Peace Fellowships in Connecticut

- None

Training and Technical Assistance Providers for Peace Fellowships

- Advance Peace

Place-Based Interventions and Firearm Safety Events

Although there are not clearly established place-based interventions to reduce gun violence within Connecticut, place-based interventions, including community gardens, green space additions/improvements, and building and sidewalk improvement have been shown to have impacts on decreasing gun violence when specifically used in neighborhoods with a history of community gun violence. A recent study showed a randomized-controlled intervention of building improvement that indicated reductions in crime in Philadelphia and ongoing efforts are under way in a similar program in New Orleans.[33] Importantly, these improvements in vacant lots could serve as catalyst events for multiple programs to come together to collaborate, and the impacts of these interventions could be longstanding.[34]

Existing Community Gardens in High-Risk Neighborhoods

- Hazel Street Community Garden (one among some 40 community gardens in New Haven)
- New Haven Botanical Garden of Healing
- The Little Red Hen Community Garden, Mead Street, New Haven

Efforts in Connecticut including the 2021 Statewide Firearm Safety and Gun Buyback Event as well as local municipal and individual police department buyback events (New Haven and Hamden) allowed many of the above groups to collaborate and raise awareness around firearm safety and community violence prevention.[35] [36] Organizations like Swords to Plowshares

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[32] National Council on Crime and Delinquency. (2015). Process Evaluation for the Office of Neighborhood Safety.

[33] South EC, MacDonald J, Reina V. Association Between Structural Housing Repairs for Low-Income Homeowners and Neighborhood Crime. JAMA Netw Open. 2021 Jul 1;4(7):e2117067. doi: 10.1001/jamanetworkopen.2021.17067. PMID: 34287632.

[34] Moyer R, MacDonald JM, Ridgeway G, Branas CC. Effect of Remediating Blighted Vacant Land on Shootings: A Citywide Cluster Randomized Trial. Am J Public Health. 2019 Jan;109(1):140-144. doi: 10.2105/AJPH.2018.304752. Epub 2018 Nov 29. PMID: 30496003; PMCID: PMC6301418.

[35] Violano P., Bonne S., Duncan T., Pappas P., Christmas AB., Dennis A., Goldberg S., Greene W., Hirsh M., Shillinglaw W., Robinson B., Crandall, M. Prevention of firearm injuries with gun safety devices and safe storage: An Eastern Association for the Surgery of Trauma systematic review. Journal of Trauma and Acute Care Surgery. 2018; 84(6):1003-1011. doi: 10.1097/TA.0000000000001879.

[36] Bonne, S., Violano, P., Duncan, T., Pappas, P., Baltazar, G., Dultz, L., Schroeder, M., Capella, J., Hirsch, M., Conrad-Schnetz, K., Rattan, R., Como, J., Jewell, S., Crandall, M., Prevention of Firearm Violence Through Specific Types of Community-Based Programming: An Eastern Association for The Surgery of Trauma Evidenced-Based Review. published online ahead of print, 2021 Mar 4]. Ann Surg. 2021; 10.1097/SLA.0000000000004837. doi:10.1097/SLA.

Northeast take firearms and make them into garden tools for green space initiatives. Similarly, community events that provide devices to promote safe firearm storage have proved effective.[37]

Existing Events in Connecticut

- Statewide Gun Buyback
- Swords to Plowshares Northeast
- Individual Police Department and Municipality Gun Buyback and Safety Lock Give Away Events (New Haven, Hamden)

Programs That May Have Detrimental Impact

An important part of selecting evidence-based programs is not just knowing which programs are effective, but also actively discouraging programs that don't work or may be potentially harmful. One such example is "Scared Straight" programs.

Scared Straight programs are typically designed with the intent to deter crime and criminal behavior by exposing at-risk children or youths to firsthand experience of correctional institutes. 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.[38]

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.[39] 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.[40]

Funding Mechanisms

Lack of funding is often one of the main barriers to launching or expanding any of the CVI programs described above. Fortunately, recent actions at the federal level have created multiple new sources of funding. This creates an unprecedented opportunity to develop CVI ecosystems to promote community safety.

It is important to note that expanded opportunities for funding do present logistical challenges. With many options available, different funding streams may be better fits for different programs. Additionally, grant application and reporting requirements can be a barrier for smaller programs, which would benefit from organizational support. For those reasons, the creation of local offices (commonly referred to as Offices of Neighborhood Safety) and state offices (State Violence Intervention and Prevention Programs) would be wise.

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[37] Rowhani-Rahbar A, Simonetti JA, Rivara FP. Effectiveness of Interventions to Promote Safe Firearm Storage. Epidemiol Rev. 2016;38(1):111-24. doi: 10.1093/epirev/mxv006. Epub 2016 Jan 13. PMID: 26769724.

[38] https://onlinelibrary.wiley.com/doi/pdf/10.4073/csr.2013.5

[39] https://pubmed.ncbi.nlm.nih.gov/23974377/

[40] https://injuryprevention.bmj.com/content/21/2/140

The American Rescue Plan

The American Rescue Plan (ARP) was signed into law by President Biden on March 12, 2021. Designed as an economic relief bill for the COVID-19 pandemic, the legislation infused $1.9 trillion in economic stimulus. Importantly, a large proportion of the funding is directed to state and local governments to respond to the public health emergency. These funds are to be distributed over the course of three years.

Given that the COVID-19 pandemic brought with it record levels of gun violence, the federal government deemed violence prevention efforts as allowable use of ARP funds.[41] In practice, this means that individual cities, counties, and state governments can each utilize funds for CVI programming. To date, over a billion dollars has been allocated for violence prevention efforts through the ARP.

Overall, the state of Connecticut received $4.35 billion in ARP funding. Of this, $2.6 billion was distributed to the state, with the remainder to cities and counties. Governor Lamont has pledged $3 million in CVI funding, but significant opportunity remains at the state, county, and local levels.

Congressional Community Project Funding

After being discontinued over the last decade, Congressional “Community Project Funds” (formerly known as earmarks) have returned. In this process, each member of Congress, in both House and Senate, is able to create a budgetary line-item for projects in their districts.

As of this writing, several dozen members of Congress have listed CVI programs as dedicated community projects, including those representing Connecticut. While the final budget has not yet been signed into law, the combined proposals from the House and Senate are approximately $40 million.[42]

Community Project funds represent a solid opportunity for start-up funding for CVI programs. For example, the funds could be well used for programmatic technical assistance to either start-up/expand or for training and certification for frontline violence intervention specialists. Since representatives are unlikely to use these funds for a single project in perpetuity, this mechanism should be thought of in tandem with other funding streams for long-term sustainability.

Federal Grant Programs

The Biden-Harris Community Violence Intervention plan included new, unprecedented access to 26 different federal grant programs.[43] These programs span a variety of sectors, including the Department of Justice, Department of Health and Human Services, Department of Housing and Urban Development, Department of Education, and Department of Labor. While most of the funding is competitive rather than exclusive to CVI programming, it amounts to billions of dollars in potential funding.

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[41] https://home.treasury.gov/policy-issues/coronavirus/assistance-for-state-local-and-tribal-governments/state-and-local-fiscal-recovery-funds

[42] https://appropriations.house.gov/transparency

[43] https://www.whitehouse.gov/briefing-room/statements-releases/2021/04/07/fact-sheet-more-details-on-the-biden-harris-administrations-investments-in-community-violence-interventions/

As would be expected with a large number of potential grants, each is tailored to different types of applicants. For example, some may be targeted to individual programs, others to municipalities, and others to researchers. This highlights the importance of the creation of coordinating structures, such as local Offices of Neighborhood Safety and state Violence Intervention and Prevention Programs, to ensure maximum utilization of the various funding streams as well as coordination.

Of the 26 opportunities, a few are worth discussing specifically. First, the Edward Byrne Memorial Justice Assistance Grant should be noted as one of the Department of Justice's largest programs for CVI work. In 2019, its annual budget was $264 million. Although the funding was historically spent by law enforcement agencies, the new guidance is clear that CVI programs are eligible applicants. Similarly, Project Safe Neighborhoods is also available through the DOJ, though with a significantly smaller budget.

The Victims of Crime Act (VOCA)

The Victims of Crime Act's Crime Victim Fund (CVF) is also worth discussing specifically. It provides money for both crime survivors as well as victim assistance providers. Importantly, the CVF is funded by money from fines and fees levied from criminal convictions rather than tax dollars. As a result, in 2020, it had a budget of approximately $2.3 billion.

In recent years, the CVF had been declining in total size as a result of decreased criminal prosecutions. This is expected to reverse after the passage of the "VOCA Fix to Sustain the Crime Victims Fund Act of 2021."[44] This new law is expected to increase the fund total by depositing penalties and fines from non-prosecution and deferred prosecution agreements in the CVF. In addition, the law provides states with significant flexibility in administering the funds by allowing VOCA administrators the option to provide no-cost extension to grant recipients, allowing the 20% match requirements to be waived, and allowing states the option to waive requirements that programs "promote victim cooperation with law enforcement."

These changes can be leveraged to launch and expand CVI programs in Connecticut. Connecticut's VOCA assistance block grant from the federal government grew from $5.3 million in 2014 to more than $20.4 million in 2017 and $36.4 million in 2018.[45] This provides a significant source of new funding for victim service providers in Connecticut. The state administering agency for VOCA in Connecticut, the Office of Victim Services, has dedicated some of this VOCA assistance funding to programs focusing on direct victim services for unserved/underserved victims of crime.

VOCA assistance funding presents an important opportunity to direct more resources to HVIPs that serve underserved gunshot victims at high risk of retaliation and reinjury. More and more state VOCA administrators are taking advantage of this opportunity and are specifically leveraging VOCA assistance grants to help scale up HVIPs. For example, both New Jersey and

[44] https://www.congress.gov/bill/117th-congress/house-bill/1652

[45] National Association of VOCA Assistance Administrators (NAVAA), Crime Victims Fund - State Victim Assistance Formula Grants, http://www.navaa.org/budget/18/VOCA%20Victim%20Assistance%20Grants.pdf.

Virginia utilized VOCA funding to launch state-wide networks of hospital-based violence intervention programs.[46, 47]

However, Connecticut has created only one community violence intervention VOCA grant program specific to HVIPs or gunshot victims: Hartford Communities That Care's HVIP, with Mothers United Against Violence as a partner.

Medicaid Reimbursement

Medicaid is the primary health insurer of the predominantly young, low-income males who experience community violence, paying for almost 40% of the cost for violent injuries treated in emergency departments.[48] As a result, Medicaid is financially responsible for medical costs associated with the nation's high levels of community violence. Given that the program is jointly financed by the state and federal governments, these costs directly impact Connecticut's budget.

As a program, Medicaid plays a critical role in the recovery of violently injured patients. Its coverage affords benefits not only to standard medical care, but also to a wide range of additional, targeted services to address the population's psychosocial and mental health needs. For this purpose, Medicaid can be a powerful tool to support CVI initiatives, particularly HVIPs, targeted trauma-informed care, and other models that utilize health-based approaches.

President Biden included Medicaid coverage for violence prevention services as part of his Community Violence Intervention plan.[49] These details were subsequently outlined in an April, 2021 webinar by the Centers for Medicare and Medicaid Services, which outlined a variety of mechanisms for states to provide Medicaid coverage for violence prevention-related services and supports.[50] Following this, Connecticut passed HB5677, "An Act Concerning the Availability of Community Violence Prevention Services Under Medicaid," which will enact reimbursement for community violence interventions. These provisions will go into effect in 2022.

HB5677 created a pathway for reimbursement by violence prevention professionals. It specifically covers services to address trauma-informed care, violence prevention strategies such as conflict mediation and retaliation, and case management practices. It also set training and certification requirements for eligible violence prevention professionals.

The statewide Connecticut HVIP Collaborative, with medical, policy, and frontline intervention team members, formed and received support from key lawmakers in 2020. In an information sharing process, the CT HVIP Collaborative led the charge for legislation regarding Medicaid reimbursement for these services, by briefing legislators, providing national best practice data, and gaining unanimous legislative support for the utilization of Medicaid funds for frontline violence intervenors. Connecticut should ensure this mechanism is available broadly to other service providers in the state. To accomplish this, direct outreach to ensure provider awareness

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[46] https://www.nj.gov/oag/oag/Report-to-the-Legislature-on-the-New-Jersey-Violence-Intervention-Program-Final-April-28-2021.pdf

[47] https://www.governor.virginia.gov/newsroom/all-releases/2019/may/headline-840545-en.html

[48] https://doi.org/10.1016/j.ajem.2018.03.070

[49] https://www.whitehouse.gov/briefing-room/statements-releases/2021/04/07/fact-sheet-more-details-on-the-biden-harris-administrations-investments-in-community-violence-interventions/

[50] https://www.medicaid.gov/state-resource-center/downloads/allstatecall-20210427.pdf

is critical. For some organizations, creating either the infrastructure or partnership for medical billing would be crucial. For others, training and technical assistance funding so frontline workers meet certification requirements may be needed.

The Build Back Better Act

A potential source of funding for CVI initiatives is President Biden's proposed "Build Back Better Act." The $1.7 trillion jobs and social safety net bill includes a $5 billion investment in community violence prevention and intervention. Unlike other sources of funding, this would be solely dedicated to CVI work. At present time, the dollars would be spread out over eight years, with half distributed through the Centers for Disease Control and Prevention and the other half through the Department of Justice.

As of this writing, the Build Back Better Act has passed the U.S. House and is awaiting consideration by the Senate. Most experts believe the CVI funding is likely to remain in the bill, though it cannot be assumed. The Senate has reported a goal of passing the bill before the end of the 2021 calendar year.

If passed, the $5 billion in funding will still require work by the administration for implementation. Under the Senate's Budget Reconciliation process, the funding must go through existing DOJ and HHS programs. However, the specific mechanism is yet to be determined. The bill language does indicate that the funding should go to areas disproportionately affected by community violence, for which several areas in Connecticut would qualify.

Recommendations

I. Emphasize the Implementation and Evaluation of Key Programs:

- **Violence Intervention:** Community and Hospital Programs built on established evidence-based frameworks, focused on directly intervening around interpersonal or group conflict and providing intensive case management services to victims or those at elevated risk of violence, as well as negotiating ceasefires and shifting neighborhood cultural norms.

  The programs must utilize a trauma-informed care framework and ensure those at high risk have access to mental health services, such as cognitive behavioral therapy. Examples include:

  - HVIPs (Hospital-based Violence Intervention Programs)
  - Violence Interruption Programs /Cure Violence
  - GVI (Group Violence Intervention)

- **Survivor Support Services:** Programs focused on providing social services and psychological support for survivors of gun violence, including the community at large.

II. Implement Effective Evidence-Based Programs:

- **Central Statewide and Citywide Offices or Centers of Violence Prevention.** It is clear that coordination between programs and services must be a core element of success. As much as possible, central systems of reporting outcomes and informatics should be created, including comprehensive evaluation services and shared resources specifically for community-based organizations on the frontlines.

- **Trauma-Informed Care.** This framework is for training program providers to engage victims and individuals at elevated risk of violence to improve long-term outcomes. It encourages providers to be knowledgeable about the widespread impact of trauma and treat accordingly.

  Many communities that have experienced high rates of community violence are distrustful of institutions like healthcare and criminal justice systems. Using a trauma-informed approach, violence prevention professionals are specially trained to break through this distrust and value “credible messengers” on their teams, who often come from the communities in which they work and thus can better engage program participants.

- **Place-Based Strategies and Coordinated Events.** Promising strategies on place-based interventions exist, including vacant lot and green space improvements, and these interventions hold the possibility of coordinated events for multiple programs to raise awareness around community violence prevention. Similarly, gun violence prevention statewide events can be used to leverage fundraising and coordination.

The Gun Violence Intervention and Prevention Advisory Committee

Report of the Policy and Funding Subcommittee

Background

Public Act 21-35/Senate Bill 1 declared racism to be a public health crisis. Section 9 of the Act established an Advisory Committee to advise the legislature's Public Health and Human Services committees on establishing a Commission on Gun Violence Intervention and Prevention to coordinate the funding and implementation of programs and strategies to reduce street-level gun violence in the state.

The Advisory Committee was tasked with the following:

1. Consult with community outreach organizations, victim service providers, community violence and gun violence victims and researchers, and public safety and law enforcement representatives on strategies to reduce these types of violence;
2. Identify effective, evidence-based community violence and gun violence reduction strategies;
3. Identify strategies to align state agency resources to reduce this violence;
4. Identify state, federal, and private funding opportunities for community violence and gun violence reduction initiatives; and
5. Develop a public health and community engagement strategy for the Commission on Gun Violence Intervention and Prevention.

The Problem

Gun violence is a public health crisis. According to the Giffords Law Center, "Gun violence is one of the most urgent public health crises of our time, with nearly 115,000 Americans killed or injured by bullets each year. Nowhere is this more evident than in historically underserved urban communities, many of which suffer from gun death rates that dwarf the national average."[1]

On average in CT, every day someone is shot with a gun, and every other day, someone is killed from gunfire. While Connecticut has the sixth lowest ***rate*** of gun deaths in the nation, we still have an unacceptable level of gun homicide. Gun homicide and injury disproportionately affect communities of color in our largest cities. Equality can't be achieved if people aren't safe in the communities where they live.

In Connecticut there were 105 gun homicides in 2020, and there were already 91 gun homicides as of October 2021. [2]

The CT cities are hit the hardest. Bridgeport, Hartford, and New Haven homicides account for 70% of the statewide total. New Haven saw a 58% increase in confirmed shots fired this year compared to 2020 (as of the beginning of November 2021).

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[1] I**nvesting in Intervention: The Critical Role of State-Level Support in Breaking the Cycle of Urban Gun Violence,** December 18, 2017, Giffords Law Center

[2] Source: CT Office of the Chief Medical Examiner

2020 saw sharp increases in smaller cities as well, especially in places like Waterbury, which saw a dramatic 500% increase in gun violence in 2020 FN?.

In 2019 the leading cause of violence related injury for teens and adults, ages 15-34, was firearm homicide, according to the Centers for Disease Control and Prevention (CDC).

The Burden of Gun Violence in Connecticut Falls Disproportionately On Communities of Color

Gun violence in Connecticut disproportionately takes the lives of Black Americans; approximately 56 percent of the state's gun homicide victims are Black, five times the proportion who live here. Young Black men are profoundly vulnerable, killed by guns at 39 times the rate that young white men are. Nationally, Black males fall victim to firearm homicides nearly 17 times higher than White males. Latinx communities are also deeply impacted. While Latinx make up close to 14 percent of the state's population, they account for approximately 23 percent of gun homicide victims in the state.[3]

To achieve racial equity, preventing community gun violence must be part of the discussion. Equality cannot be achieved if everyone isn't safe in the communities where they live, regardless of where that is. Sadly, this is not the case in Connecticut.

Gun Violence is Local and Focused

Gun Violence has statewide impact but is very local in nature. Most street-level gun violence exists primarily within cities and confined to specific neighborhoods. These neighborhoods are typically in lower income areas where resources and opportunities are scarce. Furthermore, violence is generally perpetrated by a small high-risk group of individuals. 40% of those shot is killed or injured again within 5 years[4]. Some violence reduction strategies need to be addressing quality-of-life issues.

The Cost of Gun Violence

Beyond the loss of life, gun violence has a tremendous economic cost. It is estimated that the total direct cost to Connecticut taxpayers of all forms of gun violence is $90 million per year. The tangible costs, including lost income, is estimated at $430 million annually, and the societal cost brings the total to $1.2 billion each year. Nationwide, evidence-based and evidence-informed, community-centric prevention and intervention programs have proven records of success.[5]

Identifying the Solution

States, towns, and cities across the country are investing in community-based, community-centric solutions reducing gun violence, and are demonstrating that these approaches work. These strategies are focusing on reducing gun violence not only with violence intervention, but also prevention and aftercare.

Through a combination of legislative and executive action, states across the country are investing in the executive branch infrastructure to fund, implement, support and oversee

[3] Center for Disease Control and Prevention, National Center for Health Statistics 2017 CDC. National Center for Injury Prevention and Control, Web-based Injury Statistics Query and Reporting System (WISQARS) Nonfatal Injury Reports. (link)
[4] Community Justice Action Fund, Policy and Advocacy Update 2021
[5] US Congress, Joint Economic Committee: A State-By State Examination of Economic Cost of Gun Violence, September 18, 2019

community-based violence prevention programs. These include California, Colorado, Illinois, Massachusetts, Maryland, New Jersey, Pennsylvania, Wisconsin and Virginia. Cities around the country have also established Offices of Gun Violence Prevention, although mostly where populations are substantially larger than even Connecticut's largest cities.

National experts including the Giffords Law Center, the PICO National Network, and the Community Justice Reform Coalition identify six key elements that should be present in any state plan to invest in urban gun violence prevention and intervention programs:

- Focus on High-Risk People and Places
- Implement Evidence-Based Strategies
- Provide Robust State-Level Coordination
- Conduct Regular Program Evaluations
- Commit to Long-Term, Stable Funding
- Facilitate Community Input and Engagement

The establishment of a Commission on Gun Violence Intervention and Prevention, a state-level grant-making authority tasked with funding and implementing evidence-informed, community-centric, programs and strategies to reduce street-level gun violence, could provide the necessary coordination, funding, and comprehensive strategic planning to greatly reduce gun violence in CT.

Recommendation: Elements of the Commission

Establish a state-level grant-making authority, the Commission on Gun Violence Intervention and Prevention, to:

- Determine community-level needs by engaging with community.
- Secure state, federal, and other monies to provide stable funding.
- Establish grant criteria, award grants, guide implementation, offer technical expertise, and monitor outcomes.
- Identify, study, and assess the efficacy of potential community-based programs.
- Be staffed with dedicated resources and multi-disciplinary expertise, stable, dedicated budget-line funding.
- Receive support from an Advisory Council composed of community stakeholders, public policy experts, GVP organizations and others with stake in health of CT's urban centers.

The Commission would have dedicated staff with multi-disciplinary expertise who would bring the attention needed to address the magnitude of Connecticut's community violence problem. Among its primary responsibilities, the Commission would secure state, federal, and other monies to provide stable and predictable funding to support violence prevention and intervention programs. It would establish grant criteria, award grants, guide implementation, offer technical expertise, and monitor programs to ensure objectives are met.

Support of Evidence Based and Evidence Informed Strategies

Sustained funding and support of community-centric strategies have been proven to work across the country and in CT. The State of Connecticut often provides violence prevention and

intervention services to disproportionately indigent populations. Many victims of violence are injured and return for care to trauma center and other services with greater injuries. These physical and mental injuries are difficult to treat and can have a ripple effect throughout the community. Evidence-informed solutions that could be effective in reducing gun violence fall into three main categories: Prevention, Intervention and Aftercare.

1. **Prevention:** committed to stopping violence before it begins (primary prevention efforts). Prevention efforts work to:
    - Monitor violence-related behaviors, injuries, and deaths.
    - Conduct research on the factors that put people at risk for or protect them from violence.
    - Provide programs and services that address mental health needs, targeted youth development programs aimed at serving the population at risk for violence, and employment programs targeting the population at risk for violence.
2. **Intervention**: Community, cognitive-behavioral intervention and hospital programs that are focused on directly intervening in incidents of violence, negotiation ceasefires or safe zones in communities, and shifting community mindsets around violence.
    - *Community Violence Intervention (CVI):* Street-level violence interrupters/intervention is data-driven and utilizes multiple sources of information that are critical to street outreach workers. Data from Police, hospitals with support from the city are critical to connect the community to the institutions designed to serve them. Services include providing conflict mediation to the highest risk individuals, utilizing well-respected community members (credible messengers) with ties to the community to mobilize and create trust with the people, and collaboration with law enforcement. This approach de-escalates violence and provide conflict resolution in group or individual settings. It also provides intensive case management to those impacted by violence. Case management efforts may target drivers of violence.
    - *Cognitive-Behavioral Intervention:* Programs focused on changing mindsets. Designed to help people examine the relationship between their thoughts, emotions, and behaviors. The ultimate goal is to provide skill so people can pause to gather information, emotions, or plan next steps that will lead to better outcomes. The mindfulness and tangible skills acquired for this practice improves mental health and improves lifestyles for those engaged in violence. Services may include training, employment, and counseling.
    - *Hospital-based violence intervention programs (HVIPs):* HVIPs are multidisciplinary programs that identify patients at risk of repeat violent injury and link them with hospital- and community-based resources aimed at addressing underlying risk factors for violence. HVIPs are multidisciplinary programs that combine the efforts of medical staff with trusted community-based partners to provide safety planning, services, and trauma-informed care to violently injured people, many of whom are boys and men of color.
    - *Group Violence Intervention:* In Connecticut, one example comes from Project Longevity, the group violence intervention (GVI) strategy (also known in other States as “Operation Ceasefire) that has led to reduced gun violence rates where the

program operates. A 2015 Yale study concluded that the program was associated with a monthly reduction of five group-member involved shootings and homicides. Project Longevity uses a strategy that has shown violence can be reduced dramatically when community members and law enforcement join together to directly engage with groups and clearly communicate a community message against violence, a law enforcement message about the consequences of further violence and an offer to help for those who want it. To accomplish this, law enforcement, social service providers, and community members are recruited, assembled and trained to engage in a sustained relationship with violent groups.

3. **Aftercare:** Aftercare Services are available to victim/survivors and their families. Services and programs are focused on providing social services and medical care. Social services can include peer or pastoral counseling services, funeral services for the families, as well as employment and housing support. Medical care services could include aftercare for mental and physical health needs resulting from a violent incident. Services for survivors are essential as well as including survivors in the creation of public policy and legislation.

    - *Trauma Centers:* Services offered by trauma recovery centers include trauma-informed clinical case management; evidence-based individual, group and family psychotherapy; crisis intervention; medication management; legal advocacy and assistance in filing police reports and accessing victim compensation funds; and are offered at no cost to the patient. These types of comprehensive services and assistance are intended to help people who have experienced violent crime, including patients who suffered gunshot wounds, as well as victims of sexual assault, domestic violence, human trafficking, and hate crimes, and those who had a family member assaulted or killed. To provide this breadth of services, trauma recovery centers utilize multidisciplinary staff members that might include psychiatrists, psychologists, social workers and outreach workers.
    - The use of aftercare and discharge models that form an alliance between the trauma center and social service providers in the community. Nontraditional interventions will require the collaboration with hospital departments (emergency medicine, surgery, trauma, social work) and outside agencies, such as the courts and probation and parole. Case management, discharge planning, continuous care treatment teams, and violence intervention models offer positive alternatives to the current method of addressing the multiple problems of victims of violence who frequent the Emergency Department.

The case for action is strong. Around the nation, various program models have proven track records of reducing interpersonal gun violence, including hospital-based violence intervention, violence interrupters and group violence intervention. The challenge in Connecticut, however, has been securing adequate and stable funding for these programs, and ensuring that a comprehensive portfolio of solutions is deployed, including prevention, intervention and after-care. To date, the state has focused most of its efforts on Project Longevity, the law enforcement-led group violence intervention strategy that works to steer individuals at highest risk of gun violence away from further acts of violent crime.

Law enforcement has a critical role in gun violence prevention and intervention. But in addition to the Project Longevity focused-deterrence strategy, and enforcement of our state’s strong gun

laws, Connecticut needs to invest in a comprehensive portfolio of solutions that goes beyond policing.

There are a large number of crisis intervention and prevention programs that have the potential to reduce community violence. Having a standing grant-making capability to identify and assess the efficacy of these programs, secure funding, and ensure goals are being met is needed to address the unacceptable levels of violence in our urban communities.

Additionally, the Commission should develop an objective grant criteria to support evidence-informed solutions as well. There are many innovative approaches to reducing gun violence, however every community is different, and reduction strategies must be tailored specifically to those communities most affected, with the assistance of the communities. The Commission would also develop appropriate metrics to measure success, while still maintaining objectivity and accountability.

Technical Assistance and Research

Many community-based organizations that are also doing prevention, intervention, and aftercare services in communities do not have the staffing or resources to access State and federal level funding streams. Assistance should be made available to organizations to assist with grant applications as well as developing a strategy for appropriate evaluation for continued success of funded organizations. Appropriate metrics need to be developed to measure success and to ensure that funded groups are effective. A research arm of the commission would be critical to help identify the root causes of gun violence, the location of the violence and available services, as well as study the effect of funding choices made by the commission. Such research and data should be made publicly available.

Future Advisory Council

Under current legislation the Advisory Committee that was established as part of SB1 will be terminated by operation of law. However, an Advisory Council, similar in scope and membership, should be established to provide important guidance for the Commission. The State should commit to fortifying and sustaining the Commission's ability to engage regularly with the providers and recipients of violence prevention services by maintaining an advisory committee to support the work of the Commission. This future Advisory Council should comprise community stakeholders, public policy experts, researchers, GVP organizations and others with stake in health of CT's urban centers. The State cannot address community level gun violence without the community at its center.

State Coordination

There is a broad array of state executive and judicial agencies, commissions, and offices that have a role in gun violence intervention and prevention, along with individuals, providers, and various other stakeholders.

The State should determine and implement the most expedient vehicle to consolidate existing advisory and oversight authority in order to advance development of a seamless, coordinated, and integrated approach to violence intervention and prevention.

Achieving an optimal system that addresses the needs of all of Connecticut's people will require efficient delivery of a comprehensive array of effective services and the maximizing of all available government and commercial resources.

Other States (And Cities) That Have Adopted Similar Programs to Address Community Violence

CT has led the way on gun violence prevention legislation and has been a model for the rest of the nation. However, compared to at least seven other states, coordination is one area where CT lags the rest of the nation:

Illinois. In November 2021, Illinois Gov. Pritzker signed an executive order declaring gun violence a public health crisis and committed $250 million to "directly reduce and interrupt violence in our neighborhoods." The order further funds the Reimagine Public Safety plan, a data-driven and community-based violence prevention strategy, and creates a new Office of Firearm Violence Prevention, which will give technical assistance, training and policy recommendations to Illinois communities with the highest rates of gun violence.

Colorado. In June 2021, Colorado Gov. Polis signed a bill creating an Office of Gun Violence Prevention, tasked with gun violence prevention education, establishing a grant program to fund community-based prevention programs and coordinating data collection and research. The Office is housed in the Dept of Public Health and Environment, with an executive director and at least two full-time staff. Its first-year appropriation is $3 million.

California. In 2019 the California Violence Intervention and Prevention (CalVIP) Grant Program was established by the legislature to appropriate $30 million to cities and community-based organizations with the purpose of reducing homicide, shootings and aggravated assault through evidence-based initiatives.

Massachusetts. The Safe and Successful Youth Initiative (SSYI) is a standing program to fund ongoing efforts that focus on reducing violence among high-risk youth. Funding has ranged from $4.5 million to $11.4 million since it began in 2012. Cities where SSYI funded programs operate have seen a reduction of more than 5 violent crime victims per 100,000 residents, representing nearly 1,000 victimizations prevented over a three-year period from 2011-2013.

New Jersey. The governor signed into law a Violence Intervention Program in 2020, and the state since as awarded $20 million in multi-year grant funding to nine hospital-based violence intervention programs.

Virginia. Also in 2020, the General Assembly established the Virginia Gun Violence Intervention and Prevention Fund to make grants to support evidence-informed gun violence intervention and prevention efforts. Gov. Northam proposed and the legislature approved $2.6 million in funding for the 2021-22 biennial budget.

Maryland. In 2018 the legislature established the Maryland Violence Intervention and Prevention Program (VIPP) with $4 million of seed money. In consultation with the VIPP Advisory Board, the Governor's Office of Crime Control and Prevention administers the program to provide competitive grants to local governments and nonprofit organizations to fund evidence-based health programs or evidence-informed health programs.

Funding the Commission

Connecticut is well positioned to benefit from substantial increases in federal appropriations and grant funding to all states. It is important that Connecticut secures its fair share of federal grants, appropriations, and other sources of funding. Maximizing Connecticut's share of federal funding should not be an ad hoc endeavor; it requires dedicated staff to identify opportunities and secure grants. A Commission on Gun Violence Intervention and Prevention will enable our state

to direct its focus to securing available federal funds to more effectively operationalize, implement, and sustain our state's gun violence intervention and prevention efforts.

In his request for FY2022 discretionary funding, the President asked Congress for $200 million for local implementation of community violence intervention (CVI) programs. His administration also directed five agencies to prioritize CVI grants across 26 different federal funding streams, and the Build Back Better Act calls for $5 billion over eight years, a level that policy advocates believe will be maintained in the scaled back package, having passed the House and anticipated to be voted on in the Senate before the beginning of 2022.

To assist localities, Congress enacted and the President signed into law the American Rescue Plan Act (ARPA), authorizing $130 billion in funding for local governments to counter the economic toll of the COVID-19 pandemic. ARPA allows states and local governments to spend relief funds (a) in response to COVID-19 and its negative economic impacts, including support to nonprofit organizations, and (b) for costs related to premium pay for essential workers during COVID-19. Local governments can utilize ARPA funds to prevent or address gun violence in cities because increased gun violence and the need for expanded violence intervention programs can be traced to the impact of the pandemic, and violence intervention professionals are performing essential frontline work to protect the public and interrupt gun violence.[6]

With the potential for this level of funding from the federal government, there needs to be a well-established and objective strategy for utilizing these funds cost effectively. As mentioned above, a Commission would ensure that Federal money was utilized responsibly and most productively, provided such Commission is sufficiently staffed.

The Commission could be funded in a variety of ways:

- ***Operate within Existing Appropriations:*** In some instances, the costs of administering a commission, including capital, operations, and staff, may be absorbed within existing appropriations to a state agency (e.g., OPM Criminal Justice and Planning Division). One such possibility is to provide the Department of Public Health's Office of Injury Prevention with the resources it requires to fulfill the mandate it was given when established by statute in 1993. Its duties include developing sources of funding to establish and maintain programs to prevent interpersonal violence, including homicide. The defined scope of "injury prevention" clearly includes gun violence even though the term "gun" is not in the statutory language.

  Municipal health departments could also be empowered to assist with the administration of grants as well as to support the establishment of municipal Offices of Gun Violence Prevention, such as New Haven's brand-new Office of Violence Prevention.

- ***Reallocate Existing Unexpended Appropriations:*** As an interim measure, the state could opt to reallocate existing unexpended appropriations to sustain the Commission before such appropriations lapse.

- ***Create Specific Allocations for Gun Violence Prevention:*** The state could include specific line items in the General Fund budget, issue bonds, or establish specific uses of certain tax revenue to sustain violence prevention efforts.

[6] Everytown Research and Policy Fact Sheet: ARPA for Gun Violence Reduction 4.5.21

- *Use Federal Funds to Sustain the Commission:* The following federal funds offer potential long term solutions for funding the Commission and other activities at both the state and municipal level:
    - **Build Back Better Act**: $5 billion proposed to be dedicated to Community Violence Intervention (CVI) Strategies.
    - **Break The Cycle of Violence Act**: $6.5 billion dedicated to CVI Strategies.
    - **2022 Federal Budget:** $229 million dedicated to CVI Strategies.
    - **Congressional Earmarks:** Members of Congress may fund community projects – $21 million requested for CVI.

State-Level Grant Funding Options

In addition to the aforementioned funding sources, there are additional federal funding sources including 26 Federal Grant Sources that were identified by the Biden Administration. Some of those funding sources include:

- ***Byrne Justice Assistance Grant*** (Byrne JAG).
- ***Victims of Crime Act (VOCA)*** – All 50 states have compensation programs designed to provide direct reimbursement to individual crime survivors and their families. Most state compensation programs have similar eligibility requirements and offer comparable types of benefits. Through VOCA's state crime victim compensation program, the Office for Victims of Crime uses a set mathematical formula to determine the size of award funding for these state-level programs. Victim compensation can play a critical role in helping to break cycles of interpersonal violence. VOCA assistance grants may be used to fund services for crime survivors that respond to their immediate emotional, psychological, and physical needs, including assisting survivors with stabilizing their lives, facilitating survivor participation in the criminal justice system, helping survivors access victim compensation, connecting them with mental health services, and working to help restore their sense of security and safety.[7] VOCA has been expanded this year and might be a resource for CVI and Aftercare strategies.
- ***Project Safe Neighborhood Grants*** – The Department of Justice will make clear to all judicial districts that they can support CVI programs through Project Safe Neighborhoods (PSN) funding and technical assistance. PSN is designed to make neighborhoods safer through a sustained reduction in violent crime. PSN is a GVI strategy similar to Project Longevity. The solicitation was posted May 3, 2021.
- ***Medicaid*** – In 2021, the Connecticut General Assembly enacted Public Act 21-36 which made community violence intervention and prevention services eligible for Medicaid reimbursement. It is important to note that no current appropriation for violence prevention services was included in the biennial budget approved by the General Assembly in 2021. The state is presently engaged in pre-launch tasks, including the establishment of a certification process by the Department of Public Health (DPH), and the definition of the Medicaid benefit and creation of data and measures for outcomes and assessment by the Department of Social Services (DSS). We look forward to the

[7] Source: Giffords Law Center

implementation of a Medicaid covered benefit for these services, to establishing a rate of reimbursement that at the very least, covers the costs of providing these services.

Targeted state grants to groups within a community identified at the highest risk of perpetrating or being victimized by violence should also be maintained (i.e., GVI/Project Longevity Funding). Also, the establishment of a competitive state grant program for municipalities disproportionately impacted by violence could similarly be created.

Finally, the General Assembly should enact legislation to establish this Commission to demonstrate its commitment to addressing the public health crisis of gun violence.

Respectfully Submitted by the Subcommittee Co-Chairpersons:

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CT AGAINST GUN VIOLENCE

CARL SCHIESSL
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December 2021

The Gun Violence Intervention and Prevention Advisory Committee

Report of the Subcommittee on Community Engagement & Public Health

Introduction

The Gun Violence Intervention and Prevention Advisory Committee was established to advise the Connecticut General Assembly on the funding and implementation of programs and strategies to reduce gun violence. In specific, the Advisory Committee's purpose is to advise the legislature's Public Health and Human Services joint standing committees on establishing a Commission to coordinate the funding and implementation of evidence-based, community-centered programs and strategies to reduce street level gun violence in the state.

The act requires the Committee to report findings and recommendations to the Public Health and Human Services committees by January 1, 2022.

The Advisory Committee received five charges, which it regards as mandates:

1. Consult with community outreach organizations, victim service providers, community violence and gun violence victims and researchers, and public safety and law enforcement representatives on strategies to reduce these types of violence;
2. Identify effective, evidence-based community violence and gun violence reduction strategies;
3. Identify strategies to align state agency resources to reduce this violence;
4. Identify state, federal, and private funding opportunities for community violence and gun violence reduction initiatives; and
5. Develop a public health and community engagement strategy for the Commission on Gun Violence Intervention and Prevention.

The Community Engagement and Public Health Subcommittee's primary goal concerns mandate Number 5: to develop a public health and community engagement strategy for the Commission on Gun Violence Intervention and Prevention. Our aim in this report is to help create an infrastructure to include the community in an inclusive and equitable manner to develop a successful gun violence prevention and intervention strategy. We also were charged with identifying organizations and individuals doing the work in the communities across Connecticut and inviting the partners to be a part of a public hearing to provide their testimony to become a part of the final record and to be incorporated into the final report. Polls show that America is ready for a new approach, and legislators at the congressional and state levels are embarking upon new ways to begin to include the public.

The full Advisory Committee met four times from the beginning of November through December 2021 and held a public hearing on November 17, 2021. The intent of the public hearing was to demonstrate the importance and urgency of incorporating the agencies and individuals doing the work and bringing forward their passion and the nuts and bolts perspectives on the work. This effort will also help produce better outcomes and results.

Recommendations

After weighing the homicide data presented from the Connecticut Violent Death Reporting System and hearing testimony from law enforcement officials, clergy, surviving victims of gun violence, and loved ones left behind by violence, the Community Engagement and Public Health

Subcommittee recommends as feasible and actionable the creation of a standing Commission to address gun violence intervention and prevention. Specifically, our committee recommends the following:

1. The Commission should include but not be limited to representation from State agencies such as Public Health, Education, Children & Family Services, Environmental Protection, Public Safety, Juvenile Justice, Housing, and Economic and Community Development. For example, the Department of Children & Family Services can have a direct impact on why young people may engage in specific behavior which could lead into violence based upon a lack of family structure which is consistent with a deteriorated sense of family. This assessment is based upon the dysfunction of the home, lack of parental guidance, and one-person households, not a typical family makeup. Historically, the Department of Education has taken a hands-off approach and has relied on the local school boards to make decisions and to provide the direct input in creating any remedies which they find necessary to address issues. In this instance the committee understands the value of the input and how more resources and support from the Department of Education can better serve the situation.

2. The Commission should draw upon best practice and technical guidance as appropriate to develop a comprehensive strategy to deal with the problem of serious, violent, and chronic juvenile delinquency. One sample approach is from the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention (OJJDP, 2020). Risk-focused prevention is a major component of such strategies. In the OJJDP example, the outline of key risk factors covers four areas – community, family, school, and individual/peer – described in more detail below. We recommend that such protective factors (strengths, assets) in our community be incorporated into our violence prevention strategies as well.

3. The Community Engagement and Public Health Subcommittee chairs should be standing members of the Commission.

4. The Commission's effort should focus on the following objectives:
    a. Maximize efforts and resources to effectively reduce the level of risks and increase the protective factors in the community.
    b. Provide concrete data and information trends to inform decision making and benchmark progress.
    c. Strengthen the ability to track crime prevention program effectiveness.
    d. Promote the process of institutionalizing prevention in the community.
    e. Place the responsibility for health and behavior problems on identifiable risk factors, not on people.
    f. incorporate strength-based practices designed to empower our youth and develop local solutions.
    g. Identify and review systemic impediments which our youth face on a day-to-day basis that are root causes of violence[1]. Specifically, address the systemic

[1] A recent Washington Post ABC poll showed that while concern about crime is rising, Americans want solutions outside of policing. In fact, 75% of all US adults believe that increasing funding for poor communities can effectively reduce crime.

community risk factors which have caused racial disparities in the juvenile justice system for Black and Brown youth.

h. Research and identify the geographical areas which are most impacted by gun violence and conduct asset mapping within these communities.

5. The Community Engagement platform should focus on several elements which will embrace several community engagement strategies. This will involve consulting, collaborating and empowerment of people from communities through their active participation with the Commission.
    a. The focus should include both participation at the highest level and the grassroots “boots on the ground “level. In order for this commission to be effective in the work which it is charged to do, it has to be inclusive from the bottom up. Make certain that representatives from the community are at the table when decisions are being made about crime prevention by the government and other institutions.
    b. Identify key community-based organizations and individuals involved in violence prevention work to be part of round table discussions, and work groups to provide their recommendations to public health and other agencies on how to prevent gun violence. Involve the community proactively in developing crime prevention strategies versus only engaging them after the violence has occurred.
6. Make resources available (consolation and mental health services) for families of homicide victims, perhaps consider having the lead law enforcement authority call 211 mobile crisis to the scene of the incident.
7. Ensure that communities experiencing violence and trauma have sufficient advocates/mentors/ leaders, such as social workers, to help communities navigate the services, victim services, and mental health services available to them.

Community Risk and Protective Factors

Selection of the Communities to be Assessed

The selection of communities assessed is based on risk factors in different communities within Connecticut impacted by gun violence/violence.

Risk Factors

The community, school family and individual/peer group risk factors for each community will be summarized, analyzed, and discussed as part of a community engagement effort. The indicators of each risk factor will be discussed across each community. Presenting the information in this manner will allow one to see the range in the level of risk associated with each factor across the communities and at times the State, and then later to get a clear picture of each individual community. According to the Justice Department’s Office of Juvenile Justice and Delinquency Program (2020), there are risk factors in each community that are predictors of substance abuse, delinquency, teenage pregnancy, school dropout, and violence.

The subcommittee’s analysis of risk and protective factors, respectively, trained attention on the community, family, school, and individual-peer levels, noting that numerous models advance comprehensive strategies for preventing community violence. Whether drawing upon the risk factor rubric of the OJJDP, that from the Centers for Disease Control, or those advanced by

such expert practitioners as author Thomas Abt in his book, *Bleeding Out*, it is clear that weighing the data-driven risk factors facing each community is crucial to effective prevention.

At the same time, the full Advisory Committee has cautioned, there is no single set of one-size-fits-all risk factors. Instead, each community's risks will vary.

The need to fully understand the unique risk factors present in each locale is one of the best reasons to ensure genuine neighborhood and community engagement in violence prevention.

OJJDP's **Community Risk Factors**, which are not rank ordered, include:

- Extreme economic deprivation
- Availability of firearms
- Availability of drugs
- Community laws and norms favorable toward drug use, firearms, and crime
- Medial portrayals of violence
- Transitions and mobility
- Low neighborhood attachment and community organization
- Poor community police relations

Family Risk Factors include:

- Family history of trauma
- Family strain due to lack of resources
- Homelessness
- Domestic violence
- Exposure to lead in the household
- DCF involvement
- Favorable parental attitudes and involvement in problem behavior(s)

School Risk Factors include:

- High proportion of students who qualify for free school lunch
- Lack of diversity in teachers and school administration
- Lack of resources in school (inadequate funding)
- High rates of out-of-school suspensions and expulsions
- Unsafe school climate
- High student to teacher ratio
- Prevalence of bullying in school

Individual/Peer Risk Factors include:

- Truancy
- Unaddressed trauma/including PTSD and complex trauma
- Early and persistent antisocial behavior
- School suspensions
- Rebelliousness
- Low literacy

- Friends who engage in problem behavior(s)
- Favorable attitudes toward problem behavior(s)
- Early initiation of problem behavior(s)
- high adverse childhood experiences (ACE's)

Protective Factors

We recommend also that strategies focus on strengthening protective factors in violence prevention, including civic engagement, gainful employment, school engagement, high educational attainment, prosocial norms, genuine commitment to race equity, inclusion principles and practices within institutions, and safe and stable housing.

Individual Protective Factors include:

- Resilient temperament
- Intolerant attitude toward deviance
- Good-natured
- High IQ or high-grade point average
- Positive social orientation; enjoyment of social interactions
- Religiosity
- Female gender (even with same risk factors, girls are less likely than boys to become violent)

Family Protective Factors include:

- Connectedness to family or adults outside of the family
- Adults who behave as role models for children, who solve problems without violence
- Adults who set clear standards for behavior and by showing the benefits and consequences of behavior
- Ability to discuss problems with parents
- Perceived parental expectations about school performance are high
- Frequent shared activities with parents
- Consistent presence of parent during at least one of the following: when awakening, when arriving home from school, at evening mealtime, and when going to bed; " Involvement in social activities

School Protective Factors include:

- Counseling and Mediation
- After social activities
- Youth engagement in school safety planning
- Violence prevention coordinators/specialists in school
- Low rates of out of school suspensions and expulsions
- Equity, diversity and inclusion in teacher recruitment and retention, and in school administration
- Efforts to identify and support students who are habitually truant with counseling, mentoring, tutoring, mental health screening and other systems of care
- Parent engagement
- Healthy & safe school environment

Community Engagement and Partnership

Active participation by community organizations, businesses and individual members is needed for the development and delivery of services in their community.

Public and Community Engagement Best Practices

1. Engage a wide variety of community businesses and organizations including culturally specific resources, about the work of the agency and create ongoing partnerships
2. Build networks to ensure funding, recruit volunteers, and sustain other types of community support.
3. Enhance public safety and efficiency of services through input and commitment from community partners to ensure a continuum of support for victims.
4. Ensure clarity of roles and responsibilities in joint efforts on behalf of victim
5. Develop partnerships that establish the program as a valued and essential victim services resource that positively affect the quality of life for the community.
6. Present evaluation data to the community to promote services and gain support.
7. Be transparent about the scope of program services when communicating with the public.

Public Engagement Platform Strategies

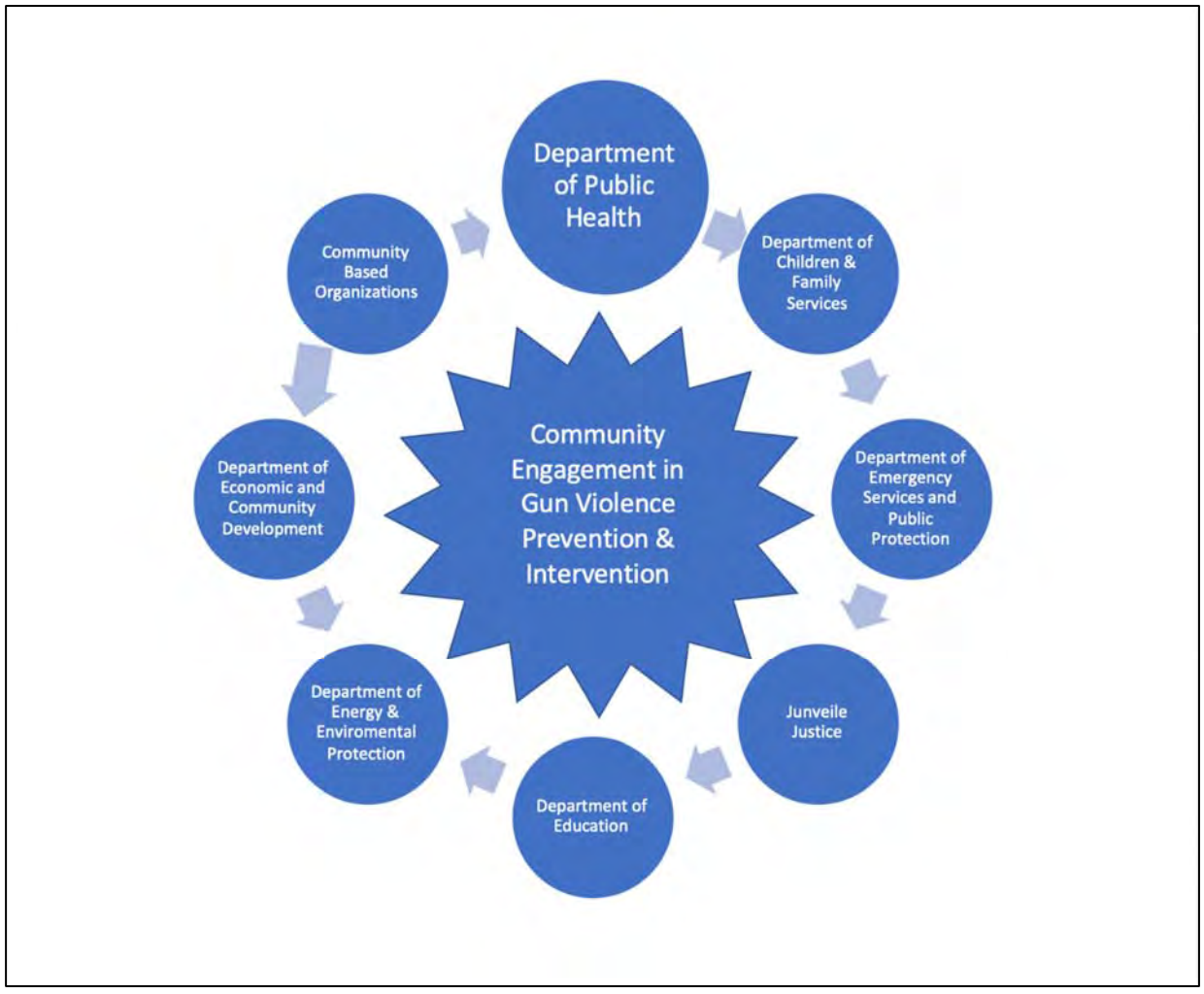
1. **Listening Sessions and Polling:** For example, to inform our legislative agenda, we could convene “listening sessions” across Connecticut inviting community members from the towns/cities most impacted by gun violence. These can be conducted through face-to-face convenings with COVID restrictions in place, as well as online. If conducted online, participants can be provided an introduction, then be assigned to break out rooms to discuss the issues they see as most important when thinking of violence prevention through a public health lens. Breakout groups can present a summary to the whole group and also take part in a brief electronic poll to mark their top three priorities among all topics discussed. These results from the poll highlight topics most frequently discussed across all listening sessions and allow participants to weigh in on setting priorities/strategies in their communities.
2. **Focus Groups:** Focus groups provide another hands-on approach which allows the community participants to be included. This method can engage participants who may feel more comfortable talking in person in small groups and can go more in depth in specific areas of interest.
3. **Door to Door/ Neighbor to Neighbor Outreach and Polling:** This is an effort to engage with members of the community who might not attend community meetings or events. Additionally, this approach allows the Commission to learn more about residents’ concerns, advertise meetings, introduce the Commission to the community, and poll residents.
4. **Charrette Work Improvement Protocol:** The community is involved in work improvement processes, with neighborhood revitalization groups based upon specific regions or locations, at this link:

https://ncs.uchicago.edu/sites/ncs.uchicago.edu/files/uploads/tools/NCS_PS_Toolkit_BST_Set_C_CharretteProtocol.pdf

Final Comments

Identification of organizations which have an impact on success in eliminating gun violence in the urban communities is critical to the success of this work. The criminal justice system is financially and ethically untenable, plagued by the unsustainable cost of incarceration, high recidivism rates' devastating impact on children of incarcerated parents, and the burden and collateral consequences of a criminal conviction. Community engagement is critical in order for this work to be effective. The focus of our efforts should provide our Public Health representative the necessary tools to gather and analyze data from selected communities in order to identify levels of risk and protective factors, and to develop effective prevention strategies with measurable outcomes.

The following graphic, developed by Mothers United Against Violence Director of Project Development and Management Deborah Davis, is based on the idea of creating a collaborative effort – and illustrates how important teamwork is to community engagement in gun violence prevention and intervention.



The Commission on
Women, Children, Seniors, Equity & Opportunity

CWCSEO

Connecticut General Assembly

Report of the

GUN VIOLENCE INTERVENTION AND PREVENTION ADVISORY COMMITTEE

Submitted to the Connecticut General Assembly
Public Health and Human Services Joint Standing Committees
January 1, 2022

APPENDIX B:

HEARING TESTIMONY & SUBJECT MATTER EXPERT PRESENTATIONS

Appendix B1

Record of Written and Oral Testimony, Public Safety Hearing, November 5, 2021

Appendix B2

Subject Matter Expert Presentations, November 12, 2021

Appendix B3

Record of Written and Oral Testimony, General Public Hearing, November 17, 2021

APPENDIX B1

Record of Written and Oral Testimony, Public Safety Hearing, November 5, 2021

Transcripts of written testimony from the following witnesses are included in this appendix:

1. Bishop Jim Curry, Co-Founder, Swords to Plowshares Northeast
2. Hartford Foundation for Public Giving
3. Curt Leng, Mayor of Town of Hamden
4. Michele Voigt, Co-Founder and CEO, Violent Crime Survivors

The following witnesses provided oral testimony:

1. Rev. Dr. Anthony Bennett, Mt. Aery Baptist Church
2. Ed Calderon, Supervisor, RYASAP StreetSafe Bridgeport
3. Aquil Crooks, Outreach Worker, RYASAP StreetSafe Bridgeport
4. Bishop Jim Curry, Co-Founder, Swords to Plowshares Northeast
5. Detective Sean Dolan, Public Information Officer & Major Crimes Unit, Hamden Police Department
6. Brian Foley, Public Information Officer, Connecticut Department of Emergency Services and Public Protection
7. Keisha Gatison, Director of Re-entry Welcome Center, Project MORE, Inc.
8. Lt. Paul Grech, Bridgeport Police Department
9. Assistant Chief Karl Jacobson, New Haven Police Department
10. Judy McBride, Director, Strategic Partnership Investments, Hartford Foundation for Public Giving
11. Latesha Nelson, Career Employment Resource Specialist, Project MORE, Inc.
12. Sean Reeves, Sr., Co-Founder, S.P.O.R.T. Academy
13. Chris Senecal, Senior Public Policy and Media Relations Officer, Hartford Foundation for Public Giving
14. Michele Voigt, Co-Founder and CEO, Violent Crime Survivors

Testimony at the Gun Violence, Intervention and Prevention
Public Safety Hearing
November 5, 2021

Chairman Woods and members of the Advisory Committee. Thank you for this opportunity to speak.

My Name is Jim Curry. I am a retired bishop of the Episcopal Church in CT and a resident of New Haven. I am a co-founder of Swords to Plowshares Northeast. We are a 501©3 organization that works with towns and cities to organize gun buybacks and then under police supervision destroy the guns so that using blacksmithing and wood turning skills we can transform those weapons of potential harm from accidents, suicides, and crimes into gardening tools (instruments of hope and nurture). We give these tools away to community gardens, churches, schools, and youth violence interruption programs. We also sell our tools to individuals to support our work. We are a volunteer organization that relies on donations to do our work. We encourage people to voluntarily give up the guns that are a danger in their homes and we advocate for safe storage of guns by make gun safes and locks available. We also encourage people to invite us to bring the forge to their community. We are mobile and can augment almost any other approach to gun violence prevention in our cities and towns. We are experiential and hands on. We find that having family members of gun violence victims participate in the transformation process is very cathartic for them.

I am here today to speak to a multi-pronged and collaborative and experiential approach to gun violence prevention. And I want to underscore the need to support public/private partnerships.

Swords to Plowshares has captured the imagination of people across this state and operates under the words of Isaiah – and translated for today – the passage goes something like this: They shall beat their guns into garden tools. Neighbor shall not raise up gun against neighbor, neither shall they learn violence anymore. Part of our value is that we captured an ancient hope and put it into concrete modern terms. This gun ---this tool. And ---those guns turned in are not just thrown in a grinder to be silently disposed of – they become evidence that we need not be bound to the violence of guns

We are an educational outreach program that spans our cities and towns. Two weeks ago, we set up the forge at the Hartford Gun Buyback and at least 30 people (many of whom were mothers of the victims of homicide by gun) beat on guns at the forge. This process of transformation not only creates tools, it gives power and hope to people who have been harmed greatly by guns in our society. This Sunday we will be in Hebron, CT. On Tuesday, Nov. 16, we will have our forge working for members of Congress on. Capitol Hill at the invitation of Senator Blumenthal and Rep. DeLauro.

We believe this new commission can be an information clearing house and source of coordination for anti-violence groups across the state. We seek cooperation, not competition in anti-violence work.

Gun Buybacks seem very effective if you listen to press reports – but we need to collect data and analyze it to be evidenced based. Swords to Plowshares has been doing this kind of work from our inception. We also see a need to fund more research about the value of Community Gardens and green spaces in our neighborhoods. We need to go from anecdotal stories to evidence based research. This work will require access to funding by small community focused groups like ours.

We need to look more carefully at new strategies to invite people in our communities to give up their guns. We must be nimble, mobile, and innovative. Swords to Plowshares wants to be a visible and consistent presence in schools, youth programs, and community centers. We want to partner with gardeners, of course, but also with artists, teachers, and community outreach activists. We want to work together with you to increase local activism.

Thank you

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Hartford Foundation for Public Giving Testimony to Gun Violence Intervention and Prevention Advisory Committee

November 5, 2021

Good morning, Chairman Woods and members of the Gun Violence Intervention and Prevention Advisory Committee. The Hartford Foundation for Public Giving is grateful for this opportunity to submit testimony on the programs we support to enhance public safety and reduce community and gun violence. The Foundation appreciates the Committees efforts to not only receive input from public safety, law enforcement, emergency first responders, criminal justice representatives, violence prevention professionals and activists, but also engage with people who have lived experience dealing with violence and the justice system as this is a cornerstone of the work we do.

The Hartford Foundation for Public Giving is the community foundation for the 29-town Greater Hartford region. We manage approximately $1 billion in assets, distributing $52 million in grants to promote equitable opportunity for all residents in our region.

This testimony focuses on the Foundation's support for violence prevention efforts and believe public-private partnerships have an important role to play. Both sectors must work together to implement strategies that engage youth and recognize and build on their inherent abilities. We are stronger together and we encourage the public sector to join the Harford Foundation and growing number of local and national philanthropic and nonprofit organizations in prioritizing in policy and funding trauma-informed, asset-based programs and services.

Applying an equity lens is critical to developing effective solutions. This effort also requires better local crime data, so we know who the perpetrators of crime actually are. This will allow us to address the often-unsubstantiated perception that youth are solely responsible. Our work also seeks to recognize the impact on victims and their families. With an historic federal investment in our state and local government, now is the time for collaboration to realize these goals that can support the health of our youth and their communities.

As part of our work to dismantle structural racism and improve social and economic mobility for Black and Latinx residents of Greater Hartford, the Hartford Foundation seeks to address this using multiple strategies working in partnership—from supporting basic human needs, community organizing, increased employment of black and Latinx residents including artists of color, to increasing the number of Hartford residents living in higher opportunity neighborhoods in and outside the city.

The Foundation awards grants to organizations engaged in violence prevention, intervention, trauma informed care and youth development and engagement services. For example, since November 2018, the Foundation has supported several Hartford nonprofit agencies that formed the Hartford Community Safety Coalition (CSC), a collaborative effort to create healthy communities through a reduction of violence and trauma in Hartford.

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The Hartford Foundation has focused on opportunity youth, who are not in school or working and may be involved in the foster care or the juvenile justice systems. Data continue to show that youth of color are far more likely to be referred to juvenile justice services than their white peers, and at younger ages. Early involvement in the juvenile justice system can have a lasting impact, disconnecting youth from their families and communities and limiting their access to opportunities and often making it more challenging to achieve their potential. And given what we know about youth brain development and risky behavior they can engage in, the Foundation supported raising the minimum age of juvenile court jurisdiction from age seven to age 12. This has resulted in a more developmentally appropriate approach by utilizing existing support, mentoring and counseling provided by the state, youth service bureaus, nonprofit community-based services and juvenile review boards.

Despite significant challenges faced by opportunity youth, national research demonstrates that focused, place-based and holistic approaches can tap the resilience possessed by many opportunity youth, helping them to re-engage with school and work and preventing disconnection in the first place. Together, our grants have built upon the Foundation's historic investments in opportunity youth and meet the clear and urgent need for interventions in support of young mothers and other youth and address the rising gun violence and impacts of COVID-19.

The Foundation recognizes there are many other efforts and community-based organizations in Hartford that create an ecosystem of youth-serving agencies. Our grantmaking to support collaboration among proximate, violence interrupters in Hartford through the launch of the Community Safety Coalition has highlighted the ongoing need for increased coordination among organizations in this space and other youth development prevention and intervention programs that have the training and capacity to provide ongoing support to youth at risk of involvement in community violence.

These efforts are designed to meet youth where they are and offer consistent, long-term engagement. We know from our work that youth and young adults need *meaningful* opportunities to develop their skills and to navigate life with support. The best programs give participating youth the ability to inform and lead program activities. Interventions like the Hartford Youth Service Corps also provide young people with the opportunity to give back to their community, and for the community to see inner city youth supporting residents in their neighborhoods, while providing a paycheck so youth can support themselves and help their families.

In 2018, the Foundation awarded a three-year, $260,000 grant to the Center for Children's Advocacy (CCA) to expand its services to adolescents and young adults from Greater Hartford who are making the difficult transition from justice-system confinement or Department of Children and Families involvement. CCA's legal support provides the groundwork that can help youth reestablish important connections, find a safe place to live, get back into school or get a job that leads toward future security. As you are aware, **restorative justice** focuses on rehabilitation by reconciling issues an individual needs address with their victims and the community at large. CCA used a portion of the Foundation's grant to partner with the Center for Restorative Justice at Suffolk University to implement restorative practices in Connecticut's two secure juvenile detention facilities (which are operated by the Judicial Branch), and the secure facility that houses youth under 18 who are charged and sentenced in the adult criminal justice system (which is operated by the Department of Correction (DOC)). As more jurisdictions are using restorative practices, we are seeing fewer youth involved in the justice system, by helping to ensure that they are supported in building new skills to be successful.

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In 2020, the Foundation partnered with the Travelers Championship to co-fund a $400,000 police training initiative led by the University of New Haven's Center for Advanced Policing and Tow Youth Justice Institute. The **Connecticut Institute for Youth and Police Relations** program is working with police departments throughout Greater Hartford to help officers in balancing the demands of public safety and the best interests of Black, Latinx and other diverse youth. A program goal is to build bridges between the police and communities they serve. Instruction is provided by University of New Haven faculty with expertise in youth justice, child development, and community policing. The curriculum also includes conversations with justice-involved youth and staff from agencies that serve youth. The focus is on changing approaches to situations that arise in the field and strategies for deescalating them while integrating restorative justice approaches. The first class of 14 officers graduated in September and has begun implementing these strategies in their local departments in Hartford, West Hartford, East Hartford, Glastonbury, Bristol, Windsor, and the University of Connecticut.

This year, the Foundation, along with its partners the Dalio Education and Tow Foundation, and the City of Hartford announced a $9.6 million investment to support opportunity youth, individuals aged 16 through 24 who are currently disengaged from school or work. The funding will go to COMPASS Youth Collaborative, Our Piece of the Pie (OPP) and Roca, Inc. The Foundation's funds provide flexible, core support to these organizations for individualized, trauma-informed, and high-touch programs.

- Roca is a national youth-serving organization that is currently working in Massachusetts and Maryland. It is now operating in Hartford, specifically serving young women, including young mothers who are victims of abuse and neglect.
- OPP is significantly increasing the capacity of the Youth Service Corps, allowing it to serve additional young people, in addition to the approximately 250 youth they currently serve each year. Mayor Luke Bronin led the creation of the Youth Service Corps in 2016 to give young people part-time jobs as well as one-on-one coaching and coaching.
- COMPASS is expanding its Peacebuilders program, increasing the number of violence interrupters in Hartford working to de-escalate conflict and build relationships with the hardest to reach youth.

The Foundation looks forward to continuing its work with policymakers, nonprofits and residents to develop effective long-term policies to ensure that all Connecticut families live in safe, healthy, and strong neighborhoods. Now more than ever opportunity youth need us to recognize and build on their individual strengths and to commit to helping them reach their potential for themselves, their families and their communities. Thank you for the opportunity to provide testimony.

If you have any questions, please feel free to contact our staff at policy@hfpg.org or 860-548-1888.

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Text Testimony from Curt Leng, Mayor of Town of Hamden

The Town of Hamden stands in firm solidarity with towns, cities and communities across Connecticut as we seek to address the scourge of gun violence within our neighborhoods. Gun violence is tragic and senseless, and takes the lives of innocent, loving and caring individuals every single day. Hamden has had its own experiences with gun violence in our community, and we've worked directly with Dr. Violano in addressing these issues.

In 2020, Hamden held its first ever Gun Buy Back program. The Town and the Hamden Police Department partnered with Yale New Haven Hospital's Injury & Violence Prevention Program, the Injury Free Coalition for Kids of New Haven, the New Haven Police Department, the Newtown Action Alliance, and the Episcopal Church to put the program together and get the word out to the local greater New Haven community. The gun buyback was held in the spirit of public safety and prevention to make our homes and community safer. AND IT WORKED.

In total, there were 149 firearms turned in. That number broke the record for any gun buyback sponsored by Yale New Haven Hospital in the region. Of those 149 firearms, 3 were classified as assault weapons, 3 were derringer-style pistols, 71 were rifles/shotguns, and 72 were pistols/revolvers. Additionally, several hundred rounds of ammunition were handed in, as well as 14 BB and pellet guns. One person brought in a sword.

While a great success, its important to remember that the goal of the event was to prevent guns from falling into the wrong hands, such as those of curious children, people suffering from a suicidal episode, those suffering from dementia, perpetrators of domestic partner intimidation and violence, and also chances of guns being targeted for theft and ending up in the hands of criminals. Programs like this work, and make a real difference, and are needed in more communities across our State.

Cooperative action is the best way to address the issue of gun violence. Hamden also recently joined the US Conference of Mayors National Gun Safety Consortium, which is currently conducting a request for proposal on behalf of its membership to identify and procure firearm safety devices and related products that will strengthen efforts to protect law enforcement, their families and the general public; while also reducing instances of firearm theft, accidental discharges, and general firearm security.

Gun Violence, Gun Safety, and Prevention goes beyond what is just happening in the streets - it extends all the way through our local government, including how our governments and police departments respond to these issues when they are playing out in real life. We have to be prepared to address all opportunities and avenues for improving the way in which we engage with our constituents, and the ways in which we serve them safely and effectively.

We owe this to ourselves, to our constituents, to our family and our friends. Together we can defeat this.

Andrew Woods, Chairman
Dr. Pina Mendillo Violano, Administrator

November 5, 2021

RE: Written Testimony Gun Violence Intervention and Prevention Advisory Committee public safety hearing on Friday, November 5th, 2021

Chairman Woods and members of the committee, I am Michele Voigt, cofounder and CEO of Violent Crime Survivors, a community-based, survivor-lead, wrap-around organization supporting victims and survivors of violent crime.

I have worked with survivors of gun violence for four years in CT, through my prior role as the Statewide Survivor Lead for Moms Demand Action. For 20 years I ran one of Los Angeles County's largest community based human service agency. My aunt was a victim of gun violence.

Our safety and justice systems must protect crime victims, survivors, and those who are at-risk of becoming a victim of crime.

Few safety and justice policy debates are informed by a comprehensive examination of the experiences and views of crime victims and survivors.

One in four people have been a victim of crime and roughly half of those have been the victim of a violent crime

Survivors of violent crime are four times more likely to be *repeat* crime victims. Victims of crime experience significant challenges in recovery and healing. Two out of three victims did not receive help following the incident.

Unaddressed trauma often gives way to more cycles of violence. Hurt people hurt.

Left untreated, trauma makes victims more susceptible to depression, substance abuse, unhealthy relationships, and unemployment. It increases the likelihood of becoming violent themselves, edging away at the often thin line between victim and perpetrator.

To break the cycle of violence it is imperative that we address trauma and the totality of the individuals, their losses and their needs, and that includes their rights to justice as a victim and survivor. Understanding how public safety conversations, hearings and proposed legislation affects survivors and victims of violent crime is critical.

To reduce violence, we must improve our care of violent crime victims and survivors.

Many are rarely seen as victims or survivors deserving access to justice and support services. In economically disadvantage communities and those of color, the gap between those who experience violence and those who receive help is especially pronounced.

There are many proven solutions to increasing public safety and reducing gun violence.

Today I ask you to consider Community Based Trauma Recovery Centers, one stops of sorts, a kaleidoscopic of care for victims of violent crime and their families in which case managers and mental health professionals trained in trauma help people surmount violation and loss.

Where in addition to therapy, clinicians help survivors navigate the maze that faces a violent crime victim, from filing a police report, testifying against a perpetrator, applying for victim compensation, housing, employment, legal advocacy, and developing support systems to simply survive. This in coordination with hospital based intervention and violence interruption programs.

Violence interruption and hospital based violence prevention programs are effective. These programs must be fully funded and accessible.

We encourage the addition of community based Trauma Recovery Centers as an effective strategy to reduce all violent crime including gun violence.

There are now over 15 trauma recovery centers in California, Ohio, and Michigan, with more on the way.

For more information, I refer you to the Alliance for Safety and Justice and Californians for Safety and Justice.

Thank you for your time and consideration.

Michele Voigt
Violent Crime Survivors
CEO / Cofounder
Greenwich, CT

APPENDIX B2

Subject Matter Expert Presentations, November 12, 2021

1. Kyle Fischer, MD, MPH, Policy Director, The Health Alliance for Violence Intervention (The HAVI)
2. Greg Jackson, Executive Director, Community Justice Action Fund
3. Aswad Thomas, MSW, National Director, Crime Survivors for Safety and Justice

THE HEALTH ALLIANCE *for* VIOLENCE INTERVENTION

New Funding Opportunities for Violence Prevention and Intervention

Kyle Fischer, MD, MPH

Policy Director, the HAVI

Overview - Funding Opportunities

Immediate Funding Opportunities

- Federal Community Violence Grants
  - Recent VOCA Legislation
- Medicaid

Strategic Funding Opportunities

- The Built Environment and Infrastructure

New Opportunities

BRIEFING ROOM

FACT SHEET: More Details on the Biden-Harris Administration's Investments in Community Violence Interventions

APRIL 07, 2021 • STATEMENTS AND RELEASES

Link to White House Announcement

Immediately:

- 26 Separate Federal Funding Streams identified for violence prevention services
- Across multiple agencies:
  - DOJ, HHS, HUD, Education, Labor

Examples…

AGENCY	TOTAL	SITE LINK
Department of Justice	$758,650,000	
Byrne JAG	$484,000,000	https://bja.ojp.gov/program/jag/overview
Byrne Criminal Justice Innovation	$18,900,000	https://bja.ojp.gov/funding/opportunities/o-bja-2021-60003
Community Policing Development	$3,000,000	https://cops.usdoj.gov/cpdmicrogrants
Cops Hiring Program	$156,000,000	https://cops.usdoj.gov/chp
Smart Policing	$8,000,000	https://www.ojp.gov/funding/explore/current-funding-opportunities#OpenSols
Second Chance Act	$12,750,000	https://bja.ojp.gov/funding/opportunities/o-bja-2021-58002
Strategies to Support Children Exposed to Violence	$7,000,000	https://ojjdp.ojp.gov/programs/children-exposed-violence
Comprehensive Youth Violence Prevention and Reduction	$11,000,000	https://www.ojp.gov/funding/explore/current-funding-opportunities#OpenSols
School Violence Prevention Program	$53,000,000	https://cops.usdoj.gov/svpp
Hospital-Based Victim Services	$2,000,000	https://www.ojp.gov/funding/explore/current-funding-opportunities#OpenSols
Center for Culturally Responsive Victim Services	$3,000,000	https://www.ojp.gov/funding/explore/current-funding-opportunities#OpenSols
Project Safe Neighborhoods	guidance	https://bja.ojp.gov/program/project-safe-neighborhoods-psn/overview
National Gang Center	guidance	https://ojjdp.ojp.gov/programs/national-gang-center
Victims of Crime Act	guidance	-

Key Programs

- Edward Byrne Memorial Justice Assistance Grants (Byrne JAG)
  - $264m annually (2019)
- Project Safe Neighborhoods
  - $20m annually (2020)
- Victim of Crime Assistance (VOCA)
  - $2.3b annually (2020, fluctuates)

A Focus on VOCA

- Federal Grant Program that funds money for crime survivors and victim assistance providers
- The Crime Victims Fund consists of payments from criminal convictions
  - ***NOT Taxes***
- The Crime Victims Fund balance is trending down after historic highs

The VOCA Fix

The VOCA Fix

- Passed Senate 100-0
- Deposits penalties and fines from non-prosecution and deferred prosecution agreements into the Crime Victims Fund
- Gives states flexibility in administration

New State Flexibility with VOCA

- States can waive requirements that programs “promote victim cooperation with law enforcement”
- States MUST waive 20% match requirements during pandemic and MAY waive match after
- Administrators can provide no-cost extensions to VOCA recipients

Current Challenge with 26 Programs:

- Onus is on communities and programs to actively monitor grant announcements
- No simple or automated mechanism to make this easy
- Upside: Some non-profits/advocacy organizations are currently building out web tools to accomplish this

Helpful Resource

REPORT

America at a Crossroads

Reimagining Federal Funding to End Community Violence

BRITTANY NIETO | MIKE MCLIVELY | DECEMBER 17, 2020

https://giffords.org/lawcenter/report/america-at-a-crossroads-reimagining-federal-funding-to-end-community-violence/

Medicaid: The basics

Medicaid

Medicaid Funding: The U.S. Department of Health and Human Services is organizing a webinar and toolkit to educate states on how they can use Medicaid to reimburse certain community violence intervention programs, like Hospital-Based Violence Interventions

Additional Medicaid Resources at www.thehavi.org/additionalresources

AP NEWS

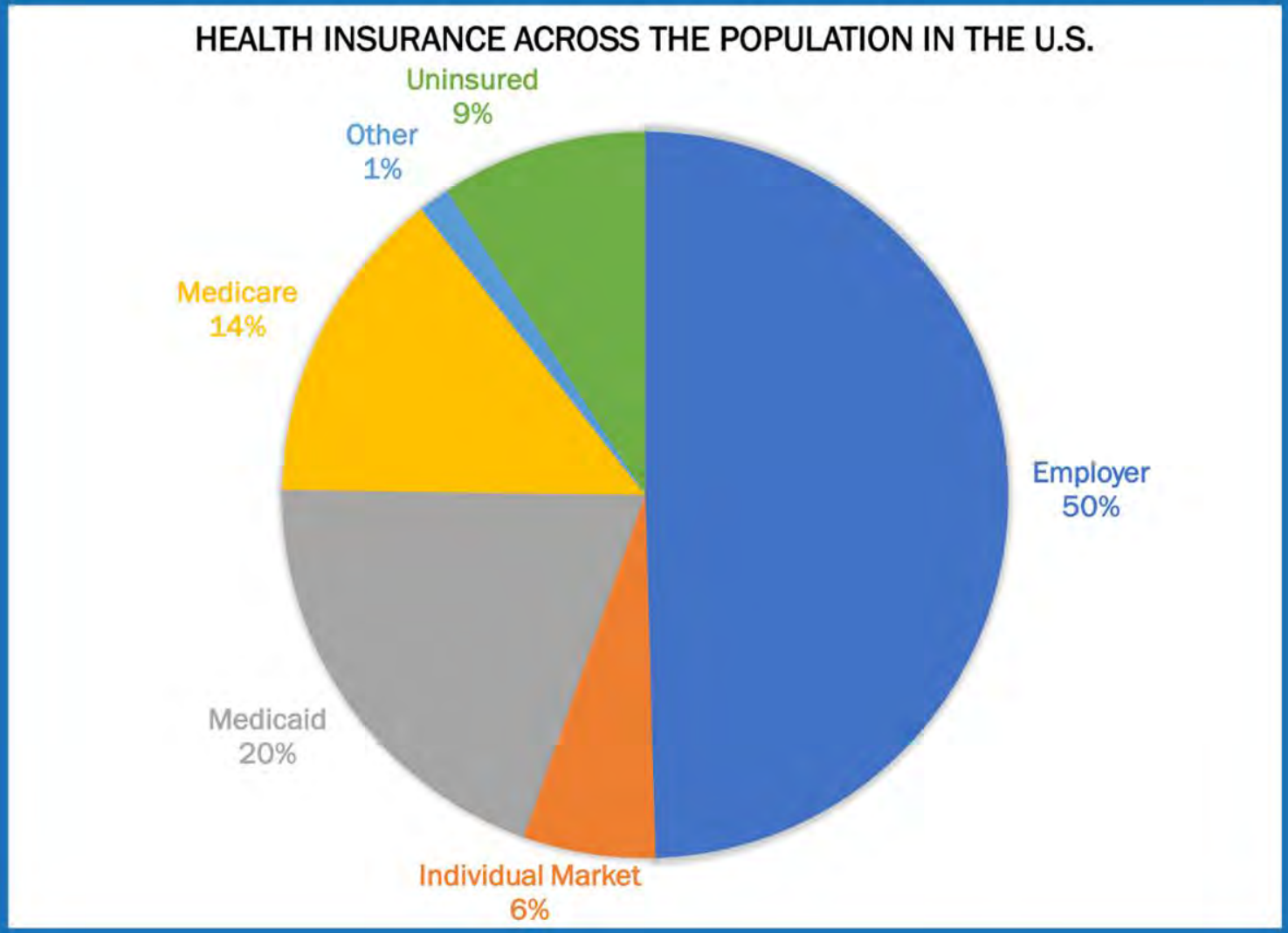
Connecticut looks to use Medicaid funds to address gun crime

By SUSAN HAIGH July 27, 2021

THE HEALTH ALLIANCE for VIOLENCE INTERVENTION

What is Medicaid?

- A federal health insurance program
- Partnership between the Federal Government and States
- Generally covers: Pregnant women, children, low income individuals



THE HEALTH ALLIANCE for VIOLENCE INTERVENTION

Annual Budget: $613.5 billion

THE HEALTH ALLIANCE *for* VIOLENCE INTERVENTION

Medicaid is a lifeline for violently injured patients

Nearly 2/3 of violently injured patients are either Medicaid patients or uninsured.

THE HEALTH ALLIANCE *for* VIOLENCE INTERVENTION

Medicaid is flexible for states

THE HEALTH ALLIANCE *for* VIOLENCE INTERVENTION

Medicaid adds opportunity to promote trauma-informed care.

THE
HEALTH ALLIANCE
for VIOLENCE
INTERVENTION

What are the benefits for HVIPs?

- Acknowledge existing value of violence prevention professionals
- Increase job security of VPPs
  Eliminate bureaucratic perception of the position as a "cost center"
- Diversify HVIP and other violence prevention program funding streams

HAVI
THE HEALTH ALLIANCE *for* VIOLENCE INTERVENTION

How medical billing works…

Provider
(NPI #)

Service
(CPT code)

Payer

The scope and size of Medicaid reimbursement for violence prevention is highly dependent on the service models utilized in the state

Opportunities in the Bipartisan Infrastructure Bill?

The New York Times

To Combat Gun Violence, Clean Up the Neighborhood

Oct. 8, 2021

Mark Makela for The New York Times

JAMA Network | Open™

Original Investigation | Public Health

Association Between Structural Housing Repairs for Low-Income Homeowners and Neighborhood Crime

Eugenia C. South, MD; John MacDonald, PhD; Vincent Reina, PhD

Abstract

IMPORTANCE The root causes of violent crime in Black urban neighborhoods are structural, including residential racial segregation and concentrated poverty. Previous work suggests that simple and scalable place-based environmental interventions can overcome the legacies of neighborhood disinvestment and have implications for health broadly and crime specifically.

OBJECTIVE To assess whether structural repairs to the homes of low-income owners are associated with a reduction in nearby crime.

DESIGN, SETTING, AND PARTICIPANTS This cross-sectional study using difference-in-differences analysis included data from the City of Philadelphia Basic Systems Repair Program (BSRP) from January 1, 2006, through April 30, 2013. The unit of analysis was block faces (single street segments between 2 consecutive intersecting streets) with or without homes that received the BSRP

Key Points

Question Are targeted investments in structural repairs to homes of low-income owners associated with reduced crime in Black urban neighborhoods?

Findings In this cross-sectional study using difference-in-differences analysis of 13 632 houses on 6732 block faces in Philadelphia, Pennsylvania, the housing repair intervention analyzed was associated with a 21.9% reduction in total crime. Increasing the number of

https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2782142

Lead Abatement

- Known risk factor for violence
- Removal of lead from gasoline theorized to be a factor in the “Great Crime Decline” of the 1990s
- $15 billion in infrastructure bill

ELSEVIER

Neurotoxicology and Teratology

Volume 24, Issue 6, November–December 2002, Pages 711-717

Bone lead levels in adjudicated delinquents: A case control study

Herbert L. Needleman, Christine McFarland, Roberta B. Ness, Stephen E. Fienberg, Michael J. Tobin

Show more

https://doi.org/10.1016/S0892-0362(02)00269-6

Questions?

KyleF@TheHavi.org

COMMUNITY JUSTICE ACTION FUND

Conversation On Our Efforts To End Gun Violence

Community Justice Starts With You.

The Community Justice Action Fund is changing the conversation on gun violence prevention by leading with the people closest to the pain of everyday gun violence.

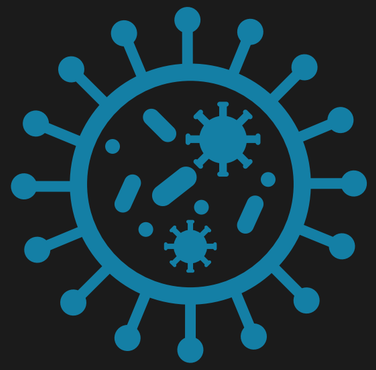
We are working to eliminate the gun violence epidemic by:

- Changing the narrative around gun violence in America.
- Building political power through community amongst activists, policymakers, concerned citizens and community leaders.
- Advancing bold policy agendas at the state, local, and federal level.

THE GUN VIOLENCE EPIDEMIC

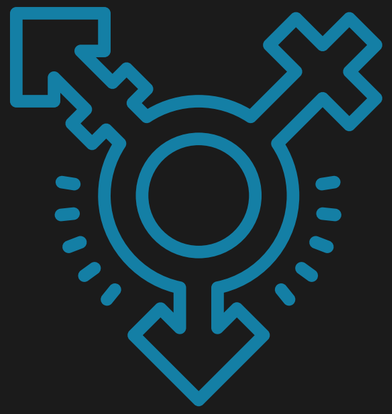
More than 100,000 people are injured or killed by guns every year

74% of all gun homicides victims in 2019 were Black or Latinx



Gun violence is spiking in Black and brown communities during the COVID-19 pandemic

Police violence against Black & Latinx people continues to destroy our communities



Violence against women, and LGBTQ people, particularly transgender women, continues to plague our communities.

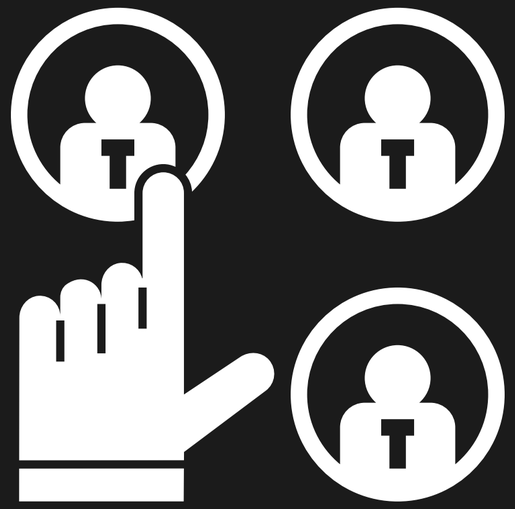
Gun violence costs our U.S. economy approximately $280 Billion EVERY YEAR

ADDRESSING VIOLENCE IN OUR COMMUNITIES

Violence Intervention	Community or Hospital Violence Intervention	Survivor and Victim Services	Healing and Trauma Services
Reducing Risk Factors	Proactive Cognitive Behavior Therapy Programs	Strategic Workforce Development & Education Programs	Addressing Firearm Access and Malicious
Addressing Root Causes	Housing and Environmental Issues	Physical, Emotional and Mental Wellness	Economic and Social Inequities

COMMUNITY VIOLENCE INTERVENTION AND PREVENTION STRATEGIES

FOCUS ON THOSE MOST AT RISK



60% OF GUN VIOLENCE CAN PREDICTED THROUGH A SOCIAL NETWORK ANALYSIS

40% OF THOSE SHOT ARE KILLED OR INJURED AGAIN WITHIN 5 YEARS

LESS THAN 2% ARE CONNECTED TO 80% OF COMMUNITY VIOLENCE

THIS POPULATION IS THE HARDEST TO REACH WITHOUT TARGETED STRATEGIES

COMMON EVIDENCE BASED VIOLENCE PREVENTION MODELS

FUND PEACE

INVEST IN US

VIOLENCE INTERVENTION

Community and Hospital Programs focused on directly intervening interpersonal or group conflict, negotiating ceasefires and shifting neighborhood cultural norms.

VICTIM AND SURVIVOR SUPPORT SERVICES

Programs focused on providing social services for survivors of gun violence, including resources like housing, employment, trauma therapy, etc.

COGNITIVE BEHAVIOR THERAPY

Programs focused on changing the mindset, mental health and ultimately the lifestyle of those most at-risk of gun violence.

YOUTH EMPLOYMENT SERVICES

Programs focused providing youth employment for youth most at risk to gun violence, which include wrap around services and resources.

COMMUNITY OR STREET VIOLENCE INTERVENTION

PROGRAM EXAMPLES

Cure Violence Model
Operation Ceasefire

SUCCESSES

32% Reduction in
Chicago Homicides
Where Implemented

KEY RESOURCES FOR SUCCESS

Credible Messengers De-Escalation &
Conflict Resolution Resources to Individuals
In Need Effective Case Workers

PROGRAM CHALLENGES

Requires Sustained Funding
Geographic Focused Approach
Credible Messengers Are Key
Heavy Training Investment

HOSPITAL BASED VIOLENCE INTERVENTION

PROGRAM EXAMPLES

Shock Trauma Center (Baltimore)

The HAVI (National)

SUCCESSES

Participants 6x less likely to be hospitalized for subsequent violent injury.

KEY RESOURCES FOR SUCCESS

Data on Repeat Admissions

Access to Patients & Families

Resources to Individuals In Need

PROGRAM CHALLENGES

Resources for Participants

Hospital Access & Integration

Independent of Law Enforcement

COGNITIVE BEHAVIOR PROGRAMS

PROGRAM EXAMPLES

Operation Peacemaker (CA)
Pathways Program (DC)

SUCCESSES

50% Reduction in Citywide Gun Violence in 5 Years (Richmond CA)

KEY RESOURCES FOR SUCCESS

Accurate Program Targeting

Intensive Resources Including Social Services, Counseling, Educational and Professional Training

Financial Incentive for Participation

PROGRAM CHALLENGES

Small Cohorts Required Public Opinion on Incentives
Facility Safety Investment Interagency Support Needed

SURVIVOR SUPPORT

PROGRAM EXAMPLES

Office of Neighborhood Safety & Engagement (DC)
Milwaukee Office of Violence Prevention (WI)

SUCCESSES

Most Offenders were once survivors of gun violence.

KEY RESOURCES FOR SUCCESS

Access to Health Care System and Patients Intensive Resources Including Social Services, Counseling, Educational and Professional Training

PROGRAM CHALLENGES

Navigating Health Care Workload Challenges Resource Strain Managing Expectations

BIDEN FUNDING ACTIONS TO DATE

“Today, we’re taking steps to confront not just the gun crisis, but what is actually a public health crisis" - President Joe Biden, April 12, 2021

- **Committed $5 Billion In His American Jobs Plan**
- **Adjusted Eligibility for 26 Existing Funds To Address Violence ($10+ Billion)**
- **Proposed $210 Million Dedicated To These Efforts In His FY2022 Budget**
- **Released American Rescue Plan Guidance to Fund CVI with ARPA funds from the Department of Treasury and Department of Education**
- **Launched CVI Collaborative To Fund 16 Cities Through Philanthropies**

STATES, COUNTIES AND CITIES Across America Are Making HISTORIC Investments

STATE HIGHLIGHTS

California - $200 Million
District of Columbia - $193 Million
Illinois - $150 Million
New York - $138 Million
Michigan- $75 Million
New Jersey - $45 Million
Minnesota - $15 Million
Tennessee - $10 Million
Virginia - $4 Million
Connecticut - $3 Million

CITY HIGHLIGHTS

Philadelphia, PA - $155.7 Million
Indianapolis, IN - $45 Million
Oakland, CA - $18 Million
Miami, FL - $8 Million
Atlanta, GA - $7.5 Million
Buffalo, NY - $6 Million
Columbus, OH - $19.7 Million
Cincinnati, OH - $5 Million
Akron, OH - $24 Million
Milwaukee, WI - $3 Million
Richmond, VA - $1.5 Million
Charlotte, NC - $2 Million
St. Louis, MO - $11.5 Million
Minnesota, MN - $15 Million
Baton Rouge - $2.5 Million
Los Angeles - $20 Million

FEDERAL FUNDING

SHORT TERM PROGRESS

EXECUTIVE ACTIONS TO REFINE 26 EXISTING GRANTS

Biden refined 26 programs across 5 agencies to include violence intervention and prevention programs as eligible applicants.

~$10+ BILLION NOW ELIGIBLE
TO GRANT TO CVI

AMERICAN RESCUE PLAN GUIDANCE TO FUND CVI

Department of Treasury & Education advised that $350 Billion prioritize violence intervention efforts. Funds were allocated directly at the State, County and City levels.

~$350 BILLION NOW ELIGIBLE
TO ALLOCATE TO CVI

MEDICAID COVERAGE EXTENDED FOR GUN VIOLENCE SERVICES

The White House shared guidance that expanded the eligibility of Medicaid to cover violence prevention related services and supports nationwide.

STATE CHANGES
ILLINOIS
CONNECTICUT

WHITE HOUSE CVI COLLABORATIVE

The White House spearheaded the creation of a CVI Collaborative composed of 16 philanthropies supporting CVI strategies in 16 cities.

TBD

FEDERAL FUNDING

LONG TERM OPPORTUNITIES

REQUIRE PASSAGE IN CONGRESS TO SUCCEED

BUILD BACK BETTER ACT

President Biden proposed $5 Billion in funding as part of his $3 Trillion American Jobs Plan. This is the largest jobs plan in American History. We need Congress to PROTECT the funds as negotiations and changes are made to the Bipartisan Infrasture Bill's Reconciliation Package.

$5 BILLION DEDICATED
TO CVI STRATEGIES

BREAK THE CYCLE OF VIOLENCE ACT

Ihis Act will invest $6.5 Billion in funding to invest in community led or focused violence prevention / intervention strategies including creating a federal Office of Violence Prevention, $5B for CVI Strategies and $1.5B for youth employment opportunities.

$6.5 BILLION DEDICATED
TO CVI STRATEGIES

2022 FEDERAL BUDGET

The President requested $210 million be invested in violence prevention strategies and solutions through both the DHHS and DOJ. These funds will need to be solidified through the Congressional Appropriations process.

$229 MILLION DEDICATED
TO CVI STRATEGIES

CONGRESS EARMARKS

Members of Congress can fund community projects directly in their district through Federal earmarks. Many champions and urban based Members should prioritize violence prevention in their submission to Congressional leadership.

$21+ MILLION REQUESTED
FOR CVI STRATEGIES

COMMUNITY JUSTICE ACTION FUND

Learn More And Take Action
www.cjactionfund.org
@CJACTIONFUND

2021 CVI FUNDING ADVOCACY TIMELINE OF EVENTS

2019

Break the Cycle of Violence Act Introduced

Congressional Hearing on Urban Violence

Winter 2020

White House Transition Recommendations

Invest In Us Coalition Created

Summer 2020

Police Violence is Gun Violence Campaign

Peace Is Essential Campaign

Winter/Spring 2021

Historic White House CVI Meeting

Fund Peace Campaign

White House Exec Actions

Summer 2021

White House DC CVI Site Visit

National Fund Peace Tour

American Rescue Plan Guidance

Break the Cycle of Violence Re-Introduced

Fall 2021

$5 Billion Included In Build Back Better Act (DHHS & DOJ)

Break The Cycle Gets Out Of Committee

Billions Of Local Funding Investments

Supporting Crime Survivors

Aswad Thomas, MSW
National Director
Crime Survivors for Safety and Justice

Aswad Thomas - A Survivor of Gun Violence

“While recovering from gun violence in Hartford, I decided to replace despair and resentment with action. I started by sharing my story then I made a commitment to stop cycles of violence that for decades have plagued too many communities of color.”

From Healing to Action

Q&A

Shooting victim finds new pursuit

Basketball standout was set to go pro before attack

Aswad Thomas, who is booked to speak at the Two Days in May Conference on Victims Assistance, tells a story about two young men of color who come from the same poor neighborhood.

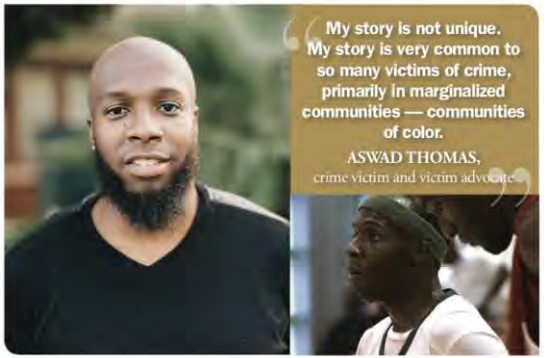
One is Thomas himself.

Of the men in his family, including cousins, five have been shot and seven have been incarcerated.

"They were my nontraditional role models — individuals who I did not want to follow in their footsteps," Thomas, 36, said in an interview.

So he focused on school and basketball, becoming the first member of his family to go to college. He graduated with honors in 2009 from Elms College in Chicopee, Massachusetts.

A point guard on the basketball team, he also led the school to its first berth and first victory in the NCAA's Division III tournament.



he said. "Law enforcement came to visit several

Hartford Courant

Op-Doc: The Sweetest Land

Unlikely lessons from one of Americas most violent small cities

Opinion / Op-Eds / Op-Ed: The Sweetest Land

Hartford Shooting Survivor Stands Against The Violence

Aswad Thomas, 27, shows where a bullet was removed after he was shot twice during an armed robbery attempt. Thomas graduated from Elms College in Chicopee, Mass., and later earned a master's degree from UConn's School of Social Work. (Mark Mirko / Hartford Courant)

By ASWAD THOMAS

From this article

Rally

OCT. 21, 2014

Our History

- **Crime Survivors for Safety and Justice (CSSJ) launched** in July 2012
- **The goal** was to bring in new, more representative victims voice (underserved communities)
- **Our emphasis** has been on reaching out to diverse survivors and advancing approaches to public safety that stop cycles, expands trauma recovery and prevents future harm
- **CSSJ is a national network of 91,000** crime survivors joining together to share our stories, heal together, and advocate for a justice system that prioritizes healing, prevention, and recovery over more spending on incarceration.
- **Our Impact: Secured more than $500 million in state and federal funding to expand** trauma recovery support services to victims of violent crime. **Grown Trauma Recovery Centers** from one to 39 across the country. **Helped to pass 36** legislative bills across the country. **Expanded access** to victim compensation in five states. **Released dozens** of reports and policy briefs.


CRIME SURVIVORS SPEAK
THE FIRST-EVER NATIONAL SURVEY
OF VICTIMS' VIEWS ON SAFETY AND JUSTICE
The National Survey of Victims' Views is the first-of-its-kind research on crime survivors' experiences with the criminal justice system and their preferences for safety and justice policy.

IS THE CRIMINAL JUSTICE SYSTEM MEETING VICTIMS' NEEDS?

Two out of three victims surveyed received no help following the incident

Of those that receive help, it is not through the criminal justice system

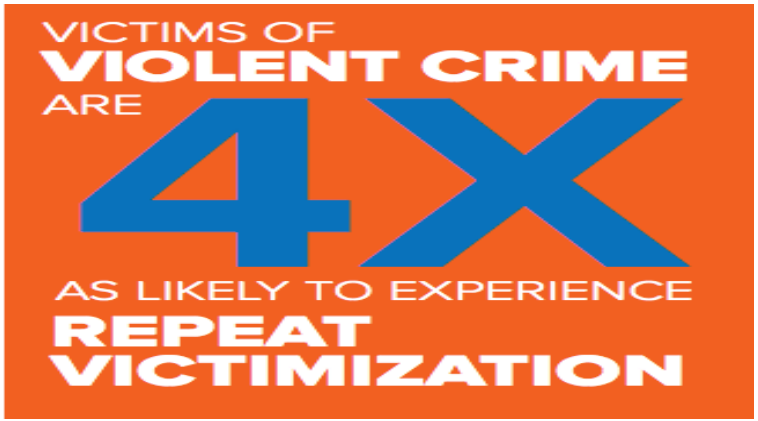
Of the victims that do report receiving help, the majority received it from family and friends or the hospital, not the criminal justice system.

- 40 percent received recovery help from family and friends
- 35 percent received recovery help from hospitals

For young people, a lack of support can have particularly acute impacts

The lack of access to recovery supports has a negative impact on victims' future stability, and this is particularly acute for those at most risk of being a victim of crime: young people.

Crime Survivors Need Help to Recover and Heal from Victimization

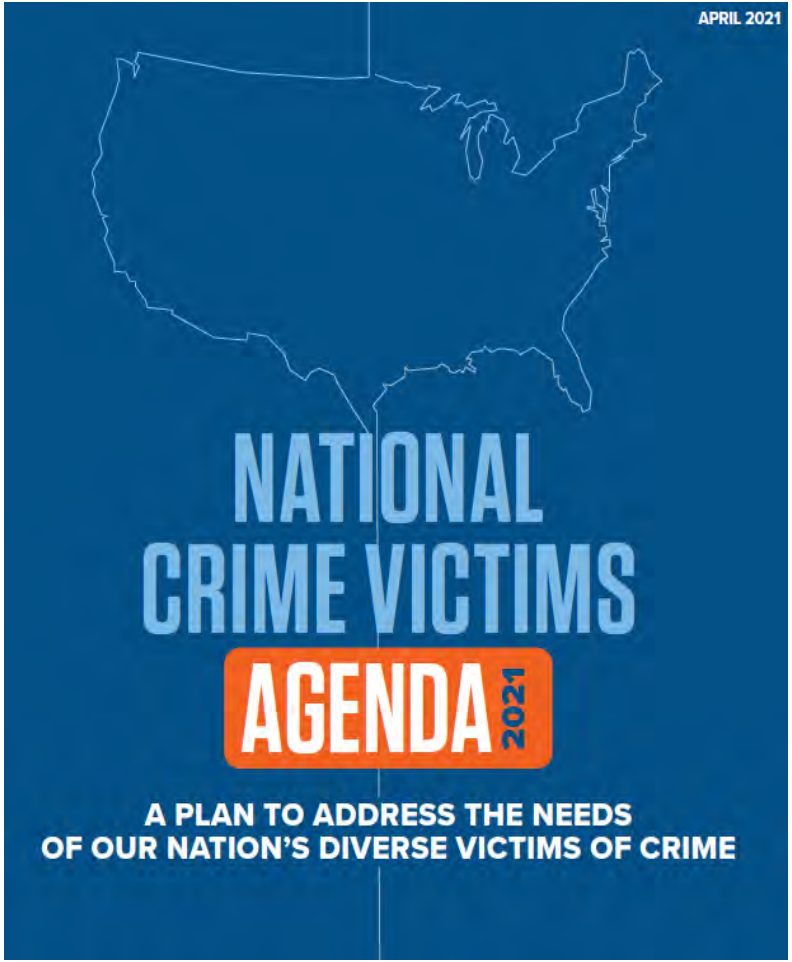


- 8 in 10 report experiencing at least one symptom of trauma
- Only 1 in 10 report receiving help from the District Attorney or prosecutor's office

Crime Survivors Need Help to Recover and Heal from Victimization

Survey findings indicate that **ONE IN FOUR** people have been crime victims in the past 10 years, and half of those were victims of a violent crime.

- Communities of color have been the hardest hit by crime and violence – rates of victimization are highest for people who are young, black, low-income, and residents of urban areas


APRIL 2021
NATIONAL
CRIME VICTIMS
AGENDA 2021
A PLAN TO ADDRESS THE NEEDS
OF OUR NATION'S DIVERSE VICTIMS OF CRIME

Addressing The Needs of Survivors

EXPAND VICTIMS' RIGHTS

- Increase legal protections for victims to prevent job and housing loss while victims are recovering from a crime.
- Expand victims' civil legal services to help victims stabilize.
- Ensure dignity, respect, and support for the victims of unsolved crimes.

Addressing The Needs of Survivors

END DISCRIMINATION

- **Expand victim services eligibility to all victims of crime and violence.**
- **Ensure equal access to compensation and services.**

Addressing The Needs of Survivors

ENSURE MORE URGENT HELP, LESS RED TAPE

- Reach more survivors in crisis—and faster.
- Cover actual costs of recovery and extend deadlines for help.
- Invest in community-based victim services providers.
- Ensure trauma recovery services are widely available.
- Fund urgent crisis needs—now.

Trauma Recovery Center (TRC) B72

Why TRCs? Limited or No Victim Support

Most victims do not access any recovery support

- Two thirds of victims do not get help
- It's inaccessible or it's not known that help exists
- Impacts of unaddressed trauma are lasting:
  - Loss of stability (jobs, homes), coping through drugs or alcohol, cycles of intergenerational trauma, re-victimization or becoming a perpetrator

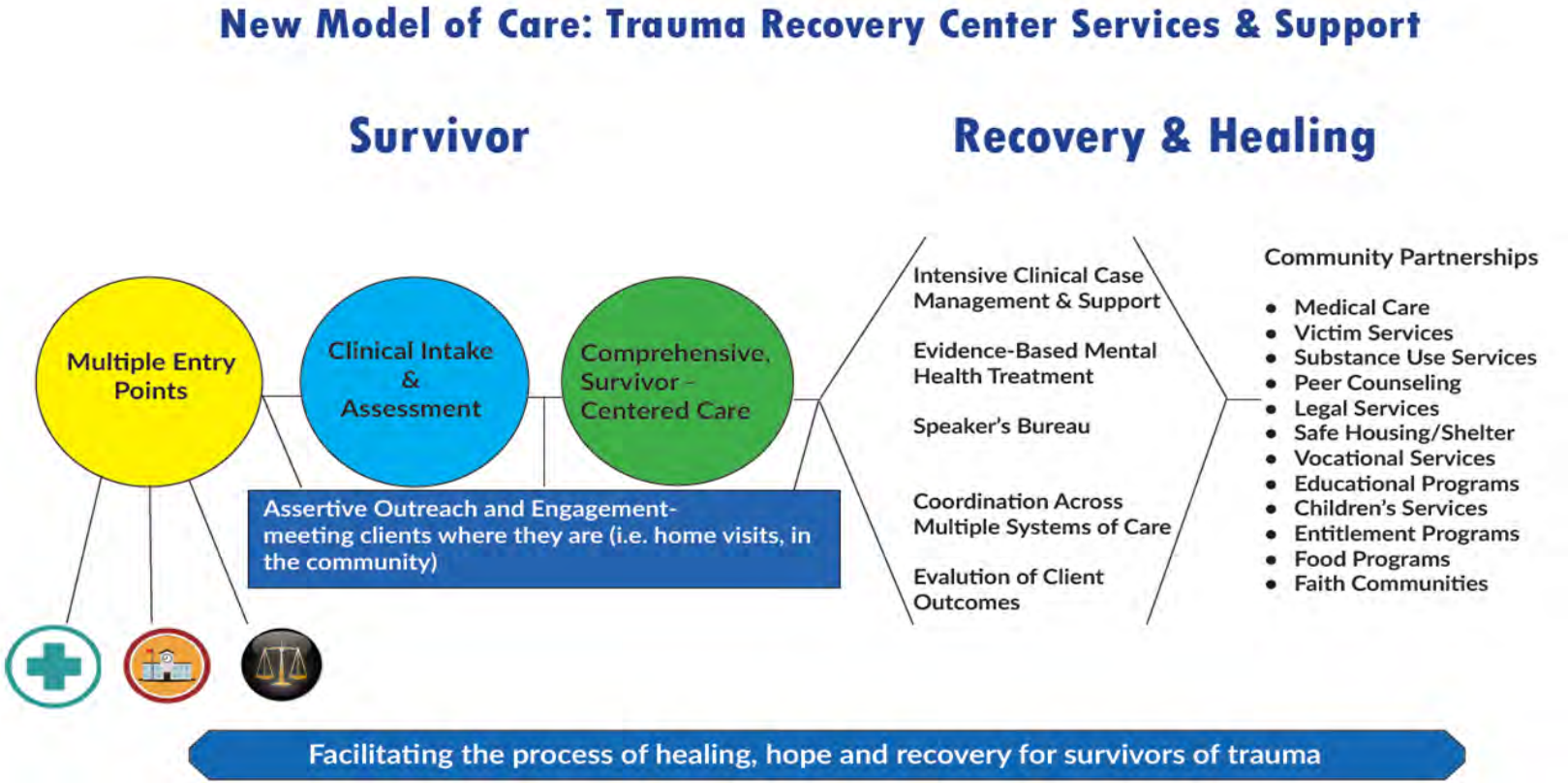
For those that access, traditional mental health support is too narrow

- Office visits only, no home visits
- No practical assistance, no coordination with other systems
- Feeling, insight, disclosure oriented
- Does not directly address social or racial inequities

Core Elements

- Assertive outreach and engagement with underserved populations
- Serving survivors of all types of violent crimes
- Clinical case management
- Multidisciplinary team
- Use of trauma-informed, evidence-based practices
- Coordinated care tailored to individual needs
- All are welcome!

How TRCs work?



Impact of TRCs

More Victims Access Supportive Services and the Justice System

- Increased rate of sex assault survivors receiving mental health from **6% to 71%**
- Increased access to mental health services **72%** TRC vs 38% usual care
- Increased cooperation with police – a **69%** increase in police reports filed

Victims Experience Improvement in Health and Life Functioning

- **74%** show an improvement in mental health
- **51%** show an improvement in physical health
- **52%** show a decrease in alcohol use
- PTSD symptoms decrease **46%**
- Depression symptoms decrease **47%**
- Impacts hold across different TRCs that have been studied

Trauma Recovery Centers

Northern California
- Alameda County TRC - Family Justice Center, Alameda County
- Partnerships for Trauma Recovery, Berkeley
- Ruby's Place TRC, Castro Valley
- Solano TRC, Fairfield
- Fathers & Families of San Joaquin, Stockton
- UC San Francisco TRC, San Francisco

Southern California
- Long Beach TRC, Long Beach
- Downtown Women's Center/Peace Over Violence, Los Angeles
- CSUN - Strength United, Northridge
- Harbor-UCLA TRC, Torrance
- HOPICS/SSG TRC, Los Angeles
- Chadwick Center for Children & Families, San Diego
- Miracles Counseling Center TRC, Gardena
- Christian Counseling Center, Redlands

Illinois
- Advocate TRC, Chicago
- Condell TRC, Lake County
- OSF STRIVE TRC, Peoria
- OSF STRIVE TRC, Rockford
- Survivors Recovery Center (SIU) TRC, Springfield

Iowa
- Central Iowa TRC, Des Moines

Ohio
- Seven Hills TRC, Cincinnati
- May Dugan TRC, Cleveland
- MetroHealth TRC, Cleveland
- Brenda Glass TRC, Cleveland
- OhioHealth TRC, Columbus
- OSU-STAR TRC, Columbus
- Citilookout TRC, Springfield
- MercyHealth TRC, Toledo

Pennsylvania
- Central PA Center for Trauma & Healing – TRC, Harrisburg

New Jersey
- Jersey City Medical Center TRC, Jersey City
- Newark Community Street Team, Newark
- University Hospital TRC, Newark
- CarePlus TRC, Paramus

Georgia
- Grady Hospital TRC, Atlanta

34 TRCs Nationally (as of 5.1.2021)

Questions / Answers

Contact Information

Aswad Thomas, MSW

National Director, Crime Survivors for Safety and Justice

Email: aswad@safeandjust.org

Cell: (860) 888-4092

Website: www.cssj.org

APPENDIX B3

Record of Written and Oral Testimony, General Public Hearing, November 17, 2021

Transcripts of written testimony from the following witnesses are included in this appendix:

1. Rhea Ahuja, Student, Hopkins School; Member, Amnesty International Chapter
2. Shaurice Bacon, Student Engagement Team, Regional Youth Adult Social Action Partnership, Bridgeport
3. Daya Baum, Student, Hopkins School; Member, Amnesty International Chapter
4. Kim Beauregard, President and CEO, InterCommunity Health Care
5. The Rev. Robert Bergner, Co-Founder, Swords to Plowshares Northeast; Priest-in-Charge, Grace & St. Peter's Church, Hamden
6. Dr. Kevin Borrup, Executive Director, Injury Prevention Center, Connecticut Children's Medical Center (joined by Dr. Brendan Campbell, Director of Pediatric Trauma)
7. Connecticut Hospital Association
8. Noa Diarrassouba, Student, Hopkins School; Member, Amnesty International Chapter
9. Dione Dwyer, Parent Advocate, President of Resident Council at PT Barnum Housing Complex, Bridgeport
10. Reginald Eadie, MD, M.B.A., President and CEO, Trinity Health of New England
11. Karen Edwards, MD, MPH, Retired Pediatrician, Professor of Public Health and Adjunct Professor of Pediatrics, Stamford Resident
12. Carolyn Graves, Bridgeport
13. Dr. Charles Johndro, Emergency Department Attending Physician, Hartford Hospital
14. Larry Johnson, Program Director, Hartford Care Response Team, Hartford Communities That Care (with Kent Ashworth, Volunteer Research Assistant)
15. The Rev. Nancy Kingwood, M.S., M.A., Executive Director, Greater Bridgeport Area Prevention Program Inc. (GBAPP)
16. Jennifer Lawlor, Co-Founder, Violent Crime Survivors
17. Peter Murchison, Ridgefield Resident and Member of the Wilton Quaker Meeting
18. Jonathan Perloe, Director of Communications, CT Against Gun Violence
19. Isabel Pizarro, Student, Hopkins School
20. Bob Reilly, Hamden
21. Kate Roschmann, CT Chapter Leader, Moms Demand Action for Gun Sense in America
22. Rabbi Ari Rosenberg, Executive Director, Association of Religious Communities)
23. Ben Simon, Student, Hopkins School, New Haven
24. Dr. Dwayne Smith, CEO, Housatonic Community College
25. John Torres, Executive Director, Bridgeport Caribe Youth Leaders
26. Kelvin Young, Community Health Worker, InterCommunity Health Care

The following witnesses provided oral testimony:

1. Kian Ahmadi, Student, Hopkins School; Student Coordinator, Amnesty International
2. Kent Ashworth, Volunteer Research Assistant, Hartford Communities That Care
3. Cherell Banks, Coordinator, Youth Nonviolence Trainer, CT Center for Nonviolence
4. Thayer Barkley, Founder, Sisters at the Shore
5. Henrietta Beckman, Mothers United Against Violence
6. The Rev. Robert Bergner, Co-Founder, Swords to Plowshares Northeast; Priest-in-Charge, Grace & St. Peter's Church, Hamden
7. Dr. Kevin Borrup, Executive Director, Injury Prevention Center, Connecticut Children's Medical Center
8. Dahmarre Bournes, Greater Hartford Youth Leadership Academy, Hartford Communities That Care
9. Christopher Brechlin, Director of Data & Digital Systems, COMPASS Youth Collaborative
10. Dennis Broadnax, RYASAP StreetSafe Bridgeport
11. Breanna Brown, Greater Hartford Youth Leadership Academy
12. Rev. Henry Brown, Co-Founder and Executive Director, Mothers United Against Violence
13. Sally Connolly, Co-Chairperson, Preventing Gun Violence Task Force, Unitarian Society of New Haven and Hamden
14. Aquil Crooks, Outreach Worker, StreetSafe Bridgeport
15. Deborah Davis, Director of Project Development and Management, Mothers United Against Violence
16. Harold Dimbo, Project Longevity, Bridgeport
17. Carol Dorsey, Mothers United Against Violence
18. Karen Edwards, MD, MPH, Retired Pediatrician, Professor of Public Health and Adjunct Professor of Pediatrics, Stamford Resident
19. Shirley Ellis-West, Executive Director, Urban Community Alliance, Inc
20. Barbara Fair, Community Member
21. Celeste Fulcher, Community Member
22. Freddie Graves, Mothers United Against Violence
23. Dr. Charles Johndro, Emergency Department Attending Physician, Hartford Hospital
24. Dean Jones, Director, COMPASS Youth Collaborative
25. Aki Johnson, Bridgeport Youth
26. Jennifer Lawlor, Co-Founder, Violent Crime Survivors
27. William Love Jr., Leader, Danbury Area Justice Network
28. Anthony Marshal, Founder, Peace in The Streets
29. Ebony McClease, Legislative Coordinator, Amnesty International USA CAGV
30. Da'ee McKnight, Family Reentry, Inc. & Fatherhood Engagement Specialist
31. Rev. Dr. John Morehouse, Senior Minister, Unitarian Church in Westport
32. Peter Murchison, Ridgefield Resident and Member of the Wilton Quaker Meeting
33. Po Murray, Chairwoman, Newtown Action Alliance
34. Jonathan Perloe, Director of Communications, CT Against Gun Violence
35. Logan Phillips, Community Member
36. Elijah Ratner, Student, Hopkins School
37. Carmen Rodriguez, Mothers United Against Violence

38. Kate Roschmann, CT Chapter Leader, Moms Demand Action for Gun Sense in America
39. Dr. Dwayne Smith, CEO, Housatonic Community College
40. Dawn Spearman, You Are Not Alone
41. John Torres, Executive Director, Bridgeport Caribe Youth Leaders
42. Maria Van Gelder, APRN, Nurse Practitioner Trauma, Yale New Haven Hospital
43. Pepe Vega, BA, CPS-T, Violence Prevention Professional, Yale New Haven Hospital
44. Kim Washington, Mothers Demand Action, Hamden Police Commissioner
45. Vanessa Williams, Mothers United Against Violence
46. Pastor Doran Wright, Neighborhood Church Black Rock; CT Coordinator, Straight Ahead Ministries
47. Adam Yagaloff, Staff Attorney, Right Direction: Homeless Youth Advocacy Project

Hi, my name is Rhea Ahuja and I am representing Amnesty International. I am in full support of the *Connecticut Initiative to Prevent Community Gun Violence*. I was a second grader when my friend, also in second grade, was in Sandy Hook during the massacre. He was only one room away from the shooter. 28 people were killed in a school: a place millions of children attend every single day. My mom picked me up from school that day in tears. My parents, and many others, were horrified to send their children to school, because what if their kids never get to come home? What if they get murdered at six years old? As the state in which Sandy Hook occurred, we should know better than to overlook the horrific repercussions of guns. We need an institution responsible for preventing gun violence in our schools, malls, movie theaters, grocery stores, etc. The violence of guns is undeniable and as a state we must take initiative to prevent any and all injuries and deaths caused by guns. *Connecticut Initiative to Prevent Community Gun Violence* is proven to be affected, and must be invested in by the state. Thank you!

Thanks,

Rhea Ahuja

November 17, 2021

Hello Committee members,

I'm Shaurice Bacon, I'm a Bridgeport native, who works with PT Partners, Street Safe and RYASAP. I have been working with and throughout the community, and my testimony is not to ask for funding but a cry for services. We the community won't ask for more policing, but we would like mental health first aid taught in the police academy. We are tired of seeing members of the community being shocked by tasers and abused roughly because cops aren't aware of other ways to de-escalate mental health situations. We the community don't want programs who come to us with the things they think we need. We would like programs to ask us what we need. Our youth should be included in our conversations being that most of them are already making real world adult decisions. Our community needs different programs to help curve the issue of gun violence. The programs that are often spoken about are housing, academic tutoring, music, sports, arts, film, career training, coding, and other technology programs. These programs along with mental health awareness and programs would most likely curve the issue of gun violence. My community experiences gun violence often and I'm no stranger to it, but I also know that there is so much talent and potential in my community.

Thank you for your time,

Shaurice Bacon
Student Engagement Team
Shaurice@ryasap.org
c: (203) 989-5542

Testimony
November 17, 2021

Hello, my name is Daya Baum, I am fifteen years old and I live in Hamden, Connecticut. I attend Hopkins School in New Haven, and I am a member of our Amnesty International Chapter. Along with Amnesty, **I support the establishment of an office for gun violence prevention.** Our state must have consistently funded strategies in order to reduce our unacceptably high levels of violence so that we can live in a safe community. We urgently need to understand and recognize the needs of the people in our community, so that we can properly protect them.

Hartford, Bridgeport, and New Haven account for over fifty percent of gun homicides in the state of Connecticut. My friends and I spend most of our time in New Haven, and reading headline after headline about shootings in the county makes us fearful for our lives. A few weeks ago, I was hanging out with some friends at school, when the topic of guns came up. Apparently, my friend said, a student at Hamden High was expelled for possessing firearms at school. From what I heard, the student had a burst of anger and threw his bag across the room. Five guns spilled out of his backpack. My friends didn't seem to be quite surprised, so I took the hint that no one else was scared, and I blurted something along the lines of "oh yeah, there's no other place like Hamden!" Looking back on this moment, surprise and fear overcame me. The lack of effective action scares me and makes me feel vulnerable and sometimes unsafe- even in places like my hometown or my high school.
No one should ever feel unsafe. Unfortunately, our current system does not adequately protect people and disproportionately hurts people of color. Gun violence is a public safety issue**.** It is crucial that we implement organized, strategic, community centric programs to reduce gun violence in our community. Now that the Biden administration is devoting 5 billion dollars of federal funding to violence prevention programs it is imperative and only fair to Connecticut residents that we establish a state-level grant-making authority to fund gun violence prevention programs.

Thank you all for your time.

Daya Baum

Testimony for CWCSEO Hearing on Gun Violence

Thank you for this opportunity. I'm Kim Beauregard, the President and CEO of InterCommunity Health Care. We're a nonprofit community health center providing primary care, mental health care, and addiction recovery services in Hartford, East Hartford, and South Windsor.

Gun violence is a critical and preventable public health problem. It shares the same root causes as other forms of violence, such as bullying, intimate partner violence, sexual violence, child abuse and elder abuse. Risk factors that increase the risk of violence include family conflict, poverty, unemployment, having a substance use disorder, experiencing child abuse, neglect, and exposure to other traumatic stressors, called adverse childhood experiences, or ACEs. For example, young people growing up in unsafe neighborhoods may witness violence at home, be bullied at school, and join a gang for a sense of belonging.

Things that make it less likely that people will experience violence or that increase their resilience when they are faced with risk factors are called protective factors. These protective factors include coordination of resources and services among community agencies, access to mental health and addiction recovery support, connectedness to school and the community, and pro-social peers. Youth who feel connected and committed to school are at a lower risk of perpetrating violence and are at a lower risk for suicide.

There are opportunities at every stage of life to remedy the negative effects of trauma and help people heal. Comprehensive solutions should include greater access to prevention and intervention programs, and culturally competent, trauma-informed mental health and addiction recovery services and supports. Policies and programs that identify and provide treatment for all persons suffering from mental illness and substance use disorders should be a priority.

The American Psychological Association endorses psychological and educational interventions that promote healthy family and social development, and reduce aggressive behavior and gun violence across the lifespan. Yet we know that many people have difficulty accessing appropriate care. Mental Health America's report "2022: The State of Mental Health in America" states that in Connecticut, nearly 19 percent of adults report having a mental illness. More than half receive no treatment, even if they have insurance. The report shows that 65.6 percent of Connecticut youth with major depression did not receive treatment. While rates of mental health treatment are low for all youth with major depression, youth of color are significantly less likely to receive depression treatment than white youth. In addition, 3.74 percent of Connecticut youth have a substance use disorder, or approximately 10,000 kids.

Prevention of violence begins in early childhood with programs to help parents raise emotionally healthy children. We also need to identify and intervene with troubled individuals who are threatening violence. We advocate for community-based, collaborative problem-solving models to address the prevention of gun violence, using prevention and intervention strategies.

Sources:

https://www.apa.org/pubs/reports/gun-violence-prevention

https://www.preventioninstitute.org/sites/default/files/publications/Connecting%20the%20Dots%20Links%20Among%20Multiple%20Forms%20of%20Violence2.pdf

https://mhanational.org/issues/state-mental-health-america (to download the 2022 Report)

SWORDS TO PLOWSHARES NORTHEAST

November 16, 2021

My name is Bob Bergner. I am the priest in charge at Grace and St Peter's Episcopal Church in Hamden and a freelance musician in the Greater New Haven area. I am also one of the co-founders of Swords To Plowshares Northeast, an organization that works in collaboration with municipalities, local police departments and other community groups to organize and finance gun buy back programs. We then take and destroy bought back guns and literally forge the remaining gun parts into garden tools and jewelry. The garden tools are then given to community gardens, schools, and youth violence interruption programs. We also work with a variety of youth groups and support programs for those returning to the community from incarceration, teaching basic blacksmith skills and encouraging personal growth and transformation.

As a former chaplain at a Level 1 trauma center, I have witnessed firsthand the tragic ravages of gun violence on our streets and the sad aftermath of misused unsecured guns in the home. Living in a city where considerably more than a hundred shootings take place each year, I have seen emergency department gurneys filled with young men--almost always young men--in critical condition or worse, victims of gratuitous urban gun violence. I have also sat with young parents as they made the excruciating choice of whether to keep their teenage son on life support after he was shot in the head while playing with an unsecured gun in a home. And, although I don't recall encountering gun suicide victims, in a country where more than half of 40,000 annual gun deaths are suicides, no doubt several passed through the emergency department during my time as a hospital chaplain.

The pathway out of this terrible situation is at once straight forward and wildly complex. At the straight forward end, every home with a gun in it should be furnished with the capacity for safe gun storage and every gun owner should be encouraged if not obliged to use that safe storage properly so that neither teenagers and young children at play nor older adults suffering from suicidal or violent ideation can have access to them. People with guns "in the back of a closet" since someone's husband or grandfather died or people who have a hunting rifle in their home that has not been used in years, should be strongly encouraged to participate in one of the several gun buy back programs that now take place around our state.

Reducing gun violence on our streets is a more complex matter, intertwined as it is with educational and vocational disparities between our communities. This is where creative, collaborative initiatives like Swords to Plowshares Northeast are so important--bringing together, as they do, diverse stake holders and offering new vision and new possibility, a new conversation about guns and their place in a civil society.

But neither the straight forward path to gun safety nor the more complex path to community transformation are likely to succeed without comprehensive coordination and guidance at the statewide level. All too often we see the fragmentation of groups working on issues like these with each group working in its own silo at cross purposes with other groups with which it ought to collaborate. As well, large scale data collection is necessary if we are to know why, when, where and how gun violence is taking place and whether our prevention efforts are ultimately having a positive effect. That is why a structure like an Office of Community Gun Violence Prevention is essential if our state is going to reverse current trends and awaken from the nightmare of rampant gun violence that it is now living.

TESTIMONY OF
DR. KEVIN BORRUP AND DR. BRENDAN CAMPBELL
SUBMITTED TO THE
GUN VIOLENCE INTERVENTION AND PREVENTION ADVISORY COMMITTEE
PUBLIC HEARING
November 17, 2021

Chairman Andrew Woods, Primary Administrator Dr. Pina Violano, and other esteemed members of the Advisory Committee, thank you for the opportunity to share our thoughts regarding gun violence intervention and prevention.

My name is Kevin Borrup and I am the Executive Director of the Injury Prevention Center at Connecticut Children's Medical Center. I am submitting this testimony in support this committee's work, which strives to ensure that community violence prevention services are intensified in Connecticut through the creation of a structure that will concentrate resources in the communities most in need. Dr. Campbell, Director of Pediatric Trauma at Connecticut Children's, joins me in this testimony.

Before commenting on the bill, I want to provide some background about the Injury Prevention Center that is a part of our Office for Community Child Health (OCCH). At Connecticut Children's, we know that only about 10% of children's overall health and well-being is determined by the health care services they receive. Furthermore, 80 to 90% of our desired outcomes for children are driven by social, environmental, and behavioral factors. OCCH works to improve the social determinants of health such as housing, transportation, food and nutrition, and family support services. We know that strong families, healthy homes, and healthy communities build healthy children. Supporting and strengthening community violence prevention services is part of this work.

Connecticut Children's along with many of our hospital and community-based partners who are testifying or sit on this committee are currently working together to strengthen existing hospital-based violence intervention programs (HVIPs) and to build new programs and partnerships where they do not exist already. When people are hurt badly in our communities, they end up at Connecticut Children's or another Level 1 Trauma Center. Our job is to save their lives with medical interventions and then seek to address underlying issues. We know that a brief intervention in the hospital followed by intensive community-based case management services that connects our patients with appropriate resources can help to reduce the number of future hospital visits. These supportive resources range from food and housing to mental health services and jobs programs.

But, as important as intervention services are, they are not enough to end violence in our communities. As tertiary prevention programs, they are not designed to get at the root causes of violence. We need robust support for primary prevention efforts to do the upstream work that ensures that children and families receive the supports they need to grow and develop so that violence is never viewed as a viable or desirable option.

On November 9th, an informational forum on children's behavioral health was held by Speaker of the House Matt Ritter, where many of these primary prevention strategies were mentioned. Department of Children and Families Commissioner Vanessa Dorantes spoke of establishing an Urban Trauma Performance Improvement Center, ostensibly with the charge to address urban trauma exposure. This would be a positive step as we know that exposure to trauma can have lifelong consequences that contribute to a host of negative outcomes.

In the same forum, Elena Trueworthy, Director of the Office of Early Childhood's Connecticut Head Start State Collaboration Office talked about the implementation of a universal home visiting program, prenatally and for the first five years of life. These programs, these ideas, should be supported by this Advisory Committee in its recommendations. We know, and the research shows, that these kinds of early interventions improve outcomes across the board. In fact, home visiting programs are proven to improve family relationships, advance school readiness, reduce child maltreatment, improve maternal-infant health outcomes, and increase family economic self-sufficiency. Home visiting programs employ a multi-generational strategy to address parent and family socio-economic challenges.

It is our hope that the Advisory Committee, while supporting intervention strategies, looks more broadly to address primary prevention through the social-ecological lens that looks to factors at the individual, relationship, community, and societal levels.

An innovative comprehensive approach that is cross-agency, focusing on the intensification and concentration of supports in our hardest hit communities, can make a difference. This will require a high level of collaboration across state agencies, making connections across disparate programs as well as partnering in a meaningful way with community-based organizations, hospital systems, law enforcement and juvenile justice. Connecticut Children's supports the establishment of a Commission on Gun Violence Intervention and Prevention to engage in this work.

Thank you for your consideration of our position. If you have any questions about this testimony, please contact Emily Boushee (eboushee@connecticutchildrens.org), Government Relations Associate.

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CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
GUN VIOLENCE INTERVENTION AND PREVENTION
ADVISORY COMMITTEE
Wednesday, November 17, 2021

The Connecticut Hospital Association (CHA) appreciates this opportunity to serve as a member of the Gun Violence Intervention and Prevention Advisory Committee established by Public Act 21-35. We are pleased to offer the following testimony in support of the creation of a Gun Violence Intervention and Prevention Commission.

Connecticut hospitals have been collaborating with community partners for years to advance trauma-informed case management services to victims of violence, with the common goals of starting the healing process, supporting victims and their families, and preventing further violence. Hospital-based initiatives in Hartford, New Haven, and Bridgeport have focused on the needs of those who have suffered physical assault injuries (e.g., gunshots, stabbings, and blunt trauma) and sexual assault, as well as victims of human trafficking. These efforts and related work in other states led to the establishment of a national hospital violence intervention program (HVIP), coordinated by the Health Alliance for Violence Intervention (HAVI), which provides training and certification for violence prevention professionals (VPPs).

VPPs often make an initial connection with victims while they are still in the hospital. They are available to victims and their families to coordinate victim assistance services under the Victims of Crime Act, connect victims with mental health services, including brief trauma-focused therapy, coordinate post-discharge medical follow-up for the treatment of injuries, connect victims with opportunities for employment and educational advancement, and coordinate referrals to community-based services for food, clothing, and legal advocacy. VPPs also focus on mitigating the risk of retribution in the hours and days after an incident.

New state laws establishing state agency approval of programs to train and certify VPPs and covering these services under the Medicaid program will promote the implementation of HVIPs and related initiatives across the state.

CHA supports the establishment of a Commission on Gun Violence Intervention and Prevention to coordinate the funding and implementation of evidence-based, community-centered programs and strategies, such as HVIPs, to reduce street-level gun violence in

coordination of efforts among community outreach organizations, victim service providers, hospitals, and public safety and law enforcement officials on strategies to deliver services. Such a commission would facilitate the development and implementation of community violence and gun violence reduction strategies, the alignment of state agency resources, the identification of federal, state, and private funding opportunities, and would enable all partners to be guided by evidence-based data to develop best practices.

A Gun Violence Intervention and Prevention Commission will enable our state to implement a unified, consistent, and sustainable statewide approach for hospitals, agencies, and community-based violence intervention programs to deliver targeted case management services to victims of violence and their families. For these reasons, CHA and Connecticut hospitals support the establishment of such a commission.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.

November 17, 2021
Noa Diarrassouba

Hi everyone and thank you all for having me. I'm Noa Diarrassouba and I'm a member of Hopkins School's Amnesty International Chapter. I'm fifteen years old and live in West Haven. I believe now more than ever we need to create an office for gun violence prevention. It is crucial that we fund community-centric programs to reduce street level gun violence.

Gun violence throughout America disproportionately affects low-income neighborhoods and people of color, especially Black people. Within Connecticut, 56% of gun homicide victims are Black despite Black people only making up 10% of the state's population. As a Black person, the rising statistics against my community leaves me feeling as though a target is on my back and I'm unaware of the incoming arrow- or in this case, bullet. My first personal experience with gun violence was almost two years ago. My mother was pulled over by a West Haven police officer and I was in the backseat. I remember my chest pounding when I saw him walk to our car. After we were let go, only then did my mom tell me that he had his hand on his gun during the entire interaction. It made me realize that I could've died if the situation escalated, which unfortunately is the reality of others.

Police brutality, homicides, shootings, and gang violence all make up the racial injustice of gun violence. As the nonprofit organization Brady: United Against Gun Violence states, "A documented 4,084 Black people were lynched in seventy-three years; 93,262 were shot dead in fourteen." Consistently funded violence prevention programs are imperative for the citizens of Connecticut to feel safe. We must invest in creating more positive influences for young adults like recreational programs. We must implement community centric strategies so that our people feel heard and safe around law enforcement. Not only would gun prevention save the lives of innocent individuals; it would also protect communities from grief and trauma and allow people to live better lives.

Written Testimony Dione Dwyer

I want to Thank you for giving me the opportunity and time to express how I feel about Gun Violence.

I am a mother of three children and I can honestly say, that for as far ba k as I can remember, especially before becoming a mother, that I could never side with the choice of guns in this society. I even had to turn in a written report on whether o was pro gun or against it... I was very much against them.

Faster forward to being a young adult and just having children, I was against it even more. I remember my first born picking up something decorative I had on my dresser and really holding consciously as you would a gun, and painted with it and proceed to make the sounds as of you were shooting. I for sure was never going to be pro guns then.

Fast forward to today as said child is now a full adult themselves, the world is scarier, and I'm still against Guns. I currently have a bullet stuck inside one of my closet door of my apartment. Even though I could have it removed, it would essentially mean the whole door would have to be taken down, inorder to remove the bullet. Either way it's a constant reminder that guns does harm to everything and everyone around it.

I can however, honestly say that I am pro choice. For the constitution says, that one has the right to protect one self and even their family. I do know this, that as a fully understanding adult, we all have the right to protect our Anatomy. I just think that guns are not always the answer. It brings more harm that Peace. Even if the you're within your right the bear arm and somehow stand your ground, it still causes a ripple effect when used and always affects the people around it even if they are not the ones physically harmed.

Best Regards,

Dione Dwyer
System Change Fellow
Parent Advocate
Resident Leader
President of Resident Council at PT Barunum.
DIONE DWYER -dwyerdionet100@gmail.com

TESTIMONY OF

REGINALD EADIE, MD, M.B.A.
PRESIDENT & CEO
TRINITY HEALTH OF NEW ENGLAND

SUBMITTED TO THE
GUN VIOLENCE INTERVENTION AND
PREVENTION ADVISORY COMMITTEE

November 17, 2021

I am Dr. Reggy Eadie, President and CEO of Trinity Health Of New England. Trinity Health Of New England includes Saint Francis Hospital and Medical Center and Mount Sinai Rehabilitation Hospital in Hartford, Saint Mary's Hospital in Waterbury, Johnson Memorial Hospital in Stafford Springs and Mercy Medical Center in Springfield, Massachusetts. In addition, our ministry includes physician practices, an ambulatory services networks, home health and post-acute services. We are more than 13,000 health care providers committed to providing compassionate care and improving the health of our community.

We have been blessed to have partnered with Hartford Communities that Care (HCTC) for the past 16 years. HCTC immediately connects with gunshot victims and their families in our Emergency Department. The goals then and now were to begin the process of healing, to provide support for the family and the victim, and to prevent further violence. In the ER, we were witnessing first-hand the senseless violence being brought about by chronic unemployment, which led to drug dealing and ultimately gang violence. Efforts to intercede evolved into what is known today as the Hartford Care Response Team (HCRT). In 2018 this team became the first member of the National Hospital Violence Intervention Program, a network coordinated by the Health Alliance for Violence Intervention (the HAVI), a national organization of hospital-community violence intervener programs which assisted us in providing professional trainings to our team.

Currently, the HCRT responds to our ED 24/7/365, whenever we have gunshot victims present. They connect with the family and with the victim either in the ER or when stabilized after surgery in the ICU. The members of the HCRT response team also work in the community to reduce the possibility of retribution in the hours and days after the inciting incident. Patients and their families are assisted in navigating the process to obtain funding through VOCA and other financial supports, behavioral health support, and to assure that the medical homecare safety net is in place.

I am proud to say that the three anchor hospitals in Hartford, in collaboration with the City of Hartford, are currently discussing a city-wide response to address the increase in gun violence. We at Trinity Health Of New England are also looking to replicate this partnership and expand it into Waterbury through St. Mary's Hospital.

Currently, we are requesting two things, an expedited review process by the Department of Social Services to get final CMS approval for Medicaid reimbursement for the services provided by these Violence Prevention Professionals. Landmark legislation was passed by the Connecticut General Assembly providing for Medicaid coverage for the services provided in our ED by the HCTC specialists. We need to ensure that this gets implemented.

The second request is for funding. Connecticut needs to make a real commitment of significant state resources to maintain and retain these programs into the future. What we are witnessing everyday is that incidents of gun violence are becoming more numerous and the follow up required more intensive than ever.

Timing is critical and the time is now.

Thank you for the opportunity to submit testimony on an issue that is very important to me, our ministry, and our community. Should you have any questions or need additional information, please contact Dan Keenan, Vice President Advocacy and Government Relations, at dkeenan@trinity-health.org.

Testimony in support of establishing an Office of Community Gun Violence Prevention at the state level

Dr. Violano and members of the Advisory Committee: My name is Karen Edwards. I live in Stamford. I am professor of Public Health and Adjunct Associate Professor of Pediatrics. I am a parent and a retired pediatrician/ public health professional. I am testifying **in support of establishing an Office of Community Gun Violence Prevention.**

Gun violence is a leading cause of preventable death and injury and disproportionately effects people from minority racial and ethnic backgrounds. Over the past two years, gun violence in Connecticut has increased dramatically: by 30% so far in 2021 compared to last year, after having increased 50% in 2020 over 2019. Gun homicides in Connecticut increased 53% from 2019 to 2020 and are concentrated in Bridgeport, Hartford and New Haven, which account for more than half of statewide gun homicides.

Gun violence affects not only those who are injured or killed but also those who witness it, especially as children, and those who live with the daily fear of gun violence in their communities. The overall impact on individuals living in communities with high levels of gun violence cries out for a solution.

We must do more to prevent gun violence, by using proven strategies that involve community stakeholders. As with any public health intervention, preventing gun violence requires an intentional plan and the administrative capacity and multidisciplinary expertise to secure state and federal resources to fund community-based prevention strategies and to successfully carry out and evaluate the funded effort. An Office of Community Gun Violence Prevention would accomplish these tasks.

The urgent need to solve this problem requires us of proven strategies. As a physician and public health professional I support gun violence prevention strategies based on high quality evidence from research and from community stakeholders. An example of such a strategy is the research-based model used by Project Longevity, described in a 2015 working paper from Yale's Institute for Social and Policy Studies. The Project uses messaging from a consortium of law enforcement, social workers and community members targeted to members of violent street groups. This type of strategy could be one of several in a portfolio of proven preventive interventions employed by the Office of Gun Violence Prevention with input from its Advisory Council.

We cannot afford to delay putting into place additional comprehensive community level strategies to prevent gun violence. Children and teens are dying, being injured and being otherwise negatively impacted for life. We must take action so <u>all</u> Connecticut children have the best chance to survive and thrive into healthy adulthood. We must prepare now for the opportunity to utilize new federal dollars to prevent community gun violence. I support the establishment of an Office of Gun Violence Prevention as the most effective path to accomplishing this.

Thank you,
Karen Edwards MD MPH
Stamford CT

November 15, 2021

Dear Reps and members of the Intervention and Prevention Support Members and Advocates.

My name is Carolyn Graves, I have been a resident of Bridgeport for over 16 years now. I am submitting my testimony in support of Intervention/ Prevention for Gun Violence.

Although this incident was not done by a youth, it had an impact on the youth that were present at the time.

Intervention/ Prevention is so needed in our community
rather an adult or a younger person. I believe that those who directly act on these shootings are dealing with some mental health issues or just outright mean!! and have no regard to the life of a human being, no emotional connection at all!

Why would a person shoot, especially in a public place or anywhere?
I would like to take this opportunity to share a incident that took place seventeen years ago in Bridgeport with my neighbor
who she and I had a lot in common with is why we both connected so well as sister friends.

First off it begins with me in the kitchen. I hear a boom sound and it smells. My thought was oh my! somebody ran over a piece of glass and busted a tire.

Unbenounced to me the sound was coming from next door. I hear screaming that my mothers been shot! By this time the ambulance, police had arrived, and other neighbors. surrounded by the house…. Throughout the day it had an impact on the children. They didn't rest well at all that night; they had experienced a traumatic situation. They didn't want to go outside the next day. Even till this day my son who suffers with anxiety the minute and hears police siren noise he immediately starts checking all the windows in the house and believes that they coming to our home considering he does suffer from mental health so that trauma he experienced was unbearable for him at the time he was about eighteen years old..

I had explained to them that the shooter was gone for a while.

Just imagine explaining to young people that were 18 and under. I say to share that gun violence has no limits.

We both were single mothers ,we both had children around the same age. She has a set of twins that are girls and another daughter and two sons.

I had four at the time, three sons and one daughter. So between the two of us nine children.

Surrounded by a lot of emotions that day and the screaming, My thoughts were who is going to stay with the children? While the mother is in the hospital with wounds from the gunshot to her face at close range. In fact we did out the bullet grazed her and it didn't hit the temple. Thankfully she survived with some swelling and shoulder the way it hit her.

At that point as I began to process the situation that it was the landlord who had shot her in her face. My thoughts were why. The children were in the house! She did mention that they were not on good terms but just never thought that would have happened.

Due to the incident he was taken to jail without bail and later arraigned to be sentenced….
Through it all
My neighbor and friend survived.

Even though that happened looking back on that incident the landlord should not have been in her presence considering that they didn't get long. Next was he was not mentally stable and should not have had access to a firearm in his possession at all.

My thoughts while looking back on it today he should have been some mediation between the two of them. He should have had restrictions to not meet her face to face and some kind of therapy for him if he had acknowledged his anger, maybe it would have been deescalated.

With that being said Gun Violence Prevention should be placed and support the efforts that will move forward for change and prevent situations of Gun Violence that my family and others had experienced.

Thanks for this opportunity.

Hartford HealthCare

Testimony of Dr. Charles Johndro
Submitted to the
Commission on Women, Children, Seniors, Equity & Opportunity,
Gun Violence Intervention & Prevention Advisory Committee
November 17, 2021

My name is Dr. Charles Johndro, and I am an Emergency Department Attending Physician at Hartford Hospital. I want to thank you for the opportunity to provide testimony in support of the establishment of a Commission on Gun Violence Intervention and Prevention.

Hartford Hospital is classified as a Level 1 Trauma Center and as such, is on the front line in treating patients with traumatic injuries caused by violence. From January 1, 2018 through August 31, 2021, of our 6,814 total patient registry, 224 patients (3%) were on the National Trauma Registry with gunshot injuries. The trauma registry, however, does not tell the whole story. The registry includes only those patients who are actually admitted to the hospital for 24 hours or more, treated in the operating room or tragically die. The registry does not include patients who suffer penetrating injuries from gun violence and are discharged from the emergency department. The registry does not include those patients and family members who suffer the devasting emotional injuries from gun violence. The actual number of victims is far greater.

As a trauma team, we are trained to quickly and expertly care for a patient's physical injuries, however, we cannot physically repair the traumatizing impact of intentional injuries on the patient, family members and community. The effects from the initial violent injury reverberate through our communities long after their initial moments. The long-lasting physical injures as well as the emotional and financial devastation for the patient and their family cannot be understated. Furthermore, the potential for retribution creates a compounding burden on families in our communities.

Through coordination and collaboration with community partners, hospital-based violence intervention programs (HVIP) present a rare opportunity to address the emotional and generational impact of violence at the moment when a patient or a family member may be most receptive to support. Evidence demonstrates that HVIP have been highly successful in reducing the risk factors associated with intentional injury and the cycle of recidivism.

In collaboration with our partners at Connecticut Children's Medical Center and St. Francis Hospital, Hartford Hospital is working to integrate community services in our emergency department beginning with embedding a partner in our trauma informed system of care. This hospital-based partner would meet with patients and families affected by violence to identify supportive community-based services. Connection with appropriate community resources will improve patient outcomes by addressing social determinants of health such as housing, transportation, food and nutrition and family support services.

The Commission on Gun Violence Prevention would serve the important role of implementing community-based violence prevention strategies and coordinating funding. As established by Public Act 21-36 authorization of Medicaid coverage for hospital-based services will significantly enhance our existing efforts to reduce gun violence and reduce the traumatizing impact of violence in our communities. The Commission will also provide guidance for the training and certification of violence prevention professionals who will serve in the community.

Thank you for your consideration. For more information, please contact Melissa Riley at 860.310.7783.

Public Hearing Testimony — November 17, 2021

Before the Gun Violence Prevention and Intervention Advisory Committee
[Under Public Law 21-35, Section 9]

Larry Johnson, Program Director, Hartford Care Response Team, Hartford Communities That Care (HCTC)
and Kent Ashworth, Volunteer Research Assistant, HCTC

This testimony comes from Larry Johnson, Program Director and certified Violence Prevention Professional with the Hartford Care Response Team (the HCRT) at Hartford Communities That Care (HCTC), and Kent Ashworth, Volunteer Research Assistant with HCTC. In the interest of time, Part I is a three-minute overview (followed by more detailed discussion in Part II).

Part I: Oral Testimony for November 17

Considering the Advisory Committee's five mandates, we took a close look at violence prevention strategies considered best practices – and identified five major obstacles that limit their effectiveness.

As with you, our focus is on how our society can do a better job of saving lives.

Since its founding in 2004 with our Saint Francis Hospital partner as the state's first hospital-linked violence intervention program (HVIP), our team in Hartford has dealt with more than 1,800 cases of violence.

In the best case scenario, we work with victims and their families over a six-month period to achieve recovery — with individualized care designed to avoid the common aftershocks of recidivism and retaliation.

But if you ask any public or private agency or institution represented at any problem-solving table, you will get the same answer: We are overmatched. The best case scenario is all too rare.

Especially since the pandemic, statewide data show sharp increases in both homicide rates and the numbers of shootings.

As the following HCTC/ HCRT Service Mapping graphic shows, we engage victims from the crisis at the crime scene and/or emergency department through the stages of follow-up care. Every case is unique, yet we do see at least five major barriers that limit the effectiveness of prevention.

Each barrier reflects a constellation of critical problems that need to be addressed with urgency:

1. **THE CULTURE OF VIOLENCE**. The root causes of the culture of violence are chronic exposure to traumatic incidents – and the funneling of guns into the streets.
2. **ACCESS TO CARE**. Largely out of fear and mistrust, well over half of gunshot survivors do not get recovery services — and are subject to re-injury, death, or to becoming perpetrators of violence.
3. **UNSAFE ENVIRONMENTS**. Survivors of gun violence return to drug-infested neighborhoods, unaffordable housing, and numerous inequities related to poverty[1]; one in 10 gunshot survivors cannot access safe, emergency shelter.
4. **UNCERTAIN SUPPORT.** With resources typically skimpy and indiscriminately allocated, support for prevention services is unpredictable.
5. **ATTRACTING AND KEEPING TRAINED STAFF**. Building the bench entails recruiting and retaining culturally aware, trauma informed frontline workers — and giving them the support they need to balance their personal lives amidst the stress of frontline work.

Addressing the conditions related to violence will require specific efforts unique to each neighborhood. Removing these aforementioned (and other noted) barriers to effective prevention would be a useful starting point.

Thank you.

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[1] According to the Economic Policy Institute, despite improvements from 1968 to 2018, significant disparities persist between the social and economic circumstances of African American and white families. The inequities cut across unemployment, wages, income, household wealth, homeownership, infant mortality, life expectancy, college graduation, and incarceration.

Part II: Frontline Perspectives on Effective Strategies — and Investing in Them

The five mandates enumerated in Section 9 of Public Act 21-35 send out a distress call for effective strategies to reduce community and gun violence, which we explore from the standpoint of obstacles. With respect to the legislature's call for strategies to align resources and the identification of state, federal, and private funding opportunities, the HCTC/ Hartford Care Response Team's frontline staff brings three key perspectives:

- With more than a decade of participation in the national network coordinated by the Health Alliance for Violence Intervention (the HAVI), our team has been a leader among more than three dozen metro area HVIPs. Drawing upon national best practices, our multidisciplinary crisis response, clinical care, and wraparound service components are designed and continuously refined to engage at-risk young men of color.

- For many years, the HCRT has refined its partnerships to emphasize results-based accountability, building relationships to target wraparound service referrals. Counseling, gang mediation, conflict resolution, mental health referrals, and access to personal injury and survivors' benefits are among the program features.
- Using actual costs data to study the return on investment implications for the hospital, Medicaid, and the tax-paying public, we engaged the Social Capital Valuations (SCV) firm and deployed its predictive model to estimate the net public benefit from our crisis response to gunshot victims. That study examined the average costs of emergency room and hospitalization care for 82 gunshot victims over a three-year period, looking at lifetime healthcare costs savings.

  The net public benefit estimated for this HCRT cohort included **Healthcare Delivery Savings** of $420,264 (a return of $3.42 for every dollar invested in crisis intervention, home health service, and outpatient care in connection with 48 responses to gunshot victims and their families); a **Violent Crime Cost Reduction** of $469,712 (a return of $5 for every dollar invested in clinical intervention with individualized sustainability plans emphasizing social/emotional learning, anger management, conflict resolution, job readiness, etc.); and a **Public Benefit from Pro-Social Lifetime Trajectories** of $2,915,059 (the net public benefit of 10 percent success – in this case, eight additional high school graduates – in increased lifetime tax revenue, decreased public assistance costs, and productive years not on Medicaid).

  In other words, a 2017 investment of $290,976 in the preventive work of the HCRT, including after-care by home health nurses, produced an estimated net public benefit of $3,805,035.[2]

In developing a future public health and community engagement strategy, we recommend that such attention to results-based accountability and return on investment (ROI) should be part of any discussion of resources and funding opportunities for community violence and gun violence reduction initiatives (the following draft graphic illustrates the array of Resources, Authorities and Providers at play in crisis response).

[2] See the January 2020 edition of the Wharton Healthcare Quarterly.

RAP Sheet*
on
Resources, Authorities, & Providers
How Hospital-based Violence Intervention Programs (HVIPs) Interact

Federal, State, Community & Philanthropic Resources

Government Departments, Offices and Sub-Agencies

Frontline and Medical Institution Teams Operating as HVIPs

Resources

Federal Victims of Crime Act

Medicaid

State Grants

City Funding

Foundation Support

Congressional Aid

New & Future Biden-Harris CVI Funding for HVIPs

?

Authorities

Federal Government
- Justice
- Health and Human Services
- Housing & Urban Dev't
- Labor
- Agriculture
  - WIC
  - SNAP
- Education

Congress

State Government
- Judicial Branch
  - Office of Victim Services

General Assembly
- MAPOC

Executive Departments
- Public Health
- Social Services
- DMHAS
- DESPP
- DCF

Municipal Government
- City Council
- Courts
- Mayor and Cabinet
  - DCYS
  - Development
  - Labor
  - Police

Public Schools

Providers

Hartford HVIP
(Hartford Care Response Team)
Hartford Communities That Care
Saint Francis Hospital
Mothers United Against Violence
Wilson Gray YMCA
Harriott Home Health Services

New Haven HVIP
Yale New Haven Hospital
CT Violence Intervention Program

Emerging HVIPs
Hartford Hospital
CT Children's Medical Center

National Partners
The Health Alliance for Violence Intervention (The HAVI)
Giffords Law Center
Provide policy information, training and technical assistance, and research support to its national networks

Emerging and Potential HVIPs
- Bridgeport StreetSafe

Intervention specialists participated in December 2020 Violence Prevention Professional (VPP) certification training provided in CT by The HAVI
- Connecticut Hospital Association

Provides consistent support and guidance as to expansion of the HVIP model to other communities of need, where law enforcement and medical institutions welcome VPPs [e.g., Waterbury]

- This RAP Sheet on the Resources, Authorities, and Providers was prepared by Hartford Communities That Care (HCTC) Volunteer Research Assistant Kent Ashworth, as a rough representation of the overlapping linkages between and among the forces at play in local crisis response to community violence. The interactions depicted here encompass the national, state, municipal, private, nonprofit, and community levels. Given the array of prevention and intervention systems, inter-agency coordination and vertical and horizontal communications are vital (the subject of a forthcoming HCTC analysis).

DRAFT for Review, 11-2-21

Additional Insights Concerning Major Obstacles to Effective Prevention

We also would like to elaborate on our discussion of major obstacles to effective prevention, with the following additional insights.

1. **THE CULTURE OF VIOLENCE**. The root causes of the culture of violence are chronic exposure to traumatic incidents – and the funneling of guns into the streets.

   Additional Insight: Our HCRT staff members all know children who regularly hear gunshots and grow up afraid to go outside. Walking to and from the bus stop in the dark is one among many common safety issues; the point is, many young people exposed to violence almost every day must adapt to live with that trauma. They have no option. Arriving at school hungry, scared, and tired, children can be stereotyped as troublemakers. But more accurately, their behavior reflects the damaging buildup of chronic trauma over time.

2. **ACCESS TO CARE**. Largely out of fear and mistrust, well over half of gunshot survivors do not get recovery services — and are subject to re-injury, death, or to becoming perpetrators of violence.

   Additional Insight: From their experiences, surviving gunshot victims have good reasons to doubt whether sharing the details of their experience would yield any benefit to them. In fact, they can't imagine how a discussion or therapy would help them survive now, judging from how many ways and times their trauma from past violent incidents was ignored, misunderstood, or interpreted as bad behavior.

   Recognizing that many surviving gunshot victims were reluctant to return for follow-up hospital care, HCRT developed a partnership under which UConn physicians provide primary care during home visits. This is just one example of efforts taken to meet clients where they are.

3. **UNSAFE ENVIRONMENTS**. Survivors of gun violence return from the hospital to drug-infested neighborhoods, unaffordable housing, and numerous inequities related to poverty; one in 10 gunshot survivors cannot access safe, emergency shelter.

   Additional Insight: Unlike victims of intimate partner violence or addiction, many victims of violent crimes have nowhere safe to "land" as they recover. Many victims fear being killed if they go back home; others fear that being publicly cited as "cooperating with the police" also could amount to a death warrant. These issues are compounded by the historic problems related to housing discrimination and eviction.

4. **UNCERTAIN SUPPORT.** With resources typically skimpy and indiscriminately allocated, support for prevention services is unpredictable.

   Additional Insight: At a fundamental level, planning effective programs is hardly possible with resources available in small, temporary, or sporadic, seemingly random amounts. Connecticut must face the question: How much is a human life worth?

5. **ATTRACTING AND KEEPING TRAINED STAFF**. Building the bench entails recruiting and retaining culturally aware, trauma informed frontline workers — and giving them the support they need to balance their personal lives amidst the stress of frontline work.

   Additional Insight: Frontline work is not a nine-to-five enterprise. Uncertain or inadequate resources ultimately mean that staff are not compensated for the hours that extend from time in the office preparing for the day, to attending meetings with partners, and responding to crises 24-7. From a quality of life standpoint, especially given the goal of retaining staff skilled at delivering results, the lack of resources for preventing violence at the frontline level sends a sorry signal.

   Violence Prevention Professionals now receive some training concerning how to deal with vicarious trauma — the significant emotional strain associated with this work. Enriching the depth and quality of this support must be a priority, as it is a critically important aspect of professionalizing VPP activity. For those who are trauma informed intervenors, trauma-informed care *within their ranks* is just as important as the it is for their clients, as they go about managing stress on a day to day basis.

Submitted November 12, 2021

Written Testimony on Gun Violence

Rev. Nancy Kingwood, MS, MA Executive Director/GBAPP, Inc.

There's an African Proverbs that states, it takes a village to raise a child. This proverb can also be applied to putting an end to gun and homicide violence. I am expressing my thoughts and concerns as a pastor, mother, grandmother and an executive director of a minority serving community- based organization in Bridgeport.

The effects of gun violence run deep and are long lasting among family members and other loved ones. If we are going to directly address gun and homicide violence we must understand, there must be a call to action. No one person or organization can do everything but collectively we can sound the alarm.

With the possibility of securing federal funding, CT has an opportunity to adequately fund local communities and other organizations to synergize to develop effective partnerships. These partnerships should include local and state law enforcement, community and faith-based organizations, behavioral health initiatives and others. This collective call to action, along with federal and state funding can provide the resources to shift this paradigm. We must work side by side with legislators to create and advance policies and shape laws as well as identify evidence-based practices on the side of prevention.

Throughout my work as a pastor and working in the social service field, I see the devastation of gun and homicide violence. Parents lose their children through either death or incarceration. This kind of trauma can last within family systems for generations. I have sat with family members that are only left with memories, questions and tears. At times, the family members are so distraught, they are not even sure if they would ever heal and "feel normal again." The trauma

wounds run deep. I recall sitting with a family whose teenage son was murdered by gun violence, the level of pain, anger and fear was so heavy, it was then I realized the best gift we can give to someone who is or has experienced so much pain, is our presence. No pastoral care or other professional training can prepare us for this work. But we continue to work on the front lines and with others because, it does take a village.

It is my prayer and ask today, that CT will be in position to advocate for additional funding and coordinate services across all sectors throughout the state. I would be remiss if I did not address the inequities in Black and Brown communities. I am unwavering in the fact unaddressed historical and generational trauma is connected to breakdowns in families and the community at large.

We have a responsibility to teach our young men about culture and ancestral history. There is saying, the way out is back through. We must take our communal families back to where the families can be restored. These cutting-edge strategies must be included in higher conversations and among funders. Trauma can be passed down. When I look in the eyes of some of our young men in the community, it seems like there is no life in their eyes. No life, no light, no hope, no future.

Our children and their families deserve the best. They deserve to grow up knowing we have done all we could do to ensure their safety and wellbeing. Please move forward on their (our) behalf. If we do not get in front of this, we have no idea where we will end up. Too many people are grieving and living through their trauma without support. As I close, I am reminded of the words of Audre Lorde, When I dare to be powerful, to use my strength in the service of my vision, then it becomes less and less important whether I am afraid. We must stand together in solidarity to combat community, gun and homicide violence. Thank you for your time today.

November 17, 2021 Written Testimony- Jenn Lawlor

Good Evening Members of The Gun Violence Intervention and Prevention Advisory Committee.
My name is Jenn Lawlor. I am a CT resident, and I am here to share some of my experience and perspective as a Survivor of deadly gun violence.

On December 9, 2018, life as I knew it stopped. My 25 yo daughter Emily was shot and killed by a cowardly sociopath she'd been dating for 3 1/2 weeks. It was on this day that every, single, part of who I was as a human being was taken from me. Trauma and grief immediately took hold…my entire life became and remains to be what is a before and an after.. and I don't believe I am alone in this description. I am confident most anyone in the "club" I am in now feels much of the same.
It was not easy deciding what to say to you tonignt. The level of suffering and secondary loss that has come with my daughter's murder is hardly describable and I am shook to my core every time I learn of someone else who now knows what I can't hardly describe to you tonight. In the past 3 yrs. I have spent many hours concerned for how many others are out there floundering and hanging on by a thread trying to keep living like this and it is NOT OKAY for our elected leadership here in CT to not be doing the same and more. It is not okay to continue to NOT make true authentic investments in Prevention when it is a fact that there are many communities where hearing gun shots has become more of a norm than not. I do not find it to be okay for elected Legislators to boast about the lower crime rate here than some other States while people…many of them the people in the districts these officials have been elected to represent, are being shot and often killed every day. I am well versed on the outstanding gun laws here in CT and I have put the time into understanding how much could change if CT were to invest in ending this epidemic. This crisis is well beyond any laws we have made here, and NO ONE is immune from becoming a victim. I am here before you knowing I am not someone who is impacted by ongoing daily gun violence in my neighborhood the way many on this call are tonight, but I do live with incredulous grief and PTSD as those two things are a common denominator for many survivors of violence. CT needs to fully fund the programs that we know can help while also creating additional easily accessible resources for mental health and trauma.
We should all be able to agree that this crisis will not go away on its own…if I did not have the family supports, I do and access to mental health I am not sure I would have lived through the hell I was placed in three years ago. CT continuing to be excited about its updated train tracks and highways while "hodge pidgin get" prevention will cause CT to never be able to get ahead of this crisis. To me that means more & more human beings injured or killed and more people living in an "after" the way I now do.

Thank you for listening.

Comments for CT Initiative to Prevent Community Gun Violence public meeting from Peter Murchison November 17, 2021

Thank you Chairperson Woods, Dr. Violano and distinguished members of the Gun Violence Intervention and Prevention Advisory Committee

My name is Peter Murchison and I live in Ridgefield.
I am also speaking today as a Quaker and a member of the Wilton Quaker Meeting. As a Quaker, we work for peace; we believe that there is "that of God" in everyone and that we are required to eliminate the causes of violence in our communities. I am so impressed with the many people on this call that are already doing the work to stop the cycle of violence. They need to be supported and the Initiative would do just that. I am honored to be on the call with these people.
Finally, I am here as part of a survivor family. My nephew, Daniel Barden, was shot and killed at Sandy Hook Elementary School.

With so many guns in the US and CT, there's not a cookie cutter approach that addresses all aspects of this crisis. Many approaches are needed.

We have good progress on some fronts. We've seen private groups like Sandy Hook Promise deliver proven results in school settings in CT and around the country. We have seen laws for safe storage, and ERPOs prevent suicides and more. (BTW – CT still needs to publicize and educate the public on our own ERPO law so more people in all kinds of communities know how to use it.)

But, one place where we need to do more is in about community violence. The state hasn't done enough in communities like New Haven, Bridgeport, and Hartford to support the good work that you are hearing about tonight. Urban communities need this help. The deaths in these communities don't get the headlines that school shootings do but each life lost leads to the same trauma, the same pain that lasts a lifetime that we suffered after Sandy Hook. It's about time that the state takes action, not only to support these groups, but to make the statement that these communities matter. We're all the same. There is "that of God" in everyone is how I would put it, but we have to take action.

CT needs grass roots organizations in these places to stop the cycle of gun violence by addressing it person to person, on the streets, in hospitals and in people's homes. It takes very special people to do this work. And very special organizations to find, fund and foster those individuals. CT has a number of these organizations - let's grow them. CT needs more of these organizations – let's find, foster, and fund them.

I believe this initiative will be life saving as are the ones already in places like NJ, Virginia, Massachusetts. CT more than most states knows the pain and lasting trauma of gun violence. My prayer, my statement and my request is for this commission to be put in place to begin these actions. Please support the Initiative.

CT Against Gun Violence

November 12, 2021

Dear Chairman Woods and distinguished members of the Gun Violence Prevention and Intervention Advisory Committee:

My name is Jonathan Perloe. For the past five years I have served as director of communications for CT Against Gun Violence. I offer this testimony on behalf of our organization, to augment the discussions among committee members, including our own executive director, Jeremy Stein.

While Connecticut has the sixth lowest rate of gun deaths in the nation, we still have an unacceptably high level of gun homicide. Gun homicide and injury disproportionately victimizes Black and brown communities in our largest cities. Senate Bill 1, which led to the creation of this Advisory Committee, declared that racism is a public health crisis. So, too, is community gun violence. To achieve racial equity, preventing community gun violence must be part of the discussion. **Equality can't be achieved if everyone isn't safe in the communities where they live, regardless of where that is.** Sadly, this is not the case in Connecticut.

That is why CT Against Gun Violence launched the *Connecticut Initiative to Prevent Community Gun Violence*. Its objective is to establish an Office of Community Gun Violence Prevention, a state-level grant-making authority tasked with funding and implementing evidence-informed, community-centric, programs and strategies to reduce street-level gun violence. Currently, 42 Connecticut-based and national organizations are partners to the CT Initiative.

The CT Initiative envisions dedicated staff resources with multi-disciplinary expertise who would bring the attention needed to address the magnitude of Connecticut's community violence problem. The Office would:

- Determine community-level needs by engaging with community leaders, state agencies, urban and public health policy experts, gun violence prevention advocacy organizations and others with a stake in the health of Connecticut's urban centers.
- Secure state, federal and other monies to provide stable and predictable funding to support violence prevention and intervention programs.
- Establish grant criteria, award grants, guide implementation, offer technical expertise and monitor programs to ensure objectives are met.
- Pilot and assess the efficacy of new and promising program models to ensure that Connecticut follows best practices and implements the highest-impact approaches.
- Develop policy recommendations where existing programs fall short of needs.

An advisory council would be established to provide strategic guidance, accountability and ensure that legislative, executive, community stakeholders and policy experts have a voice in the operation of the Office.

The need, and opportunity, to create an Office of Community Gun Violence Prevention is now.

There were 105 gun homicides in Connecticut during 2020, up 53% versus 2019. Gun homicides this year have continued at this elevated level. Deaths are concentrated in our largest cities; Bridgeport, Hartford and New Haven consistently account for up to two-thirds of statewide gun homicide totals.

Beyond the loss of life, gun violence has a tremendous economic cost. It's estimated that the cost to Connecticut taxpayers of all forms of gun violence is $90 million per year. The tangible costs, including lost income, is estimated at $430 million annually, and the societal cost brings the total to $1.2 billion each year.

With the potential for significant federal funding coming from Biden administration efforts, it is important that the state has the capacity to secure its fair share of federal grants. Maximizing Connecticut's share of federal funding should not be an ad hoc endeavor; it requires dedicated staff to identify opportunities and secure grants.

In his request for FY2022 discretionary funding, President Biden asked Congress for $200 million for local implementation of community violence intervention (CVI) programs. His administration also directed five agencies to prioritize CVI grants across 26 different federal funding streams, and the Build Back Better Act calls for $5 billion over eight years, a level that policy advocates believe will be maintained in the scaled back package currently pending in Congress.

Given the urgency, we suggest that the Advisory Committee explore additional avenues to achieve the goals of the proposed Commission on Gun Violence Intervention and Prevention that could have shorter implementation timeframes.

One such possibility is to provide the Department of Public Health Office of Injury Prevention the resources it needs to fulfill the mandate it was given when established by statute in 1993. Its duties include developing sources of funding to establish and maintain programs to prevent interpersonal violence, including homicide. The defined scope of "injury prevention" clearly includes gun violence even though the term "gun" is not in the statutory language.

The case for action is strong. Around the nation, various program models have proven track records of reducing interpersonal gun violence, including hospital-based violence intervention, violence interrupters and group violence intervention. The challenge, however, has been securing adequate and stable funding for these programs, and ensuring that a comprehensive portfolio of solutions is deployed, including prevention, intervention and after-care. To date, the state has focused most of its efforts on Project Longevity, the law enforcement-led group violence intervention strategy that works to steer individuals at highest risk of gun violence away from further acts of violent crime.

While law enforcement has a critical role in gun violence prevention, in addition to these focused deterrence strategies, and enforcement of our state's strong gun laws, Connecticut needs to invest in a comprehensive portfolio of solutions that goes beyond policing.

As written in the Break the Cycle of Violence Act, S.2275, introduced in the 117th U.S. Congress, "When properly implemented and consistently funded, coordinated, community-based strategies that utilize trauma-responsive care and interrupt cycles of

violence can produce lifesaving and cost-saving results in a short period of time without contributing to mass incarceration."

Through a combination of legislative and executive action, states across the country are investing in the organization infrastructure to fund, implement, support and oversee community-based violence prevention programs such as those proposed by the CT Initiative. These include California, Colorado, Illinois, Massachusetts, Maryland, New Jersey, Pennsylvania and Virginia. Cities around the country have also established Offices of Gun Violence Prevention, although mostly where populations are substantially larger than our largest cities. Some of these initiatives are detailed in Appendix II.

There are life-saving solutions to be found in violence intervention and prevention programs operating at the local level. Connecticut needs to invest in the organizational infrastructure to find, fund and follow these programs, as our organization and our partners have proposed in the CT Initiative to Prevent Community Gun Violence.

Thank you for considering my testimony, and your work to make Connecticut's urban communities safe from gun violence.

Kind regards,

Jonathan Perloe
Director of Communications
CT Against Gun Violence

Appendix I

Partners in the Connecticut Initiative to Prevent Community Gun Violence

ACLU Connecticut
Amnesty International USA
Association of Religious Communities (ARC)
Bridgeport Generation NOW
Coalition to Stop Gun Violence
Community Partners in Action
COMPASS Youth Collaborative
Congregations Organized for a New Connecticut (CONECT)
Connecticut Center for Nonviolence
Connecticut Early Childhood Alliance
Council of Churches of Greater Bridgeport, The
CT Violence Intervention Program
Danbury Area Justice Network
EMERGE Connecticut
End hunger Connecticut!
Ethan Miller Song Foundation
Greater Bridgeport Area Prevention Program
Greater Bridgeport NAACP Branch
Hamden Mothers Demand Action
Hamden Residents for Change
Hamden Youth Connections, Inc.
Hang Time
Hartford Communities That Care
Helping Young People Evolve
Hoops 4 All/Young Athletes 4 Change/Million Dollar Smile
Ice the Beef
Left Hearts
March for Our Lives Connecticut
Moms Demand Action for Gun Sense in America
Moral Monday CT
NAACP Connecticut
NARAL Pro-Choice Connecticut
National Association of Social Workers Connecticut Chapter
New Haven Healing Garden for Victims of Gun Violence
Newtown Action Alliance
Project Longevity
Regional Youth Adult Social Action Partnership
Sandy Hook Promise
Street Safe Bridgeport
Swords to Plowshares Northeast
Unitarian Church in Westport
Unitarian Society of New Haven, Preventing Gun Violence Task Force
You Are Not Alone

Appendix II

States that have established intentional efforts to address community violence.

In November 2021, Illinois Gov. Pritzker signed an executive order declaring gun violence a public health crisis and committed $250 million to "directly reduce and interrupt violence in our neighborhoods." The order further funds the Reimagine Public Safety plan, a data-driven and community-based violence prevention strategy, and creates a new Office of Firearm Violence Prevention, which will give technical assistance, training and policy recommendations to Illinois communities with the highest rates of gun violence.

In June 2021, Colorado Gov. Polis signed a bill creating an Office of Gun Violence Prevention, tasked with gun violence prevention education, establishing a grant program to fund community-based prevention programs and coordinating data collection and research. The Office is housed in the Dept of Public Health and Environment, with an executive director and at least two full-time staff. Its first year appropriation is $3 million.

In 2019 the California Violence Intervention and Prevention (CalVIP) Grant Program was established by the legislature to appropriate $30 million to cities and community-based organizations with the purpose of reducing homicide, shootings and aggravated assault through evidence-based initiatives.

In Massachusetts, the Safe and Successful Youth Initiative (SSYI) is a standing program to fund ongoing efforts that focus on reducing violence among high-risk youth. Funding has ranged from $4.5 million to $11.4 million since it began in 2012. Cities where SSYI funded programs operate have seen a reduction of more than 5 violent crime victims per 100,000 residents, representing nearly 1,000 victimizations prevented over a three-year period from 2011-2013.

New Jersey signed into law a Violence Intervention Program in 2020, and has since awarded $20 million in multi-year grant funding to nine hospital-based violence intervention programs.

Also in 2020, Virginia General Assembly established the Virginia Gun Violence Intervention and Prevention Fund to make grants to support evidence-informed gun violence intervention and prevention efforts. Gov. Northam proposed and the legislature approved $2.6 million in funding for the 2021-22 biennial budget.

In 2018 the Maryland legislature established the Maryland Violence Intervention and Prevention Program (VIPP) with $4 million of seed money. In consultation with the VIPP Advisory Board, the Governor's Office of Crime Control and Prevention administers the program to provide competitive grants to local governments and nonprofit organizations to fund evidence-based health programs or evidence-informed health programs.

Here is a roundup of federal, state and municipal news regarding creation and funding of the capacity to support community violence intervention programs.

Anti-Gun-Violence Testimony
11/17/21

First, I want to thank the committee for allowing me to submit a testimony and for their time.

My name is Isabel Pizarro and I'm a sophomore at Hopkins School in New Haven, Connecticut. I am a fifteen year old who lives in Hamden. As a resident in Connecticut, I am supporting the establishment of an office for gun violence prevention. Gun-violence affects everyones' lives, which is why the creation of an office to act against gun violence at a government level is crucial. The fact that 62% of gun deaths are suicides is beyond sickening. People should NOT have access to fire-arms this easily. Guns are meant to harm and kill, access to guns needs to change before anymore people fall victims to gun violence. I mentioned earlier that I am a student, which is extremely relevant when speaking about gun violence. School shootings are sometimes thought of as "Uniquely an American crisis" now while it's not unique to the United States, that doesn't take away the fact that it is still a crisis. Sandy Hook school, less than 30 miles from my elementary school. I was the same age as the first graders who were killed in the mass shooting in Newtown Connecticut. Those students should be in 10th grade today. They should've had nine more birthdays. They should have been able to learn, without fearing for their lives. During the shooting, the shooter, Lanza, had to pause to reload, allowing children to escape. Him having to pause between rounds saved children's lives. Regulations on access to guns, and the type of gun is incredibly important, and will save lives. Today, our school practices lock-down drills, preparing us for the event of a shooter on our high-school campus. Not a day goes by that I don't fear that we will have to go into lock-down. I should be able to attend school, and learn without the fear that a person with a gun will end my life and the lives of my peers and teachers. Enforcing background checks before allowing a person to own or carry a gun, and on the type of gun will literally save lives. Gun-control will save lives. Gun-violence ends lives.
Thank you again for your time.

Thu 10/28/2021 6:09 PM

Of the seven listed gun regulations by CAGV

The seventh regulation states that lost or stolen guns must be reported within 72 hours.

This must be the most abused regulation - Most lost or stolen guns are **never** reported until it's too late.

CGAV needs to strengthen the penalty for carrying lost or stolen guns.

Anyone who claims a gun is lost or stolen should be required to pay a substantial fee for any replacement of the lost or stolen gun.

They should also be held partially responsible if the gun was used as a weapon for any crime.

And it should be illegal for anyone carrying a lost or stolen gun that has been stripped of serial number.

Bob Reilly

Hamden, CT

Email: rreilly@snet.net

To: Members of the Gun Violence Intervention and Prevention Advisory Committee
From: Kate Roschmann, Chapter Leader of Connecticut Moms Demand Action
Re: Gun Violence Prevention Recommendations
Date: November 17, 2021

Dear Chairs and Distinguished Members of the Committee,

My name is Kate Roschmann, and I represent the Connecticut chapter of Moms Demand Action for Gun Sense in America. We are a grassroots organization fighting for public safety measures that will prevent gun violence. Connecticut has some of the strongest gun safety laws in the country, but with gun homicides rising, it is urgent that we do more.
In an average year, 185 people die and 576 people are wounded by guns in Connecticut. Gun violence in Connecticut, like elsewhere in the country, disproportionately affects communities of color, and young Black men in Connecticut are nearly 39 times more likely to die by gun homicide than young white men. We can't claim to value racial justice in this state if we ignore the crisis of gun violence and the collective trauma that it causes in our communities. Community-based gun violence intervention programs have been proven to prevent shootings and the trauma they cause.

Connecticut can do more to sustainably fund and expand these programs, and we must. Every year, gun deaths and injuries cost Connecticut $1 billion, and $60 million of that is paid by taxpayers. As more state and federal funding is allocated for community-based violence intervention programs, Connecticut must coordinate and leverage its various funding streams to reduce gun violence in our most impacted communities. A dedicated office of gun violence prevention will ensure that we are directing funding to community violence intervention strategies in support of their evaluation, training and technical assistance, research, and programmatic needs. We need to make sure that Connecticut communities get the resources they need, and a dedicated office will ensure that these evidence-based programs are able to continue their life-saving work.

Respectfully,

Kate Roschmann
Connecticut Chapter Leader
Moms Demand Action for Gun Sense in America

November 17, 2021

Chairman Andrew Woods
Gun Violence Intervention and Prevention Advisory Committee
% CWCSEO
165 Capitol Ave, Suite G1095
Hartford, CT 06106

Dear Chairman Woods and distinguished members of the Gun Violence Intervention and Prevention Advisory Committee:

I am Rabbi Ari Rosenberg, from New Milford, CT. I serve as the Executive Director of the Association of Religious Communities (ARC), Danbury's only purposefully interfaith nonprofit organization on the front lines preventing poverty, homelessness and domestic violence. Our mission is "To alleviate the causes of violence, suffering and hate while establishing peace, justice and human dignity."

I am testifying in support of the State taking a more intentional effort to address the crisis of interpersonal violence that is taking so many lives in Connecticut's urban areas.

The recent dramatic rise in white-supremacist, anti-semitic, anti-muslim, anti-Asian, anti-gay and other bigoted points of view are threatening the heart and soul of America. The violent attacks upon the Tree of Life Synagogue and Poway Chabad, hit no closer to home for me than the attacks upon Mother Emanuel African Methodist Episcopal church in Charleston, South Carolina, the Sikh temple at Oak Creek, Wisconsin, not to mention the United States Capitol.

In the years since President Kennedy was assassinated, more Americans have been killed by Americans with guns, right here on the homefront, than in all the wars the United States ever fought, combined. With 5% of the world's population, the United States is responsible for over 30% of the world's mass shootings of innocent civilians.

To put things in perspective, I want to run a little comparison between the United States and Israel. Because Israel has such a vital need for self-defense, a recent study found that there are 7 firearms per 100 people in Israel. Do you know how many firearms we have per 100 people in the United States? 89.

Surely we can't save everyone, but the Talmud teaches that "he who saves one life, it is as though he has saved the entire world" (Mishnah Sanhedrin 4:5). The rabbis added that: "If a person sits in their home and says to themselves, "What have the affairs of society to do with me?... Why should I trouble myself with the people's voices of protest? —if one does this, they cause the world to be overthrown" (Midrash Tanhuma, Mishpatim 2).

Leviticus 19:16 teaches, "you shall not stand idly by the blood of your neighbor." There is nothing more important in America than the right to life. If you love life, and you love children, then we can not stand idly by, while gun violence takes the lives of 30 Americans every single day.

There is an urgent need for the state to do more than we are. Through September, gun homicide in Connecticut is up 30 percent since last year. Further, this is a race issue: though only 10% of the state's population is Black, about 56% of the state's gun homicide victims are. Another 23% are Latinx.

The state is not adequately funding gun violence prevention and intervention programs. Beyond Project Longevity, the group violence intervention program, the Office of Legislative Research was not able to identify any state funding of these types of programs. Funding just one program strategy in three (now four) cities is insufficient to address the scope of the problem.

The state needs a more intentional strategy, and administrative capacity, to secure state and federal resources to provide stable funding for community-based programs based on models proven to reduce gun violence through prevention and intervention.

Creating a new commission may not be necessary to achieve the objectives laid out in SB-1 "to coordinate the funding and implementation of evidence-based, community-centric programs and strategies to reduce street-level gun violence in the state." The Office of Injury Prevention within the CT Department of Public Health was created by statute in 1993. Its duties include developing sources of funding to establish and maintain programs to prevent interpersonal violence, including homicide. The defined scope of "injury prevention" clearly includes gun violence.

Please know that churches, synagogues, masjids and temples across the state are feeling the pain of gun violence and urging our legislature to fully fund initiatives to study the problem and to protect our men, women and children.

Sincerely,

Rabbi Ari Rosenberg
Executive Director
Association of Religious Communities
24 Delay Street, Suite 4
Danbury, CT 06776

Hello, my name is Ben Simon and I'm a student at Hopkins School in New Haven, Connecticut. As someone that cares about my community, I am pro-common sense gun control for my community.

In 2020, the one-hundred-five gun homicides most affected cities my hometown of New Haven, a well as Bridgeport and Hartford. In New Haven, the richer and more fortunate Yale neighborhoods aren't immune from gun violence, such as the recent murder of Kevin Jiang that occurred blocks from my house. However, it is the historically discriminated-against and redlined communities of people of color that are most hurt by the rampant gun violence that plagues Connecticut.

I shouldn't have to stop going to my local basketball court because someone got shot there. I shouldn't have to play "firework or gunshot" when I'm trying to go to bed at night. I shouldn't have to plan my escape route if yet another person decides to shoot up their local high school. I'm tired.

GUN VIOLENCE INTERVENTION AND PREVENTION ADVISORY COMMITTEE

DR. DWAYNE SMITH'S TESTIMONY

NOVEMBER 17, 2021

Good evening. My name is Dr. Dwayne Smith, CEO of Housatonic Community College. I want to thank Senator Marilyn Moore & Chair Andrew Woods and the Gun Violence Intervention and Prevention Advisory Committee for the opportunity to provide testimony.

I speak from both professional and personal experiences on the impact of gun violence. I first arrived at Housatonic Community College in July 2020 from St. Louis, Missouri. A month later one of Housatonic's scholars was murdered, a victim of gun violence. A year later, we lost another Housatonic scholar to gun violence.

In March of 2020, my eldest son, who is an entrepreneur in Kansas City, was set up for a robbery. He was shot multiple times and left for dead. He was able to recover, but he still has permanent scars and a disability. He was fortunate; many victims of gun violence do not make it.

There is a myriad of reasons for gun violence and just as many solutions promoted. As a lifelong educator, I want to focus on the role of education. I do believe that a strong educational foundation has the power in transforming lives. Statistics bears this out. Studies suggest that there is a strong coalition between those individuals who are in the criminal justice system and their lack of education. African-Americans, specifically African-American men are the highest among any groups to be impacted by firearm homicide and it is most acute between the ages

of 20-34. Providing educational opportunities should be the linchpin in any serious movement to decreasing gun violence.

Community colleges can play a significant role in this endeavor. The majority of black and brown men who enter into higher education come through community colleges. Community colleges are nimble enough to provide various types of programs that attract diverse learners, especially those who are attempting to turn their lives around.

I would offer that providing an economic incentive through education makes a difference. At Housatonic alone, it is estimated that the last three graduating classes will earn a combined career income of close to two billion dollars. This is incredible considering that a majority of these graduates are the first in their families to graduate from college and are from low wealth families and communities; those communities that are many times caught in the crossfire of gun violence.

Partnering with Pre-K-12 educational systems, in creating a seamless educational pipeline can certainly make a difference. Community colleges can also serve as a partner in hosting robust discussions, symposiums and conferences in providing workable solutions to address the Nihilism, hopelessness and lack of opportunity that leads to the reckless state that our communities are enduring.

As CEO of Housatonic Community College, I can speak for my colleagues that comprise the Connecticut State Community Colleges, that we are eager to provide the necessary opportunities that can make a difference in the lives of all of our Connecticut citizens. Thank you.

BCYL

1067 Park Avenue
Bridgeport, CT 06604

Phone: 203.913.0073
www.bcyl.org

November 17, 2021

Re: Gun Violence Intervention and Prevention Advisory Committee Public Hearing

Dear Good Evening Chairman Woods, Senator Moore and Committee Members.

My name is John Torres, Executive Director of Bridgeport Caribe Youth Leaders. Caribe is a grass roots youth development organization serving annually, over 700 youth ages 5 to 21 and nearly 400 families. Our Objective is to provide youth with role models, mentors and support necessary for them to remain in school and have a clear pathway to college, vocational program or workforce upon graduating from high school so they can become contributing citizens in their community.

During our 18 years of serving the community, we have seen a pattern that is alarming! The number of gun violence incidents involving youth under the age of 16 and is directly impacting other youth and the community. On a recent field trip with some of our scholarship high school scholarship recipients; the conversation of gun violence came up as a classmate of some the participants was killed. I asked the group how they felt of what is going on? And Tiana one of the scholarship recipients and honor roll student stated "it is scary because it getting closer to me". "I know 3 people my age involved in shootings". Her experience is becoming more common and our youth and families are living in fear of being killed by a stray bullet or being caught in a cross-fire of violence.

In 2020 Bridgeport had 21 homicides involving guns; and September 30th of this year there has been 14 murders with many involving youngsters under the age of 16.

Caribe a member of Bridgeport's Youth Gun Violence Task Force, under the leadership of Marc Donald of RYSAP; is working together with the members of the taskforce to create a safe environment and provide the resources and hope to Bridgeport youth that will offer much needed physical, mental and social support so they can be best version of themselves.

And do not become another statistic!

I believe the State needs to invest more in preventing community gun violence that disproportionately impacts inner city communities and increase funding focused on intervention and prevention programs.

According to the Giffords Law Center, gun violence is estimated to directly cost Connecticut taxpayers at least $90 million annually. Investing more in community-based intervention and prevention programs would not only save lives and reduce the trauma inflicted on these communities, it would save money for taxpayers.Sincerely,

John Torres

Bridgeport, CT

Thank you for this opportunity. I'm Kelvin Young, Community Health Worker at InterCommunity Health Care. We're a nonprofit community health center providing primary care, mental health care, and addiction recovery services in Hartford, East Hartford, and South Windsor.

Research from the Educational Fund to Stop Gun Violence shows that the root causes of gun violence include poverty, lack of opportunity, underperforming schools, income inequality, under-funded public resources and housing, and easy access to firearms. Gun violence and other forms of violence have a profound effect on the community, and nearly everyone in communities of color is impacted.

Exposure to gun violence is associated with post-traumatic stress disorder, antisocial behavior, depression, risky alcohol, and drug use, stunted cognitive and emotional development, and an increased likelihood in engaging in violence. Far too many of people of all ages in our community have witnessed or been the victims of violence and suffer trauma as a result.

We know that trauma has damaging effects on learning, behavior, and health, especially in early childhood and adolescence. We need to do more to recognize trauma and support healing and treatment for individuals who have experienced or are experiencing trauma in any form, including the perpetrators of gun violence.

This means expanding funding for mental health and substance use. We know that more than half of adults and the majority of adolescents in Connecticut who have a mental illness such as depression or anxiety go undiagnosed or untreated, whether it's because of stigma, lack of access to care, lack of diversity in healthcare, and other barriers. This is especially true for Black and Brown communities, where there's a long history of disparity and inequities in health care.

Although most people who have a mental illness are not dangerous, for those people at risk for violence due to mental illness, suicidal thoughts, or substance use, mental health and addiction recovery treatment can often prevent gun violence. We need to support local organizations that address the social and economic problems that are at the root of gun violence. We also need community policing and police officers held accountable and trained in crisis intervention to de-escalate potentially violent situations, especially when an individual is having a mental health or substance abuse crisis. Thank you for your time.

Kelvin Young

The Commission on
Women, Children, Seniors, Equity & Opportunity

CWCSEO

Connecticut General Assembly

Report of the
GUN VIOLENCE INTERVENTION AND PREVENTION ADVISORY COMMITTEE
Submitted to the Connecticut General Assembly
Public Health and Human Services Joint Standing Committees
January 1, 2022

APPENDIX C:

SUPPORTING MATERIALS & ADDITIONAL RESOURCES

APPENDIX C1

Request to and Responses From State Agencies

The Gun Violence Intervention and Prevention Advisory Committee in November 2021 invited State agencies to share information regarding community violence and gun violence reduction initiatives within their agencies, including an articulation of the sources of funding for these initiatives. The Advisory Committee received the following responses:

1. **State Department of Mental Health and Addiction Services**
   a) ***NICS, Risk Warrants, and VATS in Connecticut,*** prepared by Michael Norko, MD, Director of Forensic Services, Connecticut Department of Mental Health and Addiction Services, 2021
   b) ***Timeline of Gun Legislation & Related Events Pertinent to Connecticut,*** prepared by Michael Norko, MD, Director of Forensic Services, Connecticut Department of Mental Health and Addiction Services, 2021
   c) ***Description of The Mental Health Adjudication Repository (MHAR)***
   d) ***Gun Control Legislation in Connecticut: Effects on Persons with Mental Illness,*** Michael A. Norko and Madelon Baranoski, Connecticut Law Review, May 2014
   e) ***Implementation and Effectiveness of Connecticut's Risk-Based Gun Removal Law: Does It Prevent Suicides?,*** Jeffrey W. Swanson, Ph.D., Michael A. Norko, MD, Mar Hsiu-Ju Lin, PhD, Kelly Alanis-Hirsch, PhD, Linda K. Frisman, PhD, Madelon V. Baranoski, PhD, MSN, Michele M. Easer, PhD, Allison G. Robertson, PhD, MPH, Marvin S. Swartz, MD, and Richard J. Bonnie, LLB, 2017
2. **Office of Legislative Research**
   a) **Response from George L. Miles, Esq., Office of Legislative Research**
3. **CT General Assembly Office of Fiscal Analysis**
   a) **Community Violence and Gun Violence Reduction Initiatives**
4. **State Department of Public Health**
   a) **The Connecticut Violent Death Reporting System and Homicide Victimology in Connecticut 2015 to 2021,** prepared by Michael Makowski, MPH, Connecticut Department of Public Health Epidemiologist, Injury and Violence Surveillance Unit
   b) **The Connecticut Violent Death Reporting System,** prepared by Michael Makowski, MPH, Connecticut Department of Public Health Epidemiologist, Injury and Violence Surveillance Unit
   c) **Background of Homicides in Connecticut 2015 to September 30, 2021,** prepared by Michael Makowski, MPH, Connecticut Department of Public Health Epidemiologist, Injury and Violence Surveillance Unit
5. **Department of Children and Families**
   a) **Response from Commissioner Vannessa L. Dorantes, LMSW**
6. **Police Transparency and Accountability Task Force**
   a) **Connecticut Bar Association Policing Task Force Report and Recommendations**, November 2021
   b) **Police Transparency and Accountability Task Force Infographic**
   c) **Policy Transparency and Accountability Task Force Annual Report,** January 2021

NICS, Risk Warrants, and VATS in Connecticut

Prepared by Michael Norko MD
Director of Forensic Services, DMHAS

Timeline

The gun control related events in Connecticut and nationally are outlined in the attached timeline. Further details about specific subjects are provided below.

Pre-NICS gun control legislation involving CT DMHAS

In PA 94-1, Section 4, the Connecticut General Assembly (CGA) prohibited gun permits to persons adjudicated not guilty by reason of mental disease or defect for 20 years after hospital release and to persons who were civilly committed in the past 12 months (codified at CGS 29-28). Following the CT Lottery Shootings in March 1998, the CGA enacted PA 98-129: Section 17 required the probate courts to report all civil commitment orders to DMHAS (civil commitment orders are other confidential); Section 18 required DMHAS to report those orders to the Department of Public Safety (DPS) when a person applies for a gun permit; Section 19 required DPS to verify mental health commitments prior to issuing gun permits. These notifications were to occur while respecting the confidentiality of these data in all three systems. In order to effectuate the bill, the Department of Information Technology (DOIT) facilitated the creation of a "black box" computer system that compared the databases and reported only matches between civil commitments and gun permits/applications to both DMHAS and DPS (now DESPP). Neither agency could search the records held by the other.

Risk warrants

In 1999, the CGA passed PA 99-212; Section 18 established the first legislation of its kind in the country permitting law enforcement to temporarily remove firearms from individuals believed to be at imminent risk to themselves or others (codified at CGS 29-38c). These laws have since become known as Red Flag Laws, or Extreme Risk Protective Orders. The law called for DMHAS to be notified of court orders of firearm removal in 29-39c(d). DMHAS has maintained a database of these notices, which has permitted research on the use and effectiveness of the state's risk warrant law (see Research section below). The database now consists of over 2200 risk warrants filed with the courts since 1999.

In 2021, the CGA passed PA 21-67, which in Section 1 allows family or household members or medical professionals to apply to the court for a risk warrant protection order (to temporarily remove firearms) when they have a good faith belief that a person poses a risk to self or others. This amendment will take effect June 1, 2022.

NICS

PA 05-283, Section 1 required that the state comply with provisions of the Brady Handgun Violence Prevention Act[1] passed by Congress in 1993, including reporting the relevant mental health adjudications (not guilty by reason of mental disease/defect, not competent to stand trial, civil commitment, appointment of conservator) to the National Instant Criminal Background Check System (NICS) of the FBI. The bill (codified at CGS 29-36/) required DMHAS, DESPP, and the Judicial Branch to enter into a Memorandum of Understanding (MOD) with the FBI to implement NICS reporting in Connecticut, without violating state or federal laws regarding confidentiality. That MOU was finalized in November 2006, utilizing the same "black box" protections of confidential mental health information.

In January 2008, Congress passed the NICS Improvement Amendments Act of 2007 (Public Law 110-180), which created fiscal incentives for states to comply with NICS reporting. DMHAS received a federal grant under this act, which was used to fund the creation of the Mental Health Adjudication Repository (MHAR), which is a digital record of past probate court adjudications and an electronic data system for future entries of probate court orders (see attached description of the MHAR). The MHAR has been used since 2011 in triennial audits by the FBI with DMHAS of the accuracy of NICS entries. In their September 2021 audit, FBI agents notified us that the FBI will want to see the actual court orders in the future, which are not contained in the MHAR. We will need to work with the FBI and the Probate Court Administrator prior to the next audit to arrange for the FBI auditors to inspect the probate court digital record system rather than the MHAR.

VATS

Following the Sandy Hook shootings, the CGA passed PA 13-3. In Sections 10 and 11, the CGA created firearms prohibition for six months following voluntary psychiatric admission (codified at CGS 29-28(b)). There was, however, no database in existence of voluntary psychiatric admissions in the state. Therefore, DMHAS and DESPP created the Voluntary Admission Tracking System (VATS) with similar "black box" protocols to those used for the civil commitment database. All psychiatric hospitals in the state (except for the VA Hospital in West Haven) report new voluntary admissions on a daily basis to the database, which automatically performs matching algorithms with the DESPP database of permits and eligibility certificates. That system was inaugurated October 1, 2013. DMHAS is periodically asked to report data on VATS prohibitions to the legislature or to the Office of Policy and Management. The system is managed by DMHAS Information Technology, which is available to produce such reports.

Research

Two major studies have been published regarding Connecticut's risk warrant statute (see attached copies of the articles):

- Norko MA, Baranoski M: Gun Control Legislation in Connecticut: Effects on Persons with Mental Illness. Connecticut Law Review 46: 1609-1631, 2014

[1] 18 U.S.C. §§ 921–922

- Swanson JW, Norko MA, Lin HJ, Alanis-Hirsch K, Frisman LK, Baranoski MV, Easter MM, Robertson AG, Swartz MS, Bonnie RJ: Implementation and effectiveness of Connecticut's risk-based gun removal law: does it prevent suicides? Law and Contemporary Problems 80: 179-208, 2017

Based on these studies and other work, Connecticut was invited to join a current national research endeavor on ERPO laws, comparing the results of these laws in six states. This study is funded by the National Collaborative on Gun Violence Research from September 2020 to September 2022. Multiple research papers are expected from this research effort related to the combined national data and to state-specific data (including Connecticut data related to criminal arrest and suicide).

In a few years, DMHAS researchers will have the opportunity to study the effects of PA 21-67 after enough data have been gathered following its June 1, 2022 effective date. It will be important to assess whether the new law leads to changes in the volume of risk warrants, their patterns of use, and further capacity to prevent harm from firearms.

DMHAS has supported several researchers involved in these studies.

From Yale University School of Medicine:

- Madelon Baranoski PhD, Professor of Psychiatry
- Tamika Hollis MBA, Research Associate
- Reena Kapoor MD, Associate Professor of Psychiatry
- Ashly Marte MS, Research Associate
- Michael Norko MD, Professor of Psychiatry

From UConn School of Social Work:

- Linda Frisman PhD, Research Professor
- Hsiu-Ju Lin, PhD, Associate Research Professor

DATE	ACT #	STATUTE / REF.	EFFECT
1923	Senate Bill 265	Chapter 252 (earliest version of current CGS 29-28)	Enacted pistol permit laws; only prohibitions: aliens and minors
1947		Sec. 715i [currently at CGS 29-29(a)]	Issuing authority may request applicant's criminal record to determine "suitability to carry…weapons". Felony convictions bar issuance of permit
1968	[Congress]	Gun Control Act: 18 USC § 922(d)(4) & 27 CFR § 478. 11	Prohibits gun possession/sale by people with mental health adjudications on federal level
3/30/81		**Reagan assassination attempt**	President, Press Secretary James Brady, Secret Service agent, and D.C. police officer wounded
1993	[Congress]	Brady Handgun Violence Prevention Act (first introduced 1987)	Required creation of NICS.[1] Required states to use instant background check system.
1994	P.A. 94-1, S. 4	CGS 29-28	Prohibits gun permit to those found NGRI[2] for 20 years after release from hospital, and those civilly committed in last 12 months
	P.A. 94-1, S. 3	53a-217c	Makes Class D Felony for gun possession by those found NGRI for 20 years after release from hospital, and those civilly committed in last 12 months
1995	P.A. 94-1, S. 16	CGS 29-36*l*	Dept of Public Safety (DPS) database established to verify status of gun permits
1997		*Printz v. U. S.* (521 U. S. 898 (1997)	USSC[3] ruling made use of NICS voluntary on part of states; otherwise violates 10th amendment if no federal funding
3/6/98		**CT Lottery Shootings**	Depressed man w/ 2 psychiatric hospitalizations kills 4 & self.
1998	P.A. 98-129, S. 18	CGS 17a-500(b)	Requires DMHAS[4] to report to DPS on civil commitments by probate court when person applies for gun permit. (S.17 required probate courts to report civil commitments to DMHAS). Ended "honor system" for civil commitment prohibition.
	PA 98-129, S. 19	CGS 29-38b	Requires DPS to verify mental health commitments prior to issuing gun permit.
4/20/99		**Columbine shootings**	2 high school students killed 13, injured 24, committed suicide
1999 (June 29)	PA 99-212, S.18	CGS 29-38c	**Permits gun seizures by police based on imminent risk to self/others, with warrant**
1999	P.A. 99-212, S. 7	CGS 29-36*l*	Established DPS as point of contact for NICS under Brady Act, S. 103
2005	P.A. 05-283, S. 4	CGS 29-28	Prohibited issuance of permit to applicant permanently prohibited from firearms pursuant to 18 USC 922 (g)(4) [mental health adjudications: NGRI, civil commitment, incompetence to stand trial, conservatorship]

[1] National Instant Criminal Background Check System
[2] Not guilty by reason of insanity. In CT, "not guilty by reason of mental disease or defect"
[3] United States Supreme Court
[4] Department of Mental Health and Addiction Services

	P.A. 05-283, S. 1	CGS 29-36*l*	Requires CT to comply with reporting to NICS of mental health adjudications & enter MOU[5] w/ FBI
Nov 2006		MOU w/ FBI took effect	Details DMHAS reporting of mental health commitments to DPS via "black box" automated system without identifying mental health information
4/16/07		**VA Tech shootings**	23 year old senior killed 32, wounded 17, killed self
1/8/08	[Congress] Public Law 110-180	NICS Improvement Amendments Act of 2007	Requires states to comply with reporting requirements, offers funds, threatens loss of funds for compliance failure; also required procedures for relief from federal firearms disability (i.e., prohibition) in each state
11/5/09		**Fort Hood shootings**	13 killed, 32 injured, gunman arrested
1/8/11		**Tucson shootings**	22-year-old kills 6, wounds 12, arrested
7/1/11	PA 11-134	45a-100	Created CT's system to comply with federal requirement for relief of firearms disability
7/20/12		**Aurora shootings**	Gunman kills 12, wounds 70 in movie theater, arrested
12/14/12		**Sandy Hook shootings**	20-year-old kills 20 children, 6 teachers, mother and self
7/1/13	PA 13-3		Sec. 8 Increased state firearm prohibition for civil commitment from 12 to 60 months & added prohibition for voluntary psychiatric admissions for 6 months after date of admission. Secs. 10-11 established reporting responsibilities for hospitals, DMHAS, DESPP[6]
10/1/13	PA 13-220, S. 20	45a-100(k)	Altered language regarding relief from federal firearms disability
6/14/21	PA 21-35, S. 9		Established a gun violence intervention and prevention advisory committee
6/24/21	PA 21-67, S. 1 (effective 6/1/22)	29-38c	Allows family or household members or medical professionals to apply directly to superior court for risk warrant protection order when they have good faith belief that a person poses risk to self/others. Requires entry into NICS of investigation orders.

[5] Memorandum of Understanding
[6] Department of Emergency Services and Public Protection (formerly DPS)

The Mental Health Adjudication Repository (MHAR)

The **Mental Health Adjudication Repository (MHAR)** is the central repository for involuntary commitment and involuntary conservator data housed at the Department of Mental Health and Addiction Services (DMHAS). The MHAR system is fed nightly by the Connecticut Probate Case Management System (CMS). This CMS data consists of involuntary conservator and involuntary commitment cases that are added and updated to the CMS system by Probate courts throughout the state. The data, once migrated to MHAR, is sent on to the Special Licensing Firearms Unit (SLFU), within Department of Emergency Services and Public Protection (DESPP) which responds with assigned ARI/NRI for all new records. Not guilty by reason of insanity and not competent to stand trial records are also imported from the Judicial system.

Automated nightly processes also compare and check data for DESPP matches for possession of firearms, etc. If a match is found, the information is prominently displayed for MHAR users, who then use the system to verify the person's location and then produce letters from DMHAS to the hospital where the individual is being treated to aid clinical staff in their work. Users can view a history of the commitment that has been provided by CMS for each matched person, as well as use the system to edit and track additional info not fed by CMS (such as firearm/permit status and hospital/institution contact information)

Tight security limits data access to an authorized user base. The system has full internal interactive search capabilities, so MHAR users can easily search for individuals and respond to external ad hoc requests from the DESPP and the FBI. This allows the appropriate data to be returned while still adhering to the Health Insurance Portability and Accountability Act (HIPAA) regulations. Ad hoc reporting is also available through the interface (both list and statistical analysis reports).

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LAW REVIEW

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Article

Gun Control Legislation in Connecticut: Effects on Persons with Mental Illness

MICHAEL A. NORKO & MADELON BARANOSKI

This Article examines the ways in which Connecticut and federal legislative efforts on gun control have affected persons with mental illness in the state and includes a brief history of that legislation in the context of tragic gun violence. There have been two major legislative and policy directions: (1) federal and state prohibitions on gun ownership related to several types of mental health adjudications; and (2) Connecticut's 1999 statute permitting gun seizures by law enforcement officers in situations of increased risk of harm to individuals—the first statute of its kind in the nation. We present available data about each of these two efforts, which show no support for the proposition that laws targeting persons diagnosed with mental illness will curb gun violence. The implications of these data are discussed, as well as the deleterious effects of stigma on the public health. The strengths of Connecticut's gun seizure law as an approach to reducing violence by people in distress are reviewed.

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I. INTRODUCTION

In 1923, Connecticut enacted its first gun control legislation in the form of pistol and revolver permit requirements.[1] At that time, the only groups prohibited from obtaining permits were aliens and minors.[2] By 1947, the Connecticut General Statutes prohibited the issuance of a permit to anyone convicted of a felony and allowed the issuing authority to request the applicant's criminal record to "make an investigation concerning his suitability to carry any such weapons."[3]

Roughly two decades later, Connecticut's firearm permitting scheme was complemented by federal gun control measures. With the Gun Control Act of 1968,[4] Congress created several broad categories of persons prohibited from possessing firearms, including those who have "been adjudicated as a mental defective or . . . committed to any mental institution."[5] The term "adjudicated as a mental defective" is now defined in 27 C.F.R. § 478.11 to include a judicial determination that a person is a danger to himself or others or lacks the mental capacity to contract or manage his own affairs, or a finding of insanity or incompetence to stand trial by a criminal court.[6] This unfortunate language was not improved upon in the NICS Improvement Amendments Act of 2007[7] and has become the subject of advocacy.[8] The federal law remains unchanged, but the

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[1] Act of June 2, 1923, 1923 Conn. Pub. Acts 3707.

[2] *Id.* at 3708–09. Minors were defined to include anyone under the age of eighteen years old. *Id.* at 3709.

[3] CONN. GEN. STAT. § 715i (Supp. 1947) (current version at CONN. GEN. STAT. § 29-29(a) (2013)).

[4] Pub. L. No. 90-618, 82 Stat. 1213 (codified as amended at 18 U.S.C §§ 921–928 (2012)).

[5] § 102, 82 Stat. at 1220 (codified as amended at 18 U.S.C § 922(d)(4)).

[6] 27 C.F.R. § 478.11 (2013).

[7] Pub. L. No. 110-180, § 3, 121 Stat. 2559, 2561 (2008) (codified as amended at 18 U.S.C. § 922).

[8] *See, e.g.*, Michael A. Norko & Victoria M. Dreisbach, *Letter to the Editor*, 36 J. AM. ACAD. PSYCHIATRY & L. 269, 269–70 (2008) (urging Congress to delete the phrase "adjudicated as mental

Federal Bureau of Investigation (FBI) agreed in 2008 to refer to these individuals using neutral terms in documents.[9] Unfortunately, however, as late as November 2011 the FBI referred to its "Mental Defective File" in testimony to the Senate Judiciary Committee, Subcommittee on Crime and Terrorism.[10] In Connecticut, these definitions apply to probate orders of civil commitment, appointments of a conservator of person or estate, and the two criminal court findings identified in the United States Code.[11]

The Brady Handgun Violence Prevention Act[12] was introduced to Congress in 1987 and enacted in 1993.[13] It required a five-day waiting period for gun purchases, but also stipulated that this term would sunset after five years.[14] The Brady Act further prompted the Attorney General to establish the National Instant Criminal Background Check System (NICS) within five years.[15] While NICS was under development, the Brady Act required state officers to conduct background checks—but the U.S. Supreme Court held that the directive was unconstitutional.[16] In 1998, NICS came into existence and the five-day waiting period lapsed, allowing for immediate gun purchases.[17]

With this preliminary regulatory framework now in place, Part II of this Article will proceed to discuss more contemporary developments in Connecticut's mental health-related firearm prohibitions. Notably, this will include a presentation of empirical data relating to warrants served for "imminent risk" gun seizures in Connecticut. Part III will explore Connecticut's experience with the NICS reporting scheme. Part IV will

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defective" and replace it with "the subject of a mental health adjudication"); *see also* Jana R. McCreary, *"Mentally Defective" Language in the Gun Control Act*, 45 CONN. L. REV. 813, 862–63 (2013) ("The use of *adjudicated as a mental defect* is not only outdated, but is (and always should have been deemed) pejorative. This language should be updated to reflect what most have understood it to be: a prohibition against a person who, because of a mental deficiency or intellectual disability, is unable to manage her affairs.").

[9] *See* Michael A. Norko, *Letter to the Editor*, 36 J. AM. ACAD. PSYCHIATRY & L. 428, 428 (2008) (informing readers that the FBI intended to rewrite their coding manuals and reports to no longer use the term "mental defective"); *see also National Instant Criminal Background Check System (NICS) Operations 2012*, FED. BUREAU INVESTIGATION, http://www.fbi.gov/about-us/cjis/nics/reports/2012-operations-report (last visited Apr. 15, 2014) (quoting the language of 18 U.S.C. § 922(g)(4), but elsewhere using the phrase "prohibiting mental health adjudications).

[10] *The Fix Gun Checks Act: Better State and Federal Compliance, Smarter Enforcement: Hearing Before the Subcomm. on Crime & Terrorism of the S. Comm. on the Judiciary*, 112th Cong. (2011) (statement of David Cuthbertson, Assistant Dir., Criminal Justice Information Services Division, Federal Bureau of Investigation).

[11] CONN. GEN. STAT. § 17a-495 (2013).

[12] Pub. L. No. 103-159, 107 Stat. 1536 (1993) (codified as amended at 18 U.S.C. §§ 921–922 (2012)).

[13] *Id.*; S. 466, 100th Cong. (1987); H.R. 975, 100th Cong. (1987).

[14] § 102, 107 Stat. at 1536–37.

[15] § 103, 107 Stat. at 1541.

[16] Printz v. United States, 521 U.S. 898, 923 (1997).

[17] *National Instant Criminal Background Criminal Background Check System*, FED. BUREAU INVESTIGATION, http://www.fbi.gov/about-us/cjis/nics (last visited Apr. 15, 2014).

describe Connecticut's most recent firearm legislation, which followed the tragedy at Sandy Hook Elementary School. Transitioning into a critical assessment of this entire regime of firearm prohibitions, Part V will identify lessons to be learned about risk factors for violence and regulatory efficacy. Part VI concludes with forward-looking recommendations.

II. CONNECTICUT'S MENTAL HEALTH-RELATED FIREARM PROHIBITIONS

Connecticut legislation related to mental health and gun regulations has taken two directions: (1) placing prohibitions on gun permits based on various mental health adjudications; and (2) creating a mechanism for the temporary seizure of legally owned guns from those deemed to pose a risk of imminent personal injury without arrest or criminal investigation. The first avenue of applying mental health prohibitions to gun ownership was initially an intra-state mechanism, but now it is consistent with federal law and based on the foundation of background checks for sales and permits. The second approach, however, was unique at its inception and remains a rare approach today, with only Indiana having subsequently enacted a similar law.

A. *Prohibition of Permits*

The Connecticut General Assembly first enacted mental health prohibitions for gun permits in 1994.[18] In their present-day form, these prohibitions prevent gun permits from being issued to anyone who has been discharged from custody within the last twenty years after being "found not guilty of a crime by reason of mental disease or defect," or who has been involuntarily committed to a psychiatric hospital within the last five years.[19] Possession of a pistol or revolver by such prohibited persons is a Class C felony.[20] The Department of Emergency Services and Public Protection (DESPP) is responsible for maintaining a database, which sellers or transferors of pistols or revolvers "may access" to determine whether a permit is valid, revoked, or suspended.[21] For some time following enactment, however, there was no system in place to monitor whether persons applying for gun permits were subject to mental health-

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[18] *See* Act of July 7, 1994, No. 94-1, § 3(a), 1994 Conn. Acts 1527, 1530 (Spec. Sess.) (codified as amended at CONN. GEN. STAT. § 29-28(b) (Supp. 2014)) (making mental health treatment history a potential element of criminal possession of a pistol or revolver).

[19] CONN. GEN. STAT. § 29-28(b).

[20] *Id.* § 53a-217. Prior to October 1, 2013, such possession was a Class D felony. In Public Act 13-3, the General Assembly changed the penalty to a Class C felony, "for which two years of the sentence imposed may not be suspended or reduced by the court." *See* Public A. 13-3, 2013 Gen. Assemb., Reg. Sess. § 45 (Conn. 2013), *available at* http://www.cga.ct.gov/2013/ACT/pa/pdf/2013PA-00003-R00SB-01160-PA.pdf.

[21] *Id.* § 29-36*l*(a).

related prohibitions.

On March 6, 1998, an accountant at the Connecticut Lottery Corporation killed four co-workers with a gun and knife before committing suicide.[22] He had been involved in a seven-month dispute over his salary and lack of promotion.[23] Notably, the perpetrator had a history of depression, had attempted suicide in the past, and was receiving treatment.[24] Less than three months after this tragedy, the Connecticut General Assembly passed Public Act 98-129, which, among other things, created a system for checking whether individuals had been subject to the gun prohibitions based on civil commitment.[25] This ended what had been essentially an honor system for persons applying for permits. Probate courts must now report commitment orders to the Department of Mental Health and Addiction Services (DMHAS) within three business days.[26] Further, DMHAS must report those commitment orders to DESPP "for a person who applies for or holds a permit or certificate."[27] In turn, DESPP must verify mental health commitment information prior to issuing a gun permit "in such a manner as to only receive a report on the commitment status of the person with respect to whom the inquiry is made."[28]

Prior to these enactments, the records of commitments in probate court, records of gun permits held by the DESPP, and psychiatric records held by DMHAS were all considered confidential. Public Act 98-129 called for exceptions to each of these confidentialities and for special handling of the releases of the relevant information to apply only to individual permit holders or applicants.[29] To accomplish the dual objectives of reporting and maintaining confidentiality, DESPP and DMHAS collaborated with the Department of Information Technology to create a "black box" computer system that would compare the databases held by each agency for matches and report only those matches to both

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[22] Jonathan Rabinovitz, *Rampage in Connecticut: The Overview; Connecticut Lottery Worker Kills 4 Bosses, Then Himself*, N.Y. TIMES (Mar. 7, 1998), http://www.nytimes.com/1998/03/07/nyregion/rampage-connecticut-overview-connecticut-lottery-worker-kills-4-bosses-then.html?pagewanted=all&src=pm; John Springer, *March 7, 1998: Worker Kills 4 Bosses, Self at Lottery Site*, HARTFORD COURANT (Mar. 7, 1998), http://articles.courant.com/1998-03-07/news/hc-lottery-shooting-newington-1998_1_lottery-president-otho-brown-connecticut-lottery-headquarters-matthew-e-beck.

[23] Rabinovitz, *supra* note 22.

[24] *Lottery Gunman's Parents: "We Love You Matt—but Why?,"* CNN (Mar. 8, 1998), http://www.cnn.com/US/9803/08/lottery.killings/index.html.

[25] Act of May 27, 1998, No. 98-129, §§ 17–19, 1998 Conn. Acts 516, 527–30 (Reg. Sess.) (codified as amended at CONN. GEN. STAT. §§ 17a-499, 17a-500(b), 29-38b).

[26] CONN. GEN. STAT. § 17a-499.

[27] *Id.* § 17a-500(b).

[28] *Id.* § 29-38b.

[29] §§ 17–19, 1998 Conn. Acts at 527–30.

agencies.[30] A match thus occurs when a permit holder is civilly committed or when a person who had been civilly committed applies for a permit. Neither agency can search the database of the other agency.

As of March 1, 2013, 6700 civil commitments were reported by the probate courts to DMHAS. Among those commitments, 71 unique matches were identified (an occurrence rate of 1%). Of those matches, all but one was for an individual who was committed sometime after being granted a gun permit. Put differently, only one person attempted to apply for a gun permit after having been civilly committed (an occurrence rate of 0.015%).

B. *Temporary Seizure of Legally Owned Guns*

On June 29, 1999, the Connecticut General Assembly passed Public Act 99-212.[31] As initially proposed, the bill would have made relatively minor changes to sections 29-28 through 29-32 of the Connecticut General Statutes.[32] But the final form of the Act, apparently influenced by the Connecticut Lottery shooting,[33] created a process for gun seizure.[34] As a result, after obtaining a warrant, law enforcement officers can now seize firearms from any person who is deemed to pose "a risk of imminent personal injury to himself or herself or to other individuals."[35]

Crucially, this process for gun seizure avoids stigmatizing persons with mental illness since the risk, as defined, could be related to a number of circumstances, including recent threats or acts of violence and recent acts of cruelty to animals.[36] In reviewing the warrant application, judges can consider the reckless use of a firearm, a history of the use or attempted or threatened use of force against others, illegal use of controlled substances, abuse of alcohol, and prior involuntary psychiatric hospitalization.[37] Thus, although mental health history might be a factor in assessing dangerousness in a given situation, it is only one of several factors that

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[30] The description of this computer system is based on the personal experience of one of the authors, who has worked extensively with DESPP. The civil commitment data in the ensuing paragraph is available to him in connection with his official duties at DMHAS.

[31] Act of June 29, 1999, No. 99-212, 1999 Conn. Acts 790 (Reg. Sess.) (codified as amended in scattered sections of CONN. GEN. STAT.).

[32] S.B. No. 1166, 1999 Gen. Assemb., Reg. Sess. (Conn. 1999).

[33] Adam Gorlick, *Gun-Seizure Law Targets the Unstable*, L.A. TIMES, Oct. 24, 1999, at 25. The legislative atmosphere may also have been influenced by the tragedy at Columbine, which occurred just two months prior to the passing of Public Act 99-212. On April 20, 1999, the nation was shocked by the Columbine shootings, in which two high school students killed thirteen people and injured twenty-four others at their school before taking their own lives. HON. WILLIAM H. ERICKSON, COLUMBINE REVIEW COMM'N, THE REPORT OF GOVERNOR BILL OWENS 139 (2001).

[34] § 18, 1999 Conn. Acts at 801–02.

[35] CONN. GEN. STAT. § 29-38c(a).

[36] *Id.*

[37] *Id.*

might lead to a court's finding of imminent risk that justifies gun seizure.

Courts must also consider the need for emergency mental health intervention. Should a court find that a person "poses a risk of imminent personal injury . . . it shall give notice to [DMHAS] which may take such action pursuant to chapter 319i as it deems appropriate."[38] Chapter 319I is entitled "Persons with Psychiatric Disabilities," and it includes provisions for psychiatric hospitalization and treatment within the least restrictive alternatives.[39]

Connecticut's "imminent risk" statute, which, as described, permits a law enforcement officer to instigate the seizure of a gun before its owner is taken into custody in connection with an act of violence, was considered the first of its kind.[40] In 2006, after an August 2004 incident left one police officer dead and four other officers wounded, Indiana passed a similar law that permits firearm seizure without an arrest—or even a warrant.[41] No other states have followed this line of legislation to date.

C. *Implementation and Use of the "Imminent Risk" Gun Seizure Statute in Connecticut*

From October 1, 1999, through July 31, 2013, 764 warrants for "imminent risk" gun seizures have been served in Connecticut, with 53% of them being served since 2010.[42] This increase in served warrants over time is a statistically significant increase compared to what would be expected due to random variation alone.

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[38] *Id.* § 29-38c(d).

[39] *Id.* ch. 319I.

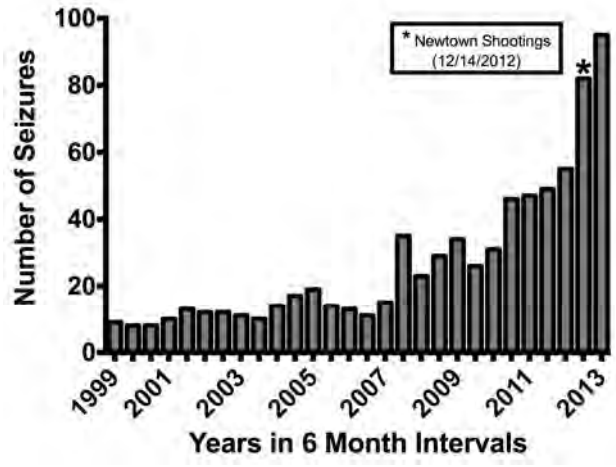
[40] Gorlick, *supra* note 33.

[41] 2006 Ind. Acts 445 (codified as amended at IND. CODE § 35-47-14-3 (2013)); *see One Officer Killed, Four Others Wounded in Southside Shootout: Suspect, Mother Also Dead*, WIBC (Aug. 18, 2004), http://www.wibc.com/news/story.aspx?id=31679 (providing local reporting on the shooting tragedy).

[42] The courts copy all warrant applications to DMHAS so that the Department "may take such action pursuant to chapter 319i as it deems appropriate." CONN. GEN. STAT. § 29-38c(d). The warrant applications are supplied in advance of the hearing so that jail diversion clinicians in the courts may be prepared to offer assistance to the individual at the time of the hearing. The related data analysis reported in this Article, and detailed especially within this Part II.C, is derived from the authors' private review of all of these 764 warrant applications.

FIGURE 1

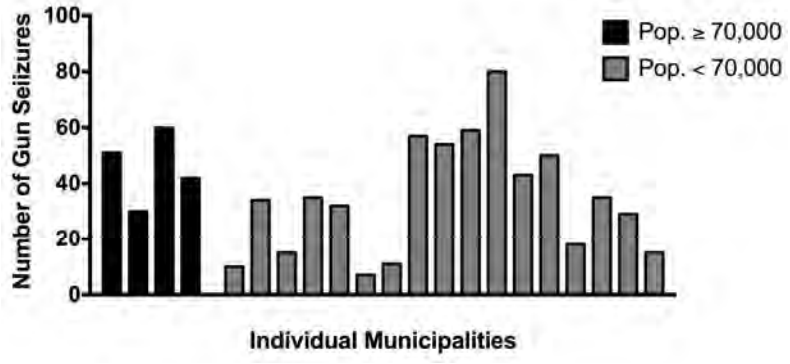
FREQUENCY OF GUN SEIZURES FROM 1999 THROUGH 2013



The extreme spike in the number of warrants served corresponds to the months after the Sandy Hook shootings. As reflected in Figure 1 above, however, the increase in seizures began in 2008 and trended upward again in mid-2010.

FIGURE 2

DISTRIBUTION OF TOTAL GUN SEIZURES ACROSS LARGE AND SMALL CONNECTICUT MUNICIPALITIES



Warrants were served in 164 of the 169 towns in Connecticut. As reflected in Figure 2 above, the resulting seizures occurred at a higher rate (based on number of seizures per population) in smaller towns (populations under 70,000) than in larger municipalities. Smaller towns comprise 31% of Connecticut's population but accounted for 76% of the gun seizure warrants; large municipalities account for 69% of the population but

contributed only 24% of the warrants.

Warrants were served to seven hundred men (91.5% of the total served warrants) and sixty-four women (8.5% of the total served warrants). The persons served with warrants ranged in age from 21 to 92 years, with an average age of 47.4 years.[43] The 64 women were between the ages of 30 and 84. The men ranged in age from 18 to 92, with 16% under the age of 30 and 0.6% over the age of 90. Twenty-seven percent of those served warrants were married. Five percent, all men, were veterans; eight of whom had been deployed to a war zone within the year before the warrant was served.

Review of the police reports indicated that for both men and women, the plurality of the calls were from family or friends of the gun owners. But, surprisingly, the second most frequent alerts came from people unrelated to the gun owners, including landlords, neighbors, and members of the public. Calls from clinicians and employers each accounted for about 5% of the reports. Six percent of the men and 2% of the women made the call reporting their own distress.

Over 400 (53%) of the warrants concerned the risk of self-harm. However, the nature of the risk varied significantly by gender: 83% of women posed a risk to themselves with the firearm, compared to 51% of the men.[44] Reports for the men indicated that 24% posed a risk to others and an additional 9% were viewed as a risk to both themselves and others. For the women, only ten (15%) were viewed as risky to others and only two (3%) posed a risk to themselves and others.[45]

Notably, the majority of gun owners who were served warrants had no history of psychiatric treatment. Only 20% of the men and 30% of the women had been involuntarily hospitalized in the past. Even fewer—10% of the men and 20% of the women—had received services from DMHAS. At the time of the gun seizure, only 1% of the men and none of the women were in active treatment.

Also, police noted at the time of confiscation that about 30% of both men and women showed evidence of alcohol consumption, and less than 5% of the men were described as using street drugs (marijuana and cocaine). Moreover, police reports noted that 10% of both men and women indicated using prescribed pain medications.

In 596 (78%) of the cases, the police reports described events and circumstances associated with the increased risk of violence with a firearm. The two most frequently cited triggers were "conflict in the relationship with a significant other" and "depression." Grief secondary to the death of

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[43] The standard deviation was 14.7 years.

[44] This represented a statistically significant difference ($p = 0.029$).

[45] Not all of the warrant applications are contained in this data, so the figures do not add up to one-hundred percent.

a family member was described in 5% of the reports; health concerns and financial concerns each accounted for 5% as well. Problems with co-workers and neighbors were described in 4% of the cases.

The triggers did not vary by gender, but they did by age. For 53% of those 35 years and younger, relationship conflict was the primary stressor. For those 60 years and older (about 19% of the total population), the main sources of stress were death of a significant other (42%) and failing health (39%). All four of the men over 90 years of age had lost their spouse within the previous two years.

When the police served the warrant, the majority of the gun owners were sent to the emergency departments (ED) of the local hospital by the police: 60% of the men and 80% of the women required an emergency evaluation. Only 20% of the gun owners were arrested, while 16% (all of whom were men) were arrested *and* sent to the ED. Unfortunately, the results of the ED assessments were not reported to DMHAS. Future research will include a follow-up concerning the ED assessment after the gun seizure.

Another reporting gap in the law and associated policies is that the outcome of the mandatory hearing after the seizure (where judges decide whether the firearms can be returned) is not reported to DMHAS. In over 70% of the cases, the outcome of the hearings was unknown. For the cases with outcomes reported, the judges ruled that the weapons needed to be held by the state 68% of the time. Weapons were returned in only twenty of the reported cases. In fifteen other cases, guns were given to a family member; in thirty cases, the guns were destroyed.

III. NICS REPORTING

A. *Connecticut Legislation and Reported Data*

In 2005, the Connecticut General Assembly enacted legislation requiring that the state comply with provisions of the Brady Act and report relevant mental health adjudications within the state to NICS.[46] Thus, under Connecticut law, a gun permit may not be issued to any applicant who is prohibited from gun ownership under 18 U.S.C. § 922(g)(4)—in notable avoidance of the prejudicial language in the federal code that refers to adjudication as a "mental defective."[47] The resulting statute also prompted DESPP, DMHAS, and the Judicial Department to enter into a memorandum of understanding (MOU) with the FBI "for the purpose of

[46] Act of July 13, 2005, No. 05-283, 2005 Conn. Acts 1116 (Reg. Sess.) (codified as amended in scattered sections of CONN. GEN. STAT.).

[47] CONN. GEN. STAT. § 29-28(b).

implementing [NICS] in the state."[48] That MOU was finalized in November 2006, at which point the data system in place relating to civil commitments was used to forward information about those individuals as prohibited persons directly to NICS without DESPP seeing the records and without identifying mental health information.[49]

The legislation requiring such reporting affected tens of thousands of Connecticut residents without regard to whether they were seeking firearm licenses. From 2003 to 2012, the following mental health adjudications were tallied in Connecticut:

- Incompetent to stand trial: 2094 (approximately 200 per year).
- Civil commitment: 5014 (approximately 500 per year).
- Not guilty by reason of mental disease or defect: 51 (approximately 5 per year).
- Conservatorship: approximately 20,000 (approximately 2,000 per year).

The number of persons reported to NICS during this ten-year period contrasts sharply with the number of persons who sought and were denied gun permits. From 2005 to 2010, there were fourteen reported denials of gun permit applications.[50] If one allows for a rough comparison between these overlapping periods, based on the categories bulleted above the occurrence rate would be approximately 0.09%.

B. *NICS Improvement Amendments Act of 2007*

On April 16, 2007, a twenty-three-year-old senior at Virginia Tech used two semi-automatic handguns to kill thirty-two people and wound an additional seventeen before killing himself.[51] The young man had previously been declared mentally ill and dangerous to himself and was ordered to attend outpatient treatment.[52] This event strengthened the link in public opinion between mental illness and dangerousness[53] and spurred

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[48] *Id.* § 29-36*l*(d)(2).

[49] This account is based on the personal experience of one of the authors, who participated in the interagency work group. The data in the subsequent bullet list is made available to him in connection with that role.

[50] Office of Policy & Mgmt., State of Conn., NARIP Fiscal Year 2011 Grant Application, Attachment No. 2: NICS Record Improvement Plan 19–20 (2011) (on file with author).

[51] VA. TECH REVIEW PANEL, MASS SHOOTINGS AT VIRGINIA TECH 5, 71, N-3 (2007), *available at* http://www.washingtonpost.com/wp-srv/metro/documents/vatechreport.pdf.

[52] *Id.* at 48.

[53] *See* Marilyn Price & Donna M. Norris, *National Instant Criminal Background Check Improvement Act: Implications for Persons with Mental Illness*, 36 J. AM. ACAD. PSYCHIATRY & L.

the NICS Improvement Amendments Act of 2007.[54] By making federal funds available to the states for participation and threatening loss of funds granted under the Omnibus Crime Control and Safe Streets Act of 1968 for failure to participate adequately, Congress aimed to encourage states' reporting to NICS.[55] However, because of severe limitations in states' ability to collect and report relevant records, the Department of Justice "has not administered [the Act's] reward and penalty provisions."[56] As of April 2014, thirty-six states had passed laws authorizing or requiring the submission of mental health records to NICS.[57] An additional seven states authorize or require the collection of mental health records in in-state databases only.[58]

Unfortunately, the passage of the NICS Improvement Amendments Act has been followed by further tragedies. The Fort Hood shootings occurred on November 5, 2009, leaving thirteen persons killed and thirty-two injured.[59] The Tucson shootings occurred on January 8, 2011, leaving six persons killed and thirteen wounded.[60] The Aurora shootings occurred on July 20, 2012, with twelve persons killed and fifty-eight others injured.[61] The Tucson shooter and the Aurora suspect have both been reported as having psychiatric illnesses.[62]

During the time of these tragedies, Connecticut responded to a provision in the NICS Improvement Amendments Act that induced states to create a system for providing relief from the federal firearms prohibition, i.e., a "firearms disability" program.[63] After a legislative

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123, 125 (2008) ("The new centerpiece of federal legislation affecting the purchase of firearms by persons with a history of mental illness . . . was introduced after the Virginia Tech tragedy . . . .").

[54] *See* Pub. L. No. 110-180, § 2, 121 Stat. 2559, 2560 (2008) (acknowledging that the Virginia Tech tragedy renewed the need for a more robust background check system).

[55] *Id.* § 104, 121 Stat. at 2569.

[56] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-684, GUN CONTROL: SHARING PROMISING PRACTICES AND ASSESSING INCENTIVES COULD BETTER POSITION JUSTICE TO ASSIST STATES IN PROVIDING RECORDS FOR BACKGROUND CHECKS 24 (2012).

[57] *Mental Health Reporting Policy Summary*, L. CENTER TO PREVENT GUN VIOLENCE, http://smartgunlaws.org/mental-health-reporting-policy-summary/ (last visited Apr. 15, 2014).

[58] *Id.*

[59] Billy Kenber, *Nidal Hasan Sentenced to Death for Fort Hood Shooting Rampage*, WASH. POST, (Aug. 28, 2013), http://www.washingtonpost.com/world/national-security/nidal-hasan-sentenced-to-death-for-fort-hood-shooting-rampage/2013/08/28/aad28de2-0ffa-11e3-bdf6-e4fc677d94a1_story.html.

[60] Alan R. Felthous, *The Involuntary Medication of Jared Loughner and Pretrial Jail Detainees in Nonmedical Correctional Facilities*, 40 J. AM. ACAD. PSYCHIATRY & L. 98, 98 (2012).

[61] Dan Frosch & Kirk Johnson, *Gunman Kills 12 at Colorado Theater; Scores Are Wounded, Reviving Debate*, N.Y. TIMES, July 21, 2012, at A1.

[62] *See* Felthous, *supra* note 60, at 98–99 (describing the Tucson shooter's psychiatric illness); Brady Dennis et al., *Suspect in Shooting Was Seeing Psychiatrist*, WASH. POST, July 28, 2012, at A1 (stating that the Aurora shooter was seeing a University of Colorado psychiatrist who studies schizophrenia).

[63] *See* Pub. L. No. 110-180, § 103(c), 121 Stat. 2559, 2568 (2008) (making a state's eligibility for certain grant monies contingent upon certification that it has established a firearms disability program).

attempt to comply with this requirement failed in 2010,[64] the Connecticut General Assembly adopted Public Act 11-134 on July 8, 2011.[65] This created a process whereby a person prohibited from firearms possession under 18 U.S.C. §§ 922(d)(4) and 922(g)(4) based upon an adjudication in Connecticut can petition the probate court for relief from the federal firearms disability.[66] The applicant bears the burden of proving by clear and convincing evidence that he or she "is not likely to act in a manner that is dangerous to public safety, and . . . granting relief from the federal firearms disability is not contrary to the public interest."[67] The applicant must make criminal, medical, mental health, and other records available to the court.[68] As of this writing, a relief hearing as created in Public Act 11-134 has not occurred.[69]

IV. THE SANDY HOOK TRAGEDY AND PUBLIC ACT 13-3

It is a still-painful memory that on December 14, 2012, a twenty-year-old gunman took the lives of twenty young school children and six teachers at the Sandy Hook Elementary School, as well as his mother, before killing himself.[70] The final report of the State's Attorney, released on November 25, 2013, states:

> [T]he shooter had significant mental health issues that affected his ability to live a normal life and to interact with others, even those to whom he should have been close. As an adult he did not recognize or help himself deal with those issues. What contribution this made to the shootings, if any, is unknown as those mental health professionals who saw

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This inducement was only linked to providing relief from federal firearms prohibitions; the NICS Improvement Amendments Act did not similarly induce states to create a relief mechanism for their own prohibiting statutes. *See id.* § 105, 121 Stat. at 2569–70 (outlining the requirements of a qualifying firearms disability program, which is only identified as one that serves persons affected by 18 U.S.C. §§ 922(d)(4), (g)(4)).

[64] S.B. No. 458, 2010 Gen. Assemb., Reg. Sess. (Conn. 2010).

[65] Act of July 8, 2011, No. 11-134, 2011 Conn. Acts 1670 (Reg. Sess.) (codified as amended at CONN. GEN. STAT. § 45a-100 (2013)).

[66] CONN. GEN. STAT. § 45a-100(a). Connecticut's system only provides relief in connection with the federal firearms prohibitions under 18 U.S.C. §§ 922(d)(4) and 922(g)(4), and does not extend to state mental health prohibitions articulated in section 29-28 of the Connecticut General Statutes. *Id.*

[67] *Id.*

[68] *Id.*

[69] This information is available to one of the authors in connection with his participation in an interagency work group.

[70] STEPHEN J. SEDENSKY III, OFFICE OF THE STATE'S ATT'Y, JUDICIAL DISTRICT OF DANBURY, REPORT OF THE STATE'S ATTORNEY FOR THE JUDICIAL DISTRICT OF DANBURY ON THE SHOOTINGS AT SANDY HOOK ELEMENTARY SCHOOL AND 36 YOGANANDA STREET, NEWTOWN, CONNECTICUT ON DECEMBER 14, 2012, at 1–2 (2013) [hereinafter SANDY HOOK REPORT], *available at* http://www.ct.gov/csao/lib/csao/Sandy_Hook_Final_Report.pdf.

> him did not see anything that would have predicted his future behavior. He had a familiarity with and access to firearms and ammunition and an obsession with mass murders, in particular the April 1999 shootings at Columbine High School in Colorado. Investigators however, have not discovered any evidence that the shooter voiced or gave any indication to others that he intended to commit such a crime himself.[71]

The Connecticut General Assembly's sweeping response to the Sandy Hook tragedy took form in Public Act 13-3, which was approved on April 4, 2013, more than seven months before the final report was available.[72] There are three sections of the Act that are particularly relevant to the purposes of this Article. Section 8 raised the state prohibition on permits and gun possession from twelve to sixty months following an individual's release from civil commitment.[73] Given that the federal prohibitions under NICS are indefinite, this change would only be relevant in the event that a person who was civilly committed is able to successfully gain relief through the probate court from the federal firearms prohibition.[74] At that point, then, the new state prohibition of sixty months would remain in effect.

The most significant change for persons with mental illness is found in sections 10 and 11 of the Act, which create a firearms prohibition of six months from the date of a voluntary psychiatric admission.[75] This is an interesting development under state law in that no due process procedures exist in relation to voluntary admission, yet this clinical process deprives an individual of Second Amendment rights via state prohibition, without involvement of NICS reporting.[76] As was the case with civil commitment

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[71] *Id.* at 3.

[72] Act of April 4, 2013, No. 13-3, 2013 Conn. Acts 27 (Reg. Sess.).

[73] § 8, 2013 Conn. Acts at 54–55 (codified as amended at CONN. GEN. STAT. § 29-28(b) (Supp. 2014).

[74] *See* 28 C.F.R. § 25.9(a) (2013) (noting that NICS will indefinitely retain "records that indicate that receipt of a firearm by the individual to whom the records pertain would violate Federal or state law . . . unless they are cancelled by the originating agency"); *see also* 18 U.S.C. § 922(d)(4), (g)(4) (2012) (prohibiting individuals who have been "committed to any mental institution" from buying, transporting, or possessing a firearm); CONN. GEN. STAT. § 45a-100 (allowing individuals to petition for relief from a federal firearms disability and noting that successful petitions will result in the cancellation of the individual's record in NICS).

[75] §§ 10–11, 2013 Conn. Acts at 55–57 (codified as amended at CONN. GEN. STAT. § 29-28(b)).

[76] In 2012, the U.S. Court of Appeals for the First Circuit noted in dicta that such temporary prohibitions might be constitutionally permissible. United States v. Rehlander, 666 F.3d 45, 49–50 (1st Cir. 2012) ("Congress might well be able to impose a temporary ban on firearms possession . . . if procedures existed for later restoring gun rights."). Given that the state prohibition for voluntary psychiatric hospitalization expires automatically in six months, without the need for further procedures, the requirements proposed in *Rehlander* may well be satisfied.

prohibitions in 1999, there was no mechanism in place to effectuate this new prohibition, as there was no database of voluntary admissions in the state. As a result, DMHAS and DESPP created the Voluntary Admission Tracking System ("VATS"), an entirely new data system with similar "black box" protocols to the system created for civil commitments.[77] Private psychiatric hospitals can now upload data about new voluntary admissions to this confidential database that has an automated matching process with the DESPP database of permits and eligibility certificates. That system became operational on October 1, 2013.

As of December 2, 2013, thirty of the states' thirty-two hospitals with psychiatric admission units had reported data to VATS, covering a total of 2619 admissions. Of those admissions, seventy-three matched with individuals holding active permits or possessing guns (an occurrence rate of 2.8%). None of the matched individuals were in the DMHAS system.

Anecdotal reports from the hospitals have focused on two different concerns. The first is for people like armed security guards and law enforcement officers who would be unable to work for at least six months following a voluntary admission, with the potential for more long-lasting consequences. Some of these patients may be advised to seek hospitalization in neighboring states in order to receive appropriate psychiatric care without jeopardizing their livelihoods—an undesirable response to the dilemma. The other concern has been related to individuals who are well-known and do not want the fact of their hospitalization to be released to anyone outside of the hospital to which they have turned for help.

V. CRITICAL LESSONS

A. *Gun Seizure Data Do Not Support Psychiatric Diagnoses as a Risk Factor for Gun Violence*

Fourteen years of implemented gun seizure legislation in Connecticut provide empirical results that indicate several important patterns and critical lessons:

- The risk from firearms was not significantly related to mental disease diagnoses. Nearly 80% of those who had a firearm confiscated had no history of diagnosed mental illness and less than 1% were in treatment at the time of confiscation.
- The profile that emerges from Connecticut's experience is

[77] The description of VATS is based on the personal experience of one of the authors. The data in the following paragraph is available to him in connection with his official duties at DMHAS.

> that of people in crises. The triggers varied across the ages but represented common life struggles—relationship breakups, health problems, death in the family, and financial burdens. Family members and friends recognized the crises and the risk. Most often, the risk was of suicide and self-harm.
>
> - The majority of persons subject to gun seizure due to an "imminent risk" required further evaluation at a hospital.
> - The most common profile is that of men from a town rather than a city, thirty to sixty years of age, facing a variety of stressors. Although that represents the majority, both genders and all ages—including those over ninety years of age—were represented.

So what can we learn from the data? Collectively, the results indicate that the risk factors are the circumstances—not the person and not a diagnosis. As circumstances converge and coping strategies and supports are overwhelmed, the risk for self-harm increases; a person's function, thought processes, judgment, and problem-solving are affected. The decline in function does not necessarily mean that a person is mentally ill or that the persons meet diagnostic criteria for a mental illness. A decline in function does, however, mean that in the presence of a potentially dangerous device, risk in general increases. For example, when someone is upset, they likely do not drive a car as carefully as they would under normal circumstances.

Although persons with diagnoses of depression and other mental disorders may be at increased risk for violence, including suicide,[78] when such persons are treated their risk for violence to others[79] and themselves

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[78] *See* Jeffrey W. Swanson et al., *Violence and Psychiatric Disorder in the Community: Evidence from the Epidemiologic Catchment Area Surveys*, 41 HOSP. & COMMUNITY PSYCHIATRY 761, 764–65 (1990) (finding that 10–13% of respondents with major mental disorders reported violence in the previous year, compared to 2% of respondents with no disorder).

[79] *See* Olav Nielssen et al., *Homicide of Strangers by People with a Psychotic Illness*, 37 SCHIZOPHRENIA BULL. 572, 577 (2011) (finding that stranger homicide by psychotic persons is extremely rare and is even rarer among patients receiving pharmacological treatment); *see also* AM. PSYCHIATRIC ASS'N, RESOURCE DOCUMENT ON ACCESS TO FIREARMS BY PEOPLE WITH MENTAL ILLNESS (2009), *available at* http://www.psych.org/File%20Library/Learn/Archives/rd2009_Firearms.pdf (noting the research literature supporting the finding that individuals with mental illness who are in regular treatment are much less likely to commit violent acts); Henry J. Steadman et al., *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, 55 ARCHIVES GEN. PSYCHIATRY 393, 400 (1998) (finding that among mentally ill patients who were not using substances, violence in the year after hospitalization was not statistically significantly higher than for the community sample without mental illness or substance abuse).

decreases.[80] In fact, following treatment such persons pose a risk of violence that is no greater than that of the general population.[81] Further, among treated individuals mental health status is a poor predictor of violence by comparison to other non-mental-health factors.[82] Connection with treatment provides therapy and medication, but also—and importantly—a safety net and monitoring not available to many persons without mental illness who fall on hard times.

There is another consideration. In the presence of decreased function, heightened negative emotion, helplessness, and despair, and in the presence of crises, the availability of guns does impact the immediacy and severity of risk. The means available for self-harm or for harm to others are a relevant factor in determining the severity and probability of harm. Guns are in the class of lethal means. Like jumping from a tall building or hanging, guns deprive an individual of the opportunity to reverse the harm done from an impulsive act. With lethal means, the opportunity for intervention by others and the effects of reconsideration, ambivalence, and second thoughts are greatly diminished. A law or policy that removes guns during periods of crises has the potential to reduce the severity and immediacy of risk.

The results of the gun seizure law have relevance to policy development and legislation. As evident in these data, the public used the available access to help. People recognized the risk and the need for intervention over seven hundred times.[83] Police across the state used the statute and policy to intervene legally and safely.[84] The results suggest that laws and policies that increase access to resources and solutions during

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[80] *See* Olav B. Nielssen & Matthew M. Large, *Untreated Psychotic Illness in the Survivors of Violent Suicide Attempts*, 3 EARLY INTERVENTION IN PSYCHIATRY 116, 121 (2009) (finding an "odds ratio of about 20 to one toward an increased risk of violent suicide in first episode psychosis when compared to the annual risk after treatment").

[81] *See* Bruce G. Link et al., *The Violent and Illegal Behavior of Mental Patients Reconsidered*, 57 AM. SOC. REV. 275, 290 (1992) (explaining that if a patient is not having a psychotic episode, or his or her problems do not include psychotic symptoms, "then he or she is no more likely than the average person to be involved in violent/illegal behavior"); Steadman et al., *supra* note 79, at 400 (explaining that "public fears of violence on the street by discharged patients who are strangers to them is misdirected").

[82] *See* Link et al., *supra* note 81, at 290 (asserting that "the excess risk of violence posed by mental patients is modest compared to the effects of other factors"); Dale E. McNeil et al., *Utility of Decision Support Tools for Assessing Acute Risk of Violence*, 71 J. CONSULTING & CLINICAL PSYCHOL. 945, 949 (2003) (suggesting that clinical factors are only predictive of violent behavior during periods of acute illness, and that other factors explain violence after periods of treatment and recovery); Michael A. Norko & Madelon V. Baranoski, *The State of Contemporary Risk Assessment Research*, 50 CAN. J. PSYCHIATRY 18, 21 (2005) (describing violence as being "significantly correlated with various socio-demographic and environmental factors, while the contribution of mental illness is relatively small"); Swanson et al., *supra* note 78, at 764 (reporting that 16% of eighteen- to twenty-four-year-old males of the lowest socioeconomic status group reported violence in the previous year).

[83] *See supra* text accompanying note 42.

[84] *See supra* Part II.B.

crises and times of increased risk can work to reduce violence. It is impossible to tell how much violence was averted and how many deaths and injuries the legislation has prevented. We cannot prove for any individual case that the law made a difference—i.e., the individual, despite a risky situation, might not have committed a violent act with firearms. The gun seizure law was not employed in the Sandy Hook shootings; the Sandy Hook Final Report does not indicate that anyone noted the increased risk and notified authorities before the event began.[85] We do know, however, that when the seizure law was implemented, the risk of violence was reduced by removing lethal means of violence and, in most cases, bringing the individual for professional evaluation.

B. *Low Rates of Permit Matches for Mental Health Factors Indicate Minimal Effectiveness of Prohibiting Laws*

As noted above, the rate of matches between the DESPP database of permits and individuals previously subjected to civil commitment is exceedingly low at 0.015%.[86] A somewhat higher, but still low, matching rate of 2.8% was found in the first two months of voluntary admission data across the state.[87] This latter number may change as more data are gathered over a longer period of time. Also very low is the rate of denials of Connecticut gun permit applications based on mental health adjudications reported to NICS (approximately 0.09%).[88] The national rate of denials based on mental health adjudications in NICS records as of March 2010 was 0.7%.[89]

These figures are consistent with data about the rates of serious violence committed by individuals with psychosis recently reported in a meta-analysis of seven research studies from Western countries.[90] Stranger homicides by offenders with psychosis were identified as extremely rare—one in 14.3 million is victimized per year.[91] If the rate of schizophrenia in the population is considered to be 1% (which is the measured rate in the United States),[92] the risk of people with schizophrenia committing a stranger homicide is estimated to be about one in 140,000 patients per

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[85] *See* SANDY HOOK REPORT, *supra* note 70, at 9–10, 32–35 (describing the details of the incident with no mention of increased risk or notification to officials).

[86] *See supra* note p. 1615.

[87] *See supra* note p. 1624.

[88] *See supra* p. 1620.

[89] Paul S. Appelbaum & Jeffrey W. Swanson, *Gun Laws and Mental Illness: How Sensible Are the Current Restrictions?*, 61 PSYCHIATRIC SERVICES 652, 653 (2010).

[90] Nielssen et al., *supra* note 79, at 575.

[91] *Id.*

[92] *See Schizophrenia*, NAT'L INST. MENTAL HEALTH, http://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml (last visited Mar. 3, 2014) (noting that about one percent of Americans suffer from schizophrenia).

year.[93] Notably, 64% of the homicide offenders had never been treated with antipsychotic medications before, often despite years of symptoms and dysfunction.[94] Only 12% of the homicide offenders were in active treatment—a differential of treated and not-treated groups similar to the results of our gun seizure data noted above.[95] There were no studies available for the meta-analysis from the United States, where the rate of homicide in general and the rate of psychosis might be higher than the countries that were studied. Still, as one researcher has noted, these data tell us that for every person with schizophrenia who demonstrates risk factors identified in the meta-analysis and who commits a stranger homicide, there are tens of thousands with the same risk profile who will not.[96]

Studies in the United States and Sweden demonstrate that about 5% of all violence is attributable to persons with mental illness, most of which is not committed with guns.[97] While the NRA has supported efforts to target people with mental illness in gun control efforts,[98] there is little evidence to support the effectiveness of such prohibitions in controlling gun violence.[99] The available data indicate the impossibility of differentiating between individuals with mental illness who might become perpetrators of gun violence and the vast majority of such individuals who will not be violent.[100]

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[93] Nielssen et al., *supra* note 79, at 575.

[94] *Id.* at 576.

[95] *Id.*; *see supra* Part II.C.

[96] Jeffrey W. Swanson, *Explaining Rare Acts of Violence: The Limits of Evidence from Population Research*, 62 PSYCHIATRIC SERVICES 1369, 1371 (2011).

[97] Jeffrey W. Swanson, *Mental Disorder, Substance Abuse, and Community Violence: An Epidemiological Approach*, *in* VIOLENCE AND MENTAL DISORDER 101, 118 (Henry J. Steadman & John Monahan eds., 1994); Appelbaum & Swanson, *supra* note 89, at 653; Seena Fazel & Martin Grann, *The Population Impact of Severe Mental Illness on Violent Crime*, 163 AM. J. PSYCHIATRY 1397, 1399 (2006).

[98] *See* Marilyn Price & Donna M. Norris, *National Instant Criminal Background Check Improvement Act: Implications for Persons with Mental Illness*, 36 J. AM. ACAD. PSYCHIATRY & L. 123, 127 (2008) (noting the NRA's support in passing the NICS Improvement Amendments Act).

[99] *See, e.g.*, Jeffrey W. Swanson et al., *Preventing Gun Violence Involving People with Serious Mental Illness*, *in* REDUCING GUN VIOLENCE IN AMERICA: INFORMING POLICY WITH EVIDENCE AND ANALYSIS 33, 36–37 (Daniel W. Webster & Jon S. Vernick eds., 2013) ("[T]here is no evidence to suggest that merely filling the NICS with more records of people with gun disqualifying mental health histories would have any measurable impact on reducing firearm violence . . . ."); Liza H. Gold, *Gun Violence: Psychiatry, Risk Assessment, and Social Policy*, 41 J. AM. ACAD. PSYCHIATRY & L. 337, 340 (2013) ("[T]here is little evidence of any kind to suggest that gun restriction policies for the seriously mentally ill actually prevent the small subgroup of dangerous individuals with mental illness from committing acts of violence."); Emma Elizabeth McGinty et al., *Gun Policy and Serious Mental Illness: Priorities for Future Research and Policy*, 65 PSYCHIATRIC SERVICES 50, 53 (2014) (discussing the lack of evidence and consensus among experts of the effectiveness of gun restrictions policies on the mentally ill).

[100] *See* Nielssen et al., *supra* note 79, at 577–78 ("[T]he extreme rarity of stranger homicides among untreated patients who are in contact with health services and by previously treated patients

VII. CONCLUSION

A. *Future Directions*

The initial evaluations of the gun seizure data indicate the need for further research. Follow-up of ED evaluations after gun seizures and of the outcomes of the hearings are critical to understanding the full effect of the law. The experience with prohibitions based on voluntary admissions is too short at the time of this writing to make any predictions about the law's potential effects; continued monitoring of these data is warranted.

The low rates of gun permit and sale denials based on mental health adjudication reports in NICS do not inspire confidence that these processes will lead to decreased violent crime among people with mental illness.[101] Moreover, a recent study of more than 23,000 persons with serious mental illness in Connecticut found that since NICS reporting began, 96% of the crimes committed by this group were not committed by persons who had a NICS-qualifying mental health adjudication in their history.[102]

Beyond specific legislation, we also need to explore other avenues for public access to mental health and supportive interventions. For example, providing "special interventions in ordinary places" is an approach in early stages of consideration. Public places, schools, churches, libraries, and other gathering places are points at which information on risk factors, signs of distress, and how to access help can be disseminated without stigma. Efforts to de-stigmatize psychiatric conditions and their treatment are underway by the National Alliance on Mental Illness (NAMI) and other organizations.[103] Evaluation of the effectiveness of such efforts has not been conducted. The Affordable Care Act and centralized care centers can be vehicles for reaching persons who would benefit from psychiatric and mental health interventions during critical times. Incorporation of new technologies can also benefit the dissemination of services. All of these innovations are risk management strategies targeting the impairment and suffering of persons in crises without unfairly associating people with

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means that identification of individual patients who might kill a stranger is not possible."); Swanson, *supra* note 96, at 1370 ("For every homicide perpetrator with schizophrenia who fits the profile of risk factors, there are tens of thousands of people with the same risk factors who will never commit a homicide.").

[101] *See* Appelbaum & Swanson, *supra* note 89, at 653 (noting that by December 2006, records citing "mental defect" constituted only 0.4% of all NICS denials).

[102] Swanson et al., *supra* note 99, at 35, 48.

[103] *See, e.g.*, *Fight Stigma*, NAMI, http://www.nami.org/template.cfm?section=fight_stigma (last visited Apr. 15, 2014), (promoting "StigmaBusters," an advocacy group that "seek[s] to fight inaccurate and hurtful representations of mental illness"); *National Anti Stigma Campaign Launched*, NAMI (Dec. 4, 2006), http://www.nami.org/Template.cfm?Section=top_story&template=/ContentManagement/ContentDisplay.cfm&ContentID=52424 (describing NAMI's partnership with the federal government to produce "a sustained national PSA campaign to reduce stigma and encourage support of people with mental illnesses").

mental illness with violence.

B. *The Danger of Stigma*

The consequences of stigmatizing psychiatric disorders have been well described for those with these diagnoses and their families. Stigma creates a barrier to access to treatment.[104] The labels are hurtful and demeaning and reduce a person to a diagnosis.

Less described are the counter-productive results that stigma and labels create. An approach that creates a simple explanation for violence and identifies a group to blame for tragic and unpredictable acts is appealing. It is also wrong. The data do not, in general, support a predictable link between mental illness and serious violence. The effort to use mental illness to predict mass killings with firearms is useless due to the infrequency of such incidents (despite the trauma they cause and the attention they garner).[105] Therefore, targeting persons diagnosed with mental illness as a means of reducing gun violence will be futile.

Such thinking is also dangerous to the safety of the public. Assuming that a diagnosis appropriately and accurately identifies the risky person could lead to mistreatment of those with psychiatric diagnoses and also misdirect our attention to and appreciation for risk. In our gun seizure data, "labeled" people were not the ones who presented risks with firearms.[106] Risks came from ordinary people in problem circumstances.

To maximize the safety of the public and to prevent gun violence, our attention must focus on signs that people are struggling and are in distress. With or without a diagnosis, the presence of mental distress, social isolation, pain, suffering, and decreased function and problem solving ability is evidence that people need help. By helping such people with available and effective services, we will reduce risk and avert violence.

There is a further risk to stigma and labeling. After a tragic, violent event, and in the wake of the extraordinary suffering experienced by families and communities, the perpetrator is often described in highly charged language. Yet, condemnation of the perpetrator—without further examination of the person's life—is an inadequate approach to prevention of future tragedies. When the actor is labeled as evil, we miss the opportunity to explore the trajectory that ended in the violence. Even more troubling is that the label prevents other families from accessing help for a

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[104] S. Clement et al., *What Is the Impact of Mental Health Stigma on Help-Seeking? A Systematic Review of Quantitative and Qualitative Studies*, PSYCHOL. MED., Feb. 26, 2014, at 1, 7.

[105] *See* Swanson, *supra* note 96, at 1369 (noting that mass shootings are extremely rare, and mental health researchers do not possess epidemiological data or risk assessment instruments to reliably predict such events).

[106] *See supra* Part VI (noting that nearly 80% of gun seizures were from people with no history of mental illness or treatment and less than 1% were in treatment at the time of the firearm confiscation).

troubled loved one; such labeling decreases the chances of early detection and intervention. Those individuals behind recent violent attacks had past histories marked by isolation and distress, not criminal activity. Appreciating the acts of violence as acts of desperation is not an expression of charity; rather, it is a utilitarian analysis that can lead to strategies for intervention and prevention.

Such interest and exploration are not as easy as labeling and blaming, but will be more effective. We know that such an approach works because our country faced a similar crisis in the past. When AIDS and its transmission were first identified, some commentators called for the overt labeling—even tattooing—of persons diagnosed with the disease.[107] The idea was that the public would know who carried the disease and protect themselves from them. With further thought, we recognized that only universal precautions would help treat everyone with the same caution and care. The universal precaution with violence is this: crises and conflict are often overwhelming; when people need help, it is risky to all of us not to provide it.

Connecticut's gun seizure law is a good example of the application of applying universal precautions and universal access. The law allows families and the public to access intervention when the risk of harm increases. The law provides immediate but temporary relief during crisis without relying on diagnosis. At the same time it provides due process and preserves Second Amendment rights.

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[107] *See* William F. Buckley, Jr., *Crucial Steps in Combating the AIDS Epidemic: Identify All the Carriers*, N.Y. TIMES, Mar. 18, 1986, at A27 ("Everyone detected with AIDS should be tattooed in the upper forearm and on the buttocks . . . .").

IMPLEMENTATION AND EFFECTIVENESS OF CONNECTICUT'S RISK-BASED GUN REMOVAL LAW: DOES IT PREVENT SUICIDES?

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I
INTRODUCTION

Developing practical, effective, and legally sustainable policies to separate firearms from people at risk of harming themselves or others presents a potentially important, but challenging, public health opportunity for gun violence prevention in the United States. Risk-based, temporary, preemptive gun removal is a legal tool that four states—Connecticut,[1] Indiana,[2] California,[3] and Washington[4]—have adopted, and which has recently attracted considerable

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1. CONN. GEN. STAT. § 29-38c (1999).
2. IND. CODE ANN. § 35-47-14 (2006).
3. CAL. PENAL CODE § 18100 (2016).
4. Washington Individual Gun Access Prevention by Court Order, Initiative 1491 (2016).

interest among policymakers in other jurisdictions.[5] To date, there has been little empirical scrutiny of these laws in practice and there are important unanswered questions about how they work: What are the legal and logistical barriers to implementing risk-based gun removal laws? Do they target the right people? Are the laws fair? Do they actually help reduce gun deaths?

In 1999, following a highly publicized mass shooting,[6] Connecticut became the first state to pass a law authorizing police to temporarily remove guns from individuals when there is "probable cause to believe . . . that a person poses a risk of imminent personal injury to himself or herself or to other individuals[.]"[7] Connecticut's innovative statute established the legal practice of preemptive gun removal as a civil court action based on a risk warrant, a process that neither requires nor generates a record of criminal or mental health adjudication as its predicate.[8] Our research study provides an analysis of the characteristics, implementation, and outcomes of gun removals conducted under Connecticut's risk warrant law during the period of October 1999 through June 2013.[9] This article summarizes key features of the study in an effort to inform other states that are considering the adoption of similar gun-seizure laws.

Part II sketches the relevant policy landscape in order to demonstrate that point-of-purchase background checks are a necessary but insufficient component of a strategy to reduce gun violence in the United States, and that risk-based preemptive gun removal schemes provide a complementary policy to bridge the gap. Part III briefly recounts the history of enactment and gradual implementation of Connecticut's risk-based gun removal law, beginning with the high-profile homicide that drove public opinion to support the law. Part IV describes our research study's quantitative and qualitative methods and data sources. Part V presents the results of the study. It first describes the characteristics of gun removal cases in Connecticut. Next, it summarizes views of stakeholders regarding the effectiveness and fairness of gun removal, as well as particular challenges faced in implementing the risk warrant law. It then analyzes suicides committed by the individuals from whom firearms had been seized to

5. Six additional states—Illinois, Michigan, Minnesota, Missouri, New York, and Virginia—had introduced similar bills by the end of 2016. E-mail from Kelly Roskam, General Counsel, Educational Fund to Stop Gun Violence, to author (Dec. 8, 2016) (on file with author). Nevada introduced a similar bill, S.B.387, on March 20, 2017. *See* Nev. S.B. No. 387, (Mar. 20, 2017), http://www.leg.state.nv.us/Session/79th 2017/Bills/SB/SB387.pdf

6. *See* Jonathan Rabinovitz, *Rampage in Connecticut: Connecticut Lottery Worker Kills 4 Bosses, Then Himself*, N.Y. TIMES (Mar. 7, 1998), http://http://www.nytimes.com/1998 /03/07/ nyregion/rampage-connecticut-overview-connecticut-lottery-worker-kills-4-bosses-then.html?_r=0 [https://perma.cc/E585-2UZ5] (describing a shooting in which a thirty-five-year-old lottery worker used a semiautomatic handgun to kill four executives at the Connecticut Lottery headquarters in Hartford).

7. CONN. GEN. STAT. § 29-38c (1999).

8. *See id.* (describing the statutory criteria and process for gun removal as a civil judicial determination on the basis of probable cause to believe there is imminent risk of gun violence but not requiring any criminal charge or record).

9. *Implementation and Effectiveness of Dangerous Persons' Gun-Seizure Laws in Connecticut and Indiana*, research study funded by a grant from the New Venture Fund (Fund for a Safer Future) to Duke University; GA 0327014, Jeffrey Swanson, Principal Investigator (2014–2018).

determine whether the policy saved lives, and concludes with an estimate of the number of gun removal cases that are necessary to avert one suicide. Part VI summarizes the findings and draws key policy implications. Finally, Part VII renders the study's conclusion.

II
THE POLICY LANDSCAPE:
THE LIMITS OF BACKGROUND CHECKS AND THE POTENTIALLY IMPORTANT ROLE OF RISK-BASED PREEMPTIVE GUN REMOVAL LAWS

Intentional gun violence in the United States remains a daunting public health problem—diverse in its surrounding circumstances, complex in its causal pathways, and far reaching in its social and economic consequences.[10] How to solve the problem remains the subject of a contentious and partisan political debate, pitting public safety interests against the Second Amendment right.[11] The 1994 Brady Law's[12] requirement of point-of-purchase background checks for firearm sales from federally licensed dealers has long been the mainstay of federal and state efforts to prevent gun violence. This is arguably a necessary but insufficient policy approach.[13] Wide variation in the operational criteria for gun restrictions across states, inconsistencies in local policies and practices that apply these criteria to individual cases, and major gaps in state authorities' reporting of gun-disqualifying records to the National Instant Criminal Background Check System (NICS), all contribute to inefficient identification of people who should not have guns.[14]

Existing statutory schemes thus fall short of the practical goal of implementing gun prohibitions for dangerous people because most states have not closed point-of-purchase loopholes[15] and, with few exceptions, have no

10. *See* Centers for Disease Control and Prevention (CDC), *Injury Prevention & Control: Data & Statistics*, *Web-based Injury Statistics Query and Reporting System* (WISQARS™), Fatal Injury Reports and Nonfatal Injury Reports (2016), http://www.cdc.gov/injury/wisqars/index.html [https://perma.cc/7F3C-2EPY] (reporting that 33,599 fatal and 81,034 nonfatal gun injuries occurred in the United States in 2014); *see also* Garen J. Wintemute, *The Epidemiology of Firearm Violence in the Twenty-First Century United States*, 36 ANN. REV. PUB. HEALTH 5, 8–16 (2015) (discussing recent trends and current statistics of U.S. gun violence).

11. *See generally* PHILIP J. COOK & KRISTIN A. GOSS, THE GUN CONTROL DEBATE (2014) (explaining that the appropriate role of gun control in reducing gun-related violence is the subject of a long-running policy debate).

12. Brady Handgun Violence Prevention Act, Pub. L. No. 103-159, § 107 Stat. 1536 (1994).

13. *See* Philip J. Cook & Jens Ludwig, *The Limited Impact of the Brady Act: Evaluation and Implications*, *in* REDUCING GUN VIOLENCE IN AMERICA: INFORMING POLICY WITH EVIDENCE AND ANALYSIS 21, 28 (Daniel W. Webster & Jon S. Vernick eds., 2013) (explaining that the Brady Act's background check requirement is too narrow because many criminals obtain guns through unregulated secondary markets).

14. Federal firearms law is nested in widely variable state civil commitment practices. *See* Paul S. Appelbaum & Jeffrey W. Swanson, *Gun Laws and Mental Illness: How Sensible are the Current Restrictions?* 61 PSYCHIATRIC SERVS. 652, 652–54 (2010) (discussing the limitations of imposing gun restrictions based on mental health).

15. *See* LAW CENTER TO PREVENT GUN VIOLENCE, UNIVERSAL BACKGROUND CHECKS,

policies in place to proactively remove guns from legally prohibited persons.[16] At a more fundamental level, the federal prohibiting criteria themselves, as defined in the 1968 Gun Control Act[17] and mirrored in many states' statutes, tend to correlate poorly with actual risk of violence and suicide. The rules are both over- and under-inclusive, insofar as they prohibit many people at a very low risk of violence from owning guns while also failing to identify many others who are at a high risk of violence.[18]

SUMMARY OF STATE LAW, http://smartgunlaws.org/gun-laws/policy-areas/background-checks/universal-background-checks/ [https://perma.cc/T379-KF4E] (reporting that only eight states—California, Colorado, Connecticut, Delaware, New York, Oregon, Rhode Island, and Washington, as well as the District of Columbia currently require comprehensive background checks for all transfers of all classes of firearms, including purchases from unlicensed sellers); *see also* U.S. Dep't of Just., Off. of the Inspector Gen., *Review of ATF's Project Gunrunner* 10 (Nov. 2010), http://www.justice.gov/oig/reports/ATF/e1101.pdf [https://perma.cc/CU35-MKQM] (noting that "individuals prohibited by law from possessing guns can easily obtain them from private sellers and do so without any federal records of the transactions").

16. *See* Garen J. Wintemute, et al., *Evaluation of California's Armed and Prohibited Persons System: Study Protocol for a Cluster-Randomised Trial*, INJURY PREVENTION 1, 1–5 (2016) (discussing the problem that large numbers of legal gun purchasers in the United States subsequently become prohibited from firearms due to a criminal conviction, mental health-related adjudication, or domestic violence order of protection, or acquire some other gun-disqualifying status under federal or state law; that "almost no attention has been given to interventions focused on [these] individuals. . ."; and discussing California's innovative Armed and Prohibited Persons System as a proposed state policy solution but one that lacks research evidence for its effectiveness). Insofar as background-check laws and policies are focused solely on regulating point-of-sale firearm transfers, they stop short of providing a mandate or authority for local law enforcement agents to assertively search for and remove any guns that may already be in the possession of a person who transitions to a gun-prohibited status. However, a gun-disqualified person who is found incidentally to possess guns may be subject to criminal charges of illegal gun possession under state law. An example appears in *United States v. Rehlander*, 666 F.3d 45 (1st Cir. 2012), a case involving a criminal defendant, Nathan Rehlander, who was indicted in Maine for illegal gun possession under 18 U.S.C. § 922(d)(4) due to a previous involuntary civil commitment—but only after police had later encountered Rehlander in responding to an assault complaint and discovered his gun-disqualifying mental health history; there had apparently been no removal of guns from Rehlander when he first acquired the status of a gun-prohibited person.

17. *See* Gun Control Act of 1968, 18 U.S.C. § 922(d)(4) (2006) (most common disqualifying criteria include felony convictions, unlawful immigration status, and adjudication related to mental illness).

18. *See* Jeffrey W. Swanson, Allison G. Robertson, Linda K. Frisman, Michael A. Norko, Hsiu-Ju Lin, Marvin S. Swartz & Philip J. Cook, *Preventing Gun Violence Involving People with Serious Mental Illness*, *in* REDUCING GUN VIOLENCE IN AMERICA: INFORMING POLICY WITH EVIDENCE AND ANALYSIS 33, 36 (Daniel W. Webster & Jon S. Vernick eds., 2013) ("The very small proportion of people with mental illnesses who are inclined to be dangerous often do not seek treatment before they do something harmful; they therefore do not acquire a gun-disqualifying record of mental health adjudication[.]"). There is limited evidence that background checks can substantially reduce gun violence risk in people with serious mental illness. In our recent study in Connecticut, we matched and merged mental health, court, and arrest records for 23,292 persons diagnosed with schizophrenia, bipolar disorder, or major depression who were receiving services in the state's public behavioral healthcare system. We found a six percent reduction in violent crime in gun-disqualified individuals attributable to Connecticut's initiating a policy of reporting records to NICS in 2007. However, while the NICS-reporting effect was statistically significant, it turned out to be substantively trivial; the policy affected only seven percent of the study population of persons with serious mental illness, while ninety-six percent of the violent crimes recorded for that population were committed by persons who were not exposed to the policy, that is, not disqualified on the basis of a mental health adjudication history. As a result, the estimated net reduction in violent crime in the population was miniscule—a tiny fraction of one percent.

The current epidemic of suicide in the United States[19] illustrates a large loophole in the mental-health-related criteria for restricting at-risk individuals from buying guns.[20] Over half of suicides in the United States are completed with guns,[21] and many of those guns are legally obtained.[22] Most people who die by suicide suffer from a mental disorder such as depressive illness,[23] but only a small proportion of them have a record of involuntary civil commitment or other gun-disqualifying mental health or criminal adjudication.[24] Similarly, a substantial proportion of those at risk for committing violent crimes with guns do not have a record that would prohibit them from purchasing or possessing firearms.[25]

The sheer number of privately owned firearms already in existence in the United States—approximately 357,000,000 guns, by one government estimate[26]—

19. *See* Sally C. Curtin, Margaret Warner & Holly Hedegaar, *Increase in Suicide in the United States, 1999–2014*, CDC (Apr. 22, 2016), http://www.cdc.gov/nchs/products/databriefs/db241.htm [https://perma.cc/4W54-XKPZ] (finding that the age-adjusted suicide rate in the United States increased twenty-four percent between 1999 and 2014).

20. *See* Appelbaum & Swanson, s*upra* note 14, at 652–54 (explaining that states' incomplete reporting to the NICS and the tenuous link between mental health defects and risk of violence create gaps in firearm regulation); *see also* Jeffrey W. Swanson, Paul S. Appelbaum & Richard J. Bonnie, *Getting Serious about Preventing Suicide: More "How" and Less "Why,"* 314 J. AM. MED. ASS'N 2229, 2229–30 (2015) (suggesting that seizing firearms of those involuntarily hospitalized and enacting mandatory reporting to the NICS could be important tools in suicide prevention).

21. Suicide accounted for 41,149 deaths in 2013, and fifty-one percent of these suicides involved guns. Melonie Heron, *Deaths: Leading Causes for 2013*, 65 NAT'L VITAL STAT. REP. 2, 41 (2016), https://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_02.pdf [https://perma.cc/F7UC-QKR3].

22. *See* K. M. Grassel, Garen J. Wintemute, M. A. Wright & M. P. Romero, *Association Between Handgun Purchase and Mortality from Firearm Injury*, 9 INJURY PREVENTION, 48, 48–52 (2003) (The authors matched California death records to state handgun purchase data and determined that 14.6 percent of persons who died from gun-related suicide had legally purchased a handgun within a two-year period before their death.).

23. *See* Jonathan Cavanagh, Alan Carson, Michael Sharpe & Stephen Lawrie, *Psychological Autopsy Studies of Suicide: A Systematic Review*, 33 PSYCHOLOGICAL MEDICINE, 395, 395–405 (2003) (reporting that ninety-one percent of persons who died by suicide had a mental disorder, on average across seventy-six studies).

24. *See* Jeffrey W. Swanson, Michele M. Easter, Allison G. Robertson, Marvin S. Swartz, Kelly Alanis-Hirsch, Daniel Mosely, Charles Dion & John Petrila, *Gun Violence, Mental Illness, and Laws that Prohibit Gun Possession: Evidence from Two Florida Counties*, 35 HEALTH AFF. 1067, 1067–75 (2016) (finding that in Florida, seventy-two percent of severely mentally ill gun suicide victims were found to be legally eligible to purchase a firearm on the day they used one to end their own life); *see also* Lesley C. Hedman, John Petrila, William H. Fisher, Jeffrey W. Swanson, Dierdre A. Dingman & Scott Burris, *State Laws on Emergency Holds for Mental Health Stabilization*, 65 PSYCHIATRIC SERVS. 529, 529–35 (2016) (finding that in many states, police commonly detain persons in a mental health crisis and transport them to a treatment facility, where they are briefly held before either being discharged or persuaded to sign into a hospital voluntarily, neither of which results in gun disqualification in most states, notwithstanding elevated risk of harm to self or others that may coincide with involuntary hospitalization).

25. *See* Swanson et al., *supra* note 24 at 1071 (finding that in Florida, thirty-eight percent of a large study population of persons with mental illness who were arrested for violent, gun-involved crimes were not prohibited from firearms at the time).

26. *See* Christopher Ingraham, *There Are Now More Guns than People in the United States*, WASH. POST (Oct. 5, 2015), https://www.washingtonpost.com/news/wonk/wp/2015/10/05/guns-in-the-united-states-one-for-every-man-woman-and-child-and-then-some/ [https://perma.cc/62L5-7RT5] (compiling estimates using firearm manufacturing, importing, and exporting data from the Congressional Research Service, combining Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) data with U.S. Census

further limits the effectiveness of any policy that relies solely on stopping a risky person from acquiring a new gun. There should be a concomitant means of gun removal. Guns are extremely durable devices that many owners retain indefinitely and pass down through generations. Meanwhile, U.S. gun manufacturers have continued to increase their output of new guns, particularly in recent years—from 5.6 million guns in 2009 to 10.9 million guns in 2013.[27] This means there are probably now more guns than there are people in the United States, though guns are not evenly distributed in the population.[28] Moreover, individuals at high risk of violence commonly have access to firearms at home, even if they would not qualify to buy a gun themselves, because they live in households with guns legally purchased by family members or others.

An estimated nine percent of adults in the United States have problems with impulsive, angry behavior and have access to firearms at home; these are individuals who admit that they "break and smash things" when they get angry, and many of them would meet diagnostic criteria for a mental health problem such as a personality disorder.[29] However, less than ten percent of these angry, impulsive, gun-possessing adults have ever been hospitalized for a mental health problem, and thus would never have lost their gun rights by dint of a mental-health-based restriction.[30] One such angry individual was Craig Stephen Hicks, the legal owner of a cache of about a dozen firearms who, in a fit of irrational rage, shot three young Muslim people in the head in Chapel Hill, North Carolina in February 2015.[31] Notably, properly conducted federal and state background check policies were insufficient to protect the public from Hicks. Although Hicks did not meet any gun-prohibiting criteria,[32] he was nevertheless a very dangerous

estimates of population, noting also that some experts put the estimate lower—in the range of 245,000,000 to 270,000,000 guns—to properly account for attrition in the civilian firearm stock).

27. *Id.*

28. *See* Lois Beckett, *Gun Inequality: U.S. Study Charts Rise of Hardcore Super Owners*, THE GUARDIAN (U.K.) (Sept. 19, 2016) (discussing results of a new unpublished Harvard/Northwestern survey, released exclusively to news outlets, which found that approximately half of the nation's guns are "concentrated in the hands of just 3 [percent] of American adults—a group of super-owners who have amassed an average of 17 guns each"); *see also* Behavioral Risk Factor Surveillance System (BRFSS), North Carolina State Center for Health Statistics, 2001, http://www.schs.state.nc.us/SCHS/brfss/2001/us/firearm3.html [https://perma.cc/KPP8-4884] (documenting wide regional variation in household gun ownership rates, ranging from under ten percent of households in some states to more than sixty percent of households in other states).

29. *See* Jeffrey W. Swanson, Nancy A. Sampson, Maria V. Petukhova, Alan M. Zaslavsky, Paul S. Appelbaum, Marvin S. Swartz & Ronald C. Kessler, *Guns, Impulsive Angry Behavior, and Mental Disorders: Results from the National Comorbidity Survey Replication (NCS-R)*, 33 BEHAV. SCI. L. 199, 209 (2015) (reporting on the prevalence of impulsive angry behavior combined with access to firearms, and the significant association between personality disorders and the combination of impulsive anger with gun possession).

30. *Id.*

31. *See* Sarah Kaplan, *Suspect in Chapel Hill Killings Described as Troublemaker, Obsessed with Parking*, WASH. POST (Feb. 12, 2015), https://www.washingtonpost.com/news/morning-mix/wp/2015/02/12/alleged-chapel-hill-killer-described-as-neighborhood-bully-obsessed-with-parking-and-noise/ [https://perma.cc/GU5Z-D2XD] (suggesting that the suspect's extraordinary anger was known to neighbors).

32. *See* Anne Blythe, *Craig Hicks Becomes Symbol in Gun Politics*, NEWS & OBSERVER (Raleigh, N.C.) (Apr. 11, 2015), http://www.newsobserver.com/news/local/counties/orange-county/article

man who went on to use a legally obtained firearm to carry out a horrifying multiple homicide. What went wrong in the Hicks case? It would be tempting to see it simply as an egregious example of the mismatch between our gun-disqualifying criteria and actual risk. After all, Hicks's neighbors were well aware that he had a serious anger problem, and that he had guns; it appears that people were quite afraid of him.[33] Would adding more inclusive criteria for restricting such people from purchasing guns have saved the lives of the three young people? Probably not, because Hicks already had a dozen guns sitting in his apartment.[34] Rather, in order to effectively deter and prevent people like Hicks from using guns in a harmful way, a different kind of law would have been needed: a legal tool to effectively remove guns from a dangerous person who already possesses them, that is, a preemptive, risk-based gun seizure law that would apply to dangerous-but-not-otherwise-gun-prohibited persons.

III
BRIEF HISTORY OF A RISK-BASED PREEMPTIVE GUN REMOVAL LAW IN CONNECTICUT

On March 6, 1998, a disgruntled accountant with the Connecticut Lottery Corporation used a 9mm Glock pistol and a knife to murder four co-workers before shooting himself in the head.[35] The shooter, Matthew Beck, had previously attempted suicide and was being treated for depression.[36] In response to the public outcry over this incident as well as the infamous Columbine shooting the following year, state lawmakers passed Public Act 99-212 in 1999.[37] Connecticut thereby became the first state to authorize seizure of firearms from putatively dangerous persons who are not otherwise legally prohibited from purchasing or possessing guns, before they have committed an act of violence.[38]

18279290.html [https://perma.cc/3KF8-HQS7] ("Until his . . . arrest on three first-degree murder charges, Hicks was a gun owner with a valid conceal-carry permit and a cache of about a dozen firearms.").

33. Kaplan, *supra* note 31.

34. Blythe, *supra* note 32.

35. Rabinovitz, *supra* note 6.

36. *Id.*

37. Only two months after the lottery shooting, the Connecticut General Assembly passed PA 98-129, An Act Concerning Handgun Safety, which required the creation of a protected database regarding civil commitments and gun permits. The gun seizure provision began as a minor modification of gun permit statutes (C.G.S. 29-28 to 29-32) introduced in January 1999. After the Columbine shootings on April 20, 1999, the Bill was expanded to permit gun seizures with a warrant. It is encoded under CONN. GEN. STAT. § 29-38c. *See* Michael A. Norko & Madelon Baranoski, *Gun Control Legislation in Connecticut: Effects on Persons with Mental Illness*, 46 CONN. L. REV. 1609, 1615 n.33 (2014) (discussing the "legislative atmosphere" after the Connecticut Lottery shooting and the Columbine shooting); *see also* Transcript of Connecticut General Assembly House Debate on Bill Number 1166, June 7, 1999, pages 5412, 5432, 5502, 5507, 5522, and 5526 and Senate Debate on same bill, June 4, 1999, pages 3116, 3123, and 3126 (referring to the Lottery or Columbine shootings). The bill ultimately became Public Act 99-212.

38. In 2006, Indiana enacted a similar law, codified as amended in IND. CODE § 35-47-14-3 (2013). It allows police to seize guns from "dangerous persons" without a warrant, pending a judicial hearing. The state has the burden of showing, by clear and convincing evidence, that the person was dangerous at the time of the firearm seizure. If the court retains a firearm, the individual may petition for its return 180

The new law emerged from earlier policy discussions in Connecticut about how to identify risky people who should not possess guns, while also maintaining confidentiality of records that might include private health information; one proposal had focused on having psychiatrists evaluate mentally ill individuals for safety to possess firearms.[39] However, mental health stakeholders were concerned that such a law might stigmatize people with mental illness.[40] As the draft of the law evolved, it was written deliberately to exclude mental illness per se from among the reasons for attributing risk sufficient to remove someone's guns,[41] and it included sufficient procedural safeguards to satisfy gun-rights advocates in the legislature that the civil rights of law-abiding gun owners would not be needlessly infringed.[42] In the end, the proposal for a gun removal scheme

days after each court hearing. In 2014, California became the third state to pass a risk-based gun removal law, creating what is called a Gun Violence Restraining Order. Elliott Rodger was the legal owner of three 9mm pistols when he embarked on a killing spree in Isla Vista, California, in May 2014, leaving six dead and fourteen injured before turning a gun on himself and ending his own troubled life. Rodger's parents had been concerned enough about their son to ask the police to check on him. Law enforcement officers paid a social welfare visit to Rodger's residence but determined that he did not meet criteria to be detained. However, advocates for risk-based preemptive gun removal laws have argued that if such a law had been in place at the time, police could have searched for and seized Rodger's firearms. In the aftermath of the shooting, the California State Assembly passed and Governor Brown quickly signed CAL. COM. CODE § A.B. 1014, legislation authorizing the Gun Violence Restraining Order. *See* Shannon S. Frattaroli, Emma E. McGinty, Amy Barnhorst & Sheldon Greenberg, *Gun Violence Restraining Orders: Alternative or Adjunct to Mental Health-Based Restrictions on Firearms?* 33 BEHAV. SCI. L. 290, 302–03 (2015); *see also* Joshua Horwitz, Anna Grilley & Orla Kennedy, *Beyond the Academic Journal: Unfreezing Misconceptions about Mental Illness and Gun Violence Through Knowledge Translation to Decision-Makers*, 33 BEHAV. SCI. L. 356, 363 (2015) (describing the role of research evidence in advocating for this law). In 2016, Washington State became the fourth state to enact a preemptive, risk-based gun removal law, Initiative 1491, Washington Individual Gun Access Prevention by Court Order (2016), which authorized the use of the Extreme Risk Protection Order (ERPO).

39. Michael A. Norko, *Legislative Consultation and the Forensic Specialist*, *in* BEARING WITNESS TO CHANGE IN FORENSIC PSYCHIATRY AND PSYCHOLOGY PRACTICE 197 (Ezra E. H. Griffith, Michael A. Norko, Alec Buchanan, Madelon Baranoski & Howard V. Zonana eds., 2016); *see also* Norko & Baranoski, *supra* note 37, at 1614 (describing collaboration between state agencies—the Departments of Emergency Services and Public Protection, Mental Health and Addiction Services, and Information Technology—to create a system that would "accomplish the dual objectives of reporting [records of gun-disqualified individuals] and maintaining confidentiality"; a "black box" computer database for sharing confidential records was eventually devised).

40. *See* Norko & Baranoski, s*upra* note 37, at 1629–31 (discussing methods of de-stigmatizing psychiatric conditions and their treatments).

41. *See* Connecticut Network, *Michael Norko Statement to the Connecticut Criminal Justice Policy Advisory Commission* (Nov. 17, 2016), http://www.ctn.state.ct.us/ctnplayer.asp?odID=13447 [https://perma.cc/QNL4-GMVM] (describing his personal recollection of mental health stakeholders' successful efforts to advocate for language in the bill that that would not single out people with mental illness as categorically at risk, but rather focus on periods of crisis and behavioral indicators of risk: "The collaboration that occurred between the mental health community and the legislature at the time allowed for us not to take the road of making this a law about people with mental illness, but rather a law about people who are in periods of crisis, who are in a temporary stage of risk. And so the law did not require any finding of mental illness, per se. It required probable cause, it had a requirement for a hearing within 14 days of the gun removal, and the guns could be held for up to one year, or at the hearing, they could be returned to the owner."); *see also* Transcript of House Debate on Bill Number 1166, June 7, 1999, at 5380, 5402, 5404, 5446, 5480 and Senate Debate, June 4, 1999, at 3139 (explaining that the bill was not meant to focus on mental illness per se, but on a person in a dangerous situation from any cause).

42. *See* Connecticut Network, *Michael Lawlor Statement to the Connecticut Criminal Justice Policy*

based solely on "imminent risk"[43] regardless of mental health history was seen as less stigmatizing.[44] The law passed with strong bipartisan support.[45]

Specifically, the Connecticut statute allows police, after independently investigating and determining probable cause, to obtain a court warrant and remove guns from anyone who is found to pose an imminent risk of harming someone else or himself or herself.[46] In confirming probable cause and determining imminent risk, the judge must consider recent threats or acts of violence and recent acts of cruelty to animals.[47] The judge may also consider: reckless gun use or display; a history of the use, attempted use, or threatened use of physical force against other persons; prior involuntary psychiatric hospitalization; and illegal use of drugs or alcohol abuse.[48]

The typical case begins with a call to the police concerning a person who is thought to pose risk of harming someone with a gun. The police take the report and must conduct an independent investigation to gather facts that might support a determination of "probable cause to believe that (1) a person poses a risk of imminent personal injury to himself or herself or to other individuals, (2) such person possesses one or more firearms, and (3) such firearm or firearms are within or upon any place, thing or person . . . ."[49] If the police find evidence that they consider supportive of such probable cause, they may issue a statement to this effect, signed by two officers as co-affiants.[50] The police officers' statement

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Advisory Commission (Nov. 17, 2016), http://www.ctn.state.ct.us/ctnplayer.asp?odID=13447 [https://perma.cc/LP8R-RN2E] (describing the legislative history of Connecticut's risk warrant law: "[W]hen this bill was considered by the legislature, there [were] all the usual gun rights advocates on one side, and the so-called anti-gun advocates on the other side. But the end result, just to be clear, was a very strong bipartisan approval of this bill after a very elaborate analysis of the pros and cons of the initiative, and inclusion into the law of a whole series of procedural safeguards to ensure that the police wouldn't overreach here, and that there would be checks and balances all the way through . . . . [T]he vote in the House of Representatives that year was 103 to 47, and among the Republicans. . . there was 28 'yes' votes and 19 'no' votes. And in that 28 'yes' votes were some of the principal gun rights advocates who were members of the House of Representatives that year. At the end of the day, when it was finally enacted, [the law] incorporated enough safeguards to build a level of comfort among the gun rights advocates in the legislature, and outside. In fact . . . the Connecticut Sportsman Association was supportive . . . And in the Senate, the vote was 29-6, and that included 11 Republican votes, including some of the strongest gun advocates who were members of the Senate at the time . . . So, I just want to point out that when it was enacted, a lot of time was spent trying to get the balance right.").

43. CONN. GEN. STAT. § 29-38c (1999).

44. Norko & Baranoski, *supra* note 37, at 1615.

45. Michael Lawlor, *supra* note 42; *see also* Remarks of Sen. Williams, Transcript of Senate Debate on Bill Number 1166, June 4, 1999, at 3103 ("[T]his bill is a product of both Republicans and Democrats of both Senators and Representatives. Of both gun control advocates, and sportsman advocates. And there is much to recommend in this bill.").

46. CONN. GEN. STAT. § 29-38c (1999).

47. *Id.*

48. *Id.*

49. *See id.* (As a condition for a judge issuing a gun removal warrant, the statute requires that a "state's attorney or police officers have conducted an independent investigation and have determined that such probable cause exists and that there is no reasonable alternative available to prevent such person from causing imminent personal injury to himself or herself or to others with such firearm.").

50. *See id.* (The statute requires that the risk complaint be made "on oath by any state's attorney or

requesting a risk warrant then goes to a Superior Court Judge, who may issue the warrant in an expedited fashion. Such a request may also be submitted to the judge directly by the state's attorney, either as the originator of the complaint or upon reviewing a statement submitted first to the state's attorney by police officers.[51] The warrant then goes back to the police, who proceed to the residence of the subject, at which they may search for guns and seize any guns and ammunition they find.[52]

The police also must make a decision about what to do with the person of concern. Options include arresting the person if there is evidence they have committed a crime, transporting the person to a hospital emergency department for evaluation if there is evidence they are in a dangerous mental health crisis and might meet commitment criteria, or leaving the person alone.[53] If the person is arrested, criminal proceedings will follow, and if the person is taken to a hospital, they may be admitted or released. Within fourteen days of the gun removal, the court must hold a hearing to decide whether to return the guns to the person or hold the guns for up to one year.[54] Although the standard for the initial police seizure is probable cause, at the hearing the state must prove by clear and convincing evidence "that the person poses a risk of imminent personal injury to himself or herself or to other individuals."[55]

Those whose guns are removed also become ineligible to hold a permit, which is required to purchase or possess a firearm in Connecticut.[56] One gun owner subjected to firearm seizure under the Connecticut law challenged its constitutionality, arguing that it violates the Second Amendment to the United States Constitution. The recent Connecticut Appellate Court opinion in *State v. Hope* rejected this argument:

> Section 29-38c does not implicate the Second Amendment, as it does not restrict the right of law-abiding, responsible citizens to use arms in defense of their homes. It restricts for up to one year the rights of only those whom a court has adjudged to pose a risk of imminent physical harm to themselves or others after affording due process protection to challenge the seizure of the firearms. The statute is an example of the longstanding 'presumptively lawful regulatory measures' articulated in *District of Columbia v. Heller* . . . . We thus conclude that § 29-38c does not violate the [S]econd [A]mendment.[57]

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assistant state's attorney or by any two police officers, to any judge of the Superior Court[.]").

51. *Id.*

52. While this describes the procedure de jure, there is also a de facto practice in which police often take guns initially as part of "securing the scene" and apply for the warrant later. This is described in part V.B of the article, in the words of a police officer who was interviewed for the study.

53. Norko & Baranoski, *supra* note 37, at 1619.

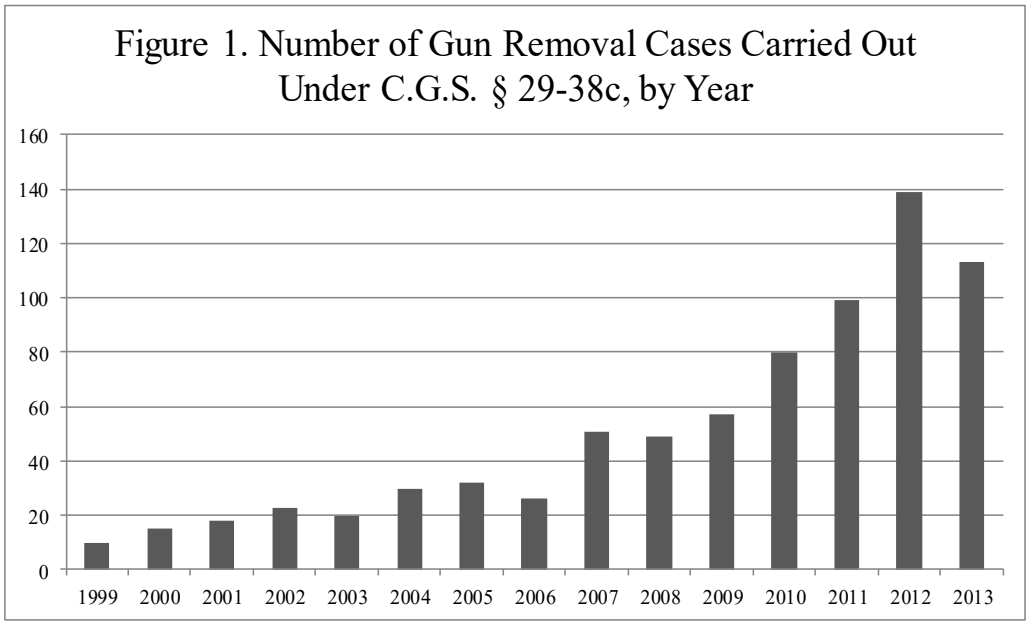
54. CONN. GEN. STAT. § 29-38c(d).

55. *Id.*

56. CONN. GEN. STAT. § 29-36f(b) addresses pistols and revolvers; CONN. GEN. STAT. § 29-37p(b) addresses long guns. The gun owner must appear before the Board of Firearms Permit Examiners in order to have the firearms permit reinstated. *Id.* This additional process was the reason the appeal in *State v. Hope* was not considered moot despite the firearms having been returned to the owner more than a month before the appeal was heard. State v. Hope, 133 A.3d 519 (Conn. App. Ct. 2016).

57. *Hope*, 133 A.3d at 524–25.

Despite initially high expectations that the statute would be widely used, very few gun removals were carried out during the first eight years after the law went into effect—about twenty per year, on average, from 1999 through 2006, as shown in Figure 1. The limited number of cases may have been due to the complexity and time-consuming nature of the removal procedures, explored further in part V. However, following 2007 (the year of the mass shooting at Virginia Tech University), the annual number of gun removals increased about fivefold—to about 100 cases per year—reaching a cumulative total of 762 by the end of June, 2013.[58]



58. The cutoff date for the study data collection was June 30, 2013. Thus, the number of cases for that year is incomplete and should not be interpreted to show a real decline in total cases from 2012 to 2013. In fact, subsequent data collection (by the DMHAS Division of Forensic Services, Michael Norko MD, Director) revealed a total of 184 gun removal cases in 2013, representing the highest number per year through 2016; the data subsequent to July 1, 2013 were not included in the analyses for this current research project.

IV
THE STUDY'S RESEARCH METHODS AND DATA SOURCES

Our study employed a mix of quantitative and qualitative research methods, combining descriptive analysis of semi-structured key informant stakeholder interviews with statistical analysis of merged administrative records for the population of persons subjected to gun removal in Connecticut (762 in total from 1999–2013).[59] Wide-ranging, open-ended interviews were conducted and audio-recorded with eleven individuals who were strategically selected to provide in-depth information relevant to gun seizure policy implementation and practice. These informants included judicial and law enforcement officers and administrators, mental health professionals, advocates, and a family member of a young adult diagnosed with schizophrenia. This article quotes and comments on selected passages from interviews that were particularly illustrative of legal actors' perspectives on the purpose of the gun removal law, the need to balance public safety interests with individual rights, practical and legal barriers to using the law, and how these barriers might be addressed.

State courts provided data on all gun seizures conducted under C.G.S. § 29-38c during the study period. We created a systematic database of descriptive characteristics of all individuals whose guns were removed and the circumstances surrounding gun seizure in these cases. These gun seizure cases were matched and merged with statewide arrest records, services utilization records in the public behavioral health system, and death records including cause of death, with a specific focus on suicides using guns versus other methods. Also assembled were records of arrest leading to conviction and public behavioral health service encounters for the period beginning twelve months before, and ending twelve months after the gun seizure event. The features of risk-based gun removal, and the characteristics of the population subjected to it were further explored by conducting descriptive statistical analyses of all gun removal cases, as well as longitudinal analysis of criminal arrest and behavioral health treatment in these cases, comparing the period before and after gun removal.

The study undertook a quasi-experimental analysis of the effect of the gun seizure policy on suicides by: (1) using the known case fatality rates for different methods of suicide to estimate the total number of suicide attempts represented by the recorded number of deaths by suicide; (2) extrapolating a counterfactual number of would-be suicide deaths, that is, excess deaths that would have occurred if the gun seizure subjects had kept their guns and used them in suicide

59. Unless otherwise cited, the source of all statistics reported in the article is the authors' original analysis of the data described in part IV. The study was sponsored by the Fund for a Safer Future. The formal name of the study in the Duke Health Institutional Review Board is: *Implementation and Effectiveness of 'Dangerous Persons' Gun Seizure Laws in Connecticut and Indiana*. In order to protect the confidentiality of private health information contained in the matched mental health records of individuals who were subject to gun removal under the risk warrant law, the data were de-identified within the relevant state agencies in Connecticut prior to delivery of the data to Duke University for analysis. Privacy concerns and appropriate protections thus preclude the publication here of more specific information tied to individual persons.

attempts at the same rate as other gun-owning men in the United States; (3) estimating the number of lives saved by subtracting the actual number from the counterfactual estimate of suicide deaths; and (4) calculating the number of gun removal cases needed for each averted suicide, by dividing the total number of removal cases by the estimated number of prevented suicides.[60]

The Connecticut Department of Mental Health and Addiction Services (DMHAS) coordinated the process of matching and merging the gun seizure database with other state agencies' longitudinal records pertaining to these individuals. The Judicial Branch provided data on court hearing outcomes. The Department of Emergency Services and Public Protection provided records for arrests resulting in convictions, with statutory charges. The Department of Correction provided data on any incarcerations. The Department of Health provided death records, including cause of death, with a special focus on suicides and whether guns were involved. Finally, DMHAS itself provided data on psychiatric diagnoses and services utilization for mental health and substance use disorders. The study was reviewed and approved by the Duke Health Institutional Review Board, the State of Connecticut Department of Mental Health and Addiction Services Institutional Review Board, and the Yale University Institutional Review Board.

V
RESULTS OF THE RESEARCH STUDY

A. Prevalence And Characteristics Of Risk-Based Gun Removal Cases In Connecticut

The aggregate demographic characteristics of the study population (N=762) provide a profile of the typical gun seizure subject in Connecticut as a middle-aged or older married man. Almost all (ninety-two percent) of gun removal subjects were male. Of those whose marital status was known and reported, eighty-one percent were married or cohabiting. Five percent were military veterans, and thirty-one percent of these veterans had been deployed in the year before gun removal. Subjects ranged across the adult age spectrum, with an average age of forty-seven years at the time of gun removal; the oldest was ninety-three. In three cases, a minor was listed as the person of concern on the risk warrant, because the law was invoked as a means to remove unsecured guns from the possession of adults due to concern for the safety of an at-risk child.[61]

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60. Equations were as follows: Estimated N suicide attempts = $\sum_{K=1}^{M}(N_k * (\frac{1}{cfr_k}))$, where N = number of recorded suicides, K = suicide method (1 to m), and cfr is the case fatality rate. Counterfactual N suicide deaths = $\sum_{K=1}^{M}(A_k * p_k * cfr_k)$, where A = estimated number of suicide attempts, K = suicide method (1 to m), and cfr is the case fatality rate. Estimated number of lives saved = Counterfactual N – Actual N suicide deaths. Estimated number-needed-to-remove = N total removals/ estimated number of lives saved.

61. These types of cases may not have been anticipated by the legislators who enacted the law and may reach beyond the class of cases the legislators expressly intended to cover. Whether the statute should be construed to include them raises an interesting issue of statutory interpretation on which

About half (forty-nine percent) of the gun removal cases were initially reported to the police by an acquaintance of the person of concern; forty-one percent of reports came from family members and eight percent from employers or clinicians. The other fifty-one percent were reported by people who either did not know the person of concern or did not disclose their relationship to the police. The social circumstances and emotional features of risk that led to these gun removal actions were diverse—ranging from anger and conflict between intimate partners, to emotional distress over financial problems, to the sadness of loss in old age.

The specific information written by police on the risk-warrant petitions was available for review in 702 gun-removal cases. Suicidality or self-injury threat was listed as a concern in sixty-one percent of cases, and risk of harm to others was a concern in thirty-two percent of cases. There was some overlap between these two categories, with risk of harm to both self and others noted in nine percent of cases. In sixteen percent of cases, the risk-warrant form did not indicate the type or object of risk that was being alleged, leaving unspecified whether the concern for gun removal was potential harm to self, others or both. Such cases tended to involve persons who appeared to the police to be severely psychotic, intoxicated, emotionally agitated, or some combination of these states, raising general safety concerns. Examples of brief narratives recorded on risk warrant forms include:

- "extremely paranoid and delusional, set up wooden device to barricade door to house"
- "history of bipolar, diabetic, intoxicated and yelling, went from paranoid to agitated to upset"
- "highly intoxicated, disorganized and paranoid, references to firearms and officer involved shooting on site, diagnosis of mental illness although no medicine according to mother"
- "emotionally sick and not eaten for past four days, mother in hospital, despondent and intoxicated"
- "eighty-two year old woman, disoriented, did not want to go to hospital, evidence of dementia, wanted to bring gun to hospital"[62]

Police found and removed guns in ninety-nine percent of cases when they conducted a search, and they removed an average of seven guns from each risk-warrant subject. In seventeen percent of all cases, the gun removal process culminated in a concurrent arrest. This could have been due to the nature of the original incident reported to police or to the subject's uncooperative response during the police encounter. Only four percent were convicted in connection with an arrest on the day of the gun seizure. Most gun removal subjects were not

Connecticut judges appear to have differed. While some judges were willing to issue such warrants, another judge stated in an interview that he had refused to issue risk warrants to remove guns from households in cases where a child was named as the subject of the warrant request; in this judge's view, such cases should instead have been referred to child welfare authorities.

62. Risk Warrant Forms, Implementation and Effectiveness of 'Dangerous Persons' Gun Seizure Laws in Connecticut and Indiana, Duke Health Institutional Review Board, Protocol No. 00055585.

involved with the criminal justice system; about eighty-eight percent had no other arrests leading to conviction for any crime during the year before or after the gun removal event.

Six percent had been arrested in the year before seizure, and six percent were arrested in the year after. Two percent were arrested both in the year before and year after gun seizure.[63] By contrast, in fifty-five percent of cases police were sufficiently concerned about the mental health or intoxicated condition of the subject that they transported the individual to a hospital emergency department for evaluation. In twenty-seven percent of cases, the individual was not detained—was neither transported to a hospital nor arrested—following gun seizure.

Most risk-warrant subjects were not known to DMHAS at the time of gun removal. Only about twelve percent had received treatment for a mental health or substance use disorder in the DMHAS system during the year before gun seizure. However, many of these individuals came into contact with DMHAS as an indirect result of the gun removal action, so that twenty-nine percent received treatment in the system during the year *following* gun seizure. Of the 348 cases with any (lifetime) matched record in DMHAS, forty-five percent were diagnosed with a mental illness only (no substance use disorder),[64] twenty-six percent with a substance use disorder only (no mental illness), and twenty-nine percent with both mental illness and substance use disorder.

Treatment entry in many cases occurred because police found the subject of the risk warrant in an apparent mental health crisis and transported the individual to a hospital emergency department for evaluation, where they were admitted for an acute inpatient stay and then discharged to outpatient behavioral health treatment follow-up in the community. These data suggest, then, that the gun removal intervention sometimes functioned as a signal event and a portal into needed treatment, in addition to being a public safety action to remove lethal weapons at a time of high risk.[65]

Outcomes of court hearings challenging gun removal were known for thirty percent of cases. Most of the others failed to appear in court and, importantly, lost their legal gun access by default. Among cases with known outcomes at hearing, results were as follows: guns held by police, sixty percent; guns ordered destroyed or forfeited, fourteen percent; guns returned directly to the subject, ten percent; guns transferred to another individual known to the subject and legally eligible to possess guns, eight percent; other, eight percent.

63. The study could only obtain records of arrests that led to criminal convictions. Thus, these figures underestimate the number of police encounters before and after the gun seizure.

64. Thirty-nine percent of those with a mental health diagnosis had a serious mental illness. Of those with a serious mental illness, seventeen percent had schizophrenia, twenty-three percent had bipolar disorder, and sixty percent had major depression.

65. It must be noted that still more seizure incidents may have resulted in private mental health care—for which records were not available to the study.

B. The Practice Of Gun Removal In Connecticut: Stakeholders' Perspectives On Potential Benefits And Barriers To Implementation

To obtain a more textured and nuanced understanding of the gun removal policy in Connecticut, we interviewed a variety of respondents, including police supervisors and front-line police officers, prosecutors, judges, a mental health clinician, and a family member of a young adult with schizophrenia who had a history of violent behavior. We explored their perspectives on the need for, and purpose of the gun removal law, its intended target population, practical and legal barriers to its use, police responses to these barriers, and the perceived effectiveness of gun removal as a tool for reducing gun violence and suicide. In what follows, we quote and comment on interviews that were particularly illustrative of legal actors' views of the gun seizure law—its purpose and process, as well as challenges to implementation and how these challenges can be addressed.

One respondent was a former prosecutor who had participated in many risk-warrant gun removal proceedings under C.G.S. § 29-38c. He described a hypothetical case in which the law could be used to separate guns from an individual who clearly poses a significant risk of harm to self or others, but has not committed a crime, does not necessarily have a mental illness, and would not otherwise be legally prohibited from purchasing and possessing a firearm:

> A lot of times the people who have their weapons seized are not having a bad life—they're having a bad moment. A lot of times they're in darkness for a day . . . . It's the wife just told him, "We're getting a divorce," and they begin drinking, or they [make] suicidal comments to somebody . . . . [Let's say] my wife [and I] had a disagreement. I have two pistols and a rifle, and what I did was I left the house, and she saw me leave the house. I put the guns in my car and the last thing I said to her was, "You know what? I am done here. I'm done with everybody. I'm finished." And I had a couple of gin and tonics in me, and I said "I'm going to go to my favorite place and no one's ever going to see me again." She calls the police. I've committed no crime; I haven't threatened anybody. She calls the police and gives the police identifying information of the truck I left in. She knows that my favorite place as a little boy was Penwood State Park. The police department goes down and finds my truck at the Penwood State Park. You know what I was doing? I was just having a couple more gin and tonics at the present time. They roll up on me. "Sir, is everything okay?" "Yeah everything's just fine. Why?" "Well, we got a call that you were a little disconsolate." They do a warrant. They secure the guns.[66]

The attorney further articulated the law's rationale by noting its public safety purpose and its specific applicability to cases where the police would otherwise lack clear authority to intervene and to remove guns—situations where people have, as he put it, "violent propensities that do not rise to [the level of] a criminal event for an arrest, but nonetheless [we] have to take these guns from them for the protection of themselves and the public."[67] While thus noting that the law

66. Interview with Connecticut Prosecutor, Implementation and Effectiveness of 'Dangerous Persons' Gun Seizure Laws in Connecticut and Indiana, Duke Health Institutional Review Board, Protocol No. 00055585. In compliance with approved IRB protocol, a different name is used for the state park mentioned in the first quotation.

67. *Id.*

primarily serves the public's interest in safety, the attorney also emphasized the need to be reasonable and fair to the individual respondent in gun removal actions—highlighting the importance of legal due process protections commensurate with abridging an individual right and removing a person's private property.[68] Such legal safeguards, in his view, motivate both the temporary feature of gun seizures and the conditioning of rights restoration upon evidence of reduced risk:

> Politically, I believe that [gun removal under C.G.S. § 29-38c] is what the public wants us to do. They want us to take affirmative steps, [but let people] have their day in court. No one's saying . . . . "We're taking your property and you're never going to get it back." That's not fair. That's not reasonable. [We are saying] you'll have a day in court when you're no longer in crisis. When you're receiving treatment, you may get those weapons back.[69]

To the concern that gun removal might be carried out unfairly in reliance on a single police officer's biased report of risk, the attorney noted a system of checks in the risk warrant's requirement that a series of three observers concur.[70] This, he believed, should reassure those who fear that the power to remove guns could be abused:

> [I]t gives them a certain amount of reassurance that they're not just counting on the police to make this determination. You have three sets of eyes [that] have looked at this. You have the police who are on the scene, the State's Attorney who is going to . . . read a report and see if [evidence of risk] is there, and then a third set [of eyes], the judge, who is now going to look at it, and again—separate from being on the scene and being there—reading over just a report within those four corners, making a determination as to whether you can do something which is rather large, in that you are going to remove a person's Constitutional rights. So, having three sets of eyes I think is probably important.[71]

And yet, despite this nod to fairness and due process, the former prosecutor also seemed to allow for discretion—even some manipulation of the legal rules—based on the legal actors' own perceptions of a subject's character and the nature of the risk at stake. Indeed, rather than relying too much on an adversarial system of legal representation to ensure fairness in every case, he described a kind of collaborative application of leverage by the State's lawyer and the judge—almost implying that this was somehow appropriate because the action in question involves only a civil deprivation and not a criminal sanction. Specifically, in

68. *Id.*

69. *Id.*

70. *See* CONN. GEN. STAT. § 29-38c (1999) (The statute refers to the roles of three kinds of actors in the risk warrant process—police officers, a state's attorney, and a judge of the Superior Court. In the typical case, all three of these actors will have considered and concurred that the available evidence supports the required probable cause determination for a risk warrant. Technically, though, a risk warrant could be issued on the basis of concurrence between only two sets of actors: the police and the judge, or the state's attorney and the judge: "(a) Upon complaint on oath by any state's attorney or assistant state's attorney or by any two police officers, to any judge of the Superior Court, that such state's attorney or police officers have probable cause to believe . . . such judge may issue a warrant commanding a proper officer to enter into or upon such place or thing, search the same or the person and take into such officer's custody any and all firearms and ammunition.").

71. *Id.*

response to a question about whether the subjects of gun removal should have access to legal representation, the attorney gave this answer:

> It's not a criminal matter; it is a civil matter. . . . You [as a subject of gun removal] have an option. One, you can roll your dice with the hearing. Two, you can say to me [as the State's lawyer] right now, "I am not comfortable going forward without an attorney." And I will go up and tell the judge you would like counsel. And [you] would be told, "We are not going to have the hearing [now] and you're not going to get the guns back." And then [people think,] "Oh, I'm going to have to pay for an attorney now to get my guns back?" [So the hearing goes forward.] That happens most of the time . . . I would then go into chambers and lay it out for the judge exactly what we talked about. I would say, "Look, I think this guy is a good guy," or "I think this guy is a borderline guy."[72]

Despite such efforts to make the law work at the judicial level, there are significant barriers to carrying out these gun removal actions at the policing level, which hampers broader implementation of the statute. When asked to explain why such a small number of gun removals have been completed throughout the state—less than fifty cases per year, on average, since C.G.S. § 29-38c was enacted in 1999[73]—the attorney pointed to a mismatch between available police staffing resources in most departments and the statutory requirement that two officers appear as co-affiants before a judge to obtain the risk warrant:

> Most law enforcement agencies in this state are less than forty officers. [That] means that for any one given shift, you have a supervisor and two patrol officers. With [the requirement of] two affiants that have to appear in front of a judge, you have no police on the street. So a supervisor or a law enforcement executive is going to say, "Do you really need to do that warrant? Do you really need to draft it right now, at 3:00 in the morning on Halloween? Okay? We don't have the staff for that." So that goes to the wayside and you run, or you roll the dice. [If you] roll, you run the risk of whether this person's going to go out and be violent.[74]

Other logistical issues may impede wider use of the gun removal law. A police administrator was among several interviewees who identified the problem of gun storage as a significant barrier:

> [If we take someone's gun], we now have a piece of property . . . and we're stuck with it. What do we do with it for the next 200 years? It sits in our gun cabinet. So we may look at other alternatives, you know—[store it with] family members who have the legal right to own firearms.[75]

A former police officer likewise expressed concerns about the law's implementation and effectiveness, pointing first to the statute's "obscure" nature and the cumbersome aspects of the risk-warrant process:

> Do I think 29-38C—when it was written, when it was drafted, and how it had been utilized pre-Sandy Hook—was effective? No, I don't believe it was effective. Why? It was an obscure statute. It was something that was labor-intensive. It was something that required an affiant, a co-affiant, supervisor's review, State's attorney's office review, and approval and a judge's signature and then, of course, execution on that warrant. Okay, so I didn't think it was a streamlined, timely process. I know that traditionally

72. *Id.*

73. Norko & Baranoski, *supra* note 37.

74. *Id.*

75. Interview with Connecticut Police Administrator, Implementation and Effectiveness of 'Dangerous Persons' Gun Seizure Laws in Connecticut and Indiana, Duke Health Institutional Rev. Board, Protocol No. 00055585.

> with a lot of this stuff, the state will come up with something and the citizenry and law enforcement doesn't even know it exists. And that has happened time and time again.[76]

The former officer seemed to imply that the gun removal statute has amounted to little more than another unworkable policy concocted by obtuse state lawmakers and bureaucrats, promulgated top-down without properly informing either the rank-and-file officers who would be expected to carry out the policy or the public that might be affected by it.

As if to illustrate the possible perverse consequences of what he sees as a poorly implemented law, the former officer went on to describe a particular case in which the police seized a citizen's guns without following the required legal procedures, and a judge then improperly decided to retain the guns at the hearing anyway, notwithstanding evidence of the police officers' illegal removal action. Despite expressing some human understanding for a risk-averse judge's improper decision in the case, the respondent argued that the ultimate result of such official malfeasance is loss of public trust in the legal system, and a sense of betrayal especially among law-abiding gun owners who are otherwise inclined to trust the police. This is a point that he thinks is lost, ironically, on many lawmakers and judges:

> Just from a human point of view I understand, you know, if you're a judge, you don't want to give the guns back and have something happen the next day and be on the front page. But you still should follow the law . . . . The judge didn't [follow the law], and we got all this embarrassing testimony . . . . Firearms owners especially feel put-upon. I don't think the legislature, I don't think the judiciary realizes how, how strongly offended people are by that . . . . These are people that have trust in the system . . . . These are people that support the police, were in the military, you know, read the paper and when somebody is arrested they assume he's guilty because "the police don't arrest people who aren't guilty." I mean, that's who these people are. And then they come up with stuff like this, their whole universe is shaken, you know, and that's very distressful for people. Nobody recognizes that.[77]

Still, some police supervisors and field officers who were interviewed did express general support for the risk-warrant law, as they explained how they carried out its legal requirements in practice on a fairly routine basis. The police administrator described in detail how the police can, in many cases, quickly fill out the required form, obtain a warrant from a judge on call, and carry out a gun removal action within a few hours' time:

> I mean, most of it is a [three to five] line narrative. You know, "We got a report of a guy wanted to commit suicide. I showed up, he was sitting in the corner with a loaded .357. He said to me, he wanted to commit suicide. I talked to him and he put it down. We sent him to the hospital. He owns additional firearms [and] we want to take them all." So you take this . . . down to a judge, and there are judges on call in the State of Connecticut twenty-four hours a day . . . and [we] have a very regular working relationship with them. The judge's phone rings at two o'clock in the morning, it's us, and one of us drives over there with a warrant. He reviews it, signs off on the bottom of it, we go back and we take all the guns. In the meantime, officers are sitting at the location where all the

76. Interview with Connecticut Police Officer, Implementation and Effectiveness of 'Dangerous Persons' Gun Seizure Laws in Connecticut and Indiana, Duke Health Institutional Rev. Board, Protocol No. 00055585.

77. *Id.*

> guns are, and securing it, our subject is gone to the hospital. We get the warrant signed, we go back to the house and we collect everything related to the gun . . . firearms, obviously, ammunition, components for making ammunition, gun powder and those kinds of things, because if they are there, anybody with the internet in twenty minutes could build something.[78]

In the same interview, however, this police supervisor explained how police officers often circumvented the risk-warrant process out of an immediate concern for safety at the scene. In pressing circumstances, it seems that police have other justifications for removing guns, and may need the risk-warrant only to continue holding the weapons once the immediate risk of the scene has passed:

> The process of obtaining control over firearms [can] happen very quickly . . . in the absence of a warrant, as a matter of fact. It can happen that way. What we end up doing is following up with one of these warrants [after seizing the guns], and then we serve it on ourselves, basically. We serve it on the caretaker of the records department. She has control of the guns once we get them here, and we end up serving her with the warrant. And then that starts the documentation of what we did . . . . "This is what we seized as a result of this warrant," and then we file it with the court . . . . We are at that point compelled to complete the return of service, provide the copy of the entire thing to the subject of the warrant. Our guy is going to be locked up in evaluation at that point in time . . . . So we have to go to the civil court clerk . . . and so the civil clerk would get a copy of our warrant now. They stamp the receiving of the warrant, and create a record, where the individual who is the subject of the warrant now gets notification that in two weeks, this day, you're going to have a hearing about these guns.[79]

Regarding the problem of delay in obtaining a risk warrant, one lawyer suggested that a solution would be to change the law to resemble provisions currently available under domestic violence circumstances, in which the officer merely needs probable cause to believe that significant risk exists in order to seize weapons, with the warrant being obtained later:

> Officers have the ability to short circuit that whole warrant process under domestic violence circumstances in which a weapon was used, present, or on-scene at the time of the incident. Officers can seize those and take them for safekeeping. What we would like to see is a . . . scheme like the domestic violence provisions [where] . . . once probable cause is determined we've met that Fourth Amendment threshold. Okay? Once probable cause is determined, the officers, if there's a weapon on scene, or there's availability of weapons, we can seize. They can go back and do the warrants later.[80]

In summary, the shared perspectives of key respondents in the gun removal process help us to better understand both the potential benefit that a risk-based gun removal law may offer in terms of public safety, as well as some of the key reasons why it is challenging to widely implement such a law while safeguarding individual rights and ensuring legal due process in every gun seizure case.

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78. Police Administrator, *supra* note 75.

79. Police Officer, *supra* note 76. An additional illustration of this alternative process is found in *State v. Hope*, where the firearms were seized by police responding to a call of concern by the owner's wife. Four days later, the warrant was issued. 133 A.3d 519, 523 (Conn. App. Ct. 2016).

80. Interview with Connecticut Attorney, Implementation and Effectiveness of 'Dangerous Persons' Gun Seizure Laws in Connecticut and Indiana, Duke Health Institutional Rev. Board, Protocol No. 00055585.

C. Suicide Outcomes In Connecticut's Gun Seizure Population

A match of gun removal cases to state death records revealed that twenty-one individuals had completed suicide at some time following the gun removal event.[81] This equates to an annualized suicide rate of 482 per 100,000 in the study population, based on an average of 5.7 years at risk per person. This rate is approximately forty times higher than the average suicide rate of twelve per 100,000 per year in the general adult population of Connecticut during the same period.[82] Importantly, however, only six of the twenty-one suicides in the study were carried out with guns, while fifteen used other means: ten by suffocation or hanging, two by vapor poisoning, two by drug overdose, and one by a self-inflicted stab wound to the chest.

The proportion of these suicides that involved guns (twenty-nine percent) was lower than the corresponding gender-matched proportion for all adults in Connecticut, averaged across the same years (thirty-five percent),[83] and much lower than would have been expected in a population of gun owners (at least sixty-five percent).[84] This is consistent with a gun-deterrent effect associated with removal. Police had removed an average of six guns from each of these individuals.

Considering the initial court hearing decisions in these cases, three of the six eventual gun suicides involved individuals whose guns had been held pending further action. In the other three cases, the hearing outcome was listed as unknown, presumably because they failed to appear and thus lost their gun rights for twelve months by default. Among those who used other means of suicide, three initial court hearing decisions were held pending further action and twelve were unknown.

Notably, none of the six gun suicides occurred during the twelve-month period following gun seizure when the law allowed guns to be retained by police.

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81. The death records were matched and provided to the study investigators by the Connecticut Department of Health.

82. CDC, *supra* note 10 (providing the most current online report of fatal and nonfatal injury statistics collected by the CDC, by year, region, type of injury, and demographic category).

83. *Id.*

84. The proportion of suicides that use guns, that is, the number of firearm suicides (FS) divided by the total number of suicides (S), or FS/S, has been shown to be highly and reliably correlated with the rate of (survey-reported) gun ownership at the state level: r = (approximately) 0.81. Indeed, the correlation is so strong that researchers have used the time-varying FS/S proportion as a proxy measure of change in state gun ownership rates. See Deborah Azrael, Philip J. Cook & Matthew Miller, *State and Local Prevalence of Firearms Ownership: Measurement, Structure and Trends*, 20 J. QUANT. CRIM. 43, 43–62 (2004) (finding that the F/FS ratio is a more effective proxy for gun ownership than several other indicators, including NRA membership per capita). To illustrate, in the ten states (including Connecticut) with the lowest household gun ownership rate (averaging seventeen percent), guns were involved in thirty-nine percent of male suicides and sixteen percent of female suicides. In contrast, in the ten states with the highest household gun ownership rate (averaging fifty-six percent), guns were involved in sixty-nine percent of male suicide and forty-four percent of female suicides. With respect to these gun seizure subjects in Connecticut, then, the FS/S rate arguably should have been even higher than in these high gun-owning states, because the baseline rate of gun ownership was, by definition, 100 percent (absent the intervening gun seizure).

Instead, all of these gun suicides occurred after the date when these individuals would have become eligible to have their guns returned or to once again legally purchase guns. Regarding the timing of suicide in those who used means other than guns, five of the non-gun suicides occurred within twelve months of the seizure event; four more occurred within sixteen months. Overall, the time from the date of gun removal to date of death by suicide was considerably longer for those who used guns (average 3.7 years) than for those who used other means (average 2.2 years.) This finding is consistent with the explanation that gun removal effectively delayed access to guns for use in suicide (typically for twelve months or more), while those who used other means would have had access to those means at any time.[85]

Eighteen of the suicide victims were men, and three were women. Their ages at death ranged from thirty-three to seventy-five years, with an average of fifty years. Two were United States military veterans, one who had served in the Vietnam War and the other in the Iraq-Afghanistan War, deployed in the year before his guns were removed. Seven of these individuals were reported to be intoxicated at the time of the seizure event (six with alcohol, one with a prescription drug).

Eleven of the twenty-one suicide victims had been transported to a hospital emergency department in conjunction with their gun removal event. Nine of them had received treatment in Connecticut's public behavioral health system, and three had been involuntarily committed to a psychiatric hospital. Of those with treatment records, five were diagnosed with a serious mental illness, five with a substance disorder, and three with both. While six had a matching historical record with the Department of Correction, none had been convicted of a crime in the twelve months preceding the removal event. However, one individual had an arrest resulting in conviction in connection with the gun removal event itself, and two had an arrest resulting in conviction during the twelve months following gun removal.

When people have their guns removed and go on to commit suicide anyway, it would seem that the policy has obviously failed in these particular cases. However, because the majority (seventy-one percent) of the suicides in the study used methods other than guns—and specifically used methods that are known to be less lethal than guns—it is possible that the policy was beneficial overall, and that there would have been even more suicides without it in place. To test this, we estimated the total number in the sample who attempted suicide by alternative means and survived. We then estimated the additional number who would have died if their guns had not been taken away, based on independent

85. Two stories with different endings illustrate this finding. In the first case, police received a call from a man in his early thirties who "sounded very depressed, said he had consumed alcohol and explicitly threated to kill himself with one of his firearms." Police seized four rifles and two shotguns in the case. The man eventually did complete suicide with a firearm, but not until six years later. In the second case, a middle-aged man threatened to shoot himself after his wife asked for a divorce. His guns were removed and ordered held pending further action. This second man also completed suicide, just over one year later, but by means of hanging—not with a gun.

evidence as to the proportion that would have used a gun instead of a less lethal means in their suicide attempt. More specifically, using the known case fatality rates associated with each of the suicide methods used,[86] we extrapolated the number of suicide attempts represented by each completed suicide, according the following formula:

Estimated N suicide attempts = $\sum_{K=1}^{M}(N_k * (\frac{1}{cfr_k}))$ where N=number of recorded suicides, K=suicide method (1 to m), and cfr is the case fatality rate.

Table 1 displays the result of these calculations and yields an estimate of 142 suicide attempts.

Table 1. Completed Suicides and Estimated Number of Suicide Attempts, by Method of Self Injury, among Connecticut Gun Seizure Cases

Method of intentional self-injury	Completed suicides	Case fatality rate*	Estimated nonfatal attempts	Estimated total attempts
Firearm	6	87.0%	1	7
Hanging/strangulation	10	72.7%	4	14
Poisoning - gas	2	37.5%	3	5
Poisoning - drugs	2	2.7%	72	74
Incision/cut	1	2.4%	41	42
Total	21	14.6%	121	142

Using this calculated number of suicide attempts, we created a counterfactual data array to estimate the additional number of suicide deaths that would have occurred in the absence of the gun seizure policy. Construction of the counterfactual required making an assumption about what proportion of gun-owning men in the baseline (pre-intervention) target population who are inclined to attempt suicide would use a gun in their suicide attempt.[87] In our study, the target population could best be described as men who own multiple guns and are deemed to pose a high risk of harming themselves or others with a gun. There are

86. Case fatality rates for specific suicide methods in the Connecticut population are calculated by combining data on suicide deaths with data on hospital discharges for intentional self-inflicted injuries, using 2012 as the index year. Data on the number of suicide deaths by each means were obtained from the Connecticut Office of the Chief Medical Examiner. Data on the number of hospital discharges for self-inflicted injuries by each means were obtained from the Connecticut Hospital Inpatient Discharge Database, Department of Public Health. The means-specific case fatality rate is given by the number of suicides for each particular method, divided by the sum of suicides and intentional self-injury hospital discharges for that method.

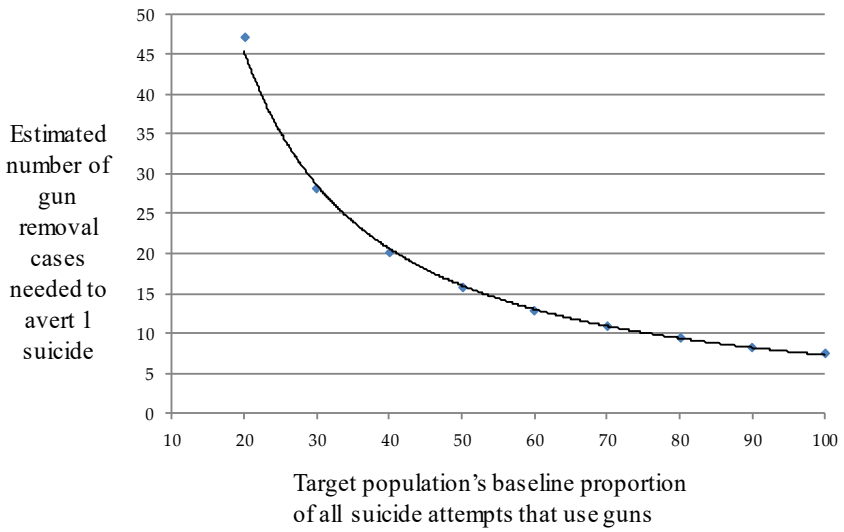
87. The large majority (ninety-two percent) of gun seizure cases were men.

no precise data for this specific population as to the distribution of preferred suicide methods. However, we were able to estimate this information for our study population using state-level, year-specific data on the frequency of different suicide methods among men, the estimated number of suicide attempts for each method in each state, based on known case fatality rates, and the linear correlation of the (survey-derived) rate of gun ownership in each state[88] with the estimated proportion of gun involvement in adult male gun suicides in each state.[89]

Specifically, the state-level linear correlation between the probability of gun ownership for any adult in a given state and the proportion of adult male suicide attempts using guns was r = 0.79. We used the resulting regression equation to calculate the probability that any adult male who owns a gun and attempts suicide will use a gun in doing so, rather than some other method. That result (p = 0.39) was used, in turn, to create the counterfactual hypothesis to estimate the number of excess fatalities that could have been expected in the absence of gun seizure, and then the number of gun seizure cases needed to prevent one suicide. The result for the latter was approximately twenty.

We consider that this initial estimate—twenty gun seizures for every averted suicide—is likely the most conservative, because it does not account for any excess risk of gun suicide associated with being identified as a gun seizure

Figure 2. Estimated Number of Gun Removal Cases Needed to Prevent One Suicide in a Population at High Risk for Suicide, as a Function of the Target Population's Baseline Proportion of All Suicide Attempts that Use Guns



88. See Bindu Kalesan, Marcos D. Villarreal, Katherine M. Keyes & Sandro Galea, *Gun Ownership and Social Gun Culture*, 22 INJ. PREVENTION 1, 1–5 (2015) (finding a close correlation between social gun culture, gun ownership, and firearm suicide).

89. CDC, *supra* note 10.

candidate and determined by a judge to be at high risk of harming self or others specifically with a gun. Indeed, it would seem reasonable to expect a much higher chance than thirty-nine percent that such a high-risk, multiple-gun-owning, male gun-seizure candidate would have chosen a gun, and not something else, as the preferred method of suicide, if his guns had not been removed by the police. Rather than speculating on this, we calculated the mathematical relationship between the expected proportion of gun use in suicides in a given target population, and the corresponding number of gun seizures that would be needed to avert a single suicide in that population. The model assumes that the hypothetical target population resembles the research study population of gun-removal cases in Connecticut with respect to the underlying prevalence of suicide attempts. The association follows a curvilinear form and is displayed in Figure 2.[90]

This graph illustrates that a gun seizure policy in any particular jurisdiction would be expected to be more or less efficient in preventing suicide as a predictable function of how often guns tend to be used in suicide attempts in the target population. If the law is applied to a population at risk in which guns are used very rarely as a method of suicide, it may be necessary to conduct a great many gun removals in order to prevent a single suicide. However, when the law is applied to a population at high risk of using guns in any suicide attempts, it may take far fewer gun removal cases to prevent one suicide.

As an example, if approximately seventy percent of the estimated 142 gun seizure suicide attempters in the Connecticut gun seizure database had used guns, 101 gun suicide attempts would have been expected, resulting in eighty-eight completed gun suicides. Assuming that the remaining forty-one non-gun suicide attempters had used alternative means in the same proportions as observed in the actual data, and applying the appropriate weighted average of lethality rates to those other means of suicide, we would have expected an additional five non-gun suicides, for a total of ninety-three—or seventy-two more suicides than the twenty-one that actually occurred. Dividing the total number of gun seizures by this estimated number of averted gun suicides (762/72) yields an estimate of approximately one averted suicide for every ten to eleven gun seizure cases. That calculation is illustrated in Table 2.[91]

90. Estimate is derived from a state-level regression of the proportion of suicides that involve guns on the household gun ownership rates, and by extrapolation of the number of suicide attempts from case fatality rates applied to reported suicides by different methods in each state.

91. The counterfactual assumes that gun-owning men who attempt suicide in Connecticut would be as likely to use a gun in their suicide attempt as all men who attempt suicide in a high gun-ownership state. Estimated number of fatalities based on firearm suicide rates among Connecticut adults, 1999–2013, are reported by CDC WISQARS™ data. CDC, *supra* note 10.

Table 2. Estimated Suicide Prevention Effect of Connecticut's Gun Removal Policy

	Suicide outcomes for actual gun removal cases		Counterfactual (hypothetical) data assuming no gun removal		Estimated policy effect	
	Attempts	Fatalities	Attempts	Fatalities	Number of averted suicides	Number needed to remove
Firearm	7	6	101	88		
Other means	135	15	41	5		
Total	142	21	142	93	72	10.6

VII
SUMMARY AND IMPLICATIONS

Every day in the United States, more than 230 people are injured in gunfire and about ninety of them die—sixty of them by their own hand.[92] Almost ninety percent of people who attempt suicide survive, and the large majority of those survivors do not go on to die in a subsequent suicide attempt; they are far more likely to die from some other cause later in life.[93] However, people who use a firearm in that first suicide attempt almost never get a second chance; nationally, only about nine percent of gun suicide attempters survive.[94] Using the law to prohibit a suicidal person from purchasing a gun is a good idea, but one that will not work—even with a comprehensive background check system—as long as those who are inclined to harm themselves do not fall into some category of persons prohibited from possessing or purchasing firearms under federal or state law. New research evidence suggests that people who die from self-inflicted gunshot wounds, even those suffering from a serious mental illness, typically have no gun-disqualifying record of any criminal or mental health adjudication.[95]

92. *See* CDC, *supra* note 10 (here extrapolating a daily rate of firearm injury and mortality from the WISQARS™ report of all fatal and nonfatal gun injuries in 2014).

93. *See* David Owens, Judith Horrocks & Allan House, *Fatal and Non-Fatal Repetition of Self-Harm: Systematic Review*, 181 BRIT. J. OF PSYCHIATRY 3, 193, 193–99 (2002) (discussing results of a systematic review of published follow-up studies of survivors of suicide, which found that only seven percent of such survivors eventually died of a subsequent, fatal suicide attempt).

94. *See* CDC, *supra* note 10 (The survival rate for gun suicide attempts—9.0 percent—is calculated by dividing the total number of firearm suicides—3,320—by the sum of fatal and nonfatal intentional self-injuries with a firearm—36,919—as reported in the CDC's WISQARS™ databases for 2014).

95. *See* Swanson, *supra* note 24, at 1071 (reporting that sixteen percent of the Florida study subjects who died from suicide had a gun-disqualifying criminal record only, ten percent had a gun-disqualifying mental health adjudication record only, two percent had both types of disqualifying records, and seventy-

Indeed, the large majority of them would have been able to legally buy a gun on the day they used one to end their own life.[96]

In a country where guns are highly prevalent and where the right to purchase and possess them is constitutionally protected,[97] it would seem prudent for states to adopt carefully tailored, civil (rather than criminal), public-safety-minded laws designed to separate guns from dangerous people—laws specifically targeting those few individuals who pose a clear and present risk of harm to themselves or others but who are not otherwise restricted from purchasing or possessing guns. The exercise of state authority to remove guns from private citizens under such risk-based regimes must, of course, be checked by appropriate due-process protections commensurate with abridging constitutional rights, including the opportunity for timely restoration of gun rights when risk recedes. Connecticut pioneered the use of these temporary preemptive gun removal laws, but research has been lacking to inform other jurisdictions about the particular challenges of implementing the laws, including evaluating their effectiveness and their cost to personal liberty.

This article has presented the results of an extensive, mixed-methods empirical study of Connecticut's experience with its pioneering gun removal law. As this study demonstrates, there has been a considerable shift between the original impetus for the statute—public concern over a highly publicized homicide—and the actual use of the law—concern over harm to self and the risk of suicide, with referrals often coming from family members. This law took several years to begin to work itself into routine practice as a useful tool for public safety and suicide prevention. Considerable barriers to implementation, such as the real and perceived time burden placed on police officers, seem to have prevented more extensive application.

Is the risk-warrant law being implemented and enforced fairly in Connecticut? Securing the guns first, getting the warrant later is not uncommon. While this reversed sequence might appear to raise due-process concerns, it was clear from our interviews that police officers often justified it on the basis of an immediate risk to public safety at the scene. To the extent that some officers may also deviate from the statutory process for reasons of expediency and convenience, there could be some benefit in systematic education through the Department of Emergency Services and Public Protection focused on the risk-warrant law, as well as development of specific gun removal protocols to improve police practice in this area.

Is the risk-warrant law targeting the right people, and does it actually work to reduce gun-related violence and suicide? It is difficult to answer the question

two percent had neither).

96. *Id.*

97. Following the Supreme Court's interpretation of the Second Amendment right as articulated in *Heller v. District of Columbia*, 554 U.S. 570 (2008) and *McDonald v. City of Chicago*, 561 U.S. 742 (2010), the limited role of law in preventing gun violence in the United States is mainly to keep guns out of the hands of dangerous individuals.

about violence to others without more cases to study, given the low base rate of gun-related aggravated assault and homicide in the population.[98] Also, the fact that our study only had access to the records of arrest resulting in conviction—and we know independently that the majority of gun-related arrests in Connecticut do not result in convictions—posed a further obstacle to accurately measuring this outcome.[99] Still, that almost nine out of ten gun seizure subjects had no convictions during the year before or after the gun removal event suggests that the policy is not targeting criminally involved individuals. This stands to reason, because a criminal background often precludes legal gun ownership in the first instance; police would not typically need to invoke a civil risk-warrant statute to separate guns from a known or accused criminal offender.

With respect to suicide, however—and suicide concern was the most common type of risk motivating these gun removals—the data from Connecticut may provide the basis for a productive policy discussion. First, the law in Connecticut has de facto targeted a population of people at exceedingly high risk of suicide, about forty times higher than that of the general population of the state. And to summarize the key finding, the study found that twenty-one individuals in the gun seizure database had died from suicide—six of them with guns and fifteen by other means. Using Connecticut population data on the case fatality rate associated with various means of suicide, we estimated that these twenty-one suicides represented 142 suicide attempts, 121 of them being nonfatal. This, in turn, allowed us to calculate by extrapolation how many additional fatalities could have been expected if these individuals had retained their guns, and had alternatively used a gun to attempt suicide. In this manner, we estimated that approximately ten to twenty gun seizures were carried out for every averted suicide. Are those numbers low or high? Is this a fair public health tradeoff? That is for policymakers to decide; but these data can help frame what is in the balance between risk and rights.

VII

CONCLUSION

Gun violence in America remains a multifaceted public health problem whose long-term solution calls for evidence-based public policies to address a range of contributing factors: gun safety concerns, illegal trafficking and access, as well as social and psychological determinants of assaultive and self-injurious behavior. But in a nation with a constitutionally protected individual right to bear arms, a gun-celebrating culture, powerful political and corporate gun interests, and a very high prevalence of private gun ownership, there are stiff headwinds

98. *See* CDC, *supra* note 10 (reporting that Connecticut's average annual rate of gun homicide between 1999 and 2015 was 2.16 per 100,000 inhabitants); *see also* Fed. Bureau of Investigation, Uniform Crime Reports, https://www.ucrdatatool.gov (reporting that Connecticut's average annual rate of aggravated assault between 1999 and 2012 was 164.7 per 100,000 population).

99. *See* Swanson, *supra* note 18, at 38 ("Independent analysis from the Office of Legislative Research in Connecticut has shown that about ninety-two percent of firearms violations (for example, illegal possession, transfer, and use of a firearm in a crime) in the state do not result in convictions[.]").

facing any form of firearms regulation. That guns are here to stay in America implies that efforts to reduce gun violence must be mainly about preventing dangerous behavior and restricting access to guns by individuals who demonstrate a significant risk of harming themselves or others. How to do that effectively and fairly, given the legal requirements for removing gun rights on the one hand, and the inherent scientific difficulty of predicting violent behavior on the other, is the essential challenge for policymakers and researchers.

Many current policies in the field of gun violence prevention are focused on improving the efficacy of background checks to identify and deter prospective gun purchasers who are legally prohibited from owning firearms.[100] However, background checks alone may fail to prevent gun violence in some cases because the prohibiting criteria correlate poorly with risk, and because guns are often acquired in private transactions not subject to background checks. Thus, many individuals at risk have ready access to firearms—sometimes multiple firearms—in their homes. In a country with more privately owned guns than people[101] and many states with large percentages of households having firearms, strategies to prevent gun violence must consider ways to mitigate the risk posed by guns that are already possessed by persons who may be inclined to harm others or themselves.

Laws that authorize police to remove guns from persons at risk of violence or suicide appear to be a logical and complementary approach to background checks in preventing gun violence. This study advances the field of gun violence prevention also by providing new information regarding the challenges to implementation of removal laws in one state. Potential changes to the law could streamline the gun-removal process and make it easier for police to take preventive action when appropriate. One such change, which was suggested by an expert respondent interviewed for this study, would be to allow police to remove guns immediately with probable cause; this would be similar to current practice in domestic violence situations where a gun surrender requirement is triggered by an ex parte temporary order of protection.[102] This study suggests that

100. See Bureau of Just. Stat., FY 2016 NICS Act Record Improvement Program (NARIP) (CFDA #16.813), at https://www.bjs.gov/content/pub/pdf/narip16sol.pdf [https://perma.cc/BDS2-PL35] (providing an example of such a policy: "The NICS Improvement Amendments Act of 2007, Pub. L. 110-180 (NIAA or the Act), was signed into law on January 8, 2008, in the wake of the April 2007 shooting tragedy at Virginia Tech. The Virginia Tech shooter was able to purchase firearms from a Federal Firearms Licensee (FFL) because information about his prohibiting mental health history was not available to the NICS, and the system was therefore unable to deny the transfer of the firearms used in the shootings. The NIAA seeks to address the gap in information available to NICS about such prohibiting mental health adjudications and commitments, and other prohibiting factors. Filling these information gaps will better enable the system to operate as intended to keep guns out of the hands of persons prohibited by federal or state law from receiving or possessing firearms. The automation of records will also reduce delays for law-abiding persons to purchase firearms.").

101. *See* Ingraham, *supra* note 26 (discussing one recent estimate that there are 357 million privately owned firearms in the United States, which is more than the estimated U.S. population of 320 million).

102. *See* Wes Duplantier, *New Connecticut Law Requiring Guns Be Surrendered in Restraining Order Cases Takes Effect Saturday*, NEW HAVEN REG. (Sept. 30, 2016) (describing the enactment of Public Act No. 16-34, An Act Protecting Victims Of Domestic Violence: "[The new law] requires a person to

risk-based gun removal laws, even as currently implemented in Connecticut, can be at least modestly effective in preventing suicide. Expanded police training in the features of such a law and police protocols for safely removing guns from persons at risk of harm to self or others might further enhance the law's utility and public safety benefit.

Millions of Americans every year undergo a personal background check to purchase a firearm, and over ninety-eight percent of them are approved.[103] Some small proportion of those legal gun buyers will later experience a period in their lives when they pose a serious, knowable risk of interpersonal violence or suicidality—engaging in threatening or dangerous behavior[104] apparent to those around them—yet will not be legally or practically prohibited from accessing guns. The evidence presented in this article suggests that enacting and implementing laws like Connecticut's civil risk warrant statute in other states could significantly mitigate the risk posed by that small proportion of legal gun owners who, at times, may pose a significant danger to themselves or others. Such laws could thus save many lives and prove to be an important piece in the complex puzzle of gun violence prevention in the United States.

surrender their firearms if they are subject to a temporary restraining order. It further bars them from getting those guns back until there is a court hearing.").

103. *See* Jennifer C. Karberg, Ronald J. Frandsen, Joseph M. Durso & Allina D. Lee, *Background Checks for Firearm Transfers, 2013–14 Statistical Tables*, BUREAU OF JUST. STAT. (2016) (discussing trends in the recorded number of background checks conducted on prospective purchasers of firearms and the number of gun purchase attempts that are denied due to a background check).

104. *See* Swanson, *supra* note 29 (discussing estimates from a nationally representative survey that approximately nine percent of adults in the United States have impulsive angry behavior problems—such as a tendency to "break and smash things" when angry—and also have access to firearms).

OFFICE OF LEGISLATIVE RESEARCH
Objective Research for Connecticut's Legislature

eResponse

December 8, 2021

Senator Moore:

In connection with the Connecticut Gun Violence Intervention and Prevention Advisory Committee, you asked us to provide summaries of initiatives passed by the legislature within the past five years to prevent, reduce, or intervene against gun violence or community violence, as well as their current funding sources.

(It is our understanding that the Advisory Committee has reached out to executive agencies, such as the Office of Policy and Management (OPM) and Department of Public Health (DPH), for summaries and funding sources for other current initiatives.)

Please be aware that this does not contain an exhaustive list of all possible anti-gun or community violence initiatives. We have limited this response to initiatives expressly concerning and limited to "gun violence" or "community violence." We have not included new programs or changes to existing programs, including ones involving the school or judicial systems, that have broader applications.

Initiatives

Within the past five years, there were three initiatives passed, all in 2021, directly concerning the prevention, reduction, or intervention against gun violence or community violence.

Project Longevity Initiative Expansion

As of July 12, 2021, PA 21-153 expanded the "Project Longevity Initiative" to include Waterbury and required the OPM secretary to submit a plan to implement it statewide to the Public Safety and Security Committee by February 1, 2022.

Project Longevity is a comprehensive community-based initiative to reduce gun violence in Connecticut's cities through a joint effort among community members, law enforcement, and social service providers to focus an anti-violence message on highly active street groups. Prior to this year, the project had already been in place in New Haven, Hartford, and Bridgeport since 2013.

In order to ensure or support Project Longevity's implementation in Waterbury, the OPM secretary must (1) provide planning and management assistance to municipal officials in the city and (2) do anything necessary to apply for and accept federal funds allotted or available to the state under any federal act or program. As has been the case for the other cities, the secretary may use state and federal funds as appropriated for this implementation.

For more information on Project Longevity, please see this webpage and this OPM webpage.

Medicaid Community Violence Prevention Services

Effective October 1, 2021, PA 21-36 requires the Department of Social Services commissioner to amend the state Medicaid plan to provide coverage for community violence prevention services for certain beneficiaries (i.e., those who have received medical treatment for an injury sustained from an act of community violence and received certain referrals for these services). The commissioner must do this by July 1, 2022, provided federal law allows it and the Centers for Medicare and Medicaid Services approves it and provides federal matching funds.

The act also establishes training requirements for individuals seeking certification as a "certified violence prevention professional," including on community violence prevention strategies. Relatedly, by January 1, 2022, DPH must approve at least one accredited training and certification program for these professionals. Additionally, the act establishes documentation and compliance requirements for entities that employ or contract with these professionals.

Gun Violence Intervention and Prevention Advisory Committee and Related Commission

Section 9 of PA 21-35 established the Connecticut Gun Violence Intervention and Prevention Advisory Committee. As you are likely aware, the Advisory Committee's main purpose is to advise the Public Health and Human Services committees on establishing a Commission on Gun Violence Intervention and Prevention to coordinate the funding and implementation of programs and strategies to reduce street-level gun violence. Its findings and recommendations are due to those legislative committees by January 1, 2022.

Relatedly, although there has not been any legislation formally establishing the Commission on Gun Violence Intervention and Prevention, Section 89 of the state's FY 22-23 bond act (PA 21-111) authorizes a total of $13 million in state general obligation bonds ($5 million in FY 22 and $7 million in FY 23) for OPM to provide grants to the Commission on Gun Violence Prevention and Intervention [sic].

Current Funding Sources

We asked the Office of Fiscal Analysis for assistance with providing current funding sources for anti-gun or community violence initiatives. Please find its response attached.

We hope this is helpful. Please let us know if you have any additional questions.

Best,

George

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Community Violence and Gun Violence Reduction Initiatives

Source: Connecticut General Assembly Office of Fiscal Analysis

This document identifies specific funding examples for FY 22 & FY 23 of agencies working to address community and gun violence. It should be noted that while these are specific programs/agencies that focus on violence reduction, there are many examples of agencies and programs that work with the goal of reducing violence but are not included as that is not the sole focus of those programs. Examples include but are not limited to the Office of the Victim Advocate, Department of Correction, and the Judicial Department Court Support Services Division.

Office of Policy and Management

Account/Grant	Description	FY 22	FY 23
Project Longevity*	Project Longevity is a Community and Law Enforcement initiative to reduce serious violence in three of Connecticut's major cities: New Haven, Bridgeport, and Hartford.	1,298,813	1,298,813
Justice Assistance Grants	JAG is the Federal grant program that assists states and local governments with the prevention and control of crime and improvement of the criminal justice system. The state appropriates funding as part of its maintenance of effort for Federal JAG funding.	786,734	790,356

*FY 22 and FY 23 Project Longevity includes $350,000 in FY 21 carryforward funding in each year.

Department of Community and Economic Development*

Account Name	Program/Grant Recipient	FY 22	FY 23	Description
Other Expenses	RYASAP Bridgeport	150,000	150,000	Nonprofit that serves the greater Bridgeport area. RYASP (Regional Youth Adult Social Action Partnership) works to ensure the safe and healthy development of youth, young adults, and families by actively engaging organizations, public officials, and community leaders around issues that matter to the community.
Other Expenses	CT Violence Intervention Program	100,000	100,000	Nonprofit that works to combat gun violence and keep youth engaged.
Other Expenses	Hartford Communities that Care	100,000	100,000	A nonprofit 501 (c) (3), community-based organization founded in 1998, whose mission is to create a thriving, non-violent and drug free environment for youth and families. As a leader and advocate for victims of violence and trauma in underserved communities, HCTC identifies, develops and implements culturally appropriate, high quality and evidence-based crisis response, mental health and supportive programs, partnerships and policies to improve the lives of youth and adult victims of crime and their families.
Other Expenses	Street Safe Bridgeport	100,000	100,000	StreetSafe Bridgeport provides a way for our young people to move away from the violence and toward safe, healthy and productive futures. SteetSafe takes a universal approach placing highly trained Outreach Workers who are dedicated to developing face to face, consistent connections to proven risk youth in order to interrupt conflict and guide them toward resources such as jobs, housing, mental health, and educational opportunities.
Other Expenses	SAVE - Norwalk	100,000	100,000	Serving All Vessels Equally (SAVE) - help address youth and gang-related violence, empower parents of youth involved in disruptive and violent behavior, connect clergy leaders with youth in one-on-one counseling relationships and get truant youth back into school or into the workplace. Target population is boys and girls ages 14 to 18 who live primarily in the under-served areas of the city.

* All funding is from FY 21 carryforward funding.

Judicial Department

Account	Description	FY 22	FY 23
Youth Services Prevention	Provides grants to various nonprofits around the state, to be used for youth services including violence prevention. Grants are specifically earmarked in the biennial budget.	5,170,000	5,169,997
Youth Violence Initiative	The Youth Violence Initiative is a program to reduce gun violence amount young people in Bridgeport, Hartford, New Haven, Danbury, Meriden, Waterbury, and West Haven. The program will utilize youth development programs, the settlement house model, and other evidence based models to reduce gang affiliation and youth violence. Grants are either passed through to the muncipalities for distribution or ear marked in the biennial budget.	2,296,420	2,299,486

Division of Criminal Justice

Account	Description	FY 22	FY 23
Shooting Taskforce	The Shooting Taskforce is a partnership between the Division of Criminal Justice Inspectors and municipal police staff to reduce firearm violence in the cities. Funding includes 11 staff members who work with the Bridgeport, Hartford, and New Haven police departments, as well as other expenses, training and equipment.	1,140,234	1,192,844

The Connecticut Violent Death Reporting System and Homicide Victimology in Connecticut 2015 to 2021*

Presented by Michael Makowski, MPH

October 15, 2021

Injury and Violence Surveillance Unit
Community, Family Health and Prevention Section
Connecticut Department of Public Health

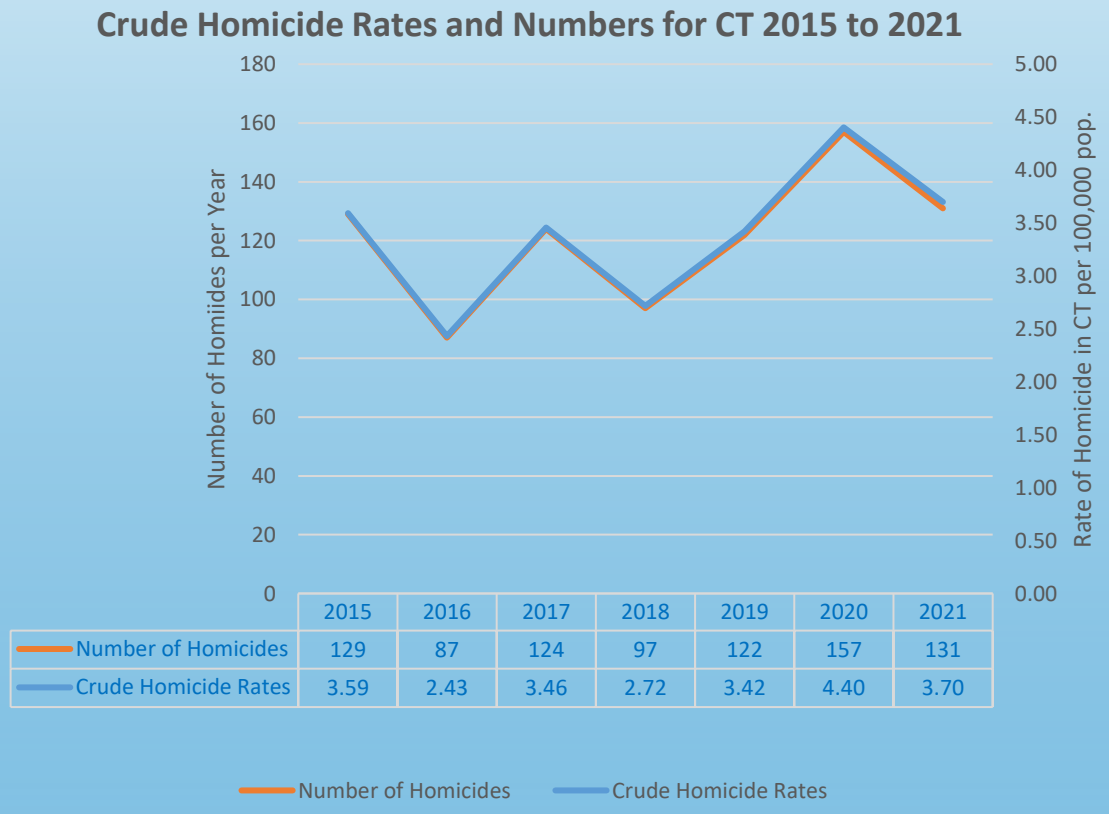
CTVDRS Data about Homicide Victims

The Connecticut Violent Death Reporting System (CTVDRS) collects data about the **victims of homicide**; limited information about perpetrator

- Data sources: LE reports, Supplementary Homicide Reports, Family Violence (DESPP), OCME investigation, autopsy and toxicology data
- Data collection began in 2015

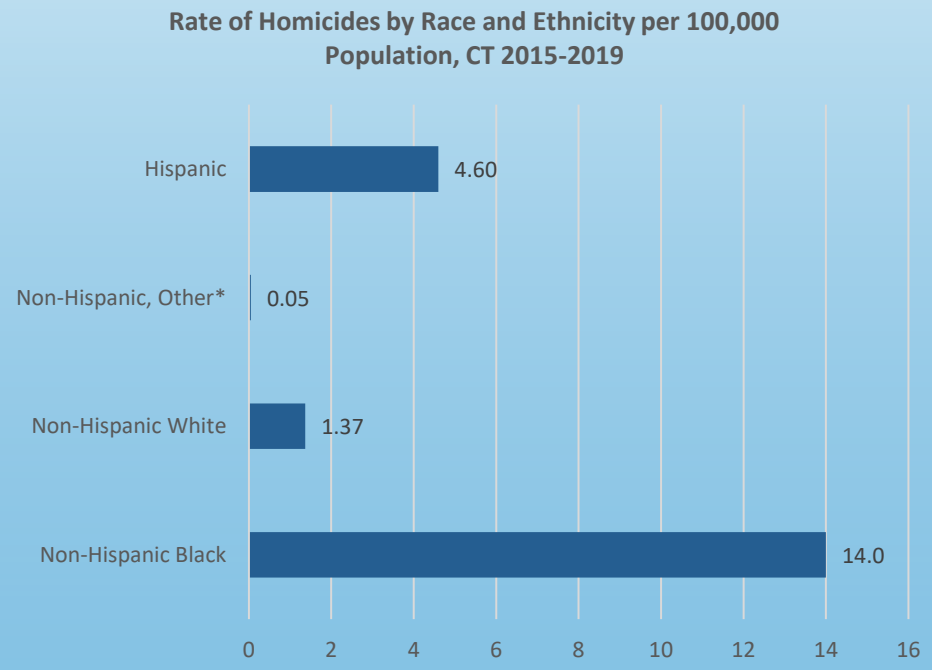
* Data from Connecticut Violent Death Reporting System (CTVDRS) 2015 to September 30 th, 2021

Homicide Rates In Connecticut 2015 to Present



- 2020 and 2021 data is preliminary* Rates are provisional, currently using 2019 population data for CT
- As September 30,2021 there were 131 homicides

Comparison of Homicide Rates Pre-Pandemic (2015 to 2019) to Pandemic (2020) by Race/Ethnicity

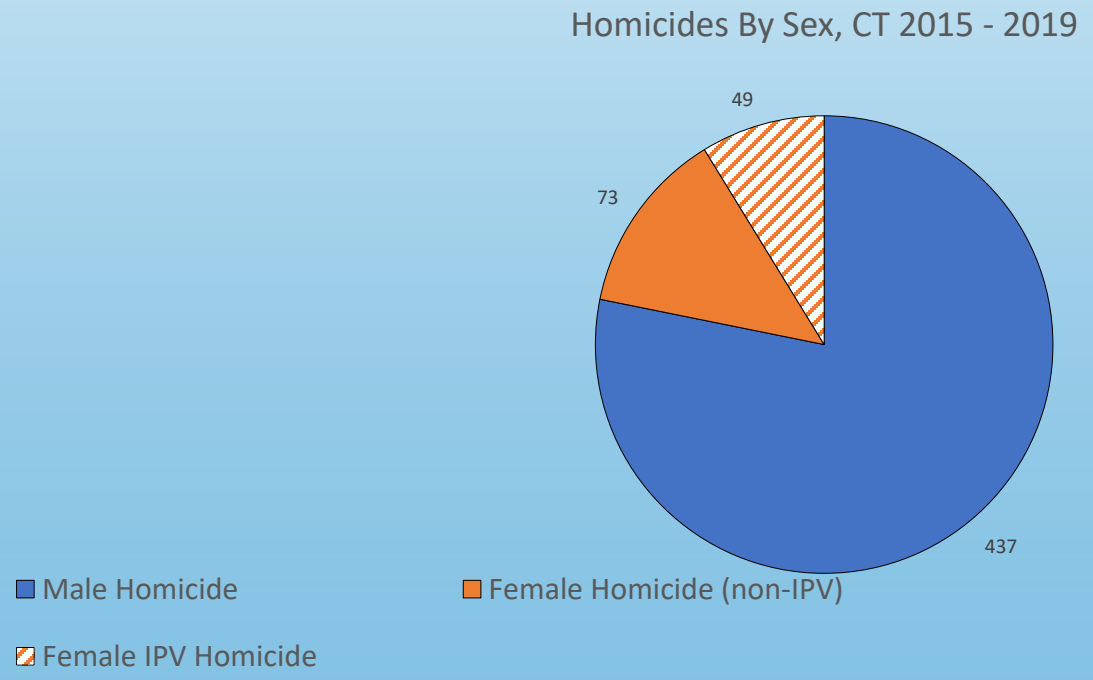


Comparison of Homicide Rates Pre-Pandemic (2015 to 2019) to Pandemic (2020) by Race/Ethnicity

Race/Ethnicity	Average Number Homicides (2015 to 2019)	Crude Rate *2015-2019	Crude Rate*2020	Number of Homicides 2020	Rate Difference 2015 to 2019 Compared to 2020
Non-Hispanic Black	51	14.0	20.6	76	+ 47%
Non-Hispanic White	33	1.40	1.40	33	No change
Hispanic	27	4.60	7.82	47	+ 70 %

*per 100,000 CT population

Homicide 2015 to 2019



CTVDRS Data Lethal Means 2015 to 2021

Years	Weapon Type	Number of Homicides by Weapon Type	Total Number of Homicides for 2015 to 2019	Rate Weapon Death per 100 Homicides
Pre-Pandemic (2015to 2019)	Firearm	343	559	61.3
	Sharp Force Injury (Stabbing)	69	559	12.3
Pandemic				
2020	Firearm	108	157	68.7
	Sharp Force Injury (Stabbing)	31	157	19.7
2021	Firearm	96	131	73.2
	Sharp Force Injury (Stabbing)	13	131	9.9

Circumstances of Homicide/ Possible Areas for Intervention

- For 2015 to 2019 homicide circumstances were known for 80% (N=452)of the cases (LE and OCME reports)
- Gang* or groups involvement: rate 9 per 100 homicides

* Defined by law enforcement as organized gangs as Bloods, Crips and Latin Kings

Circumstances	Number of Occurrences	Rate per 100 Homicides
Disputes/Arguments	167	36.9
Commission of a Crime:		
Assault	132	29.2
Robbery	63	13.9
Drug Trade	48	10.6
Drug Involvement	86	19.0

Substance Use in Homicides 2015 to 2021

Rate of Positive Drug Results from Blood at the Time of Autopsy
2015 to 2019 **(N= Number of Homicides (559))**

Drug	Number of Positives	Rate per 100 Homicides
Marijuana	171	30.5
Alcohol	135	24.1
Opiates	66	11.8
Cocaine	56	10.1
Benzodiazepines	41	7.3

Rate of Positive Drug Results from Blood at the Time of Autopsy
2020 to 2021 **(N= Number of Homicides (288))**

Drug	Number of Positives	Rate per 100 Homicides
Marijuana	150	52.0
Alcohol	66	22.9
Cocaine	48	16.6
Opiates	42	14.5
Benzodiazepines	12	4.5

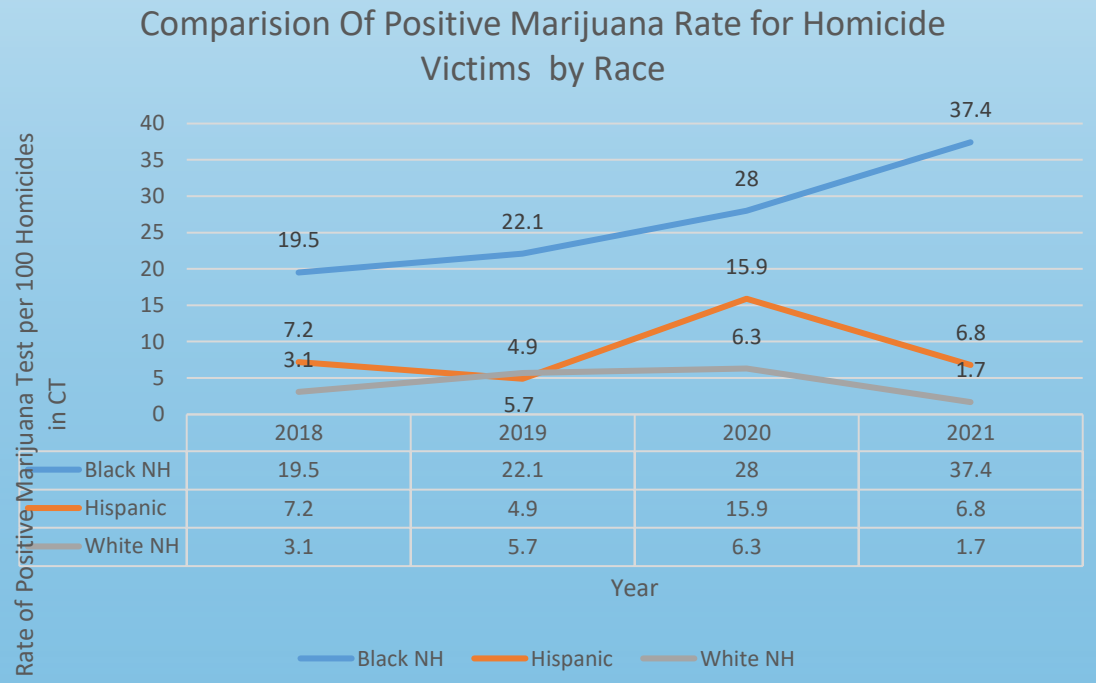
Substance Use in Homicides by Race/Ethnicity

Number of Positive Marijuana Results by Race by Year *

	2018	2019	2020	2021
Black NH	19	27	44	49
Hispanic	7	6	25	14
White NH	3	7	10	7
Other NH (Asian, Native American, Pacific Islander)	0	1	0	1
Number of Homicides	97	122	157	131

* Note: Rates calculated from counts less than 20 should be interpreted with caution due to the variability of small numbers resulting in low reliability of rates

Rate of Positive Marijuana Results at the Time of Autopsy by Race per 100 Homicides



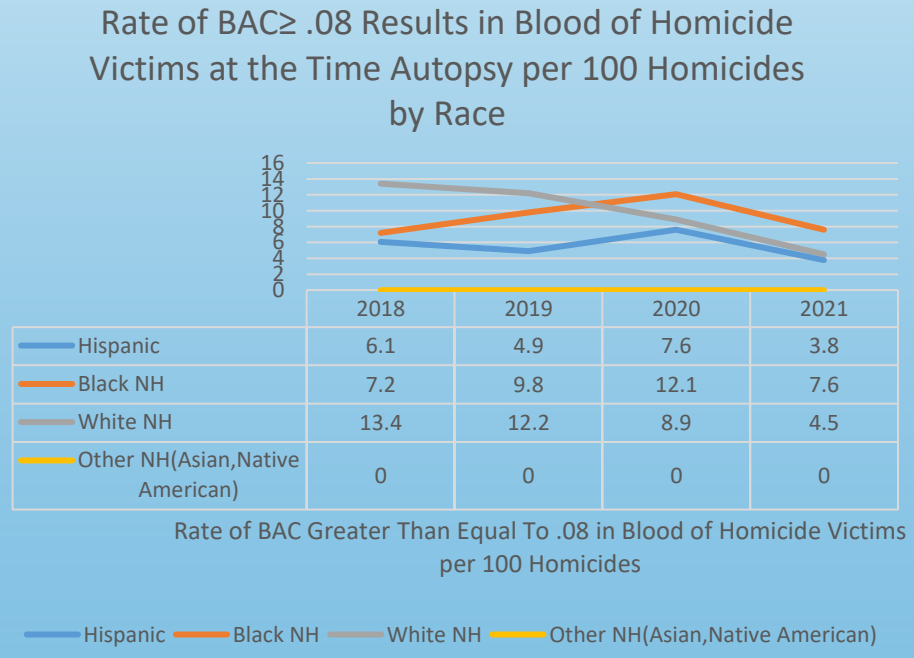
Substance Use in Homicides by Race/Ethnicity

Number of Alcohol Results (BAC ≥ .08)by Race by Year *

	2018	2019	2020	2021
Black NH	7	12	19	10
Hispanic	6	6	12	5
White NH	13	15	14	6
Other NH (Asian, Native American, Pacific Islander)	0	0	0	0
Number of Homicides	97	122	157	116

*note: Rates calculated from counts less than 20 should be interpreted with caution due to the variability of small numbers resulting in low reliability of rates

Rate of Alcohol Results (BAC ≥ .08) by Race per 100 Homicides

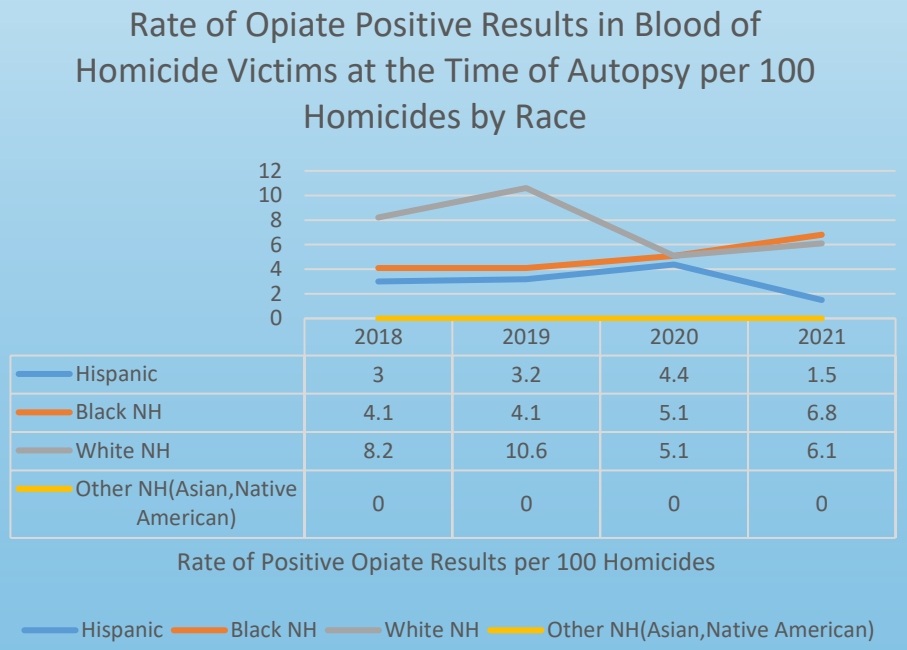


Substance Use in Homicides by Race/Ethnicity

Number of Positive Opiate Results *

	2018	2019	2020	2021
Black NH	4	5	8	9
Hispanic	3	4	7	2
White NH	8	13	8	8
Other NH (Asian, Native American, Pacific Islander)	0	0	0	0
Number of Homicides	97	122	157	116

* Note: Rates calculated from counts less than 20 should be interpreted with caution due to the variability of small numbers resulting in low reliability of rates

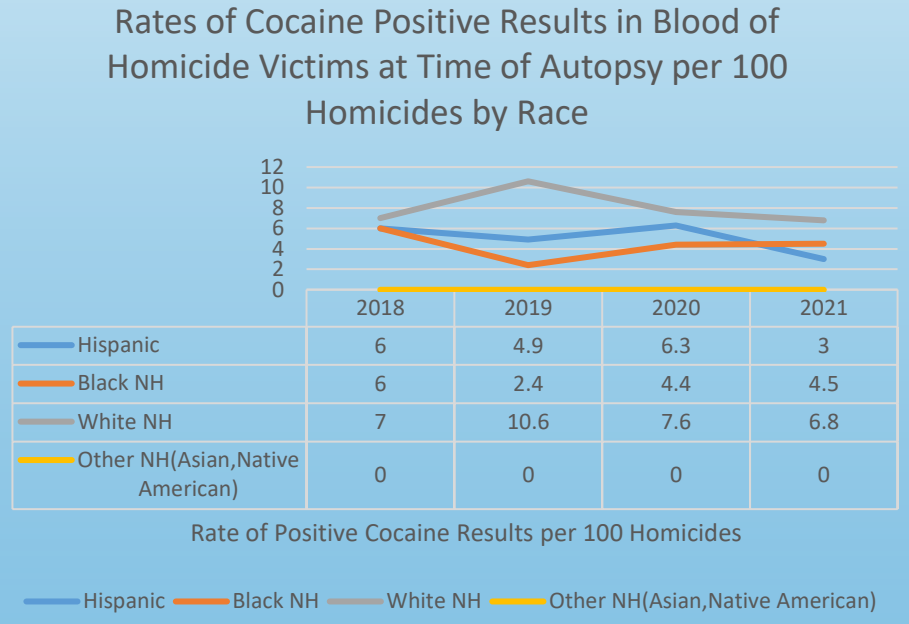


Substance Use in Homicides by Race/Ethnicity

Number of Positive Cocaine Results *

	2018	2019	2020	2021
Black NH	6	3	7	6
Hispanic	6	6	10	4
White NH	7	13	12	9
Other NH (Asian, Native American, Pacific Islander)	0	0	0	0
Number of Homicides	97	122	157	116

* Note: Rates calculated from counts less than 20 should be interpreted with caution due to the variability of small numbers resulting in low reliability of rates



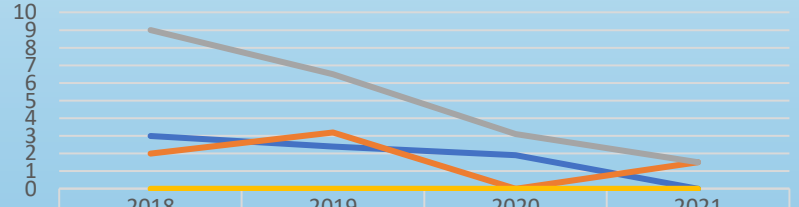
Substance Use in Homicides by Race/Ethnicity

Number of Positive Benzodiazepine Results *

	2018	2019	2020	2021
Black NH	2	4	0	2
Hispanic	3	3	3	0
White NH	9	8	5	2
Other NH (Asian, Native American, Pacific Islander)	0	0	0	0
Number of Homicides	97	122	157	116

* Note: Rates calculated from counts less than 20 should be interpreted with caution due to the variability of small numbers resulting in low reliability of rates

Rates of Benzodiazepine Results in Blood of Homicide Victims at Time of Autopsy per 100 Homicide by Race



	2018	2019	2020	2021
Hispanic	3	2.4	1.9	0
Black NH	2	3.2	0	1.5
White NH	9	6.5	3.1	1.5
Other NH(Asian,Native American)	0	0	0	0

Rate of Positive Benzodiazepines Results per 100 Homicides

Hispanic Black NH White NH Other NH(Asian,Native American)

Theories of Homicide Victimization

A. **Subculture of Violence**: theme of violence that make up the life-style, the socialization process, interpersonal relationships of individuals living in similar conditions; not necessary to use violence to solve problems, but have greater exposure, susceptibility to violent victimization; **retaliation a major theme**

B. **Informal Social Control**: a form of self-help " the expression of a grievance by unilateral aggression such as personal violence"; used by people of lower social status who have reduced access to formal control institutions-police; offenders may use crime as a means of **retaliation or censure** when they cannot or will not seek police help

Theories of Homicide Victimization

C. **Lifestyle**- an individual's lifestyle influences their exposure to high-risk situations, placing them as a potential target for victimization

1. **history of alcohol, and drug misuse**
2. ***gang membership***
3. ***criminal history (incarceration, arrests***)
4. **routine activities- convergence of space and time of motivated offenders, and suitable targets**

All three theories share a common theme: the convergence of vulnerable people, risky people and risky places

The Connecticut Homicide Victimology

Questions?

Contact:
Susan Logan, MS, MPH; Supervising Epidemiologist
Susan.Logan@ct.gov

Mike Makowski, MPH; Epidemiologist
Michael.Makowski@ct.gov

Main office phone: 860-509-8251

The Connecticut Violent Death Reporting System

Response from Michael Makowski, MPH
Connecticut Department of Public Health Epidemiologist Injury and Violence Surveillance Unit

The Connecticut Violent Death Reporting System (CTVDRS) was established in 2014 and is maintained through a cooperative agreement with the federal Centers for Disease Control and Prevention (CDC) and housed in the Connecticut Department of Public Health Office of Injury Prevention. This standardized database is part of the National Violent Death Reporting System (NVDRS) developed and funded by the Center for Disease Control (CDC).

The CTVDRS grant/ cooperative agreement with the CDC is 100% federal funds. We are in year 3 of the current grant. Renewal for 5 years will begin 9/1/2022.

Currently, NVDRS is implemented in all 50 states, the District of Columbia, and Puerto Rico. The goal of NVDRS is to provide states and communities with a clearer understanding of violent deaths. A thorough understanding of the complex circumstances surrounding these violent deaths will provide useful information in the development of prevention strategies. NVDRS provides insight into the potential points for intervention and ways to evaluate and improve violence prevention efforts.

The CTVDRS is an incident-based, relational database that combines information from multiple sources. Together, these multiple sources provide comprehensive context and answers to the questions (who, what, when, where, and why) leading to violent deaths.

Main data sources include:

- Medical examiners' reports (including the toxicology reports)
- Death certificates and law enforcement reports (state and local)

Violent deaths:

According to the NVDRS definition, a violent death is a death that results from the intentional use of physical force or power, threatened or actual, against oneself, another person, or a group or community. Violent deaths include:

- Homicides
- Suicides
- Deaths by legal intervention
- Unintentional firearm injury deaths
- Injury deaths of undetermined intent

All violent deaths occurring in Connecticut and violent deaths of Connecticut residents occurring out of state are included in the CTVDRS.

CTVDRS mission statement:

Our mission is to collect, analyze, and disseminate accurate and comprehensive de-identified, aggregate Information of violent deaths in Connecticut to inform effective and efficient prevention strategies and public policies necessary for public safety and community well-being.

Michael Makowski, State Department of Public Health

Background of Homicides in Connecticut 2015 to September 30, 2021

Data Sources and Definitions

Connecticut homicide data was collected at the State Office of the Chief Medical Examiner and police departments across the state through a federally funded (the CDC) violent death surveillance project called the National Violent Death Reporting System (NVDRS). According to NVDRS specifications, the definition of a violent death is as follows: A violent death is a death that results from the intentional use of physical force or power, threatened or actual, against oneself, another person, or a group or community. The person using the force or power need only have intended to use force or power; they need not have intended to produce the consequence that occurred. According to this definition, violent deaths include, suicides, homicides, deaths from legal intervention, terrorism, deaths of undetermined intent, and accidental firearms deaths.

The major sources of violent death data for Connecticut Violent Death Reporting System (CTVDRS) are the Office of the Chief Medical Examiner (autopsy, investigator, and toxicology data), death certificates from the CTDPH Office of Vital Records, and law enforcement reports that include Supplementary Homicide Reports from the Department of Emergency Services and Public Protection (DESPP), the Connecticut State Police. The data gleaned from these reports include the circumstances of suicides (e.g. depression, relationship problems) and homicides (e.g. committed during a crime such as a robbery or intimate partner violence). With these data, CTVDRS and the key stakeholders target violence prevention efforts.

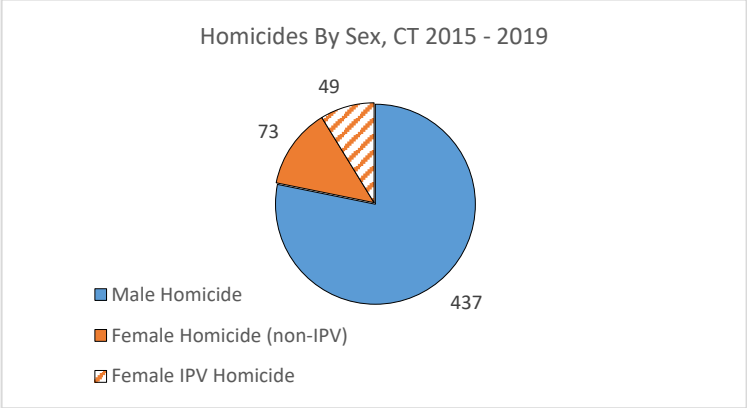
CTVDRS began data collection on January 1, 2015 and data collection is on-going. The data presented in this report is from January 1, 2015 to September 30, 2021.

Homicides 2015 to 2019 Pre-Pandemic

There were 2,581 violent deaths in Connecticut from 2015 to 2019. Homicide accounted for 22% (N=558) of the violent deaths. Connecticut averaged 112 homicides per year.

Homicides 2015-2019: N=559

- Connecticut averaged 112 homicides per year
- The average age for Non-Hispanic Black homicide victims was 32 years old
- The average age for Hispanic homicide victims was 31 years old
- The average age for Non-Hispanic White victims was 47 years old
- The average age for Other Non-Hispanic (includes Asian, Native American, Pacific Islander) was 35 years old



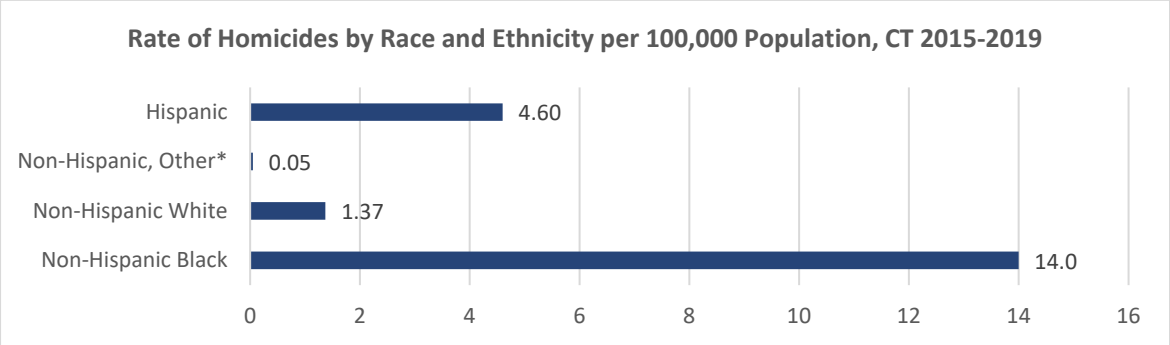
- 78 % of the homicide victims were males; 22% of the homicide victims were females

Number of Homicides by Race/Ethnicity

Race/Ethnicity	Number of Homicide Victims	Percentage of Homicides
Hispanic	**124**	**22%**
Other Non-Hispanic (Asian, Native American, Pacific Islander)	**15**	**2%**
Non-Hispanic Black	**255**	**46%**
Non-Hispanic White	**165**	**30%**

N=559

Homicide Rates* by Race/ Ethnicity



* 100,000 CT population; Other Non-Hispanic (includes Asian, Native American, Pacific Islander)

From 2016 to 2019, the homicide rate increased for Non-Hispanic White victims by 49 %; (Rate 2016= 1.03 per 100,00, rate 2019= 1.53 per 100,000)

- From 2016 to 2019, the homicide rate increased for Hispanic victims by 33%; (Rate 2016= 3.37 per 100,00, rate 2019= 4.49 per 100,000)
- There were no observed trends concerning Non-Hispanic Black homicide rates

Homicide Weapons

- Firearms 61% (N=341)
- Sharp Force Injuries 12% (N=69)
- Other (N=149)

Homicide Rates for the 5 Largest Connecticut Cities‡ 2015 to 2019

5 Largest Cities‡	Number of Homicides	Homicide Rate*
Hartford	126	20.4
Bridgeport	78	10.6
New Haven	60	9.2
Waterbury	45	8.3
Stamford	15	2.3

‡ Population ≥ 100,000; * per 100,000 town-specific population

- The State's 5 largest cities accounted for 58% (N=324) of the homicides

Homicide Rates of CT Non-Large Cities‡‡ with at least 5 Homicides 2015 to 2019

Non-Large Cities‡	Number of Homicides	Homicide Rate*
New London	11	8.1
East Hartford	12	4.8
Hamden	9	2.9
Meriden	8	2.7
West Haven	7	2.6
Norwalk	6	1.4

‡‡ Population less than 100,000; *per 100,000 town-specific population

Circumstances of Homicides as Collected from CTVDRS data

- For 2015 to 2019 homicide circumstances were known for 80% (N=452) of the cases (LE and OCME reports)
- "Gang*"/ groups involvement: rate 9 per 100 homicides; * gang as defined by local police- organized gangs such the Bloods, Crips, Latin Kings ect.

Circumstances	Number of Occurrences	Rate per 100 Homicides
Disputes/Arguments	**167**	**36.9**
Commission of a Crime:		
Assault	**132**	**29.2**
Robbery	**63**	**13.9**
Drug Trade	**48**	**10.6**
Drug Involvement	**86**	**19.0**

Substance use in Homicides

According to Ezell[i], substance use increases a person's risk to violence by some mechanism, either by impairment, leading to vulnerability or some other behavioral change.

Most Common Substances Found in Blood Toxicology Results of Homicide Victims 2015 to 2019 at the Time of Autopsy*

Drug	Number of Positives	Rate per 100 Homicides
Marijuana	**171**	**30.5**
Alcohol	**135**	**24.1**
Opiates	**66**	**11.8**
Cocaine	**56**	**10.1**
Benzodiazepines	**41**	**7.3**

***(blood samples are collected with 24 hours of the incident)**

Homicides for 2020- 2021 (Pandemic) in Connecticut

The Covid-19 pandemic of 2020 impeded our daily lives and routines. Citizens were "locked down" and told to socially distance from each other. Based on preliminary 2019 and 2020 data, in 2020, Connecticut experienced **a 41% increase in the homicide rate (2020 homicide rate =4.40 deaths per 100,000 CT population, N=157) compared to the 5-year rate (3.12 per 100,000 CT population) for 2015 to 2019.** As of September 30, 2021, Connecticut has experienced **a 16% increase in the homicide rate (2021 homicide rate =3.70 deaths per 100,000 CT population, N=131) compared to the 5-year rate (3.12 per 100,000 CT population) for 2015 to 2019.**

Comparison of Homicide Rates Pre-Pandemic (2015 to 2019) to Pandemic (2020- 2021)**

	2015	2016	2017	2018	2019	2015-2019	2020	2021**
Rates*	**3.59**	**2.43**	**3.46**	**2.72**	**3.42**	**3.12**	**4.40**	**3.70**
Number of Homicides	**129**	**87**	**124**	**97**	**122**	**559**	**157**	**131**

*per 100,000 CT population** homicides of 9/30/2021

Comparison of Homicide Rates Pre-Pandemic (2015 to 2019) to Pandemic (2020) by Race/Ethnicity

Race/Ethnicity	Average Number Homicides (2015 to 2019)	Crude Rate *2015-2019	Crude Rate*2020	Number of Homicides 2020	Rate Difference 2015 to 2019 Compared to 2020
Non-Hispanic Black	51	14.0	20.6	76	+ 47%
Non-Hispanic White	33	1.40	1.40	33	No change
Hispanic	27	4.60	7.82	47	+ 70 %

*per 100,000 CT population

- Non-Hispanic Black homicide rate increased 47%
- Non-Hispanic White homicide rate remained unchanged
- Hispanic homicide rate increased 70%

Comparison of Lethal Means Pre-Pandemic (2015 to 2019) to Pandemic (2020 to 2021*)

Years	Weapon Type	Number of Homicides by Weapon Type	Total Number of Homicides for 2015 to 2019	Rate Weapon Death per 100 Homicides
Pre-Pandemic (2015to 2019)	**Firearm**	**343**	559	**61.3**
	Sharp Force Injury (Stabbing)	69	559	12.3
Pandemic			**Total Number of Homicides for 2020 & 2021***	
2020	**Firearm**	**108**	157	68.7
	Sharp Force Injury (Stabbing)	31	157	19.7
2021*	**Firearm**	**96**	131	**73.2**
	Sharp Force Injury (Stabbing)	16	131	12.2

* data as of 9/30/2021

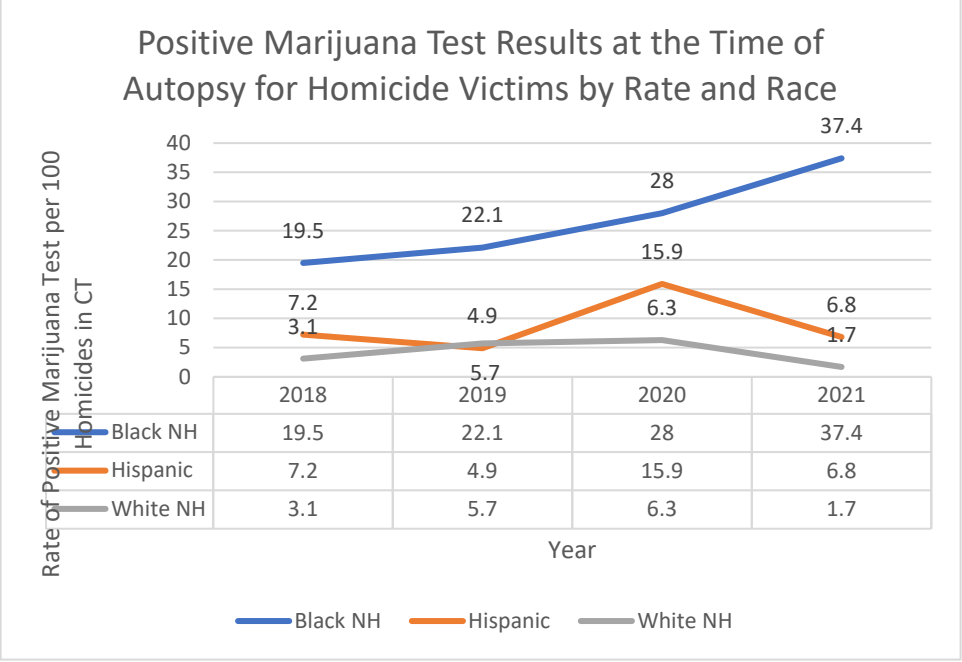
Most Common Substances Found in Blood Toxicology Results of Homicide Victims 2021 at the Time of Autopsy*

Drug	Number of Positives	Rate per 100 Homicides
Marijuana	**71**	**54.2**
Alcohol	**34**	**25.9**
Opiates	**17**	**12.2**
Cocaine	**15**	**11.4**
Benzodiazepines	**5**	**3.8**

***(blood samples are collected with 24 hours of the incident); N=131**

Number of Positive Marijuana Results at the Time of Autopsy by Race by Year (2018 to 2021*) These numbers correspond with the graph below.

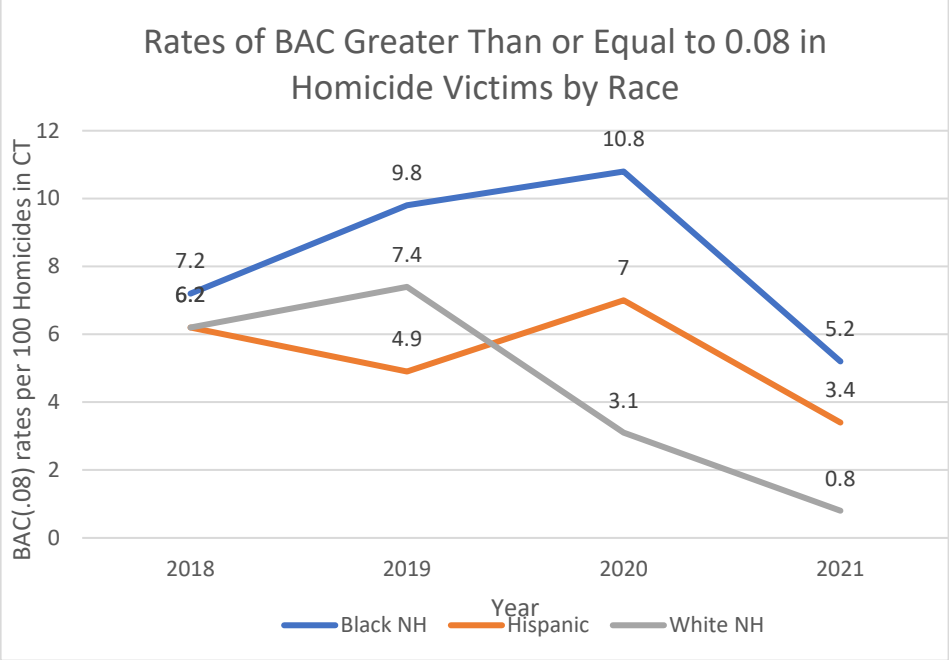
	2018	2019	2020	2021
Black NH	19	27	44	49
Hispanic	7	6	25	8
White NH	3	7	10	6
Other NH	0	1	0	0
Number of Homicides	97	122	157	131



Alcohol Results (BAC ≥ .08)

	2018	2019	2020	2021
Black NH	7	12	17	6
Hispanic	6	6	11	4
White NH	7	11	8	3
Other NH		1	1	
Number of Homicides	97	122	157	131

Rate of Blood Alcohol Content (BAC) ≥ .08 in Homicide Victims by Race



Theories of Homicide Victimization[ii]

There are multiple factors that could cause a homicide.

A. **Subculture of Violence**: theme of violence that make up the life-style, the socialization process, interpersonal relationships of individuals living in similar conditions; not necessary to use violence to solve problems, but have greater exposure, susceptibility to violent victimization; **retaliation a major theme**

B. **Informal Social Control**: a form of self-help " the expression of a grievance by unilateral aggression such as personal violence"; used by people of lower social status who have reduced access to formal control institutions- police; offenders may use crime as a means of **retaliation or censure** when they cannot or will not seek police help

C. **Lifestyle**- an individual's lifestyle influences their exposure to high-risk situations, placing them as a potential target for victimization

1. **history of substance misuse**
2. ***gang or groups affiliation***
3. ***criminal history (incarceration, arrests***)
4. **routine activities- convergence of space and time of motivated offenders, and suitable targets**

All three theories share a common theme: the convergence of vulnerable people, risky people and risky places.

[i] **Examining the Role of Lifestyle and Criminal History Variables on the Risk of Homicide Victimization**, M Ezell et al, Homicide Studies, Vol 13, Number 3, May 2009; retrieved 10/19/2021

[ii] **Examining the Role of Lifestyle and Criminal History Variables on the Risk of Homicide Victimization**, M Ezell et al, Homicide Studies, Vol 13, Number 3, May 2009; retrieved 10/19/2021

From: DCF COMMISSIONER <DCF.COMMISSIONER@ct.gov>
Sent: Wednesday, December 8, 2021 2:41 PM
To: Violano, Pina <Pina.Violano@cga.ct.gov>; 'awoods@hartfordctc.org' <awoods@hartfordctc.org>
Cc: MYSOGLAND, KEN <KEN.MYSOGLAND@ct.gov>
Subject: RE: Request for Information for the Gun Violence Intervention & Prevention Advisory Committee [not-secure]

Good Afternoon Chairman Woods and Dr. Violano,

DCF has no initiatives specific to reducing gun violence however, the Urban Trauma model and capacity building as well as our domestic violence/IPV specific work has a nexus to this topic.
Also, attention to our fatherhood work may also be encompassed in this concern.

VANNESSA L. DORANTES, LMSW
COMMISSIONER
CT DEPT OF CHILDREN & FAMILIES
505 HUDSON STREET
HARTFORD, CT 06106
commissioner.dcf@ct.gov (860)550-6300
"I do my best because I'm counting on *YOU counting on me..."*
m Angelou

Connecticut Bar Association Policing Task Force (CBAPTF)

Report and Recommendations

November 4, 2021

TABLE OF CONTENTS

INTRODUCTION

In the wake of the murder of George Floyd and amid growing concern regarding policing in our country, the Connecticut Bar Association ("CBA") formed a Policing Task Force ("PTF"). The mission of the Task Force was to bring together a group of informed people with varied backgrounds, perspectives, and experiences in an effort to provide some practical suggestions regarding policing in Connecticut. The strength of our group lies in its diversity and its dedication to working together despite our different viewpoints. The PTF consists of 22 people, including community members and activists, attorneys and academics with varied practices and work experiences, and current and former members of state and federal law enforcement, including two Police Chiefs and the Chief State's Attorney.

Since its inception in June 2020, the PTF met on a weekly basis, attended community listening sessions, and elicited the advice and counsel of the state judiciary, individual police officers, and representatives of police unions. The Task Force has issued twenty-three recommendations which were unanimously approved by CBA. This Report documents the work of the Task Force and our recommendations, all of which are the product of respectful but rigorous debate and informed by legal and other research.

Policing in America, particularly today, is very hard. Police leaders and police officers face substantial challenges. In Connecticut, we are fortunate to have many dedicated officers and respected police leaders some of whom are recognized nationally as models for their innovative and progressive work. Our recommendations are not meant to undermine their leadership or the critical work of these officers. Rather, the goal of our work is to create additional positive change, an evolution in policing that will better support both the police and the communities they serve.

As background, the CBA appointed three attorneys to serve as the Co-Chairs of the PTF: Deirdre Daly, a partner at a Stamford law firm and the former United States Attorney for the District of Connecticut; Rev. Keith King, a religious leader in New Haven and a former federal prosecutor in Connecticut; and Alexis Smith, the Executive Director of New Haven Legal Assistance. Members of the Task Force each joined one of four Committees: Data Collection, Police Oversight, Moral Recognition, and Reimagining Police. The Committees met regularly—often weekly—for over a year. PTF members also recruited fourteen others, mostly attorneys and academics, to join the Committees; to a person, these members made invaluable contributions to our work. A full list of Task Force and Committee members follows this introduction.

The Committees worked independently and presented recommendations that were examined and ultimately voted on by all PTF members. The Data Collection Committee reviewed in detail approximately 86 incidents since 2001 in which Connecticut police officers and state troopers used deadly force. Connecticut State's Attorneys have investigated and prepared detailed reports regarding these incidents in accordance with the applicable statute, *see* Conn. Gen. Stat. § 51-277a(c). The reports focus on whether the use of physical force by the police officer(s) violated state law, and in most all incidents, there was a finding that the use of force was justified under the law.

Relying on the information contained in these public investigative reports, the Committee prepared a comprehensive dataset that documents critical facts relating to these incidents. There is a dearth of information regarding police deadly force incidents nationwide. We believe collecting, synthesizing, and publicly sharing the relevant data for these incidents in Connecticut is critical to any meaningful assessment of police work. A link to the dataset is included in this Report.

The Oversight Committee examined how police departments, local communities, and state governments resolve allegations of systemic and individual instances of police misconduct. The Committee reviewed internal affairs divisions, civilian review boards, hiring practices, consent decrees, and pattern-or-practice lawsuits. We evaluated police department accreditation standards. And we surveyed how citizen complaints are recorded across the state. In all these inquiries, we asked: What are the options? What works? What is not working? Does one size fit all? Our specific recommendations are outlined below. The simple takeaway is that regardless of the specific oversight measures a department or municipality may choose to implement, the most successful organizations will foster a culture of transparency, accountability, and professionalism. That is, by living "the examined life," leadership will do the hard but necessary work of asking what we did wrong and how we can avoid that outcome again.

The recommendations of the Moral Recognition Committee are rooted in an acknowledgement that there is often distrust in the police, with deep historical roots, among African-Americans, other people of color and their communities. We hope Connecticut's police departments will use our recommendations to repair and strengthen police-community relationships. We seek to create opportunities for departments to learn about, discuss and address the root causes of this present and historic distrust. Through reconciliation initiatives, diversity, equity, and inclusion trainings, and community conversations, we believe police departments can build more just, equitable, and effective police-community relationships, and address the past and present impacts of structural and systemic inequality in law enforcement.

The Reimaging Police Committee examined the appropriate scope of police responsibility, considered calls for deploying alternative responders and related support proposals, and examined relevant police training and policies. The Committee also explored redefining public safety and combating systemic inequality by investing in programs that address the root causes of violence and crime (*e.g.*, lack of employment opportunities, housing, quality education, or health care) by creating economic ecosystems in under-resourced communities.

Finally, the Task Force partnered with the Police Transparency and Accountability Task Force created by the General Assembly ("PTATF"). With the permission of the CBA, we shared all our draft recommendations with the PTATF to ensure they had the benefit of our thoughts on a timely basis. A number of our recommendations were adopted by the legislature.

TASK FORCE MEMBERS

Co-Chairs

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Former United States Attorney for the District of Connecticut (2013-2017)

Keith King
Senior Pastor, Christian Tabernacle Baptist Church, New Haven
Former federal prosecutor (AUSA, District of Connecticut)

Alexis Smith
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Task Force Members

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Ken Barone
Associate Director, University of Connecticut, Institute for Municipal and Regional Policy

Troy Brown
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Richard Colangelo
Chief States Attorney, State of Connecticut

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Community Organizer, New Haven

Doris Dumas
President, Greater New Haven NAACP

Maggie Castinado
Vice President, Connecticut Bar Association (CBA)
Senior Assistant Public Defender, New Haven Past President, Connecticut Hispanic Bar Association

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Kean Zimmerman
Claims Counsel
President-Elect Connecticut Hispanic Bar Association
Co-Chair of the Diversity Equity and Inclusion Committee, Connecticut Bar Association

ACKNOWLEDGEMENT

The Co-Chairs are grateful for the hard work and dedication of all the Task Force and Committee members. We deeply appreciate the candor, patience, and thoughtfulness that you brought to our work. We learned a great deal from each of you.

Special thanks to **Amani Edwards**, Director of Diversity and Human Resources at the CBA, for keeping us organized and focused. Her many contributions were invaluable to us.

I. DATA COLLECTION COMMITTEE

The Data Collection Committee was tasked with reviewing use of deadly force incidents investigated by the Division of Criminal Justice between 2001 and 2020. The Division publishes a detailed report of the findings from each use of deadly force incident, dating back to 2001. The reports include a thorough examination of each investigation and all relevant facts. To our knowledge, there has never been an attempt to thoroughly review each detailed report for the purpose of developing a database with basic facts compiled for each incident. This Committee developed a database that includes basic incident information, subject information, officer information, and relevant investigative information. In addition to the data available in the public reports, the Committee also requested additional officer level information from police agencies involved in these incidents.

In addition to the development of a database, the Committee drafted a series of other recommendations based on the expertise of the Committee and our assessment of the data collected.

I.A. Committee Members

Deirdre Daly, Chair

Ken Barone

Richard Colangelo

Calvin Woo

Frank Rudewicz (Committee only)
Principal and Counsel, CliftonLarsonAllen
Former Officer, Hartford Police Department

Kean Zimmerman

I.B. Use of Deadly Force Database

The Committee reviewed 86[1] use of deadly force incidents investigated by the Division of Criminal Justice between 2001 and 2020. Of the 86 incidents reviewed, the Division completed investigations of 82 incidents and four incidents are still under investigation. For the incidents under investigation, the Committee reviewed preliminary reports. All investigation reports can be found on the Division of Criminal Justice website. The full dataset compiled by the Committee can be found on the Connecticut Bar Association Policing Task Force website.

In Connecticut, there are a total of 94 municipal police departments: 29 departments employing more than 50 officers, 50 employing between 20 and 50 officers, and 15 with fewer than 20 officers. State police are comprised of 11 distinct troops. Although there are an additional 80 jurisdictions that do not have organized police departments and are provided police services by the state police, either directly or through provision of resident troopers, incidents that occur within one of these jurisdictions are categorized with their overarching state police troop. Additionally, a

[1] The Committee did not review any 2021 incidents because investigative reports were not yet completed for most of those incidents.

total of 13 special agencies also exists in the state. There are approximately 7,000 municipal police officers and 900 state police troopers in Connecticut.

The law governing use of deadly force investigations has evolved over the last six years. Between 2001 and 2015, the State's Attorney in the judicial district where the incident occurred was responsible for conducting the investigation. At the time, investigations were required whenever a police officer, in the performance of his or her duties, used deadly physical force on someone and that person died. The Connecticut General Assembly made two significant changes to this process in 2015: (1) investigations would now be completed when an officer uses any type of physical force and death results, and (2) the Chief State's Attorney must designate a State's Attorney from a judicial district other than the one where the incident occurred or appoint a special assistant state's attorney or special deputy assistant state's attorney to investigate the incident. In 2019, the General Assembly modified the process again to require an investigation to determine the appropriateness of an officer's use of deadly force on another person, even if death does not result[2]. In 2020, the General Assembly passed Public Act 20-1, which established the Office of the Inspector General (IG) within the Division of Criminal Justice. The IG is now responsible for investigating all use of deadly force incidents.

Of the 86 incidents reviewed, 76 resulted in the death of the subject. Since 2001, 36 municipal police departments and the Connecticut State Police have been involved in use of deadly force incidents. Of the 36 departments, 21 were involved in only one incident, six were involved in two incidents, six were involved in three incidents, and four were involved in more than three incidents. Departments with 50 or fewer officers account for 19% of all incidents, departments with between 51 and 150 officers account for 30% of all incidents, and departments with over 150 officers account for 51% of all incidents. Six agencies (Bridgeport, Connecticut State Police, East Hartford, Hartford, New London, and Waterbury) account for 51% of all use of deadly force incidents in Connecticut. Hartford Police have been involved in the largest number of deadly force incidents of any policy agency since 2001.

In addition to publishing a detailed investigative report when deadly force is used in Connecticut, it is our sincere hope that the IG will maintain a public database such as the one this Committee developed. Understanding statewide and departmental data trends is a critical component of finding solutions to reduce or eliminate these tragic incidents from occurring in the future.

I.C. Factual Observations from the Use of Deadly Force Database

The Committee made five meaningful factual observations from the data, which have been used to inform several other Task Force recommendations. Those factual observations are outlined below:

1. Almost half of the incidents involved people struggling with mental health conditions. Police responding to these incidents report that 46% of the incidents involved people who were emotionally disturbed/in mental distress and/or deemed suicidal. This data calls out

[2] There was one investigation of deadly use-of-force in 2019 that did not result in the death of the subject and four in 2020.

for municipalities and law enforcement to seriously consider the role that mobile crisis units or other social services can play in supporting responses to police calls.

2. Half of the subjects/victims of deadly force incidents were either Black or Hispanic. In 30% of the incidents, the subject/victim was Black; and in 20% of the incidents, the subject/victim was Hispanic. While there are factors that might begin to explain this racial disparity—including the racial composition of neighborhoods where some of these incidents occur—the hard truth is that half of the subjects/victims of deadly force incidents are persons of color. In this same vein, of the 86 deadly force incidents we have reviewed, 18 individuals involved were unarmed. Of those 18 individuals, 39% were Black and 28% were Hispanic.

3. Six police departments/agencies (Bridgeport, Connecticut State Police, East Hartford, Hartford, New London, and Waterbury) were involved in 51% of all deadly force incidents; and the same six departments were each involved in more than three such incidents. These departments would most benefit from the implementation of robust early warning systems.

4. In 26% of the incidents, a vehicle was involved, usually as part of a pursuit. On November 14, 2019, the Police Officer Standards and Training Council (POSTC) adopted an updated Model Pursuit Policy in accordance with Public Act 19-90, Section 5. Recognizing that pursuits of fleeing motor vehicles present a danger to the lives of the public, police officers, and those inside the vehicles, the policy serves as the minimum standard for all police pursuits. The policy is robust and detailed. At its core, the policy permits pursuits only when an officer reasonably believes that the driver or occupant has committed, or is attempting to commit, a crime of violence or that there are exigent circumstances that warrant the timely apprehension of a suspect because of potential harm to the public. Officers are prohibited from discharging their firearms at a vehicle or its occupants unless the occupants are using or threatening the use of deadly physical force against the officer of another person by means other than the vehicle. This pursuit policy, which was borne out of the type of data analysis being conducted in many areas of policing, is a meaningful development in minimizing the occasion of deadly force incidents engendered by police car pursuits.

5. Most of the incidents occurred on the second shift (3:00 p.m. – 11:00 p.m.), and the vast majority of officers who fired their weapons were between 26-35 years old and relatively new to policing, having under ten (and in many cases, under five) years of experience. The reports do not always make clear whether supervisory personnel were dispatched and on scene prior to the use of force. The presence of experienced supervisory personnel on scene, particularly when incidents may involve significant threat to the safety of officers and others, may help to facilitate safer outcomes. We recommend reinforcement of, and adherence to, model guidelines issued by POSTC and the national Commission on Accreditation for Law Enforcement Agencies ("CALEA"), which include directives requiring, whenever possible, that supervisors and/or veteran officers respond to the scene

of serious incidents, including all shooting calls (other than calls concerning hunters), verified robbery calls, burglaries in progress, serious assaults, hostage or barricaded suspect calls, officer-needs-assistance calls, kidnapping, incidents involving large groups, strikers or protesters, and incidents involving individuals experiencing mental health or suicide-related issues.

I.D. Committee Recommendations

Recommendation 1: Additional Inspector General (IG) Responsibilities

The IG should be directed to make findings regarding whether police officers involved in incidents under investigation violated any department procedures, policies, or protocols during the incident and, if such violations occurred, whether discipline should be considered.

Rationale:

A review of the investigative Reports on the use of deadly force by Police Officers authored by Division of Criminal Justice from 2001 to the present (the "Reports") shows that, in accordance with the applicable statute, *see* Conn. Gen. Stat. § 51-277a(c), the Reports focus on whether the use of physical force by the police officer(s) violated state law. In several Reports, although there is no finding of a violation of state law, the facts plainly demonstrate that the police officers violated police procedures, policies, or protocols. Accordingly, we recommend that the IG, who is most familiar with the facts of the incidents, also make independent findings regarding potential violations of police procedures, policies, and protocols.

Recommendation 2: Required IG Report Information

Public reports issued by the IG concerning police use of deadly force should include a comprehensive recitation of the facts to ensure public confidence in the investigative process. In addition to the facts germane to each incident and the legal analysis as to whether the use of physical force was permissible under the law, all such reports should include:

1. A timeline of significant events relevant to the incident, including whether mental health considerations may have contributed to the incident.
2. Information concerning the police officers involved in the incident, including, but not limited to:
    a. Officer demographics (race, ethnicity, gender, age);
    b. Officer's number of years of service (including years with other police agencies);
    c. Officer rank and assignment at the time of the incident (*e.g.*, patrol or any specialized unit);
    d. Whether the officer has been involved in other deadly use of force incidents and the officer's role in such incidents;
    e. Whether the officer has been involved in any other use of force incidents where physical injury resulted, or may have resulted, within three years of the current incident;

f. A review of the officer's relevant disciplinary file and related records, including any relevant findings of misconduct and any related discipline or remedial action imposed;
g. The number of relevant citizen complaints filed against the officer; the general nature of the allegations in any such complaints; any substantiated findings of misconduct by the officer; and any relevant disciplinary or other remedial action taken as a result of such findings; and
h. A review and summary of the officer's training records.

3. Information concerning the victim/subject of the incident, including, but not limited to:
   a. Demographic information (race, ethnicity, gender, age);
   b. Town of residence; and
   c. Any evidence indicating that the officers involved in the incident were aware at the time of the incident that the victim/subject previously had been arrested or convicted of a violent offense; had been involved in the use of force against police officers; or had possessed or was believed to possess at the time of the current incident, a firearm.
4. The identification of any police department procedures, policies, or protocols that were violated during the incident.
5. Recommendations for future actions. *See, e.g.*, Report of the State's Attorney Concerning the Death of Edward R. Gendron, Jr.

Rationale:

The Task Force has reviewed the Reports concerning deadly use of force incidents since 2001. These incidents were investigated by at least 23 different State's Attorneys, each of whom made his or her own determination about the types of information to report. The above-described information was not consistently included in the Reports. To ensure all relevant facts are available to the public, and to enable meaningful analysis of these incidents over time, the above-described information should consistently be reported.

Recommendation 3: Use of Deadly Force Database

The IG should create and maintain a public database of pertinent information derived from completed investigative reports issued by the IG concerning police use of deadly force.

Rationale:

The Division of Criminal Justice must investigate and determine whether the use of physical force by a police officer(s) violates state law. From 2001 to the present, in accordance with the applicable statute, *see* Conn. Gen. Stat. § 51-277a(c), Reports on the Use of Deadly Force by Police Officers were authored by Connecticut State's Attorneys. Section 33(a) of the Act provides that the IG must now conduct such investigations and issue public investigative Reports.

To promote transparency with the public and to facilitate detection of any trends or patterns of problematic behavior, a public database that captures relevant information from each incident is necessary. The public database should, at a minimum, include the following information:

- Basic Incident Information: Date, time, location, weather conditions, officer initiated, or officer dispatched;
- Subject Information: name, gender, race, ethnicity, age, town of residence;
- Indicate whether death occurred because of police use of force, and while in police custody or in a medical facility;
- Nature of initial interaction and underlying alleged offense;
- Activity that lead to incident (based on CT use of force form);
- Subject's resistance resulting in application of force (based on CT use of force form);
- Control methods used (based on CT use of force form);
- Officer Information: unique officer ID, assignment at time of incident, race, ethnicity, gender, age, years of service, prior involvement in other deadly use of force incidents, number of complaints on record at the time of the incident, prior relevant discipline; and
- Investigative Information: camera footage available and type (body cam, dash cam), charges filed, officer discipline imposed.

Recommendation 4: IG Candidate Eligibility

Section 33(a) of An Act Concerning Police Accountability, Public Act 20-1 (the "Act") should be amended to permit candidates outside of the State Division of Criminal Justice ("DCJ") to be eligible for the position of IG and for positions within the staff of the Office of the Inspector General ("OIG").

Rationale:

Section 33(a) of the Act states:

> "There is established the Office of the Inspector General that shall be an independent office within the [Connecticut State] Division of Criminal Justice. Not later than October 1, 2020, the Criminal Justice Commission . . . shall nominate a deputy chief state's attorney from within the division as Inspector General who . . . shall lead the Office of the Inspector General. The office shall: (1) Conduct investigations of peace officers . . . ; (2) prosecute any case in which the Inspector General determines a peace officer used force found to not be justifiable . . . or where a police officer or correctional officer fails to intervene in any such incident or to report any such incident . . . ; and (3) make recommendations to the Police Officer Standards and Training Council . . . concerning censure and suspension, renewal, cancelation or revocation of a peace officer's certification."

The Act requires that all candidates for IG and OIG staff positions be drawn from within the DCJ. *See id.* (IG); *id.* § 33(j) (OIG staff). This precludes the Criminal Justice Commission from selecting potential IG and OIG staff from a larger pool of well-qualified candidates including, but not limited to, federal prosecutors, private practitioners from the plaintiffs' bar, and civil rights attorneys. It is critical that OIG investigations have the full confidence of the public and avoid any appearance of a conflict of interest. Candidates drawn exclusively from the DCJ could, however, appear to have such conflicts given that they regularly work with police officers, some of whom

may be the subject of OIG investigations. Candidates who are independent from the DCJ, on the other hand, would be less likely to have the appearance of such a conflict of interest. Accordingly, we recommend that the Act be amended to permit the Criminal Justice Commission to consider candidates outside of the DCJ for IG and OIG staff positions.

Recommendation 5: Granting IG Subpoena Authority

The IG should be granted the authority to issue subpoenas to civilians who may have witnessed a use of force incident and/or may have relevant knowledge or information regarding the incident.

Rationale:

Section 33(g) of the Act states: "The Inspector General may issue subpoenas to municipalities, law enforcement units, . . . Department of Correction and any employee or former employee of the municipality, unit or department (1) requiring the production of reports, records or other documents concerning [the Inspector General's] investigation . . ., and (2) compelling the attendance and testimony of any person having knowledge pertinent to such investigation."

If the IG can subpoena only law enforcement and municipal employee witnesses, the OIG's investigations will not have the benefit of the testimony of civilians who may have witnessed or participated in the incidents, or who may possess documentary evidence (*e.g.*, video recordings, medical records) relevant to the investigation. Without compulsory process, the IG will be unable to compel civilian witnesses, who may be unwilling or fearful of cooperating in such investigations, to provide relevant testimony or other evidence.

Recommendation 6: Early Warning System Pilot Program

Certain police departments should develop and implement an early intervention system ("EIS") pilot program to detect and prevent adverse incidents. Those departments whose officers are involved in the greatest number of deadly force incidents would most benefit from such a program. We recommend an EIS program that would identify police officers most at risk of adverse incidents through a data-driven approach based on the model developed by the Center for Data Science and Public Policy at the University of Chicago ("UC").

Rationale:

Most Connecticut police departments do not have an EIS. Those departments that do have such systems use a threshold-based model which, for example, "flags" officers who have a threshold number of citizen complaints within a designated time period. Although these programs attempt to identify officers with patterns of problematic performance or signs of stress in order to prevent adverse incidents, they tend to have a high rate of false flags. This can overload departments and undermine the efficacy and legitimacy of the EIS.

The UC-based EIS model has been deployed by departments across the country and been shown to be more accurate and effective than the threshold-based model. The UC model is based on a broader set of data, including officer demographics, training, days off, secondary jobs to detailed police activities (traffic stops, dispatches, arrests, use of force, vehicle pursuits) and

civilian compliments, complaints, and civil lawsuits. Using machine learning to detect patterns that precede adverse incidents, the model analyzes thousands of variable combinations (stops, arrests, use of force incidents, dispatches) over time to determine which factors best identify officers at risk. The model then generates risk scores that the department can use to identify officers for whom intervention may be appropriate.

The EIS system would be developed in collaboration with the department, including the definition of what constitutes an "adverse incident" (for which an Internal Affairs investigation leads to a finding) and what kind of intervention (training, counseling, disciplinary action) is most appropriate for particular findings.

As communities discuss the potential reallocation of police resources, an investment in the development and use of a UC-based EIS that is data-driven would be beneficial. Piloting this program in a small number of departments would be a worthwhile first step.

II. POLICE OVERSIGHT COMMITTEE

The Police Oversight Committee was developed to review internal police department discipline practices and related labor laws; examine the role of Internal Affairs Departments; review current external investigative processes and the role of civilian review in deadly force and other police misconduct matters; and address the need for pattern-or- practice investigations at the state level.

II.A. Committee Members

Doris Dumas, Co-Chair

Michael Gustafson, Co-Chair

Vanessa Avery

Brian Foley (Committee Only)
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Former Police Officer, Hartford Police Department

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Dan Noble (Committee Only)
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Vernon Riddick

II.B. Committee Recommendations

Recommendation 7: Statute of Limitations Extension in Section 41(g) of P.A. 20-1

The one-year statute of limitations for bringing an action pursuant to Section 41 of P.A. 20-1 should be extended to three years.

Rationale:

Section 41(g) of the Act provides: "A civil action brought pursuant to this section shall be commenced not later than one year after the date on which the cause of action accrues."

Three reasons support extending the statute of limitations to three years.

First, the one-year limitations period is tied to the period of time that police departments are required by statute to retain body-camera footage. At first blush, this seems logical. Our research shows, however, that as a matter of custom and policy, police departments retain body-

camera footage involving use-of-force incidents for up to four years. Moreover, an aggrieved citizen contemplating a lawsuit could put a police department on notice and request that the department retain its body-camera footage beyond the one-year statutory floor.

Second, the one-year limitations period is very short. This may serve as an artificial barrier to the filing of meritorious cases or, alternatively, force plaintiffs' counsel to file lawsuits prematurely so as not to exceed the limitations period.

Third, the federal district court will likely adopt the statute of limitations established in Section 41(g) of the Act for civil rights lawsuits brought in the District of Connecticut pursuant to 42 U.S.C. § 1983. "Since Congress did not enact a statute of limitations governing actions brought under § 1983, the courts must borrow a state statute of limitations." *Lounsbury v. Jeffries*, 25 F.3d 131, 133 (2d Cir. 1994). "In Connecticut, the three-year limitations period set forth in Conn. Gen. Stat. § 52-577 is applicable to claims asserted under section 1983." *Harnage v. Shari*, No. 16 Civ. 1576 (AWT), 2020 WL 5300913, at *3 (D. Conn. Sept. 4, 2020). Extending the statute of limitations to three years will preserve the status quo for Section 1983 lawsuits brought in the District of Connecticut.

Recommendation 8: Modification to Mandated Accreditation Standards

The accreditation standards for law enforcement agencies should be revised to give police chiefs the option of complying with the Connecticut Police Officer Standards and Training Council ("POSTC") Tier III standards ("Tier III standards"), or the national Commission on Accreditation for Law Enforcement Agencies ("CALEA") standards. Those departments opting to achieve Tier III accreditation by 2025 should reach Tier I accreditation by 2021 and Tier II accreditation by 2023.

Rationale:

The Act requires that all departments satisfy the CALEA standards. Currently, only 24 of 92 departments in Connecticut are CALEA certified. The Tier III standards are very similar to the CALEA standards but include additional state-specific standards. The CALEA standards also include a facility-update requirement that differs from the facility-update component required by the state accreditation process, including requirements relating to detention centers and the location of evidence storage. Under the current CALEA on-site assessment process, assessors from outside of Connecticut spend a minimal amount of time at each police department (2-3 days) reviewing policies, practices, and facilities, as well as conducting staff interviews. Most of the department's files are reviewed remotely by assessors who may be unfamiliar with Connecticut law and regulations. By contrast, the Connecticut Tiered Accreditation Program uses a POSTC assessor and a local team of three or four assessors who are familiar with Connecticut law and regulations to review the department's policies, practices, and facilities.

In addition, adoption of the Tier III standards would result in significant cost savings for many departments. CALEA requires departments to recertify every five years at significant cost, typically $15,000 over the course of the assessment period. Although Bill 6004 provides some funding (via issuance of bonds), the costs of CALEA accreditation are expected to be a major

challenge for many departments. Although Tier III requires recertification every four years, it is much more cost-effective.

Recommendation 9: Citizen Complaint Form and Database

The Police Officer Standards and Training Council (POSTC) should be tasked with updating and developing a statewide standardized form and process for reporting citizen complaints. The form should (1) state clearly that complaints can be made anonymously and do not need to be notarized; (2) request information about the race, ethnicity, and gender of the police officer and complainant, among other information; (3) be available online and easy to locate; (4) be available in hard copy at local police stations and other municipal buildings, including public libraries; and (5) be available in Spanish and/or other foreign languages, depending on the needs of the local population.

In order to promote transparency and facilitate detection of any problems or patterns of behavior, police departments should promptly submit complaint data to an online database maintained by the Office and Policy Management ("OPM"). Departments should report complaint data without the names or other identifying information of complainants or police officers. Instead, OPM and departments should use unique tracking numbers for officers and complainants that will allow for the determination of whether other complaints have been filed against the officer and whether the complainant has filed other complaints. The OPM database should be publicly accessible and searchable.

POSTC should determine which types of complaints must be submitted to OPM by departments, to include racial profiling, discourteous behavior, and excessive force complaints. POSTC should not permit departments to wait to report required data until after complaints are investigated and substantiated. POSTC must develop an audit policy to ensure that departments are making the complaint form widely available and promptly submitting the required data to OPM. On a bi-annual basis, OPM should publicly issue a report on complaint data received during that time period. OPM could outsource maintenance of the database and analysis of the complaint data to a university.

Rationale:

Public Act 20-1 does not address citizen complaints. POSTC has developed certain minimum standards for reporting complaints, but we found that these are insufficient. Currently there is no standardized statewide form for reporting citizen complaints. Nor is there a central repository for collecting complaints, a database for analyzing them, or a method for publicly reporting such data. The model complaint form developed by POSTC in 2015 has certain problems, including not making clear that the complaint can be reported anonymously. The form also needs to be updated to ensure that important data is regularly collected. For at least certain categories of citizen complaints, including complaints about excessive force, racial profiling, and discourteous behavior, this lack of standardized data collection and reporting is particularly problematic.

Recommendation 10: Establishment of Civilian Review Boards

Section 17 of P.A. 20-1 should be amended to require all communities with police departments, or under the jurisdiction of the Connecticut State Police Resident Trooper Program, establish a Civilian Review Board (CRB) (if one does not already exist). For the purpose of this recommendation, communities that have an active police commission with oversight of the police department shall be considered to have satisfied the requirement of having a CRB.

Rationale:

This recommendation will further the goals of the Police Accountability Act because it will bring standards, oversight, and consistency to all of our Connecticut communities regardless of police jurisdiction. A fundamental purpose of the Act is to provide standards for, and oversight of, the police officers and departments tasked with keeping communities safe. CRBs are a proven accountability mechanism that provide an independent review of police departments. In carrying out this function, CRBs serve as a check and balance on the exercise of police authority, which, in turn, fosters civilian trust, police transparency, and community engagement.

Recommendation 11: Minimum Standards for Civilian Review Boards

Section 17 of P.A. 20-1 permits municipalities to establish a Civilian Review Board by ordinance. Section 17(a) requires that ordinances establishing CRBs shall, at a minimum, set forth the following:

1. The scope of authority of the CRBs;
2. The number of members of the CRBs;
3. The process for the selection of board members, whether elected or appointed;
4. The term of office for board members; and
5. The procedure for filling any vacancy of the membership of the CRBs.

The Committee surveyed 24 different CRBs from across the nation. While the Committee's survey was not exhaustive, the CRBs that were reviewed varied in size, scope, composition, and authority. The survey included CRBs from municipalities and counties with populations ranging from 37,000 in Amherst, MA, to nine million in Los Angeles County. The Committee also reviewed and considered the U.S. Department of Justice publication, *Citizen Review of Police*.

Although Section 17(a) outlines the minimum requirements for a CRB ordinance, the legislation does not offer specific guidance for establishing a CRB. This is understandable considering the different needs of the communities that CRBs might serve. Municipalities should consider the minimum standards outlined in the rationale below when creating a CRB pursuant to Section 17(a) of P.A. 20-1.

Rationale:

A. The scope of authority of the civilian police review board:

The following factors should be considered when deciding between an investigatory-based or review-based CRB:

- Does the police department have a history of being open and transparent with the community?
- Is the police department currently under a consent decree/federal oversight, or does it have a history of being under a consent decree/federal oversight?
- Does the municipality have the funding and resources needed to finance an investigative CRB (including office equipment, computers, video equipment)?
- What are the implications for failure to comply with subpoenas?
- What enforcement measures are available to compel subpoena compliance?

These questions will assist a municipality in deciding what type of CRB to choose. A community with a police department that has a demonstrated track record of being open and transparent with the community may chose a review-based CRB. Conversely, an investigative-based CRB is more appropriate for a police department that is currently, or was previously, under a federal consent decree and/or is working to create stronger trust with the community.

An investigative-based CRB will be labor-intensive and require members to have an investigative background and training. The CRB will require subpoena power to compel witnesses and/or the production of documents. The CRB will conduct administrative internal affairs investigations that are not intended to be a substitute for, or to interfere with, any related criminal investigation. As provided in Section 17, the IG will have the authority to stay a CRB investigation to prevent interference with an ongoing criminal investigation. An investigative-based CRB is also likely to have significant collective bargaining implications.

A review-based CRB, by contrast, will evaluate a department's own internal affairs investigation to assess whether it was objective, factual, and thorough. The CRB will sustain or reject the findings and make recommendations to the Chief of Police or other individuals who have the authority to discipline officers.

B. The number of members of the civilian police review board

The Committee recommends that a CRB contains at least five members and not more than eleven members. The attached CRB survey identifies boards ranging from five to eleven members. To avoid votes ending in a tie, boards should be composed of an odd number of members. Using 60% of members in attendance as the basis for a quorum, a board consisting of five members would need only three members in attendance to conduct business. The Committee does not believe it would be adequate for a CRB to have fewer than three persons deciding the issues coming before a CRB. On the other hand, a CRB with too many members may present difficulties in attaining a quorum. Also, too many people on a CRB may lead to unproductive lengthy debates and discussions of differing opinions, thereby slowing the review process.

C. The process for the selection of board members, whether elected or appointed

CRBs are charged with assessing interactions between police officers and civilians, sometimes based upon conflicting accounts and evidence. To ensure that their factual findings and proposed recommendations are respected by all parties involved, members of CRBs must be

viewed as objective and impartial. Accordingly, the selection of CRB members must be approached with thoughtfulness and care.

The CRB selection process should yield a diverse CRB with members of different genders, races/ethnicities, professional backgrounds, experiences, and worldviews. The process of selecting CRB members, whether elected or appointed, should include a background check. The background check should not be used unfairly to preclude any individual's participation, but rather to elicit a diverse collection of lived knowledge and identify possible implicit biases. Prospective board members should also be required to participate in training, including citizen's academy, scenario training, ride-along, and confidentiality training. CRB members should also be required to sign a confidentiality agreement prior to their appointment.

D. The term of office for board members

We recommend that CRB members' terms be staggered, thus reducing the likelihood of an entire CRB turning over at the same time. Terms should be for a minimum of two years and generally for a maximum of five years. There should also be a maximum number of terms that a CRB member can serve before a break in service. Members must recognize the civic commitment attached to the role, and absent hardships and personal emergencies, members should serve their full term. CRBs require consistency of membership to garner adequate collective knowledge in order to perform their mission effectively.

E. The procedure for filling any vacancy in the membership of the civilian police review board

Depending on the amount of time remaining in the vacated term and the amount of training required for new board members, it may be in the CRB's best interest not to fill a vacancy. Should the CRB choose to fill the vacancy, however, the process should consider the perspective of the initial selection committee and the existing CRB's opinions. The selection committee or the CRB should fill vacancies either by vote or appointment.

There should also be a process to address the removal of a board member. The following factors should be considered as a basis for removal: breach of confidentiality; breach of ethics (*e.g.*, using one's position of power to coerce another, falsifying information, nepotism, and failing to disclose conflicts of interest); a pattern of poor attendance; or other conduct unbecoming of a board member. It is essential to recognize that accountability, trust, and integrity are just as integral for CRB members as they are for police officers.

Recommendation 12: Mental Health

Public Act 20-1 should be amended to prohibit discharging, disciplining, discriminating, or otherwise penalizing a police officer because of the results of a behavioral health assessment.

Connecticut General Statutes § 7-291d currently states: "(a) No law enforcement unit, as defined in section 7-294a, shall discharge, discipline, discriminate against or otherwise penalize a police officer, as defined in section 7-294a, who is employed by such law enforcement unit solely because the police officer seeks or receives mental health care services or surrenders his or her

firearm, ammunition or electronic defense weapon used in the performance of the police officer's official duties to such law enforcement unit during the time the police officer receives mental health care services. The provisions of this subsection shall not be applicable to a police officer who (1) seeks or receives mental health care services to avoid disciplinary action by such law enforcement unit, or (2) refuses to submit himself or herself to an examination as provided in subsection (b) of this section."

We recommend amending section 7-291d(a) as follows: "(a) No law enforcement unit, as defined in section 7-294a, shall discharge, discipline, discriminate against or otherwise penalize a police officer, as defined in section 7-294a, who is employed by such law enforcement unit solely because (i) the police officer seeks or receives mental health care services; (ii) the police officer surrenders his or her firearm, ammunition, or electronic defense weapon used in the performance of the police officer's official duties to such law enforcement unit during the time the police officer receives mental health care services; or (iii) because of the results of a behavioral health assessment conducted pursuant to section 7-291e. Nothing in this subsection should be construed as preventing a law enforcement unit from considering the results of a behavioral assessment in evaluating whether a subsequent fitness-for-duty evaluation is appropriate.

Rationale:

Section 16 of An Act Concerning Police Accountability, Bill 6004, requires behavioral health assessments for police officers when they begin their employment, not less than once every five years, and for good cause shown. The CBATF's proposed amendment seeks to protect law enforcement officers who undergo required periodic behavioral assessments or for good cause shown. The proposed amendment will help eliminate any stigma or adverse employment effects that may result from such assessments.

The CBATF makes this recommendation because ensuring the health and wellbeing of all police officers is a priority and serves the public good. Police officers should be encouraged to disclose mental health issues and to seek treatment without fear of discipline, loss of employment, or any other adverse effect on their careers. The same legal protections that are currently afforded officers who voluntarily seek or receive mental health care services should be extended to officers when they are required to obtain behavioral health assessments.

This recommendation is not intended to shield any officer from a more comprehensive follow-up examination, should such an examination be deemed necessary. The CBAPTF also encourages municipalities and police departments to consider requiring behavior assessments of officers more frequently than once every five years and allocating additional resources to permit more frequent assessments and availability of mental health treatment for officers.

Recommendation 13: Pattern-or-Practice Enforcement Authority to the Attorney General

Public Act 20-1 should be amended to grant civil "pattern-or-practice" enforcement authority to the Attorney General. This authority would be invoked only when there is evidence of a persistent pattern of misconduct in a police department or evidence of a regular practice in place that unlawfully discriminates or violates civil rights, rather than an isolated incident. The remedy for a pattern-or-practice violation must include whatever reforms may be necessary within

the police department to remedy systemic problems such as use of excessive force, racial profiling, and other biased policing and unlawful practices. To be effective, pattern-or-practice enforcement authority must include authorization to conduct investigations, including issuing subpoenas and civil investigative demands, as well as the power to commence litigation when appropriate.

Rationale:

An Act Concerning Police Accountability, Public Act 20-1 (Bill 6004), does not include civil authority for pattern-or-practice review. This authority lies beyond the scope of the criminal authority granted to the IG. Although the federal Government has the authority to conduct pattern-or-practice investigations, the Connecticut Attorney General does not currently have this authority. Because the federal Government has a national focus, systemic and egregious misconduct in local police departments which are lower profile or less urgent relative to departments outside of the State may go unchecked.

State government is in the best position to monitor local police departments for patterns and practices of civil rights abuses. The Connecticut Attorney General is already well positioned to provide necessary oversight and accountability. The Office of the Attorney General is focused solely on the State of Connecticut, and it has the expertise and capacity to investigate and bring any necessary cases.

By definition, "pattern-or-practice" authority is only invoked when there is evidence of a persistent pattern of misconduct in a police department or evidence of a regular police practice that unlawfully discriminates or violates civil rights, rather than an isolated incident. The goal of a pattern-or-practice action is to secure whatever reforms may be necessary within a department to remedy systemic problems such as use of excessive force, racial profiling, and other biased policing and unlawful practices.

In response to concerns about the limitations of this authority, the grants of authority in other jurisdictions around the country can be instructive. Distinct from criminal investigations or charges that may be pursued for a single violation of law, this authority is aimed at addressing multiple instances and systemic abuses or violations within a department. State AG enforcement may avoid the costs associated with similar DOJ enforcement by consent decree (which may require a court monitor and a more expansive scope of review and/or modification) and shorten the mandated period of oversight.

Recommendation 14: Use of Force by Police Officers

The Connecticut General Assembly should pass H.B. 6462, *An Act Concerning Use of Force by a Peace Officer*[3]. On March 8, 2021, the Judiciary Committee unanimously approved H.B. 6462 (Joint Favorable Substitute), which provides that Section 29 of Public Act 20-1 of the July special session concerning the use of force by peace officers (1) shall take effect on January 1, 2022; and (2) shall be amended:

[3] At the time that this report was released, H.B. 6462 was passed by the Connecticut General Assembly and signed into law by the Governor.

A. to clarify that whether a police officer's actions were "objectively reasonable" should be determined based upon "the given circumstances at that time," rather than just "the circumstances";
B. to require that before a police officer may use deadly force, the officer must, among other requirements, have "reasonably determined that there are no available reasonable alternatives to the use of deadly physical force," instead of requiring officers to have "exhausted" any such reasonable alternatives;
C. to require that before a police officer may use deadly force, the officer must, among other requirements, "reasonably believe that the force employed creates no unreasonable risk of injury to a third party," rather than a "substantial" risk of such injury;
D. to require that before a police officer may use deadly force to "effect an arrest of a person whom he or she reasonably believes has committed or attempted to commit a felony which involved the infliction of serious physical injury," the officer must, "where feasible," provide "warning of his or her intent to use deadly physical force";
E. to require that before a police officer may use deadly force to "prevent the escape from custody of a person whom he or she reasonably believes has committed a felony which involved the infliction of serious physical injury," the officer must also reasonably believe that the person "poses a significant threat of death or serious physical injury to others" (and, "where feasible," provide "warning of his or her intent to use deadly physical force"); and
F. to require that, for purposes of evaluating whether actions of a police officer are "reasonable" under the statute, the (non-exhaustive) factors to be considered include whether "any unreasonable conduct" of the officer led to an increased risk of an occurrence of the situation that precipitated the use of such force, rather than "any conduct" of such officer.

Rationale:

The task force supports passage of H.B. 6462 as adopted on a unanimous, bipartisan basis by the Judiciary Committee. The bill makes small, but important, textual amendments to Section 29 Public Act 20-1 of the July special session that are consistent with the spirit and intent of last year's Police Accountability Act. These amendments provide important clarifications that will help further guide the use of deadly force by police officers in the field. The amendments also provide additional protections for the public against unreasonable uses of deadly force by the police. Lastly, the bill provides a realistic timeline for implementation of the new use of deadly force statute that will allow police officers in the state to be properly trained on the law.

III. MORAL RECOGNITION COMMITTEE

The Moral Recognition Committee was developed to review how to publicly address past injustices and recommend any relevant trainings for police. Their work is rooted in an acknowledgement that there is often distrust in the police, with deep historical roots, among African Americans, people of color and their communities. The work of the committee focused on creating opportunities for police departments to learn about, discuss and address the root causes of this present and historic distrust.

III.A. Committee Members

Alexis Smith, Chair

Troy Brown

Maya Donald

Preston Tisdale

Cecil Thomas

Kitty Tyrol

III.B. Committee Recommendations

Recommendation 15: Police-Community Reconciliation Training

The state of Connecticut should create a Reconciliation Collaborative with the Office of Policy and Management, Criminal Justice Policy and Planning Division and other stakeholders to implement a reconciliation program throughout the state.

Rationale:

The National Initiative for Building Community Trust and Justice provides a framework for police-community reconciliation consisting of the following five components, which they have utilized in a select number of cities. We strongly support efforts already underway by Connecticut's Office of Policy Management (OPM), via *An Act Concerning Police Accountability*, to coordinate the State's efforts around reconciliation.

We further suggest OPM collaborate with local organizations to develop and implement a reconciliation initiative using the following five components:

1. Fact-finding**.** Departments shall engage in a fact-finding process in an effort to explore police departments' past harms (such as enforcing Jim Crow laws) and present harms maintained through policies and practices with detrimental effects on safety, equity, and justice.
2. Acknowledgment of harm**.** Police leadership will deliver acknowledgments of harm that recognize past and present harms, as well as ongoing problems that fuel mistrust between the police and community.
3. Sustained listening**.** Listening sessions shall be designed to be intimate and non-adversarial to encourage community members to share their experiences with and insights about law enforcement candidly.

4. Narrative collection and sharing**.** Narratives will capture community members' perceptions of police and the police's perceptions of communities.
5. Explicit commitments to changing policy, practice, and culture that continue the legacy of racial bias and discrimination**.** Departments shall commit to make changes and improvements in areas identified through the listening sessions.

All police departments in Connecticut shall participate in this initiative.

Funding shall be used to compensate individuals, community members, and organizations for their time on developing and implementing the reconciliation initiative.

No funding shall be used to compensate individual officers for attending any aspect of the reconciliation initiative. Individual departments shall be required to compensate their officers from the department budget.

All reconciliation efforts shall be evaluated on an ongoing basis. Some metrics for evaluation might include:

- number of departments participating each year;
- number of listening sessions, including number of attendees and topics discussed;
- increased community voice and representation to inform policy, procedures, and practices;
- new policies and practices implemented as a result of reconciliation;
- changes in diversity of police departments;
- increases in community trust of police; and
- reduction of police violence in the community.

Recommendation 16: Mandatory DEI, Racial Justice, and Implicit Bias Professional Development and Training

All Connecticut Police Departments should work with local or national organizations and municipal leadership to identify, develop, and facilitate professional development and trainings that address issues of Diversity Equity and Inclusion (DEI), Racial Justice, and implicit bias.

Rationale:

Trainings should be mandatory and offered to all police officers annually. Departments may consult with the Connecticut State Police Officer Standards and Training Council (POST) as a resource for training and tracking methods. At the completion of each training, each police officer will be required to complete an assessment with a minimum pass rate of 80%. We also recommend regular assessments that measure incremental learning and attainment.

Trainings and professional development should be conducted by experienced DEI trainers. We recommend a blend of current and/or retired police officers and non-officer co-facilitating trainings. Trainers should be individuals with a diversity of identity, lived experience, experience/interaction with law enforcement and professional experience within the criminal legal system. All trainers must have experience with DEI training and facilitation. Trainings are best delivered in diverse cohorts, drawing from a variety of diverse communities and police

departments. We strongly suggest this be accomplished in partnership with regional communities and police departments.

We further recommend that POST hire a full-time DEI coordinator/trainer to identify appropriate evidence-based/best practice models of DEI training. The POST Council Racial Justice Working Group, *see* Recommendation 17(e) below, shall develop and conduct a hiring process for the DEI coordinator. The coordinator should be experienced in, and should demonstrate expertise in, the following areas:

- DEI training—programs and models;
- Commitment to systems change;
- Knowledge about law enforcement/law enforcement background; and
- Comprehensive education and expertise on Race, Systemic Racism, African-American History and the History of Policing.

The coordinator's job duties shall include:

- Addressing cultural and historical practices within police departments, as they relate to DEI;
- Identifying training curricula in conjunction with POST leadership and community/non-profit groups with expertise and experience in racial justice;
- Creating or obtain training curricula;
- Identifying learning objectives, processes, and outcomes;
- Facilitating trainings using a Train-the-Trainer model;
- Securing Trainers/Facilitators and/or Subject-Matter Experts to provide training;
- Participating in local community forums;
- Coordinating trainings across communities and regions in the State;
- Establishing an Evaluation Process including quantitative and qualitative measures and data; and
- Issuing Annual Reporting.

Finally, we recommend increasing annual training hours for officers from 20 hours to 40 hours, including a minimum number of DEI training hours per year comprising a mix of mandated trainings and electives.

Recommendation 17: Public Trust Assessments

Police departments and local communities should create a public trust assessment that enable communities through surveys to provide feedback regarding public trust and confidence in police departments.

Rationale:

We acknowledge the yearning within the community, particularly communities of color, for healing with respect to its relationship with the police. For the purposes of this recommendation, the word "community" is not limited to individuals who reside in a particular geographic area served by a particular police department. Rather, we use this term to mean all

individuals who reside, work, or travel to and through such geographic area for basic activities of human life such as recreation, worship, social and economic activities.

Police departments should receive regular and ongoing feedback regarding how police officers are regarded within the community, particularly among communities of color. Finally, the police training programs recommended in 17(b) above, must be assessed for their efficacy and impact within the community. For all of these reasons, it is important for members of the community to convey their thoughts and concerns about how their local law enforcement respond to the community's needs and conduct themselves. One way to achieve this is for the public to know the police are held accountable for any and all acts of racial bias and discrimination. The POST Council Racial Justice Working Group (See Recommendation 17e) shall oversee these efforts.

Every two years, the community shall have the opportunity to participate in a Public Trust Assessment, consisting of an electronic survey, as well as focus groups and community conversations, to obtain candid feedback from the community regarding public trust and confidence in the police department, with a particular focus on assessing the impact and efficacy of trainings and other DEI, cultural competence, public trust, and racial justice initiatives.

The Public Trust Assessment electronic survey shall allow for the provision of anonymized, aggregated feedback. The survey shall be broadly disseminated within the community and shall allow respondents to provide anonymous identifying information, including:

- demographic information such as age, gender, gender identity, race, ethnicity, national origin, and sexual orientation;
- the geographic area where the respondent resides, works or otherwise connects with the municipality; and
- other appropriate data in order to determine response trends.

The survey should allow for the provision of narrative, open-ended feedback as well as responses to standardized direct questions.

The POST Council Racial Justice Working Group shall retain an organization with appropriate expertise and experience to develop a standardized Public Trust Assessment Survey Toolkit, for implementation within each municipality.

The Civilian Review Board, Police Commission, or similar governmental entity should coordinate the implementation of the PTA survey. The entity tasked with implementing the PTA survey should ensure a broad variety of outreach methods, including community canvassing, electronic and social media. The results of the survey should be aggregated and published in a report that is made broadly available to the public on the municipality's website.

The survey should allow for feedback regarding the following topics, among others:

- The community members' views of the police (individually, and as a system and arm of law enforcement);
- Views of police-community relationships;

- Perceptions of crime and neighborhood conditions;
- Willingness to partner with the police on crime control and prevention; and
- Perceptions of police response to calls and interactions in community.

In addition to the electronic survey described above, Police departments should hold regular and consistent community forums and listening sessions to hear from the individuals in the community they serve. All police departments shall work with community groups and grassroots organizations to hold forums to hear from community members about their experiences with their local law enforcement. These forums should be facilitated listening sessions, where police provide an intimate, non-adversarial forum for community members to share their experiences with and insights about law enforcement. These sessions will serve as a key mechanism for identifying narratives and informing specific changes to policy and practice that are then reported back to community members in subsequent listening sessions.

Finally, a reflective process should be established by which the forums are recorded and/or documented to include a list of attendees, speakers, summary, action steps and follow up and made available for public review.

Recommendation 18: Racial Bias and Racial Hostility Screening

All police departments should screen for racial bias and racial hostility. We strongly urge police departments to implement tools at the time of recruitment and hiring to screen for racial bias, racial hostility, and racial animus. In particular, we urge police departments to develop a tool to assess biases for officers after hiring and certification. This assessment should be conducted annually, possibly in coordination with the annual mental health assessment.

If an officer is identified to have such biases, the department leadership shall provide resources and take all necessary actions to eliminating such biases. The department may also implement a professional development plan to address biases which may be having an impact on the perception of the officer within the community and/or the officer's perception of the community. Where racial bias or hostility results in sufficiently severe officer misconduct, the department should implement appropriate discipline.

Recommendation 19: POST Council Racial Justice Working Group

We recommend that the POST Council (POST) form a Racial Justice Working Group (RJWG) to oversee and facilitate the implementation of professional development and training and a public trust assessment. The RJWG shall consist of interested current members of POST, as well as additional representative members as described below. Appointing authorities who select members of POST shall ensure that the overall composition of POST and the RJWG reflect the demographic diversity of Connecticut.

To ensure the success of the RJWG, we recommend the addition of the following representative positions to POST, initially as ad hoc members, and then as permanent positions as soon as feasible:

- A representative of an organization serving formerly-incarcerated individuals;

- A representative of a social services organization serving low-income communities in Connecticut;
- A representative of the Office of the Chief Public Defender;
- An individual with expertise in trauma-informed law enforcement practices;
- An individual with expertise in mental health and well-being;
- An individual with expertise in data collection and statistical analysis;
- Three representatives from community organizations advancing racial justice and equity in Connecticut's major metropolitan areas; and
- Four representatives of faith organizations, including at least one representative of a faith organization based in one of Connecticut's major metropolitan areas.

In the next legislative session, Conn. Gen. Stat. § 7-294b should be amended to ensure that the individuals identified as members of the RJWG become full and permanent members of POST.

Rationale:

POST has already taken significant steps to establish a Social Justice Advisory Committee (SJAC) whose mission as described below comports with our recommendation for a RJWG. We applaud POST for establishing the SJAC, recruiting diverse members to serve on the SJAC, and articulating a clear mission. In addition to these meaningful steps, we recommend that the SJAC be renamed as POST's Racial Justice Working Group and that members of the RJWG be afforded full status as representatives of the POST Council.

Mission of SJWC:

- Meet 4x/year January, April, July, and October.
- Define and recommend to POSTC, the mission and purpose of SJWC as it relates to POSTC.
- Discuss, review and recommend annual ln-service Diversity Equity and Inclusion (DEI), racial justice and implicit bias training curricula showing a commitment to system change.
- Discuss POSTC's role to oversee and facilitate DEI, social justice and public trust training initiatives.
- Provide guidance and recommendations related to POSTC policy and training objectives.
- Make recommendations to the POSTC regarding implementation tools and process used to screen police applicants for racial bias and hostility.
- Develop and recommend to the POSTC, an implementation plan to address bias which may have an impact on the officer's perception of the community.
- Discuss sustainability, resources, and cost of programs.
- Discuss/recommend the development of instructor criteria and endorsement for a DEI and social justice related training.
- Report to POSTC during regular meetings of progress and recommendations.

IV. REIMAGINING POLICE COMMITTEE

The Reimagining Police committee was developed to examine the appropriate scope of police responsibility; review proposals for alternative responders and related support; and examine relevant police trainings and policies.

IV.A. Committee Members

Rev. Keith King, Chair

Dr. Maysa Akbar, Chair (Committee Only)
Assistant Clinical Professor, Yale University School of Medicine

Alan Bowie, Jr. (Committee Only)

BIC, Senior Legal Counsel
Past President, Crawford Black Bar Association

Maggie Castinado

Patrick Cooney

Matthew Denny (Committee Only)
PhD Candidate in Political Science, Yale University

Charlie Grady

Theresa Hopkins-Staten (Committee Only)
President, Eversource Foundation and Vice President, Corporate Citizenship and Equity, Berlin

Rev. Skip Masback (Committee Only)
Former Managing Director, Yale Center for Faith and Culture

Demar Lewis (Committee Only)
PhD Candidate in Sociology & African American Studies, Yale University

Gwen Samuel (Committee Only)
Founder and President of Connecticut Parents Union

Arthur W. Thomas III (Committee Only)
Director of Entrepreneurial Initiatives and Inclusive Economic Opportunity, The Community Foundation of Greater New Haven

IV.B. Committee Recommendations

Recommendation 20: Feasibility Study on the use of Social Workers and Mobile Crisis Units by Police

Section 18 of P.A. 20-1 should be expanded to include a comprehensive feasibility study on the use of social workers and mobile crisis units by police in Connecticut. In support of this study, the CBATF, in collaboration with the Police Transparency and Accountability Task Force, would assess the DESPP and police evaluations submitted to POSTC on the use of social workers to respond remotely to calls for assistance, to respond in person to such calls, and/or to accompany police officers on calls where the experience and training of a social worker could provide assistance.

Rationale: Section 18 of the Act states:

> "Not later than six months after the effective date of this section, the Department of Emergency Services and Public Protection and each municipal police department shall complete an evaluation of the feasibility and potential impact of the use of social workers by the department for the purpose of remotely responding to calls for assistance, responding in person to such calls or accompanying a police officer on calls where the experience and training of a social worker could provide assistance. Such evaluation shall consider whether responses to certain calls and community interactions could be managed entirely by a social worker or benefit from the assistance of a social worker. Municipal police departments shall additionally consider whether the municipality that the police department serves would benefit from employing, contracting with or otherwise engaging social workers to assist the municipal police department. Municipal police departments may consider the use of mobile crisis teams or implementing a regional approach with other municipalities as part of any process to engage or further engage social workers to assist municipal police departments. The Commissioner of Emergency Services and Public Protection and each municipal police department shall submit such evaluation immediately upon completion to the Police Officer Standards and Training Council established under section 7-294b of the general statutes."

The mobile crisis team approach to public safety is well known in Connecticut, particularly with respect to responses to children and adolescents and others experiencing behavioral or mental health needs or crises. *See* Mobile Crisis Intervention Services Performance Improvement Center (PIC) Annual Report: Fiscal Year 2019. Several Connecticut cities and towns have adopted, or are adopting, mobile crisis unit (or "Co-Responder Team" or "Crisis Intervention Team") strategies. See, for example, descriptions of such programs in Hartford, New Haven, and a consortium comprised of Suffield, Windsor Locks, East Windsor, and Granby.

Moreover, the movement to mobile crisis team approaches to public safety has been robustly supported by the U.S. Department of Justice and by funding provided by the federal Substance Abuse and Mental Health Administration and the Connecticut Department of Mental Health and Addiction Services. *See, e.g.*, Law Enforcement Best Practices: Lessons Learned from the Field; Building Safer Communities: Improving Police Responses to Persons with Mental Illness; and Police Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement Responses for People Who Have Mental Health Needs. Both former President Trump and President Biden have expressed support for the co-responder model. *See* Trump Executive Order on Safe Policing for Safe Communities and Joe Biden's Criminal Justice Policy.

The mere fact that the General Assembly has mandated that police departments submit feasibility and impact studies is no guarantee that the opportunities created by the legislation will be fully grasped. While some police departments will see the Act as an opportunity to recommend imaginative movements toward adoption of mobile crisis unit policing, the responses are almost certain to be highly variable. If we wish to see the DESPP and the municipalities meaningfully consider these opportunities, we must support their efforts by supplying them with the resources and advocacy necessary to fully consider the options available to them.

Recommendation 21: Creation of municipal civilian interview panels and a community, cops & culture exchange program

The Connecticut General Assembly should appoint a commission to create (1) municipal civilian interview panels to participate in hiring, review, and promotion decisions for police officers, and (2) a community, cops and culture exchange program (a "CCC Exchange Program").

As the implementation of these recommendations will require more thought and resources, we recommend that the Connecticut General Assembly appoint a commission comprised of all stakeholders to develop a strategy and implement a program that will consider the concerns of the community and all of the stakeholders, but would include the elements, objects, and goals of the recommendation.[4] The commission or the board shall consist of a diverse cross-disciplinary group of people to include, among others, representatives from these various groups: public defenders, the defense bar, clergy, members of the legislature, community members, law enforcement, civil rights attorneys, mental health experts, and advocates of low-income communities. The commission shall also explore various funding sources to implement the recommendations. We recommend that POSTC require all police departments to adopt these programs, when developed by the commission.

While the appointed commission would be charged with resolving the logistical details of developing and implementing these two programs, we recommend that they also be charged with including the following minimal requirements for each proposal:

1. Civilian Interview Panel for Hiring

The civilian interview panel for hiring should be composed of a diverse group of citizens (*e.g.*, chamber of commerce; non-profit, religious and cultural organizations; youth groups and neighborhood watch groups, etc.) from the municipality that is hiring new police officers. Members of the panel should be chosen by that municipality's elected officials. Panel members will meet with the candidates prior to those candidates being fully hired as police officers. The civilian interview panel will make a report to the hiring agency either supporting or declining to support the candidates.

2. Civilian Interview Panel for Promotions

The civilian interview panel for promotions should be composed of a diverse group of citizens (*e.g.*, chamber of commerce; non-profit, religious and cultural organizations; youth groups and neighborhood watch groups, etc.) from the municipality that is promoting police officers to command staff positions. Members of the panel should be chosen by that municipality's elected officials. Panel members will meet with the candidates prior to those candidates being promoted to command staff positions. The civilian interview panel will make a report to the hiring agency either supporting or declining to support the proposed promotions.

[4] Implementation Guide at p. 14: "Each community should use the final report as a tool to review the current status of their own law enforcement organization and to identify ways to strengthen police-community dialogue and collaboration. Formally appoint a new or existing task force or working group including law enforcement unions and community representatives to review and address the recommendations contained in the report."

3. Community, Cops, and Culture Exchange Program

The Community, Cops, and Culture Exchange Program shall assemble a committee that will work to create academic, cultural, and practical educational experiences for municipal and state police cadets. The committee shall be composed of Connecticut residents consisting of diverse race, gender, ethnic, religious and aged community members, but shall not have political elected officials. The curriculum developed by the committee will be utilized by all POST certified police organizations in Connecticut.

An ongoing-fitness-for-service assessment rubric, metrics of success will also be created by the committee for use by POSTC instructors and all field training officers. All cadets must be deemed fit for service by the committee after reviewing their written assessments by training officers of POSTC.

- The academic curriculum comprised of culturally diverse materials by the committee must be included or added to the existing POST curriculum wherever it is not a duplicate of current curriculum.
- The CCC Exchange must begin during the second week of the academy cycle for all agencies and run continuously through the final week of the academy.
- The total minimum hours of the CCC Exchange program is ninety-six (96) total hours. This is a combined total of academic/written and practical exchanges with diverse members of at least three (3) communities. The cadet's town/city of employment shall count as one (1) community.
- The other (2) communities should include urban neighborhoods of color such as Hartford, New Haven, New Britain, Bridgeport, Middletown, New London, Danbury, Meriden, Stamford, Waterbury, or Norwalk.
- Cadet exchanges in suburban communities such as: West Hartford, New Canaan, Danbury, Madison, Essex, Bloomfield, Vernon, Milford, etc. would be relative for cadets that are employed by urban police departments.
- The cadets shall not be armed during their in-person exchanges with community members and are required to wear their standard "uniform of the day." This ensures that their experience in the community is one from a clearly identified role of police officer.
- Exchanges between recruits and residents would take place in various community-based settings such as churches, school auditoriums, and non-profit community spaces.
- The interactions will be controlled and in non-hostile settings with invited community members and civilian facilitators.
- These practical interactions will support relative classroom learning.
- It is recommended that the CCC Program should include a minimum of two (2) total weekend days (Sat. & Sun.) for the trainees' broader experiences.
- The entire concept of CCC Exchange is null and void if the cadet/trainees do not experience physically visiting and being immersed in diverse communities.

Rationale:

Our work in support of this recommendation reflects three animating concerns: (1) the tireless work of police officers protecting our communities from crime and violence is essential to our communal well-being and cannot be "defunded"; (2) a century of national police-reform commissions has established again and again that, despite good intentions and hard-won gains, lawless violence by some police against people of color remains intolerably chronic[5,6,7,8]; and (3) while continued incremental reform is essential, it has become clear that real, enduring change will not occur unless and until there is a fundamental "reimagining" or culture change in the nature of policing.

Our recommendations are based on many studies, including: (1) the Report on Lawlessness in Law Enforcement issued by the National Commission on Law Observance and Enforcement (the "Wickersham Commission"); (2) The Challenge of Crime in a Free Society, issued by The President's Commission on Law Enforcement and Administration of Justice (the "Katzenbach Commission"); (3) the Report of the National Advisory Commission on Civil Disorders (the "Kerner Commission"); and (4) the Final Report of the President's Task Force on 21st Century

[5] 4 The National Commission on Law Observance and Enforcement (the "Wickersham Commission") Report on Lawlessness in Law Enforcement (1931)("…the use of physical brutality, or other forms of cruelty, to obtain involuntary confessions or admissions is widespread. Protracted questioning of prisoners is commonly employed. Threats and methods of intimidation, adjusted to the age or mentality of the victim, are frequently used, either by themselves or in combination with some of the other practices mentioned. *Physical brutality, illegal detention, and refusal to allow access of counsel to the prisoner is common*." p. 4, *emphasis supplied) and (* "the practices were particularly harsh in the case of Negroes" and "in some of the worst cases the victims were Negroes") at pp. 158-159. Citing scores of cases of barbarous treatment of men, women and children of color. (Severe whippings, murder, "riding the electric monkey", beatings, illegal detentions, near drownings, and "tastes" of electric chair current.) *passim.*

[6] The President's Commission on Law Enforcement and Administration of Justice (the "Katzenbach Commission") The Challenge of Crime in a Free Society 15 (1967), https://www.ncjrs.gov/pdffiles1/nij/42.pdf. ("… The Commission found overwhelming evidence of institutional shortcomings in almost every part of the United States. Besides institutional injustices, the Commission found that while the great majority of criminal justice and law enforcement personnel perform their duties with fairness and understanding, even under the most trying circumstances, some take advantage of their official positions and act in a callous, corrupt, or brutal manner.") at p. viii. *and* ("Commission studies also showed, and in this finding responsible police officials concur, that too many policemen do misunderstand and are indifferent to minority-group aspirations, attitudes, and customs, and that incidents involving physical or verbal mistreatment of minority-group citizens do occur and do contribute to the resentment against police that some minority-group members feel." *And* ("Commission observers in high-crime neighborhoods in several cities have seen instances of unambiguous physical abuse officers striking handcuffed suspects, for example. They have heard verbal abuse. They have heard much rudeness.") 102.

[7] The National Advisory Commission on Civil Disorders (the "Kerner Commission") Report of The National Advisory Commission on Civil Disorders (1968) (*Quoting* commission testimony of University of Michigan Professor Albert Reiss "In predominantly Negro precincts, over three-fourths of the white policemen expressed prejudice or highly prejudiced attitudes towards Negroes. Only one percent of officers expressed attitudes which could be described as sympathetic towards Negroes. Indeed, close to one-half of all police officers in predominantly Negro high-crime-rate areas showed extreme prejudice against Negroes. What do I mean by extreme racial prejudice? I mean that they describe Negroes in terms that are not people terms. They describe them in terms of the animal kingdom.") at p. 160 *and* ("Virtually every major episode of urban violence in the summer of 1967 was foreshadowed by an accumulation of unresolved grievances by ghetto residents against local authorities (often, but not always, the police.)") 147.

[8] The President's Task Force on 21st Century Policing ("The Obama Task Force") Final Report of the President's Task Force on 21st Century Policing (2015) ("In establishing the task force, the President spoke of the distrust that exists between too many police departments and too many communities—the sense that in a country where our basic principle is equality under the law, too many individuals, particularly young people of color, do not feel as if they are being treated fairly.") at p. 5. *and* ("The need for understanding, tolerance, and sensitivity to African Americans, Latinos, recent immigrants, Muslims, and the LGBTQ community was discussed at length at the listening session, with witnesses giving examples of unacceptable behavior in law enforcement's dealings with all of these groups.) 52

Policing (the "Obama Task Force"). The central insight of these studies is that reforming police departments requires cultural change. As the Obama Task Force concluded:

There's an old saying, "Organizational culture eats policy for lunch." Any law enforcement organization can make great rules and policies that emphasize the guardian role, but if policies conflict with the existing culture, they will not be institutionalized, and behavior will not change. In police work, the vast majority of an officer's work is done independently outside the immediate over-sight of a supervisor. But consistent enforcement of rules that conflict with a military-style culture, where obedience to the chain of command is the norm, is nearly impossible. Behavior is more likely to conform to culture than rules.[9]

This was not a new insight. As the Wickersham Commission concluded in 1931 (in the context of unfair criminal prosecution), "But changes in machinery are not sufficient to prevent unfairness. Much more depends on the men that operate the machinery . . . the most important safeguards of a fair trial are that these officials want it to be fair and are active in making it so. As Mr. Wigmore has said: All the rules in the world will not get us substantial justice if the judges and counsel have not the correct living moral attitude toward substantial justice."[10]

The Katzenbach Commission[11], the Kerner Commission[12] and the Obama Task Force on 21st Century Policing each understood that changing the intent—the hearts and minds—of police officers required a culture change driven by the development of trusted, collaborative partnerships between police departments and the communities they serve. As President Obama's Task Force on 21st Century Policing (the "President's Task Force") emphasized:

It must also be stressed that the absence of crime is not the final goal of law enforcement. Rather, it is the promotion and protection of public safety while respecting the dignity and rights of all. And public safety and well-being cannot be attained without the community's belief that their well-being is at the heart of all law enforcement activities. It is critical to help community members see police as allies rather than as an occupying force and to work in concert with other community stakeholders to create more economically and socially stable neighborhoods.[13]

To advance the goal of developing collaborative partnerships, the President Obama's Task Force advanced several concrete recommendations to implement their general recommendation:

[9] The Obama Task Force on 21st Century Policing 11.
[10] Wickersham Commission 347.
[11] Katzenbach Commission 100: "A community-relations program is not a public-relations program to 'sell the police image' to the people. It is not a set of expedients whose purpose is to tranquilize for a time an angry neighborhood by, for example, suddenly promoting a few Negro officers in the wake of a racial disturbance. It is a long-range, full-scale effort to acquaint the police and the community with each other's problems and to stimulate action aimed at solving those problems. Community relations are not the exclusive business of specialized units, but the business of an entire department from the chief down. *Community relations are not exclusively a matter of special programs, but a matter that touches on all aspects of police work. They must play a part in the selection, training, deployment, and promotion of personnel; in the execution of field procedures; in staff policymaking and planning; in the enforcement of departmental discipline; and in the handling of citizens' complaints.*" (*Emphasis supplied*)
[12] Kerner Commission 154: "Despite its problems, we believe that meaningful community participation and substantial measure of involvement in program development is an essential strategy for city government. The democratic values which it advances – providing a stake in the social system, improving accountability of public officials – as well as the pragmatic benefits which it provides far outweigh the costs."
[13] *See* Obama Task Force on 21st Century Policing, *supra* note 7, at 42.

> Law enforcement agencies should develop and adopt policies and strategies that reinforce the importance of community engagement in managing public safety. Community policing is not just about the relationship between individual officers and individual neighborhood residents. It is also about the relationship between law enforcement leaders and leaders of key institutions in a community, such as churches, businesses, and schools, supporting the community's own process to define prevention and reach goals.[14]

President Obama's Task Force's concrete recommendations specifically included programs to (1) include diverse community leaders in local police department hiring, review and promotion; and (2) develop meaningful opportunities for diverse community leaders to participate at every level of officer training in ways that foster deep understanding and engagement with the full complexity and diversity of the communities the officers are being trained to serve.

Recommendation 22: Implementation of the federally mandated 988 crisis hotline and expansion of behavioral health crisis response and suicide prevention services

The Connecticut General Assembly should establish legislation to (1) implement the federally mandated 988 crisis hotline system; (2) enhance and expand behavioral health crisis response and suicide prevention services statewide; and (3) fund the system through SAMSHA and DMHAS grants, reimbursements from private and public insurers, and funds raised by imposing a federally authorized excise tax on commercial mobile services or IP-enabled voice services.

Legislation implementing the federally mandated 988 crisis hotline system has already been introduced, passed, and/or signed into law in eighteen states. We propose a recommendation that the General Assembly enact legislation in a form that aligns with the Substance Abuse and Mental Health Services Administration's National Guidelines for Behavioral Health Crisis Care Best Practices Toolkit,[15] the model bill published by the National Association of Mental Health Program Directors,[16] which reflects the robust approaches reflected in the bills passed in Washington State[17] and introduced in New York State.[18]

Rationale:

Police officers perform the indispensable service of protecting our communities from crime and violence and promoting public safety. Police recruitment and training necessarily focus

[14] *See* Obama Task Force on 21st Century Policing, *supra* note 7, at 42.
[15] Substance Abuse and Mental Health Services Administration, National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit (2020). https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.
[16] National Association of State Mental Health Program Directors, Model Bill for Core State Behavioral Health Crisis Services Systems (2021). https://www.nasmhpd.org/sites/default/files/Model%20Bill%20for%20a%20Core%20State%20Behavioral%20Health%20Crisis%20Services%20System.pdf.
[17] http://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1477-S2.SL.pdf?q=20210617050746
[18] https://legislation.nysenate.gov/pdf/bills/2021/A7177B.

on fielding officers equipped by temperament and training for the dangerous job of "containing and controlling" criminal and violent behaviors.

Yet, as communities have repeatedly failed to provide adequate resources for addressing recurring crises in behavioral health (*e.g.*, mental illness, substance abuse, homelessness, domestic violence, child neglect and abuse), we have asked our police to expand their services to address innumerable behavioral health emergencies well beyond their core vocation and training. There is an old saying that "when your only tool is a hammer, it is tempting to view every problem as a nail." Similarly, when your principal tool is "contain and control" by the use or prospect of force, then too many behavioral emergencies will seem like threats to be controlled instead of illnesses to be treated.

There will always be, of course, some percentage of behavioral health emergencies that present a sufficient, imminent threat of violence that a police presence will be necessary but sending police as the default first responders in every case reflects a lack of nuanced judgment that inevitably results in multiple adverse consequences. First, turning reflexively to armed law enforcement officers misuses and overextends our already thinly stretched police departments. Second, we deprive the individuals suffering behavioral crises of the professional mental health response they need. Third, we cycle behavioral patients through repeated, costly, and ineffective emergency department admissions and discharges instead of referring them to the care resources that might break the cycle of substance abuse, homelessness, and mental illness at a fraction of the cost. Fourth, we end up unnecessarily routing a significant percentage of behavioral crisis sufferers into the criminal justice system, with the multiplying expenses of arrest, adjudication, incarceration, and probation. Finally, we dramatically increase the risk of police use of lethal force, particularly when the subject is person of color.

Research conducted over the past decade by the United States Department of Justice and other federal agencies has generated repeated recommendations for more nuanced responses to persons suffering behavioral crises.[19] These recommendations have been echoed by calls from many organizations such as the United States Conference of Mayors,[20] the Leadership Conference on Civil and Human Rights,[21] the National League of Cities and Arnold Ventures,[22] and the Center for Policing Equity[23] for adoption of "mobile crisis unit," "co-responder," and/or "crisis intervention team" alternatives to relying exclusively on armed law enforcement "contain and control" responses.

In several ways, Connecticut police departments and state agencies have taken a leadership position in experimenting with or deploying mobile crisis unit, co-responder and/or crisis

[19] Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice (2010) *passim;* U.S. Department of Justice Office of Community Oriented Policing Services ("COPS"), Law Enforcement Best Practices: Lessons Learned from the Field 37-46 (2019); Substance Abuse and Mental Health Services Administration, National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit *passim* (2020).
[20] United States Conference of Mayors, Report on Police Reform and Racial Justice 14-15 (2020)
[21] The Leadership Conference on Civil and Human Rights, New Era of Public Safety: A Guide to Fair, Safe, and Effective Community Policing 152-167 (2019).
[22] National League of Cities and Arnold Ventures, Mental Illness, Substance Use, and Homelessness: Advancing Coordinated Solutions through Local Leadership 1-5 (2019)
[23] Center for Policing Equity, A Roadmap for Exploring New Models of Funding for Public Safety 4 (2020)

intervention team models, often with funding from the Connecticut Department of Mental Health and Addiction Services ("DMHAS"). For instance, in 2002, the Connecticut Department of Children and Families ("DCF") began shifting crisis responses from armed police officers to mobile crisis teams staffed by mental health professionals ("Emergency Mobile Psychiatric Services," now called: "Mobile Crisis Intervention Services", http://www.empsct.org/.).[24] By 2015, DCF had already established fifty-three memoranda of understanding with community-based mental health care providers.[25] DMHAS funds a statewide "Call 211" hotline operated by the United Way that provides referral and, occasionally, mobile crises responses staffed by mental health professionals. Most municipalities and many Connecticut State Police troops have sent at least some of their officers for formal crisis intervention team training. Finally, section 18 of the state's recently enacted Police Accountability Act requires the Department of Emergency Services and Public Protection and each municipal police department "to complete an evaluation of the feasibility and potential impact of the use of social workers by the department for the purpose of remotely responding to calls for assistance, responding in person to such calls or accompanying a police officer on calls where the experience and training of a social worker could provide assistance."

These are worthy and important initiatives, and we should certainly recommend a continuation of commitment, research, and development in each of these areas. Yet, we have already experienced the financial and logistical challenges to scaling up these programs further.

[24] Fendrich, M., Kurz, B., Ives, M., & Becker, J. *for* The Child Health and Development Institute of Connecticut, Inc., Evaluation of Connecticut's Mobile Crisis Intervention Services: Impact on Behavioral Health Emergency Department Use and Provider Perspectives on Strengths and Challenges 8 (2018). "Connecticut's Mobile Crisis Intervention Service (Mobile Crisis) program, which is grant-funded by the Department of Children and Families (DCF), was first implemented in 2002 (O'Brien, Mulkern, & Day, 2003; Vanderploeg, Lu, Marshall, & Stevens, 2016). The program aims to "serve children in their homes and communities, reduce the number of visits to hospital emergency rooms, and divert children from high-end interventions (such as hospitalization or arrest) if a lower level of care is a safe and effective alternative" (Vanderploeg et al., 2017, p. 6). The program provides free services to youth who are 18 years and younger, and to 19 year-olds who still attend high school (Vanderploeg et al., 2016). Vanderploeg et al. (2016) described three key components and other integral features that comprise Mobile Crisis. The information contained in the following section was adapted from their article. The first key component is the provider network. Mobile Crisis provides coverage to the entire state of Connecticut through six service areas, each of which utilizes up to three sites (there were a of 14 provider sites as of 2016; these numbers expanded, as indicated in Section III), that are responsible for different geographic regions of the state. Each service area has a Mobile Crisis director, access to a child and adolescent psychiatrist, and Master's level clinicians in the fields of social work, psychology, marriage and family therapy, and related fields. Mobile Crisis clinicians work with clients to develop crisis safety plans. Other features of their work include "crisis stabilization and support, screening and assessment, suicide assessment and prevention, brief solution-focused interventions, and referral and linkage to ongoing care" (Vanderploeg et al., 2016, p. 106). The Mobile Crisis team's approach is guided by collaboration with families, schools, hospitals, and other providers. The maximum Mobile Crisis episode length is typically 45 days, but can be extended if necessary. Clients can also return to Mobile Crisis as many times as needed after the episode is closed. The second key component is the call center. Clients can access Mobile Crisis services by dialing 211 (although our focus groups revealed that there were direct lines of engagement at some sites). A call specialist will solicit basic information from the caller and refer police or ambulances services if warranted. Otherwise, if the call occurs during Mobile Crisis mobile hours (Monday through Friday: 6:00 am-10:00 pm; weekends and holidays: 1:00 pm-10:00 pm), the call specialist will connect the caller to Mobile Crisis through a warm transfer. Based on the call specialist's recommendation, Mobile Crisis will respond in one of three ways: immediate mobile, deferred mobile, or telephone. In mobile responses, Mobile Crisis clinicians will meet clients wherever they are experiencing a crisis in the community. During immediate mobile responses, clinicians will meet the client within 45 minutes of the call (In 2015, Mobile Crisis achieved this response time 89% of the time.). If the call occurs outside of Mobile Crisis mobile hours, the call specialist will connect the caller to a non-Mobile Crisis clinician and Mobile Crisis will follow-up with the caller during mobile hours. The third key component is the Performance Improvement Center (PIC), which was created in 2009 and is housed at the Child Health and Development Institute of Connecticut (CHDI). PIC is charged with "standardized practice development; data collection, analysis, reporting, and quality improvement; and workforce development" (Vanderploeg, 2016, p.105).

[25] Department of Children and Families, Connecticut Children's Behavioral Health Plan: Progress Report 8 (2015)

One need only survey the municipal and state police responses to the feasibility and impact studies required by Section 18 of the Police Accountability Act to see a catalogue of potential obstacles.

Fortunately, federal legislation and regulations mandating a nationwide "988 Hotline" has intersected with concerns underscored by the George Floyd murder to inspire a bipartisan, national movement to implement the federal "988" mandate with statewide mobile crisis response capacities staffed by professional health care workers. States across the country have been moving expeditiously to enact implementing legislation taking advantage of the federal law's grant of authority to fund the mobile crisis response services with fees and charges imposed on commercial mobile services or IP-enabled voice services.[26]

Federal 988 Legislative and Regulatory History

The federal 988 legislative and regulatory history was ably summarized in a May14, 2021 blog posted by the Substance Abuse and Mental Health Services Administration entitled, entitled, "Groundbreaking Developments in Suicide Prevention and Mental Health Crisis Service Provision":

> In 2018, Congress passed and the President signed into law, the National Suicide Hotline Improvement Act in which SAMHSA and the Veterans Administration were called upon to report to the Federal Communications Commission (FCC) regarding the effectiveness of the existing National Suicide Prevention Lifeline and the potential value of a three digit number being designated as the new national suicide prevention number. The FCC subsequently recommended to Congress that the number 988 be designated as the new national suicide prevention number. On July 16, 2020, the FCC issued a final order designating 988 as the new NSPL and Veterans Crisis Line (VCL) number. This order gave telecom providers until July 16, 2022 to make every land line, cell phone, and every voice-over internet device in the United States capable of using the number 988 to reach the Lifeline's existing telephony structure. On October 17, 2020, the National Suicide Hotline Designation Act of 2020 was signed into law, incorporating 988 into statute as the new Lifeline and VCL phone number.

One of the most significant provisions of the 988 legislation was the express provision of authority to the states to impose and collect fees or charges "applicable to a commercial mobile service or an IP-enabled voice service" to fund "9-8-8 related services if the fee or charge is held in sequestered account to be obligated or expended only in support of 9-8-8 services, or enhancements of such services."

Permitted expenses included: (1) ensuring the efficient and effective routing of calls made to the 9-8-8 national suicide prevention and mental health crisis hotline to an appropriate crisis center; and (2) personnel and the provision of acute mental health, crisis outreach and stabilization

[26] Substance Abuse and Mental Health Services Administration, "Blog: Groundbreaking Developments in Suicide Prevention and Mental Health Crisis Services Provision" https://blog.samhsa.gov/2021/05/14/groundbreaking-developments-suicide-prevention (May 14, 2021)

services by directly responding to the 9-8-8 national suicide prevention and mental health crisis hotline.

State Responses to the Federal 988 Legislation and Regulation

Many states have recognized that the federal legislation and regulation, particularly its grant of authority to impose fees and charges on mobile and IP-enabled voice call services, provides a powerful tool that can be used to address both the suicide and mental health crises and the concerns underscored by the George Floyd murder.

Three states have already passed and signed 988 legislation into law (Washington, Virginia, and Utah); three states have passed 988 legislation (Alabama, Indiana, and Nevada), twelve states have introduced 988 legislation (Oregon, California, Colorado, Idaho, Kansas, Kentucky, Massachusetts, Nebraska, New York, New Jersey, Rhode Island, and Wisconsin), and new 988 legislation is already anticipated in at least three more states (Arkansas, Pennsylvania, and South Carolina.)[27]

Many of the state bills already enacted or introduced reflect guidance provided by SAMSHA's published best practices for behavioral health crisis care[28] as well as model bills promoted by various mental health advocacy groups.[29] While there is substantial variation among and between the various state bills, virtually all of them seek to capture the advantages identified by SAMSHA:

- More people in suicidal and mental health crisis will be helped. Sources of increased contacts (calls, chats, and texts) include baseline contact volume, new contact volume, and contacts diverted from 911 and other crisis hotlines.
- Those in crisis will be more likely to receive help from those most qualified to provide support.
- More effective triage means less burden on emergency medical services, emergency departments, law enforcement, etc. so that their agencies can be appropriately focused their limited resources on those areas for which they are best trained.
- The attention the transition to 988 has brought to crisis services has led to an opportunity for states to reimagine their crisis service provision, and to ensure adequate financing of 1) mobile crisis services, 2) crisis center hubs and 3) crisis stabilization services.[30]

[27] Substance Abuse and Mental Health Services Administration, "Blog: Groundbreaking Developments in Suicide Prevention and Mental Health Crisis Services Provision" https://blog.samhsa.gov/2021/05/14/groundbreaking-developments-suicide-prevention (May 14, 2021)

[28] Substance Abuse and Mental Health Services Administration, National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit (2020). https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.

[29] National Association of State Mental Health Program Directors, Model Bill for Core State Behavioral Health Crisis Services Systems (2021). https://www.nasmhpd.org/sites/default/files/Model%20Bill%20for%20a%20Core%20State%20Behavioral%20Health%20Crisis%20Services%20System.pdf.

[30] Substance Abuse and Mental Health Services Administration, "Blog: Groundbreaking Developments in Suicide Prevention and Mental Health Crisis Services Provision" https://blog.samhsa.gov/2021/05/14/groundbreaking-developments-suicide-prevention (May 14, 2021)

In our view, SAMSHA's summary of benefits omits one of the most consequential benefits of shifting the primary burden of responding to behavioral health crisis from armed law enforcement officers to mental health professionals. At least 23% of all fatal shootings by police officers in the line of duty since 2015 involved victims with known mental illness.[31] Further, almost half of the fatal police incidents in Connecticut since 2001 involve people struggling with mental health conditions. Police responding to these incidents report that 46% of the incidents involved people who were emotionally disturbed/in mental distress and/or deemed suicidal. This data calls out for municipalities and law enforcement to seriously consider the role mobile crisis units or other social services can be used to support responses to police calls.

> *"Mental illness, unlike age, is its own risk factor for police violence. The Fatal Force project found that approximately one in four people shot and killed by police were experiencing a mental or emotional crisis at the time of the shooting.*
>
> *However, the finding that Black men exhibiting signs of mental illness are also at higher risk of police killing than white men, particularly while unarmed, is indicative of a concerning pattern in policing: While white men with mental illness are more likely to be given treatment, Black men with similar behaviors are more likely to be criminalized for their actions."*[32]

To put the matter as starkly as possible, every behavioral health crisis successfully addressed by mental health professionals instead of by armed police officer will significantly reduce the risk of the patient being fatally shot. No one has ever been shot by a police officer who was not at the scene.

Recommendation 23: Targeted Investments to Increase Economic Mobility

The Connecticut General Assembly should establish a board or commission comprised of relevant stakeholders to develop a strategy to provide targeted and holistic investments to increase economic mobility. Those investments need to:

1. cultivate ecosystems that will foster economic mobility in under-resourced communities;
2. increase access to viable pathways to high-wage employment, education, and vocational training for Connecticut's underemployed; and
3. prioritize creating viable pathways to home- and business-ownership for Connecticut's under-resourced communities.

[31] Washington Post Database of Police Shootings, https://www.washingtonpost.com/graphics/investigations/police-shootings-database/.

[32] Kara Manke, "Stark racial bias revealed in police killings of older, mentally ill, unarmed Black men" U.C. Berkeley News, October 5, 2020. *Citing* The Washington Post Database of Police Shootings *and* Marilyn D. Thomas PhD, MPH[a], Amani M. Allen PhD, MPH[b], "Black and unarmed: statistical interaction between age, perceived mental illness, and geographic region among males fatally shot by police using case-only design," 53 Annals of Epidemiology, January 2021, 42-49. https://www.sciencedirect.com/science/article/abs/pii/S1047279720302957?via%3Dihub

Rationale:

There remains a need for substantial investments in mental health care; affordable, high quality health care; accessible housing; healthy food options; good paying jobs; quality and safe education options; and other social services. These underfunded systems have led to the police routinely being thrust into a role of addressing these various social issues, a role for which they were not created and which they are not fully equipped to manage.

We must meet community needs with thoughtful investments and avoid inserting the police into roles in which they must be the primary or only public response. If we ask too much of the police, and not enough of ourselves, our residents will always get too little.[33]This will require, in the words of the Kerner report, "compassionate, massive, and sustained" efforts to address racial inequality and concentrated poverty. As reforms to the criminal justice system are fully realized in Connecticut, it is imperative that savings be reinvested into the systems outlined above. If Connecticut were to make an initial investment of $300 million dollars, this would be roughly equivalent to how much would be saved if Connecticut's Corrections budget was reduced to its 2008 level. With a declining prison population, and alternatives to incarcerations, these savings are possible. Reinvesting public funds can create socioeconomic interventions that lead to economic mobility and that will attract the attention of other private institutional and individual investors to reduce systemic social inequities in Connecticut.

We recognize, however, that the implementation of these recommendations will require more thought and resources. Therefore, we recommend that the Connecticut General Assembly establish a board, or a commission comprised of relevant stakeholders to develop a strategy to achieve these recommendations.

[33] The United States Conference of Mayors, *Report on Police Reform and Racial Justice*, 14.

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POLICE TRANSPARENCY & ACCOUNTABILITY TASK FORCE

Established by Public Act 19-90 Section 6 to study police transparency and accountability.
Continued by the passage of Public Act 20-1, which added additional priorities for evaluation and recommendation.

TASK FORCE PRIORITIES

- COMMUNITY POLICING & CRIME REDUCTION
- OFFICER WELLNESS & SAFETY
- TRAINING & EDUCATION
- POLICY & OVERSIGHT
- TECHNOLOGY & SOCIAL MEDIA
- BUILDING TRUST & LEGITIMACY

The Task Force established 3 subcommittees to advise them on various aspects of its legislative charge in preparation for the issuance of its final report. Each subcommittee is chaired by a Task Force member and comprised of a minimum of 4 Task Force members & 4 community members.

PUBLIC AWARENESS SUBCOMMITTEE

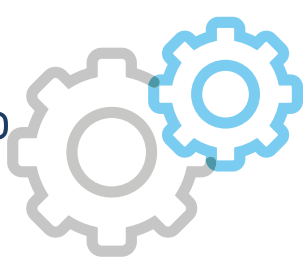
1. Coordinating public awareness & outreach efforts
2. Determining how & where to conduct public listening sessions, coupled with community surveys
3. Assessing the efficacy of annual community surveys

IMPROVING POLICE INTERACTIONS WITH DISABILITY COMMUNITY SUBCOMMITTEE

1. Examining police officers' interactions with individuals with a mental, intellectual or physical disability
2. Assessing resource allocation for diversionary programs

LOGISTICS SUBCOMMITTEE

1. Reviewing & developing a course of action for the remaining prelimary priorities & recommendations
2. Engaging with the Governor & General Assembly to ensure coordination of efforts with respect to legislation & administrative actions relative to the Task Force's purview
3. Determining structure & scope of final report



For more information please visit
www.ctpolicetransparency.com
where you can learn about:
-Task Force members
-The status of recommended legislation
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Annual Report of the Police Transparency & Accountability Task Force

January 2021

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I. Introduction

The Police Transparency & Accountability Task Force (PTATF) was initially established under Public Act 19-90 in July 2019. Per the public act, the task force was to examine: (1) police officer interactions with individuals with a mental, intellectual, or physical disability; (2) the feasibility of police officers who conduct traffic stops issuing a receipt to each stopped individual that includes the reason for the stop and records the demographic information of the person being stopped; and (3) any other police officer and transparency and accountability issue the task force deems appropriate. It also established a reporting requirement for a preliminary (January 1, 2020) and final (December 31, 2020) report. In June 2020 the PTATF issued a preliminary report (see Appendix A). The full Task Force is comprised of 13 members:

- **Daryl McGraw** (Co-Chairperson)
- **Commissioner James Rovella** - Department of Emergency Services and Public Protection *(ex-officio/non-voting)*
- **Sergeant John Szewczyk** - Hartford Police Department *(retired)*
- **Jonathan Slifka** – Executive Assistant to the Commissioner of the Department of Aging and Disability Services
- **Joshua Hall** – State Representative 7th House District
- **Chief Keith Mello** – Milford Police Department
- **Deputy Police Chief Maggie Silver** – UCONN Police Department
- **Undersecretary Marc Pelka** - Criminal Justice Policy and Planning Division, Office of Policy and Management *(ex-officio/non-voting)*
- **Rev. Steven Cousin** – New Haven Bethel AME Church
- **Richard Colangelo** – Chief State's Attorney *(ex-officio/non-voting)*
- **Sergeant Shafiq Abdussabur** – New Haven Police Department *(retired)*
- **Chief Thomas Kulhawik** – Norwalk Police Department
- **Chief William Wright** – Wallingford Police Department

In July of 2020 the Connecticut General Assembly then passed Public Act 20-1, making modifications to the task force by adding priorities for examination. They are:

1. Strategies communities can use to increase minority police officer recruitment, retention, and promotion;
2. Strategies communities can use to increase female police officer recruitment, retention, and promotion;
3. The merits and feasibility of requiring (a) police officers to procure and maintain professional liability insurance as an employment condition or (b) a municipality to maintain the insurance on its officers' behalf;
4. Establishing laws for primary and secondary traffic violations;
5. Establishing a law that requires police traffic stops to be based on enforcing a primary traffic violation;

6. How a police officer executes a warrant to enter a residence without giving audible notice of the officer's presence, authority, and purpose before entering in Connecticut and other states, including address verification procedures and any documentation an officer should leave for the residents where the warrant was executed;
7. How a professional bondsman, surety bail bond agent, or a bail enforcement agent takes into custody the principal on a bond who failed to appear in court and for whom a re-arrest warrant or a capias was issued in Connecticut and other states, including the address verification process and whether any documentation is left with a resident where the warrant was executed; and
8. Whether any of the grounds for revoking or cancelling a police officer's certification should result in a mandatory, rather than discretionary, POST revocation or cancellation.

PA 20-1 also extended the reporting deadlines of the PTATF a full year, with the preliminary report due on or by December 31, 2020 and the final report on or by December 31, 2021. The Task Force will terminate upon the completion of its final report or December 31, 2021 – whichever is later.

This report serves as the PTATF's preliminary report under the requirements of PA 20-1.

Per PA 19-90 and 20-1, the PTATF is supported by the administrative staff of both the Judiciary and Public Safety committees of the Connecticut General Assembly. Members would like to thank Judiciary Committee administrator, Deborah Blanchard, for her diligent efforts to support its work. In addition, the PTATF has received ongoing support by the staff of the Institute for Municipal and Regional Policy (IMRP).

For more information on the PTATF, please visit its website: https://www.ctpolicetransparency.com/, as well as the Judiciary Committee's webpage.

II. Subcommittees

In its June 30, 2020 meeting, the PTATF approved the creation of subcommittees to "advise the Task Force on various aspects of its charge per PA 19-90 in preparation for the issuance of its final report." Each subcommittee is comprised of four task force members, along with four to five non- Task Force members, and is chaired by a Task Force member. Non-Task Force members are appointed by the subcommittee chair, in consultation with the Task Force chair. Upon the passage of PA 20-1 the subcommittee structure has remained the same. The three subcommittees are:

- The Public Awareness Subcommittee
- Improving Police Interactions with Disability Community Subcommittee
- The Logistics Subcommittee

The **Public Awareness Subcommittee** is chaired by Daryl McGraw. The main objectives of the Public Awareness Subcommittee include: 1) coordinating public awareness and outreach efforts; 2) determining how and where to conduct public listening sessions, coupled with community surveys; and 3) assessing efficacy of annual community surveys.

- *Task Force members*: Daryl McGraw, Atty. Richard Colangelo, Rev. Steven Cousin, Chief Keith Mello, and Dep. Chief Maggie Silver.
- *Non-Task Force members*: Steven Hernandez (CWSEO), Andy Friedland (ADL), Tamara Lanier (NAACP)

The **Improving Police Interactions with Disability Community Subcommittee** is chaired by Jonathan Slifka. The main objectives of the Improving Police Interactions with Disability Community Subcommittee include: 1) examining police officers' interactions with individuals with a mental, intellectual, or physical disability; and 2) assessing resource allocation for diversionary programs.

- *Task Force members*: Jonathan Slifka, Undersecretary Marc Pelka, Chief Thomas Kulhawik, and Dep. Chief Maggie Silver.
- *Non-Task Force members*: Rayla Mattson, Michelle Duprey, Alvin Chege, Doris Maldonado

The **Logistics Subcommittee** is chaired by Rep. Joshua Hall. The main objectives of the Logistics Subcommittee include: 1) reviewing and developing a course of action for the remaining preliminary priorities and recommendations; 2) engaging with the Governor and Connecticut General Assembly to ensure coordination of efforts with respect to legislative and administrative actions relative to the Task Force's purview; and 3) determining structure and scope of final report.

- *Task Force members*: Rep. Joshua Hall, Chief William Wright, Shafiq Abdussabur, John Szewczyk
- *Non-Task Force members*: Ken Green, Mel Medina, Stephen Saloom, Tanya Hughes, Cheryl Sharp

Each of the subcommittees established recommendations within their own meetings that were then sent to the full Task Force for evaluation, amendment, and vote. As of January 18, 2021, the Task Force has

endorsed four recommendations and one assessment. There were also two recommendations provided to the Task Force that failed passage.

The following three sections contain the recommendations and assessment as noted above.

III. Endorsed Recommendations of the Task Force

As of 01/18/2021:

Recommendation #1: Inspector General

Section 33 of Public Act 20-1 should be modified to permit candidates outside of the Division of Criminal Justice be eligible for the position of Inspector General and for positions within the staff of the Inspector General's Office.

Implementation of Section 33 should be delayed until April 1, 2021 if the recommended change is unable to be made prior to the appointment of a candidate.

Rationale:

An Act Concerning Police Accountability, Bill 6004 ("the Act"), Section 33(a) states:

"There is established the Office of the Inspector General that shall be an independent office within the [Connecticut State] Division of Criminal Justice. Not later than October 1, 2020, the Criminal Justice Commission . . . shall nominate a deputy chief state's attorney from within the division as Inspector General who . . . shall lead the Office of the Inspector General. The office shall: (1) Conduct investigations of peace officers . . .; (2) prosecute any case in which the Inspector General determines a peace officer used force found to not be justifiable . . . or where a police officer or correctional officer fails to intervene in any such incident or to report any such incident . . .; and (3) make recommendations to the Police Officer Standards and Training Council . . . concerning censure and suspension, renewal, cancelation or revocation of a peace officer's certification."

The Act requires that all candidates for the position of Inspector General (IG) and for IG staff positions be from within the Division of Criminal Justice ("DCJ"). See also Section 33(j) (IG Office Staff). This precludes the Criminal Justice Commission from making selections from a larger pool of well-qualified candidates including, but not limited to, federal prosecutors, private practitioners from the plaintiff's bar and/or civil rights attorneys. As these other potential candidates are independent from the DCJ, they would avoid the appearance of a conflict of interest which members of the DCJ will face as they regularly work with police officers some of whom will be the subject of the IG investigations. As it is critical that these investigations have the full confidence of the public and avoid any appearance of a lack of independence, we recommend that the Act be amended to allow the Criminal Justice Commission to consider candidates outside of the DCJ for the position of IG as well as IG staff positions.

Recommendation #2: Accreditation

It is recommended that Section 44 of Public Act 20-1 be amended to remove the requirement that all law enforcement units be required to obtain and maintain CALEA accreditation by 2025. Alternatively, the law should require that all law enforcement units must obtain and maintain the Connecticut Police Officer Standards and Training Council ("POSTC") Tier III accreditation standards by 2025. All law enforcement units should achieve Tier I state accreditation by 2022 and Tier II accreditation by 2023.

Rationale:

An Act Concerning Police Accountability, Bill 6004, requires that all departments satisfy the CALEA standards. Currently, 24 of 92 departments in Connecticut are CALEA certified. CALEA is designed to be a voluntary program. There is an annual cost to obtain and maintain accreditation. The annual cost varies from between $5,000 and $8,000 depending on the size of the agency.

The process for obtaining CALEA accreditation begins with a review of departmental files by a trained Compliance Service Members (CSM). CSM's review approximately 25% of the department files each year. On-site assessments are conducted by a trained team, typically led by an active or retired police chief or other high-ranking professional. Assessors are not associated in any way with the agency being reviewed and come from another state. On-site visits are scheduled for two to three days to verify compliance. Assessors conduct interviews with staff, observations, ride-alongs, building tours, community interviews, and a public hearing. Additional focus areas that are pre-determined are also reviewed. Any issues previously identified by the CSM are also reviewed. A comprehensive report is completed, reviewed by CALEA staff, reviewed by the CALEA Commission, and a hearing is held. During the hearing commissioners can ask questions of the agency and then decide on accreditation or reaccreditation.

Connecticut has developed its own tiered accreditation program, overseen by the Police Officer Standards and Training Council (POSTC). There is no annual cost for a department to obtain state accreditation. Agencies are assessed by local assessors where directives, policies and agency activities are reviewed. The Tier III state accreditation standards are robust and have additional state specific standards. The state should continue to find ways to encourage and incentivize CALEA accreditation, but the program should remain voluntary. A mandated state accreditation program would help to ensure standards are more uniform across departments in Connecticut. The state should consult with POSTC to ensure that funding is available for the increased number of agencies that would need to be accredited under this program. Additional resources will be paramount to the success of the state program. There will need to be ample staff and trained assessors to manage the increased demand that will come with a mandated state program. POSTC should develop a plan for phasing departments into the accreditation program and a plan to manage reaccreditation on a rotating schedule.

Recommendation #3: Compliance with POSTC Standards

If a municipal police department, the Department of Emergency Services and Public Protection or any other department fails to comply with the Police Officer Standards and Training Council mandated reporting policy as outlined in POSTC General Notice 20-9, as amended, the POSTC shall recommend and the Secretary of the Office of Policy and Management may order an appropriate penalty in the form of the withholding of state funds from such municipal police department, the Department of Emergency Services and Public Protection or other departments.

POSTC shall adopt standards for compliance with the mandatory reporting requirement in the Connecticut Law Enforcement Standards Policies and Practices (CLESP). Failure to comply shall result in loss of accreditation in one or more CLESP tiers.

Rationale:

Pursuant to a new POSTC general order, all police chiefs and the DESPP commission are mandated to report and provide documentation of certain violations to the council for review. The violations committed by any certified police officer of any rank include: (1) the unreasonable, excessive, or illegal use of force that caused or would reasonably cause death or serious physical injury to another person, (2) the duty to intervene to stop the unreasonable, excessive or illegal use of force or to fail to notify a supervisor, (3) the intentional intimidation or harassment of a member of a protected class, and (4) the prohibition against hiring police officer dismissed for misconduct or who resigned or retired while under investigation.

Under this policy, POSTC has no consequence to impose on a department or DESPP that fails to comply with the mandated reporting and submission of documentation requirements. The general order states failure to supply all required documentation shall result in delays or refusal to bring a request to the POST Council Certification Committee for review.

POSTC should have recourse and an appropriate recourse exists under the current state racial profiling law (CGS §54-1lm, Alvin W. Penn Racial Profiling Prohibition Act). Under this law, municipal police departments and DESPP are required to submit specific traffic stop data to OPM. OPM is authorized to withhold state funds from departments that fail to comply.

Recommendation #4: In-Service Training for Interactions with the Disability Community

It is recommended that the Police Officers Standards and Training Council (POSTC) develop, with input from the disability community and ADA experts, a standardized mandatory minimum in-service training regarding interactions with the disability community.

Rationale:

The POSTC provides training on this topic during recruit training. However, police departments may or may not provide additional in-service training regarding interactions with the disability community. Developing a minimum standard for in-service training, with input from the disability community, would ensure that all officers receive ongoing training throughout their careers.

IV. Endorsed Assessment Regarding Liability Insurance

The Insurance Law Center[1] at UConn Law School was asked by the task force to review several insurance issues related to recent changes in Connecticut law in Public Act No. 20-1. Pursuant to this Act the Police Transparency and Accountability Task Force ("***Task Force***") has been expressly tasked with examining:

(1) the merits and feasibility of requiring police officers to procure and maintain professional liability insurance ("***PL Insurance***") as a condition of employment;
(2) the merits and feasibility of requiring a municipality to maintain PL Insurance on behalf of its police officers; and
(3) the impact that Section 41 of the Act (which modifies the scope of the "qualified immunity" defense available to a police officer if that police officer has been accused in a civil lawsuit of violating a person's constitutional rights) will have on the ability of a police officer or municipality to obtain PL Insurance.

Working with the Task Force, we have reviewed and synthesized the following information:

- Presentations and written material from the Connecticut Bar Association's Policing Task Force (CBA), Connecticut Interlocal Risk Management Agency (CIRMA), Connecticut Council of Municipalities, and police unions.
- Various law enforcement liability insurance forms provided by CIRMA.
- Our own research, including loss control and risk management resources provided by CIRMA and several private insurers, comparing relevant Connecticut and federal qualified immunity provisions for government actors, a brief analysis of the private insurance market for individual police officers, and our background knowledge of insurance markets.

While providing a list of caveats is routine for these types of reports, we need to emphasize that the Subcommittee was not able to obtain the information from insurers– at least as of now – that would be necessary to provide a more confident and complete analysis. This includes information about the aggregate premiums collected for municipal liability insurance, aggregate claims paid, and of this amount the total dollar amount paid for law enforcement liability coverage. Nor could we obtain information about how—if at all—insurers plan to change underwriting or pricing practices in light of the new statute.

Merits and feasibility of requiring police officers and municipalities to maintain professional liability insurance [questions (i) and (ii)].

Perhaps the best way to answer these questions is through reviewing how police officers and municipalities are already covered. We assume that all municipalities in Connecticut have some form of

[1] The Insurance Law Center is the pre-eminent academic center for the study of insurance law and regulation in the US, and offers the only LL.M. Program in Insurance Law in the country. https://ilc.law.uconn.edu/

liability insurance that covers law enforcement actions, or are self-insured.[2] As is standard with most liability insurance purchased by any organization, employees such as police officers are included as insureds provided they are acting in the scope of their employment. This means they would normally be covered under the municipality's liability insurance and defended along with the municipality in civil lawsuits arising out of law enforcement activities. A typical description of "who is an insured" reads:[3]

> **WHO IS AN INSURED**
>
> 1. The individual Coverage Sections may contain specific provisions regarding WHO IS AN INSURED. It is important to refer to each Coverage Section in addition to the following provisions.
>
> 2. You are an insured as shown as named insured in the Declarations.
>
> 3. Each of the following is also an insured to the extent indicated:
>
> > a. Your elected or appointed directors, officers, officials, and members of any boards or commissions, but only with respect to their duties as your directors, officers, officials, or board or commission members.
> >
> > b. Employees of any school district named in the Declarations who hold the position of Superintendent or Assistant Superintendent, Administrator or Assistant Administrator, Principal or Assistant Principal or any equivalent administrative position, but only for acts within the scope of their employment by you.
> >
> > c. Your employees, other than those included in a. and b. above, but only for acts within the scope of their employment by you, or in the case of a *"leased worker,"* while performing duties related to the conduct of your business. However, none of these employees are covered for:
> >
> > > (1) "Bodily injury" or "personal injury" to you; or
> > >
> > > (2) "Property damage" to property owned or occupied by or rented or loaned to that employee, or any of your other employees except "autos."

CIRMA's "Law Enforcement Liability" insuring agreement incorporates this definition and defines "personal injury" to include coverage for claims alleging civil rights violations and assault and battery.[4]

[2] CIRMA told us they insure 85% of the municipal market in Connecticut. The larger cities tend to be "self-insured," though very likely they have excess insurance with private insurers to cover larger claims against them. We have not explored this area.

[3] This language is from CIRMA's "specimen policy language" it provided the Subcommittee on December 15, 2020, page 11. The yellow highlighting is ours.

[4] CIRMA's policy, pp. 56-62; the expanded personal injury definition is on page 62.

While CIRMA's insurance policy expands the scope of actions and claims that would be covered under "Law Enforcement Liability," individual police officers must still be acting within "the scope of their employment" to be covered under the municipality's liability policy. However, Connecticut law (and essentially that of every other state) generally requires liability insurers to defend *all* claims in a lawsuit if even one allegation or cause of action is potentially covered under the insurance policy, unless and until a final determination is reached that an individual officer's actions were so egregious as to be considered intentionally malicious.[5] Since most lawsuits would very likely allege some violations that are covered, we believe that as a practical matter this potential coverage gap would not result in municipalities and police officers also named in the complaint losing an insurer-provided defense.[6] As we briefly discuss below, any personal liability insurance an officer obtains would likely similarly exclude such actions from coverage under that policy.

Questions (i) and (ii) reference police officers obtaining their own professional liability insurance to cover them for civil liability associated with their work. Based on our research, there is at best a limited market for individual liability insurance for police officers.[7] At least one provider of liability insurance for law enforcement personnel, the National Rifle Association, appears to no longer sponsor this product. The Subcommittee has asked individuals and organizations who have brought this issue up about specific policies and insurers and no relevant evidence has been forthcoming.[8] Further, we believe it is likely that obtaining such insurance would provide minimal value to the individual officer for the following reasons:

(1) As discussed above, municipal liability insurance policies would generally cover individual police officers, as well as the municipality in civil claims;
(2) An individual policy would likely include the same limitations or exclusions that exist in municipal policies;[9] and

[5] This means that the insurer would not have to pay the damages awarded by a jury for intentionally malicious conduct.
[6] CIRMA's Law Enforcement Liability policy covers claims alleging civil rights violations, along with assault and battery. We do not know if police officers or municipalities have ever lost insurance coverage due to the allegations in a lawsuit—anecdotal information suggests they have not.
[7] CIRMA told us they were unfamiliar with any such products in Connecticut.
[8] There was some discussion of officers obtaining coverage from PORAC, which is a legal defense fund available to police officers if their departments are members (https://porac.org). As an employee benefit plan, PORAC is largely governed by federal law—the Employee Retirement Income Security Act. PORAC provides a legal defense for civil, criminal, and administrative proceedings against a police officer acting within the "scope of his or her employment," but It does *not* apply when the department (or municipality) or its insurer is defending the police officer. How this benefit would be triggered in civil lawsuits is unclear, at least to us. If the reason an insurer/municipality is not defending the officer in these situations is because the officer's actions were sufficiently egregious to be considered "outside the scope of their employment," that similar requirement would presumably also exclude a defense from PORAC. We have no information on how many police officers in Connecticut have this benefit, how it has been utilized, and whether and how often it has provided a defense that officers otherwise would not have. For these reasons, PORAC's legal defense benefit does not affect our conclusions regarding the limited utility and availability of individual liability insurance for police officers.
[9] Liability Insurance is generally reluctant to provide coverage for "intentional acts," defined loosely as behaviors that are under a policyholder's control. The reason is moral hazard: insured policyholders cannot be granted carte blanche to undertake risky or tortious conduct, knowing that their insurer will pay for any liability that results.

(3) The policy limits (amount of coverage) of a municipal policy would be significantly more than what individual officers could obtain on their own.

Similarly, it is unlikely that most homeowners and renter's insurance would cover police officers for claims arising while on duty. These policies typically exclude liability arising from "professional services" and similar work-related activities. While the Subcommittee has heard anecdotally of police officers purchasing endorsements to their homeowner's policy that would provide this coverage, it has not been provided any examples. We are also skeptical that such insurance would provide any more coverage than already included within municipal liability policies, and would likely include similar exclusions, as we described above.

To summarize, standard municipal liability policies already cover claims against individual police officers along with the municipality. This is not a unique feature, as employees are typically included as "insureds" in any commercial liability insurance policy. While there are specific exclusions within this coverage, as there are for any liability policy, these exclusions have been narrowed for purposes of law enforcement liability, at least for the CIRMA policy form we have been provided. There appears to be at best a very limited market for individual liability insurance covering law enforcement personnel, and we have seen no evidence that these policies would provide additional coverage above that already provided municipalities.

The impact that Section 41 of the Act . . . will have on the ability of a police officer or municipality to obtain PL Insurance [question (iii)].

This is the most difficult of the three questions to respond to, as the lack of actual data renders any conclusion necessarily tentative. Our bottom line, however, is that we have seen no evidence that would lead us to believe that Section 41 will have significant impact on the market for municipal Professional Liability insurance.

Police Liability Claims

The cost of liability insurance generally tracks how insurers perceive and evaluate the risks of a claim—the potential number of claims, the defenses available, and the costs of defending policyholders and paying for settlements or adverse verdicts.[10] Assessing these complexities is what actuaries do, and is a vital part of the underwriting process.

[10] Also relevant are how municipalities and individual police officers perceive and respond to these changes (e.g., additional training or changes in use of force protocols), how plaintiffs'' attorney evaluate laws, and ultimately determinations by courts and juries.

We believe the CBA's draft analysis of Section 41[11] is the most persuasive of the outside presentations to the Task Force on Section 41's effects.[12] The CBA notes that Section 41 does not eliminate qualified immunity for municipalities and police officers, but rather reorients Connecticut law to resemble existing federal law in these areas. Municipalities and individual police officers have always been subject to lawsuits under federal as well as state law, and Section 41 should not significantly expand existing liability in this area.

To assess whether Section 41 will raise insurance premiums for municipalities, we would ideally seek to estimate quantitatively whether it will increase the cost of defense and the total volume or the success rate of claims against police departments. We lack the data to do this. Nevertheless, we believe that the law does not significantly expand liability. The law does create a new cause of action in state court, mirroring almost exactly the existing federal liability structure; but it does not expand liability beyond what is already illegal under current law. It is possible that state juries might be more willing to find officers or municipalities liable than federal juries are, but we have not seen any reason to believe that would occur, and short of that, there is little reason to think that Section 41 will increase either the number or the size of payouts by defendants or their insurers. Hence, it should have little or no effect on premiums.

Section 41 does eliminate the interlocutory appeal in state court actions, meaning that defendants cannot appeal a decision (e.g., denial of a summary judgment motion) until after a verdict has been reached. In theory, the elimination of the interlocutory appeals is disadvantageous to defendants, because they are obliged to go through the entire process of a trial before they can seek to correct a "false negative" (erroneous denial of their motion to dismiss). In practice, however, the effects of eliminating interlocutory appeals are likely to be small, for two reasons. First, such appealable false negatives are quite rare, according to the best empirical evidence available.[13] And second, interlocutory appeals do not seem to play a major role in limiting defendant exposure: The Schwartz study found that only 12% of those appeals led to a reversal in whole (which would be necessary to avoid a jury trial).[14]

Overall Municipal Liability Coverage

Law enforcement liability coverage is only one component of a package of liability coverages that are included in a municipal insurance policy. For example, such policies also include, among others, property

[11] The CBA's Policing Task Force met virtually with the Subcommittee on October 20, 2020 and provided several draft recommendations (subject to later approval by the CBA) on the impact Section 41 may have on litigation in this area. The Connecticut Conference of Municipalities' November 6, 2020 memo to the Subcommittee believes changes in Section 41 would expand claims and litigation under state law, though it does not provide information supporting its conclusion.

[12] We have not independently evaluated or conducted our own examination on whether and how Section 41 would measurably alter the litigation climate for claims and lawsuits against municipalities and individual police officers. This would be a much larger project and one requiring both additional time and resources.

[13] A study of 1,183 police misconduct cases filed in five federal districts around the country revealed that just seven (0.6%) were dismissed at the motion to dismiss stage and just thirty-one (2.6%) were dismissed at summary judgment on qualified immunity grounds. So the basis for interlocutory appeals is quite limited. Joanna C. Schwartz *How Qualified Immunity Fails*, 127 YALE L.J. 2 (2017).

[14] Schwartz, *Id.* at 40. The CBA's Policing Task Force draft recommendation on this issue states "There should be consideration given" to whether interlocutory appeals in "a limited set of circumstances" should be allowed.

and auto insurance (at least for CIRMA). Even if Section 41 were to increase liability exposure for municipalities, and accordingly raise the cost of law enforcement liability insurance, the overall effect on the pricing and affordability of liability insurance for municipalities depends on the share of law enforcement liability premiums in the total premium paid for liability coverage.[15] The Subcommittee has asked for this information, but has not yet received it. Based on our own experience and anecdotal evidence, we believe that law enforcement liability premiums likely are a small percentage of the overall premium for municipal liability insurance. If true, then increases in the law enforcement liability component of a comprehensive liability policy should have a negligible overall impact on the cost of liability insurance for municipalities. Of course, this tentative conclusion could easily be tested and re-evaluated if the Subcommittee were able to obtain information over a multi-year period on the premiums collected and number and cost of claims overall under municipal liability insurance programs, and this same information for the subset of law enforcement liability insurance coverage.

Absence of Industry Response to Section 41

When asked, CIRMA stated at its October 27 presentation that they had not conducted an analysis or forecast of Section 41 to evaluate whether it would generate significant new liability or increase the number and cost of claims against municipalities and police officers, nor did they plan to do so. As part of the underwriting process, insurers routinely examine changes in liability laws to evaluate what their future effects may be. This allows them to set appropriate premiums and to design or redesign insurance policy forms; insurers' solvency and profitability depend in part on these evaluations. This is an ongoing process as new information, including claims, become available after the laws take effect. That CIRMA has not evaluated Section 41 to determine its potential effects on municipal liability suggests to us that CIRMA believes Section 41 will not appreciably effect the liability of municipalities for law enforcement activities. CIRMA has also told the Subcommittee it is not modifying the law enforcement liability coverage form (terms and conditions of coverage) for the upcoming 2021-2022 policy year.

Accordingly, we do not believe, based on the limited evidence available, that Section 41 will measurably increase liability premiums for municipalities. Of course, that conclusion is subject to revision if additional information is forthcoming.

Conclusion:

Municipal liability insurance already includes individual police officers as insureds under the policy and defends them along with the municipality so long as the police officer is acting within the scope of their duties. We have not seen evidence that individual officers have actually incurred personal liability not otherwise covered by the municipality's insurance policy. While it is possible that police officers may be able to obtain their own insurance covering their actions, the market is very limited and the policies

[15] For example, if law enforcement liability accounts for 20% of the total costs of a municipal liability policy, and Section 41 increases the cost of law enforcement liability by 10%—which seems unlikely—the *overall* cost of municipal liability would go up by 20%x10% = 2%.

available would almost certainly come with similar exclusions and conditions to those in the municipal liability policy, providing little additional coverage as a result.

We agree with the Task Force that to date no evidence has been provided demonstrating that Section 41 would significantly alter existing liability laws and defenses or substantially increase the cost of municipal liability insurance.

V. Listening Sessions

With the passing of Public Act 20-1 a remaining charge of the Task Force is to form recommendations on any other police transparency and accountability issue deemed appropriate. In order to do this the Public Awareness Subcommittee created the opportunity to hold community listening sessions. The first round of listening sessions included eight listening sessions held in the month of September 2020. These sessions were held every Thursday with a 10-12 pm session, and a 6-8 pm session.

Upon reviewing the feedback from the first round of listening sessions, a second round was created in order to serve the young adult population of Connecticut. These sessions were created with the intent that community members ranging from the ages of 18-25 would come and share their own testimony. These listening sessions occurred during the month of November 2020 and featured three supporting CT universities as co-sponsors, including, the University of New Haven, Central Connecticut State University, and UCONN. Each university hosted their listening session, putting forth students as the moderating voice of the session.

Members of the Task Force were present at every session in order to weigh in and listen to community members give testimony about their encounters with the police. These testimonies were recorded and then turned into major themes reports by a supporting group to the Task Force, Everyday Democracy. Everyday Democracy also conducted a survey for those who attended the listening sessions to further study these issues in the community. From these findings, recommendations were formed for the Task Force and Subcommittees to consider. The below appendices provided at the survey results and major themes reports for both the September and November listening sessions hosted by the Task Force and co-sponsoring groups **(See Appendix B).**

VI. Next Steps

In the coming months, the PTATF will continue to work towards achieving its statutory mandate of providing recommendations regarding the remaining items it is charged to examine. This work will culminate in the issuance of its final report, either on or before December 31, 2021.

Appendix A: June 2020 Preliminary Report

State of Connecticut PA 19-90

Police Accountability and Transparency Task Force

Draft preliminary report on Priorities/Recommendations

June 30, 2020 *(updated)*

Introduction

Public Act No. 19-90 established a task force to study police transparency and accountability. The task force is comprised of 11 voting members and 3 non-voting members, with two of the members serving as co-chairs. To date one chair has been appointed. Per Pa 19-90, the task force shall examine:

(1) Police officer interactions with individuals who are individuals with a mental, intellectual or physical disability;

(2) the feasibility of police officers who conduct traffic stops issuing a receipt to each individual being stopped that includes the reason for the stop and records the demographic information of the person being stopped; and

(3) any other police officer and transparency and accountability issue the task force deems appropriate

The task force shall issue two reports, a preliminary and final report, the latter of which shall be by December 31, 2020. This document shall serve as the task force's preliminary report.

Preliminary Priorities and Recommendations

The most recent meeting of the task force occurred on June 8, 2020. In the wake of the killing of George Floyd by a white Minneapolis police officer and the ensuing social unrest across the state, nation and world, the task force was asked by the Governor, the Attorney General and the Judiciary Committee chairs to act urgently to address the multitude of issues brought to light in this and other recent interactions between police and members of the black community. The following recommendations stem from the conversations held at the June 8 meeting.

Universally agreed by all members is the utilization of President Obama's 21st Century Policing Task Force Final Report[16] and Implementation Guide[17] to form a basis from which the task force can systematically address police accountability and transparency in Connecticut. This document is not unfamiliar to Connecticut, as it was also used as a guide for the February 2018 Final Report of the CT Police Training Task Force, whose recommendations and subsequent action were also discussed in the June 8th meeting.

[16] https://cops.usdoj.gov/pdf/taskforce/taskforce_finalreport.pdf

[17] https://noblenational.org/wp-content/uploads/2017/02/President-Barack-Obama-Task-Force-on-21st-Century-Policing-Implementation-Guide.pdf

The 21st Century Policing report lays out 6 pillars that form the foundation for change, from which 59 recommendations and 92 action items are systematically laid out as mechanisms for this change. The pillars are:

1. Building Trust and Legitimacy

2. Policy and Oversight

3. Technology and Social Media

4. Community Policing and Crime Reduction

5. Training and Education

6. Officer Wellness and Safety

Through input from each task force member, and utilizing the six pillars as reference points, the task force makes the following **22 preliminary priorities and recommendations** *(highlighted and numbered below):*

Pillar One: Building Trust and Legitimacy

Role of policing in past injustices • Culture of transparency and accountability • Procedural justice: internal legitimacy • Positive nonenforcement activities • Research crime-fighting strategies that undermine or build public trust • Community surveys • Workforce diversity • Decouple federal immigration enforcement from local policing

1. **Change the culture of policing – adopt a guardian versus warrior culture of policing.** (Rec. 1.1)
    a. Adopt procedural justice framework as for internal and external policies and practices to guide police interactions with the citizens they serve. (Rec. 1.4)
    b. Incorporate restorative justice practices into policing using community-based organizations.
2. **Publicly address the role of policing in past injustices.** (Rec. 1.2)
    a. Ensure police training includes accurate depiction on the history of policing.
3. **Make all departmental policies and procedures available online** (Rec. 1.3)
4. **Task Force should conduct regional listening sessions, coupled with community surveys, by the end of the summer to seek public input in the final report.**
    a. Require agencies to periodically track the level of trust in police by their communities just as they measure changes in crime. Annual community surveys, ideally standardized across jurisdictions and with accepted sampling protocols, can measure how policing in that community affects public trust. (Rec. 1.7)
5. **Examine police officers' interactions with individuals with a mental, intellectual, or physical disability.**
    a. Ensure resources are available for diversionary programs
6. **Ensure each officer commits to 500 hours of community engagement activities within Connecticut's major urban centers as prior to receiving initial officer certification.**
    a. Explore residency requirement for police officers

7. **Duty to intervene**
    a. Make it mandatory that officers report misconduct and intervene when they see wrongdoing, with criminal penalties if they fail to do so.
    b. All officers complete a mandatory Peer Intervention Program at the academy and receive annual refresher Peer Intervention Training.
        i. A successful peer intervention program has been EPIC. It stands for Ethical Policing Is Courageous. The core concepts of the program were developed by a Holocaust survivor. After Hurricane Katrina, New Orleans Police Department in collaboration with other community partners developed a comprehensive and mandatory peer intervention curriculum for all their officers to promote a culture of high quality and ethical policing.
        ii. A Peer Intervention program not only puts the onus and oversight on the officers, but it continues drives home the message that they have a duty to act when a fellow police officer engages in misconduct. The training reinforces the officer's role as active bystanders and diminishes the power of the police culture that emphasizes the so called "blue wall of silence".

<u>Pillar Two: Policy & Oversight</u>

• Community input and involvement • Use of force • Nonpunitive peer review of critical incidents • Scientifically supported identification procedures • Demographic data on all detentions • Mass demonstration policies • Local civilian oversight • No quotas for tickets for revenue • Consent and informed search and seizure • Officer identification and reason for stops • Prohibit profiling and discrimination, in particular as it relates to LGBT and gender nonconforming populations • Encourage shared services between jurisdictions • National Register of Decertified Officers

8. **Develop an independent external investigating authority**- This authority should fulfill the following goals:
    a. Public must trust that deadly use of force incidents and incidents involving excessive use of force are investigated with credibility and integrity.
    b. Mechanism for state to conduct a patterns and practice investigation in response to civil rights violations, including police misconduct.
    c. Law enforcement agencies should establish a Serious Incident Review Board comprising sworn staff and community members to review cases involving officer-involved shootings and other serious incidents that have the potential to damage community trust or confidence in the agency. The purpose of this board should be to identify any administrative, supervisory, training, tactical, or policy issues that need to be addressed. (Rec. 2.2.6)
    d. Law enforcement agencies should implement nonpunitive peer review of critical incidents separate from criminal and administrative investigations. (Rec. 2.3)
9. **Prohibit chokeholds, and neck restraints**
10. **Reform Internal Affairs**
    a. Ensure that the internal affairs process is transparent and accountable
    b. Community involvement in internal affairs investigations.
11. **Reform citizen complaint process**

a. Require all law enforcement agencies operating in the State of Connecticut to accept electronic complaints and clearly lay out complaint procedure on their website.
b. Create a statewide public database of police complaints by department and officer, listed by status (filed, pending, outcome)

12. **Require officers to identify themselves by their full name, rank, and command (as applicable) and provide that information in writing to individuals they have stopped. In addition, policies should require officers to state the reason for the stop and the reason for the search if one is conducted. (Rec. 2.11)**
13. **Law enforcement agencies should report and make available to the public census data regarding the composition of their departments including race, gender, age, and other relevant demographic data. (Rec. 2.5)**
14. **Identify state labor issues that prevent police administrators from easily removing unfit officers**
    a. Explore fair police union contracts
    b. Explore with POSTC the offenses and procedure for decertifying officers
15. **Amend Alvin Penn Law to include racial/ethnic/gender/religious data collection of Pedestrian stops (Trespass, Loitering, Disorderly Conduct), Breach of Peace, and Interfering with Police Officer.**

Pillar Three: Technology & Social Media

• New technology standards for compatibility and interoperability • Address human rights and privacy concerns • Technology designed considering local needs and people with special needs • Body-worn cameras and other emerging technologies • Public records laws—update to keep up with emerging technologies • Transparency and accessibility for the community through technology • Develop new less than lethal technology

16. **Evaluate the effectiveness of other less than lethal force tools** (Rec. 3.6)
17. **Mandate body-worn cameras in all departments**
    a. Law enforcement agencies should review and consider the Bureau of Justice Assistance's (BJA) Body Worn Camera Toolkit to assist in implementing BWCs. (Rec. 3.3.3)

Pillar Four: Community Policing & Crime Reduction

Community engagement in managing public safety • Infuse community policing throughout law enforcement organizations • Use multidisciplinary teams • Protect the dignity of all • Neighborhood problem solving • Reduce aggressive law enforcement that stigmatizes youth • Address the school-to-prison pipeline • Youth engagement

18. **End broken windows policing**
    a. Stops for low-level administrative and equipment offenses should be secondary (i.e. police can no longer stop a car for these reasons)
    b. Law enforcement officers should be required to seek consent before a search and explain that a person has the right to refuse consent when there is no warrant or probable cause. Furthermore, officers should ideally obtain written acknowledgement that they have sought consent to a search in these circumstances. (Rec. 2.10)

c. Discontinuing police officers from chasing and pursuing "stolen vehicles," unless, vehicle is classified as carjacking with a weapon. Police officers' scope of duties should not include "Vehicle Recovery Police" for insurance agencies.
d. Amending CT Statues Public Drinking, Loitering and Disorderly Conduct that require and allow officers to "self-initiate" enforcement that has led and continues to be used as racial and bias policing tactic that results in disproportional police contact and enforcement.
e. Redefine "Police Scope of Duties." Get police out of performing Non-Policing Matters. Discontinuing duties such as responding to- Homeless Calls, Medical Calls, MVA (no-injuries) Calls, Civil Investigations, Frauds (Credit Card /Banks/Checks), Counterfeit Bills, School Resource Officers, Building Code Enforcement, Loitering, Public Drinking, Enforcing Legal Marijuana Card Verification and Receptacle Storage.

19. Mandate community oversight of all police departments

a. Some form of civilian oversight of law enforcement is important in order to strengthen trust with the community. Every community should define the appropriate form and structure of civilian oversight to meet the needs of that community. (Rec. 2.8)

Pillar Five: Training & Education

High quality training and training innovation hubs • Engage community members in trainings • Leadership training for all officers • National postgraduate program of policing for senior executives • Incorporate the following in basic recruit and in-service trainings: o Policing in a democratic society o Implicit bias and cultural responsiveness o Social interaction skills and tactical skills o Disease of addiction o Crisis intervention teams (mental health) o Reinforce policies on sexual misconduct and sexual harassment o How to work with LGBT and gender nonconforming populations • Higher education for law enforcement officers • Use of technology to improve access to and quality of training • Improve field training officer programs

20. Review state's accreditation program and explore ways to support both state or national accreditation for all police departments in CT

Pillar Six: Officer Wellness & Safety

Multifaceted officer safety and wellness initiative • Promote officer wellness and safety at every level • Scientifically supported shift lengths • Tactical first aid kit and training • Anti-ballistic vests for every officer • Collect information on injuries and near misses as well as officer deaths • Require officers to wear seat belts and bulletproof vests • Pass peer review error management legislation • Smart car technology to reduce accidents

21. Ensure early intervention through assistance, correction action and discipline
22. Implement psychological evaluation of officers into the recertification process

Next Steps: Additional priorities for consideration

- Review recommendations from:
  - Justice Reinvestment Framework for Corrections built out to incorporate the entire CJ system (including policing): https://maketheroadny.org/pix_reports/Justice%20Reinvestment%20Final%20Report.pdf
  - Equal Justice Initiative's 2020 Report on Reforming Policing in America (Bryan Stevenson was a member of 21st Century Policing Task Force) https://eji.org/wp-content/uploads/2020/06/Reforming-Policing-in-America-2020.pdf
  - Campaign Zero https://www.joincampaignzero.org/
  - 1999 POLICE-INVOLVED SHOOTING INVESTIGATIONS: THE GOVERNOR'S LAW ENFORCEMENT COUNCIL Report
- How to organize work:
  - Subcommittees
    - Structure
    - Adding Community Members
    - Legislative, Administrative, and general recommendations
  - Community listening sessions
  - Final Report

Appendix B: Listening Session Reports

State of Connecticut PA 19-90

Police Accountability and Transparency Task Force

September Listening Session Summaries: Survey Results/Major Themes Report

September 2020

Survey Summary Results:

Everyday Democracy
Ideas & Tools for Community Change

Police Transparency and Accountability Task Force
Listening Sessions Survey Summary Results
October 20, 2020

Introduction

The Connecticut Police Transparency and Accountability Task Force held eight Listening Sessions in September 2020. There were two Listening Sessions every Thursday. After the passing of Public Act 20-1, one of the remaining charges of the Task Force is the ability of Task Force members to form recommendations on "any other police transparency and accountability issue that the Task Force deems appropriate." The Task Force hosted Listening Sessions with the goal of gathering public input around what topics the Task Force could focus on to work towards police transparency and accountability. Each participant was given three minutes to share their testimonies. Initially, in-person Listening Sessions were planned for specific locations such as New Haven, Bridgeport, Hartford, and New London. However, due to COVID-19 and social distancing measures, all of the Listening Sessions were conducted virtually on the Zoom platform. This report summarizes results from surveys sent to participants who testified during the Listening Sessions.

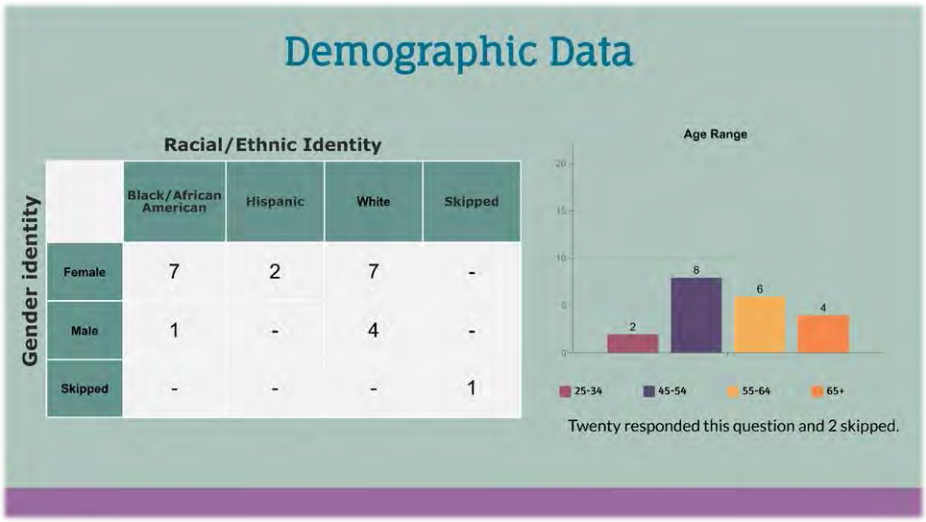
Method

The Evaluation, Research and Learning (ERL) team at Everyday Democracy designed the survey using Survey Monkey. The Institute of Municipal and Regional Policy at Central Connecticut State University emailed the survey link to participants after each Listening Session. ERL analyzed and reported on the survey results.

Respondent Characteristics

Of the 56 participants who testified in the Listening Sessions, 22 participants responded to the survey, which is a 39% response rate. The demographic data pictured in the infographic below

shows that most respondents identified as white, there were more females than males represented, and most people reported being between the ages of 45-54.



Eleven respondents indicated that they were not affiliated with any organization. Nine respondents represented advocacy organizations, one represented the business sector, and one represented a service provider.

Respondents resided in a variety of counties in Connecticut. The results in the table below show the counties that were represented. Three respondents skipped this item. For a breakdown of the cities and towns, please see the table in the **Appendix**.

Counties	Hartford	New Haven	Fairfield	Windham
Number of Respondents	12	4	2	1

Listening Session Results

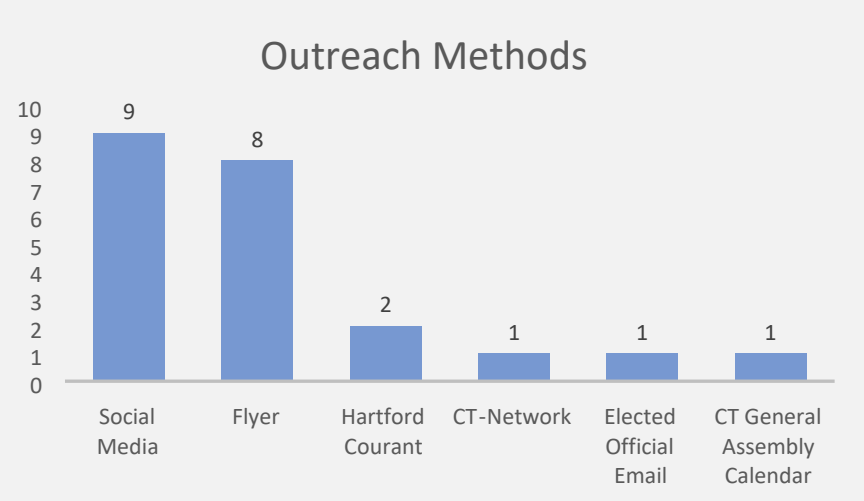
Most respondents felt comfortable and heard. Respondents rated their experience in the Listening session in four areas using an agree/disagree Likert scale ranging from 'strongly disagree' to 'strongly agree.' They also had a 'not sure' option.

The percentages for agreement/strong agreement were combined as were the percentages of disagreement/strong disagreement to give an aggregate total percent for each item. The results are shown in the table below.

Survey Items	Percent disagree/strongly disagree	Percent agree/strongly agree	Percent Not sure
1. I felt comfortable sharing in the Listening Session.	9%	91%	0%
2. I felt that what I shared was heard.*	9%	82%	5%
3. I felt that Task Force members were listening to suggestions for improving police transparency and accountability.	9%	82%	9%
4. I feel that suggestions for improving police transparency and accountability will be used to make improvements.	5%	59%	36%

**One respondent skipped this item.*

Best outreach approach was social media. Respondents were asked to indicate how they heard about the Listening Sessions. The chart below shows the different ways they learned about it and the method that reached the most people.



Advocacy strong motivator for testifying. Respondents were asked to provide a brief statement for what motivated them to participate in the Listening Session. Nine respondents indicated advocating for individuals or communities who are disproportionately affected by the police. One respondent commented that police transparency was a "*life or death*" matter for their community.

Interactions with panelists most helpful. This result was reported by a majority of respondents. Additional helpful aspects of the Listening Sessions people identified were: being able to share personal views and hearing other's points of view. Some comments were as follows:

"Informal Q & A following some testimonies, receptivity of Task Force members."

"The taskforce members reflecting back what they heard."

"*Chairperson's style made all testifying very comfortable."*

"Opportunity to share my story and be heard."

"Listening to opinions of others from different areas and backgrounds helps to get a better look at how people in the state feel about policing and what they think needs to change."

No follow up plan least helpful. This result was the most pronounced for respondents in the Listening Sessions. A few respondents also commented about the time allotments and the lack of engagement from law enforcement as not helpful. Some comments included:

"Not knowing what will happen to our recommendations."

"Disproportionate use of time. Early testimony went on for long periods and those at the end of the session got 3 min with no dialogue or questions exploring subject matter."

"3 minutes was much too short for me because there was decades of police injustice…in telling the story it was re-traumatizing and became emotionally overwhelming."

"The chiefs of police did not speak during the session, it would have been beneficial if recognized they heard the speaker."

Conclusion

According to the survey data, the Listening Sessions were a meaningful way for the public to engage and share recommendations with the Task Force. This was evidenced by responses and comments of respondents about the experience. For example, some people referenced the positive interaction between them and the Task Force members and panelists. In particular, being acknowledged by the chairperson who also showed interest through follow up questions, helped them feel heard.

While the Listening Sessions were, for the most part, a positive experience according to survey respondents, some areas for improvement did emerge. In moving forward with similar public engagement events, some areas to consider include:

- Providing a clearer follow up plan that lays out how participants' recommendations will be used.
- Examining ways to enhance engagement between all groups at public events, especially between participants and law enforcement.
- Assessing outreach practices to ensure that there is representation from communities of primary interest for future events. In this case, the data revealed that few participants in the Listening Sessions who completed the survey, resided in the cities/towns that the Task Force was seeking to engage, initially.

Overall, these survey results provide validation that the Listening Sessions proved to be a productive first step for engaging the public to get their input and recommendations on improving police transparency and accountability in Connecticut. An important takeaway is that among survey respondents, there is interest in being involved with future activities of the Task Force.

Appendix

City/Town of Respondents

City or Town	Total Number of Respondents
Hartford	3
West Haven	2
Bloomfield	2
Newington	2
Shelton	1
Brookfield	1
Simsbury	1
Manchester	1
Willimantic	1
Cheshire	1
Milford	1
Wethersfield	1
West Hartford	1
Avon	1
	3 Skipped

Major Themes Report:

Major Themes Report

September 2020 Listening Sessions

This report is prepared for the Connecticut Police Transparency and Accountability Task Force

by the Evaluation, Research, and Learning Team

October 26, 2020

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Introduction

The Connecticut Police Transparency and Accountability Task Force held eight Listening Sessions in September 2020. There were two Listening Sessions every Thursday. After the passing of Public Act 20-1, one of the remaining charges of the Task Force is the ability of Task Force members to form recommendations on "any other police transparency and accountability issue that the Task Force deems appropriate." The Task Force hosted Listening Sessions with the goal of gathering public input around what topics the Task Force could focus on to work towards police transparency and accountability. Fifty-six participants testified in total. Each participant was given three minutes to share their testimonies. Initially, in-person Listening Sessions were planned for specific locations such as New Haven, Bridgeport, Hartford, and New London. However, due to COVID-19 and social distancing measures, all the Listening Sessions were conducted virtually on the Zoom platform.

This report summarizes the major themes from the Listening Sessions in response to four questions:

1. What was the participant's experience with the police?
2. What factors, institutions, and policies affected participant's experience with the police?
3. What were the impacts of the police interaction?
4. What recommendations did participants suggest for the Task Force?

Method

Transcripts for the eight Listening Sessions were provided by the Institute for Municipal and Regional Policy at Central Connecticut State University. There were also written testimonies, but they were not incorporated within the analysis and scope of this report. Everyday

Democracy provided staff support to review, code, analyze, and write the major themes report. Two staff initially supported the primary evaluator in coding the first two Listening Sessions and identifying what questions to ask to organize the results. Two additional staff provided additional

review, coding support, and the discussion of emerging themes. One of the two staff reviewed and coded six Listening Sessions and provided an additional discussion on emerging themes. The primary evaluator wrote the report with the support of the Evaluation, Research and Learning Team.

Key Findings for Major Themes

1. What was the participant's experience with the police?

There were more participants who shared secondhand experiences with the police than there were participants who shared firsthand accounts. Both secondhand and firsthand interactions with the police elicited many feelings that participants expressed during the Listening Sessions, which affected their views towards the police.

Secondhand Experience: National and local incidents of police killings and brutality were mentioned most frequently by participants. These incidents seemed to be on participants' minds because they referenced them multiple times in their sharing. For some participants, secondhand incidents evoked the question, "What if that happened to me, my family, or my community?" The following were some of their comments:

"The murder of George Floyd shone a spotlight on this racial disease that has penetrated the very entity that has been sworn to protect and serve."

"My primary concern was not being killed on my front steps like Andrew Finch was."

"But I guess when I read about that boy in Utah, they got shot. It just, it's always in the back of parents like me."

"Two of which are Mubarak Soulemane, who was 19 years old and Anthony Vega, who was 18 years old. They're both are now deceased young people who didn't even live to see their twenties because of…reckless behavior by, state troopers and local Wethersfield police officers."

"Two separate incidents within a matter of like 30 minutes, where two people in my community were, disrespected and violated by the police."

"*I live two blocks away from when Devon Eaton shot at Stephanie [Washington]."*

Another way that secondhand experiences with police were shared was through advocacy. Advocates expressed what individuals in their communities experienced from encounters with the police. See below for some of their comments:

"People with disabilities have experienced…police officers question[ing] if they really have a disability or not. Sometimes they're being denied interpreters, just flat out."

"Many of the young people that we serve and that we see being arrested in school are our young people with disabilities and the majority of these young people that we represent are often also youth color."

Firsthand Experience: Although participants shared a few positive firsthand interactions with the police, a majority of what was shared were negative experiences with the police. One positive experience that a participant described was when a trained police officer helped her safely de-escalate a situation involving her daughter, who is autistic. The negative interactions that participants described include "aggressive" questioning, being stereotyped, racial profiling, abuse of authority, physical altercations, and loss of life. See below for some of their comments:

> *"So he [law enforcement] ignores me and asks my son again, "What's your name," in a very aggressive manner…I was so shaken that he would even approach my son in such an aggressive manner."*
>
> *"And he's also a type one diabetic, and he has syringes with him at all times. And, he has incidents with police. They always assume that he was a drug addict and sorta treated him that way."*
>
> *"And when I asked the officer why he was stopping me, his response was you don't belong here. Although furious, upset, and taken aback, I was more concerned…for my grandson, not knowing what to expect from the officer who had stopped me with his hand on his holster and over his gun."*
>
> *"They falsified reports, they falsified warrants, they lied by omission."*
>
> *"Instead of calling me to notify me of the incident or what happened instead, what he [law enforcement] did is interrogated my son for over 20 minutes and then arrested him. He arrested my seven-year-old son in front of his mother."*
>
> *"I was assaulted and dragged out of my car by two New Haven police officers due to a traffic stop."*
>
> "*My son was calm, never a threat, but not complying with direction to leave the shower when he was first excessively pepper-sprayed, and then stomped in the face by exlieutenant Carlos Padro. My beautiful son was left unconscious and dying, if not already dead."*

Feelings towards the police: While a few participants expressed respect, appreciation, and support for law enforcement including participants who shared a negative police interaction, the secondhand and firsthand interactions with police resulted in more unfavorable feelings towards

the police. These feelings included fears, distrust, disrespect, feeling criminalized and the inability to secure accountability or justice. These feelings were primarily expressed by individuals and advocates for communities of color, disabilities, and mental health. The following is a sample of what participants shared:

"Why should I fear if my 21 and 23-year-old son walking in public, just because of the color of your skin… I mean, how does a mother feel when she has to say these words?"

"We know currently the police…respond when wellness checks are needed within our communities. But how well can I be when someone with a loaded weapon on their hip who was authorized to use lethal force and kill me if they perceive me as a threat…."

"As parents, we have a lot of fear about the police and our fear is that the police do not have adequate training, or knowledge about autism. I know the police have a lot going on, but we're really fearful that our kids could be out in the community. A police officer an officer wouldn't know how to interact with them."

"How is an arresting officer to know that the person they are interacting with has a disability or in this case suffers from schizophrenia?"

"I have talked to countless incarcerated young people in our conversations, many expressed, a lack of trust in the system that displays abuse of authority."

"The second one is it really deals with the lack of trust between the police and law enforcement and the community... I looked at Monday's video that happened at Blue Hills Avenue. You know, there's a lack of trust. I talked to people in the community and our staff talked to people in the community. And we are hearing from residents that we don't even call the police anymore."

"*When you…politely ask a question, you're not given a response oftentimes…I get that officers have to do their jobs. We understand that…we have to have accountability, but there must be accountability and respect that's mutual.* "

"I don't feel every officer, belongs in our community. They have no respect for us. They don't want to understand us."

"There are decent people that live in our neighborhoods…We are not all criminals that live here."

"Despite well-meaning people at every turn, no one has the authority to interrogate Mr. Fuchs and his staff. No one has the authority to conduct an independent objective investigation into Abe's death."

Law Enforcement Perspectives: There were two self-identified law enforcement officers who are currently active on the force and testified. Three common themes they shared were concerns about officer safety, removing the "bad" police, and wanting to engage the community more. Concerns about officer safety pertained to the application of the Police Accountability Bill and legislation the Task Force is working on. They expressed that the legislation will potentially

restrict or change the job of police officers to the degree that it would decrease officer and public safety. See below for some of their comments:

"I feel that the legislation and some of the provisions that you'd want to make recommendations about are taking my ability not only to protect myself, let's leave that alone, but you're taking my ability away from protecting the children in my community."

"Something the task force and maybe our state legislators should be looking towards is how can we streamline and come up with a better process, not to hire the bad apples."

"I would like to see more of…community building and trust building… I want to be part of my community…And I will always stand on the side of the people who want to come together and rebuild the trust together and build a community together growing into mutual accountability and responsibility."

In addition, highlighting some of the examples that the two law enforcement officers shared for engaging the community could illuminate how community members and police diverge in their conceptualizations of community engagement. Different understandings of community engagement between police and community members are significant because they could result in negative and even fatal encounters with civilians. See below for their comments:

"I bring 600 presents to the housing projects at Christmas time, the FOP [Fraternal Order of Police] gives to me to distribute. These are kids that would never have a Christmas, very important. Burgers and dogs for summer picnics. We try to do all of these things."

"Most of the time I stopped cars to make contacts, to get to know the people that are there. If there is a violation, that's going to be evaluation. Most of the time I give verbal warning written warning, but I get to know the people."

2. What factors, institutions, and policies affected participant's experience with the police?

Participants identified additional factors, institutions, and policies that influenced their or their community's experience with the police. Race was the most notable factor that participants identified as well as economic inequalities across Connecticut towns and cities. Three institutions and factors that participants identified as having a significant effect on their experience with the police were law enforcement itself, schools, and mental health. Of the three, law enforcement was the most widely discussed institution. The Connecticut Police Accountability Bill that was passed in July 2020 was also discussed frequently by participants. The differing perspectives expressed reveal how participants viewed police accountability. *Factors: Race* Race was a salient factor in how participants described their interactions with the police. This included racial patterns of traffic and pedestrian stops, stereotyping, the disproportionate number of Black/African and Hispanic/Latinx individuals and youth who are impacted at "*every point of the justice system*," and the racism embedded in law enforcement as an institution. There were some

participants who self-identified as white, who acknowledged the privilege they have when engaging with police. See below for their comments:

"Have you seen what happens to black people when they question the police officer? They escalate."

"I really have to state that in the immigrant community…especially those of us from the Caribbean, there is a relationship with the police that begins fine when you just come. But once you move into…the American system…, then you find that that relationship changes and people get afraid and concerned…even walking on the streets becomes a problem."

"I am white, and my son is white. And with that skin color comes an unspoken privilege."

Factors: Economic Inequalities Participants also identified economic disparities that have accumulated over time across towns and cities that influence how law enforcement polices under-resourced areas. See below for their comments:

"A lot of the youth in the communities… would rather have Connecticut invest in a basketball court or provide their schools with resources that their wealthier peers have.

They'd like mentors and real opportunities to make legal money, not invest money in SWAT gear and other items. They never once said they need more police."

"There are obvious reasons that our community is in the shape that it is, it's generational, right? Because wherever there is poverty, you're going to have issues with crime…So, the whole system needs to change, and I think officers need to be educated when they come into our community that listen, people don't choose to live this way, and kind of educate them as to why conditions are the way they are, and not to treat everyone like criminals."

Institutions: Law Enforcement Participants expressed that police have too many jobs, especially when intervening during mental and/or behavioral health crises. Participants observed that police seemed to demonstrate a lack of knowledge and skills when interacting with individuals with disability, mental and behavioral health needs or a victim of sexual assault. This lack of knowledge and skills resulted in police misinterpreting the actions of the individual. Misinterpreting actions, therefore, unnecessarily escalated the situation resulting in unfortunate outcomes for the individual and police. The following is a sample of what participants shared:

"We have given police officers a job that is just not something that the vast majority of them have the skillset for, and that's not really their fault."

"No amount of training is going to prepare officers to do the job that is really designed for mental health clinicians."

"And often when a deaf or hard of hearing person wants to say something and is having difficulty understanding the police officer, it creates more issues. And often for deaf blind persons, they also require a lot of physical touch because they're not able to not only hear you, but they're also not able to see you."

"The symptoms of trauma look very much like the cues of deception, cues law enforcement are taught to look for in interviews and interrogations. And, so reading trauma responses incorrectly really harms a sexual assault victim."

Participants also identified an "authority bias" within law enforcement. Some examples that participants named were police investigating themselves when a police misconduct incident occurs, police not being held to the same standards as civilians, and the words and documentation from police being valued as more credible than a civilian's words. See below for one participant's comment:

"You cannot have the police department of the person accused of misconduct doing the internal affairs investigation. That makes absolutely no sense. Of course, there's going to be bias."

Lastly, participants noted that police interactions varied by town and city. A few participants shared about how they proactively reached out to their local police departments, as in the case with Mubarak Soulemane which is shown below, Soulemane was shot and killed by the state police, who did not know about his condition. In addition, participants of color also described being treated differently depending on what town or city they are in even if they lived there.

"*If there had been de-escalation at the scene of the shooting, there would be ample time to get some information…about Mubarak, particularly from the Norwalk police department."*

"We saw at the incident at the end of this school year, other towns' police departments came into our town to handle a matter. So, it doesn't matter what my connection and my relationship is with my town. I'm still impacted by other police departments."

Institutions: Schools Participants identified issues of increased police or "hardening" of schools as ineffective ways to improve the quality and safety of the learning environment. Participants noted that for Black/African American and Hispanic/Latinx youth, their first interactions with the police happen outside of schools. Increasing police presence and "hardening" schools exacerbated existing negative interactions with the police with new ones such as increased school arrests. See below for their comments:

"And we've seen in the research that even if an officer is placed inside of a school to build those relationships, just having that officer in the school makes it more likely that students, especially Black and Brown students will be arrested and have a negative interaction with that officer."

"So she wasn't expelled, her charges were reduced, but that's just an example of an instance where police presence in school with a student with a disability can lead to an unnecessary arrest or criminalization of our youth, particularly youth of color."

Institutions: Mental Health Participants shared that misinformation, severely underfunded community mental and behavioral health services, and policy contribute to negative or increased police interactions. One participant suggested that a "*comprehensive change*" needs to occur for how society and police respond to people experiencing mental and behavioral health distress. See below for some of their comments:

"We cannot figure out how to improve outcomes for people with mental health and substance abuse issues who come into contact with law enforcement without understanding that the services that are available are vastly under invested in underfunded."

"Fifty years of failed mental health policy placed law enforcement on the frontlines of mental health crisis response turning jails and prisons into the new asylums."

Participants also shared how the interaction between practices in these institutions and factors in participant's lives could result in more adverse police interactions. For example, one participant suggested that addressing and resourcing the mental health needs of youth could be a better alternative to school safety than increasing police presence. Similarly, if mental health services were more heavily invested in, police may not have to be the first responders to address a mental and behavioral health crisis. Another participant noted that people with mental health and substance abuse issues disproportionately come into contact with the police because of housing insecurity, which is related to race and economic inequalities.

Policy: Police Accountability Bill The policy that was most discussed during the Listening Sessions was the Police Accountability Bill. There were more participants who expressed support of the bill, citing that passing the bill and ending qualified immunity was a step in the right direction towards greater police accountability. In addition, the bill represented that the state heard and acted upon community concerns about the lack of police accountability. At the same time, there were participants who expressed that they did not support the bill. They voiced concerns that the bill would result in police leaving the force and increased lawsuits against police officers. The discussion generated about the Police Accountability Bill suggested there could be misinformation about the application of the bill in the public and further discussion may be beneficial among community members, law enforcement, and legislators.

"The biggest thing we want to say, we want to definitely support the police accountability bill, because we would like to know that our concerns are considered."

"If officers want to develop relationships with communities, we have to start by increasing trust by ensuring that police are held to the same standard as other community members. This is why I am in full support of ending qualified immunity."

"First under the police accountability act…there will be an overwhelming number of frivolous lawsuits will, which will indeed inundate our court systems."

"Finally, qualified immunity…Threats of mass resignation by officers, frankly, is a time warned strategy and overblown. Mass findings of lawsuits by citizens and in a frivolous manner is [not] born out historically…"

3. What were the impacts of the police interaction?

Loss of Life: Three participants shared that they had lost a family member or represented a family who lost a family member due to police shooting or negligence in investigating. This does not include the many names of victims both nationally and locally that were mentioned by participants.

Racial Trauma: The feelings towards police expressed by participants demonstrated that Black/African Americans and Hispanic/Latinx communities experienced racial trauma after repeated negative interactions with law enforcement. See below for their comments:

"I am black, my husband is black, and I am also a mother to a black son. I've been told too many stories by black men about how they've been treated in Connecticut and I refuse for my son and my husband to be included to that list."

"I oftentimes question when I go out…it passes my mind, I'm Hispanic. And you can very quickly tell that I am Hispanic by just running my plate and you get my license…and I'm oftentimes…questioned as to what I'm doing in a particular neighborhood."

"*So much of what's happening is now the result of generations, of loss of power and trauma suffered by Black people and people of color. And we really need to acknowledge and address this."*

Advocates noted that racial trauma disproportionately affected youth of color and youth of color with disabilities. The impacts described were widened achievement gaps and lower graduation rates, which increased the school-to prison pipeline. In addition, some participants noted that their children witnessed their parents or relatives being arrested, physically harmed, or racially profiled at a traffic stop, which demonstrated the ripple effect of one police incident within a family or community.

Resources: Some participants noted spending personal resources to seek police accountability or time to rectify a falsified police report, wrongful conviction, or jail records. Interacting with the police also resulted in being involved with other parts of the legal and jail system, which required additional time and resources to navigate them. See below for some of their comments:

"We have literally spent hundreds of thousands of dollars trying to properly investigate his death. The economic and emotional toll of this lack of transparency and accountability on my family is immeasurable."

"This case then spread like a virus to superior court, family court, DCF [job], as a result of all of this…The time, the money, the health toll that it can take, the consequences already that I have shared with you are a false arrest and wrongful incarceration…"

4. What recommendations did participants have for the task force?

Participants shared recommendations in two main areas: law enforcement and community engagement. With law enforcement, the three most mentioned recommendations were additional training, accountability for police misconduct and changing or adding personnel to the police force.

Training: The testimonies overwhelmingly suggested a consensus in recommending additional training for law enforcement. In particular, training for law enforcement was highlighted in two areas: race and mental health. In training in the area of race, participants suggested increasing education on systemic racism, institutional bias, understanding the racist history of policing and racial trauma from police interactions. In addition, improving cross-racial interactions, especially in demonstrating respect towards Black/African American and Hispanic/Latinx communities was emphasized. Some of the participants' comments included:

"I believe that starts with learning the history of policing and educating our officers on the importance of why black people do not trust police…If you don't know how to communicate with people of color, you don't need to be a police officer."

"I just think they need…to have better diversity training."

"I'm here to talk about this cultural sensitivity training…around look at diversity and especially look at all the cultures that are represented in Blackness in Connecticut…Also more important cultural competency and humility training…which should be ongoing…And I think this important aspect of looking at systemic racism has to be part of the training…the kind of racism that criminalizes Black and Brown people in the United States by the police."

In the area of mental health, participants recommended increasing law enforcement knowledge, awareness, and understanding of mental health and disability issues such as autism and "invisible disabilities." Along with the increase in knowledge, learning skills to de-escalate situations through non-violent tactics with persons with mental health and/or disabilities was suggested. Participants also emphasized wanting police to treat persons with disabilities with more respect and empathy. One participant also recommended improving law enforcement engagement with persons who are houseless, a population that may have increased mental or behavioral needs. Some participants' comments included:

"If that training that is up on your website is an example of the training that cops are getting now, I am not surprised that we're continuing to have the problems that we have because looking at that…the information is old…outdated, and it contains a lot of assumptions about what people who either have a mental health condition, who use drugs, who have various diagnoses are like, and that is just not the reality of our lives and our experiences."

"*There is absolutely a place for better training for police officers around understanding and recognizing symptoms of mental health and substance abuse issues as well as protocols and policies for how to respond when police are the first to arrive on the scene and figuring out how to either call in the mental health partners that they've formed or to respond in ways that are appropriate."*

Overall recommendations for increased training for law enforcement included continuous testing on implicit and explicit bias and mandatory-state wide training for all police departments. One participant also recommended law enforcement training on victim-centered trauma, especially for victims of sexual assault.

"Police officers are asked to put themselves in harm's way every day, often with very little training beyond the academy. And given all the different kinds of training that police officers should regularly receive including crisis intervention training, instruction in the disease of addition, training on implicit bias and cultural responsiveness, procedural justice, effective social interaction, and of course, use of force and tactical skills…We need to radically rethink this and have officer's training more like four to eight hours per week."

"I hope one thing that this task force will bring away is to mandatory training because that's the only way we're going to get it."

Although there was an overwhelming consensus on increasing training and the quality of training for law enforcement, there were a few participants who voiced the limitations of training. They

suggested looking into systemic and structural changes instead of incremental changes. Furthermore, two participants mentioned including correctional officers and prosecutors in all law enforcement training recommendations, which suggest these concerns extend beyond law enforcement and into other systems in criminal justice. A few comments that illustrated this were:

"Police were designed, as we already know, to uphold a white supremacy social order…They do not, they're not designed to protect Black and Brown communities. They protections that are extended to the white communities are not extended to Black and Brown communities. It's not even a matter of a bad apple or a bad person. It's a bad system. It's an institution that was designed not to protect Black and Brown communities."

"I'm an abolitionist. And I don't believe in policing. I also don't think that your job as a task force can be complete if you don't come up with a legislative process for communities to follow, to disarm, to fund divest from policing. It's very important to acknowledge that, that there are ways in communities and cultures that live without police."

Accountability: Independent Investigations Police Civilian Review Boards, independent monitors, and independent investigators were mentioned as potential structures or positions that could ensure independent investigations. Specific suggestions about independent investigations included "*the inspector general being housed away from the police*," mandating Police Civilian Review Boards across the state, and incentivizing or providing training or resources for towns to institute Police Civilian Review Boards. See below for their suggestions:

"I think all groups should have in place mechanisms that will allow for external as well as internal reviews with public disclosure of those reviews, especially for tax based service organizations."

"Please include a method for civilians, victims and victims, families like my own to report wrongdoing to an independent review board."

"What I would like to see this committee do is to try to figure out a way where in order, the civilian review board is system is one that is key, in effectuating the goal of more police accountability so the bad apples can be taken out of police departments."

Accountability: Police Misconduct Participants expressed wanting greater accountability for police misconduct. Suggestions included condemning inappropriate police actions, improved processes in hiring and firing "bad apple" police, improved processes in reporting police misconduct, harsher or more appropriate disciplinary actions, and prosecuting officers who killed civilians. See below for their recommendations:

"Police departments should establish an early warning system to identify officers who are involved in an inordinate number of incidents that include the use of inappropriate that is specific observable force

against citizens. Such incidents should be investigated force against citizens. And if verified, the involved officers should be charged and disciplined by invoking or suspending their certifications.

"We must hold the police force accountability for respecting people with disabilities, all kinds of disabilities."

"I can speak from private life, corporate life, you fire…you got rid of them. You didn't want those people in your organization because they poisoned everything around them."

Personnel in the Police Force: Participants also brought up having a police force that represented the communities they served. In particular, race, gender, and similar lived experiences were the primary kinds of representations mentioned. In addition, there were three participants who suggested requiring police to reside in the communities and neighborhoods they served. See below for their suggestions:

"We need officers who look like us, we need to think about having officers who not only look like us, but live within our areas, and what that impact could look like."

"Another critical area to consider for change is adopting a regulation that would require a certain percentage of police department employees to live within the community they serve."

Advocates for mental health and people with disabilities recommended having certified interpreters, translators, and an ADA Accommodation Coordinator in all police departments. An advocate for victims of sexual assault recommended including a sexual assault counselor and a detective with expertise in domestic and sexual assault as well. Two participants recommended standardizing the data that police collect and making that data accessible to the public.

Community Engagement: In addition to recommendations for law enforcement, the second category that participants gave suggestions for was in community engagement. In general, participants expressed wanting opportunities for more authentic community engagement with law enforcement that included having community needs be heard and improving the way that police approach community engagement. Participants also suggested that if there are future community engagement activities, to include individuals from communities most impacted by the police such as Black and Brown women, youth of color, and youth with autism. In addition, participants suggested collaborating with community services in addressing situations that police may face. The following is a sample of their recommendations:

"The thing is the residents do not have a safe place anywhere to share their feelings without being coerced into loving police."

"I think it takes more than forum… it takes real conversation and meeting them where they are…"

"It's ultimately going to have to come back to a conversation between two groups of people who disagree to finding common ground."

"It would be beneficial to have police representatives in the public developing relationships with families like mine and creating opportunities for discussion and education."

"I think if you do not involve people who are the most marginalized, who are most likely to be impacted by whatever recommendations you make, your recommendations are not going to be as strong as they could be."

"Police departments need to be partnering with community organizations to assist in the recruiting process of diverse candidates."

"Part of the solution for that might be to engage and leverage other community resources…police shouldn't be handling most civil matters."

Discussion of Key Findings

Based on the Listening Session testimonies, the secondhand and firsthand experiences described by participants suggest that adverse police interactions for individuals from Black/African American and Hispanic/Latinx communities and individuals with disabilities and mental health issues are fairly pervasive. The feelings that come from either firsthand or secondhand experiences exacerbate the relationship between police and individuals in these communities. These feelings also demonstrate that previous or present attempts towards greater police transparency and accountability have not been adequate for these individuals and communities.

In addition, there was a minority of participants who expressed different perspectives from what was generally shared in the Listening Sessions. These dissenting views were most evident in the testimonies of the two law enforcement officers and participants who expressed not supporting the Police Accountability Bill. Although their viewpoints were in the minority, understanding their perspectives and having opportunities to hear and exchange perspectives may be beneficial given the heightened polarization on these matters.

As for recommendations, the general consensus, including the two law enforcement representatives who testified, was on improving law enforcement training to mitigate and prevent adverse interactions between police and community members. In addition, participants recommended independent and improved processes for investigations of police misconduct. Greater recourse for victims of police misconduct is needed if and when negative police interactions occur.

Areas for Further Consideration

Efficacy of Training: While law enforcement training could be a first step in increasing police transparency and accountability, further discussion may be needed in determining the benefits and limitations of increased training as expressed by a few participants. One question that emerged from this analysis is whether law enforcement training would sufficiently address the experiences and feelings that individuals from communities, who are disproportionately affected by police encounters, shared in these Listening Sessions. In addition, taking into consideration that factors and institutions outside of law enforcement play a role in affecting adverse outcomes of police interactions, as highlighted in this report, may also limit the impact of law enforcement training on greater transparency and accountability.

Authentic Community Engagement through Dialogues: Dialogues between law enforcement and community members could be another way to address community engagement. The diverging opinions expressed about the Police Accountability Bill, the role of the police in communities, and the various interpretations of what community engagement means between law enforcement and community members could be factors that support initiating dialogues. These dialogues may provide opportunities to improve relationships between community members and police as well as among community members who have different experiences with the police. Dialogues could also help include community voice in decision-making processes about police transparency and accountability.

State of Connecticut PA 19-90

Police Accountability and Transparency Task Force

November Listening Session Summaries: Survey Results/Major Themes Report

November 2020

Survey Summary Results:

Everyday Democracy
Ideas & Tools for Community Change

Police Transparency and Accountability Task Force
Young Adult Listening Sessions Survey Summary Results
December 23, 2020

Introduction

The Connecticut Police Transparency and Accountability Task Force held four Listening Sessions in November 2020. The Task Force decided to hear from young adults because their perspectives were missing from the previous sessions. Four Listening Sessions were planned to hear from young adults between the ages of 18-25. The Task Force collaborated with three university partners: University of New Haven (UNH), University of Connecticut (UConn), and Central Connecticut State University (CCSU) to host the Listening Sessions. UNH hosted the first Listening Session on November 13, 2020. UConn hosted the next two Listening Sessions on November 17, 2020. CCSU hosted the fourth Listening Session on November 20, 2020.

After the passing of Public Act 20-1, one of the remaining charges of the Task Force is the ability of Task Force members to form recommendations on "any other police transparency and accountability issue that the Task Force deems appropriate." The Task Force hosted Listening Sessions with the goal of gathering public input around recommendations they could suggest towards greater police transparency and accountability. Each participant was given three minutes to share their testimonies, followed by a brief Q&A from the Task Force panelists. Due to COVID-19 and social distancing measures, all of the Listening Sessions were conducted virtually on the Zoom platform. This report summarizes results from surveys sent to all who participated in the Listening Sessions.

Method

The Evaluation, Research and Learning (ERL) team at Everyday Democracy designed the survey using Survey Monkey. The survey was designed to capture responses from testifiers, attendees who did not testify, and the Task Force panelists at each session. The Institute of Municipal and Regional Policy at CCSU and an Everyday Democracy consultant posted and emailed the survey

link to participants during and after each Listening Session. ERL analyzed and reported on the survey results.

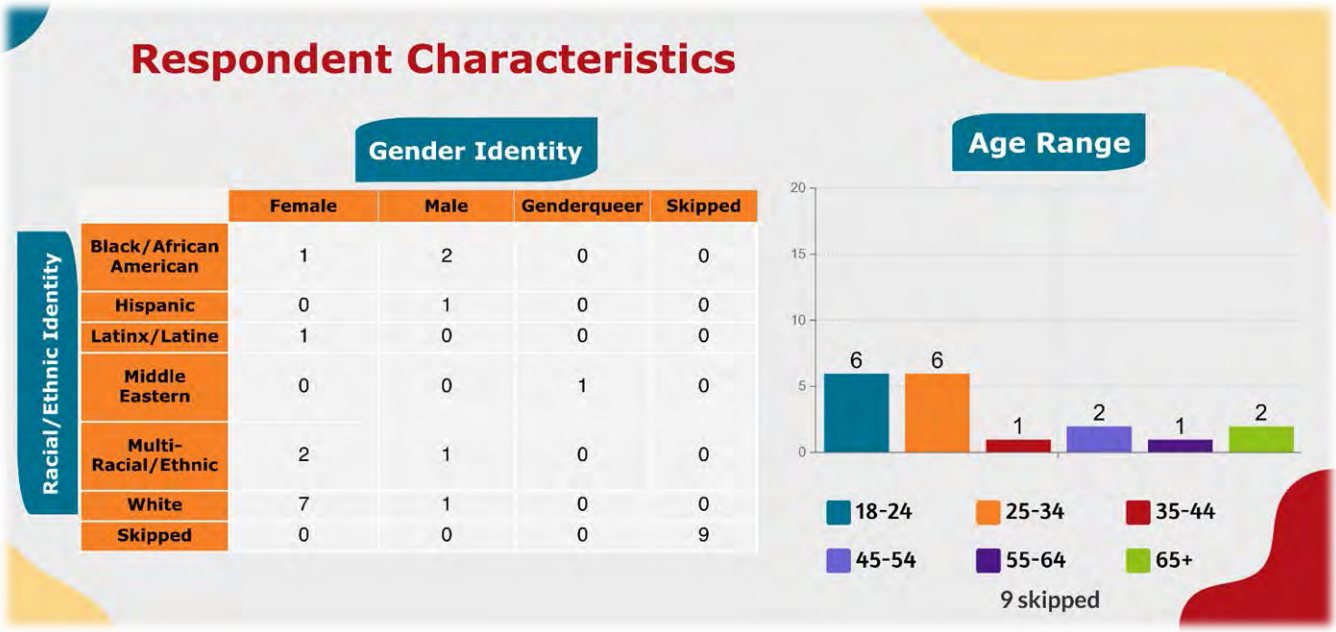
Limitations

There are two limitations to the results presented in this summary:

- The data on the total number of participants in the Listening Sessions was not available. Consequently, ERL was unable to determine the actual survey response rate.
- ERL received a total of 26 survey responses, eight of the 26 respondents indicated they testified, 14, attended but did not testify and four participants who were panelists, submitted the survey. However, 31% of the surveys submitted were incomplete.

Survey Results

Characteristics of Survey Respondents: The demographic data pictured in the infographic below shows that most respondents identified as white and there were more females than males represented. Most of the respondents were under the age of 34. Most respondents to this survey were affiliated with the University of New Haven. Please see the graph in **Appendix A** for more information about respondent's university affiliation.



Nine respondents indicated that they were not affiliated with any organization. Three respondents represented an academic institution, two respondents represented service provider organizations and a student organization/club, and one respondent each represented an advocacy and healthcare organization. Eight respondents skipped this question.

The single county where the largest number of survey respondents reported that they reside was Hartford. Several people were residents of a variety of counties in Connecticut and a few were

from out of state. Three respondents were from one of the following locations: Okatie, SC, Morganville, NJ, and Billerica, MA. The results in the table below show the counties in Connecticut that were represented. Ten respondents skipped this item.

Counties in Connecticut Represented

Counties	Hartford	New Haven	Fairfield	Tolland	Litchfield	New London
Number of Respondents	6	3	1	1	1	1

Perceptions of the Listening Sessions Experience:

All testifiers felt comfortable and heard. Respondents who testified rated their experience in the Listening Session in four areas using an agree/disagree Likert scale ranging from 'strongly disagree' to 'strongly agree.' They also had a 'not sure' option. All respondents indicated that they agreed or strongly agreed with feeling comfortable sharing, feeling heard, and that Task Force members listened to their suggestions. Six respondents indicated that they agreed or strongly agreed that their suggestions will be used by the Task Force to make improvements. One respondent indicated they were "not sure." Seven testifiers responded to this question and one skipped.

What was shared was heard. Respondents who attended but did not testify rated their experience in the Listening Session in three areas using an agree/disagree Likert scale ranging from 'strongly disagree' to 'strongly agree.' They also had a 'not sure' option. Ten respondents agreed or strongly agreed that what was shared was heard and that Task Force members were listening to suggestions made by the testifiers. One respondent each indicated they were "not sure" whether what was shared was heard or that the Task Force listened to the suggestions. Nine respondents agreed or strongly agreed that suggestions for improving police transparency and accountability will be used to make improvements. Two respondents indicated they were "not sure." Eleven attendees responded to this question and three skipped.

Motivation for participation in the Listening Sessions. People who testified: Five respondents indicated that sharing their story or "*it felt important*" motivated them. Two respondents mentioned that their professor or advisor encouraged them to testify. One respondent wanted to discuss "*the continued fear with young Black men when interacting with police.*"

People who attended/did not testify: Four respondents indicated wanting to hear other perspectives from law enforcement, community members, and the Task Force.

Hearing from others was most helpful. This result was reported by most respondents. Some additional helpful aspects of the Listening Sessions identified were: interactions with the panelists, knowledge that was shared, and a conducive format for virtual listening sessions. Some comments were:

> *"I feel that everyone who was interested in speaking was given the opportunity and that their ideas were well-received, respected and appropriately acknowledged. It was also helpful to see the support of each member in this discussion."*
>
> "*Hearing from different people of varying backgrounds and ethnic and cultural identities was most impactful."*
>
> *"Panelist commentary and questions was very helpful for me, and made me feel included and heard."*
>
> *"The facts the students and volunteers brought to the table."*

Least helpful aspects of sessions varied. Some of the comments were:

> *"Hear the same things w/ no real out of box thinking."*
>
> *"The critical comments on delivery the task force gave back to the people who gave testimonies."*
>
> *"I would have wanted to see experts in the fields of juvenile justice or mental health."*

Best outreach approach was university mailing lists. Respondents were asked to indicate how they heard about the Listening Sessions. Most respondents heard about the Listening Sessions through university mailing lists. Please see **Appendix B** for more information about how respondents heard about the event.

Listening Sessions "very good" overall. Respondents were asked to rate the overall quality of the event from a scale of 1 to 5 with 1 = poor and 5 = excellent. The average was a 4.4 with eight skipped responses.

Conclusion

According to the survey data, the Listening Sessions were a meaningful way for young adults and the public to engage and share recommendations with the Task Force. This was evidenced by comments from respondents about their experience testifying or attending. For example, many people referenced the positive interaction between them and the Task Force members. In addition, many valued hearing from other perspectives.

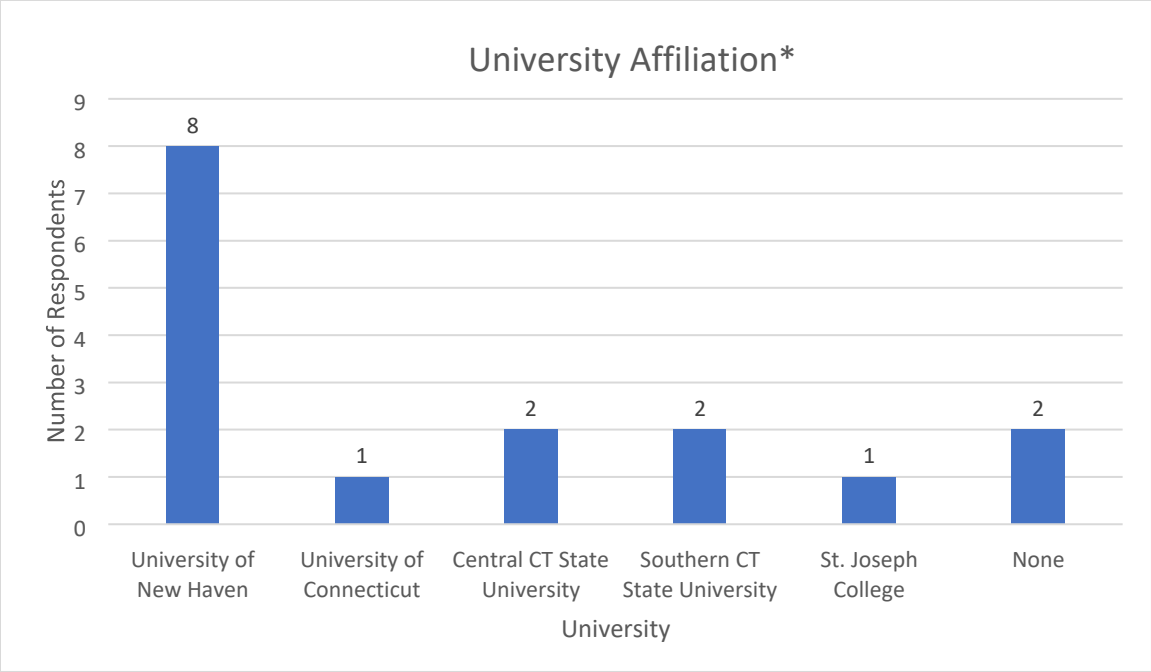
While the Listening Sessions were, for the most part, a positive experience according to survey respondents, two areas of improvement did emerge. In moving forward with similar public

engagement events, two areas to consider include:

- Assessing outreach practices and barriers to participation to ensure that more young adults, especially non-student young adults, are included and feel prepared to testify.
- Continuing to examine ways to enhance engagement between all groups at public events.

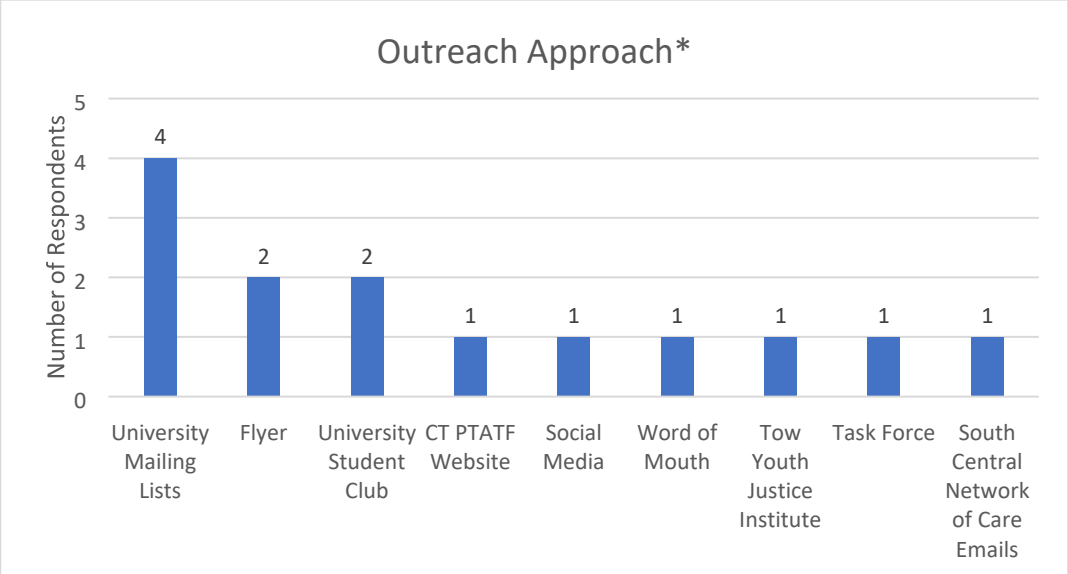
Overall, these survey results provide support for the efficacy of Listening Sessions as an initial step in engaging young adults. The sessions provided space for young adults to express their concerns and offer recommendations for change that will hopefully be used to help inform changes in law enforcement policies and practices. This is an important step towards improving police transparency and accountability.

Appendix A



***8 Skipped**

Appendix B



***15 Skipped**

Major Themes Report:

Major Themes Report

November 2020 Young Adult Listening Sessions

This report is prepared for the Connecticut Police Transparency and Accountability Task Force

By the Evaluation, Research, and Learning Team

January 8, 2021

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Introduction:

The Connecticut Police Transparency and Accountability Task Force held Listening Sessions in November 2020. The Task Force determined that the voices of young adults were missing from the previous Listening Sessions held in September 2020. As a result, four Listening Sessions were conducted with young adults aged 18-25 during November 13th-20th.

The Task Force collaborated with three university partners: University of New Haven (UNH), University of Connecticut (UConn), and Central Connecticut State University (CCSU) to host the Listening Sessions. UNH hosted the first session on November 13, 2020. UConn hosted the next two on November 17, 2020. CCSU hosted the fourth session on November 20, 2020.

After passage of Public Act 20-1, one of the remaining charges of the Task Force was to form recommendations on "any other police transparency and accountability issue that they deemed appropriate." The Task Force hosted Listening Sessions with the goal of gathering public input around what topics to focus on for working towards police transparency and accountability. Each participant was given three minutes to share their testimonies, followed by a brief Q&A by the Task Force panelists. Due to COVID-19 and social distancing measures, all Listening Sessions were conducted virtually on the Zoom platform.

This report summarizes thematic recommendations that were identified from the Listening Sessions' data. These findings are organized according to three questions:

1. What recommendations did participants suggest?

2. What were participants' interaction with the police? 3. What were the impacts of these police interactions?

Following these findings, a section highlighting themes that panelists discussed and correspond to participant recommendations is included. Lastly, a discussion of the findings is presented.

Method:

The four listening sessions were transcribed by the Institute of Municipal Regional Policy (IMRP) at CCSU and sent to Everyday Democracy. Three individuals- two from Everyday Democracy and one from IMRP at CCSU coded the transcripts. The three individual coders met to discuss the codes and themes in order to establish inter-coder reliability. The themes presented in this report reflect the agreed upon conclusions of the coders of the data.

There were 25 testimonies in total from the four Listening Sessions.[18] Although these Listening Sessions were intended for participants between the ages of 18-25, there were some testifiers outside of that age group. For this report, all testimonies were themed, although not presented by age group. People who testified were not required to indicate their age as a condition of giving testimony which precluded the separation of testimonies by age groups. The majority, 14 of the 25 testimonies, were given by participants from UNH.

Recommendations:

Law Enforcement: Training

The recommendation that was suggested most often was increased and improved training for law enforcement. This recommendation applied to improving interactions and communication with people with disabilities, health needs, and the African American community. Some comments are presented below:

"We need to allow the law enforcement to understand the culture that they're working in. And the culture is more of how do you work with young Black Americans that are in a culture where they feel threatened soon as they are interacting with a police officer."

"Educating police more thoroughly on privilege is a step towards healing the fear and distrust that many black and brown people feel towards law enforcement."

"We need to start looking at different adequate de-escalation techniques and interventions to help these individuals that are part of the justice system that have mental illness."

Law Enforcement: Accountability

Participants recommended reviewing current law enforcement procedures such as auditing current police training programs and reviewing traffic stops.

18 In this report, testimonies are defined as any person who shared their perspective during the Listening Session whether or not they formally registered prior to the Listening Session. Testifiers were also not Task Force members or panelists.

"I ask that a [comprehensive review of the basic training program] be done through a thorough evaluation of the course in its entirety by an outside party... I also ask that as part of that evaluation, a review of how subject hours are allocated be conducted to allow for more attention to social interaction, training and public health education."

"I further call for an audit of the breakdown of the 900,000 however many hours that POST offers during the initial training period and a recommitment to including six hours of training on youth issues since this has already been passed into law several years ago."

"[Traffic enforcement] is the premier reason for police community contact. So, I think by doing something in traffic enforcement and traffic enforcement stops, we can influence the behaviors of people outside of policing people in the community."

Law Enforcement: Hiring

Participants also recommended improving hiring practices. This included hiring more police officers of color, who are from the communities they police and having Crisis Intervention Teams (CIT) in law enforcement agencies.

> *"In Hartford, specifically 11% of the police department is Black. Well, the city is 36%. 35% of Danbury's population is Latino, but only 9% of that police department makes up of that ethnicity. 11.4% of Meriden's population is Black, but only 3% of those officers are African American, so obviously recruitment is still a problem is in this state."*
>
> *"I believe that there should be a great effort and push towards hiring within the communities and it's just start at a very young level of removing the stigmas of our Black and Brown people of not wanting to become police officer."*
>
> *"Also, I'm very happy to let you know that our crisis department is hiring a CIT to actually be with the police department, because it's very important that you have someone that has a background in mental health services."*

Community Partnership

Participants recommended that police partner with community organizations in mental health, behavioral health services and people with disabilities. In addition, two participants recommended investing funding into historically divested communities and two participants suggested implementing more preventative measures that police can take before an incident happens.

"So definitely working to try to figure out whether we need a partnership with social workers or... an intervening force to assist that's a little bit less militarized...in their approach to maybe really help cover the needs of those mental and physical health issues."

"I would be inclined to believe that a recovery coach would be, or a peer support specialist or recovery support specialist would be more suitable based on the fact that possibly the issue would be where people are being in need of assistance because of the substance use or alcohol use most of the time…to alleviate that person from going to prison or jail."

"CT needs to invest in public schools. We need to invest in mental health resources and others so our local communities and our Black and Brown communities can grow."

"If there was just some communication beforehand that we can reach out and talk to them before it happened, then it's different. Cause...once something happened, you don't want to hear anything. Cause then you already got your blinders up. Like something happened, we gotta take care of it, you know, but maybe we could have stopped it if we just talked to him before it happened."

Police Interactions:

Although there were positive police interactions shared in the testimonies, they were outnumbered by negative interactions that were shared. Negative police interactions were mostly characterized by disrespect, poor communication, escalation, and feelings of fear/anxiety. Despite the variety of contact points from people with different backgrounds and situations, participants expressed having negative experiences with the police. Please see below for some participant comments:

Positive Interactions:

"Once I was stopped by a police officer, he kind of went through what I did, told me what I needed to do to correct the action and was just positive about the whole experience."

"When our family had to call 911 for a heart attack in the family and they showed up and handle that super well."

Negative Interactions:

"I think police officers don't have respect...I think they look at especially people of color...on the lower level. And when you look at somebody differently and that's your approach, you don't look at them."

[In response to whether there was any communication about being placed on the deadly weapon offender registry] *"Absolutely not. So I was convicted…I was told that I was going to be placed on this upon release from prison at parole. I was told I had to go down to Middletown and register at the place. So, I registered, and I was completely unaware of what they call address verifications or address checks."*

"So, one time they just came in, bringing it at a level or intensity where the whole situation was not at… and it was nearly impossible to...bring the temperature down, or even have a... response or talk with a police officer to make them feel at least more comfortable or at least to treat us, like other human beings."

"The first thing I saw was several male police officers, four standing up and, and there's probably two more in my house. And there were two EMT's working on my oxygen and blood pressure. But I remember kind of freaking out because that was the first time that 911 had been called for one of my seizures and for other reasons, I don't really like strangers surrounding me or touching me especially men… I just had six police officers loitering in my kitchen, making comments about my house and my pets, taking repeated information from my friend that they already had asked her hey are you using drugs, which is a whole different issue that I've had with officers when I have a seizure. They always think that it's an overdose even though I have a bracelet that says epilepsy."

Impact

Fears of police

Participants expressed that they feared future police interactions because of the inconsistent interactions they have had with police. One participant noted the fear of retaliation if they reported an incident. Another expressed that they would not call on the police to respond to their situation in the future. These fears were more pronounced for participants who shared about their experience as African Americans and/or who have mental health needs and disabilities. One participant described the protocol they use and have taught their sons to use during a traffic stop. Some of their comments were:

"When the cops come to your door, how are they coming? Are they coming with respect? Or they come in hostile, you know, there's two ways."

"There's also the implied not really implied chances of retaliation or whatever, it mostly pushes you towards let's just listen completely and not even talk back."

"We have several clients that are in situations where they're not the perpetrator, but they wouldn't call the police because they're afraid of what the police don't do because of their experience with the police previously."

"I really got stuck on the limits of consent searching based on the fact that, you know a lot of black, young American men, African-American men really experience fear when one gets pulled over…So I pulled into the parking lot... I rolled my window down like I told my two sons. I told them how to engage with police. I said, roll your window down, put your hands on...your steering wheel and be polite."

Long Term Consequences

Participants also expressed the long-term impacts from one police interaction. These long-term consequences include feeling "*targeted*" and disrupting daily life.

"I also didn't know that when you receive employment in a different town, they send your paperwork over to that town's police. So immediately I was, you know, I was targeted and I didn't, and I didn't know this either."

"Because once again, as everybody knows, once you get legally involved with the system that carries with you for a very long time, not only does it carry with you for a very long time, it also puts restrictions to you."

UConn Evening Listening Session

There were no formal testimonies given during the UConn evening Listening Session. The Task Force members and panelists used that time to discuss a comment that an attendee submitted via Zoom Chat. The attendee was "*interested in learning more regarding recruitment of more diverse police officers, cultural sensitivity training, and citizen police oversight efforts.*"

This section includes three themes that describe the discussion among panelists, which included Task Force members, law enforcement and elected officials. These themes were identified because they respond to the recommendations made by participants who testified in the other listening sessions.

Law Enforcement Training and Education Requirements:

Increasing and improving law enforcement training was mentioned most often by participants who testified. One law enforcement officer stated that police would welcome more training. The challenge to receiving more training, however, is whether elected officials and the public decides to fund police training.

"And there's nobody that wants more training than police officers and police chiefs... We would love to go to school for two years. And if the elected officials in our towns and cities and the state decide to fund that, and our residents decide to fund that we would love to do that."

The barriers and benefits for educational requirements for law enforcement were discussed extensively. One testifier shared that it was more important for law enforcement to come from the communities they police than to require higher education degrees. In addition, three challenges that panelists identified were a) Educational requirements becoming barriers for recruitment that limit the candidate pool b) Systemic racism within higher education institutions c) Debt accrued from higher education that disqualify candidates.

One testifier suggested mandating educational requirements and improving the quality of education as their top recommendation. Some of the panelists who discussed the importance of mandating educational requirement elaborated further, mentioning that a) Mental health professionals who work with people with disabilities, mental health or behavioral health needs are required to have higher educational degrees b) Higher educational degrees professionalize

the force c) Higher education gives the opportunity for an individual to interact with people of diverse backgrounds d) Higher education provides opportunity to improve communication and leadership skills.

"When you look at the degrees that people need to pursue to work in the disability community social work and such, a lot of it is master's degree level… kind of education that's required."

Hiring and Retention:

Participants who testified recommended hiring more police officers of color and officers who come from the communities they serve. Law enforcement described many efforts their agencies have made to attract a diverse pool of candidates. However, law enforcement cited that hiring, retaining law enforcement of color and replacing retired officers were challenges. Some of the reasons provided were losing candidates during the background check phase, improving the culture of law enforcement agencies, and inconsistent hiring standards across the state.

"And then there's a background phase, which is part of a polygraph and a psychological and other things...those are all required...We lose about 80% of men and women, not every agency, but many agencies lose about 80%."

"The recruitment plan looked at the retention numbers and the retention numbers for minority officers, and I'm not talking terminations or retirements, just for people leaving on their own free-standing you know, in good standing. It was much higher for minority officers leaving. So, we've got to create the culture within departments where we're going to have all officers feel comfortable working there."

"There is a lot of subjectivity, you know, among departments as to who they take or don't take. And that leads to some people that maybe would have been good officers being disqualified in one place and not another."

Addressing bias in hiring standards

In response to the challenges law enforcement raised about hiring and retaining more officers of color, two panelists discussed how the subjectivity of law enforcement hiring standards are susceptible to societal and individual bias. One panelist shared that hiring standards do not account for the historic, economic divestment in the African American community, which prevent implementing equitable hiring practices and retention of minority officers.

"There's a high level of subjectivity to the standard. And I don't even know if I would call it a standard because it's not a standard that applies in every department...Because without a way of checking the standards and figuring out whether they are actually legitimate standards, if the level of subjectivity allows in individual biases or societal biases, then you're going to have built in these things that operate against your ability to recruit and therefore retain the populations you need."

"And so how we looked at it was given the wealth gap that we have in this country, I don't know an African American who hasn't been behind on their bills or everything is all paid up. So just by that alone, if that's the standard we're using to eliminate, you know, qualified people, that pool is going to get smaller."

Discussion and Conclusion:

Most of the testifiers recommended increasing and improving training and hiring officers of color, which panelists also discussed. Additional research and review of current studies, however, need to be considered to determine the efficacy of increasing training and hiring police officers of color. For example, one recent study conducted with the New York City Police Department concluded "insufficient" evidence of the effectiveness of implicit bias training in reducing racial disparities in police enforcement.[19] In addition, considering evidence that demonstrates whether increasing law enforcement training reduces violent or lethal encounters with people with disabilities would be beneficial.

As for the effectiveness of hiring more police officers of color in reducing racial discrimination in police enforcement, studies have shown conflicting results. One study suggested that hiring a "critical mass" of Black police officers may be needed to reduce police violence towards Black citizens.[20] In addition, one panelist mentioned that retaining minority officers as a challenge and suggested re-examining the culture of law enforcement agencies to understand this challenge further. Therefore, additional research about the benefits and limits of investing in more training and hiring police officers of color would be important to consider in conjunction with the recommendations provided in these Listening Sessions.

In addition, supplemental recommendations beyond training may need to be considered. As mentioned in the testimonies, participants described feeling trauma, fear, and disrespect when engaging with police, which training or hiring more officers of color may not sufficiently address. One participant expressed,

"If police officers or the institution of police were... to explicitly acknowledge that they are working in an institution, which is deeply rooted in racism and discrimination that people of color perhaps would be more

19 Worden Robert, et al. "The Impacts of Implicit Bias Training in the NYPD" July 2020 https://www.theiacp.org/sites/default/files/202009/NYPD%20Implicit%20Bias%20Report.pdf. Accessed January 2021.

20 Sean Nicholson-Crotty, Jill Nicholson-Crotty, and Sergio Fernandez, "Will More Black Cops Matter? Officer Race and Police-Involved Homicides of Black Citizens," *Public Administration Review* 77, no. 2 (2017): pp. 206-216, https://doi.org/10.1111/puar.12734.

open to the career...Police brutality is like in the spotlight of everybody's minds right now. And I think a lot of the men and women, the Black men and women who are being murdered tend to be younger or middle aged. It's really something that my generation is not willing to let go of."

Acknowledging the connection between the history of racism and dehumanizing policing practices in communities of color and people with disabilities could be a positive first step, especially for the young adult generation. Hearing from young adults in both university and non-university settings could continue the work started at these Listening Sessions.

APPENDIX C2

Other Publications

1. ***Aligning Systems with Communities to Advance Equity Through Shared Measurement: Guiding Principles***, American Institutes for Research, 2021
2. ***First Generation EV-ROI Model for Hartford Communities That Care's Hartford Crisis Response Team/Hospital-Linked Violence Intervention Program****,* Social Capital Valuations, 2019
3. ***Connecticut Analyses of Evidence-Based Programs,*** *Institute for Municipal and Regional Policy (Results First Connecticut),* Central Connecticut State University, November 2020
4. ***Results First Clearinghouse Database,*** *The Pew Charitable Trusts (link only): https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database*
5. ***On the Front Lines: Elevating the Voices of Violence Intervention Workers (Executive Summary),*** Giffords Law Center to Prevent Gun Violence, 2021
6. ***Age of Gunshot Wound Victims in New Haven, 2003-2015,*** The Policy Lab Working Paper, Institution for Social and Policy Studies, Yale University, 2017.

Journal Articles

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5. Wang, E. A., Riley, C., Wood, G., Greene, A., Horton, N., Williams, M., Violano, P., Brase, R. M., Brinkley-Rubinstein, L., Papachristos, A. V., & Roy, B. (2020). Building community resilience to prevent and mitigate community impact of gun violence: conceptual framework and intervention design. *BMJ open*, *10*(10), e040277. DOI: 10.1136/bmjopen-2020-040277
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7. Floyd, A. S., Rivara, F. P., & Rowhani-Rahbar, A. (2021). Neighborhood disadvantage and firearm injury: does shooting location matter?. *Injury epidemiology*, *8*(1), 10. DOI: 10.1186/s40621-021-00304-2
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Aligning **Systems** with **Communities** to Advance **Equity** through **Shared Measurement**

Guiding Principles

AIR®
American Institutes for Research®

Robert Wood Johnson Foundation

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Contents

Introduction

"I think the system is designed to not be equal, and for it to work for us, we need to be part of the process. In order to have an equal role, we have to have a seat at the table and not on the menu. We need to be there, be activists to be heard. The system is designed to keep us outside, so we need to make that space. We need to see that people who are being impacted by these decisions being at the table, being compensated for their time, taking their voices seriously, and being treated fairly and with respect."

— Community resident, Denver, CO

A Vision for Shared Measurement that Aligns Systems with Communities to Advance Equity

The various systems within communities—including medical care, public health, housing, education, transportation, justice, and human services—directly influence the health and well-being of community members. These systems often operate independently from each other in silos, with each system's policies and practices solely reflecting their own bodies of knowledge, producing and reinforcing fragmentation.

Further, these systems' policies and practices have perpetually excluded, marginalized, and disadvantaged some communities of people—especially people of color, creating long-standing inequities in health and well-being. Yet these inequities cannot be attributed to, or addressed by, any single system or sector. Community members understand the interconnectedness of social factors that contribute to their health and well-being (e.g., health, education, nutrition) and know that achieving equitable health and well-being requires a holistic view and approach by all the systems in their communities. As one Chicago resident explained, people know their community is changing for the better "when holistically they are able to get all of their needs met. I should not have to go to [other neighborhoods] in order to get my needs met. Everything that I need should be within my community because that's how my community thrives."

From communities' perspectives, systems must be aligned because each system cannot independently address the holistic concerns of community members. To break down silos and effectively address these inequities, systems must work together with each other and with community members to collectively align their actions with the needs and priorities of the communities they serve, particularly communities that historically have been harmed the most. One way to do this is with shared measurement.

What Is Shared Measurement?

Shared measurement is using a common set of measurable goals that reflect shared priorities across systems and with community members.

The process of shared measurement includes:

- Defining what to measure; how to measure; where, when, and from whom to collect data; and why the measures are important;
- Choosing specific metrics, data sources, and methods;
- Using measurement to support cross-systems alignment; and
- Understanding what measurement means in the context of communities' own history, narratives, and experiences.

What are things to consider as we discuss measurement?

Assumptions underlying measurement can include perceptions about people, places, or systems; views about what kinds of information are most important to consider (e.g., things that can be counted and things that cannot); and biases about how the world works, what improvements are needed, and how to go about making changes.

Why Use Shared Measurement for Alignment Toward Equity?

Shared measurement has the power to create change in systems' policies, practices, and norms to transform measurement from a tool that reinforces the status quo to one that shifts power to communities by:

- Defining collective goals and mobilizing collective action;
- Monitoring progress toward goals and evaluating success;
- Generating buy-in and trust among different systems and communities; and
- Creating benchmarks for accountability and shared learning to mitigate and rectify harm.

Looking at efforts across the United States, when communities and systems partner together around shared measurement to advance equity, it can lead to tangible improvements in outcomes, such as hospitalizations, infant mortality, reading proficiency, and homelessness. For example, the Cincinnati All Children Thrive initiative collaborated with more than 30 organizations and community members to work toward the goal of making Cincinnati's children the healthiest in the nation through strong community partnerships. Community members co-designed programs by identifying important issues in specific neighborhoods. They also co-lead the improvement teams that participate in implementation, monitoring, and measure tracking. In the program focusing on reducing racial disparities in birth outcomes, this community partnership has so far shown a 24% decrease in Black infant mortality rate compared to the previous 5 years.

In this initiative and others, we've seen that alignment rises from strong, equitable partnerships undergirded by trust and humility; authentic, long-lasting commitment to equity; a shared, bold vision for growth; and inclusion of diverse perspectives that recognizes communities are not a monolith and amplifies voices that historically have been suppressed or dismissed or that have gone unheard. When

used as a tool for alignment, shared measurement focuses on measures that are meaningful to all partners and goals for success that are actionable and accountable to all partners.

Guiding Principles to Align Systems with Communities to Advance Equity through Shared Measurement

The American Institutes for Research (AIR), with funding from the Robert Wood Johnson Foundation, developed five Guiding Principles to inform measurement that effectively aligns systems' actions with the needs and priorities of the communities those systems serve, particularly communities that historically have been harmed the most by inequities. The AIR team, including consultants in equity and community engagement, developed these principles through a modified Delphi process in partnership with an 18-member expert stakeholder panel and a seven-member steering committee consisting of leaders in cross-systems alignment, measurement, and community engagement from across the nation (see Appendix A for a list of contributors and Appendix C for a methods overview).

Measurement that aligns systems with communities toward equitable outcomes:

1. Requires **upfront investment** in communities to develop and sustain community partner capacity;
2. Is **co-created** by communities to center their values, needs, priorities, and actions;
3. Creates **accountability** to communities for addressing root causes of inequities and repairing harm;
4. Focuses on a **holistic and comprehensive view** of people and communities that highlights assets and historical context; and
5. Reflects **shared values** and intentional, long-term efforts to build and sustain **trust**.

While aspirational, these principles and accompanying guidance for putting them into practice intend to show how community members, system leaders, service providers, and policymakers actively engaged in cross-systems efforts can use shared measurement as a tool to align decisions, policies, and practices toward equitable health and well-being. It is through sustained, collective, and intentional actions that progress toward equity is achieved.

In applying these principles, we encourage all partners in shared measurement to have transparent discussions about what key concepts and terms mean within their own context. We have provided a framework and some definitions as a starting point to these conversations in Appendix B. In addition, partners are encouraged to co-define roles and norms for transparency and accountability.

Five Guiding Principles for Using Shared Measurement to Align Systems with Communities to Advance Equity

Measurement That Aligns Systems with Communities Toward Equitable Outcomes…

1. Requires Upfront Investment in Communities to Develop and Sustain Community Partner Capacity.

- Co-design of measurement requires upfront and sustained investment of time, money, and other resources to build and strengthen economic and social assets in communities through activities such as job creation, skill building, racial equity training, and local events to foster social cohesion, which directly address existing challenges.
- This investment is essential to building authentic partnerships among stakeholders engaged in measurement, including community members; community-based organizations; grantmakers; community initiative implementers, anchor institutions, and nonprofit organizations; and local, state, and national leaders.
- Authentic partnership means that all partners have decision-making authority in every step of measurement from start to finish, including the design, data collection, data analysis and interpretation, and dissemination or publishing of results.
- Readiness to advance equitable, authentic partnerships may vary depending on past actions and relationships. Building and sustaining capacity for these partnerships requires all stakeholders to invest time in readiness self-assessment and ongoing self-reflection to check biases and behaviors.

Real-World Examples of Community Investment in Shared Measurement Efforts

How Cincinnati All Children Thrive (ACT) Has Invested in Its Community: Cincinnati ACT developed an ***improvement course*** called IMPACT U to build capacity and capability within communities and systems. The course enables people to collaborate across systems, use data in similar ways, and learn how to test frequently and improve. Cincinnati ACT also designed a separate training course tailored for community residents to give them tools to solve problems, build capacity, and create community leaders who can work with systems directly.

Partners: Healthcare, public health, education, community-based organizations

How the Community Schools Initiative (CSI) Has Invested in Its Community: CSI provides *professional development and technical assistance* to increase the skills and capacity of partners and the communities they work with. For example, the Family League of Baltimore, a partner to Baltimore City Community Schools, launched a summer institute in 2014 to train new community partners on ways to develop and fulfill a results-based vision. This investment is essential for identifying resources, funding sources, and developing buy-in to build and sustain support and interest in the community school.

Partners: Healthcare, government, philanthropy, commerce, community-based organizations, faith-based organizations, social services, occupational development, sports and recreation

2. Is Co-Created by Communities to Center Their Values, Needs, Priorities, and Actions.

Co-creation requires shared power, diversity in perspectives, and shared ownership of data.

Shared Power

- As co-creators, power is shared such that no one entity dominates the measurement process or dictates the concepts measured. Checks, balances, incentives, and mandates—where required—are established to avoid perpetuating existing power imbalances, recognizing that these imbalances directly impact data ownership.
- In creating shared power, it is important to identify multiple and meaningful opportunities for community members to have a clear role; early and ongoing involvement; and power, agency, and decision-making authority at all stages of measurement. This includes:
  - selecting measures
  - making key data decisions, such as what data to use, who will collect data, and when and how to collect data
  - analyzing, interpreting, and making sense of measure results

- refining measurement as needed in response to findings
- deciding how measures will be reported and used, and by whom

Diversity in Perspectives

- All partners co-creating measurement recognize and welcome diversity in perspectives, experiences, culture, and priorities within communities and prioritize marginalized voices in decision making. Recognizing and welcoming diversity means intentionally creating frequent and ongoing opportunities for shared learning through dialogue and partnership among the wide range of stakeholders within communities. Shared learning opportunities reinforce a mutual appreciation for the knowledge and wisdom that each stakeholder brings to the conversation, including the shared and varied experiences of community members, especially with the tangible effects of systems, policies, and practices within their communities.
- Opportunities to partner around measurement are open to a wide range of community partners, with emphasis on supporting and building capacity where needed for partnership among individuals who bring direct lived experience with the systems, policies, or outcomes at the heart of the measurement effort.
- Community members have agency to share their positions, solicited or unsolicited. Communication is open, transparent, and bi-directional with embedded feedback loops.

Shared Ownership of Data

- Data creation is a collective effort with all involved partners as shared owners of the data, especially the communities from which those data are derived.
- Communities have full access and authority to use their own raw and manipulated data. They are recognized as creators of information, not solely recipients of information. Communities evaluate, reexamine, refine, and if needed, reject measurement strategies or interpretations that misalign with or misrepresent them or their goals. Communities' roles as measurement co-creators continues throughout the measurement lifecycle, recognizing that community needs and priorities shift over time.

Real-World Examples of Co-Creation in Shared Measurement Efforts

How San Antonio 2020 (SA2020) Co-Created With Community Members: In SA2020, community members have a clear role as well as power, agency and decision-making authority at all stages of measurement. SA2020 ***used a community-wide visioning process*** to identify priorities for making San Antonio residents the healthiest in the nation. Community members informed selection of measures to annually track progress toward this vision, and reviewed and approved baseline measures before they were put in use. Currently, SA2020 is asking community members about changes they would like to see in a shared vision for the next decade. "If you have a vision that a community wrote, and said that these are the results we are seeking from our nonprofits, from our elected officials, from our media, from our corporations, and as a community, we are holding you accountable to that—it sort of shifts the way that institutions function, or it should." — SA2020

Real-World Examples of Co-Creation in Shared Measurement Efforts

Partners: Nonprofit organizations, corporations, foundations, local government agencies, educational institutions, member trade organizations

How **Cincinnati All Children Thrive (ACT)** Co-creates With Community Members: Cincinnati ACT established the *ACT Learning Network* where partners and community members collaborate to identify focus areas. Within the network, community members are part of improvement teams who are responsible for tracking progress and achieving outcomes. The learning network creates frequent and ongoing opportunities for shared learning through dialogue and partnership among the wide range of stakeholders within communities. As part of the learning network, stakeholders and community members meet twice a year to share their learning, have a chance to talk and learn together, and celebrate successes.

Partners: Healthcare, Public health, education, community-based organizations

3. Creates Accountability to Communities for Addressing Root Causes of Inequities and Repairing Harm.

Root Causes of Inequities

- Measurement focuses on root causes of inequities, not symptoms of inequities. This includes measuring the impact of policies, practices, and structures that create and perpetuate inequities, and highlighting how systems affect people in multiple ways (i.e., intersectionality). An example is measuring the effects of racist policies (e.g., redlining) on communities of color.
- Measurement creates accountability for addressing root causes when communities use measurement to identify their needs, define goals, monitor progress toward those goals, and define the ways that root causes harm community members.

Repairing Harm

- To minimize the risk of harm and unintended consequences from measurement, communities shape the purpose of measurement, the stories used to make sense of measured data, and actions taken in response to measurement.
- Communities define when measurement itself causes harm, such as when measuring inequities is used to reinforce negative narratives about communities or when inequities are highlighted but not addressed.
- Communities' roles in assessing real and potential harm begin in the earliest stages of measurement and continue throughout the life of a measurement effort. This includes transparent decisions about who is to be held accountable when measurement causes harm. Transparency in decisions, roles, and actions supports accountability and shared power.

- A diversity of perspectives is needed in monitoring for harm because harm may be experienced differently by different members of a community.
- When communities determine that measurement has created harm, entities using measurement must not dismiss or perpetuate that harm. Rather, those using measurement are accountable to communities through open acknowledgement and transparent, collaborative, restorative actions.

Real-World Examples of Accountability in Shared Measurement Efforts

How the Connect SoCal Initiative Created Accountability: Connect SoCal uses federal environmental justice measures to minimize the risk of harm and unintended consequences from measurement to under-resourced communities. Connect SoCal ***hosted a series of stakeholder workshops*** with community members and environmental justice groups in which community members shared their concerns and shaped the purpose of measurement, the stories used to make sense of data, and actions taken in response to measurement. For example, community members expressed concerns about the proximity of warehouses and truck routes near schools. In response, Connect SoCal recommended restricting sensitive public facilities, such as schools and hospitals, from being located near industrial facilities or high-volume roadways that pose a hazard to health and safety.

Partners: Association of local governments and agencies from six counties and 191 cities across Southern California

How the LA County Homeless Initiative Created Accountability: By ***publicly funding the initiative through voter-approved taxes***, this built an expectation of transparency and accountability to the public and government. Investment of tax dollars to fund the initiative influences how the initiative uses and reports on measures. For example, when planning implementation and evaluation, partners determine the measurement processes and outcomes, evaluate measures regularly, and report them through interactive data dashboards, quarterly progress reports, annual evaluation reports, and 2-year report cards. At public meetings like town halls, the initiative shares these measures and discusses results with stakeholders and community members to track progress and support accountability and public transparency.

Partners: County government, community development and housing, health services, social services, education, children and family services, consumer and business affairs, probation, sheriff's department, philanthropy

4. Focuses on a Holistic and Comprehensive View of People and Communities That Highlights Assets and Historical Context.

- Measurement highlights communities' assets, resilience, and resources, not just areas for improvement. These assets are understood in the context of past injustices (e.g., slavery, segregation, unethical research, mandatory minimum sentences) that have negatively impacted communities and led to the inequities observed today.
- Quantitative information from measurement is balanced with stories and qualitative information from community members to frame measurement around how communities define themselves, their strengths, and expressed needs and goals.
- A holistic focus considers the myriad factors affecting community members' health and well-being, as they define it. These factors may include multiple systems such as healthcare, transportation, food, education, public health, and other human and social services as well as other cultural or lived experiences of health and well-being. It also requires measurement at the individual, system, and population levels.

Real-World Examples of Adopting A Holistic and Comprehensive View of People and Communities in Shared Measurement Efforts

How SA2020 Adopted A Holistic and Comprehensive View: SA2020 takes into account community members' priorities and concerns to get a holistic understanding of the needs and assets in a community. The initiative raises awareness of the historic and systemic root causes of inequities, such as racial segregation, that affect community health. The initiative ***reports data disaggregated by race, gender, and locale for its 62 measures to tell a more complete story of its progress***. SA2020 uses measurement to identify targeted, race-conscious opportunities for focused programs, policies, and interventions. For example, breaking down data by race enabled the city to prioritize investment of resources during the COVID-19 pandemic to address the needs of people living in under-resourced communities.

Partners: Nonprofit organizations, corporations, foundations, local government agencies, educational institutions, member trade organizations

How the Vermont Health in All Policies Initiative Adopted a Holistic and Comprehensive View: In Vermont, the health department is working with partners to ***measure whether helping residents weatherproof their homes reduces healthcare costs and use***, like emergency department visits and hospitalizations. With support from the Health in All Policies Task Force, a Weatherization+Health initiative is ensuring that when residents receive services to help protect their homes from temperature changes and moisture, they are screened for additional health, energy, and housing needs and referred to necessary support.

Real-World Examples of Adopting A Holistic and Comprehensive View of People and Communities in Shared Measurement Efforts

Partnerships with hospitals have also provided integrated weatherization and health services to patients who have trouble breathing or who are at risk of injury from falling. Measures to track progress include data collection that will help partners understand the extent to which unhealthy housing conditions are common and allow the health department to track improvement over time.

Partners: Public health, 13 state agencies, departments, and organizations, including health, transportation, agriculture, education, human services, and natural resources

5. Reflects Shared Values and Intentional, Long-Term Efforts to Build and Sustain Trust.

- Measurement reinforces trust, relationship building, and accountability when partners agree on shared values and goals and everyone has a clear role in measurement they can recognize, identify with, and continually act on. Community members' trust is earned over time and can be achieved and sustained through:
  - acknowledging mistrust and its root causes;
  - being accountable within and across systems to address social, economic, and political structures and policies that create and perpetuate racism and exclusion, income inequality, and conditions and environments that diminish health (e.g., food insecurity, poor housing, reduced access to care); and
  - promoting transparency throughout the measurement process about decisions, actions, and the resulting outcomes.
- Measurement helps systems become more trustworthy partners by engineering into systems structures and incentives for accountability to communities.

Real-World Examples of Building Shared Values and Trust in Shared Measurement Efforts

How the Community Schools Initiative (CSI) Built Shared Values and Trust: Local partners participating in community schools define goals related to their shared vision and focus on measures related to those goals. Once partners ***define goals, shared measurement guides community schools toward building the right approach for achieving those goals***. For example, the United Way COMPASS Community Schools Initiative in Pennsylvania uses Results-Based Accountability™ planning to start with the results in mind and then map backwards to the services and programs needed to achieve those results.

Real-World Examples of Building Shared Values and Trust in Shared Measurement Efforts

Community schools then use the measures they collect to self-evaluate, learn, and hold their collaborative leadership accountable. “The accountability on the partnership and the collaborative leadership itself are within the performance measures. Are we going to deliver these things? Are the numbers going in the direction we’d like it to go in? Are the percentages going in the direction we would like it to go in? And so together, they hold themselves accountable.” — Community Schools Initiative

Partners: Health, government, philanthropy, commerce, community-based organizations, faith-based organizations, social services, occupational development, sports and recreation

How the Vermont Health in All Policies Initiative Built Shared Values and Trust: This initiative ***appointed a task force to share information among state agencies and identify opportunities for collaboration and support***. The task force includes representatives from agencies focused on agriculture, commerce and community development, education, human services, natural resources, transportation, public service, health and administration. Through the task force, the initiative showed agencies what they were already doing to contribute to a Health in All Policies framework, helping partners agree on shared values and goals early on and ensuring that everyone has a clear role in measurement they can recognize, identify with, and continually act on. “We started by talking to people in specific agencies and asking how they are already contributing to this Health in All Policies philosophy, and then asking what more they can do. It was a matter of getting people to the table and having them see that they are already doing this work, so it wasn’t a big lift right away. And then nudging people to the next step, asking, ‘What more can we do? What else can we do?’” — Vermont Health in All Policies

Partners: Public health, 13 state agencies, departments, and organizations, including health, transportation, agriculture, education, human services, and natural resources

Conclusion

This set of principles offers guidance for ways that systems and communities can use shared measurement as a tool to align decisions, policies, and practices toward equitable health and well-being. By using these resources, community members, system leaders, service providers, and policymakers can be more effective in collectively improving the health and well-being of their communities.

Appendix A: Contributors

The American Institutes for Research team, including consultants in equity and community engagement, developed these principles through a modified Delphi process in partnership with an 18-member expert stakeholder panel and a seven-member steering committee of leaders in cross-systems alignment, measurement, and community engagement from across the nation.

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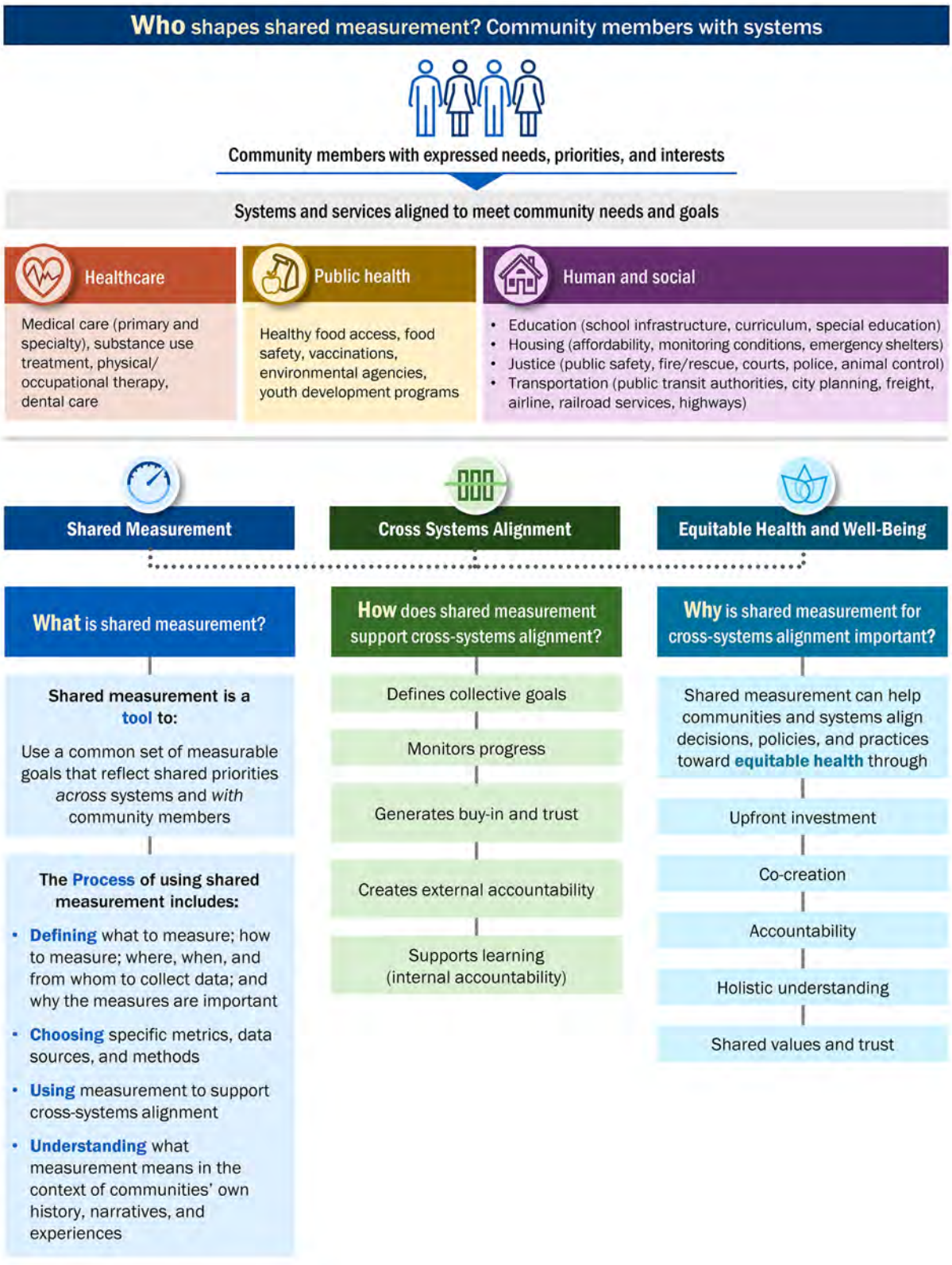
Appendix B: A Framework for Aligning Systems with Communities to Advance Equity through Shared Measurement

Key Concepts and Definitions

The purpose of this framework is to create a shared understanding of core concepts essential to the set of principles for shared measurement. This framework builds on the concept of shared measurement introduced in the Collective Impact model.[1] The American Institutes for Research adapted this concept to the context of cross-systems alignment efforts based on learnings from a review of 43 cross-systems alignment initiatives through an ongoing environmental scan, key informant interviews, a deep exploration of six initiatives through use cases, insights from virtual community listening sessions in six communities across the United States, and advice from steering committee members. Recognizing the diversity of experiences and perspectives that people bring to cross-systems alignment work, we offer working definitions of these core concepts, including community, systems, shared measurement, cross-systems alignment, equitable health and well-being, and principles (Exhibit B-1).

[1] The Collective Impact model describes shared measurement as a system for collecting data and measuring results consistently across all participating organizations to ensure that efforts remain aligned, that they hold participants accountable, and that they enable participants to learn from one another's successes and failures. Source: Kania, J., & Kramer, M. (2011, winter). Collective impact. *Stanford Social Innovation Review*. https://ssir.org/articles/entry/collective_impact

Exhibit B-1. A Framework for Advancing Equity through Shared Measurement



Glossary of Core Concepts

Core Concept	How it Relates to Shared Measurement
Community has no single definition. It can refer to geography or a group that self-identifies by age, ethnicity, gender, sexual orientation, disability, illness, or health condition. It can refer to a common cause, a sense of identification or shared emotional connection, shared values or norms, mutual influence, common interest, or commitment to meeting a shared need.[a]	The priorities and concerns of community members are central to understanding how systems can work to create community health and well-being.
Systems are the organizations, programs, infrastructure, and activities within communities that shape the way that people work, live, play, and pray. Systems are made up of people who use resources to build and maintain infrastructure to carry out programs, activities, and functions following set policies, practices, and procedures.	Systems within communities (including medical care, public health, housing, education, transportation, justice, and human and social services) provide services that directly influence the health and well-being of community members.
Shared measurement uses a common set of measurable goals that reflect shared priorities across systems and with community members.	Shared measurement helps systems and communities systematically define collective goals, monitor progress, generate buy-in, and create accountability within organizations and communities.
Cross-systems alignment requires that systems think and work together in fundamentally new ways to improve the health and well-being of the people and communities they serve.[b]	Systems that work together with communities to address community priorities and concerns are more effective in collectively improving the health and well-being of their communities.
Equitable health and well-being means that everyone has a fair and just opportunity to be as healthy as possible. **Health**[c] means physical and mental health status and well-being, distinguished from healthcare.	Achieving equitable health and well-being requires reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.
Excluded or marginalized groups[c] are those who often have suffered discrimination or been excluded or marginalized from society and the health-promoting resources it offers. These groups have been pushed to society's margins, with inadequate access to key opportunities. They are economically and/or socially disadvantaged. Examples of historically excluded/marginalized or disadvantaged groups include—but are not limited to—people of color; people living in poverty, particularly across generations; religious minorities; people with physical or mental disabilities; LGBTQ persons; and women.	Social exclusion, marginalization,[c] discrimination, and disadvantage can be measured, for example, by indicators of wealth (such as income or accumulated financial assets), influence and prestige, or social acceptance (for example, educational attainment and representation in high executive, political, and professional positions). They also can be measured by well-documented historical evidence of discrimination (such as slavery; displacement from ancestral lands; lynching and other hate crimes; denial of voting, marriage, and other rights; and discriminatory practices in housing, bank lending, and criminal justice).

Core Concept	How it Relates to Shared Measurement
Shared power is a governance structure, system, or way of working in which no one entity or individual dominates decision making or actions. All partners have equal agency, authority, and capacity to act, say, decide, do, or challenge. Sharing power seeks to keep the ability to affect outcomes in the hands of those who are affected.	Sharing power through measurement means shared processes to (a) *define* what to measure, how to measure, from whom to collect data, and why the measures are important; (b) *choose* specific metrics, data sources, and methods; (c) *use* measurement to support cross-systems alignment; and (d) *understand* what measurement means in the context of communities' own history, narratives, and experiences.
Accountability is how individuals accept responsibility for and hold themselves to their goals and actions, acknowledge the impact of those decisions and actions on the groups to whom they are responsible, and take steps to rectify harm or unintended consequences that occur. Accountability requires transparent and consistent communication about roles, processes, and outcomes.	Measurement creates and reinforces accountability by quantifying goals, tracking progress toward those goals, and providing transparent mechanisms for reporting on performance.
Investment means intentional and sustained implementation of resources (time, funding, skill-building activities, economic and social development) to develop trusting relationships, build capacity, share learning, and improve the social and structural environments in ways that advance equity and growth.	Investing in measurement capacity building among community partners, and developing skills and capabilities for co-creation and power sharing among systems stakeholders, can support shared measurement.

Notes:

[a] Community-Campus Partnerships for Health. Frequently asked questions. https://www.ccphealth.org/frequently-asked-questions/

[b] Robert Wood Johnson Foundation. (n.d.). Cross-sector alignment glossary. Align for Health. https://www.alignforhealth.org/glossary/

[c] Braverman, P., Arkin, E., Orleans, T., Proctor, D., & Plough, A. (2017). *What is health equity? And what difference does a definition make?* Robert Wood Johnson Foundation. https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html

Appendix C: Overview of Principles Development

The American Institutes for Research (AIR) developed the five principles for Aligning Systems with Communities to Advance Equity through Shared Measurement through a collaborative, modified Delphi process. A modified Delphi method is an iterative process that systematically and progressively gathers input from a panel of stakeholder experts to determine group consensus.

Panelists

AIR purposefully recruited and engaged a panel of 18 experts with expertise in cross-systems alignment, measurement, and community engagement who brought a wealth of experience in working to understand and/or address the needs and priorities of communities that are most at risk of inequities. The panel included leaders involved in initiatives to improve health outcomes at the national, state, and local levels; policymakers; "bridge builders" who work to connect public health, healthcare, human and social services, and other systems with communities; and community members and advocates.

Process

Over the course of 6 weeks (September 16, 2020, through October 28, 2020), AIR guided the panel through three rounds of activities, including four facilitated virtual meetings (including an introductory meet-and-greet to introduce panelists to each other and the team, and to set expectations) and three online surveys to develop the set of stakeholder-driven principles.

To support panelists throughout the Delphi process, we developed and shared a detailed resource guide that described key learnings from all previous project activities, including a conceptual framework for shared measurement, use case examples of measurement practices applied within five multi-system alignment initiatives, perspectives from listening sessions held in six diverse communities, and a draft set of nine principles derived from these formative activities. We also developed a brief, 8-minute introductory video to accompany the guide. All panelists received equal compensation for their time and participation.

Surveys

Following the meet-and-greet, AIR administered online surveys before each panel meeting. Surveys asked panel members to rate and re-rate (if applicable) each of the draft principles in terms of importance for inclusion as a principle (4-point Likert scale: omit, possible candidate for inclusion, desirable candidate for inclusion, essential for inclusion) and offer new recommendations, edits, etc. via open-ended responses. For each survey round, we summarized ratings using percentages; we equally weighted the views of all panelists (survey responses were anonymous). Based on survey responses, we grouped the draft principles into three categories:

- Prioritized Principle: If at least 75% of participants rated a principle in the "essential" category

- Principle to Consider for Omission: If at least 75% of participants rated a principle in the "omit" category
- Potential Principle: All remaining principles—if less than 75% of participants rated a principle in the "essential" and/or "omit" category

We analyzed qualitative responses for themes and patterns.

Meetings

Before each meeting, AIR sent an email reminder with key takeaways from the previous survey. Two expert facilitators co-moderated each meeting, which we structured to include a combination of full- and small-group interaction (breakout rooms). During meetings, facilitators engaged participants in icebreaker/warm-up activities, communicated meeting objectives and guiding questions, set the tone for discussion by acknowledging external events/factors that might impact reactions, recapped key learnings from previous surveys and meetings, asked probing questions to uncover perspectives on the principles, summarized what participants heard from panelists before the end of each call, and shared reminders for upcoming activities. All meetings were audio-recorded with participants' permission. After each meeting, we shared key takeaways, detailed meeting notes, and recording links with panelists. In addition, after the meetings, we revised draft principles based on feedback obtained on the survey and during discussion; we included these revised principles, as appropriate, in the next survey. The project team held 1-hour debrief calls after each meeting and subsequent planning calls upon finalizing key takeaways.

Evolution of Principles

- AIR began the Delphi process with nine draft principles for Round 1 (Survey 1 and Meeting 1), which we developed based on key learnings from early project activities.
- After Meeting 1, we integrated two principles into others, and we added two new principles, yielding a total of nine principles going into Round 2 (Survey 2 and Meeting 2).
- After Meeting 2, we integrated four of the nine principles into others and added no new principles, leaving a total of five principles going into Round 3 (Survey 3 and Meeting 3).
- During Round 2, panelists recommended the addition of a preamble to contextualize the principles and a glossary of key terms; we included these in Survey 3 in addition to the five revised principles.
- After Meeting 3 (end of the Delphi process), we revised the principles based on feedback. The five principles presented above reflect these changes.

Exhibit C-1. presents key points from panel discussions, suggestions for principle revisions, and modifications applied in each round of the modified Delphi process.

Exhibit C-1. Panel Feedback on Principles, by Round

Modified Delphi Round	Key Points	Suggestions	Modifications
Round 1	• Recognize diverse and divergent community voices • Shared language is important • Data and measurement can cause harm • Accountability is critical and relevant across principles	• Be explicit about what is meant by "those who have experienced inequities" • More clearly define "harm" • Reframe as asset based • Need principles on community investment and data ownership • Tease apart concepts (overlap) and adjust language around "systems" and "communities"	• Combined the draft principle on centering the needs, values, and priorities of community members with the principle on co-creation • Combined draft principle on not harming communities with the draft principle on addressing root causes • Added two new principles on data ownership and investment in community
Round 2	• Need to name shared power and shared decision making as important • Language should encourage collaboration and a dynamic process • Importance of a shared learning environment • Need to frame principles with intention and clarity • Level setting around key concepts is important • Concerns and questions about implementation	• Several concepts need further definition (e.g., community, authentic engagement, whole person) • Address redundancy across principles • Include a preamble to accompany the principles • Include a list of key terms and definitions • No new principles recommended	• Drafted a preamble to contextualize the principles that included list of key terms and definitions • Consolidated to five principles • Added questions about implementation to Survey 3
Round 3	• Support for preamble and definitions • Need to apply a process lens to this work; it is iterative • Key steps to building buy-in • Communication is important • Power must be shared	• Some suggestions for reorganizing parts of preamble and revising definitions; moving definitions to an appendix • Suggested revisions to language or order across the five draft principles (e.g., community investment first)	• Revised language in preamble/introduction to address concerns regarding tone • Added sections and headers to break up language in introduction • Included project's shared measurement framework as an appendix; integrated new key terms and definitions into framework glossary

Modified Delphi Round	Key Points	Suggestions	Modifications
Round 3 (continued)	• Implementation requires time and resources • Equity must be integrated into systems and power structures		• Reordered principles to present the upfront investment in communities principle first • Integrated example practices that reflect principles from use cases • For co-creation principle, moved shared power up to first concept and integrated "equitable, sustained partnership" into this section • For accountability principle, created two categories: one on accountability for addressing root causes of inequities and one addressing the need to repair harm when it occurs • For trust principle, added language addressing sustainability focus and the need to engineer trust into systems and not just focus on the interpersonal aspect of trust • Added appendices with list of stakeholder experts and brief overview of methods

Suggested Citation

Hilliard-Boone, T., Lavelle, M., DePatie, H., Adhikari, S., Ali, Maliha, Childers, T., Firminger, K., Ogletree, A., Pathak-Sen, E., Powell, W., & Schultz, E. (2021). *Aligning Systems with Communities to Advance Equity through Shared Measurement: Guiding Principles.* (Prepared for the Robert Wood Johnson Foundation). Crystal City, VA: American Institutes for Research. Available at www.air.org/sharedmeasurement

FOR MORE INFORMATION ABOUT THIS PROJECT

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First Generation EV-ROI Model for Hartford Communities That Care's Hartford Crisis Response Team/ Hospital-Linked Violence Intervention Program

Background

In 2004, Hartford Communities That Cares (HCTC) created the Hartford Crisis Response Team (HCRT) in partnership with Trinity-St. Francis Hospital and Medical Center in Hartford to address the mental health and medical needs of victims assaulted or by gunshot, knife wounds, or blunt trauma. The HCRT connects with victims at a moment of significant crisis, offering trauma-informed, culturally responsive care and case management, clinical care, safety planning, peer support, information, referrals, and connections to community resources. HCTC interrupts the cycle of violence working within the healthcare system, reducing future morbidity and mortality, preventing retaliatory violence, and increasing community safety. HCRT services include immediate and post-crisis interventions, gang mediation, conflict resolution, mental health and substance abuse services and referrals, and access to personal injury and survivor benefits compensation and reimbursement. Based on its exemplary work over the past fourteen years and implementation of evidence-based standards, HCTC has received designation as the State of Connecticut's only Hospital-Linked Violence Intervention Program and is one of only 30+ such programs in the nation. HCTC is a member of the National Network of Hospital-Based Violence Intervention Programs (NNHVIP), implementing a public health, family-centered approach to addressing community violence and providing victims' assistance. Since 2004, HCTC has responded to and supported 722 fatal and non-fatal shooting victims and their families.

Shooting incidents / victims in Hartford, Connecticut have ranged between 105 and 143 from 2011 through 2017. Hartford has experienced a 33.8% increase in shootings in 2018 over 2017 and is on pace for a record-breaking 178 shootings in 2018 (95 shootings through July 21st, 2018, up from 71 shootings in 2017 through July 21st, 2017). Saint Francis Hospital and Medical Center, located in the heart of Hartford, with 617 beds and 65 bassinets, is the largest Catholic hospital in New England, and serves many of these shooting victims. The Saint Francis mission is "to serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities." Their Core Values include: **"Reverence** - We honor the sacredness and dignity of every person; **Commitment to Those Who are Poor** - We stand with and serve those who are poor, especially those most vulnerable; and **Stewardship** - We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care."

In keeping with Saint Francis' mission and core values, Hartford Communities That Care (HCTC) applied for and received funding from Trinity Health / Saint. Francis Hospital Wellbeing 360 to support the HCTC-initiated Crisis Response Team/ Hospital-Linked Violence Intervention Program (HCRT) activities among residents living in the City of Harford who were victims of a violent crime, treated and discharged from Trinity Health / Saint Francis Hospital.

HCTC has committed to supporting (20) twenty victims of gun violence with immediate emergency crisis intervention, connection to follow-up medical care, and the provision of long-term recovery services. This three-pronged approach seeks to create short-, intermediate- and long-term outcomes. HCTC has contracted with Social Capital Valuations, LLC (SCV) to monetize those outcomes for the purpose of calculating the return on investment for services rendered by HCTC's HCRT.

SCV's Expected Value – Return On Investment (EV-ROI)

SCV developed Expected Value-Return on Investment (EV-ROI) as a predictive model that combines a commonly accepted probability theory (expected value) with a common approach that businesses use to make financial decisions (return on investment). Expected value is the probability of an occurrence multiplied times the absolute dollar value of that occurrence. For instance, if a person bought enough lottery tickets to acquire a 10% chance of winning $1,000,000, then we would say the expected value of winning = 10% x $1,000,000 or $100,000. If it cost that person $50,000 to buy those lottery tickets, then we can say that every $1 invested would be expected to return $2 in revenue.

EV-ROI Applied to HCTC's HCRT

The first step in calculating the EV-ROI of any program is to create a logic model that depicts the linkages between a program's purpose, inputs, activities, outputs and outcomes so that readers may gain a comprehensive view of the program's pathways to intended outcomes. The logic model for the HCTC NCRCS program is offered on the following page. Note that the boxes that are bordered in red indicate aspirational positions and services to be offered contingent upon finding the requisite funding.

Logic Model: Neighborhood Crisis Response and Community Support (NCRCS)

Mission Statement: Provide immediate and on-going medical, emotional, psychological, communal and spiritual support for victims of urban gun violence and ensure proper follow-up care that optimizes recovery and positive long-term outcomes for the victims, and reduces hospital emergency room utilization and costs for taxpayers and commercial insurers.

Inputs

What We Invest

- Trinity Health/St. Francis Hospital and Medical Center
- Harriot Home Health Services
- The Ct. Department of Mental Health and Addiction Services
- The City of Hartford
- Ct. Department of a Social Services / Medicare-Medicaid
- Commercial insurance providers
- Patients and Their Families

Activities

What We Do

HCTC Project Director/Lead Facilitator:
- First point of contact and lead crisis coordinator
- Assigns HCTC staff, Community Caregiver (CC) and LCSW
- Develops and facilitates trauma-informed trainings for forty (40) volunteer CCs and fifteen (15) paid staff.
- Co-leads monthly NCRCS planning meetings

The Crisis Response Team (PD/Staff/CC):
- Provides rapid on-site response to victims of violent crime within 0-24 hours of initial call
- Connects victim and/or family with Office of Victim Services
- Secures funding for burial, emergency medical bills, safe housing, food, other essential supports and follow-up

15 HCTC Staff:
- Receive training in pre-crisis (prevention), crisis (intervention) and post-crisis (advocacy, referral, treatment and support)
- Conduct intakes and do data entry
- Determine Medicaid eligibility, and help clients apply

HCTC Licensed Clinical Social Worker (LCSW):
For twenty (20) victims of violent crime discharged from St. Francis
- Accepts referrals from Trinity Health / St. Francis Hospital
- Conducts intakes and assessments
- Provides an Individualized Sustainability Plan (ISP)
- Provides trauma counseling to victims and their families
- Provides group and individual behavioral health therapy

2 Case Managers:
- Coordinates internal services offered by the LCSW and CC
- Coordinates external services including Harriet Home Health, OVS, Legal, Housing, Educational, and Job-related training.

The 40 Community Caregivers (CC):
- Receives training in pre-crisis (prevention), crisis (intervention) and post-crisis (advocacy, referral, treatment and support)
- Are matched with and establish therapeutic alliance w/ client
- Mentors and offers spiritual, emotional and communal support
- Advocates for and accompanies clients / provides transportation to other supports such as:
  - -Office of Victim Services (OVS),
  - -Legal (including court/criminal justice follow-up),
  - -Housing (including temporary housing and relocation),
  - -Educational (including tutoring, GED, and college), and
  - -Job readiness, skills, and placement training

20 Clients: Commit to LCSW, CC, and CIS to accomplish ISP

Outputs

What We Produce

- Training curricula
- # and % of requests for help that are answered within 24 hours
- # and % of families that receive funding for: burial, medical care, housing, food and other essential supports during time of crisis
- # of Intakes and Assessments
- # and % of clients who utilize Harriot Home Health Services
- # of clients receiving trauma counseling and behavioral health support at HCTC
- # and % of crisis clients who establish long-term Individualized Sustainability Plans
- # of Mentor – Mentee Matches
- # and % of Mentor – Mentee Matches that last at least 1 year
- # and % of Clients who are eligible for Medicaid are covered
- # and % of CC's and staff with completion of training certifications
- # and % of clients who follow through with referrals made by LCSW and CC
- # and % of clients and families who utilize mental health and grief counseling services in non-traditional or non-clinical settings

Outcomes

Short - Learn

- HCTC paid & volunteer staff become aware of services potentially available to clients and log info into resource DB
- Paid & volunteer staff reach out to and get to know managers of government and community services
- Collaborators and partners (e.g., including criminal justice, educational and faith) know about and understand the mission of NCRCS
- CC/Staff KSA's are increased in the areas of Crisis Prevention Intervention, De-escalation Techniques, Crisis Debriefing, CPR / First Aid, Psychological First Aid, Post Trauma Stress Management, Peer Service Delivery, Group Facilitation, Referrals, and Suicide Risk Assessment.
- Clients' KSA's are increased in the areas of: - Trauma
  - Healthy Habits
  - Coping Skills
  - Self-Awareness
  - Conflict Resolution
  - Communication
  - Available Supports

Intermediate – Action

- Collaborators provide outreach and welcome interactions with clients and their mentors
- # and % of clients who make use of a variety of services offered by collaborators and partners
- # and % of clients who practice less risky behaviors (including no drug usage, no gang involvement)
- # and % of clients who adopt pro-social behaviors such as involvement in community and school-sponsored events and activities
- # and % of clients who attend group and individualized counseling, school, tutoring, and job training
- # and % of clients who utilize less costlier methods of treatment such as outpatient and in-home physical & mental health care and other social/emotional supports to heal

Long – Condition

- Less gang involvement
- Decreased retaliation and re-victimization rates
- Decreased utilization of hospital emergency room
- Decreased 30-day hospital readmission rate
- Overall improved health condition for client / victim of gun violence
- Decreased probability of 1st time gun violence at the community level
- Increased educational attainment and graduation rates
- Increased employment rates
- Decreased need for public assistance
- Decreased rates of involvement with criminal justice system

and % of clients who are on track for accomplishing the goals laid out in their ISP

Calculation Methodology

From the upper most box of the logic model we see that the mission of the HCTC HCRT is to, "Provide immediate and on-going medical, emotional, psychological, communal and spiritual support for victims of urban gun violence and ensure proper follow-up care that optimizes recovery and positive long-term outcomes for the victims and reduces hospital emergency room utilization and costs for taxpayers and commercial insurers." EV-ROI calculations are always conservative valuations in the sense that it is not always possible (or practical) to monetize all of the possible outcomes. In this case, measuring the emotional, psychological, communal and spiritual growth in economic terms may strain a reader's credulity, but we can examine and estimate: 1) the value of follow-up medical care provided in the home that prevents re-admission; 2) social-emotional learning that leads to less retaliation, fewer violent crimes and fewer visits to the emergency department for serious injury; and 3) embarking on a positive life trajectory that leads to high school graduation and/or vocational training and ultimately a full time job and a career.

1 & 2) Harriot Home Health Services plus Primary Care Provided by Dr. Diez: The value of follow-up medical care that prevents emergency room use and hospital re-admission.

Trinity-Saint Francis provided a spreadsheet with medical cost information for individuals who were treated for injuries inflicted by handgun (and other mechanisms) at Trinity-Saint Francis between January 1, 2015 and June 14, 2017. That information was sorted on age and on mechanism so that only individuals who were injured by handguns were included. The average hospital charges for that demographic was $79,454.

HCTC is teamed-up with Harriot Home Health Services (HHHS) and Dr. Diez at Trinity-St. Francis to provide in-home and out-patient treatment of gun-shot victims and other victims of violent crimes after they are released from Trinity-Saint Francis. HCTC referred 15 of the 25 non-fatal gunshot victims to HHHS for in-home care, and HHHS cared for an additional 32 seriously injured victims that were referred directly from the hospital to HHHS. The savings from this care is two-fold. First, the 15 gun-shot victims directly referred to HCTC and 32 other victims referred by HHHS (for a total of 47 patients) that would have otherwise returned to the emergency room for routine follow-up care at high ER costs, are seen in their homes and at Dr. Diez's office at a much lower cost. Second, better care means fewer of these victims return to Trinity-Saint Francis for re-admission.

1) Emergency Room Savings

Because Trinity-Saint Francis does not bear the cost of in-home services provided by HHHS, the cost savings differential for lower ER usage for Trinity-St. Francis is the difference in the cost of patients using Dr. Diez versus patients using the ER as their primary care physician. According to the U.S. Agency for Healthcare Research and Quality the cost of a doctor visit in a hospital emergency department averaged $922, while a physician office visit averaged $199 in 2008[1].

[1] https://archive.ahrq.gov/news/newsroom/news-and-numbers/042011.html

This $723 differential would be $944 in 2017 dollars[2]. If all 47 patients seen in their home by HHHS and as out-patients by Dr. Diez would have otherwise gone to the emergency room twice, then a total of $944 x (2 visits per patient x 47 patients) = $88,736 in Trinity-Saint Francis care is saved.

2) Hospital Readmission Savings

If the regime of HHHS in-home care coupled with visits to Dr. Diez eliminates hospital readmission, and since according to a previous study of gunshot victims[3] 12.4% are readmitted, then 12.4% of the 47 victims, or 5.8 victims could potentially avoid readmission. Since, according to the same past study[4], the readmitted victims come back 2.3 times, and that their additional costs are 9.6% higher than their initial costs, then the additional cost equals 1.096 x $79,454 or $87,082. If 5.8 victims are saved from returning to Trinity-Saint Francis, then a total of $505,076 would be saved (5.8 x $87,082).

Cost for HHHS and Dr. Diez

Based on trends and outcomes experienced by Harriot Home Health Services, client will utilize 3 months of homecare, including wound care, hygiene care, coping skills/community referrals, physical therapy and wound care supplies. According to Harriot Home Health Services, their annual fee for 18 skilled nursing visits, 2 social worker visits, 3 physical therapy visits, 36 hours of an aide, and $500 in wound supplies = $3,491 per person or $164,077 for all 47 victims of violence. According to Indeed, the average annual salary for a primary care physician in Connecticut is $185,458[4] or $89.16 per hour. The ratio of total expenses to wages in the Trinity Health system is 2.26:1[5] Therefore, the total expense per hour of Dr. Diez's time would be $201.50 per hour. If each of the 94 visits (2 each x 47 victims) lasted 30 minutes, then the cost for Dr. Diez's time would be = 47 hours x $201.50 per hour, or $9,471. The total cost of HHHS plus Dr. Diez to serve the 47 patients was $173,548.

3) HCTC Interventions: The value of social-emotional learning that leads to less retaliation, fewer violent crimes and fewer visits to the emergency department

Previously, when working with gunshot victims, HCTC would refer patients to Medicaid-paid trauma therapy practitioners located a bus ride away somewhere else in Hartford. Clients felt alienated from the bureaucracy and the cultural surrounding the services that were offered. The physical distance of the trauma therapy practitioners added another barrier to care and usually meant that clients who needed behavioral health services simply did not get those services. As a result of witnessing this negative experience, HCTC decided to enhance its offerings by hiring licensed clinical social workers to work in-house. The experience so far has shown that patients have a higher degree of trust, leading to greater patient/provider therapeutic alliance, meaning that victims of violent crimes are now receiving the behavioral health piece that had previously been missing.

[2] http://www.halfhill.com/inflation_js.html

[3] J Trauma. 1992 Oct;33(4):556-60. Initial and subsequent hospital costs of firearm injuries. Wintemute GJ1, Wright MA.

[4] https://www.indeed.com/salaries/Primary-Care-Physician-Salaries,-Connecticut

[5] Trinity Health – New England, Inc. Hartford, CT, Consolidated Financial Statements, Year Ended Sept 30, 2016

As a first order estimate of the effect of this in-house therapy we turn our attention to a program called "Becoming A Man" (BAM) that had its origins in Chicago developed by a non-profit called Youth Guidance. According to authors of an NBER Working Paper[6] "participation in the program reduced total arrests during the intervention period by 28–35%, reduced violent-crime arrests by 45–50%, improved school engagement, and in the first study where we have follow-up data, increased graduation rates by 12–19%." Furthermore, they found that juveniles at a temporary detention center reduced readmission rates to the facility by 21%. These large behavioral responses combined with modest program costs imply benefit-cost ratios for these interventions from 5-to-1 up to 30-to-1 or more. The working hypothesis is that the programs work by helping youth slow down and reflect on whether their automatic thoughts and behaviors are well suited to the situation they are in, or whether the situation could be construed differently.

HCTC believes the behavioral health interventions they are engaged in work in an analogous way by offering CBT in both a group and in individual sessions. The following chart depicts the total cost of services delivered from July 1, 2017 – June 30, 2018.

Service Delivered	# of Recipients	Cost per Recipient	Total Cost
2-each: Crisis Intervention	48	$220	$10,560
1-each: Diagnostic Assessment / Evaluation	56	$103	$5,768
12-each: Individual / Family Therapy	56	$720	$40,320
12-each: Case Management	56	$960	$53,760
6-each: Group Therapy	26	$270	$7,020
Total Cost of Services Delivered			**$117,428**

Employing the conservative low end of the benefit-cost ratios mentioned above, or a 5-to-1 benefit to cost ratio yields a benefit of $587,140 through the reduction in retaliations, fewer violent crimes and fewer visits to the emergency department. Another way of calculating the value of crisis care and therapy is to recognize that for every violent incident avoided there is an average of $79,454 in initial costs and $10,806 in follow-on costs avoided, or $90,260 in avoided costs per victim. Since it costs HCTC $117,428 to treat 82 people (56 from first four services delivered, plus unduplicated 26 receiving Group Therapy), if just two of the participants avoid a violent response to a future situation, then the program will have paid for itself and achieved a 54% return on investment (2 gun-related violent acts avoided x $90,260 = $180,520 saved, against $117,428 expended). If the program has a 10% success rate and saves 8 future incidents from happening (10% of the 82 participants), then 8 x $90,260 = $722,140 will be saved in medical costs alone, representing a return of $6.15 for every dollar expended. Given this alternative valuation method yields a value of $722,140, the $587,140 valuation is a conservative estimate.

[6] Thinking, Fast and Slow? Some Field Experiments to Reduce Crime and Dropout in Chicago; Sara B. Heller, A. K. Shah, J. Guryan, J. Ludwig, S. Mullainathan, H. A. Pollack; NBER Working Paper No. 21178 Issued in May 2015.

Embarking on a positive life trajectory that leads to high school graduation and/or vocational training and ultimately a full-time job and a career resulting in: 4) increased tax revenue and 5) public assistance savings and 6) shifting of the Medicaid burden to another payor.

Another NBER working paper[7] looks at the effect of BAM combined with tutoring. HCTC already has a precedent for offering this sort of intervention because of the work it does with the Violence Free Zone (youth mentoring). According to the study, graduation rates increased by 14 percentage points. Conservatively assuming a 10% improvement in the graduation rate for the 82 clients served through a combination of physical health and mental health services, then an additional 8 students will graduate high school or earn their GED.

4. Increased Tax Revenue. A high school graduate's median weekly income in 2015 was $678, and a high school dropout's median weekly income was $493 in 2015. These weekly incomes must be reduced by the probability of being employed, which was 94.6% for a high school graduate and 92% for a high school drop-out in 2015. These new "expected value" weekly wages are $641.39 for the high school graduate and $453.56 for the drop-out.[8] This $187.83 differential in weekly income equals $9,767 per year. Assuming a 50-year career, the differential would be $488,350 in earnings. Assuming a 2% discount rate that would equal $306,916 in additional lifetime earnings per high school graduate. Assuming an annual federal income tax of 15%, state income tax of 5% + $300, and total FICA of 15.3%, then the taxpaying public would be denied $108,641 in lifetime taxes[9] for every high school dropout. 8 additional graduates times $108,641 in lifetime tax revenue = $869,128 in taxpayer return at no incremental cost to the taxpayer.

5. Public Assistance Savings. Since high school dropouts are three times more likely to receive public assistance than high school graduates[10], high school graduation is also a predictor of public assistance savings. 37.3% of people who did not graduate from high school received means-tested benefits in 2012[11] 37.3% is 3x 12.43%, so assume that there is a 24.87% difference in the probability of receiving means-tested benefits. Applying this 24.87% differential to 8 students means 1.99 more families would have been on public assistance. Connecticut had the fourth highest average welfare benefit package among the fifty states in 2013 at $38,761[12]. Backing out $9,175 for the Medicaid portion of that public assistance package (handled separately below), the public assistance package equals $29,586. Using the CPI Inflation

[7] The (surprising) efficacy of academic and behavioral intervention with disadvantaged youth: Results from a randomized experiment in Chicago (NBER Working Paper 19862). Cambridge, MA

[8] http://www.bls.gov/emp/ep_chart_001.htm; Earnings and unemployment rates by educational attainment, 2015

[9] http://taxfoundation.org/article/2016-tax-brackets for federal rates = 15% up to $50,400 and 25% > $50,400; http://www.tax-brackets.org/connecticuttaxtable for Connecticut rates = 5% up to $50,000 + $300, and 5.5% for $50,001+ plus $2,300, and 7.65% for FICA x 2 = 15.3% for both employer and employee portions.

[10] Pennsylvania's Best Investment: The Social and Economic Benefits of Public Education; Mitra, D. and Zheng, A; The Education Law Center; Pennsylvania State University

[11] 21.3 Percent of U.S. Population Participates in Government Assistance Programs Each Month; May 28, 2015 ; https://www.census.gov/newsroom/press-releases/2015/cb15-97.html

[12] The Work Versus Welfare Trade-Off: 2013; An Analysis of the Total Level of Welfare Benefits by State; Tanner, M. and Hughes, C. (2013).

Calculator[13] that package would be $31,121 in 2017 dollars. Assuming 4 years of usage[14], that would equal $124,484 per family times 1.99 families equals $247,723 in avoided public assistance costs.6. Shifted Medicaid Burden. 100% of the young men that HCTC has provided service to have their medical expenses covered by Medicaid. Without the Crisis Intervention and subsequent clinical intervention (counseling and therapy) provided by HCTC, it is likely that these young men would continue to be covered by Medicaid. Instead, 8 of the 82 young men receiving counseling and therapy are presumed to graduate high school and successfully transition to a productive career where health care costs will be borne jointly by the employer and successful client. In an article entitled "The Lifetime Distribution of Health Care Costs"[15] the authors show in Table 3 that the Lifetime Per Capita Expenditure between the ages of 20 and 65 is $137,801 in Year 2000 dollars. Adjusting down (96.4%) for men and using a medical cost inflation calculator[16] to find that value in 2017, yields a cost of $242,086 per male for the 45-year productive work life. Multiplying $242,086 times the 8 young men equals a shift of $1,936,688 to other payors.

Summary of Benefits

The following tables summarize the economic benefits that are projected to accrue from the six outcome categories that were presented in this study. The first two lines of Table 1 depicting the benefit of home care and outpatient services, as opposed to repeat visits to the emergency room, tally $593,812 in costs savings.

Table 1 also shows HCTC Clinical Interventions with a net benefit of $469,712 and a benefit-cost ratio of 5.00 which is equivalent to a 400% return-on-investment. Embedded in that return, which is predicated on breaking the cycle of violence, are savings due to fewer victims needing care at St. Francis' ER.

Lastly, there is a lifetime taxpayers' benefit of $2,283,259 from increased tax revenue, decreased public assistance, and a shifting of the Medicaid burden to the employer and client due to a positive change in the lifetime trajectory of clients served by HCTC. This substantial public good is a favorable by-product of the HCRT project whose costs are borne by St. Francis Hospital &Medical Center and the Connecticut Depart of Health and Human Services.

Summing the short-term benefits and costs of the hospital program with the fortuitous long-term taxpayer benefits yields a combined hospital plus Medicaid and taxpayer benefit of $3,464,211 at a cost of $290,976. This means there is a net gain to the hospital, Medicaid and taxpayers of $3,173,235. The benefit-cost ratio to these three groups is 11.9 to 1.

Note that the predicted benefits are not independent from one another. In other words, the medical and behavioral health interventions, as well as the sense of connectedness clients feel

[13] http://data.bls.gov/cgi-bin/cpicalc.pl?cost1=38761&year1=2013&year2=2016

[14] https://www.census.gov/newsroom/press-releases/2015/cb15-97.html; Census report

[15] The Lifetime Distribution of Health Care Costs; Berhanu Alemayehu and Kenneth E. Warner. HSR: Health Services Research 39:3 (June 2004)

[16] https://www.halfhill.com/inflation_js.html

through group therapy, mentoring, and engagement in extra-curricular and community activities, all lead to a sense of self-esteem and self-efficacy that allows an individual to better realize the goals laid out in his or her Individualized Sustainability Plan (ISP) including their academic, vocational, and career potential.

Table 1: Summary of Benefits, Costs, and Ratios for Serving 47 Wound Victims and 82 Behavioral Health Clients by Benefit Category

Benefit Category	Benefits	Costs	Net	B/C Ratio
1) HHHS + Dr. Diez ER Savings	$88,736	$173,548	$420,264	3.42
2) HHHS + Dr. Diez Readmissions Savings	$505,076			
Subtotal for Home Care + Outpatient	$593,812	$173,548	$420,264	3.42
3) HCTC Clinical Interventions	$587,140	$117,428	$469,712	5.00
Subsequent Taxpayer Benefits	Benefits	Costs	Net	B/C Ratio
4) Increased Tax Revenue (Lifetime)	$869,128	n/a	$1,192,798	n/a
5) Public Assistance Savings (Lifetime)	$247,723			
6) 45 Productive Years not on Medicaid (age 20 to age 65) @$242,086 x 8 Careers	$1,936,688	n/a	$1,936,688	n/a
Subtotal Taxpayer Benefits	$3,053,539	n/a	$3,053,539	n/a
TOTALS	$4,234,491	$290,976	$3,943,515	14.55

Tables 2 and 3 below break out the returns for Saint Francis and governmental health agencies, respectively. Table 2 assumes that half of the benefit from medical cost savings, or $590,476, accrue to St. Francis (and the other half to Medicaid). Saint Francis' total outlay for this benefit equals $39,471 ($30,000 Well Being 360 grant plus $9,471 in outpatient costs). This equates to a net return of $551,005, with benefit-cost ratio of 14.96.

Table 2: EV-ROI for St. Francis Hospital & Medical Center

Benefit Category	Benefits	Costs	Net	B/C Ratio
½ of Home Care and Outpatient	$296,906	$39,471	$257,435	7.52
½ of Cycle of Violence Reduction caused by HCTC Clinical Interventions	$293,570	$0.00	$587,140	n/a
TOTAL ST. FRANCIS RETURN	$590,476	$39,471	$551,005	14.96

The Connecticut Department of Social Services (DSS) bears all but the $39,471 of the costs for crisis intervention, in-home care, out-patient treatment and clinical interventions. The rest of the $251,505 in costs are born by the DSS. For that investment, DSS receives better than a 10-fold return comprised of the immediate return (Home Care and Outpatient), and intermediate outcome return when the cycle of violence is broken, and a return that happens over a 45-year career when 8 young men, who would have otherwise been on Medicaid, can lead productive lives where their healthcare costs will be covered by their employers and themselves. Table 3 lays out this logic that shows this significant return on investment.

Table 3: EV-ROI for Federal and State Health Agencies

Benefit Category	Benefits	Costs	Net	B/C Ratio
½ of Home Care and Outpatient	$296,906	$134,077	$162,829	2.21
½ of Cycle of Violence Reduction caused by HCTC Clinical Interventions	$293,570	$117,428	$176,142	2.50
45 Productive Years not on Medicaid (20-65) @$242,086 x 8 Careers	$1,936,688	$0	$1,936,688	N/A
TOTAL PUBLIC HEALTH RETURN	$2,527,164	$251,505	$2,275,659	10.05

Table 4 adds the lifetime incremental taxes that are collected on incremental income, plus the savings from reduced reliance on public assistance to the bottom line of Table 3, to calculate the total return to the tax-paying public.

Table 4: EV-ROI for all Governmental Agencies

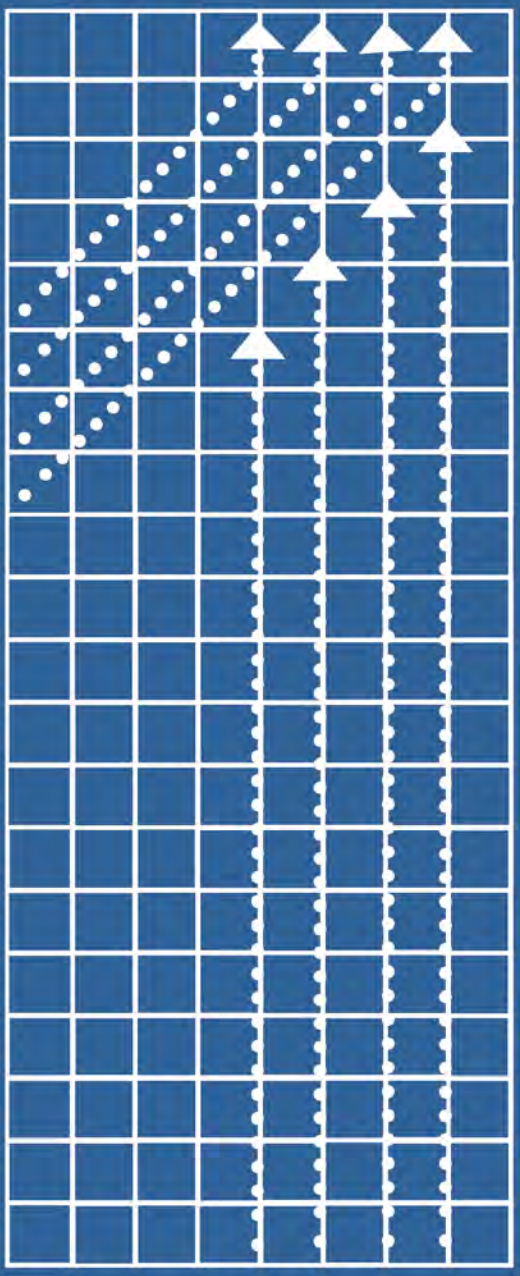
Benefit Category	Benefits	Costs	Net	B/C Ratio
Total Public Health Return	$2,527,164	$251,505	$2,275,659	10.05
Increased Tax Revenue (Lifetime)	$869,128	n/a	$1,116,851	n/a
Public Assistance Savings (Lifetime)	$247,723			
Total Public Sector Return	$3,644,015	$251,505	$3,392,510	14.49

Caveats and Recommended Next Steps

First Generation EV-ROI analyses are based on models that rely upon past studies of similar programs. Therefore, the results are estimates that represent the right order of magnitude of the results that can be expected if the program is implemented with fidelity to the model it is based upon. The next steps for transforming this First Generation EV-ROI analysis into a Second Generation EV-ROI analysis are:

1) Set up performance measurement system to verify that targets for process measures (such as training objectives for staff, and attendance at behavioral health sessions by clients) are being met.
2) Track Harriot Home Health Services provision of services and costs.
3) Track hospital costs and readmission rates beyond initial emergency room care and hospitalization for the intervention group versus hospital costs and readmission rates for a comparison group.
4) Track social emotional learning improvement for those receiving behavioral health services versus a comparison group.
5) Track arrest record and disciplinary referrals for group receiving behavioral health services versus a comparison group.
6) Track accomplishment of goals in the Individualized Sustainability Plans.
7) Track high school graduation, GED, vocational training certifications for behavioral services recipients versus comparison group.
8) Track job placement and retention for behavioral services recipients versus comparison group.
9) Compare running total of costs against value of actual and projected outcomes.

RESULTS FIRST CONNECTICUT



STATE OF CONNECTICUT

Connecticut Analyses of Evidence-Based Programs

November 2020

INSTITUTE FOR MUNICIPAL AND REGIONAL POLICY

IMRP

Central Connecticut State University

Connecticut Analyses of Evidence-Based Programs

Pursuant to
Connecticut General Statutes, Sections 4-68r and -68s

Prepared by

Institute for Municipal and Regional Policy
Central Connecticut State University
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November 2020

“Supposing is good, but finding out is better.”

-Mark Twain in *Eruption; Mark Twain’s Autobiography*

States, including Connecticut, spend billions of dollars annually on programs and services intended to address a population’s needs.

- **Do these taxpayer-funded programs work? Do policymakers have information, and can they use data to find out what programs achieve the desired outcome?**
- **What is the best return on the state’s investment?**
- **Is a program the most effective and appropriate intervention for addressing an identified need?**
- **How can Connecticut make the most of limited resources?**
- **Has Connecticut adopted a climate for decision-making that is based on research and evidence?**

The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation started the Results First Initiative to help states and counties answer these questions. Results First promotes the use of evidence-based programs and supports ways to analyze their effectiveness. Since 2010, 27 states and 10 counties have applied customizable tools to inform policy and budget processes and direct funding to effective programs that are proven to work.

In 2019, Pew-MacArthur began scaling back its work in multiple states, including Connecticut. There are now just 10 Results First states. The cost-benefit model is no longer available for use in Connecticut. To date, the work of Results First in Connecticut has featured a comprehensive benefit-cost analysis of the state’s adult criminal and juvenile justice programs. The utilization of cost-benefit analysis faces difficulty unless another tool or method of performing CBAs is identified.

Due to unavailability of the Results First cost-benefit model, this report contains no Connecticut specific benefit-cost analysis but rather a presentation of the program inventories submitted by both DOC and JB-CSSD and recommendations on how Connecticut can continue working towards utilizing benefit-cost analysis in the state budget processes.

Table of Contents

Executive Summary and Key Findings

This report on evidence-based policymaking and budgeting is prepared by the Institute for Municipal and Regional Policy (IMRP). The **November 2020** ***Benefit-Cost Analyses of Evidence-Based Programs*** presents program listings submitted by the CT Department of Correction (DOC) and CT Judicial Branch's Court Support Services Division (JB-CSSD) that are agency-identified as an evidence-based program/service. We expect that this will continue a conversation on what programs work and which need further consideration.

State law requires: (1) five specified state agencies to submit their respective program inventories annually and (2) the Institute for Municipal and Regional Policy (IMRP) to publish an annual benefit-cost analyses report of programs identified in the inventories. Agencies and legislators making policy and budget decisions are encouraged to use program inventories and the resulting benefit-cost analyses to allocate resources, prioritize program offerings, and improve program effectiveness and outcomes.

In 2019, three of the five required agencies submitted program inventories (the Judicial Branch's Court Support Services Division [JB-CSSD], the Department of Children and Families (DCF) and the Department of Correction [DOC]). The departments of Mental Health and Addiction Services (DMHAS) and Social Services (DSS) did not. Both DMHAS and DSS have previously indicated an interest in working with IMRP to pursue this effort.

In 2020, two of the five required agencies submitted program inventories – DOC and JB-CSSD – and notably without prompt. The departments of Mental Health and Addiction Services (DMHAS), Children and Families (DCF) and Social Services (DSS) did *not* submit inventories.

- **DMHAS** reports the agency has been working over the past year to collect the program and fiscal data for its inventory and continues its process for completing and submitting one.
- **DSS** reports the agency plans to complete a list and descriptions of its current programs.
- **DCF** has not provided an update.
- **JB-CSSD** and **DOC** submitted program inventories that listed a total of 108 programs and services, 18 in JB-CSSD (8 for adults and 10 for juveniles) and 90 in DOC, of which were identified by the agency as evidence-based programs or services with evidence-based programs.

As the analyses of evidence-based programs and the underlying program inventories become more robust and sustainable, the state will be able to:

- Identify the programs it funds and determine the economic cost.
- Target state, federal, and private funds to cost-beneficial, evidence-based programs.
- Promote and support the use of technology for data collection and analysis.
- Evaluate program implementation and fidelity.
- Articulate program capacity and utilization to maximize participation in effective, evidence-based programs.
- Allow adult criminal and juvenile justice agencies to share data to improve service delivery and reduce recidivism.
- Use evidence and outcome data to inform decisions on where to prioritize limited resources.

Future evidence-based policymaking and budgeting analyses can be improved by developing and sustaining the agency and analytic infrastructure to support improved decision-making. Steps include:

1. Passage and implementation of performance-review budget processes by the General Assembly in the 2021 legislative session.

2. Re-engaging the Results First Policy Oversight Committee or Appropriations Accountability subcommittee.

3. Identifying and utilizing another cost-benefit analysis model.

4. Supporting agencies with training and technical assistance.

5. Supporting technology development for data collection and program inventory reports.

6. Instituting routine program evaluations to assure program fidelity and overall effectiveness by dedicating in-agency personnel to assess state-run programs and including performance measures, program evaluation requirements, and more refined cost details in private provider contracts.

7. Dedicating adequate resources in each agency to support the preparation of complete and consistent program inventories.

8. Training staff in evidence-based policy and budget decision-making.

Guide to Evidence Based Policy and Budgeting Analyses Report

The intent of this guide is to assist users of the "Evidence-Based Policy and Budgeting Analyses." This report is produced by the Institute for Municipal and Regional Policy (IMRP) on November 1, 2020, in compliance with the legislative requirement (CGS § 4-68s) to conduct and report on benefit-cost analyses (BCA) of agency program inventories, also required by law.

The program inventory template used by the agencies lists a great deal of information on Connecticut agency programs and is designed to include the information required to utilize state-specific data. Each agency's program inventory lists all programs and identifies them as evidence-based, research-based, or promising. In addition to the analyses that the inventories support, this categorization is helpful in promoting the effort to transition to more evidence-based programs.

Also important to this effort is the use of the Results First Clearinghouse Database. This one-stop online resource provides policymakers with an easy way to find information on the effectiveness of various interventions as rated by nine national research clearinghouses employing rigorous research and evidence rankings. However, as noted previously in this report, the Results First model and data is no longer active in Connecticut.

Since this is a tool intended to enhance policy and budget decision-making, it would be appropriate if the user's review of the report was informed by a firm understanding of (1) statewide program priorities, and how each state-funded agency fits into those priorities, and (2) each agency priority and how its programs fit into those priorities. If these are not already understood, budget- and policymakers could begin by determining:

- the state's program priorities (Vision, Mission, Goals, Objectives, Activities, etc.)
- which agencies and programs advance these priorities
- which priority agency's programs fit within the state priorities*

With this fundamental understanding, evidence-based policy and budgeting can be used as a tool to help inform decision-makers as to which of these inventoried and analyzed programs are likely the most productive (efficient and effective) at achieving the established priorities. It helps to understand how activities compare on similar bases of operation and cost so that decisions conform to priorities, outcome expectations, and budgets.

I. STATUTORY CHARGE

This report is submitted pursuant to original 2015 legislation as amended in 2017, CGS §§ 4-68r and -68s (PA 15-5, June Special Session, §§ 486 – 487 and PA 17-2, June Special Session, § 247) (see Appendix A). This law advanced the work of the Results First project at Central Connecticut State University's Institute for Municipal and Regional Policy, which administers the Pew-MacArthur Results First Initiative.[1]

Results First Connecticut initially focused on the agencies associated with adult criminal and juvenile justice policy (the Judicial Branch's Court Support Services Division and the departments of Children and Families, Correction, and Mental Health and Addiction Services) and their state-funded programs that are evidence-based.

Agencies and legislators making policy and budget decisions might use program inventories and this report to allocate resources, prioritize program offerings, or improve program effectiveness and outcomes.

The 2015 law required JB-CSSD, DOC, DCF, and DMHAS to develop program inventories in even-numbered years that would provide the data for implementation of the Results First project. It included the provision requiring IMRP to develop annual benefit-cost analyses of the evidence-based adult criminal and juvenile justice programs listed in those inventories.

In 2017, the law was expanded by extending the program inventory requirement to include the DSS and require all specified agencies to incorporate all programs, not just their criminal and juvenile justice programs. It also required annual, rather than biennial, program inventories be submitted for analyses. The IMRP analyses report must use the additional and expanded inventories as the basis for its annual report.

Program Definitions

An *"evidence-based program"* incorporates methods demonstrated to be effective for the intended population through scientifically based research, including statistically controlled evaluations or randomized trials; can be implemented with a set of procedures to allow successful replication in Connecticut; achieves sustained, desirable outcomes; and, when possible, has been determined to be cost-beneficial.

A *"research-based program"* is a program or practice that has some research demonstrating effectiveness, such as one tested with a single randomized or statistically controlled evaluation, but does not meet the full criteria for evidence-based.

A *"promising program"* is a program or practice that, based on statistical analyses or preliminary research, shows potential for meeting the evidence-based or research-based criteria.

[1] The Pew-MacArthur Results First Initiative, a project of the Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, works with states to implement an innovative cost-benefit analysis approach that helps them invest in policies and programs that are proven to work. Additional information about Results First is available at http://www.pewstates.org/projects/pew-macarthur-results-first-initiative-328069.

Program inventories categorize programs as evidence-based, research-based, or promising, and include the following information for the previous fiscal year:

1. a detailed program description and the names of providers,
2. the intended treatment population and outcomes,
3. total annual program expenditures and a description of funding sources,
4. the method for assigning participants,
5. the cost per participant,
6. the annual capacity for and the number of actual participants, and
7. an estimate of the number of people eligible for or needing the program.

Such program inventories may be useful when considering OPM's and the Office of Fiscal Analysis' annual fiscal accountability reports, as well as developing and implementing within the state and agency budget processes.

Legislative Proposals

In an effort to continue the state's work toward utilizing cost-benefit analyses and increasing accountability in the state and agency budget processes, the Appropriations Committee introduced H.B. 5484: An Act Concerning Performance-Informed Budget Review in the 2020 legislative session.

The purpose of the legislation is "to update the performance-informed budget review process of state agencies. Performance-informed budget review means consideration of information and analysis concerning the programs administered by a budgeted agency…Such review shall involve a results-oriented approach to planning, budgeting and performance measurement for programs that focus on the quality of life results the state desires for its citizens and that identify program performance measures and indicators of the progress the state makes in achieving such results." (See Appendix B for the complete bill language.)

Due to COVID-19 impacting the General Assembly's work, though, there was no movement on the proposal and the work currently stands stagnant.

II. THE RESULTS FIRST INITIATIVE

Background and Update

The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation started the Results First Initiative to help states and counties answer these questions starting in 2010. Results First promotes the use of evidence-based programs and supports ways to analyze their effectiveness. Since inception, 27 states and 10 counties have applied customizable tools to inform policy and budget processes and direct funding to effective programs that are proven to work, including Connecticut.

In March 2011, at the request of then Governor Dannel P. Malloy, previous Senate President Pro Tempore Donald E. Williams, Jr., and former House Speaker Christopher G. Donovan, Results First provided state leaders with the tools, resources, and training to use the Results First cost-benefit model to help identify and support cost-effective interventions for adult criminal and juvenile offenders. Representative Toni Walker, House Chair of the Appropriations Committee, and Mike Lawlor, then undersecretary for criminal justice policy and planning, co-chaired the initial policy work group that oversaw the first phase of the effort. The Institute for Municipal and Regional Policy (IMRP) at Central Connecticut State University staffed Connecticut's Results First work to produce a program inventory and cost-benefit analysis of programs in Connecticut's adult criminal justice system.

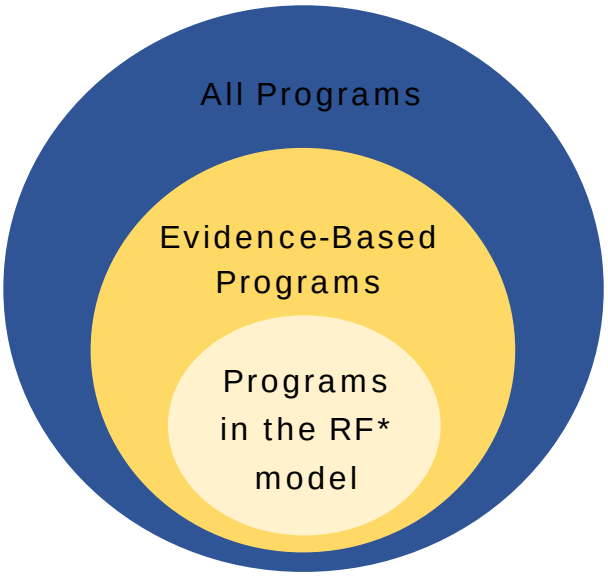
The legislature in 2013 and 2014 supported the state's Results First work by appropriating funds to IMRP to continue staffing the initiative, along with designating funds to evaluate adult and juvenile justice programs. Subsequently, in the 2014-15 biennium budget, and every state budget implemented since, the legislature has appropriated funding to IMRP to continue to assist in the development and use of the Results First cost-benefit model. In July 2015, lawmakers passed legislation requiring all state agencies to provide a program inventory to the legislature by January 1 of every subsequent year. The legislation directed IMRP to develop a benefit-cost analysis for programs in the inventory and produce a report by March 1, 2016 and annually by November 1, thereafter. Legislation enacted in 2017 further created a pilot program within the Office of Policy and Management to apply the principles of Results First cost-benefit analysis to eight grant-funded programs.

As of December 2019, though, Pew expressed concerns that the Results First Initiative is not currently being utilized by the state of Connecticut as discussed and envisioned and, without active direction from the legislature and the executive branch agencies, the state's user agreement for accessing the Results First cost-benefit model lapsed. The Pew-MacArthur Results First Initiative is currently only working with 10 states.

To date, the work of Results First in Connecticut has focused on conducting a comprehensive benefit-cost analysis of the state's adult criminal and juvenile justice programs. Thus, the expansion of cost-benefit analysis faces difficulty unless another tool or method of performing CBAs is identified.

Findings Overview and Implementation Assessment

The evidence-based policy and budgeting project involves two distinct phases: (1) preparation of an agency's program inventory, complete with descriptions and specified participant and fiscal data for all its programs; (2) identification of those programs that are evidence-based and those that match the programs included in the clearinghouses of evidence-based programs. Agencies are responsible for assessing the programs they operate with their own staff and those for which they contract with private providers. Once they list all these programs, they must present the specified data for each.



Description of Elements of the Program Inventory

Compiling a program inventory is a labor-intensive effort, involving an agency's program as well as fiscal staff. Some of the mandated agencies, while acknowledging the importance of offering evidence-base programs and collecting the supporting program data, have been unable to devote the program and fiscal staff hours necessary to compile a program inventory for this purpose.

In addition, we have found that in some cases, an agency lists a program that includes a variety of services or interventions offered alone or in some combination. If the agency is unable to isolate or disaggregate the costs of evidence-based services provided to clients under an umbrella program, offering multiple interventions that can vary from client to client, then Results First cannot provide the benefit-cost analysis for each separate intervention or assess its effectiveness.

Agencies indicate that supporting the use of evidence-based programs and determining their effect is the correct approach to providing state-supported services. One difficulty appears to be the shortage of staff necessary to devote to the efforts required to monitor and collect program data. However, the difficulties associated with compiling a program inventory should not outweigh the importance of determining the efficacy and efficiencies of programs on which the state spends millions of dollars.

*There is no current benefit-cost analysis model at this time

III. EVIDENCE-BASED PROGRAM INVENTORY INFORMATION

In October 2020, JB-CSSD and DOC submitted inventory spreadsheets to IMRP.

Tables 1 and 2 list the programs or services that JB-CSSD and DOC respectively identified as evidence-based. The tables below show important details as reported in the agency program inventories for the evidence-based programs and services they manage in Connecticut. General benefit information on evidence-based programs may be seen at Washington State Institute for Public Policy and Results First Clearinghouse Database.

The fields shown in the table below are defined as follows:

- *Program Name*: The specific, formal program name of the program.
- *Service Name*: In the case of JB-CSSD, more than one program may be included in a service. Program treatments vary and are based on the participant's risk and needs.
- *Evidence-Based Programs Offered:* The name(s) of the program found in the Results First Initiative program summaries that is similar to the Connecticut program. Results First Program Summaries describe the studies that WSIPP used to conduct the meta-analysis and calculate the average effect size of each program in the model.
- *Number of Participants Served:* The number of clients treated (regardless of program completion) in state FY 2020.
- *Budget:* The total amount budgeted by the agency for the program or service for the year.
- *Percent of Total FY 20 Program Inventory Budget:* The program cost as a percentage of the total budgeted amount for programs listed in the agency's program inventory. This is not the spending on a particular program compared to all agency program expenditures, or to the entire agency budget.

IV. AGENCY PROGRAM INVENTORIES AND FINDINGS

Judicial Branch – Court Support Services Division (JB-CSSD)

We address JB-CSSD differently in the case where two or more "programs" are offered within a single designated "service." Table 1 shows data from JB-CSSD's Adult and Juvenile program inventories the separate listings for (1) programs and (2) services, including the evidence-based programs offered within each.

For FY 20 JB-CSSD identified a total of 18 programs as evidence-based; 8 adult criminal justice programs and 10 programs justice-involved juvenile programs.

Table 1: Judicial Branch-Court Support Services Division
Evidence-Based Program Inventory Information

Program or Service Name	*Evidence-Based Program Offered*	*Number of Participants Served*	*Program Budget FY 20*	*Percent of Total Program Inventory Budget**
ADULT				
Adult Behavioral Health Services	Seeking Safety	16,568	$16,804,423	31%
Adult Sex Offender Treatment Services	Treatment in the community for individuals convicted on sex offenses	1418	3,241,845	6%
Advanced Supervision Intervention & Support Team/Start Now	Cognitive behavioral therapy (CBT) for individuals classified as high- or moderate-risk (Non-name brand only)	**CSSD Sites** 344 **DMHAS Sites** 107	969,226	2%
Electronic Monitoring	Electronic monitoring - probation	3,498	1,169,032	2%
Domestic Violence – EVOLVE	Domestic violence perpetrator treatment (Duluth-based model)	628	1,132,800	2%
Domestic Violence – EXPLORE	Domestic violence perpetrator treatment (Duluth-based model)	CSSD: 1,946 Parole: 685 Total: 2,631	1,993,297	4%
Family Violence Education Program	Domestic violence perpetrator treatment (Duluth-based model)	2761	1,116,162	2%
Alternative in the Community	Cognitive behavioral therapy (CBT) for individuals classified as high- or moderate-risk	5962 (CSSD) 137 (Parole)	16,317,620	30%

	Motivational interviewing to enhance treatment engagement			
Total Expenditures on Evidence-Based Programs and Services			**$42,744.405**	**79%**
Total Expenditures on All Programs Reported in Program Inventory*			$54,494,289	100%
Notes: Highlighted programs are included the benefit-cost analyses. * Additional program expenditures may have occurred.				
Program or Service Name	***Evidence-Based Programs Offered***	***Number of Participants Served***	***Program Budget FY 20***	***Percent of Total Program Inventory Budget****
JUVENILE				
Adolescent Sexual Behavioral Treatment and Education	Sex offender treatment (non-MST) for juveniles convicted of sex offenses	57	$698,765	2%
Multisystemic Therapy	Multisystemic Therapy for juvenile offenders	52	3,824,616	12%
Treatment Foster Care Oregon - Adolescent	Multidimensional Treatment Foster Care	8	829,126	3%
Youth Mentoring	Mentoring for juvenile offenders	51	589,101	2%
Boys Therapeutic Respite and Assessment Center	Cognitive Behavioral Therapy for child trauma Cognitive Behavioral Therapy for juvenile offenders	27	1,464,051	5%
Intermediate Residential	Multidimensional Family Therapy for substance abusers Cognitive Behavioral Therapy for juvenile offenders	18	2,351,192	8%
Adolescent Male Intermediate Program (AMIR)	Dialectical Behavioral Therapy (DBT) for juvenile offenders	10	895,843	3%
Regions Limited (Previously 'Journey House')	Dialectical Behavioral Therapy (DBT) for juvenile offenders	13	3,900,290	13%
Juvenile Staff Secure Residential Facility (JSSRF)	Cognitive Behavioral Therapy for child trauma Cognitive Behavioral Therapy for juvenile offenders	47	5,447,097	18%
Linking Youth to Natural Community	Parenting with Love and Limits	431	7,193,201	23%

	Aggression Replacement Training Cognitive behavioral therapy for juvenile offenders			
Total Expenditures on Evidence-Based Programs and Services			**$27,193,282**	**93%**
Total Expenditures on All Programs Reported in Program Inventory*			$31,034,103	100%
Notes: Highlighted programs are included the benefit-cost analyses. * Additional program expenditures may have occurred.				

Department of Correction (DOC)

For FY20, DOC identifies 90 programs as being evidence-based.

Table 2: Department of Correction
Evidence-Based Program Inventory Information

Program or Service Name	*Number of Participants Served*	*Program Budget FY20*	*Percent of Total Program Inventory Budget**
Alternatives to Violence – Advanced Workshops	83	$0 (Volunteer)	0%
Alternatives to Violence – Basic Workshops	181	0 (Volunteer)	0%
Anger Management Program	453	42,570	0.08%
Beyond Violence: A Prevention Program for Women	84	1,980	<0.00
Charlene Perkins Center	N/A	0 (Volunteer)	0.0%
Domestic Violence-Facility Based	1,186	196,020	0.36%
DUI: Home Confinement Program	720	151,640	0.28%
Electronic Monitoring	2,025	683.874	1.25%
Embracing Fatherhood	96	8,910	0.02%
Good Intentions - Bad Choices	381	36,846	0.07%
Intensive Aftercare Program – Facility Addiction Services	108	24,220	0.04%
Life Skills - A New Freedom	0	0	0
Living Free Comprehensive Reentry Services	212	34,400	0.06%
Medication Assisted Treatment (MAT) (Methadone Treatment Program [MTP])	1,400	765,274	1.4%
Non-Residential Behavioral Health\Domestic Violence\Sex Offender	1,312	1,156,570	2.12%
People Empowering People	51	0 (Volunteer)	0%
Residential Mental Health\Substance Abuse\Sex Offender	636	4,206,960	4.76%
Residential Temporary and Scattered Site Supportive Housing	887	6,283,727	12.95%
Residential Work Release (including 20 providers)	2,992	21,199,407	38.66%
Security Risk Group Program Phases 1 – 5	578	33,906	0.06%
Seven Challenges	90	30,275	0.06%
Sex Treatment Program	0	0	0
Short-Term Sex Offender Program	133	22,591	0.04%
Start Now: Units 1- 4	0	0	0
Stress & Management & Relaxation (SMARTS)	0	0	0
Technical Violators Program (TOP Program)	386	60,864	0.11%
Thresholds	1,294	0 (Volunteer)	0%
Tier One Addiction Services	396	24,977	0.05%
Tier Two Addiction Services	1,090	171,871	0.31%
Tier Four Addiction Services	560	117,734	0.22%

Unlock Your Thinking includes Behavior Intervention	62	3,274	0.01%
USD #1 - ABE – ESL - GED	3,250	12,804,277	23.45%
USD #1 – College	0	0	0
USD #1 Life Skills	N/A	48,536	0.09%
USD #1 - Voc.Ed.: Auto Body Technology	48	4,969,642	9.3%
USD #1 - Voc.Ed.: Automotive Technology	59		
USD #1 – Voc Ed.: Auto Detailing	30		
USD #1 - Voc.Ed.: Bicycle/Wheelchair Repair	27		
USD #1 - Voc.Ed.: Building Maintenance	8		
USD #1 - Voc.Ed.: Business Education	132		
USD #1 - Voc.Ed.: Carpentry	87		
USD #1 - Voc.Ed.: Commercial Cleaning	62		
USD #1 - Voc.Ed.: Computer Education	125		
USD #1 - Voc.Ed.: Computer Repair	85		
USD #1 - Voc.Ed.: Cosmetology/Barbering	86		
USD #1 - Voc.Ed.: Culinary Arts	149		
USD #1 - Voc.Ed.: Drafting CAD/CAM	30		
USD #1 - Voc.Ed.: Electro-Mechanical	42		
USD #1 - Voc.Ed.: Electronics	N/A		
USD #1 - Voc.Ed.: Graphic & Printing Technology	110		
USD #1 - Voc.Ed.: Horticulture/ Landscape	17		
USD #1 - Voc.Ed.: Hospitality Operations/ Technology	99		
USD #1 - Voc.Ed.: Machine Tool	29		
USD #1 - Voc.Ed.: Small Engine Technology	20		
VOICES (Victim Offender Institutional Correctional Educational Services)	1,294	196,020	0.36%
Total Expenditures on Evidence-Based Programs		**$52,593,175**	**96%**
Total Expenditures on All Programs Reported in Program Inventory*		$54,618,403	100%

*Additional program expenditures may have occurred.

V. FINDINGS AND RECOMMENDATIONS

Assessment of Compliance

After the expansion of the project was enacted in October 2017, the affected agencies became aware then of the implications and the requirement to complete program inventories by the October 1 deadline. IMRP staff contacted those agencies previously required to comply (JB-CSSD, DOC, DCF, and DMHAS) as well as the Department of Social Services (added through the 2017 legislation) to reiterate the new requirement to include all agency programs. As indicated in this report, though, only JB-CSSD and DOC submitted program inventories and DMHAS, DCF and DSS did not.

Findings, Recommendations and Next Steps

The Institute for Municipal and Regional Policy (IMRP) supports the principles of a deliberative, transparent, and outcome-based approach to policymaking. Even though access to the Results First Model is no longer available in Connecticut, the IMRP still believes in evidence-based policy and budgeting of which Results First was one form. The IMRP looks towards an alternative.

Since 2011, IMRP has committed itself to a vigorous implementation of the Connecticut Results First Initiative. As such, the IMRP developed relationships with those agencies required to complete the work needed to complete program inventories and apply the Results First model. Beyond that, the IMRP has reached out to the Office of Policy and Management and the General Assembly (legislative leaders, the Appropriations Committee, and staff) to promote the use of evidence-based programs and the evidence-based policy and budgeting [and former benefit-cost analyses] IMRP publishes.

Yet more could be done. If this approach is to be fully implemented in Connecticut, policy- and budget-decisionmakers must not only recognize the advantages and applications of evidence-based policy and budgeting, they must also support its integration into agency practices and the budget process, from initial development to enactment by the legislature. To realize its "highest and best use," this evidence-based tool must be supported and utilized by all the intended stakeholders. Does the state prioritize the use of evidence-based programs? What is the value of evidence-based policy and budgeting in determining the allocation of state resources to achieve agreed-upon policy outcomes? These questions linger a full nine years after Connecticut's establishment as a Results First site.

Other states such as Minnesota and Colorado provide good examples of an effective and comprehensive application of the Results First Initiative. The Minnesota Management and Budget Office (MMB) oversees the Results First Initiative there. A team of MMB analysts works with legislators, state agency and county officials, and practitioners to develop that state's inventories and reports. Since 2018, agencies must complete MMB's budget proposal form documenting evidence-based program results. Governor Walz based parts of his 2019 proposed budget on the information, and legislators use the forms to prioritize evidence-based proposals. The MMB Results First team maintain program assessments in a database,

the Minnesota Inventory. In addition, two MMB evidence policy specialists maintain an archive of benefit-cost analyses. A November 2019 Pew issue brief reports that the MMB Commissioner Frans "finds it rewarding to make possible the use of quality evidence in decision-making processes." Legislators recognize the importance of a "culture of evidence" in long-term fiscal management, particularly when anticipating a downturn in the economy. In 2018, MMB's Results First Initiative was a recipient of the University of Minnesota's Humphrey School of Public Affairs' State Government Innovation Award.

Likewise, in Colorado, the Results First team works in the Office of State Planning and Budgeting (OSPB) and has produced inventories and reports in the areas of adult criminal and juvenile justice, child welfare, behavioral health, prevention, and health policies. The OSPB's Results First team coordinates with and provides support to the Performance Management and Pay for Success units in the Governor's Office. More importantly, it consistently builds research, evidence, and data into the state's budget process. In developing the budget, OSPB (1) requires agencies to document research and demonstrated program effectiveness in their budget requests; (2) runs predictive benefit-cost analyses and evaluation designs; and (3) includes Results First benefit-cost findings, when possible. In addition, a 2007 update notes that the Colorado Results First team "coordinates with the Governor's Office chief operating officer on a long-term vision for sustaining good government practices" and offers training on evidence-based policymaking and benefit-cost analyses to stakeholders, including legislators.

When the goal is to "find out" what programs are proven to work, and maximize the benefits of taxpayer-funded spending, agencies in these states utilize evidence-based programs and have the built-in capacity to measure its program costs and benefits. The most effective way to implement the evidence-based policy and budgeting approach requires agencies to develop an accounting system that produces cost data by program and a formula for calculating its marginal costs. Armed with the evidence-based policy and budgeting information supplied by IMRP, the state budget office can then use this tool to help determine appropriate budget allocations to recommend to the governor and the legislature. Concurrently, the General Assembly's Appropriations Committee, indeed all legislators, can make more informed decisions regarding the budget, approving program expenditures based on costs and outcomes.

The implementation of evidence-based policy and budgeting in Connecticut to date confirms that a combination of additional resources and re-alignment of priorities must be devoted to this effort if the IMRP and state agencies are to comply with existing statutory requirements and reap the full benefits of this model. Staff with the knowledge and expertise to complete this project must be hired. In addition, based on positive interactions with the mandated agencies as they complete their critical element of the project, it is clear they must dedicate a considerable amount of time, effort, and resources to produce a usable program inventory. Agency budgets must include the funding to support these efforts as well.

VI. CONCLUSION

Although Pew is no longer working with Connecticut to use the Results First model and collected data thus far, the work towards utilizing evidence-based outcomes and cost-benefit analysis can continue if Connecticut seeks to move forward with alternatives. Such alternatives are discussed below.

Firstly, when alerting Connecticut Results First stakeholders that they would no longer be working in our state, alternative technical assistance opportunities were offered by Pew that would provide value to state leaders and staff without requiring significant staff resources. Such technical assistance would include: 1) assistance with state-specific research identifying gaps and opportunities for strengthening the use of evidence in budget decisions; 2) short-term training for staff on developing and using program inventories; and 3) as requested, feedback on proposed policy language or budget guidelines related to evidence-based policymaking.

Secondly, another tool that can be utilized by the Governor's Office, General Assembly, and state agencies when developing budgets is the Washington State Institute for Public Policy's Benefit-Cost Clearinghouse (WSIPP). Since the 1990s, the Washington State legislature has directed WSIPP to identify "evidence-based" policies. The goal is to provide Washington policymakers and budget writers with a list of well-researched public policies that can, with a high degree of certainty, lead to better statewide outcomes coupled with a more efficient use of taxpayer dollars.

WSIPP has developed a three-step process to draw conclusions about what works and what does not in order to achieve particular outcomes of legislative interest. First, they systematically assess all high-quality studies from the United States and elsewhere to identify policy options that have been tested and found to achieve improvements in outcomes. Second, they determine how much it would cost Washington taxpayers to produce the results found in Step 1, and calculate how much it would be worth to people in Washington State to achieve the improved outcome. That is, in dollars and cents terms, they compare the benefits and costs of each policy option. Third, they assess the risk in the estimates to determine the odds that a particular policy option will at least break even.

It is important to note that the benefit-cost estimates information available on WSIPP's website are *specific to Washington State only* and are not numbers for the state of Connecticut; however, the clearinghouse information is generic and robust enough to use as a baseline. Topics in the clearinghouse include but are not limited to: juvenile justice, adult criminal justice, child welfare, pre-k-12 education, children's mental health, health care, substance use disorders, adult mental health, public health, workforce development, and higher education. See Table 3 for examples in Adult Criminal Justice.

Program name (click on the program name for more detail)	Date of last literature review	Total benefits	Taxpayer benefits	Non-taxpayer benefits	Costs	Benefits minus costs (net present value)	Benefit to cost ratio	Chance benefits will exceed costs
Employment counseling and job training (transitional reentry from incarceration into the community)	Aug. 2016	$46,030	$13,277	$32,753	($2,528)	**$43,502**	$18.21	**88 %**
Offender Reentry Community Safety Program (for individuals with serious mental illness)	Apr. 2012	$72,384	$24,750	$47,635	($38,067)	**$34,318**	$1.90	**96 %**
Circles of Support and Accountability	Nov. 2016	$29,658	$7,199	$22,459	($4,060)	**$25,597**	$7.30	**92 %**
Correctional education (post-secondary education)	Jul. 2016	$25,614	$6,986	$18,628	($1,298)	**$24,316**	$19.74	**100 %**
Drug Offender Sentencing Alternative (for persons convicted of drug offenses)	Nov. 2016	$23,582	$7,015	$16,567	($1,690)	**$21,892**	$13.95	**99 %**
Vocational education in prison	Jul. 2016	$18,541	$5,138	$13,403	($1,553)	**$16,988**	$11.94	**98 %**
Case management ("swift, certain, and fair") for drug-involved persons	Nov. 2016	$15,582	$4,536	$11,046	$396	**$15,978**	n/a	**99 %**
Electronic monitoring (probation)	Dec. 2014	$14,357	$4,058	$10,299	$1,181	**$15,538**	n/a	**93 %**
Mental health courts	Oct. 2016	$17,893	$5,187	$12,706	($3,221)	**$14,672**	$5.56	**96 %**

*You can find all information pertaining to WSIPP's Adult Criminal Justice cost-benefit information here.

Lastly, another resource that can be used in lieu of Pew's Results First model and data is the organization, Results for America. "Results for America is creating standards of excellence, supporting policymakers in implementation and mobilizing champions committed to investing in what works." Results for America provides a national benchmark for how governments (state and federal) can consistently and effectively use evidence and data in budget, policy, and management decisions to achieve better outcomes for their residents.

With their recent publication, *2020 Invest in What Works State Standard of Excellence (State Standard of Excellence)*, Results for America identified 169 examples of data-driven and evidence-based practices, policies, programs, and systems in effect as of June 2020 in 35 states across the nation. Furthermore, Results for America has also been tracking the impact of COVID-19 on states. In their 2020 report, Connecticut is identified as one of 7 states "leading the way" toward better policy and budgeting due the state's use of data-driven and evidence-based practices. For more information on Results for America and their important work, please visit their website here.

It is important to remind legislators, policymakers, and agency heads why utilizing evidence-based and cost-benefit analysis information in budget development is necessary and imperative, especially during a time of state fiscal frugality and cutbacks. Realizing the true payback to the state in tax dollars for each dollar spent is essential as we move forward into the new decade; however, this work and efforts need to be supported and implemented by the Connecticut General Assembly to truly be beneficial as intended.

Appendix A

Program Inventories of Agency Programs and Cost-Benefit Analysis Report
Statutory Requirements
CGS §§ 4-68r and -68s, 4-68m, and 4-77c

CGS Sec. 4-68r. Definitions. For purposes of this section and sections 4-68s and 4-77c:

(1) "Cost-beneficial" means the cost savings and benefits realized over a reasonable period of time are greater than the costs of implementation;

(2) "Program inventory" means the (A) compilation of the complete list of all agency programs and activities; (B) identification of those that are evidence-based, research-based and promising; and (C) inclusion of program costs and utilization data;

(3) "Evidence-based" describes a program that (A) incorporates methods demonstrated to be effective for the intended population through scientifically based research, including statistically controlled evaluations or randomized trials; (B) can be implemented with a set of procedures to allow successful replication in the state; (C) achieves sustained, desirable outcomes; and (D) when possible, has been determined to be cost-beneficial;

(4) "Research-based" describes a program or practice that has some research demonstrating effectiveness, such as one tested with a single randomized or statistically controlled evaluation, but does not meet all of the criteria of an evidence-based program; and

(5) "Promising" describes a program or practice that, based on statistical analyses or preliminary research, shows potential for meeting the evidence-based or research-based criteria.

CGS Sec. 4-68s. Program inventory of agency criminal and juvenile justice programs. Pilot program re Pew-MacArthur cost-benefit analysis of state grant programs. Report.

(a) Not later than October 1, 2018, and annually thereafter, the Departments of Correction, Children and Families, Mental Health and Addiction Services and Social Services and the Court Support Services Division of the Judicial Branch shall compile a program inventory of each of said agency's programs and shall categorize them as evidence-based, research-based, promising or lacking any evidence. Each program inventory shall include a complete list of all agency programs, including the following information for each such program for the prior fiscal year, as applicable: (1) A detailed description of the program, (2) the names of providers, (3) the intended treatment population, (4) the intended outcomes, (5) the method of assigning participants, (6) the total annual program expenditures, (7) a description of funding sources, (8) the cost per participant, (9) the annual number of

participants, (10) the annual capacity for participants, and (11) the estimated number of persons eligible for, or needing, the program.

(b) Each program inventory required by subsection (a) of this section shall be submitted in accordance with the provisions of section 11-4a to the Secretary of the Office of Policy and Management, the joint standing committees of the General Assembly having cognizance of matters relating to children, human services, appropriations and the budgets of state agencies and finance, revenue and bonding, the Office of Fiscal Analysis, and the Institute for Municipal and Regional Policy at Central Connecticut State University.

(c) Not later than November 1, 2018, and annually thereafter by November first, the Institute for Municipal and Regional Policy at Central Connecticut State University shall submit a report containing a cost-benefit analysis of the programs inventoried in subsection (a) of this section to the Secretary of the Office of Policy and Management, the joint standing committees of the General Assembly having cognizance of matters relating to children, appropriations and the budgets of state agencies and finance, revenue and bonding, and the Office of Fiscal Analysis, in accordance with the provisions of section 11-4a.

(d) The Office of Policy and Management and the Office of Fiscal Analysis may include the cost-benefit analysis provided by the Institute for Municipal and Regional Policy under subsection (c) of this section in their reports submitted to the joint standing committees of the General Assembly having cognizance of matters relating to children, appropriations and the budgets of state agencies and finance, revenue and bonding on or before November fifteenth annually, pursuant to subsection (b) of section 2-36b.

(e) Not later than January 1, 2019, the Secretary of the Office of Policy and Management shall create a pilot program that applies the principles of the Pew-MacArthur Results First cost-benefit analysis model, with the overall goal of promoting cost-effective policies and programming by the state, to at least eight grant programs financed by the state selected by the secretary. Such grant programs shall include, but need not be limited to, programs that provide services for families in the state, employment programs and at least one contracting program that is provided by a state agency with an annual budget of over two hundred million dollars.

(f) Not later than April 1, 2019, the Secretary of the Office of Policy and Management shall submit a report, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies. Such report shall include, but need not be limited to, a description of the grant programs the secretary has included in the pilot program described in subsection (e) of this section, the status of the pilot program and any recommendations.

Sec. 4-68m. Criminal Justice Policy and Planning Division. Duties. Collaboration with other agencies. Access to information and data. Reports. (a) There is established a Criminal Justice Policy and Planning Division within the Office of Policy and Management. The division shall be under the direction of an undersecretary.

(b) The division shall develop a plan to promote a more effective and cohesive state criminal justice system and, to accomplish such plan, shall:

(1) Conduct an in-depth analysis of the criminal justice system;

(2) Determine the long-range needs of the criminal justice system and recommend policy priorities for the system;

(3) Identify critical problems in the criminal justice system and recommend strategies to solve those problems;

(4) Assess the cost-effectiveness of the use of state and local funds in the criminal justice system;

(5) Recommend means to improve the deterrent and rehabilitative capabilities of the criminal justice system;

(6) Advise and assist the General Assembly in developing plans, programs and proposed legislation for improving the effectiveness of the criminal justice system;

(7) Make computations of daily costs and compare interagency costs on services provided by agencies that are a part of the criminal justice system;

(8) Review the program inventories and cost-benefit analyses submitted pursuant to section 4-68s and consider incorporating such inventories and analyses in its budget recommendations to the General Assembly;

(9) Make population computations for use in planning for the long-range needs of the criminal justice system;

(10) Determine long-range information needs of the criminal justice system and acquire that information;

(11) Cooperate with the Office of the Victim Advocate by providing information and assistance to the office relating to the improvement of crime victims' services;

(12) Serve as the liaison for the state to the United States Department of Justice on criminal justice issues of interest to the state and federal government relating to data, information systems and research;

(13) Measure the success of community-based services and programs in reducing recidivism;

(14) Develop and implement a comprehensive reentry strategy as provided in section 18-81w; and

(15) Engage in other activities consistent with the responsibilities of the division.

CGS Sec. 4-77c. Estimates of expenditure requirements for implementation of evidence-based programs. The Departments of Correction, Children and Families and Mental Health and Addiction Services, and the Court Support Services Division of the Judicial Branch may include in the estimates of expenditure requirements transmitted pursuant to section 4-77, and the Governor may include in the Governor's recommended appropriations in the budget document transmitted to the General Assembly pursuant to section 4-71, an estimate of the amount required by said agencies for expenditures related to the implementation of evidence-based programs.

Appendix B

House Bill 5484 – AAC Performance-Informed Budget Review

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 2-33b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section:

[(1) "Program" means any distinguishable service or group of services within a budgeted agency, as defined in section 4-69, designed to accomplish a specific public goal and result in specific public benefits.**]**

(1) "Cost-beneficial" means the cost savings and benefits realized over a reasonable period of time are greater than the costs of implementation;

(2) "Evidence-based" describes a program that (A) incorporates methods demonstrated to be effective for the intended population through scientifically based research, including statistically controlled evaluations or randomized trials; (B) can be implemented with a set of procedures to allow successful replication in the state; (C) achieves sustained, desirable outcomes; and (D) when possible, has been determined to be cost-beneficial;

[(2)**]** (3) "Performance-informed budget review" means consideration of information and analysis concerning the programs administered by a budgeted agency, prepared by such agency in accordance with the provisions of subsection **[**(d)**]** (e) of this section, by the Governor and the General Assembly during the development of each biennial budget in accordance with the provisions of subsection **[**(e)**]** (g) of this section. Such review shall involve a results-oriented approach to planning, budgeting and performance measurement for programs. **[**that focus on the quality of life results the state desires for its citizens and that identify program performance measures and indicators of the progress the state makes in achieving such results.**]**

(4) "Program" means any distinguishable service or group of services within a budgeted agency, as defined in section 4-69, designed to accomplish a specific public goal and result in specific public benefits.

(5) "Program inventory" means the (A) compilation of the complete list of all agency programs and activities; (B) identification of those that are evidence-based, research-based and promising; and (C) inclusion of program costs and utilization data;

(6) "Promising" describes a program or practice that, based on statistical analyses or preliminary research, shows potential for meeting the evidence-based or research-based criteria; and

(7) "Research-based" describes a program or practice that has some research demonstrating effectiveness, such as one tested with a single randomized or statistically controlled evaluation, but does not meet all of the criteria of an evidence-based program.

(b) Not later than October 1, 2020, and annually thereafter, the Departments of Correction, Children and Families, Mental Health and Addiction Services and Social Services and the Court Support Services Division of the Judicial Branch shall each compile a program inventory of each of said agency's programs and shall categorize such programs as evidence-based, research-based, promising or lacking any evidence. Each program inventory shall include a complete list of all agency programs, including the following information for each such program for the prior fiscal year, as applicable: (1) A detailed description of the program, (2) the names of providers, (3) the intended treatment population, (4) the intended outcomes, (5) the method of assigning participants, (6) the total annual program expenditures, (7) a description of funding sources, (8) the cost per participant, (9) the annual number of participants, (10) the annual capacity for participants, and (11) the estimated number of persons eligible for, or needing, the program. For the biennium commencing July 1, 2019, and for each biennial budget thereafter, the joint bipartisan subcommittee established in subsection (e) of this section may identify one or more additional budgeted agencies to annually compile a program inventory in the manner prescribed in this subsection. The Office of Fiscal Analysis and the Institute for Municipal and Regional Policy at Central Connecticut State University shall provide technical support in the compilation of such inventories.

(c) Each program inventory required by subsection (b) of this section shall be submitted in accordance with the provisions of section 11-4a to the Secretary of the Office of Policy and Management, the joint standing committees of the General Assembly having cognizance of matters relating to the appropriations and the budgets of state agencies and finance, revenue and bonding, the Office of Fiscal Analysis and the Institute for Municipal and Regional Policy at Central Connecticut State University.

[(b) For the biennium commencing July 1, 2017, and for each biennial budget thereafter, the General Assembly shall identify one or more budgeted agencies to transmit the information and analysis specified in

subsection (d) of this section for purposes of a performance-informed budget review for the next succeeding biennium. The Office of Fiscal Analysis shall provide technical support in the identification of such agencies.**]**

[(c)**]** (d) There is established a joint bipartisan subcommittee on performance-informed budgeting consisting of seven members of the joint standing committee of the General Assembly having cognizance of matters relating to finance and seven members of the joint standing committee of the General Assembly having cognizance of matters relating to appropriations. Not later than **[**February**]** July 1, **[**2018**]** 2020, (1) the chairpersons of the finance committee shall appoint six members of the finance committee to such subcommittee, at least two of whom shall be members of the minority party, and the ranking member of the finance committee shall appoint one member of the finance committee to such subcommittee, and (2) the chairpersons of the appropriations committee shall appoint six members of the appropriations committee to such subcommittee, at least two of whom shall be members of the minority party, and the ranking member of the appropriations committee shall appoint one member of the appropriations committee to such subcommittee. The subcommittee shall be chaired by two chairpersons, each selected from among the subcommittee members. One chairperson shall be selected by the chairpersons of the finance committee and one chairperson shall be selected by the chairpersons of the appropriations committee. The term of such appointments shall terminate on December 31, **[**2018**]** 2020, regardless of when the initial appointment was made. Members of the subcommittee appointed on or after January 1, **[**2019**]** 2021, shall serve for two-year terms, which shall commence on the date of appointment. Members shall continue to serve until their successors are appointed, except that the term of any member shall terminate on the date such member ceases to be a member of the General Assembly. Any vacancy shall be filled by the respective appointing authority.

[(d)**]** (e) On or before October 1, **[**2018**]** 2020, and on or before October first of each even-numbered year thereafter, the administrative head of each budgeted agency identified in the biennial budget adopted for the immediately preceding biennium, in accordance with the provisions of subsection (b) of this section, shall transmit a report to (1) the Secretary of the Office of Policy and Management, (2) the joint standing committee of the General Assembly having cognizance of matters relating to appropriations, through the Office of Fiscal Analysis, (3) the joint standing committee of the General Assembly having cognizance of matters relating to finance, and (4) the joint standing committee of the General Assembly having cognizance of matters relating to such

budgeted agency. **[**, utilizing the results-based report format developed by the accountability subcommittee of said appropriations committee,**]** Such report shall include the following information and analysis for each program administered by such agency:

(A) **[**A statement of the statutory basis, or other basis, and the history of the program**]** The program inventory compiled pursuant to subsection (b) of this section.

(B) A description of how the program fits within the strategic plan and goals of the agency. **[**and an analysis of the quantified objectives of the program.**]**

[(C) A description of the program's goals, fiscal and staffing data and the populations served by the program, and the level of funding and staff required to accomplish the goals of the program if different than the actual maintenance level.**]**

[(D)**]** (C) Data demonstrating **[**the amount of service provided, the effectiveness of said service provision, and**]** the measurable impact on quality of life results for service recipients.

[(E) An analysis of internal and external factors positively and negatively impacting the change in quality of life outcomes over time.**]**

(D) Any other information as prescribed by the subcommittee.

[(F) The program's administrative and other overhead costs.

(G) Where applicable, the amount of funds or benefits that actually reach the intended recipients of the program.

(H) Any recommendations for improving the program's

performance.**]**

(f) Any agency or division that compiles a program inventory pursuant to subsection (b) of this section shall include in the estimates of expenditure requirements transmitted pursuant to section 4-77, and the Governor shall include in the Governor's recommended appropriations in the budget document transmitted to the General Assembly pursuant to section 4-71, an estimate of the amount required by said agencies for expenditures related to the implementation of evidence-based programs, in accordance with section 4-77c, as amended by this act.

[(e)**]** (g) The Governor and General Assembly shall consider the information and analysis transmitted by budgeted agencies pursuant to subsection **[**(d)**]** (e) of this section in developing each biennial budget. A public review of the reports transmitted by such agencies shall be incorporated into the agency budget hearing process conducted by the relevant subcommittees of the joint standing committee of the General Assembly having cognizance of matters relating to appropriations.

Sec. 2. Subsection (b) of section 4-68m of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) The division shall develop a plan to promote a more effective and cohesive state criminal justice system and, to accomplish such plan, shall:

(1) Conduct an in-depth analysis of the criminal justice system;

(2) Determine the long-range needs of the criminal justice system and recommend policy priorities for the system;

(3) Identify critical problems in the criminal justice system and recommend strategies to solve those problems;

(4) Assess the cost-effectiveness of the use of state and local funds in the criminal justice system;

Sec. 3. Section 4-77c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

[The Departments of Correction, Children and Families and Mental Health and Addiction Services, and the Court Support Services Division of the Judicial Branch may**]** Any agency or division that compiles a program inventory pursuant to subsection (b) of section 2-33b, as amended by this act, shall include in the estimates of expenditure requirements transmitted pursuant to section 4-77, and the Governor **[**may**]** shall include in the Governor's recommended appropriations in the budget document transmitted to the General Assembly pursuant to section 4-71, an estimate of the amount required by said agencies for expenditures related to the implementation of evidence-based programs, as defined in section 2-33b, as amended by this act.

Sec. 4. Subsection (h) of section 46b-121n of the 2020 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(h) The committee shall complete its duties under this section after consultation with one or more organizations that focus on relevant issues regarding children and youths, such as the University of New Haven and any of the university's institutes. The committee may accept administrative support and technical and research assistance from any such organization. **[**The committee shall work in collaboration with any results first initiative implemented pursuant to section 2-111 or any public or special act.**]**

Sec. 5. Sections 2-111, 4-68r and 4-68s of the general statutes are repealed. (*Effective from passage*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	2-33b
Sec. 2	*from passage*	4-68m(b)
Sec. 3	*from passage*	4-77c
Sec. 4	*from passage*	46b-121n(h)
Sec. 5	*from passage*	Repealer section

Statement of Purpose:
To update the performance-informed budget review process of state agencies.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

ON THE FRONT LINES:
Elevating the Voices of Violence Intervention Workers

Community violence intervention work—which involves individuals with lived experiences intervening with the small subset of people at the highest risk of violence—is critically important but also dangerous, underpaid, and undersupported. Homicides are surging in cities across the country, but we have a tremendous opportunity at our fingertips to invest in programs and individuals who have the ability to reverse this deadly and tragic trend and bring much-needed peace to our streets.

Survey Results

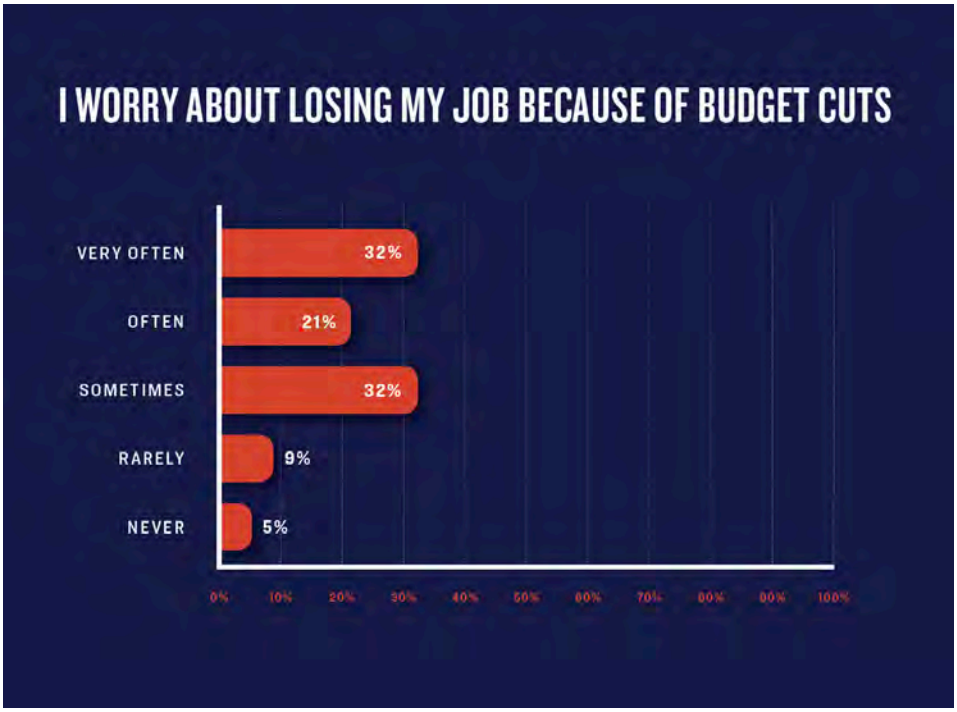
In June and July 2021, we surveyed more than 200 community violence intervention (CVI) workers in four cities, with the help of four partner organizations: the Urban Peace Institute in Los Angeles, the Oakland Department of Violence Prevention, Chicago CRED, and the Mayor's Office of Neighborhood Safety and Engagement in Baltimore. The results below reflect the experiences of 180 full-time CVI workers in these cities.

Demographic Characteristics

- The majority of CVI workers in our sample—78%—were male. The average worker was 44 years old, with workers ranging in age from 22 to 72.
- Workers overwhelmingly identified as people of color: 72% of workers identified as Black and 26% of workers identified as Latino.
- 73% of workers had been working for their current employer for at least one year, while 18% had been working for their current employer for at least five years.

Worker Compensation, Benefits, and Tangible Supports

- 75% of full-time CVI workers reported making between $30,000 and $50,000 per year.
- 86% of workers have occasional or frequent worries about losing their jobs due to a lack of funding.
- 87% of full-time workers reported that they work additional hours beyond their regular work schedule at least once a month.



Support for CVI Work

- 52% of CVI workers said they neither agree nor disagree that law enforcement support their work. Only 26% of workers fully agreed that they felt supported by law enforcement.
- 43% of respondents indicated that they did not feel they were respected by other professionals they worked with in their role, such as hospital workers and emergency services workers.
- 56% of respondents disagreed with the statement that their local government adequately supports and funds their work, while 61% of workers indicated that they disagreed that their state and federal governments adequately support or fund their work.

Access to Resources

- 68% of workers reported receiving adequate training for their role.
- 93% of respondents indicated that there were not enough CVI workers doing violence intervention work.
- 43% of respondents reported they had seen many coworkers leave the field, while just 26% of respondents fully disagreed that many coworkers had left the field.

93% OF RESPONDENTS INDICATED THAT THERE WERE NOT ENOUGH CVI WORKERS DOING VIOLENCE INTERVENTION WORK›

CVI Worker Trauma

- 53% of respondents agreed that the trauma of people they helped at work had some effect on them, with 56% of respondents reporting that within the last 30 days, they had been less productive at work due to sleep loss.
- 93% of workers indicated that they had directly witnessed gun violence and 56% reported that they had been a victim of gun violence themselves before working as a paid CVI worker.
- 94% of workers reported experiencing at least one adverse childhood experience (ACE), while 69% reported experiencing four or more ACEs.

93% OF WORKERS INDICATED THAT THEY HAD DIRECTLY WITNESSED GUN VIOLENCE BEFORE BECOMING A PAID CVI WORKER

Our survey results indicate just how far we have to go in ensuring that violence intervention workers and organizations receive the resources and support they need to do their critical work safely and effectively.

In addition to surveying 200 workers, we also conducted a focus group with executives from the surveyed organizations. The following recommendations reflect their input in addition to the survey results and research conducted by Giffords.

Recommendations

1 **Identified Issue**: CVI workers struggle with unequal pay and inadequate fringe benefits.

Recommendation: Baseline pay for CVI workers should start at $45,000 annually (with adjustments based on cost of living and overtime compensation), in addition to medical, dental, life insurance, and retirement benefits.

2 **Identified Issue**: Many violence intervention workers are dealing with their own untreated trauma while being regularly exposed to vicarious trauma at work.

Recommendation: Organizations employing CVI workers must institutionalize trauma-informed systems of self-care and ongoing support for their employees.

3 **Identified Issue**: A lack of uniform training and professional standards hamper the field of violence intervention.

Recommendation: A national certifying entity should implement minimum standards of training and experience for CVI workers.

4 **Identified Issue**: Smaller violence intervention organizations often lack the capacity to leverage public grants.

Recommendation: The government should pass federal funding to smaller community organizations through intermediaries set up specifically for this purpose.

5 **Identified Issue**: Violence intervention work suffers from a lack of awareness and financial support from local, state, and federal governments.

Recommendation: The CVI field needs to make a concerted effort to raise awareness of the importance of this work.

6 **Identified Issue**: There is little-to-no local infrastructure to support and develop violence intervention organizations.

Recommendation: Establish Offices of Violence Prevention to provide funding, support, and training for the violence intervention field at the local and state levels.

We are at a critical juncture in our battle against gun violence. We must invest—in a long-term and sustainable manner—in our nation's most impacted communities and the people doing the hard work of saving lives, using the results of this report as a roadmap for how to allocate these funds. Too many lives have been lost, and too many more are at stake. **There's no time to waste.**

Institution for Social and Policy Studies

ADVANCING RESEARCH • SHAPING POLICY • DEVELOPING LEADERS

AGE OF GUNSHOT WOUND VICTIMS IN NEW HAVEN, 2003-2015

ISPS Policy Lab Working Paper
ISPS17-03
January 2017

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AGE OF GUNSHOT WOUND VICTIMS IN NEW HAVEN, 2003-2015

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Abstract

Since the dramatic surge in violent crime among youth that swept the country during the 1980s and 1990s, gun violence in U.S. cities has largely been treated as a young person's problem. Research and resources, along with media coverage, is often directed towards addressing gun violence among teens and young adults. However, has the age distribution of gunshot wound victims remained the same over time? Using data on all gunshot wounds (GSW) treated at Yale New Haven Hospital between 2003 and 2015, we explore trends in the age distribution of GSW victims in New Haven, Connecticut. Contrary to the prevailing framing of age and gun violence, we found that GSW victims in New Haven are 27 years old on average and have become *older* over time. Over the past thirteen years, the average age of GSW victims in the city has increased steadily from 23.9 to 27.6 years old. The upward trend in average age is seen across all racial groups, as well as for both fatal and non-fatal GSW incidents. Moreover, we find that while the average age of black GSW victims increased about two years over the study period (from 24.4 to 26 years old), the average age of Hispanic and white GSW victims increased nearly eight (from 21 to 28.7 years old) and nine years (23 to 31.5 years old), respectively. The findings suggest a need to understand age and urban gun violence from a more nuanced perspective that takes into account longitudinal trends and racial disparities.

BACKGROUND

Gun violence in the United States is often portrayed and treated as an issue primarily involving youth. Media coverage on gun violence regularly features young victims.[1-2] Many policies and programs at the federal, state, and local levels are specifically focused on preventing gun violence among youth.[3] For example, the Cure Violence Program in Chicago seeks to prevent gun violence among "high risk" youth between the ages of 16 and 25 through street outreach programs, community mobilization, and public education.[4] Similarly, the Safe Streets Program in Baltimore employs street outreach workers to address gun violence among youth between the ages of 15 and 24, while the Street Outreach Workers Program in New Haven utilizes a public health risk reduction model with the goal of reducing violence among teens and young adults between the ages of 13 and 35.[5-6]

The emphasis on youth in gun violence prevention efforts is certainly well-founded. Gun violence among youth assumed a prominent role during the surge in violent crime that swept the United States during the mid-1980s to early 1990s. Indeed, in a study of trends in youth violence, Philip J. Cook and John H. Laub found that an acute increase in gun violence among youth was, in part, responsible for the dramatic rise in violent crime during this period.[7] They observed that involvement in violent crime was markedly higher among youth compared to other age groups during the 1980s, as homicide commission rates among youth under the age of eighteen "more than tripled between 1984 and 1993."[7] Cook and Laub noted that the "epidemic of youth homicide was entirely a gun-homicide epidemic," as verified rates of homicide not involving guns "remained essentially unchanged" for this age group during this period.[7]

Moreover, while violent crime in the United States has declined steeply since its peak in the early 1990s, rates of gun violence remain high, particularly among youth. In 2013, 33,636 Americans died due to injury by firearms, including homicides, suicides, and accidents; this means that on average in 2013, more than 90 Americans died due to firearm injury every day.[8] Individuals between the ages of 15 and 24 were prevalent among these figures, accounting for one-third of all deaths due to gun homicide and nearly one-fifth of all deaths due to any type of firearm injury.[8] In fact, the rate of gun homicide is 8.4 per 100,000 population for individuals between the ages of 15 and 24, which is the highest rate among all age groups and more than double the national rate.[8]

It is evident that gun violence among youth is a public health problem in demand of our utmost attention. However, have the victims of gun violence remained young over time? This paper begins to answer this question by describing trends in the age of gunshot wound victims in New Haven between 2003 and 2015 using hospital trauma registry data. New Haven has experienced rates of violent crime comparable to that of other mid-sized cities, which saw a dramatic rise in violent crime during the 1980s and early 1990s that was followed by a marked decline in violent crime during the mid- to late 1990s.[9-11] By exploring trends in the age of gunshot wound victims in New Haven over the past thirteen years, this paper provides useful analytical insight towards understanding how the legacy of youth violence in preceding decades currently shapes our perceptions of and policies towards age and gun violence in U.S. cities.

DATA

This paper analyzes data on all fatal and nonfatal gunshot wounds—including homicides, assaults, accidental injuries, and self-inflicted injuries—treated at Yale New Haven Hospital (YNNH) in New Haven, Connecticut between 2003 and 2015. YNHH is a nonprofit, academic medical center. As the only American College of Surgeons verified and Connecticut Department of Public Health designated Level I Trauma Center in the Greater New Haven area, YNHH assumes a key role in treating the city and region's gunshot wound (GSW) victims. YNHH also addresses the effects of local gun violence on community health through its participation in the Healthier Greater New Haven Partnership, a collaborative effort among public health, healthcare, government, and civic leaders to identify and respond to community health needs, as well as its sponsorship of the Greater New Haven Community Health Needs Assessment.[12]

YNHH maintains data on gunshot wounds and other trauma treated at its facilities using trauma registry software, TraumaBase (Clinical Data Management, Evergreen CO).[13] During the thirteen-year period between 2003 and 2015, a total of 1,225 GSW incidents involving 1,199 unique victims were reported.[14] Because nearly all victims in the sample experienced only one GSW incident, the analysis presented in this paper focuses on unique incidents rather than victims.[15] Each GSW incident record included data on the victim (e.g., name, age, race, gender, and address) and his/her injury (e.g., date, description, diagnoses, complications, severity score, probability of survival, disposition from emergency department, and discharge status). The analysis describes trends across these 1,225 GSW incidents based on year, race, gender, fatality, and age.[16]

In the proceeding analysis, GSW incidents refer to those injuries treated at YNHH between 2003 and 2015. While the majority of GSW incidents that occurred in New Haven during the study period were treated at YNHH, there were GSW incidents that were not treated at YNHH and therefore are not present in the data. GSW incidents in which individuals died on scene and were never transported to YNHH or individuals who were shot and did not seek treatment at YNHH are not captured in the data. These untreated GSW incidents are reflected in the differences between the annual number of GSW incidents reported by YNHH and the annual number of gun assaults and homicides reported by the New Haven Police Department (NHPD). For example, in 2013, while NHPD reported 71 gun assaults and 19 gun homicides, YNHH reported treating 69 GSWs with 14 of those being fatal. Although data on GSWs treated at YNHH do not definitively capture all GSW incidents that have occurred in New Haven over the past thirteen years, the data nonetheless provide fairly robust information that can be used to understand the city's overall trends in gun violence.

REVIEW OF GUN VIOLENCE IN NEW HAVEN

New Haven, Connecticut is a mid-sized city with a population of 129,779, a population total that has remained steady for the past two decades.[17] The city is predominantly white (42.6%) and black (35.4%), with a growing Hispanic population (27.4%) that increased by one-third between 2000 and 2010.[17-18] The city is nearly gender-balanced, with a 48.2% male and 51.8% female divide.[16] The median age is 29, about eight years younger than the national average.[17,19] One in four (25.4%) of the city's residents are under the age of 18 and one in five (20.8%) are between the ages of 20 and 34.[17,19] New Haven has struggled with poverty in the post-industrial era with approximately one out of every four residents living below the poverty line, nearly double the national average.[20] The median income for a household is $37,508, which is significantly below the national median of $51,759.[20]

Among mid-sized cities in the United States, New Haven is often said to be one of the most dangerous.[21] This is an oversimplification of the city's history of crime. Between 1940 and the late 1960s, New Haven was below or on par with the national average for violent crime. The 1980s marked a sharp shift, as the city became poorer and struggled to contain crime. Gang violence and urban upheaval contributed to a surge in violent crime in the 1980s that doubled that of the national crime rates.[9] Mirroring national trends, the last decade before the turn of the century brought a drastic drop in violent crime in New Haven, from approximately 30 crimes per 1,000 residents in 1990 to 15 crimes per 1,000 residents in 2000.[10] In recent years, the city's crime trends have been mixed. While violent crime has generally stabilized, homicides dropped to a low in 2003 and have since increased steadily to rates on par with Chicago and Oakland, although decreasing again in recent years.[11]

In particular, there have been more shooting injuries in New Haven in recent years. As shown in Figure 1, GSW incidents treated at YNHH peaked in 2009 and then declined steadily until roughly 2013. Since 2013, GSW incidents treated at YNHH have begun trending upward again, with a total of 95 GSW incidents in 2015—nearly double the number of GSW incidents that occurred in 2003 (n = 57).

As it is in most U.S. cities—and despite a prevalent focus on gun homicides—most GSW incidents in New Haven are non-fatal. As such, the overall trend in GSW incidents in New Haven ebbs and flows with levels of non-fatal GSW incidents. The annual number of nonfatal GSW incidents treated at YNHH has ranged considerably from 41 to 126, with an average of about 83 nonfatal GSW incidents per year. In contrast, fatal GSW incidents treated at YNHH have ranged from three to 18, with an average of about 11 fatal GSW incidents per year. By and large, fatal GSW incidents have been mostly flat, with minor upticks and downticks, and with consecutive decreases since 2013. Overall, GSW incidents treated at YNHH reached a low in 2004 with 49 combined fatal and nonfatal GSW incidents and a high in 2009 with 138 total GSW incidents. From 2004 to 2009, YNHH saw consecutive increases in GSW incidents, with the exception of a slight decrease from 2006 to 2007. GSW incidents have relatively stabilized within the past few years, with an average of about 90 combined fatal and nonfatal GSW incidents per year between 2011 and 2015.

Also like gun violence in other cities, GSW incidents in New Haven are marked by important racial disparities. Table 1 shows that 68% of all fatal and nonfatal GSW victims treated at YNHH between 2003 and 2015 are black; Hispanics and whites account for approximately 16% and 14% of the remaining victims, respectively. Similarly, GSW incidents in the city are unequally distributed by gender. As seen in Table 2, GSW incidents occur overwhelmingly among males, accounting for 93% of all fatal and nonfatal GSW incidents that have been treated at YNHH over the past thirteen years.

Figure 1. Number of Fatal and Non-Fatal GSW Incidents Treated at Yale New Haven Hospital, 2003-2015

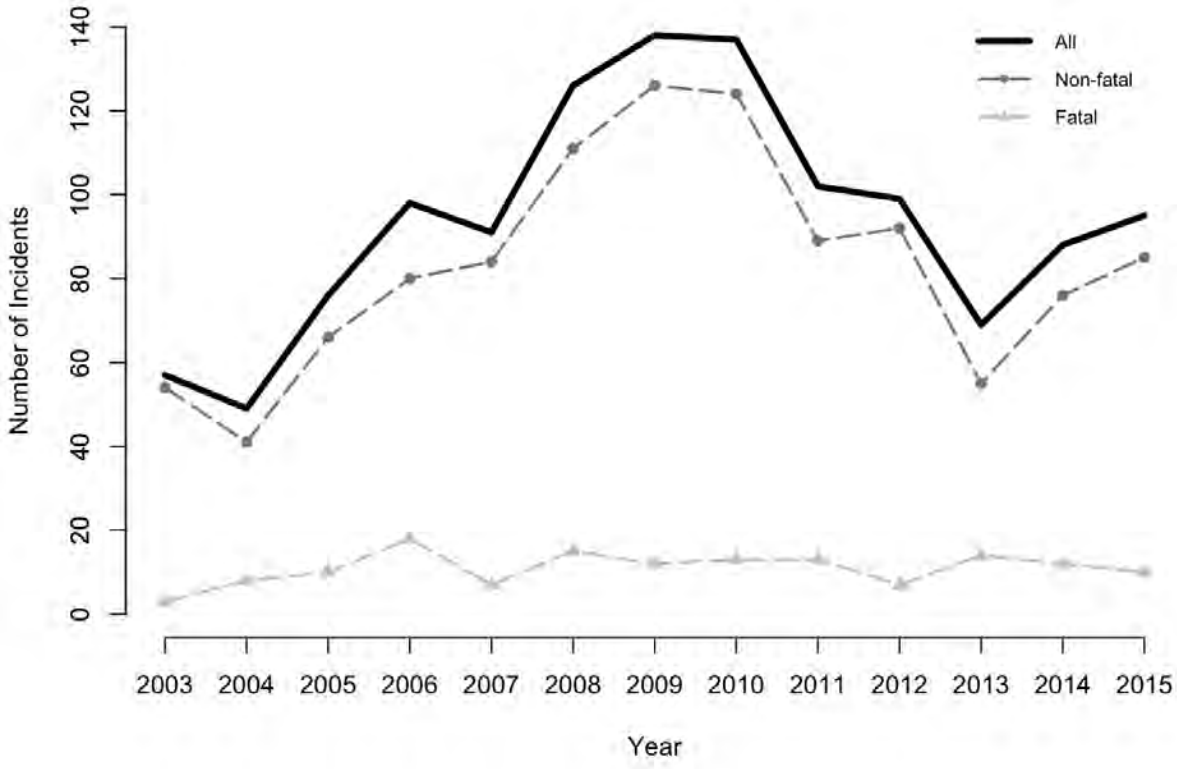


Table 1. Proportion of GSW Victims Treated at Yale New Haven Hospital by Race, 2003-2015

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	**All Years**
Black	77%	73%	54%	65%	68%	63%	73%	66%	75%	65%	72%	74%	62%	**68%**
Hispanic	7%	16%	26%	17%	18%	21%	17%	15%	10%	14%	7%	14%	16%	**16%**
White	16%	8%	17%	14%	14%	15%	9%	19%	15%	17%	14%	9%	16%	**14%**
Other	--	2%	--	1%	--	1%	--	1%	--	4%	3%	2%	6%	**1%**
No Data	--	--	3%	2%	--	1%	--	--	--	--	3%	1%	--	**1%**
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
N	57	49	76	98	91	126	138	137	102	99	69	88	95	1,225

Table 2. Proportion of GSW Victims Treated at Yale New Haven Hospital by Gender, 2003-2015

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	**All Years**
Male	91%	92%	95%	94%	97%	93%	92%	92%	95%	92%	93%	95%	89%	**93%**
Female	9%	8%	5%	6%	3%	7%	8%	8%	8%	8%	7%	5%	11%	**7%**
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
N	57	49	76	98	91	126	138	137	102	99	69	88	95	1,225

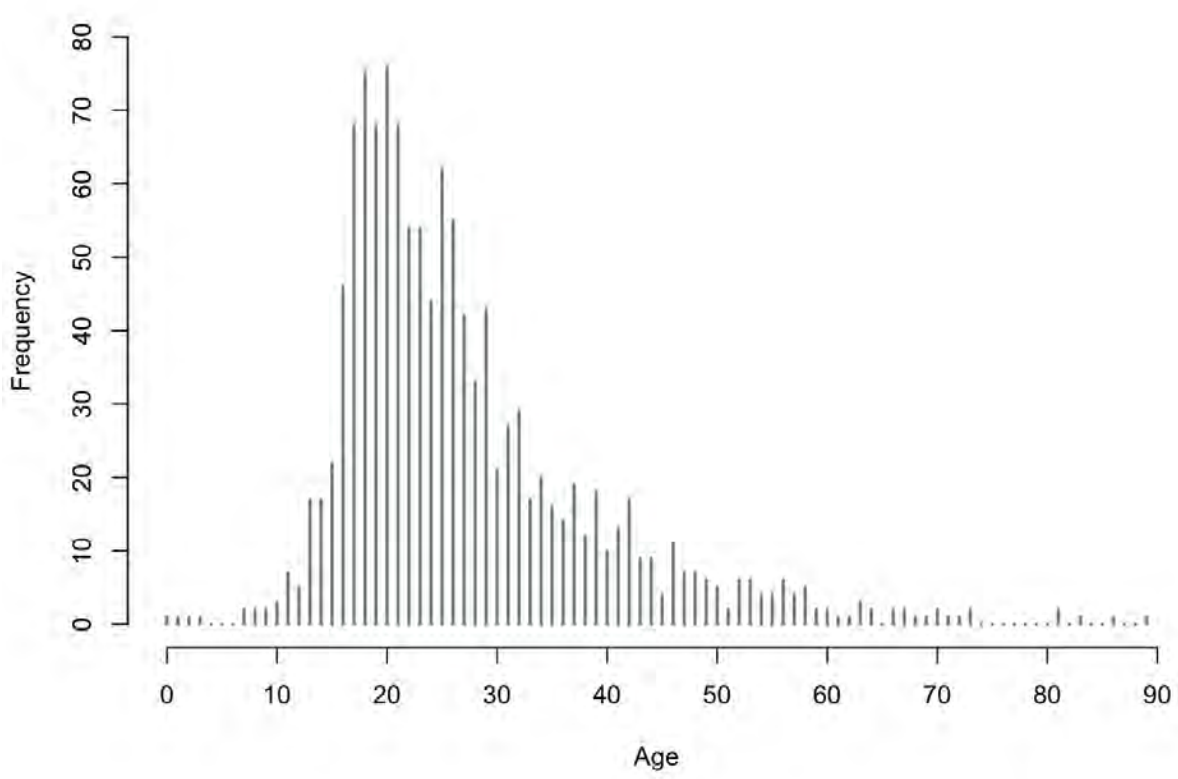
TRENDS IN AGE AMONG GUNSHOT WOUND VICTIMS IN NEW HAVEN

Given the city's relatively young population, to what extent are youth represented among GSW victims in New Haven? How does the age distribution of GSW victims vary by race or type of shooting? And, has the age distribution of victims remained stable over time? This section addresses these questions by first exploring the general age distribution of GSW victims treated at YNHH and then examining trends in GSW victims' ages over time.

General Age Distribution of Gunshot Wound Victims

Overall, GSW victims treated at YNHH range in age from less than one-year-old to 89 years old over the study period. The average age of a victim over the study period is 27 years old. Victims of fatal GSWs are, on average, four years older than victims of non-fatal GSWs; the average age of a fatal GSW victim is 31 years old as compared to 27 years old for non-fatal GSW victims. As seen in Figure 2, most GSW victims treated at YNHH over the past 13 years were between the ages of 19 and 32. Following a well-established pattern between age and crime, Figure 2 also shows that victimization peaks in the late teens to early twenties and generally declines from the late 20s onward.[22]

Figure 2. Age Distribution of GSW Victims Treated at Yale New Haven Hospital, 2003-2015



However, there are important differences in the age distribution of GSW victims treated at YNHH by race. Figure 3 displays the age of all GSW victims treated at YNHH between 2003 and 2015, disaggregated by race. Black and Hispanic GSW victims tend to be considerably younger than white GSW victims, with black victims being the youngest among all racial groups. Compared to white GSW victims, black victims are ten years younger and Hispanic victims are eight years younger on average; the average age of black, Hispanic, and white GSW victims is 25, 27, and 35, respectively. There is also greater variance in age among white GSW victims compared to black and Hispanic GSW victims. The vast majority of black and Hispanic victims are in their twenties, while most white victims are between the ages of 21 and 47.

The racial disparities in age are particularly pronounced in terms of fatal GSWs treated at YNHH. As seen in Figure 4, black and Hispanic victims of fatal GSWs are substantially younger than white victims of fatal GSWs. Relative to white victims of fatal GSWs, black victims of fatal GSWs are 19 years younger and Hispanic victims of fatal GSWs are 15 years younger on average; the average age of black, Hispanic, and white victims of fatal GSWs is 27, 31, and 46, respectively. While most black and Hispanic victims of fatal GSWs tend be in their twenties and early thirties, the majority of white victims of fatal GSWs are between the ages of 27 and 60. This pattern is striking given broader national trends indicating that the white-black gap in life expectancy has generally been decreasing over time (reaching a "record low" at 3.6 years in 2013), and that the Hispanic population has tended to have longer life expectancy on average compared to the U.S. population as a whole (81.6

versus 78.8 years in 2013).[8] Figure 4 also shows that the racial gap in age is noticeably smaller with non-fatal GSWs treated at YNHH. The average age of non-fatal GSW victims is 25, 27, and 33 for blacks, Hispanics, and whites, respectively.

Figure 3. Racial Differences in Age Distribution of GSW Victims Treated at Yale New Haven Hospital, 2003-2015

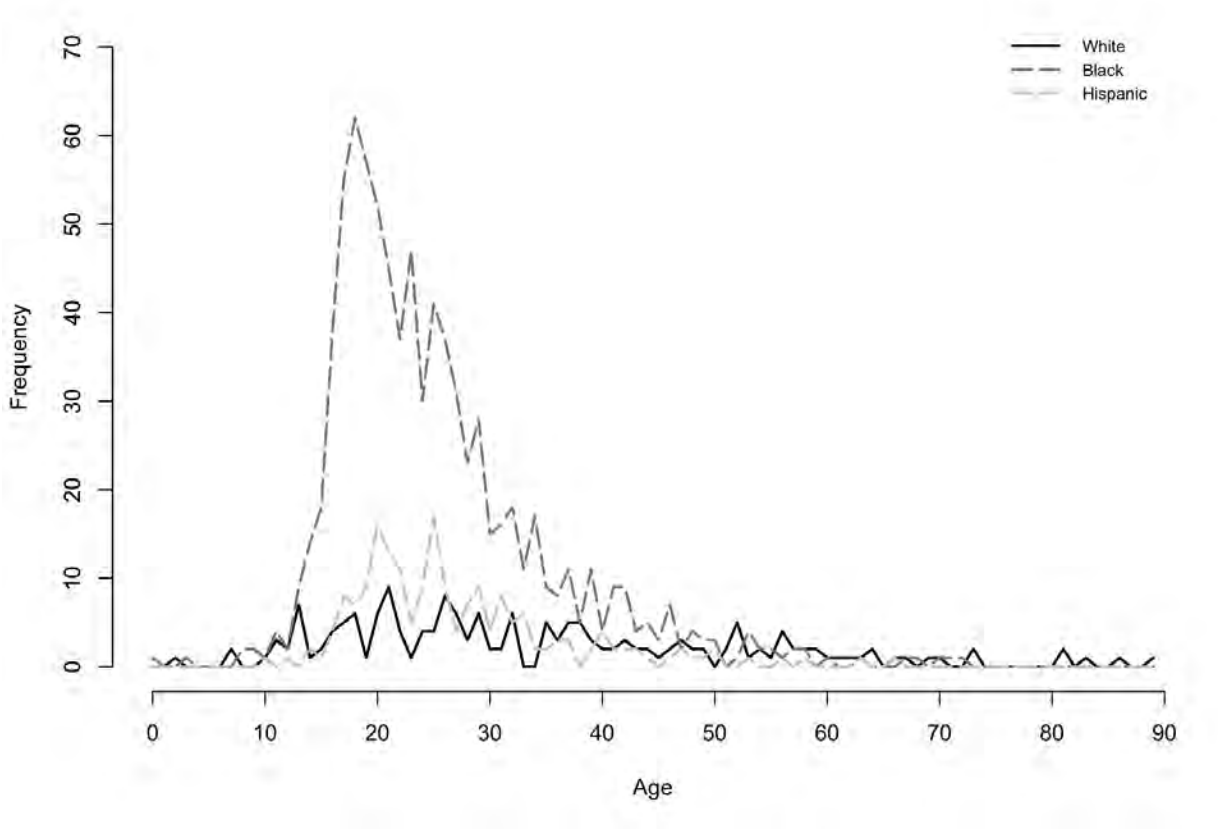
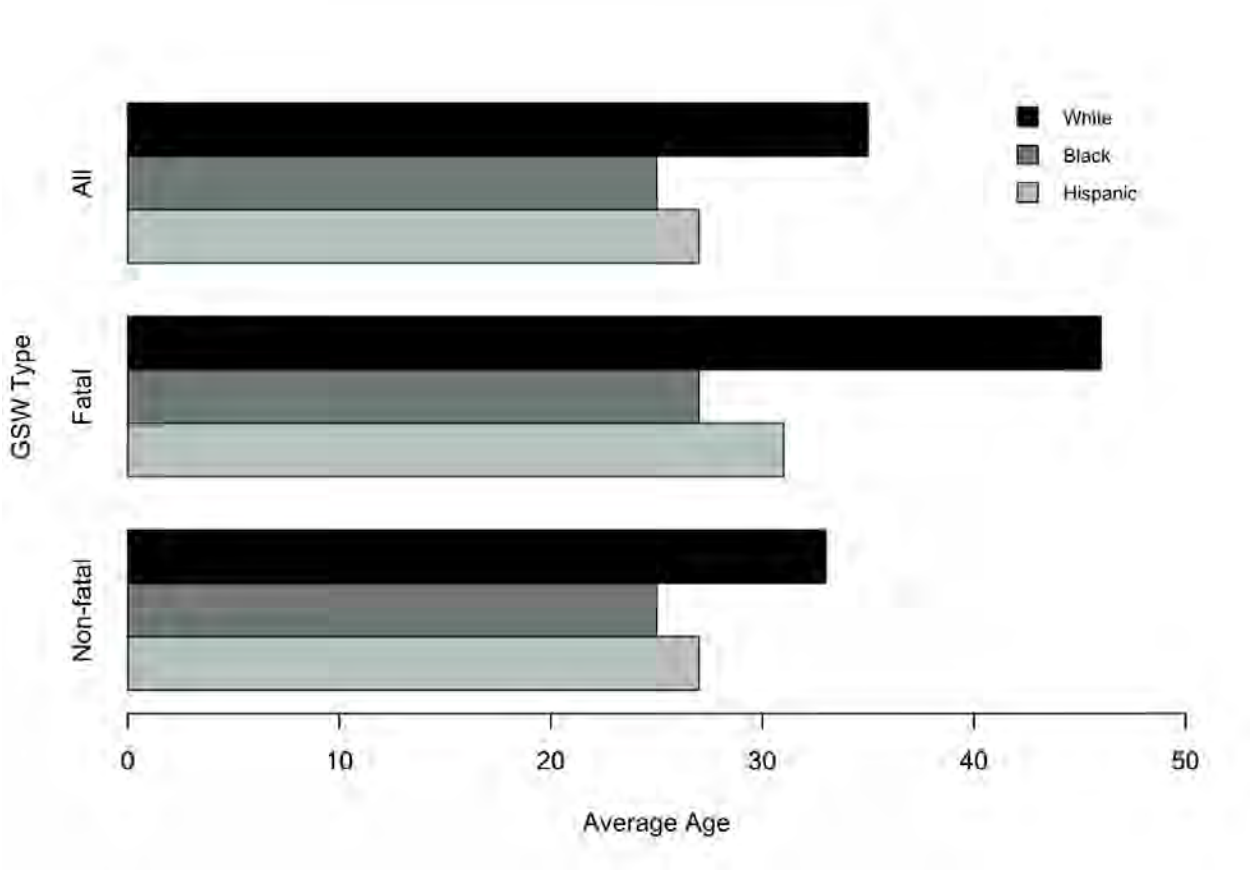


Figure 4. Racial Differences in Average Age of GSW Victims Treated at Yale New Haven Hospital by GSW Type, 2003-2015

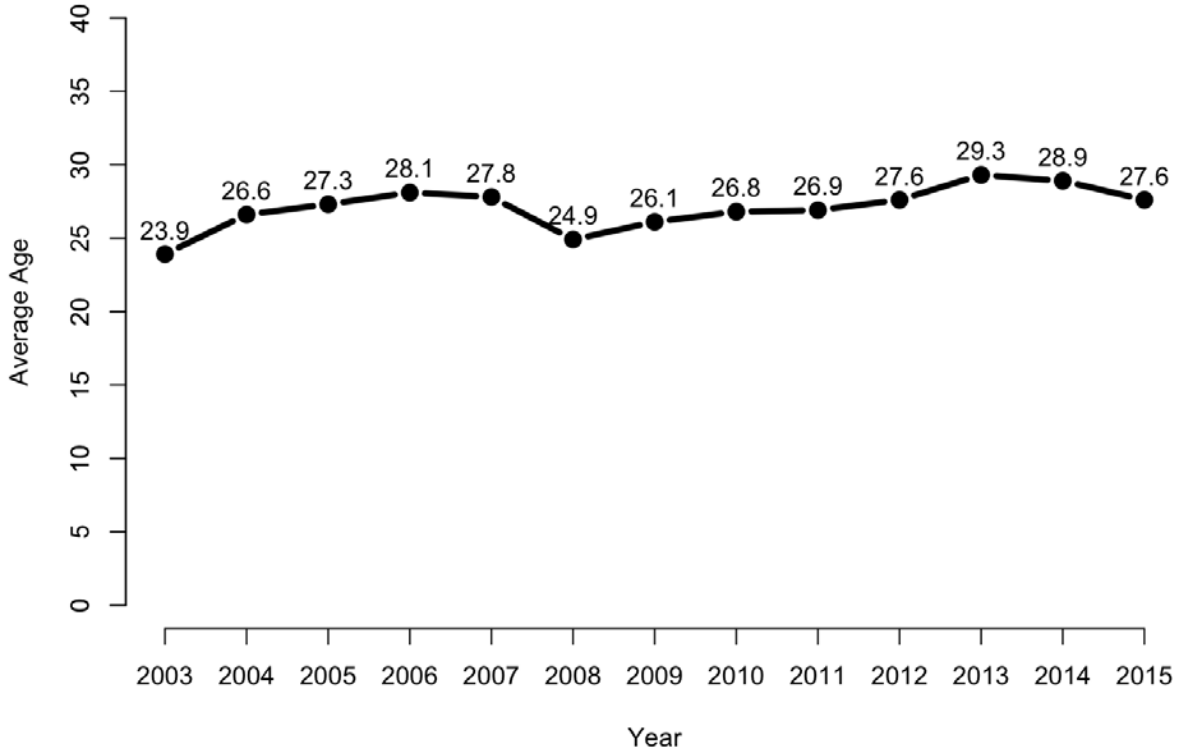


Age of Gunshot Wound Victims Over Time

Overall, the average age of GSW victims treated at YNHH has increased steadily over time. Figure 5 shows the average age of all GSW victims treated at YNHH for each year between 2003 and 2015. Over the past 13 years, the average age of GSW victims has overall increased from 23.9 to 27.6 years old. Average age inched upward each year between 2003 and 2007 before dropping considerably in 2008. Average age then resumed rising each year between 2009 and 2013, reaching the apex of 29.3 years in 2013. Although average age has decreased slightly over the past two years, the average age of GSW victims in 2015 at 27.6 years is still much older than that of most years in the past. The median age of GSW victims has similarly increased during this time, from 22 to 25 years old.

The upward trend in average age appears for both fatal and non-fatal GSW incidents treated at YNHH. Between 2003 and 2015, the average age of non-fatal GSW victims treated at YNHH increased from 24.4 to 27 years old. There were year-to-year increases in average age for all years during this period, with the exception of year-to-year decreases from 2006 to 2008 and 2013 to 2015. Similarly, the data indicate that recent victims of fatal GSWs treated at YNHH may be slightly older than those of years past. The average age of fatal GSW victims in 2015 was 32.4 years old, which was older than the average age for all but four of the preceding twelve years. However, it is important to note that because fatal GSWs occur relatively infrequently compared to non-fatal

Figure 5. Average Age of GSW Victims Treated at Yale New Haven Hospital, 2003-2015

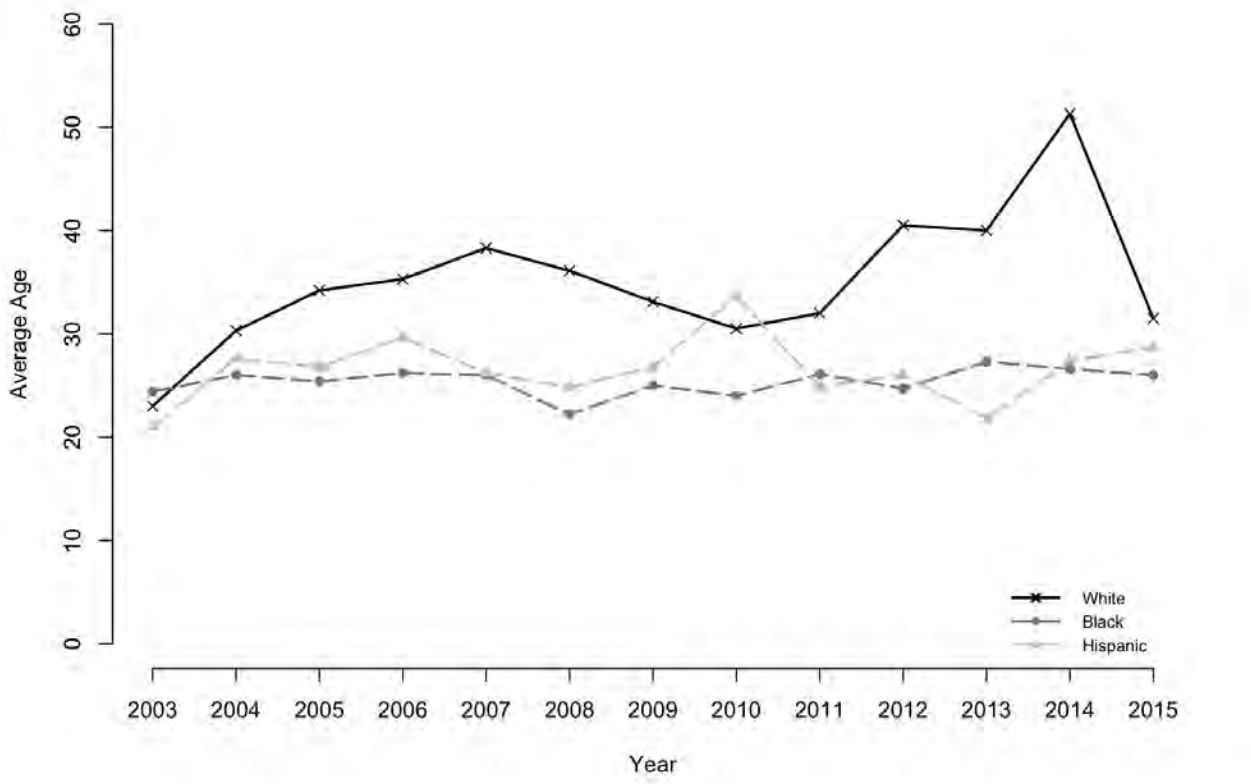


GSWs, trends in average age for fatal shootings are much more sensitive to the specific ages of victims in any given year.

The increase in the average age of GSW victims treated at YNHH is also seen across all three racial groups, though there is variation in the pace of change. Figure 6 displays the average age of white, black, and Hispanic GSW victims treated at YNHH for each year between 2003 and 2015. Over the past 13 years, the average age of white and Hispanic GSW victims has risen considerably relative to black GSW victims. While the average age of black victims increased about two years over the study period (from 24.4 to 26 years old), the average age of Hispanic and white victims increased nearly eight (from 21 to 28.7 years old) and nine years (23 to 31.5 years old), respectively.

As increases in the average age of white and Hispanic GSW victims have outpaced the increase in the average age of black GSW victims, there have been some changes in the age disparities between racial groups. Notably, the disparity in average age between white and black GSW victims has more than tripled between 2003 and 2015, increasing from 1.4 to 5.4 years during this period. The disparity in average age between white and Hispanic GSW victims has also grown slightly, increasing from 2.0 to 2.8 years over the same time period. In contrast, black and Hispanic GSW victims have become more similar in age over time, with the disparity in average age between the two racial groups decreasing from 3.4 to 2.6 years between 2003 and 2015. However, it is important to note that the age disparities between racial groups often fluctuate considerably from year to year. For

Figure 6. Average Age of White, Black, and Hispanic GSW Victims Treated at Yale New Haven Hospital, 2003-2015



example, the disparity in average age between white and black GSW victims increased consistently from 2003 to 2008, decreased consistently from 2009 to 2011, and then alternated between increasing and decreasing from 2012 to 2015. This underscores the value of looking at trends within and between racial groups over time to illuminate racial disparities and more broadly, the need to consider the continuously changing nature of gun violence as it relates to age and race.

DISCUSSION

Gun violence in U.S. cities is largely considered to be a young person's problem. Research and resources, along with media coverage, is often directed towards understanding and addressing gun violence among young people in their teens to early twenties. In contrast to this commonly-held view, our study of all gunshot wound incidents that have been treated at YNHH over the past thirteen years found that gunshot wound victims are considerably older. On average, GSW victims in New Haven were 27 years old. Nonfatal GSW victims were 27 years old on average, while the average age of fatal GSW victims was 31 years old. What's more, our study found that the average GSW victim in New Haven has gotten *older* over time. Between 2003 and 2015, the average age of GSW victims in the city increased from 23.9 to 27.6 years old—an increase of nearly four years. The

average GSW victim in New Haven is no longer an individual in their early twenties but rather an individual in their late twenties to early thirties.

Moreover, our study found that there are important racial disparities in the age of GSW victims in New Haven. Black and Hispanic GSW victims treated at YNHH were markedly younger and less varied in age than white GSW victims. The average age of black, Hispanic, and white GSW victims was 25, 27, and 35 years old, respectively, with most black and Hispanic victims being in their twenties and most white victims being between the ages of 21 and 47. This means that on average, nearly a decade separates when blacks and Hispanics tend to be victimized by gun violence compared to whites. These differences among racial groups in the average age of GSW victims have also changed over time. Between 2003 and 2015, the average age of white and Hispanic GSW victims in the city has increased much more rapidly than the average age of black GSW victims. One consequence of this is that the disparity in average age between white and black victims has more than tripled over the past thirteen years (increasing from 1.4 to 5.4 years). This suggests that increasingly, addressing gun violence in New Haven requires engaging individuals across different age *and* racial groups.

Our study is not without limitations. The study focused on the age of GSW victims only in the city of New Haven. Similar analyses of additional cities are needed to determine the generalizability of these findings, as well as to explore comparisons between cities that may vary in terms of their rates of gun violence, age distribution, and racial composition, among other factors. The study also focused on describing trends in age among GSW victims in New Haven; we have not unpacked the reasons as to *why* the average GSW victim in New Haven has become older over time and other trends have occurred. More research is needed to evaluate potential explanations such as the presence of an aging population or cohort effects. Our preliminary inquiries showed that the general population of New Haven has become slightly older over time. We also found that "repeat" GSW victims make up a very small proportion of all GSW victims in the city (n = 26 or 2% of all unique victims). All of these "repeat" GSW victims experienced two injuries and nearly all survived both injuries, with the amount of time between injuries being about 21 months on average and ranging from one month to over five years.

These limitations notwithstanding, our study demonstrates that delving into the age distribution of GSW victims—especially across age and racial groups and over time—can help provide new insight towards addressing a city's gun violence epidemic. Assuming that gun violence mostly affects youth and designing interventions and directing resources accordingly is not without basis, given the dramatic surge in gun violence among youth that swept the country during the mid-1980s to early 1990s. However, it is important to continuously evaluate the age targets of gun violence prevention programs and policies and to ensure that there is alignment between the age populations who are served by these initiatives and the actual age of gun violence victims.

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13. Trauma registry data maintained via TraumaBase (Clinical Data Management, Evergreen CO) was provided by Calvin Norway Jr., Medical Information and Technical Systems Coordinator at Yale New Haven Hospital.
14. Yale New Haven Hospital reported treating 1,226 incidents of firearm injury between 2003 and 2015. One incident was omitted from the sample because it represented an extreme outlier in age that was likely mistakenly inputted.
15. Ninety-eight percent of all victims in the sample experienced only one incident of firearm injury (n = 1,173 victims), while two percent of victims experienced more than incident of firearm injury (n = 26). Data on name, age, race, and gender were used to confirm that multiple injuries belonged to the same victim; data addresses were also used when available.
16. A binary variable indicating whether a firearm injury was fatal was created using data on the gunshot victim's disposition from the emergency department and discharge status. Any firearm injury in which either the disposition from the emergency department and/or discharge status was recorded as "Morgue" was coded as fatal.
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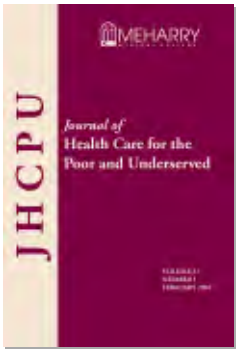
Prevention Professional for Violence Intervention: A Newly Recognized Health Care Provider for Population Health Programs



Kyle R. Fischer, Carnell Cooper, Anne Marks, Gary Slutkin

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REPORT FROM THE FIELD

Prevention Professional for Violence Intervention: A Newly Recognized Health Care Provider for Population Health Programs

Kyle R. Fischer, MD, MPH
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Anne Marks, MPP
Gary Slutkin, MD

Summary: The National Uniform Claim Committee recognized a new type of health care provider for violence intervention: prevention professional. This creates a pathway for population health interventions to obtain reimbursement through traditional medical financing systems. In addition to violence, prevention professionals may specialize in other conditions of public health importance.

Key words: Population health; health care providers; health policy; violence prevention.

Sustainable funding for population health initiatives is often challenging. Although many interventions improve care quality or reduce long-term expenditures, start-up costs and delayed financial return remain barriers to implementation. Additionally, financial benefit might actually accrue to other health system sectors that did not deliver the service. In the absence of predictable reimbursement, programs often face funding uncertainty. To bridge the gap between existing program funding models and the traditional medical reimbursement system, a new type of health care provider has been developed: prevention professionals. This paper will discuss a brief history of the provider's origin, potential benefits to using prevention professionals, and critical lessons for the advancement of prevention professionals.

Early Experiences Implementing Population Health Interventions among the Violently Injured

The development of the Prevention Professional designation originates in the field of violence prevention, with initial work beginning 25 years ago (Box 1). Research

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Box 1.

TIMELINE OF THE DEVELOPMENT OF THE PREVENTION PROFESSIONAL DESIGNATION

- 1994: First Hospital-based violence intervention program was formed
- 2009: The National Network of Hospital-based Violence Intervention Programs is created with seven founding programs
- Apr 2011: First annual conference of NNHVIP
- Apr 2011: NNHVIP publishes "Violence is Preventable," an HVIP replication guide
- 2014: State of California recognizes Violence Peer Counselor health care provider
- Nov 2014: NNHVIP applies with National Uniform Claim Committee for Violence Prevention Professional recognition
- Sep 2015: NUCC Approves "Prevention Professional" designation
- April 2016: Prevention professional included in the provider taxonomic code
- Apr 2018: First in-person Violence Prevention Professional training and certification session
- Aug 2019: 34 U.S. based HVIPs and 4 international HVIPs

indicates violent injury is commonly a recurrent health issue for an individual, rather than a chance occurrence. In fact, trauma survivors maintain a five-year re-injury rate of up to 44% and mortality of 20%.[1] In response, interventions to reduce the risk of re-injury have been developed. Hospital-based violence intervention programs (HVIP) combine brief in-hospital intervention with outpatient case management, peer mentorship, and targeted services.[2] To date, the National Network of Hospital-based Violence Intervention Programs (NNHVIP) reports 38 members.[3] These programs are located in predominately urban settings throughout the United States, Canada, England, and El Salvador (Figure 1).

Hospital-based violence intervention program evaluations demonstrate effectiveness in reducing rates of participant reinjury. To date, five randomized control trials have been conducted (Table 1).[4–8] The largest of the studies significantly decreased re-injury rates from 20.3% in the control group to 8.1% in the intervention.[5] Using a retrospective design, a San Francisco-based HVIP found at six-year follow-up, 4.5% of program participants were reinjured compared with 16% of historical controls.[9]

Community-based approaches have also proven effective in reducing violent injury. The Cure Violence Model is based on the World Health Organization's epidemic control approach to infectious disease. Its development began in 1995 and drew on public health interventions proven to interrupt transmission of HIV in Uganda[10] and tuberculosis in San Francisco.[11] It addresses violence as a learned, contagious behavior driven by norms.[12] The main program components are: interrupting transmission of violence by detecting and de-escalating disputes, intensive engagement with high-risk participants, and changing norms that accept and encourage violence.

An independent evaluation of the Cure Violence model in New York City found a 50% reduction in homicides and 63% in shootings.[13] Other replication studies of the

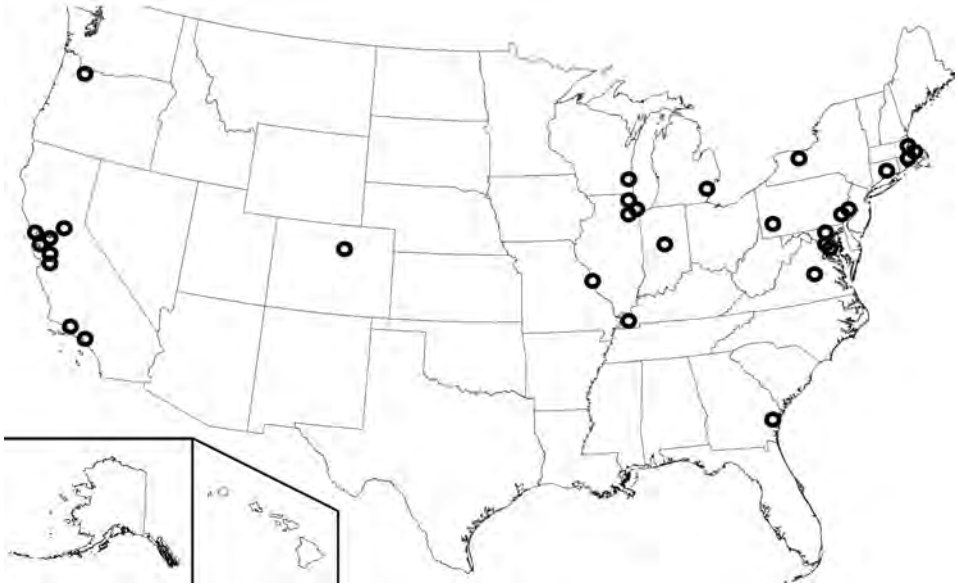

Figure 1. U.S. hospital-based violence intervention programs.

Table 1.

REINJURY RATES IN HVIP RANDOMIZED CONTROL TRIALS

	HVIP (n)	Control (n)	Stat. Sig?
Cooper 2006	5% (56)	36% (44)	Yes
Zun 2006	8.1% (96)	20.3% (92)	Yes
Aboutanos 2011	5.6% (39)	6.2% (36)	NS
Cheng 2008	5.7% (56)	7.8% (57)	NS
Cheng 2008	0% (25)	14.3%/8%[a] (25)	NS

Notes:
[a](Parental/Child report)
HVIP = Hospital-based violence intervention program.

Cure Violence model worldwide show consistent reductions in shootings, largely due to the work of the frontline violence interrupters and outreach workers (Table 2).[14–17]

While differences exist between the HVIP and Cure Violence models, there are similarities at the level of direct service delivery. Although program management may be driven by a health system leader such as a health commissioner or physician in conjunction with other clinical and social service providers, culturally competent frontline workers provide the bulk of patient-level interventions. These frontline workers, whose primary task is to address upstream injury risk factors, remain the prototype for what would eventually evolve into the prevention professional designation.

Situated within population health programs, these frontline staff perform a vari-

Table 2.

REDUCTIONS IN SHOOTINGS IN CURE VIOLENCE EVALUATION STUDIES

	City	% Reduction in Shootings	Stat. Sig?
Maguire 2018	Port of Spain (Trinidad)	45% (violent crime)	Yes
Delgado 2017	New York City	63%	Yes
Henry 2013	Chicago	19%	Yes
Webster 2012	Baltimore	44%	Yes
Skogan 2009	Chicago	41% – 73%	Yes

Box 2.

POTENTIALLY REIMBURSABLE SERVICES

- Crisis intervention
- Patient education
- Peer support services
- Patient and family support services
- Targeted case management
- Care coordination and health promotion
- Transitional care
- Mental health screening
- Mental health self-management education & training
- Alcohol and substance misuse screening

ety of tasks commonly performed in the traditional medical service reimbursement model, especially in services qualifying as case management or counseling (Box 2). San Francisco General Hospital's HVIP, the Wraparound Project, reviewed patient needs and expectations workers must be equipped address.[18] Mental health services were a priority for over half of program participants. Additionally, a significant percentage needed assistance with victims of crime compensation reimbursement, employment, housing and education. Over one-tenth (10.6%) of clients required items for personal documentation, such as driver's licenses. Services unique to violence prevention included gang intervention and tattoo removal.

During the early development of a frontline violence prevention role, the possibility of reimbursement for these services was simply not possible given that nearly 75% of gunshot wound victims were uninsured.[19] However, the ACA changed this. Medicaid Expansion now covers a larger proportion of hospital and emergency department charges for violent injuries. In the first year of implementation, Medicaid increased its share as the primary payer for gunshot injuries by 9.7%.[20] This amounts to approximately $397 million spent annually on violence-related injuries in the Medicaid Expansion

population alone.[21] As these patients gain insurance, the frontline workers who execute longitudinal care plans to prevent reinjury became logical recipients of reimbursement.

Lack of Violence Prevention Service Reimbursement Leads to New Provider Code

Despite delivery of services to a newly insured population, initial efforts to receive reimbursement proved difficult due to the health provider classification of the workers. Although several designations appeared relevant to the work performed, such as community health workers, health educators, and case managers, none of the existing designations provided an acceptable fit. For example, although the providers performed targeted case management services, their skill set encompassed unique activities distinct from those of case managers such as conflict mediation or safety planning. Furthermore, the case manager designation typically requires a higher level of educational attainment and certification than many prevention professionals.

The NNHVIP initially considered classification under the community health worker (CHW) designation, but a review of current and anticipated regulatory status indicated that this classification may be constraining for violence prevention. At present, there is substantial variability among states regarding overall recognition, training, certification requirements, and reimbursement for CHWs.[22] Given the reliance on Medicaid for violently injured patients, this specific payer was particularly important for the field. Unfortunately, many states do not reimburse CHWs through Medicaid. Others do, but only for defined conditions. (Home-based asthma care is one example.)

Although the NNHVIP could have utilized CHWs and advocated for reimbursement similar to that paid for home-based asthma therapy, this was deemed impractical. Because CHWs encompass a broad field of health care workers across the country, each state represented a different Venn diagram of financing, education, and certification, creating incentives for workers in violence prevention to match pre-specified state requirements, rather than those specific to the services delivered.

Alternatively, several benefits existed in the possibility of a new provider designation. First, it would allow the creation of more focused, uniform training and certification process. Second, with established program models, disease-specific service and patient outcomes data existed. Finally, the narrow focus allows for relatively granular cost-effectiveness data for specific payers. Overall, since research demonstrated violence prevention programs decreased patient emergency department use and hospitalizations, this created a logical argument for reimbursement.

Considering these factors, the NNHVIP proposed a new health care provider taxonomic code for those working in violence prevention. To do so, the group applied through the National Uniform Claim Committee, which elected to accept the application for a new provider code, but with a broadened scope of practice to include other population health-oriented providers. The new code is now operational under the following definition:

> "Prevention Professionals work in programs aimed to address specific patient needs, such as suicide prevention, violence prevention, alcohol avoidance, drug avoidance,

> and tobacco prevention. The goal of the program is to reduce the risk of relapse, injury, or re-injury of the patient. Prevention Professionals work in a variety of settings and provide appropriate case management, mediation, referral, and mentorship services. Individuals complete prevention professionals training for the population of patients with whom they work."[23[P.123]]

Population Health Funding Challenges are Not Unique to Violence Prevention

Funding for violence prevention programs is emblematic of challenges seen in other patient populations suitable for intervention. As is common for many population health programs, the HVIP and Cure Violence models are both funded by a combination of funds from local city and county budgets, research grants, hospital in-kind contributions, and charitable foundations.[24] On average, the annual cost of operating a hospital-based program is $350,000 to care for 90 patients,[25] while community-based approaches are approximately $400,000 for a high-risk neighborhood.[26] Notably, only a minority of programs receive reimbursement for the services delivered, creating a significant barrier to developing new programs or expanding successful ones.

If this misalignment between historical funding schemes for population health programs and typical medical care can be reconciled, then health departments, community-based organizations, hospitals, clinics, and health providers have wide-ranging opportunities to benefit health. In 2010 alone, the Centers for Disease Control and Prevention estimates over one billion outpatient visits occurred in clinics.[27] Although the primary purpose of most encounters might be for acute illness or disease management, each offers an opportunity to address social determinants of health and other upstream factors.

The Patient Protection and Affordable Care Act (ACA) and Medicare Access and CHIP Reauthorization Act enacted a variety of policies to encourage value-based care over quantity of care.[28] Importantly, these changes still rely predominately on a backbone of fee-for-service payments, a structure that inherently incentivizes treatment of disease rather than disease eradication or prevention. However, other regulations stemming from the ACA authorized states the option to reimburse non-physician providers to deliver preventive services.[29]

The combination of an evolving health care financing system in tandem with the reimbursement capabilities of non-physician providers creates an opportunity for the new "Prevention Professional" health care provider to bridge the divide between funding traditional health care and population health programs. Although originally conceived for the field of violence prevention, this provider can benefit other patient populations as well.

Next Steps and Lessons Learned

The recognition of prevention professionals is an important, but preliminary step in reimbursement for population health programs that engage in disease prevention. Notably, it is expected that individuals complete "training for the populations of patients

Box 3.

VIOLENCE PREVENTION PROFESSIONAL CORE COMPETENCIES

- Trauma-Informed Care and Trauma-Informed Practices Part 1: Understanding Trauma
- Trauma-Informed Care and Trauma-Informed Practices Part 2: Trauma-Informed Care Basics
- HIPAA & Confidentiality
- Record-keeping, documentation, and maintaining files
- Awareness and Screening for various other types of violence (domestic violence, abuse, sexual exploitation)
- Effective Management of Vicarious Trauma and Secondary Traumatic Stress
- Hospital bedside visit procedures and Professional boundaries
- De-escalation & Retaliation prevention
- Crisis Intervention and Conflict Mediation
- Personal Safety on Home and Community Visits
- Case Management and Advocacy
- Victim of Crime Compensation
- Gang and Group Violence Awareness
- Violence as a health issue & the model of hospital-based violence intervention

with whom they work."[23[P.123]] The NNHVIP, Cure Violence, and other national providers of public health approaches to violence prevention have traditionally trained new workers using best practices, on the job training, technical assistance for new programs as well as requiring all new programs to have an established "mentor."[30]

After recognition of the prevention professional designation, the NNHVIP formalized its training and certification process to include in person training and established core competencies (Box 3). This structure allows the organization to act as the certifying body for prevention professionals in the field of violence. Those working in suicide, alcohol, tobacco, or drug prevention programs interested in pursuing reimbursement under the prevention professional designation would be wise to establish an independent certification program as well. Early meetings with policymakers and regulators suggest that a successful, operational certification program is a rate-limiting step. Policymakers have consistently expressed that this component is a necessity to demonstrate quality of service providers. In its absence, policymakers fear that low-quality providers could enter the field, resulting in wasted spending for unclear patient benefit.

In addition to certification, other subspecialties contemplating the prevention professional designation should prepare robust data on program effectiveness. These data tend to be well-received when published, peer-reviewed local data are presented and backed by replication studies. Beyond health outcomes, cost-effectiveness data are essential. These data are more powerful when tailored specifically to the payer of interest. An example is evident in studies of cost-effectiveness for the Medicaid program rather than a combination of multiple payers or sectors of government.

Lastly, just as the development of the "Prevention Professional" designation was a result of lessons learned from other specialties, the promotion of the specialty should also learn from concurrent reimbursement efforts. One specific example is California's decision to reimburse non-physicians as part of its Diabetes Prevention Program.[31] Enacted through legislation in 2017, this program will undoubtedly provide tangible lessons for population health programs seeking funding through Medicaid reimbursement.

The prevention professional designation is a promising development in the advancement of population health programs into the American health system. However, a significant amount of effort remains to prove the value of this work and translate recognition into reimbursement. The NNHVIP and Cure Violence are in the midst of this process for violence prevention and have much remaining work moving forward. Those engaged in prevention of suicide, alcohol, tobacco, and substance misuse would be wise to examine the potential benefits that the prevention professional designation may bring to their fields.

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Note: Since acceptance of this manuscript, the National Network of Hospital-based Violence Intervention Programs has been re-named the Health Alliance for Violence Intervention.

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Understanding the makeup of a growing field: A committee on trauma survey of the national network of hospital-based violence intervention programs

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ABSTRACT

Background: Among Hospital Based Violence Intervention programs (HVIPs), little is known about variation in services provided, funding sources, or populations served.
Study design: Twenty-eight member programs of Health Alliance for Violence Intervention participated in a survey administered by the American College of Surgeons Committee on Trauma. Questions were quantitative and qualitative. For qualitative analysis, questions pertaining to the domains were assessed for common themes and assessed across all subject domains.
Results: All programs enroll patients injured by community violence, some by intimate partner violence (IPV), trafficking, and rarely by child or elder abuse. Programs with more funding (≥$300,000 per year) were more likely federally, state, or city funded. Lower funded programs (≤$300,000 per year) were funded by foundations or philanthropy. In both qualitative and quantitative analysis, barriers to starting or sustaining HVIPs included funding, and lack of risk reduction and mental health resources. Successful programs had stable funding, adequate staffing, and buy in from hospitals and staff.
Conclusion: HVIPs serve diverse populations in variable models. There is opportunity to expand the reach of HVIPs, and the experience if existing programs is an invaluable resource.

1. Introduction

Injuries resulting from interpersonal violence in the U.S. are prevalent. In 2017, homicide was the third leading cause of death for individuals age 15–34, accounting for large loss of life in the younger population (1). Homicide is the leading causes of death in African American men aged 15–34 years old, and second among Hispanic men of the same age, compared to less than 10% of deaths

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in their white counterparts.[2] Furthermore, it is estimated that for every 1 death from violent injury, there are an additional 40 nonfatal injuries, leading to additional disability and human cost.[3]

In an effort to combat this growing problem, Hospital Based Violence Intervention Programs (HVIPs) are becoming an increasingly prevalent injury prevention strategy in trauma centers nationwide.[4–6] HVIPs provide interventions in the hospital setting, needs assessment prior to discharge, and therapeutic long-term case management services to reduce risk of subsequent violent reinjury and perpetration.[7,8] The key strategy for these programs is the reliance on culturally competent long-term case management with a focus on addressing the root causes of violence which are impacted by the social determinants of health (9). Previous evaluations of HVIPs have demonstrated promising results in preventing violent reinjury, reducing violent crime, and substance misuse.[10]

The American College of Surgeons Committee on Trauma (ACS-COT) has partnered with the Health Alliance for Violence Intervention (HAVI), formally known as the National Network of Hospital Based Violence Intervention Programs (NNHVIP), to support the growth and development of HVIPs. With a year-to-date membership of 38 centers, HAVI is an *umbrella* organization that uses a public health approach to provide support and networking for HVIPs (http://www.thehavi.org). The HAVI membership consists of United-States based programs from all regions, primarily level 1, but also some level 2 trauma centers, in both academic and community centers. The membership is primarily urban trauma centers serving patients with a high level of interpersonal violence.

HVIPs have developed locally within motivated trauma centers and communities, but there is no standardized model.[11] Furthermore, the variety of services provided, practice patterns, funding sources, or populations served by these programs is not widely known. Although demonstrating benefit in violently injured patients, notably, no current state or national verification standards require trauma centers to have a violence intervention program.

As the HAVI and the ACS-COT have recently forged a partnership, the objective of this study was to identify the programmatic components of existing HAVI programs and to understand program and service barriers to implementation, to inform the ACS-COT as to the best way trauma centers can partner in this work. This work will identify opportunities to assist in capacity building and standardization, which will support the growth of existing programs as well as the development of new programs.

2. Methods

A survey instrument was developed by the Hospital Based Violence Intervention Program (HVIP) working group of the American College of Surgeons Committee on Trauma's (ACS-COT) Injury Prevention Committee. This is a multidisciplinary group providing leadership and resource development to support the ACS-COT mission of supporting HVIPs at trauma centers nationally. This survey was administered via Qualtrics platform (SAP, USA) and the results were de-identified and reported via Excel (Microsoft, USA) spreadsheet output. Member organizations of HAVI were invited to participate via email request.

The survey asked the role of the individual completing the survey, demographics of the population served, type of violence that prompts enrollment, staffing, funding sources and annual budget. A 5-point Likert scale was then used to measure the individual's opinion of common pitfalls faced by sites initiating, or sustaining HVIPs. A summary of the survey can be found in Table 1.

The survey also included open-ended questions about the following subject program domains: hurdles and pitfalls, funding, future challenges and needs, collaboration and advocacy. Responses were assessed for common themes, and a coding scheme was created after performing initial review of the data by 1 reviewer, which was then reviewed for agreement by a second reviewer with reconciliation of any disagreements and re-coded. A total of 3 reviewers collated the responses into themes based on the coding, and discussed any disagreements collectively to reconcile any differences in agreement. The most saturated or common themes were described and representative quotes provided. All reviewers have different clinical backgrounds, but have training and experience in qualitative research and analysis.

Survey data were deidentified and collated into a single document. Descriptive statistics were used to report survey outcomes. Qualitative analysis was then reported by the independent reviewers, and internal consistency between qualitative and quantitative results were identified. For Likert scales, number of respondents was weighted by Likert response to positive, negative or neutral to identify weighted averages for each response.

3. Results

3.1. Quantitative survey data: program demographics

Twenty-eight programs of the 38 invited participated (74% response rate) in the study, all of whom are member organizations of HAVI. Thirteen respondents identified as program directors; seven injury prevention coordinators, two outreach workers, one social worker, and one mental health professional. The remaining respondents defined themselves as “other”. Each represented a member program, so each response is from an independent HVIP.

The types of violence served by programmatic staff are summarized in Fig. 1. Twenty four (86%) of programs reported that they “frequently” see community violence and 26 programs (92%) reported that they frequently see victims of adolescent violence. Only one program reported seeing victims of child abuse frequently and all programs report that they rarely see elder abuse. About one third to one half of programs reported frequently seeing victims of intimate partner violence, sexual violence (defined as violence with a sex act by a non-intimate partner, ie, rape, and sex trafficking). Respondents were asked to estimate the racial and ethnic makeup of their participants by percent, and aggregate data is reported in Fig. 2. The age range of participants was highly variable. Seventy-six percent of programs serve a wide range of individuals aged 13–45, with variable inclusion of younger and older populations by program, and this aggregate data is also reported in Fig. 2.

The structural composition of the HVIPs and their funding sources varied greatly. Programs employed between 1 and 11 individuals with 17 programs employing between 3 and 5 individuals. Twenty-three programs (82%) employed at least one violence intervention specialist, or community health worker (typically referred to as a “frontline” worker), while the remaining program employees identified as directors, social workers or the hospital's injury prevention coordinator. Five programs (18%) consist of a single frontline worker, or frontline worker and director without any additional support. The remaining 23 (82%) programs indicated they had some support from social work, mental health, or the violence prevention professionals, indicating administrative or referral support for the frontline worker.

Budgets ranged from $50,000 to more than $500,000 per year with nearly a quarter of the programs funded at more than $500,000 per year. Twenty-one programs (75%) operate on a budget of less than $500,000 per year. The most common funding source is state funding, cited by 16 (57%) of respondents, including 11 respondents in the “high budget” range (defined as greater than $300,000 annual budget), and the remainder being considered “low budget” with annual operating budgets less than $300,000. Other frequent sources were city funding (12, 42%), philanthropy

Table 1
Summary of ACS-COT survey to HAVI programs.

General Questions	Challenges (Likert Scale)	Qualitative Questions
1. What is your individual role in the program? 2. What type of violently injured population do you serve? 3. What age range do you serve? 4. Can you provide an estimate of the race/ethnicity or the population you serve? 5. How long has your program provided services? 6. How many full time equivalent (FTEs) employees do you have in your program? 7. What are the types and number of employees you have in your program? 8. What elements do you include in program evaluation?	Which of the following were pitfalls/hurdles to Ref. 1 Starting and Maintaining a Program: 1. Buy in From Hospital Administration 2. Buy in from EM 3. Buy in from Trauma 4. Buy in from Social Services 5. Buy in from Nursing 6. Other hospital entity 7. Buy in from Community affected by Violence/CBOs 8. Perception of competing with other violence prevention groups 9. Lack of Resources for Risk Reduction/ Referral 10. Lack of Mental Health Resources 11. No major in-hospital "champion" or advocate 12. No capacity for evaluation 13. Other	1. Describe how you overcame hurdles and pitfalls in starting and sustaining your program. Broadly describe how your program is funded - has this changed over time? 2. What do you anticipate to be upcoming challenges to maintaining or growing your program? 3. What are your most immediate (next 6 months) needs? 4. What are your long-term (next five years)? 5. Do you work directly with other HVIPs? If yes, in what capacity? 6. What is the biggest value in being part of the HAVI? 7. What is the most important role the Committee on Trauma can play in this work? 8. What else do you feel is needed for these programs to thrive and become part of the fabric of trauma centers? 9. Are you involved in advocacy for hospital-based violence intervention programs? 10. What role do you feel the COT or HAVI should play in policy and advocacy of HVIPs?

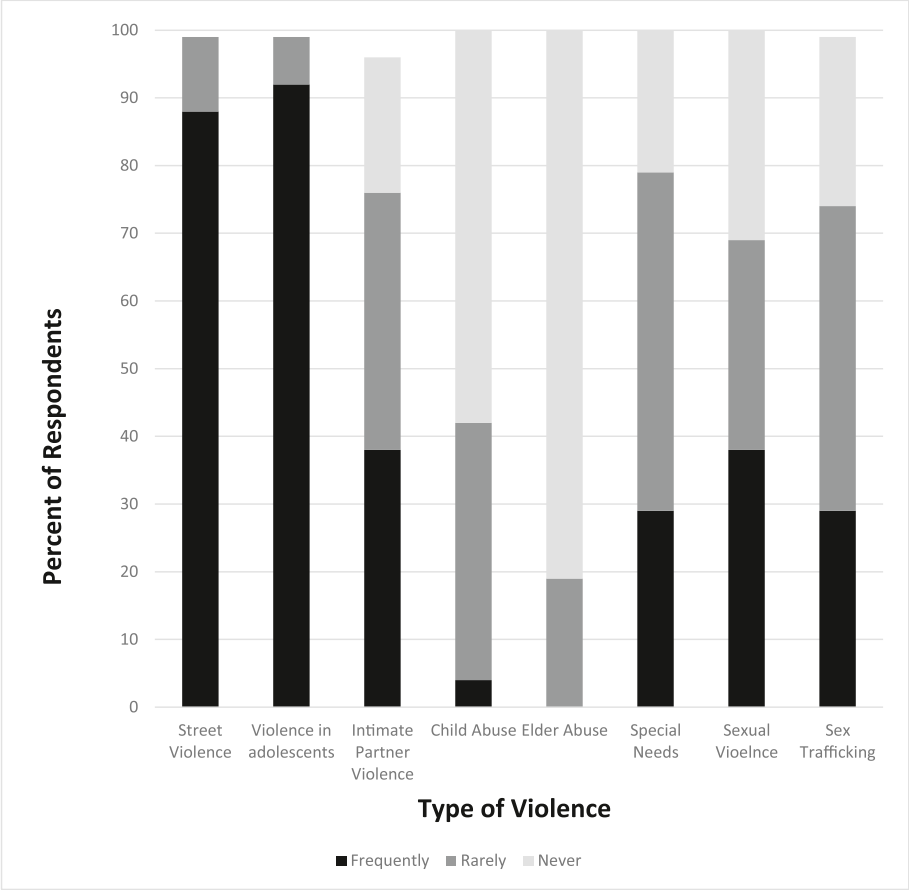

Fig. 1. Type of violence served by programmatic staff.

(9, 32%), and hospital funding (10, 36%). Those programs with large budgets were most likely to be funded by state funds, philanthropy and national foundations in concert, rather than a single funder, where lower funded programs are typically funded by philanthropy alone (Fig. 3). Additionally, those programs with large budgets typically have a multiple sources of funding.

Program evaluation was less variable with 100% of respondents indicating they collect basic demographic information such as participant age, race, and gender. Programmatic fidelity information about the number of patients approached, enrolled, and subsequent attrition was also collected uniformly across programs. Time spent in the program and time spent with outreach workers was collected in 21 (75%) programs. Long-term programmatic evaluation, however, was more variable. Twenty-one programs

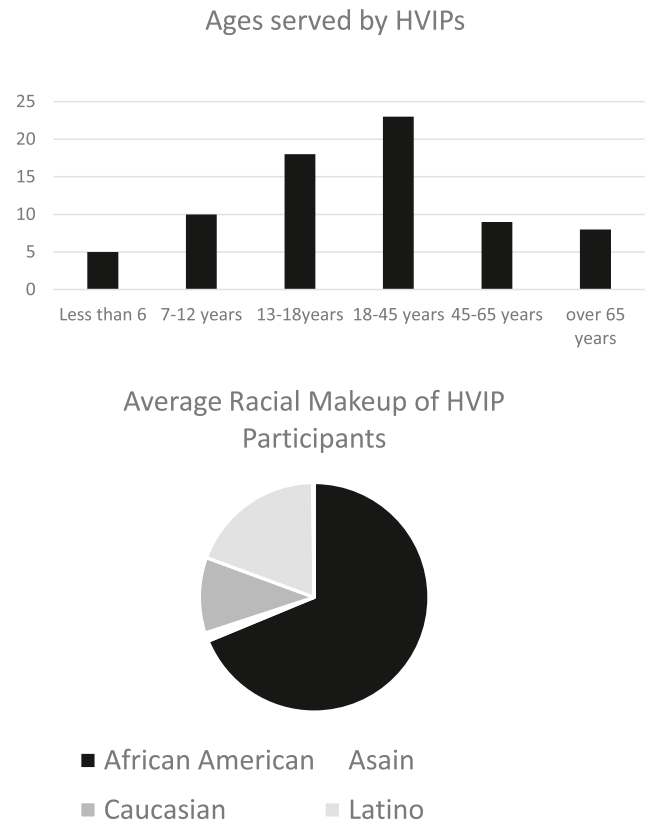

Fig. 2. Demographics of HVIP patients.

(75%) indicated they collect injury recidivism as an outcome, but only 6 collect mental health outcomes and only 4 collect qualitative outcomes.

3.2. Quantitative survey data: likert scale ratings

We asked respondents to use a Likert scale to identify a series of barriers to both starting and sustaining an HVIP. Most respondents (21, 75%) stated they "strongly agree" or "agree" that funding was a barrier. Seventeen programs (61%) stated that they "strongly agree" or "agree" that there are not enough resources to mitigate risk of violence, and 16 (57%) reported that they do not have adequate access to mental health resources. Buy-in from Emergency Medicine, Trauma and Social Work services was variable with equal distribution across the Likert scale. Issues that were generally not barriers included: buy-in from nursing, in which 20 programs (71%) were either neutral, disagreed or strongly disagreed that this was a barrier. Fig. 4 shows the weighted average of answers when the number of respondents is multiplied by the score of their response, compared to the weighted responses of sustaining a program.

3.3. Open-ended responses and qualitative results

Most participants provided responses to the open-ended questions, with 22 participants providing at least one response. Seventy-eight percent of these total program-questions were answered, representing a total of 262 qualitative responses. Some responses represented more than one theme, and these were separated and coded as independent themes. Respondents frequently mentioned that inadequate and unsustainable funding were hurdles to sustaining HVIPs (Table 2). Many participants indicated that initial primary funding sources were temporary, arising from grants and fundraising efforts. This requires significant, intensive labor that distracts from program related activities and limits guaranteed, sustained staffing and services. One respondent wrote, "*The biggest pitfall our program encounters is sustainable* funding. *We have had the opportunity to join community-based projects, which have provided limited* funding *for staff time or have pulled from our general* funds *to assist with coverage of staff, but these are stop gap measures and not reliable sources of maintaining our program in the future.*"

Many programs reported that the ability to identify and maintain adequate staffing for program services was a significant concern (Table 2). Much of this relates to adequate or reliable funding to hire and support salaried staff, including social workers and violence interventionists. One respondent wrote, "*Money and manpower are vital. Injury prevention programs often have one person covering several risk areas by themselves. If you want to reach more people or provide more in-depth services, you need to have additional staffing, which also means there needs to be additional funding.*" Some respondents specifically brought up the challenges of identifying violence interventionists that have both the cultural competency to recognize and work well with the patient populations and meet hiring criteria in the hospital setting.

Buy-in at all levels, including the community, hospital leadership, trauma surgeons, nurses, social workers and hospital security was a necessity for both securing funding and ensuring that high-quality services are provided. One respondent wrote, "*Multi-sector collaboration is key in overcoming hurdles. Knowing how violence ties into other systems and sectors then breaking down the value of the program for these sectors is key.*"

Another consistent theme for both program planning and sustainability, and for broader integration of HVIPs into hospital practice, was the importance of having evidence-based outcomes research that demonstrates the impact of HVIPs (Tables 2 and 3). Some expressed the importance of data collection and outcomes assessment early in program development, in order to collect and assess program process measures and outcomes at the start of program implementation. Many expressed the need for research to help guide evidence-based practice. The needs for expanded program services were identified as both immediate and long-term challenges, and requirements (Table 2). This includes mental health services, immediate and long-term housing support, employment and educational services, and the ability to serve a broader patient population such as the homeless and those living in remote geographical areas (Fig. 5).

Several additional themes emerged related to collaboration, support and advocacy for HVIPs (Table 3). Most indicated that the primary value of involvement with the HAVI is the ability to learn from other programs including the sharing of ideas, experiences, successes and failures to inform programs of implementation strategies at their own institutions. One respondent wrote, "*It provides us with the* support *of programs similar to ours and allows fledgling programs connect with us so we can* support *them. We are able to learn new and creative ways to engage clients and evaluate our programs.*" Respondents indicated that this form of networking allows for the sharing of ideas, and general support and encouragement for programs. Many also view HAVI as a source of best-practice information, research, training and technical support.

Respondents also supported advocacy for more research and standardization of practice, in addition to raising more awareness about violence as a public health problem and garnering community, political and inter-agency buy-in. One respondent commented, "*I think there should definitely be more advocacy from both entities. The programs work, and I believe most hospitals that adopt these programs see it, however, there needs to be buy in and* support

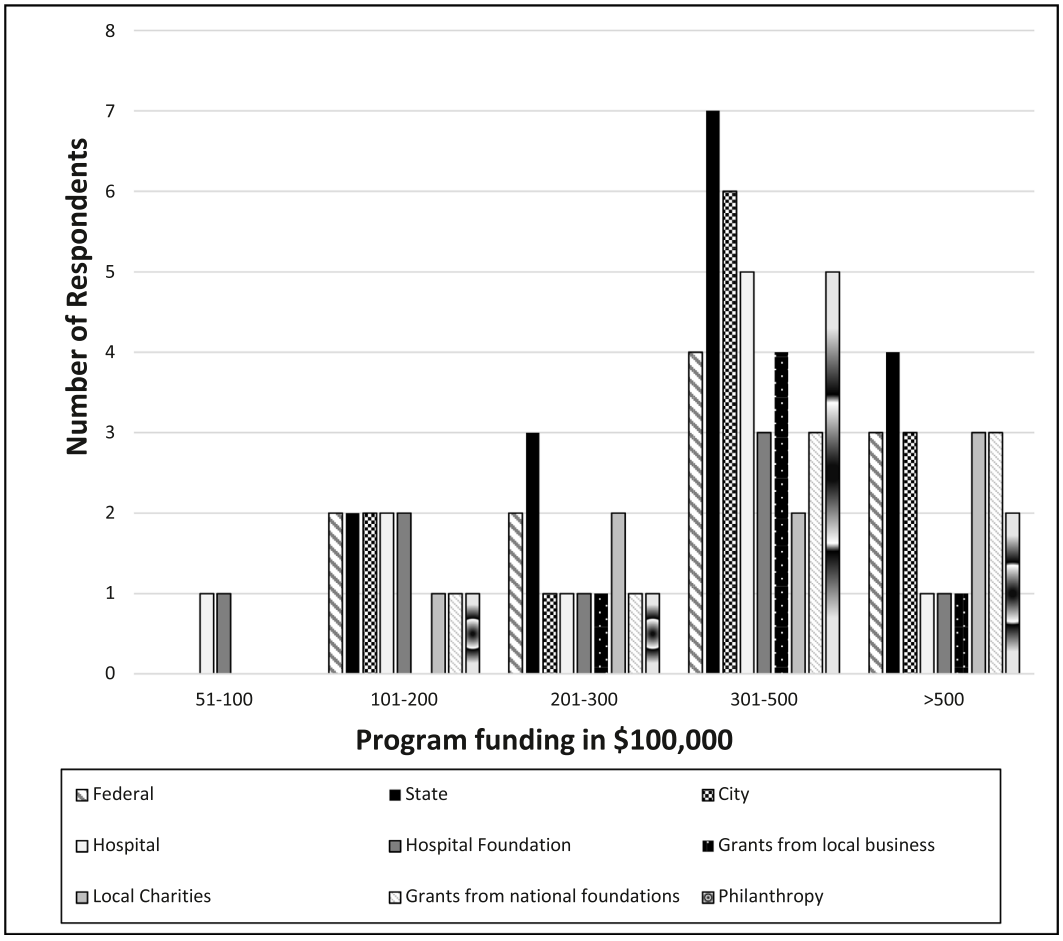

Fig. 3. Funding sources of HVIPs by annual budget.

from other agencies like schools, law enforcement, housing agencies and mental health providers."

4. Discussion

The NNHVIP was established ten years ago. Now referred to as HAVI, the focus of member organizations is to implement a public health approach to community violence by addressing risk factors of violently injured individuals. By employing culturally competent case management or partnering with community-based organizations that can provide these services, HAVI organizations link violently injured patients to risk reduction resources. These programs utilize a trauma-informed approach and focus on the social determinants of health to improve health equity in our most vulnerable populations. HAVI itself provides technical support, annual conference with presentations and networking, and an array of working groups, including, but not limited to, research, policy, mental health and front-line worker support forums. Trauma centers with fledgling programs can look to HAVI or member organizations for support, opportunities to collaborate, and a chance to contribute more broadly through working groups. Trauma centers can receive support in initiating programs, seeking funding, or advocacy for local, state, and national resources to support HVIPs.

The development trajectory of many member organizations of HAVI was captured in the October 2017 ACS-COT's Primer.[6] The Primer was written as a guide to a best practices model for hospital-based violence intervention and includes potential pitfalls and barriers to development of these complex programs. Our work here reflects a combined effort by the ACS COT and HAVI and captures the current state of affairs of member organizations. This includes the makeup of the programs, and the areas in programmatic development and sustainability that are most challenging.

Funding remains a consistent challenge for both program establishment and sustainability. The increased number of responses in the $300,000 and above are therefore indicative of diversification in the funding sources of higher funded programs essentially, that higher funded programs selected more responses than lower funded programs. One promising source of future funding lies in the reimbursement of services for community outreach workers through Medicaid Vendors. One such bill, AB-166 recently passed through the California legislature but was vetoed by the Governor in October of 2019, and several similar bills are still in process in other states.

Despite this diversification, the overall paucity of investment in violence prevention is striking when considered against the cost of hospitalization. Juillard et al. (2015) reported a net hospital system savings of over $500,000 per year when weighted against the costs of providing an HVIP.[12] Similarly, Bonne et al. (2020) report an increase of $52,000 in hospital costs for the second firearm-injury hospitalization, rendering a $520,000 per year HVIP cost-neutral if it prevents 10 instances of recidivism. With some urban centers in the United States reporting 400–600 firearm injured patients per year (and a recidivism rate of 15–20%), these hospitals are typically seeing 60–120 violently reinjured patients per year, costing those hospitals $3M-$6 M annually. Relatively speaking, a

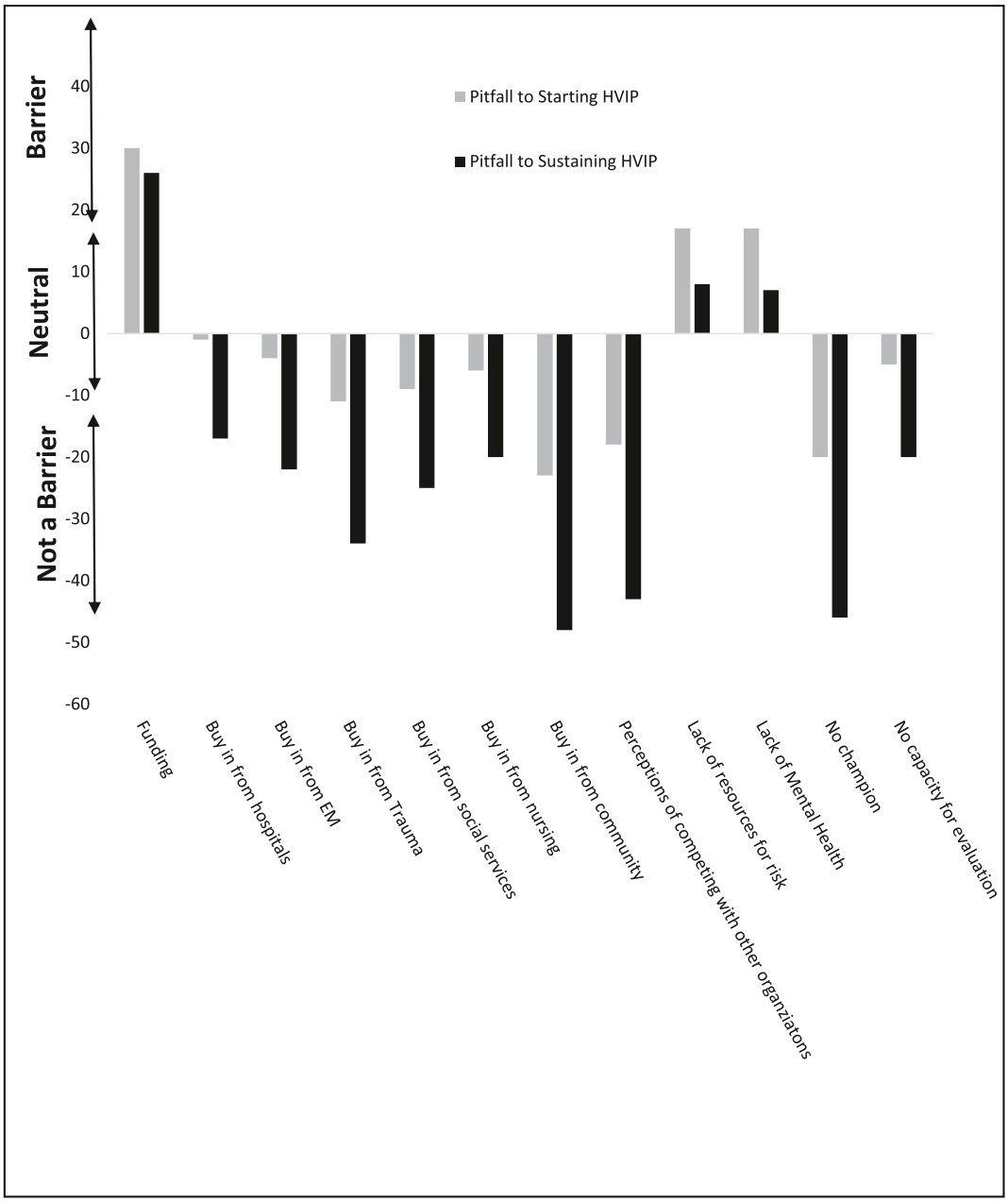

Fig. 4. Perceived barriers to both starting and sustaining a HVIP.

$500,000 program is extremely cost effective if it is able to cut the recidivism rate by 75%, as some programs have reported.[12]

We found perceived barriers to both starting and sustaining a program (Fig. 4). Interestingly, sustaining a program continued to have the same barriers of funding, lack of resources for risk and lack of mental health resources, however, to a lesser extent than starting the program. Nearly all barriers to starting a program decreased when sustaining the program. Also, interestingly, buy-in was weighted as difficult during inception but improved as the program was sustained. While stakeholder buy-in improved from program inception suggesting that over time, stakeholders from both within the hospital and amongst community partners appear to value these programs once they have been developed and the stakeholders have had a chance to see the program "in action." This also suggests the importance of seeking buy-in from critical stakeholders early in the development process and creating partnerships. Qualitative responses also indicated that buy-in is critical to programmatic success. A significant strategy to help overcome the hurdles of initiating and sustaining programs and securing funding to assist with support of programmatic activities is to raise awareness in the hospital and community about program value.

The lack of availability of mental health services is noted to be a concern across both quantitative and qualitative responses. This is particularly concerning when you consider a previous study by Smith et al. (2013) demonstrating that mental health and risk reduction resources such as employment are important for success.[9] While the solutions to the problem of mental health access are vast and challenging, one potential solution is the development of community health worker training programs that teach peer to peer mental health services in HVIPs, or the overall expansion of mental health services being provided through victim services

Table 2
Qualitative themes pertaining to program hurdles, funding and future challenges.

Subject	Most Common Theme	Representative Responses
Hurdles or pitfalls the program encountered in starting (Qualitative Question 1)	Finding staff to fulfill program and population needs	*Hiring qualified, culturally competent, licensed social workers who could bond with the clients*
	Not having buy-in or support from hospital leadership and staff for program implementation	*A plan for program implementation should include nursing, public safety, and ED and trauma/injury prevention staff in the planning process*
Hurdles or pitfalls in sustaining the program (Qualitative Question 1)	Not having adequate funding	*Significant infrastructure funding to ensure scale and core development of the organization*
	Needing buy-in and support for institutional change	*There is no trauma surgeon involvement in our program. We have involvement from the trauma director. There is disagreement among the trauma department and the hospital foundation about how to best utilize funds.*
	Not having enough or stable staffing	*Revolving door of some program staff*
Strategies utilized to overcome hurdles or pitfalls in starting and sustaining the program (Qualitative Question 1)	Raising awareness and buy-in within the hospital and community about program value	*Our program has been extremely fortunate in that it has always been well received by hospital administration and staff. At the outset, a lot of work was put in to raise awareness for our program. Our staff attended grand rounds and departmental meetings to introduce themselves and the services they would be providing.*
	Dedication to the mission and purpose of the program	*Despite issues, those involved remained dedicated to the success and sustainability of the program.*
	Securing funding	*Constant grant applications and fundraising*
Program funding (Qualitative question 1)	Combination of funding sources	*Our program is funded by federal, state, and city dollars, along with a variety of small foundations and private donors.*
	Hospital or health entity funding only	*Our hospital foundation provides funding directly to our community partners. It has not changed in 8 years we have been conducting this program.*
	Local government only	*The program is mainly funded through the Mayor's office and Department of Children Youth and Families (DCYF).*
Funding changes over time (Qualitative Question 1)	More sustainable funding from one or more sources	*Originally the program started with existing resources, which meant those involved carried additional work and responsibilities. Then, the hospital received one time funding for one year, which eventually turned into ongoing funding. The affiliated organization was awarded grant funding with* 1 FTE *ongoing funding.*
	More diversified funding sources	*First it was all hospital funding, then we were able to obtain philanthropic, federal and state funds.*
Concerns about ability to provide services (Qualitative question 2)	Concerns endorsed due to funding limitations for adequate staffing and service capacity	*In order to be more effective, we need funding to hire additional staff. This will allow us to provide case management and wrap-around services to victims of violence. With just one person providing services, they just get referrals to services but are not able to get true case management.*
	No concerns endorsed	*Funding has been stable, and luckily increased over the years. This has allowed for more people to be served and the resources to grow.*
	Concerns about reliance on grants without sustainable funding	*We rely on grant funding and so cannot promise longevity of services.*
Anticipated challenges to maintain or grow the program (Qualitative question 2)	Limited or sustainable funding	*Continued funding still looks to be the main issue, as there is more demand for resources (housing, jobs, mental health help, mentors) and never guaranteed sustainable funds.*
	Lack of adequate staffing	*Manpower to meet capacity needed for growth*
	Research that demonstrates evidence to support programs	*Demonstration of impact in the face of tight budgets*
Most immediate needs (Qualitative question 3)	Funding	*Money running out on 2 different grants for 2 positions; (we) have pending applications in — can't count on that*
	Staffing	*Expand to include more staff - social workers and credible messengers (violence interrupters, or violence intervention professionals)*
	Mental health support and resources	*Community agencies to hand clients off for mental health needs after they complete the program.*
Long-term needs (Qualitative question 4)	Funding	*Funding is always the number 1 need - if we have that we can implement strong, integrated, comprehensive, violence programming.*
	Program service expansion	*Program expansion that includes employment and education services*
	Staffing	*To keep the two social workers. To add two credible messengers and an additional injury prevention staff member.*

agencies and funding streams. Another striking point worth noting is the lack of service available to Native American patients with very few programs serving these patients, despite the known risk of violence in this population. This is very likely due to disparate geography, as Native American populations typically live outside of the urban areas that are typically served by HVIPs.

If programs can demonstrate both beneficial individual health outcomes and public health outcomes, hospital and community leadership are more likely to make an investment in HVIPs. In addition, demonstrating cost effectiveness could help support funding and institutional, government and insurance companies buy-in of HVIPs. Therefore, reliable and consistent data collection for evaluation metrics are crucial. While typical evaluation metrics such as demographic data and engagement were routinely collected, long term outcomes varied. Not all programs collected information about recidivism, and due to the limitations of healthcare data sharing between institutions, recidivism may not be accurate if the patient is seen at another center. Few centers are collecting mental health data and qualitative analysis. It is unknown if this is due to capacity problems in collecting long term outcomes or if this is reflective of a lack of expertise, but in either case, it would be critical to better understand these long-term outcomes.

Finally, respondents offered significant feedback and insight for

Table 3
Qualitative themes pertaining to collaboration and advocacy.

Subject	Most Common Theme	Representative Responses
Collaboration or work with other HVIPs (Qualitative question 5)	Working with other community programs for client services.	*We partner in prevention and outreach efforts. We also work across agencies to connect patients with resources as needed. Sometimes patients live closer to other partnered HVIP programs.*
	Collaborating to gain support, expertise in best practices and implementation	*Yes, we share information, expertise and tips for implementing and sustaining the programs. Our program has developed techniques to address secondary trauma and has an expertise in the youngest violence-involved youth*
Biggest value in being part of the HAVI (Qualitative question 6)	Learning about what other programs are doing for implementation ideas	*We are able to compare what other cities are doing that is successful and what is not. We are also able to share how to be flexible and still maintain the fidelity of the HVIP model.*
	Provides support for programs as a source of advocacy, leadership and information	*Having a network of programs doing the same very important work across the country that I can turn to for best practices and encouragement.*
What is needed for HVIP programs to become part of the fabric of trauma centers (Qualitative Question 8)	Research and data demonstrating positive outcomes and cost effectiveness	*Strong unassailable research that clearly demonstrates impact on health outcomes for individuals and the community, financial benefit*
	Requiring trauma centers to have HVIPs	*A mandate by the ACS to have a hospital-based violence intervention program for Level I trauma centers that see significant interpersonal violence*
	Financial and resource support	*Operational support, adequate staffing*
Suggested role of the COT and/or HAVI in advocacy and policy Qualitative question 10)	COT and HAVI should take the lead and act as the representation for HVIP	*When it comes to violence prevention we have a very powerful voice as it pertains to being witnesses to the violence, its toll on people closest to it and the beauty of a recovered victim. This should give us a voice to speak on the issues that could move change at the policy level.*
	Advocating that hospitals that care for a large portion of violent injury should have HVIP's	*Help in establishing expectations for major trauma centers that see a large proportion of violently injured patients*
	Supporting research and data collection	*Help develop reasonable outcomes and expectations, and standardization of approach and guidelines for best practice*

HAVI and ACS-COT leadership in the ways that organizations can leverage their influence to help HVIPs become more successful. Respondents offered the suggestion that the HAVI and COT should play a critical role in policy and advocacy and serve as the representative voice for HVIPs. Some respondents thought that the COT should consider implementation of HVIPs as mandatory for level I trauma centers and/or trauma centers that see a high proportion of injuries related to violence. Doing so would send a unified message that violence intervention services should be the standard of care, and a necessary component of injury prevention services. One

Fig. 5. Geographic Location of HVIP Membership. Existing member programs are indicated by a triangle on the map.

respondent suggested, "*For those trauma centers that have interpersonal violence as its top three mechanisms of injury, consider making it a criteria or best practice for trauma center verification.*" Overcoming the funding barriers will be critical to this approach.

Our study has several limitations. There was previously a requirement to have been in existence for 1 year before applying for NNHVIP membership, meaning that there is a lag-time bias. The survey was administered in 2018, so no programs that began from 2017 onward would be included in this survey, and reports from the HAVI Board indicate that there may be as many as twice the number of programs in existence now than 2 years ago.

Since administering this survey, the violence intervention community has reached an inflection point, with more programs than ever applying for membership in HAVI. This survey data can be used to inform new programs and support the advocacy efforts of HAVI and ACS COT on their behalf. This study also highlights the importance of establishing standardized methods for data collection and program evaluation that can be used to garner support for program development and funding, in addition to promoting quality improvement and identifying evidence-based practices. This study also highlights the need for increased advocacy related to funding for HVIPs. Although they represent a best practice for hospital-based violence intervention, the HAVI member programs often face significant financial hurdles despite the data supporting the cost effectiveness of these programs. Policies that help establish sustainable funding streams, such as those that secure compensation for the efforts of the Case Managers/Intervention Specialists, would go a long way towards establishing, maintaining, evaluating and improving these programs.

5. Conclusions

In summary, there are significant opportunities to expand the implementation, funding, and data collection in HVIPs. Opportunities also exist to educate stakeholders about the HVIP models. In addition, advocacy on the part of clinical departments, hospital administration, professional organizations and policymakers for funding that will help establishment and support HVIPs and HAVI is essential to further amplify these efforts as a nationwide best practice.

CRediT authorship contribution statement

Stephanie Bonne: Methodology, Writing – original draft, Project administration, Writing – review & editing. **Ashley Hink:** Data curation, Formal analysis, Writing – original draft, Writing – review & editing. **Pina Violano:** Data curation, Formal analysis, Writing – original draft, Writing – review & editing. **Lisa Allee:** Data curation, Formal analysis, Writing – review & editing. **Thomas Duncan:** Formal analysis, Writing – original draft. **Peter Burke:** Writing – review & editing. **Joel Fein:** Writing – review & editing. **Tamara Kozyckyj:** Data curation, Investigation. **David Shapiro:** Writing – review & editing. **Katherine Bakes:** Conceptualization, Writing – review & editing. **Deborah Kuhls:** Supervision, Writing – review & editing. **Eileen Bulger:** Conceptualization, Supervision, Writing – review & editing. **Rochelle Dicker:** Conceptualization, Supervision, Project administration, Methodology, Investigation.

Declaration of competing interest

The authors declare no conflicts of interest.

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Editorial

Why We Need Primary Youth Violence Prevention Through Community-Based Participatory Research

Each year, over 500,000 youth seek care in U.S. emergency departments for assault-related injuries [1]. Middle school-age males in urban environments both witness and directly experience violence at an elevated rate in comparison to their peers, with one national survey showing that 19% had witnessed a shooting or stabbing, and 13% had a weapon pulled on them in the past year [2,3]. Alongside this burden of violence, significant disparities exist in the U.S., with African American and Latino communities experiencing rates of violence and injury far above non-Latino, White peers [1]. The need to focus on primary prevention is incontrovertible. However, it is safe to say that a multitude of challenges confronts the effective implementation of community-supported youth violence prevention programs.

Oscós-Sánchez et al. [4] present meaningful insight into how to build primary youth violence prevention programs, with a focus on engaging Latino communities. The use of a community-based research approach, engagement through the social-ecological framework to access multiple levels of youth violence prevention, and leveraging novel technology that can reach a wider and youth-focused audience created a study that is both innovative and compelling. The study involved a community-based, randomized intervention trial with the primary outcomes of self-reported violence outside of and in school through self-administered surveys. The results showed that a Violence Prevention Program had positive effects by decreasing reported violence outside of school at 12 months, and a Positive Youth Development Program had an effect by decreasing reported violence in school at 6 months. In this time of the COVID-19 pandemic, it has become clear that longstanding public health issues like youth violence impact communities of color disproportionately, and studies like this are critical to finding public health solutions that will lead to not only behavior and policy changes but also sustainable improvements in health equity.

Central to this study was their use of community-based participatory research (CBPR) [4]. CBPR is an approach to research that allows those most affected by a health issue to be equitably engaged in research. This can have a significant impact, particularly when addressing public health problems in which traditional approaches have had only limited success, and especially in which a clear health disparity exists, such as youth violence [5,6]. Moreover, engagement of youth in the co-creation of study materials and the programmatic infrastructure, as was done in this study, is even more important to the desired outcome of a sustainable intervention [7–9]. Most strikingly, Oscós-Sánchez et al. [4] detail the process they undertook in "19 community meetings over the course of 17 months " to develop the program platform. Researchers need to acknowledge the extensive time investment undertaken by a CBPR study of this kind, knowing that through collaboration, the eventual research product is more likely to be adopted and sustained. Moreover, to build the trust that is critical to a genuine community-academic partnership, one often needs to accept an extended research timeline that can significantly impact a researcher's ability to generate/disseminate study findings and keep pace with pressing funding cycles.

The overall approach of this study is grounded by the social-ecological framework. This approach is informed by Bronfenbrenner's ecological systems theory, in which interactions between youth/young adults, caregivers, peers, and social contexts influence behavior [10]. This model emphasizes the individual at the center of the framework with their individual risk, and then emphasizes relationships with peers, family, and other close adults as the next level of risk influence on a violence-related injury, and others have shown how risk across the levels impacts violent behaviors [11]. Oscós-Sánchez et al. developed two programs to approach violence prevention from multiple levels of the framework with at least two fundamental orientations as foci in the prevention of youth violence (i.e., risk and protection). First, they developed a Violence Prevention Program focused on risk factors for violence at the community level, and then, they created a Positive Youth Development Program focused on protective factors on the individual level. Inherent to their design was the concept that activities performed during each program would influence the young person in levels of overlap, consistent with approaches to youth violence prevention advocated by the CDC [12].

Finally, the use of an Internet-based program for youth violence prevention is both innovative and timely, given a global need for online programming for social services that now struggle to provide care to those most impacted by the COVID-19 pandemic. Prior studies have shown the promise of internet-based violence prevention programming and especially the

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gamification of adolescent health messaging on topics from tobacco cessation to HIV/AIDS awareness and reducing health-risk behaviors [13,14]. Notably, this study undertook an elaborate plan to support program development that would ensure that the activities included in the online platform were based on themes that community partners had embraced.

It is important to contextualize this study in the broader spectrum of public health efforts around violence prevention and efforts to provide effective strategies to communities who have endured longstanding health disparities. The COVID-19 pandemic has brought into stark view the health disparities facing Latino communities, with one recent study pointing to staggering rates of infection and poor outcomes, not by the nature of some intrinsic aspect of the virus, but instead by the nature of societal structures in place that put communities at elevated risk, much in the same way we have seen in youth violence [15]. At this moment, we know exposure to violence has a negative impact on physical and mental health, as well as risk-taking behaviors in young people. We also know that the longstanding nature of health disparities that exacerbate these risks make it more important and urgent not only for researchers to advance the science but also for funders to see the clear and growing need to meaningfully support further research in this area.

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Survivors of gun violence and the experience of recovery

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BACKGROUND: Survivors of gun violence may develop significant mental health sequelae and are at higher risk for reinjury through repeat violence. Despite this, survivors of gun violence often return to the community where they were injured with suboptimal support for their mental health, emotional recovery, and well-being. The goal of this study was to characterize the posthospitalization recovery experience of survivors of gun violence.

METHODS: We conducted a qualitative research study with a community-based participatory research approach. In partnership with a community-based organization, we conducted in-depth one-on-one interviews and used snowball sampling to recruit survivors of gun violence. We applied the constant comparison method of qualitative analysis to catalogue interview transcript data by assigning conceptual codes and organizing them into a consensus list of themes. We presented the themes back to the participants and community members for confirmation.

RESULTS: We conducted 20 interviews with survivors of gun violence; all were black men, aged 20 years to 51 years. Five recurring themes emerged: (1) Isolation, physical and social restriction due to fear of surroundings; (2) Protection, feeling unsafe leading to the desire to carry a gun; (3) Aggression, willingness to use a firearm in an altercation; (4) Normalization, lack of reaction driven by the ubiquity of gun violence in the community; and (5) Distrust of health care providers, a barrier to mental health treatment.

CONCLUSION: Survivors of gun violence describe a disrupted sense of safety following their injury. As a result, they experience isolation, an increased need to carry a firearm, a normalization of gun violence, and barriers to mental health treatment. These maladaptive reactions suggest a mechanism for the violent recidivism seen among survivors of gun violence and offer potential targets to help this undertreated, high-risk population. (*J Trauma Acute Care Surg.* 2020;89: 29–35. Copyright © 2020 Wolters Kluwer Health, Inc. All rights reserved.)

LEVEL OF EVIDENCE: Care management/Therapeutic V.

KEY WORDS: Gun violence; mental health; outcomes.

Survivors of gun violence have considerable mental health needs following injury, with rates of posttraumatic stress disorder (PTSD) and depression ranging from 40% to 65%.[1–6] Despite this, gunshot wound survivors often return to the community where they were injured without receiving any formal evaluation of their mental health, support for their emotional needs, and little assistance in making the transition.[1] The rate of recognition of symptoms of PTSD and utilization of traditional mental health care services among this population is also low; only 15% of those needing services access care in the year after their injury.[1] In addition, survivors of gun violence are more than 20 times as likely to be reinjured as a result of repeat violence compared with the general population[7] with reported rates of reinjury through violence ranging from 6% to 44%,[6,8–10] This is also related to other significant downstream sequela because this population is four times as likely to die from a subsequent gunshot wound, and almost three times as likely to be arrested under a violence or weapon's charge.

Mental health, emotional recovery, and social well-being are important patient-reported outcome measures for survivors of interpersonal violence, including gun violence.[11] Prior studies have demonstrated that emotional responses to intentional injuries are different than those from unintentional trauma[12] and living in a community with chronic violence (as many survivors of gun violence do) is perceived as increasing the risk of retraumatization and future assaultive events.[13] This is, therefore, a chronic stressor and has a strong influence on mental health recovery. Though the mental health and social well-being of survivors of gun violence are recognized as important benchmarks for recovery, the psychological experiences of gunshot wound survivors upon reentry into the community are largely unknown.

One very high-risk population, both in terms of increased vulnerability to being the victim of gun violence as well as suffering increased rates of morbidity and mortality from gun violence, is black men.[5,14,15] In addition to the physical consequences of injury, black men also have increased susceptibility to mental illness following injury, particularly PTSD and depression. This is due to disproportionate exposure to preexposure and

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postexposure stressors including: racial discrimination, poverty, incarceration, and living in racially segregated areas with high levels of exposure to violence.[16–18] Moreover, black men are less likely to be treated for their mental health symptoms.[16,19] Despite these disparities in outcomes, relatively few studies have focused on understanding the psychological recovery experience of black men.

The aim of this study was to describe how black male gunshot wound survivors in the United States describe their experience of recovery and their perceptions of their mental, emotional, and social health following the event.

METHODS

Study Design

We used a qualitative research study design and a community-based participatory research (CBPR) approach.[20,21] Institutional review board approval was obtained through the Yale Human Subjects Committee. Members of our academic research team had over 15 years of experience working with community leaders in the Greater New Haven, Connecticut black community that we leveraged for this research partnership.[22–25] Our community/academic partnership agreed to a memorandum of understanding between the University and a nonprofit organization that had a Street Outreach Worker program working to interrupt violence within the community.

Recruitment

Our community partners used a snowball sampling method[26] to recruit adult black men with a history of a gunshot wound. Individual street outreach workers distributed flyers to community members they knew had a history of a gunshot wound. These community members then contacted the investigators. Following the interview, each participant was asked to distribute more flyers to community members in their social circle that might be eligible for the study. Participants were excluded from the study if they were not community members and/or had been injured outside of the greater New Haven area, a medium-sized metropolitan area in the northeastern United States. After the first 10 interviews, we began purposeful sampling,[26] asking participants to recruit individuals that had been shot in the last 5 years and/or were under the age of 30 yeas to ensure a diverse range of perspectives.

Interviews

Participants were informed that their interviews would be audio recorded and transcribed with the removal of any identifying information. Participants were paid US $40 in cash for their time. Consistent with CBPR principles, our whole team developed a semistructured interview guide of open-ended questions about the participant's personal experiences in New Haven, the circumstances surrounding their injuries, their experiences in the hospital, perceptions of providers, and their experience of recovery including whether they experienced symptoms of PTSD and depression (Fig. 1).

Participants were interviewed according to their preference either in an office space, their homes, the public library or another public location. Individual interviews were digitally recorded and professionally transcribed. One author (KMO), a white woman and academic researcher, conducted 13 interviews. In recognition of possible "outsider" influence on the interview, a second author (C.V.), a black man from New Haven who works as a street outreach worker, conducted seven interviews.

Data Analysis

The coding team consisted of one community member with experience in violence prevention, three investigators with experience in injury prevention research, and a qualitative research expert. We used the constant comparative method of qualitative analysis.[27] Each member of the coding committee read the transcripts and cataloged the transcript data by assigning conceptual codes to different sections and then organizing these into a codebook with themes. The coding team met approximately once per month over 5 months until the codebook was finalized to discuss themes and discrepancies between individual codes. These codes and themes were organized on Dedoose Version 8.0.35, a Web-based qualitative research software.[28] Our team concluded that we had thematic saturation (the point at which no new codes are being generated) after 15 interviews; we then completed five more interviews to confirm saturation.

The themes, along with illustrative quotations, were presented back to three groups to confirm validity and to engage in dialog about next steps: to the participants themselves (both one-on-one and at a group meeting); to our community partner organization; and to local community stakeholders (including the Center for Research and Engagement Steering Committee for New Haven Community-Academic Research, a committee for research on gun violence in New Haven, and multiple community planning meetings).

RESULTS

Sample

We conducted 20 interviews. All participants were black males. Their ages ranged from 20 years to 51 years. The time since injury ranged from less than 1 year to over 30 years, 75% had a history of incarceration and 50% reported ever seeking any form of mental health care (Table 1).

Themes

In discussing the aftermath of a gunshot wound injury, five key themes emerged as reactions to the event: (1) isolation, "It really made me not go anywhere;"[2] Protection, "I gotta protect myself;" (2) aggression: "I'll be the one doing the shooting when that happens;" (4) normalization: "It did not really matter;" and (5) barriers to mental health treatment: "They not just gonna take advice from anybody." Every participant in this study expressed at least one of these reactions (see Table 2 for exemplar quotes).

Theme 1—Isolation: "It Really Made Me Not Go Anywhere"

Following firearm injury, 65% of participants described restricting themselves from visiting particular neighborhoods, streets, and places of business. In some cases, participants physically restricted themselves to stay in their homes. Others described isolating themselves not only from certain places, but also from certain people. They described behaviors such as

Preliminary semi-structured interview guide

This interview guide will evolve throughout the research process. While this guide will be used to move the conversation along, the specific questions we pose will in part be determined by our conversations with our initial research subjects. As we continue on with interviewing and conduct preliminary analyses, we will adapt and change the guide to allow for new lines of questioning; in keeping with the iterative nature of qualitative work.

Basic information

- Tell me about yourself.
  - Ie: Where are you from? How would you describe yourself? What are your friends like?
  - Where did you go to school? How far did you go in school? What do you do for work now?
- Tell me about your family.
  - Brothers, sisters, mom, dad, children, spouse etc
- Need to know: Age, year person was shot

Perceptions of the neighborhood

- What do you think of your neighborhood? Tell me about it.
  - What are the people like? What are the good things about it? What would you change about it if you could?
- Do you feel safe in your neighborhood? Do you feel safe at your school? Do you feel safe at work? Do you feel safe at home?
- What organizations were most influential in your life? When in your life were these organizations most influential?

Patient's history with gun violence

- Tell me about how you were injured. Describe what you did that day and the events leading up to it.
  - Why do you think you were shot?
- Are there any people, places or factors that you think led to the situation where you were shot?
  - When do you think you started on this path?
- What happened when you got to the hospital? Tell me about your hospital stay. (Prompts: How did people at the hospital treat you? Walk me through what happened in the emergency room. What happened once you were in the hospital?)
  - What part of the hospital stay do you remember the most?
  - Do you think any part of the hospital stay was difficult? What was the worst part? Why?
  - Was there any part of the hospital stay that was positive for you? Can you tell me about one positive interaction with hospital staff?
  - Do you remember any particular person or story from your hospitalization? Why?

Patient's experience after the hospital

- What have you been doing since that happened?
- Since your injury have you been arrested or interacted with the police? Have you witnessed or gotten into any kind of fight/altercation?
- *If subject has not been involved in violence/criminal justice system since incident*: What do you think has helped keep you safe?
  - Why do you think others end up arrested, interacting with the police or getting into fights again?
- *If subject has been involved in violence/criminal justice system since the incident*: Why do you think it keeps happening to you?
  - What do you need to be safe?
- Can you name any services (organizations, groups, or institutions) in New Haven that work to prevent gun violence or deal with the effects of gun violence?
  - Have you used any of these services?
- Looking back, what do you think you could have done to prevent this from happening?
- If you had a younger brother or sister that you wanted to protect from getting injured like this, what advice would you give them?

Mental illness

- Have you ever had any experience that was so frightening, horrible or upsetting (including your injury) that in the past month you:
  - Have had nightmares about it causing difficulty sleeping or thought about it when you did not want to?
  - Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
  - Were constantly on guard, watchful or easily startled?
  - Felt numb or detached from other, activities or your surroundings?
- Do you know anyone with depression, PTSD or any kind of mental illness?
  - Have you ever known anyone who takes medication for a mental illness?
  - Do you think their treatment helped?
- If you had those problems, would you go seek help from a therapist or a psychiatrist or a doctor or nurse?
  - If not, what would you do want instead?
  - If so, what would be the best way to do that?

Gun violence in the neighborhood

- Do you know anyone else who has been shot?
- Besides what you just told us, have you ever been shot at before? Have you ever seen someone else get shot?
- Have you ever carried a gun around? Do you carry a gun around now?
- When there is a shooting, how do people in the neighborhood react?
  - How do the families react?
  - How do the police react?
- Why do you think there is gun violence in this community?
- What would change the situation?

Figure 1. Structured interview guide.

avoiding old associates, crowds, or limiting their social circle to only a few people.

Theme 2—Protection: "I Gotta Protect myself"

While participants discussed a long history of exposure to violence, prior to being shot many "did not think it would happen to me." After their injuries, they experienced a lost sense of invincibility. This was often exacerbated by a loss of "reputation" and "respect" from their peers and neighbors as an acute consequence of having been shot. Losing the protection of a good reputation and the perception of increased danger from their neighborhood led 55% of participants to admit that they considered carrying a gun or started to carry a gun right after they were shot.

TABLE 1. Sample Characteristics

Variables	Mean (Range) or Frequency
Age, y	36 (19–51)
Length of interview, min	38 (10–82)
Years since injury	13 (<1–32)
History of incarceration, yes	75%
History of mental illness, yes	50%
Circumstances of injury	
Targeted by someone	40%
Random/unsure	35%
Robbed	10%
Bystander	15%

Theme 3—Aggression: "I'll Be the One Doing the Shooting When That Happens"

Other participants described how they were not only more likely to carry a gun, but also more likely to use a gun. Of the participants, 15% described how every confrontation or disagreement after their initial injury was more likely to lead to gunfire.

Theme 4—Normalization: "It Did Not Really Matter"

For 50% of our participants, violence was so frequently a part of their daily lives that they were numb. They considered being exposed to violence as normal. Even the experience of being shot did not rattle or change this perception. Being shot was just a normal occurrence in their neighborhoods.

TABLE 2. Themes

Theme	Exemplar Quote
Isolation	
Physical	*It made me think that anything can happen at any given time. Anything. So, I just created my own little circle and my own little zone and stayed in it. That's what I did.*
Social	*Being that I did not know who shot me or what reasons it was for, I did not really go places. So, after getting shot mainly—I was already antisocial depending on what spots we went to—but after getting shot, it really made me not go anywhere. So, that was crazy.*
Protection	
Loss of invincibility	*I was hardheaded back then, thinking: I'm steel…like, bullets can just bounce off me. I realized that night that I'm not made of steel. That night it was plain to see that I bleed like everybody else.*
Loss of reputation	*[Once] you already been shot, you gonna have to pick up a gun because now you are twice as likely to be shot again. Because once you get shot, everybody knows it.*
Firearm carriage	*I could stay in the house and never come out never again; or, I gotta protect myself…If I had my gun, I probably woulda shot him before he shot me. You know?*
Aggression	*The last time I got shot I think that made me more security minded… Security was like, the number one priority. Never going to get shot again. I went and got a bullet proof vest…and got more guns. After that, every altercation that had to do with shooting, I probably initiated it first outta saying to myself, I'm never gonna get shot again first. I'll be the one doing the shooting when that happens.*
Normalization	
Numbing	*Just from being exposed to so much raw shit as a child, my reality was different from other realities… If I heard gun shots, that shit did not even startle me.*
A daily occurrence	*I did not really think anything of it. It did not bother me, I returned. I just went back to the neighborhood… I was still out in the neighborhood the next day selling drugs with a crutch. It did not really matter.*
Barriers to mental health treatment	
Lack of trust	*R: They had me talk to a psychiatrist and all that in the hospital when I got shot and stuff like that. Yeah. I had to.* *I: Did it help?* *R: Ahhh, somewhat. A little bit. Not much. Because they ask me questions like, "Who did it?" And stuff like that. Certain things happen in the streets, stays in the streets. You know?*
Lack of credibility	*They not just gonna take advice from anybody. Nobody does. Like, I do not give a fuck how many doctorates you got—If I do not like you, I do not like you. Fuck you and your advice.*
Credible messenger	*So, first they [the health care team] have to find somebody that they [survivors of gun violence] can relate to or somebody that they look up to as far as wanting to hear what they got to say. And then they have to get that person to go out of their way to really push them in the proper direction.*

Theme 5—Barriers to Mental Health Treatment: "They Not Just Gonna Take Advice From Anybody"

Of our participants, 50% reported interacting with mental health professionals to discuss symptoms of PTSD or depression. These participants described negative interactions with mental health professionals and a number of barriers were identified. One major barrier was a lack of trust between the provider and participant. Providers often do not share the same racial, cultural, and socioeconomic background as the participants. Participants perceived that the mental health providers had little to no concept of the context in which they live. This eroded confidence in the ability of a mental health provider to give meaningful advice. Participants suggested that instead of looking to a traditional mental health care provider, the health care team should find a "credible messenger" to provide mental health care for survivors of gun violence.

Other Themes

It should be noted that there were other themes in the codebook outside of the main purpose of the study that are not reported here. These included strained relationships between the community and police, traumatic experiences within the hospital, the important role of social media, childhood traumatic experiences, the availability of firearms within the community, and attitudes toward firearms. These will be developed further in secondary analyses of the qualitative data set.

DISCUSSION

In this qualitative study of 20 black male survivors of gun violence, participants described their perceptions and experiences of psychological recovery after intentional injury from gun violence. Five key themes emerged, all of which highlight and describe a disrupted sense of safety after surviving a gunshot injury and returning to the community in which it occurred:

Isolation, driven by fear of their surroundings and the chance the violent crime could happen again; (2) protection, the desire to carry a gun driven by a disrupted sense of safety and a motivation to project strength; (3) aggression, a willingness to retaliate with gun violence; (4) normalization, driven by the ubiquity of gun violence in the community; and (5) barriers to mental health treatment due to distrust of the medical community.

These five themes characterize the psychological and emotional experience of recovery from surviving gun violence. From these data we propose that a lack of support during the recovery period, exacerbation of symptoms of PTSD from community stressors, and maladaptive strategies in response to a disrupted sense of safety (including risky behaviors, such as carrying a firearm), suggest a mechanism for violent recidivism seen among survivors of gun violence.[5,12,29]

Our findings are consistent with other studies done in Philadelphia, Boston, and Baltimore examining the psychological and emotional reactions of survivors of violence and intentional trauma, though not necessarily gun violence.[2,5,12,13,18,29,30] Black male survivors of violence describe a loss of reputation and disrupted sense of safety exacerbated by the stress of chronic violence within their neighborhoods throughout the literature.[5,13,18,30] Multiple studies report persistent symptoms of posttraumatic stress among this population that is distinct from survivors of unintentional trauma.[2,12,29] The concordance across the literature as well as in this study suggests a larger phenomenon in urban neighborhoods where survivors of violence experience chronic stressors that exacerbate and prolong symptoms of fear and imminent threat.

Our study expands on the current literature by highlighting the various reactions that survivors of gun violence have during their recovery period in response to this disrupted sense of safety. In particular, participants discussed a range of risky behaviors and maladaptive strategies to recover their sense of safety. These reactions have been alluded to in other studies, but to our knowledge have not been explicitly stated in prior literature. Finally, our study identifies a barrier to accessing mental health treatment: distrust of mental health care providers. Our participants suggested that one solution to improving mental health care access is to hire "credible messengers" who are able to establish relationships of trust and effectively bring this alienated population into treatment.

As described in sociology literature, black young men in racially segregated urban areas with low levels of confidence in police view respect and reputation as crucial to maintaining personal safety.[31] Following victimization with a gun or other weapon, the perceived protection associated with having "respect" from the local community is acutely lost.[5,31] A number of participants described feeling like a target for further violence as a result of having lost their reputation or being acutely disrespected. Either for this reason or because the circumstances around their shooting were unknown, many developed a sense of imminent danger upon returning to their communities.

In response, participants described several different strategies to protect themselves. Physical and social isolation from friends and family was one way that participants reacted to a disrupted sense of safety. As social support may be protective against the development of PTSD,[32] this reaction may also be a source of stress that further leads to mental illness in this group. Other strategies included risky behaviors such as carriage of a weapon or firearm and/or an increased willingness to use a firearm during an altercation. These were considered an important means of self-protection following gunshot wound injury.

The "normalization" of violence described by participants reflects the extent to which these men are affected by chronic, persistent violence within their communities. This is similarly described by Smith et al.[18] among young black men in Baltimore. Given the pervasive nature of symptoms of PTSD among the population within these communities, many perceived symptoms of PTSD as "normal;" further decreasing the likelihood that they would seek care for those symptoms. It is likely that the symptoms of posttraumatic stress—anxiety, disordered thinking, difficulty sleeping, feelings of hopelessness and depression—contribute to these patients' recidivism for violent injury.[33]

Participants expressed alienation and distrust of mental health providers within their communities. The cultural, racial and socioeconomic divide between mental health providers and the participants in this study resulted in many of our participants not seeking help for symptoms of mental illness. The men in this study expressed a desire for an individual that could intervene to support and assist other young men like them following injury with a gunshot wound. This "credible messenger" would ideally be someone with a similar background, who understands the emotions and reactions these young men may have from their trauma as well as the context of their upbringing and recovery environment in communities with high levels of gun violence.

Consistent with CBPR, the community-academic partnership used the preliminary results from this study to inform the creation of the Yale New-Haven Hospital Violence Intervention Program (YNH VIP). Hospital-based violence intervention programs seek to address the poor outcome associated with gun violence by connecting survivors of gun violence with community-based services.[34] Hospital-based violence intervention programs are comprised of an interdisciplinary team of social workers, peer mentors, and clinicians who identify those needing services, either during or soon after hospitalization. They then work with the patients and their families to meet a diverse set of psychosocial, physical, and socioeconomic needs.[11]

By providing greater support for survivors of violence in the form of social work, case management and other services, YNH VIP aims to mitigate the effects of trauma following interpersonal violence. A main component of YNH VIP was training and hiring a local community member from the New Haven Street Outreach Worker program as a full-time employee of the hospital who will serve as a "credible messenger" for a targeted mental health intervention. Next steps include implementing a VIP in more communities within the Yale New-Haven Health system.

There are a number of limitations in this study. First, some of our participants were many years removed from their injury and therefore their recollections were subject to significant recall bias. Secondly, it is possible that participants were influenced by social desirability bias—the desire to appear to adhere to social norms that suggest certain behaviors are more positive or negative than others[35]—in their responses. Thirdly, the majority of the interviews were conducted by a white woman. In recognition

of possible "outsider" influence on the interview, 35% of the interviews were completed by a black man from New Haven who works as a street outreach worker. Of note, the coding team did not find major differences in the coding between those interviews conducted by K.M.O. versus C.V.. Finally, this research was conducted in a population of black men within a single metropolitan area in the northeast recruited using snowball sampling from a single community-based organization. As such, it is unclear whether our findings are transferable to other racial/ethnic groups, genders and areas in the United States.

One of our greatest challenges was recruitment of individuals to interview. Given the amount of distrust between the research and local community, particularly in communities of color in New Haven, we found that it was difficult to recruit young black men to talk to us about their experiences. This challenge was overcome, in part, by partnership with the Street Outreach Worker Program of New Haven. However, this reliance on our community partner may have biased our recruitment to include participants with a particular ideology or background.

CONCLUSION

In this study, we identify five themes which define the psychological recovery after intentional injury from gun violence. These themes describe the various strategies used by survivors of gun violence to cope with a disrupted sense of safety when returning to their communities. These maladaptive reactions suggest a mechanism for the violent recidivism seen among survivors of gun violence and offer potential targets to help this undertreated, high-risk population. For example, barriers to mental health treatment may be addressed through "credible messengers," who can develop relationships of trust with similarly injured black men. Reducing and eliminating violence exposure and traumatic stress in racially segregated, economically disadvantaged neighborhoods needs to be a key public health and mental health priority. Based on our study, investment in training community members to conduct outreach and targeted mental health interventions during recovery from firearm injury for vulnerable populations is an important area of future research.

AUTHORSHIP

K.M.O., C.V., L.J., M.S.R., and J.D. were all intimately involved with the conception and design of the project. K.M.O., S.S.H., and C.V. were responsible for the acquisition and curation of the data. K.M.O., L.J., S.S.H., M.S.R., J.D., and P.V. were on the on the coding team that analyzed and interpreted the data. K.M.O., M.S.R., R.D.B., J.D., and A.A.M. contributed to the literature search, writing and provided critical revisions. All authors contributed to editing of the final article and gave final approval of this submission.

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DISCLOSURE

All authors have no conflicts of interest to disclose.

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Building community resilience to prevent and mitigate community impact of gun violence: conceptual framework and intervention design

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ABSTRACT

Introduction The USA has the highest rate of community gun violence of any developed democracy. There is an urgent need to develop feasible, scalable and community-led interventions that mitigate incident gun violence and its associated health impacts. Our community-academic research team received National Institutes of Health funding to design a community-led intervention that mitigates the health impacts of living in communities with high rates of gun violence.

Methods and analysis We adapted 'Building Resilience to Disasters', a conceptual framework for natural disaster preparedness, to guide actions of multiple sectors and the broader community to respond to the man-made disaster of gun violence. Using this framework, we will identify existing community assets to be building blocks of future community-led interventions. To identify existing community assets, we will conduct social network and spatial analyses of the gun violence episodes in our community and use these analyses to identify people and neighbourhood blocks that have been successful in avoiding gun violence. We will conduct qualitative interviews among a sample of individuals in the network that have avoided violence (n=45) and those living or working on blocks that have not been a location of victimisation (n=45) to identify existing assets. Lastly, we will use community-based system dynamics modelling processes to create a computer simulation of the community-level contributors and mitigators of the effects of gun violence that incorporates local population-based based data for calibration. We will engage a multistakeholder group and use themes from the qualitative interviews and the computer simulation to identify feasible community-led interventions.

Ethics and dissemination The Human Investigation Committee at Yale University School of Medicine (#2000022360) granted study approval. We will disseminate study findings through peer-reviewed publications and academic and community presentations. The qualitative interview guides, system dynamics model and group model building scripts will be shared broadly.

Strengths and limitations of this study

- We use an assets-based, community resilience framework to understand and address a complex, socially involved problem, such as community gun violence.
- We use systems science informed by a community-engaged, participatory approach to elicit community assets that might be protective from gun violence.
- We use a community-engaged design process throughout to increase the likelihood of intervention sustainability.
- System dynamics modelling allows for interventions to be tested and evaluated for impact in simulation before being implemented in reality.
- The system dynamics model can be adapted for use by other communities that are also looking for approaches to mitigate gun violence.

INTRODUCTION

Community gun violence killed more than 28 000 people in the USA in 2017–2018, with racial and ethnic minorities disproportionately affected.[1] These deaths have collateral impact, as families and neighbours of these victims and perpetrators are also affected, amplifying its long-term health impacts.[2–4] Living in violence-endemic neighbourhoods is associated with chronic stress, poor cognitive performance and poor health outcomes.[5–7] In a national study of adolescents, 38% reported witnessing community violence, and 7% and 10% of those who witnessed community violence were diagnosed with post-traumatic stress disorder and depression, respectively.[8]

In addition to the negative health effects among community members, violence is strongly associated with extreme socioeconomic disadvantage and, in turn, exacerbates these disadvantages, creating a vicious

cycle. Community-level risk factors for gun violence include poverty,[9–11] unemployment and housing environments.[12 13] The association between these risk factors and violence is mediated by social cohesion and willingness to intervene in neighbourhood events—broadly conceived as the collective efficacy[14] of a community—which is itself negatively impacted by community violence.[15] Exposure to violence is associated with lower high school graduation rates and lower rates of college attendance,[16] cementing long-term economic disadvantage.[17] Compounding the negative health effects of exposure to violence, aggressive policing tactics often used in communities with high levels of violent crime have a negative impact on test scores among African-American boys,[18] while violent victimisation increases the likelihood of subsequent gun-carrying behaviours.[19] As such, because the community environment is inextricably linked to the incidence and effects of community gun violence, using a community-based approach is necessary to curb the incidence and effects of gun violence.

However, few studies have rigorously tested using an experimental design interventions to prevent and/or mitigate the broader health consequences of gun violence. The Cardiff Model is one notable example in the UK that uses real-time data to identify physical locations where violence occurs and engages multisector partners to develop interventions such as improving street lighting to reduce violence in these areas.[20 21] There are also a few intervention studies that are focused on modifying the physical attributes of neighbourhoods. Perhaps the strongest existing evidence supporting neighbourhood interventions that reduce gun violence and improve community resident health is related to greening urban landscape. A recent cluster randomised study in Philadelphia found that the greening of urban lots was associated with reduced crime and violence and improved mental well-being of community members.[22 23] Some evidence also suggests that reducing alcohol availability[24] and improving street lighting can reduce neighbourhood violent crimes.[25] These interventions are promising, but more study is needed. We do not yet know which of these interventions is the most effective or cost-effective. Emerging evidence also suggests that other potential, untapped community-level social factors—such as neighbourhood cohesion—that could influence the incidence or effects of gun violence but more research is needed.[12 26–29]

One underappreciated path to identifying effective interventions that reduce community exposure to gun violence is designing and implementing them in partnership with community leaders and residents of violence-endemic neighbourhoods. Emerging literature suggests community ownership of interventions and partnerships are important for sustaining reductions in gun violence.[30 31] In 2011, we convened a multisector partnership of city leaders, community members and academic researchers in response to a marked increase in community gun violence in New Haven, Connecticut. We conducted a study to determine if it were possible to activate community members and local officials to engage in a community-based approach to respond to gun violence.[32] Our results indicated that community members anticipate community gun violence and take action to mitigate the health impacts of community gun violence: parents were creating action plans with their children in the event of finding a stray gun or witnessing gun violence and building community coalitions to check in with neighbours after a shooting. Furthermore, those that reported higher rates of neighbourhood social cohesion and collective efficacy had lower exposure to gun violence, even after adjusting for sociodemographics, home ownership status, employment status and number of years living in the community.[32]

We received funding from the National Institutes of Minority Health and Disparities (1R01MD010403-01) to design an assets-based, community-led intervention to reduce gun violence that engages community members and that mitigates the health impacts of living in communities with high rates of gun violence. In this paper, we describe the history behind our community–academic partnership, the conceptual framework on which this work is grounded, and the methodology by which we will identify community assets and design an intervention. Our hypothesis is that a research process that uses an assets-based framework and that includes community partners from multiple sectors will lead to novel community-led interventions to prevent and mitigate the effects of gun violence for future development and testing.

CONCEPTUAL FRAMEWORK

We embed this study protocol in a disaster preparedness framework that focuses on strengthening community assets and that addresses both the psychosocial and logistical aspects of potential responses to gun violence. Our group chose to adapt *Building Resilience to Disasters*, a framework developed for disaster preparedness by RAND, to guide multiple sectors and the broader community in response to natural disasters (figure 1).[33] Our community–academic partnership recognised the strong parallels between a natural disaster and that of a 'chronic, man-made disaster' like gun violence, in terms of the immediate and long-term trauma and the importance of a community-led response.

The framework identifies eight key levers of community resilience (wellness, access, education, engagement, self-sufficiency, partnership, quality and access) which, in turn, strengthen five core components of community resilience (red boxes). Each lever was adapted for preventing or mitigating the effects of gun violence: wellness was defined as assets that promote social and economic well-being (eg, relationships with neighbours or family; barber shops or churches; and parks); access was defined as individuals' access to resources that promote physical, mental and emotional well-being (eg, access to

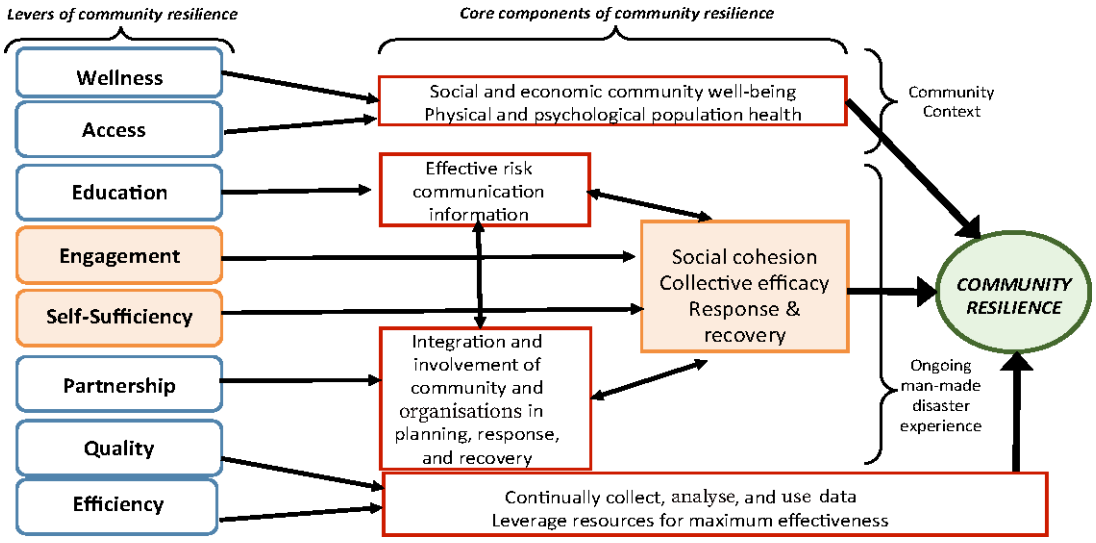

Figure 1 Building resilience to disasters, a framework from RAND for natural disaster and adapted for man-made disaster like gun violence.

a physician or therapist; a neighbour texting tree; and having a mentor); education addresses communication around guns; engagement reflects social cohesion within community and with other organisations; self-sufficiency is the ability of a community member to take action in the community to create a safe and orderly environment (eg, self-policing, starting a block watch and church organises a gun buy back); partnerships refers to developing strong connections between individuals in planning response and recovery around gun violence; quality is associated with the use or promotion of data collection, analysis and utilisation for gun violence prevention or response activities; and lastly, efficiency is the efficient use of data for gun violence prevention and responsiveness. In particular, we chose this framework given that the levers of engagement and self-sufficiency (highlighted in orange, figure 1) spoke to the role that community members had in building the core component of social cohesion, which is critical to community resilience. This framework focuses on strengthening these eight levers for preparedness, thereby improving day-to-day systems and fortifying the positive relationships that allow a community to anticipate and respond effectively to community gun violence. Responsibility for preparedness is shared across communities and all levels of government, with members of the public as full and active participants in the prevention of and response to gun violence.

METHODS

Overview

Over the course of 3 years, we will use a set of novel and complementary methods to identify and characterise existing community assets that build community resilience and may also mitigate the incidence and impact of gun violence episodes in our community (figure 2). Specifically, we will use social network analyses, spatial analyses (year 1), qualitative interviews (year 2) and system dynamics modelling (year 3) to first identify community assets, or protective factors, and then model the effects of strengthening these assets on the anticipated rates and effects of gun violence.

Social network analyses map and measure the number and strength of relationships among people and have shown that a small proportion of individuals in any given community are involved in gun violence.[34] Spatial analyses, where the unit of analysis is a neighbourhood block, have shown that gun violence takes place consistently on only a few blocks within cities. Both of these analyses will be helpful in identifying what factors put people and places within communities at risk for future gun violence and also which ones are protective. We will use these analyses to identify what we call 'positive deviants': people, organisations and neighbourhood blocks that have been successful in avoiding gun violence despite being high risk based on sociodemographic characteristics. We will then conduct qualitative interviews among a sample of these people and individuals living or working on these blocks to identify existing assets to prevent or mitigate the effects of gun violence. Lastly, we use a community-engaged approach to design a system dynamics simulation model

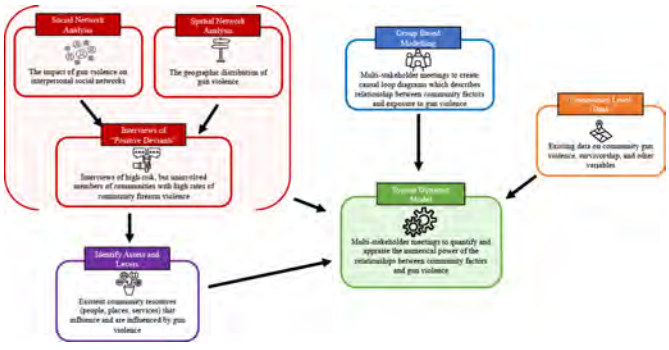

Figure 2 Incorporation of data to create a system dynamics model to identify resilience-building community assets.

of the community-level contributors and mitigators of the effects of gun violence in New Haven, Connecticut. This simulation will incorporate a community-generated casual loop diagram, data from the social network and spatial analyses, local population-based based data and themes from the qualitative interviews in its design. We will use the model to test, in silico, the anticipated effects of feasible community-led interventions on the incidence and effects of gun violence.

Social network analysis of victims and perpetrators of gun violence

We will first construct the social network of gun violence in New Haven, Connecticut, thus allowing us to better understand individual and network factors that put individuals at risk for victimisation. Victims and perpetrators of gun violence concentrate within small and identifiable social networks of largely minority men. For instance, nearly 70% of shootings in Chicago occurred within networks constituting less than 6% of the city's population.[35 36]

We will conduct a social network analysis using disaggregated arrest records and police data on gun violence from 2011 to 2016 and determine the distribution of gunshot victimisation in New Haven, Connecticut, within social networks. We will then model gun violence victimisation using a random forest model, in which the probability of future victimisation depends on individual-level attributes, the history of past victimisations and the history of past victimisations among each individual's network peers.[34 37–39] The random forest model will be used to estimate the probability that each individual will be victimised in the future, given individual and network factors.

We will use these data in two ways; first, we will identify individuals within the social network of gun violence who have had a high risk of victimisation, given individual, network and neighbourhood risk factors but have not been victimised (ie, positive deviants). These individuals will be approached to participate in qualitative in-depth interviews to elicit community assets they used to remain safe from gun violence. Second, data from the social network analysis will be used to initialise relevant rates and parameters in the system dynamics model simulating the incidence and effects of gun violence in New Haven, Connecticut. We will also be able to integrate the social network with the system dynamics model.

Neighbourhood block-level spatial analysis of gun violence events

Next, we will conduct a spatial analysis to identify blocks within the six high-violence neighbourhoods of New Haven that are at high risk for being a location for a gun violence event but have not yet been a location of such an event. Data from Boston indicate that 50% of shootings occurred on less than 3% of all city streets.[36] We will use a point-process model to identify neighbourhood blocks that have a lower or higher incidence of gun violence than would be expected based on socioeconomic and demographic factors and the level of gun violence in surrounding blocks.

We will analyse the location and timing of gunshot victimisations in New Haven, Connecticut, from 2011 to 2016 using a two-component spatio-temporal intensity model.[40] In the first component, we model the count of victimisations in each census block group as a function of neighbourhood-level socioeconomic indicators (eg, proportion of households with income below 50% of the poverty threshold; number of evictions) and demographic indicators (eg, population aged 15–34 years). The second component is a 'self-exciting' process, which allows for victimisation events to temporarily increase the probability of secondary victimisation events in spatial and temporal proximity. Based on the fitted model, we will simulate the frequency of victimisations in each census block group and identify the block groups with fewer victimisations than expected (ie, positive deviants). Like the social network analysis, we will use these data in two ways; first, we will identify neighbourhood blocks within the six high-violence neighbourhoods of New Haven, Connecticut, that are expected to have high risk for incident gun violence but where no shootings have occurred. We will approach individuals who live and/or work on these blocks to participate in qualitative interviews. Second, we will use these data to initialise parameters of the system dynamics model.

Qualitative in-depth interviews of 'positive deviants'

A 'positive deviance' approach is an approach to behavioural and social change based on the observation that in any community there are people whose uncommon but successful behaviours or strategies enable them to find better solutions to a problem than their peers, despite facing similar challenges and having no extra resources or knowledge than their peers.[41] A positive deviance approach has been applied successfully to complex problems, such as malnourishment in developing countries and hospital quality improvement projects targeting coronary heart disease[41] but not to community gun violence. Our hypothesis is that these individuals or people who live or work on these neighbourhood blocks may have leveraged community assets that have been effective in preventing gun violence.

We will conduct in-depth interviews among 'positive deviant' individuals identified in our social network and spatial analyses to elicit factors protective against gun violence. Individuals will be selected for in-depth interview based on identified positive deviant factors, such as not having personal involvement in gun violence, despite exposure to gun violence and being connected to people who have been involved in gun violence identified in our social network map (n=45). We will also conduct interviews among individuals living on the 'positive deviant' blocks identified in our spatial analysis (n=45). We will use a combined inductive and deductive coding strategy for the network-based and block-based interviews, using our community resilience conceptual framework for

categorisation of factors by the eight levers and identify each lever as an individual, organisational or built environment asset.[42] Because the community members of our research team are especially interested in interventions that build on community engagement and self-sufficiency, we will probe especially for assets that are community led. The interviews will address these questions, including: 'If you have friends who have experienced violence or victimization, what do you think might be different between you and them?'; 'How have you avoided getting involved in gun violence?'; and 'Why hasn't this block had a shooting?' (see online supplemental files appendices S1 and S2).

System dynamics modelling to identify effective community-led interventions

Recognising that the community resilience conceptual model is more complex than depicted—levers interact with each other and with other community factors to contribute to the outcome—we will use a participatory process to better understand how these levers from the resilience model, and potentially other factors, together influence the community-wide impact of gun violence. Specifically, we will use group model building, a collaborative, participatory method for involving diverse stakeholders in the design of a system dynamics model.[43] Group model building has been used to explore the key determinants of community violence and has been useful, in particular, for bridging different racial experiences of gun violence.[44] System dynamics modelling is a method that describes dynamic, multilevel, linear and non-linear processes required so that solutions to challenging social problems like gun violence can be identified.[45–51]

We will assemble a multisector group to engage in a series of these group model building sessions to create a causal loop diagram. A causal loop diagram is a visualisation of how different variables in a system are inter-related. The group will include stakeholders that represent each lever of the community resilience framework, including but not limited to police, community leaders, educators, health professionals, researchers and neighbourhood residents. Together, participants will design a causal loop diagram that describes how community factors from all eight levers in the community resilience framework influence each other and influence exposure to gun violence. The group model building sessions will be overseen by facilitators, a process coach, an assistant modeller and a community research assistant who will provide feedback and reflection on the interactions that occurred during the modelling sessions. This additional layer of feedback and reflection will provide additional insight to which we can further adapt the model.

We will use the resulting causal loop diagram to inform the design of a system dynamics model. Local data on gun violence rates, data from social network and spatial analyses, community-based assets related to the eight levers of community resilience and rates of negative health outcomes related to living in violence-endemic neighbourhoods will be further used to calibrate and validate the model.[32 52 53] We may link the social network into the system dynamics model, creating a hybrid model, if it is expected to significantly refine the output. We will review how well the structure of the system dynamics model reflects codes and themes elicited from the qualitative interviews (ie, construct validity). We will iteratively present this model to our community stakeholder group for additional refinement and modification.

The model will then be used to simulate the impact of an intervention or set of interventions aimed at preventing and mitigating health outcomes related to exposure to community gun violence. Hypothesised multicomponent community interventions will be simulated with greater or fewer of the actual components to identify the minimum set(s) of interventions required to achieve desired outcomes. We provide examples of potential neighbourhood interventions categorised by the eight resilience levers (table 1). Intervention(s) that are considered feasible by community stakeholders and effective in the simulation model will be the basis of future interventions that we will implement and test.

Patient/public involvement

Community members were involved in grant writing and budgeting and will be involved in hiring team members, study design, implementation, analysis and dissemination. Specifically, community research partners will reflect on the high-risk and low-risk areas for gun violence in New Haven and will select the areas from which we should recruit participants for qualitative analyses. For the qualitative study, community research partners will be involved in designing the interview guide, administering interviews, analysis and coding. Finally, community stakeholders will be engaged in the group model building sessions with the aim of codesigning the system dynamics model. Findings will be regularly presented during monthly meetings of our community steering committee. Coauthorship is determined ahead of time and includes community members. Any decision making throughout the course of the study is guided by our community steering committee.

ETHICS AND DISSEMINATION

The Human Investigation Committee at Yale University School of Medicine (#2000022360) granted study approval. We will disseminate study findings through peer-reviewed publications and academic and community presentations. The qualitative interview guides, system dynamics modelling and group model building scripts will be shared broadly.

DISCUSSION

Our academic–community partnership has uniquely framed gun violence as a chronic, man-made disaster and is seeking solutions in a strengths-based, disaster

Table 1 Examples of possible neighbourhood interventions categorised by resilience levers

Lever	Definition	Examples of related neighbourhood interventions
Wellness	Promote preincident and postincident population health, including behavioural health.	► Creating green spaces from vacant lots to improve safety and visual appeal of neighbourhood. ► Develop public health messaging to promote healthy lifestyles and bolster psychological wellness.
Access	Ensure access to high-quality health, behavioural health and social services.	► Work with local community health centres to have extended hours for mental health services after an episode of gun violence. ► Provide psychological first aid immediately to community members in their homes after gun violence.
Education	Ensure ongoing information to the public about preparedness, risks and resources before, during and after a disaster.	► Educate children at local schools through theatre about gun safety. ► Train community partners in proper risk communication and response to techniques to gun violence.
Engagement	Promote participatory decision making in planning, response and recovery activities.	► Engage local business owners, such as liquor store owners, in violence prevention efforts. ► Develop a community plan for re-establishing social routines and relationships and reclaiming the space of the gun violence event.
Self-sufficiency	Enable and support individuals and communities to assume responsibility for their preparedness.	► Promote programmes that recognise the vital role community members can play as 'first responders' to gun violence. ► Establish a phone or text tree that gets activated directly after an event of gun violence.
Partnership	Develop strong partnerships within and between government and non-governmental organisations (NGOs).	► Work with local police to develop texting programs to facilitate information exchange about events of gun violence. ► Determine what social networks exist and how to activate them during episodes of gun violence and to prevent gun violence.
Quality	Collect, analyse and use data on building community resilience.	► Collect and monitor measures of social networks, community resilience and gun violence to assess baseline levels and change over time. ► Share resilience and recovery-related data and lessons to improve resilience-building activities.
Efficiency	Leverage resources for multiple use and maximum effectiveness.	► Provide funding to NGOs to include planning response activities for gun violence. ► Develop plans to assess community needs for resource allocation at the onset of incident gun violence.

preparedness model that builds community resilience in order to mitigate the long-term health effects of community gun violence.[27] Our approach is based on addressing the community context within which gun violence persists, builds on community strengths, addresses all community members—rather than solely perpetrators or victims—and allows for rigorous and structured planning and evaluation. Furthermore, we will integrate data from formal social network and spatial analyses into a system dynamics model to identify feasible and effective community-led interventions. To the best of our knowledge, this will be one of the first times a formal application of systems science will contribute to interventions that build community resilience to mitigate the effects of community gun violence.

Also unique to our approach is identifying community assets that can be leveraged to mitigate the impacts of gun violence and related health sequelae. Rarely have gun violence prevention or mitigation strategies been designed to strengthen the existing assets within neighbourhoods. To date, the majority of gun violence prevention efforts are focused on risk reduction, through gun buy backs and enforcement, illicit drug use and enforcement, and gang prevention and enforcement, but these types of interventions do not necessarily address the root causes of community violence and have only been found to have short-term impact, if any.[31 33 54–57] Instead, we apply an assets-based, community-driven framework, anticipating that solutions for community gun violence can originate from both preventing and mitigating impacts of gun violence, as well as building on existing neighbourhood assets. Specifically, we will identify 'positive deviants', who are closest to gun violence and can speak firsthand about community assets that may prevent and mitigate effects of gun violence. Using this framework is innovative and may identify novel interventions, which as of yet have not been applied to community gun violence.

The utilisation of participatory modelling to address the conceptual and analytical challenges inherent in identifying and estimating the impact of multiple

community factors on chronic community gun violence is also a novel approach. Few prior interventions to reduce gun violence have been led by community or in full partnership with community, despite literature indicating the importance of community ownership and partnerships between informal (community) and formal (police and government) social control in creating sustainable reductions in gun violence.[24] We will use participatory modelling to engage the community and to identify and create informal and formal social control partnerships. Additionally, the system dynamics model that the group of community stakeholders create will be one of the first to address chronic community gun violence. Through its creation, key resilience levers can be identified and bolstered, and multifaceted interventions can be explored in an inexpensive and non-harmful trial in silico before implementation and formal evaluation in the real world. This aspect is particularly useful for community gun violence because of the many severe and inter-related negative health outcomes associated with it. The system dynamics model could also be adapted by other communities interested in designing interventions to reduce exposure to gun violence and its health impacts.

Our proposed study plan has limitations to consider. First, as with any community engaged study, it is possible community priorities may diverge from the study proposed and that the time needed to complete the work will exceed the time allotted. However, gun violence has been a major problem in our community for decades, and we have been engaged with many of these committed partners since 2011, so we expect the issue to remain salient. Second, the social network analysis approach for this model seeks to maximise the quality of network data, which may limit broader generalisability of the social network analysis. Third, while we will rely on our social network data and community member input to identify 'positive deviants' for the qualitative interviews, it is plausible that we may miss some important community stakeholders' perspectives on violence-mitigating community assets. However, we plan to sample until we reach theoretical saturation. Fourth, though we plan to use police data to conduct the spatial analyses, these data are incomplete and will miss shootings that were not reported to the police. Finally, it is possible that the group model building process and will not result in participant openness to challenging their mental models, which would make it challenging to identify novel, multisector, collaborative interventions.[58 59] However, we will engage the community stakeholders for multiple sessions over time in order to build cohesive relationships across sectors and will use the system dynamics model to increase participant openness to new ways of thinking and challenge the phenomenon of policy resistance.

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Preparing for Disaster: a Cross-Sectional Study of Social Connection and Gun Violence

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Abstract Living in communities with persistent gun violence is associated with negative social, behavioral, and health outcomes, analogous to those of a natural disaster. Taking a disaster-preparedness approach may identify targets for community-based action to respond to on-going gun violence. We assessed the relevance of adapting a disaster-preparedness approach to gun violence and, specifically, the relationship between perceived collective efficacy, its subscales of social cohesion and informal social control, and exposure to gun violence. In 2014, we conducted a cross-sectional study using a community-based participatory research approach in two neighborhoods in New Haven, CT, with high violent crime rates. Participants were ≥18 years of age and English speaking. We measured exposure to gun violence by adapting the Project on Human Development in Chicago Neighborhoods Exposure to Violence Scale. We examined the association between perceived collective efficacy, measured by the Sampson Collective Efficacy Scale, and exposure to gun violence

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using multivariate modeling. We obtained 153 surveys (51% response rate, 14% refusal rate, and 35% non-response rate). Ninety-five percent reported hearing gunfire, 58% had friend or family member killed by gun violence, and 33% were physically present during a shooting. In the fully adjusted model, one standard deviation higher perceived collective efficacy was associated with lower reported exposure to gun violence ($\beta = -0.91$, $p < 0.001$). We demonstrated that it is possible to activate community members and local officials to engage in gun violence research. A novel, community-based approach adapted from disaster-preparedness literature may be an effective framework for mitigating exposure to gun violence in communities with persistent gun violence.

Keywords Gun violence · Community resilience · Disaster · Collective efficacy · Social cohesion

Introduction

Gun assaults wound or kill 60,000 people in the USA each year, mostly young African-American and Hispanic men [1, 2]. The direct and indirect health effects of gun violence are felt not only by those involved in gun violence but also by entire neighborhoods living with chronic and persistent gun violence. Living in communities with persistent gun violence is associated with negative social, behavioral, and health outcomes including poor cognitive functioning, depression, and post-traumatic stress disorder [3–5]. Living in environments with chronic threat and perceived lack of safety is also associated with subsequent involvement in criminal activity [6–8]. Because gun assaults are disproportionately concentrated within communities where more racial and ethnic minorities live, the health consequences of gun violence are experienced disproportionately by racial and ethnic minorities [9, 10].

Current approaches to gun violence, which have focused largely on limiting access to firearms, creating safer ones, or on counseling victims and remediating perpetrators [11–18], do not address broader community factors that influence the occurrence of violence [19–23]. Furthermore, these approaches neither address the full extent of the effects of living in communities with persistent gun violence nor include the perspectives of individuals living in communities with high rates of gun violence [24–26]. In response to increases in national and local levels of gun violence in New Haven in 2011 and the mass school shooting in Newtown, CT, our community convened a new multi-sector partnership of diverse city, community, and academic organizations to address this increase in violence: the New Haven Community Violence Prevention Group (NHCVPG). Realizing that the repercussions of violent acts extend beyond perpetrators and victims and affect community members more broadly, we framed gun violence as a disaster: "a sudden event that causes great damage and/or loss of life, which produces conditions whereby the continuity of structure and process of social units becomes problematic" [27].

Understanding gun violence as a chronic, man-made disaster, we embedded our community's violence prevention plan in a disaster-preparedness framework that addressed both the psychosocial and logistical aspects of our response. Specifically, we adapted the *Building Resilience to Disasters*, a framework developed for disaster preparedness by RAND and currently used by the Office of the Assistant Secretary for Preparedness and Response, to guide multiple sectors and the broader community in response to gun violence (Fig. 1) [28]. The disaster-preparedness framework includes ways that community members themselves, in concert with local government or public safety agencies, can prepare for a disaster to prevent loss of life and to lessen the resultant fracturing of social structures. This framework focuses on strengthening multiple levers for preparedness: wellness, access, education, collective efficacy, partnership, quality, and efficiency.

Though the framework offers multiple levers for strengthening community resilience, community members and stakeholders from key sectors involved in addressing gun violence asserted that it was most important and feasible to focus our initial local efforts on the lever of collective efficacy. *Collective efficacy* is the ability of community members to leverage their social ties on their own behalf [29, 30]. Our community partners expressed that increased collective efficacy would allow the community to improve responsiveness to disaster as a result of relationships forged and capacity built to efficiently and effectively assess and address local needs, including psychosocial and logistical needs. Collective efficacy is comprised of two subscales: social cohesion (i.e., the bonds among community members) and informal social control (i.e., the capacity of a community to regulate its own members and realize

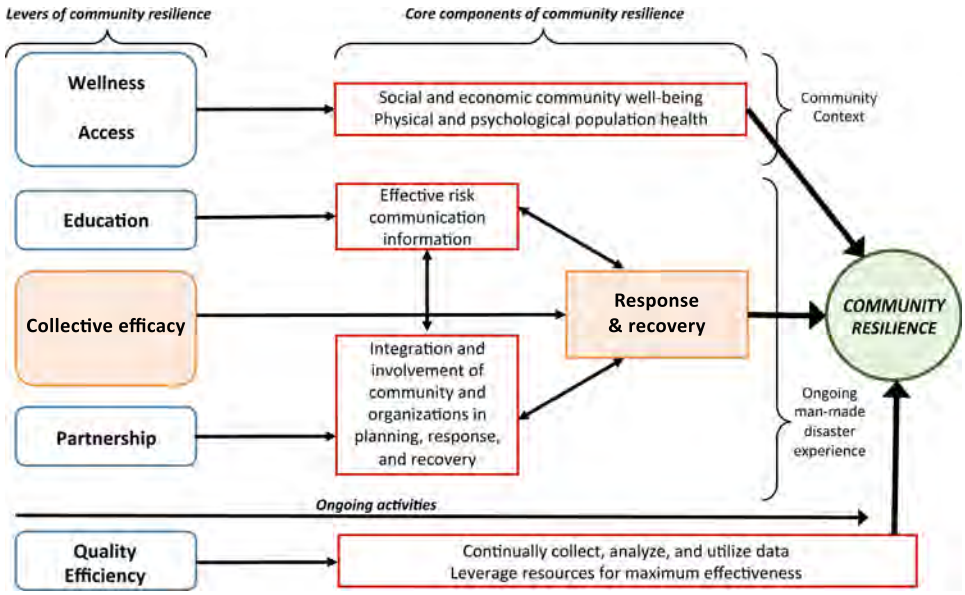

Fig. 1 RAND *Building Resilience to Disasters* framework of levers and core components of community resilience, adapted to man-made disaster

collective goals through informal rather than formal mechanisms) [29, 30].

In this study, we aimed to test the premise that this community disaster-preparedness approach would be relevant to our community that suffers from the chronic, man-made disaster of persistent gun violence. To accomplish this aim, we first sought to determine if it were possible to effectively activate community members and local officials to engage in this community-based approach to prevent and respond to gun violence. We also tested the relationship between community members' perceived collective efficacy (the selected lever of community resilience) and their reported exposure to gun violence. We hypothesized that community members with higher perceived collective efficacy would be less likely to report exposure to gun violence. If this hypothesis holds, it would suggest that efforts to increase neighborhood collective efficacy could result in reduction of exposure to gun violence.

Methods

Study Design

We used a community-based participatory research approach in which community members and researchers value each other's expertise and contribute collaboratively and equally in all phases of research [31]. We engaged in regular interaction and dialogue with community members and other stakeholders through open meetings within each neighborhood, participated in neighborhood- and city-wide forums, directed door-to-door outreach, and held meetings with key stakeholders. To examine the hypothesized inverse relationships between perceived collective efficacy, its subscales, and exposure to gun violence, we designed a cross-sectional study, which included primary data collection with a survey instrument that we administered within two self-identified high violence neighborhoods of New Haven, CT.

Study Team

In 2013, the NHCVPG created the Community Resilience Steering Committee, a multidisciplinary committee comprised of community members, service providers such as local non-profit organizations and the New Haven Police Department, and Yale University researchers to test these hypotheses. The Community Resilience Steering Committee identified community leaders and residents within two of the six neighborhoods with the highest rates of gun violence to participate in the study design, implementation, and dissemination of data.

Study Population

The two study neighborhoods have violent crime rates of 30 per 1000 residents and homicide rates of 15 per 100,000 residents [32]. The population within these neighborhoods is mostly female (55–56%), predominantly African-American (63–85%), low income (65–70% with average annual household income <US$50,000), and with high unemployment (approximately 23–25%) [33]. For the community survey, we identified households within defined areas of these neighborhoods using random walk methodology, selecting an initial household at random and then identifying every other household from that initial one [34]. Respondents were required to be at least 18 years of age, a resident of the specified address, English speaking, and able to provide verbal informed consent.

Survey Development

Exposure to gun violence, our dependent variable, was measured using the 20 items that related to gun violence in the Project on Human Development in Chicago Neighborhoods (PHDCN) Exposure to Violence instrument [35]. To create the Exposure to Gun Violence Score, we summed scores for responses to each of the 11 dichotomous items included, giving a score of 1 for each affirmative response and a score of 0 for each negative response. A score of 0 represents no exposure to gun violence, including never hearing a gunshot; each additional point signifies an exposure ranging from having a friend hurt by a violent act to having been present on more than one occasion when someone was shot.

We assessed perceived collective efficacy as our primary independent variable. In our survey, we utilized the nine-item Collective Efficacy Scale designed by Sampson et al., which is comprised of the four-item Social Cohesion Subscale and the five-item Informal Social Control Subscale [36]. We utilized the scale to assess individual-level perceptions of neighborhood collective efficacy, a variation with precedence in the literature on the original use of the scale, which was initially designed to assess these entities as group constructs [37, 38]. As a measure of the group level construct of collective efficacy, the Collective Efficacy Scale has good internal consistency and reliability and has been used in other populations with similar demographics [30].

Social cohesion represents the bonds among community members [29]. The Social Cohesion Subscale consists of four items, including "people around here are willing to help their neighbors," and "people in this neighborhood do not share the same values," to which respondents reply using a five-point Likert scale from strongly agree to strongly disagree. *Informal social control* refers to the ability of community members to achieve public order themselves through informal mechanisms [30]. The five items of the Informal Social Control Subscale ask respondents to assess on a five-point Likert scale how likely it is that neighbors would intervene under certain circumstances, such as if budget cuts threatened closure of the local fire station. We reverse scored negatively worded items and summed responses.

We collected information on respondent demographics and the characteristics of their households, including age, number of residents in household, number of children in household, number of years living in the neighborhood, home ownership, and employment status. We also gathered information reflecting how residents have or have not planned for episodes of gun violence, such as whether respondents had discussed firearms with children in their households, whether households had a family plan in case of gun violence, and whether respondents or other household members, including children, had burial insurance.

Data Collection

We recruited and trained 17 community members in research methodology and survey administration, based on the well-established *Data and Democracy* curriculum [39]. During scheduled sessions, a team of two to three surveyors approached each pre-identified household, with one surveyor administering the survey and the other survey team member(s) providing logistical support. Each household was approached once per session and up to three times in total during three separate sessions, which we varied to include weekday afternoons and evenings as well as weekend mornings and afternoons. We surveyed until we completed a minimum of 75 surveys in each neighborhood.

The trained community members obtained verbal informed consent from all participants and verbally administered the surveys. All responses were documented with paper and pencil. We debriefed with each survey team at the end of each session to assess for survey completeness and legibility, address issues with survey administration, and assess the psychological well-being of surveyors. We completed primary data collection between May and August 2014. All data were coded and transcribed into an Excel spreadsheet.

Statistical Analysis

We produced descriptive results for the full sample and stratified by neighborhood. We used chi-square tests to examine differences by neighborhood. We then assessed the association between one standard deviation (1SD) change in the perceived collective efficacy score and reported exposure to gun violence using linear regression. Unadjusted associations were assessed, followed by adjustment for the following covariates, chosen a priori based on prior literature: age group, sex, number of years residing in the neighborhood, home ownership status, employment status, and presence of children and/or older persons in the household [30]. Subsequently, we examined unadjusted and adjusted associations between 1SD change in each subscale of perceived social cohesion and perceived informal social control and reported exposure to gun violence.

All analyses were conducted using Stata 13.1 (StataCorp, College Station, TX). All statistical tests were two-tailed with alpha equal to 0.05. The Yale University Institutional Review Board approved this study.

Results

Key stakeholders, including local government officials, public safety officials, the public health department, the healthcare system, local non-profit organizations, and researchers from other disciplines, have not only remained but have become increasingly engaged in the effort to study collective efficacy and gun violence in these neighborhoods. Moreover, we successfully trained 17 volunteers from these communities to administer surveys assessing sensitive topics such as exposure to gun violence and neighborhood preparedness, with many of these trained community members remaining active in the effort after completion of the survey process.

Survey Response Rates, Demographics, and Household Characteristics

We approached 300 households and obtained 153 surveys. Our response rate was 51%, refusal rate 14%, and non-response rate 35%. Forty-five percent of respondents were 25 to 44 years of age, and 56% were female (Table 1). The median number of years that respondents had lived in the neighborhood was 8.5 years. The average household size was 3.3 residents. Nearly two thirds of respondents reported renting with a minority reporting property ownership.

Table 1 Respondent demographics and household characteristics

Respondent demographics	
Female (%)	56
Age (%)	
18–24 years	7
25–44 years	45
45–64 years	34
>64 years	14
Employment status (%)	
Full-time	43
Part-time	9
Not employed	46
Household characteristics	
Median length of time living in neighborhood (years, IQR)	8.5 (2.0–25.5)
Mean number of people living in household (*N*, SD)	3.3 (1.9)
Homeownership status (%)	
Owned by household resident	16
Rented by household resident	64
Other	20
Household employment status (%)	
At least one adult employed full-time	63
No adult employed full-time, at least one adult employed part-time	9
No adult employed part- or full-time	28
Household composition (%)	
Households with at least one resident <18 years old	56
Households with at least one resident >64 years old	58

Exposure to Gun Violence

The mean Exposure to Gun Violence Score for the total sample was 5.67 (SD 2.67; Table 2), indicating that the average respondent had more than five different types of exposure to gun violence in his or her lifetime. There was no difference in Exposure to Gun Violence Scores between neighborhoods ($p = 0.68$). Nearly all respondents had heard a gunshot (95%), and among those, 21% reported hearing a gun shot at least weekly. Two thirds reported having a family member or friend hurt by a violent act, and more than half reported having a family member or friend killed by a violent act. One third had been physically present when someone was shot, and of those, nearly two thirds reported having been present more than once when someone was shot. Among households with children, 67% of respondents had spoken with the children about guns. Approximately half of respondents living in households with families (54%) reported that they had established a family plan in case of gun violence. Forty-one percent of respondents reported having burial insurance for themselves, with 48% reporting having burial insurance for either some or all of the adult household members and 37% reporting having burial insurance for either some or all of the children in the household.

Table 2 Select items from Exposure to Violence Scale

Exposure to Gun Violence Item	Yes (%)
Have any of your family members or friends been hurt by a violent act?	67
Have any of your family members or friends been killed by a violent act?	58
Have you ever heard a gunshot?	95
If heard gunshot, when was the last time you heard a gunshot:	
Within the last week?	33
Within the last month?	22
Within the last year?	26
More than one year ago?	12
Where did that happen:	
In neighborhood?	81
In front of home?	1
In hallway/building?	1
In home?	2
At school?	1
Other location?	7
Have you heard a gunshot more than once?	84
If so, how frequently do you hear gunshots?	
Daily?	11
Weekly?	21
Monthly?	26
Less than monthly?	39
Have you ever seen or been present when someone was shot?	33
If present, did you know the person or people who got shot?	70
If present, did the person die?	46
If present, have you seen this more than once?	61
Are you afraid you or your family might be hurt by violence in your neighborhood?	36
Are you afraid you or your family might be hurt by violence in front of your home?	29
Are you afraid you or your family might be hurt by violence inside your home?	14
Are you afraid you or your family might be hurt by violence at school or work?	21

Collective Efficacy

The mean perceived Collective Efficacy Score for the total sample was 28.2 out of 45 (SD 6.97, Table 3). The mean perceived Social Cohesion Score for the total sample was 12.2 out of 20 (SD 2.98). Only one quarter of respondents either agreed or strongly agreed that people in their neighborhood could be trusted, whereas the majority (60%) either agreed or strongly agreed that people in their neighborhood are willing to help their neighbors. The mean perceived Informal Social Control Score for the total sample was 16.0 out of 25 (SD 4.81). Approximately half of respondents thought it was either likely or very likely that their neighbors would intervene if a fight occurred in front of their house, and the majority thought it was either likely or very likely that their neighbors would intervene if budget cuts threatened the local fire station. There was no difference in these scores between neighborhoods (collective efficacy $p = 0.27$, social cohesion $p = 0.31$, informal social control $p = 0.33$).

Multivariate Analysis

In the unadjusted model, 1SD change in perceived collective efficacy was negatively associated with exposure to gun violence ($\beta = -0.90$, $p < 0.001$, Table 4). Similarly, 1SD changes in social cohesion and in informal social control were negatively associated with exposure to gun violence (social

Table 3 Responses to Collective Efficacy Scale, comprised of Social Cohesion and Informal Social Control Subscales

Collective Efficacy Scale = Social Cohesion Subscale + Informal Social Control Subscale					
Social Cohesion Subscale					
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
This is a close-knit neighborhood.	12	31	31	16	9
People around here are willing to help their neighbors.	16	44	21	15	4
People in this neighborhood do not share the same values.	15	33	21	28	3
People in this neighborhood can be trusted.	7	18	36	22	16
Informal Social Control Subscale					
How likely is it that neighbors would do something about it if:	Very likely	Likely	Neither likely nor unlikely	Unlikely	Very unlikely
Children were skipping school and hanging out on a street corner?	12	20	18	31	19
Children were spray-painting graffiti on a local building?	19	30	18	18	13
A child was showing disrespect to an adult?	20	23	20	18	18
A fight broke out in front of your house and someone was being beaten up or threatened?	27	22	18	21	11
The fire station closest to your house was going to be closed down by the city because of budget cuts?	31	29	19	11	9

cohesion $\beta = -0.69$, $p = 0.002$; informal social control $\beta = -0.83$, $p < 0.001$). Results did not change after adjustment for covariates (collective efficacy adjusted $\beta = -0.91$, $p < 0.001$; social cohesion adjusted $\beta = -0.67$, $p = 0.004$; informal social control adjusted $\beta = -0.84$, $p = 0.001$).

Table 4 Correlations of one standard deviation differences in perceived collective efficacy, social cohesion, and informal social control with reported exposure to gun violence

Independent variable	Model	β	p value
Collective Efficacy	Unadjusted	*−0.90*	*<0.001*
	Model 1[a]	*−0.87*	*<0.001*
	Model 2[b]	*−0.91*	*<0.001*
Social Cohesion	Unadjusted	*−0.69*	*0.002*
	Model 1[a]	*−0.62*	*0.008*
	Model 2[b]	*−0.67*	*0.004*
Informal Social Control	Unadjusted	*−0.83*	*<0.001*
	Model 1[a]	*−0.79*	*0.001*
	Model 2[b]	*−0.84*	*0.001*

Italics indicates statistical significance ($p < 0.05$)

[a] Model 1 was adjusted for age, sex, and years living in the neighborhood

[b] Model 2 additionally adjusted model 1 for employment, home ownership, older persons living in the home, and children living in the home

Discussion

In two neighborhoods with high rates of gun violence, we demonstrated that it is possible to activate community members and local officials to engage in research about gun violence. With all of these efforts, we built local capacity and interest in designing a community-based intervention that focuses on factors over which community members believed they had control that may prevent gun violence in communities where violence is endemic. The successful completion of this study shows that a preparedness framework, which requires multi-sector partnership, is relevant and desired, even in communities with longstanding tensions between community residents and police.

Through our community survey, we found that one out of three respondents had been physically present during a shooting and almost two thirds had a friend or family member killed by gun violence. Community members were afraid that they or their family might be harmed in their own neighborhoods. Many had prepared for future episodes of gun violence, including discussing firearm safety with their children and establishing a family plan in case of gun violence. These data affirm that community members are capable of and already engaged in preparing actively for gun violence, supporting that a preparedness framework to prevent

gun violence is relevant to residents living in communities with high rates of gun violence.

As we hypothesized, adult residents who endorsed higher neighborhood collective efficacy were less likely to report having been exposed to gun violence, even after accounting for salient characteristics of the household, such as length of residence, home ownership, employment, and age of residents. These results, which assess the perception of collective efficacy and exposure to gun violence specifically, extend prior research linking the prevalence of violence, defined broadly to include interpersonal violence, assault, and gun violence, to the lower collective efficacy [30, 40].

Associated with decreased likelihood of experiencing gun violence events, perceived collective efficacy may be a protective factor. A recent longitudinal study of 1114 youth between 11 and 16 years old in Chicago found that greater collective efficacy as measured at the neighborhood level, among other factors such as family support, positive peers, and meaningful opportunities for participation, had a positive effect on the healthy development of youth exposed to violence from living in neighborhoods with higher rates of violence [41]. Higher levels of collective efficacy may also allow community members to interrupt the cycle of violence in their neighborhood, by preventing retaliatory acts in the short term and by decreasing the risk of future violence by those exposed in the longer term. For instance, Molnar et al. report that the youth were less likely to carry a concealed firearm in neighborhoods with higher collective efficacy, independent of neighborhood economic indicators and individual and family factors [42]. As our data focuses on perceived neighborhood collective efficacy, future studies will need to explore the association between neighborhood collective efficacy and exposure to gun violence and if and how building collective efficacy, and in turn community resilience, can mitigate the effects of gun violence. Future steps therefore include evaluating the effectiveness of an intervention that builds community resilience in these same neighborhoods by strengthening perceived collective efficacy, among other levers in the adapted *Building Resilience to Disasters* framework.

Limitations

Our study has limitations. First, based on 2010 Census data, between 14 and 17% of the adult population within these neighborhoods are 18 to 24 years old, so our sample underrepresents this age group which is affected by gun violence [33]. However, in sensitivity analyses, we found no significant differences between the responses of the 18- to 24-year-old respondents and the remainder of our sample. Second, we administered the survey in English only, but the relatively low percentage of households that are primarily non-English speaking (9 and 14%) allowed for assessment of the vast majority of the population within these neighborhoods [33]. Third, our non-response rate was 35%. This was due in part to the sizable number of vacant addresses within the sampling frame, which from the 2010 Census was 13 and 17% in each of the two study neighborhoods [33]. Finally, the cross-sectional design of this study limited our ability to assess causality and, more particularly, the direction of any causal association. It is possible that persistent violence erodes community members' perceptions of collective efficacy. Nevertheless, these results represent an essential first step and provide the foundation for further study.

Conclusions

The consequences of gun violence go beyond the numbers of victims wounded or killed. A novel approach to understanding and mitigating the exposure to persistent gun violence that addresses both the community social context and the community-level effects of high levels of exposure to gun violence is needed. A public health, disaster-preparedness, community-based approach that builds collective efficacy as a means of mitigating the effects of gun violence, while contributing to efforts to prevent future occurrences, is an approach worth testing.

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Compliance with Ethical Standards The Yale University Institutional Review Board approved this study.

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Neighborhood disadvantage and firearm injury: does shooting location matter?

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Abstract

Background: Firearm violence is a public health problem that disparately impacts areas of economic and social deprivation. Despite a growing literature on neighborhood characteristics and injury, few studies have examined the association between neighborhood disadvantage and fatal and nonfatal firearm assault using data on injury location. We conducted an ecological Bayesian spatial analysis examining neighborhood disadvantage as a social determinant of firearm injury in Seattle, Washington.

Methods: Neighborhood disadvantage was measured using the National Neighborhood Data Archive disadvantage index. The index includes proportion of female-headed households with children, proportion of households with public assistance income, proportion of people with income below poverty in the past 12 months, and proportion of the civilian labor force aged 16 and older that are unemployed at the census tract level. Firearm injury counts included individuals with a documented assault-related gunshot wound identified from medical records and supplemented with the Gun Violence Archive between March 20, 2016 and December 31, 2018. Available addresses were geocoded to identify their point locations and then aggregated to the census tract level. Besag-York-Mollie (BYM2) Bayesian Poisson models were fit to the data to estimate the association between the index of neighborhood disadvantage and firearm injury count with a population offset within each census tract.

Results: Neighborhood disadvantage was significantly associated with the count of firearm injury in both non-spatial and spatial models. For two census tracts that differed by 1 decile of neighborhood disadvantage, the number of firearm injuries was higher by 21.0% (95% credible interval: 10.5, 32.8%) in the group with higher neighborhood disadvantage. After accounting for spatial structure, there was still considerable residual spatial dependence with 53.3% (95% credible interval: 17.0, 87.3%) of the model variance being spatial. Additionally, we observed census tracts with higher disadvantage and lower count of firearm injury in communities with proximity to employment opportunities and targeted redevelopment, suggesting other contextual protective factors.

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Conclusions: Even after adjusting for socioeconomic factors, firearm injury research should investigate spatial clustering as independence cannot be able to be assumed. Future research should continue to examine potential contextual and environmental neighborhood determinants that could impact firearm injuries in urban communities.

Keywords: Firearm violence, Neighborhood disadvantage, Injury epidemiology

Background

Firearm violence displays a marked geographic distribution concentrated in certain areas of notable economic and social disparities. Researchers have been examining the connection between deprivation and violence for decades, using various measures of neighborhood disadvantage and violence such as violent crime (Baumer et al., 2003; Hsieh & Pugh, 1993; Lauritsen & White, 2001), and homicide (Jones-Webb & Wall, 2008). Considering firearm violence using a public health framework may identify structural risk factors to facilitate longer-term effects compared to interventions that solely focus on high-risk individuals (Branas et al., 2017).

Measures of poverty and disadvantage including income inequality (Rowhani-Rahbar et al., 2019), social capital, social mobility, and local welfare spending (Kim, 2019) have been found to be associated with firearm homicide across the United States. However, non-fatal firearm injuries make up the majority of firearm injuries and research has been limited by examining fatal firearm injury (Kalesan et al., 2017; Hipple et al., 2019). As fatality often depends on the anatomical area of injury (Beaman et al., 2000) and distance from trauma centers (Circo, 2019), relying on fatal firearm injury only may provide an incomplete understanding of the determinants of firearm injury.

In recent years, some investigators have been able to access fatal and non-fatal firearm assaults through hospital or law enforcement data. In Miami-Dade County, areas with a higher percentage of Black residents and higher percentage of single-parent households had significantly higher rates of firearm injury (Zebib et al., 2017). Firearm assaults were observed in areas with low household income in Philadelphia (Beard et al., 2017) and racial segregation in Massachusetts (Krieger et al., 2017). Nonfatal and fatal shootings in Indiana were concentrated in areas of disadvantage classified by percent unemployment, median household income, percent living in poverty, and percent female headed household (Magee, 2020). Poverty, segregation, and education were found to be predictors of firearm violence in urban California (Goin et al., 2018).

When non-fatal injury information is available, often residence is used as a proxy of location of injury. However, in King County, Washington where the city of Seattle is located, 75% of firearm assault injuries occurred in a census tract different from where the patient resided, and patients ages 18–34 had the greatest distances between injury location and residence (Mills et al., 2019). Understanding the association between neighborhood disadvantage of the injury location and risk of firearm injury can strengthen support for more structural prevention initiatives and is distinct from the risk associated with residence in an area of concentrated disadvantage.

We sought to expand the literature by examining location of both fatal and non-fatal shootings in relation to neighborhood disadvantage as a social determinant of health in the City of Seattle, Washington. We hypothesized that neighborhood disadvantage is associated with firearm assault injury, with neighborhoods at higher disadvantage experiencing greater risk of firearm injuries. This study adds to the growing literature examining neighborhood disadvantage and firearm violence in urban areas, specifically, and addresses potential limitations of prior research by employing methods that account for the non-independence of injuries across space and including both non-fatal and fatal firearm assault events at the location of injury.

Methods

This was an ecological study using Bayesian spatial analysis conducted at the census tract level in Seattle, Washington. A census tract is a subdivision of a county or similar entity and contains between 1200 and 8000 people. The city of Seattle consists of 142 census tracts including partial tracts.

Data sources

Two main data sources were used to identify firearm assault injuries within Seattle between March 20, 2016 and December 31, 2018. First, patients with a documented assault-related gunshot wound were identified from medical records at Harborview Medical Center (the regional Level I trauma center). For these analyses, we used data collected in another research project that began March 20, 2016 and ended enrollment on December 31, 2018. Since individuals who did not survive long enough to be transported to the hospital were missing from medical records, the Gun Violence Archive (GVA) was used to supplement additional cases of firearm assault injury in Seattle. GVA is an open-source dataset

that uses over 7500 sources to document incidents of gun violence in the United States (Gun Violence Archive, 2020). GVA includes both fatal and non-fatal incidents and includes a variety of coded variables and links to additional source information, typically from news sites, providing many demographic and circumstance details. When someone appeared in both datasets (i.e. someone sustained an injury and was treated in the hospital but did not survive), information from the hospital data was used. Firearm assault injury was defined as an intentional interpersonal injury involving firearms. This included assaults and homicides. Unintentional, undetermined intent, and self-inflicted firearm injuries were excluded from the analysis.

Among hospitalized patients, injury locations were identified based on hospital records. For hospitalized patients missing complete addresses, internet news archives were used to determine injury location. Injury locations are provided within GVA as addresses. All available addresses were geocoded to identify their point locations and then aggregated to the census tract level.

Neighborhood disadvantage from the National Neighborhood Data Archive (NaNDA) at the census tract level was then merged to the firearm injury file. The NaNDA socioeconomic status and demographic characteristics of census tracts uses the American Community Survey 5-year estimates from 2013 to 2017 to provide information by census tracts for the United States and Puerto Rico (Melendez et al., 2020). The index was developed using principal factor analysis (Clarke et al., 2014). Among the census measures included in the analysis, there were three factor loadings interpreted as neighborhood disadvantage, neighborhood affluence, and ethnic and immigrant concentration. The current study used the four-indicator neighborhood disadvantage index which includes proportion of female-headed families with children, proportion of households with public assistance income, proportion of people with income below poverty in the past 12 months, and proportion of the civilian labor force aged 16 and older that were unemployed. These proportions were averaged for each census tract.

For the current study, these averaged proportions were then sorted at the state level (Washington) and ranked in deciles to create a scale 1–10, with 1 being the least disadvantaged and 10 being the most disadvantaged. This creation of a rank-type format allows for easier interpretation and comparison between neighborhoods. Annual population estimates for Seattle census tracts for 2016–2018 were obtained from the Washington State Office of Financial Management (Washington State Office of Financial Management, 2019).

Statistical analysis

Bayesian Poisson models were fit to the data to estimate the association between the index of neighborhood disadvantage and firearm injury count with a population offset within a census tract. The first model was a non-spatial model with independent and identically distributed (IID) random effects. The IID model did not account for the neighboring structure but smooths outliers towards the center of the data. The second model was an Intrinsic Conditional Auto-Regressive (ICAR) Besag-York-Mollie (BYM2) model which incorporated the spatial structure of neighboring data by including both IID and spatial random effects (Riebler et al., 2016). Thereby, the model included both normally distributed error terms as well as a spatial component estimated as the weighted mean of the firearm injuries in each area's neighboring census tracts. In the spatial model, neighbors were defined as any contiguous census tracts that shared a common border. Annual population estimates of the census tract for the same time period of the study (2016–2018) were log transformed and included in the models as an offset. Both models used integrated nested Laplace approximations to estimate posterior distributions (Wakefield, 2007). Additionally, as a sensitivity analysis, a final BYM2 model was fit without including the neighborhood disadvantage index to assess the proportion of the variance that was spatial when no explanatory variables were included. All analyses were conducted in the statistical programming language R (www.r-project.org) using the INLA package (www.r-inla.org).

Ethical review

This study was approved by the University of Washington Human Subjects Division (Institutional Review Board; STUDY00000852).

Results

From March 20, 2016 through December 31, 2018, there were 219 firearm assault injuries identified in Seattle of which 191 were able to be geocoded by place of occurrence (87.2%). Of the persons experiencing these injuries, the average age was 30.8 years (SD: 11.9) and 82.7% were male. 25.1% of injuries were determined to be fatal by hospital records or according to GVA sources.

Among Seattle's 142 census tracts, the average disadvantage index was 4.76 (SD: 2.97) (Fig. 1). Over the study period, the number of injuries within a census tract ranged from 0 to 14 per census tract, with an average of 1.4 injuries. 63 tracts experienced no firearm injuries; all firearm assault injuries ($n = 191$) occurred in 55.6% of Seattle's census tracts ($n = 79$). Half ($n = 87$) of the firearm assault injuries occurred in 14 (9.9%) census tracts.

In the IID model, for two census tracts that differ in neighborhood disadvantage by 1 decile, the number of firearm injuries was expected to be higher by 27.6% (95% credible interval: 18.1, 39.0%) in the tract with the higher neighborhood disadvantage.

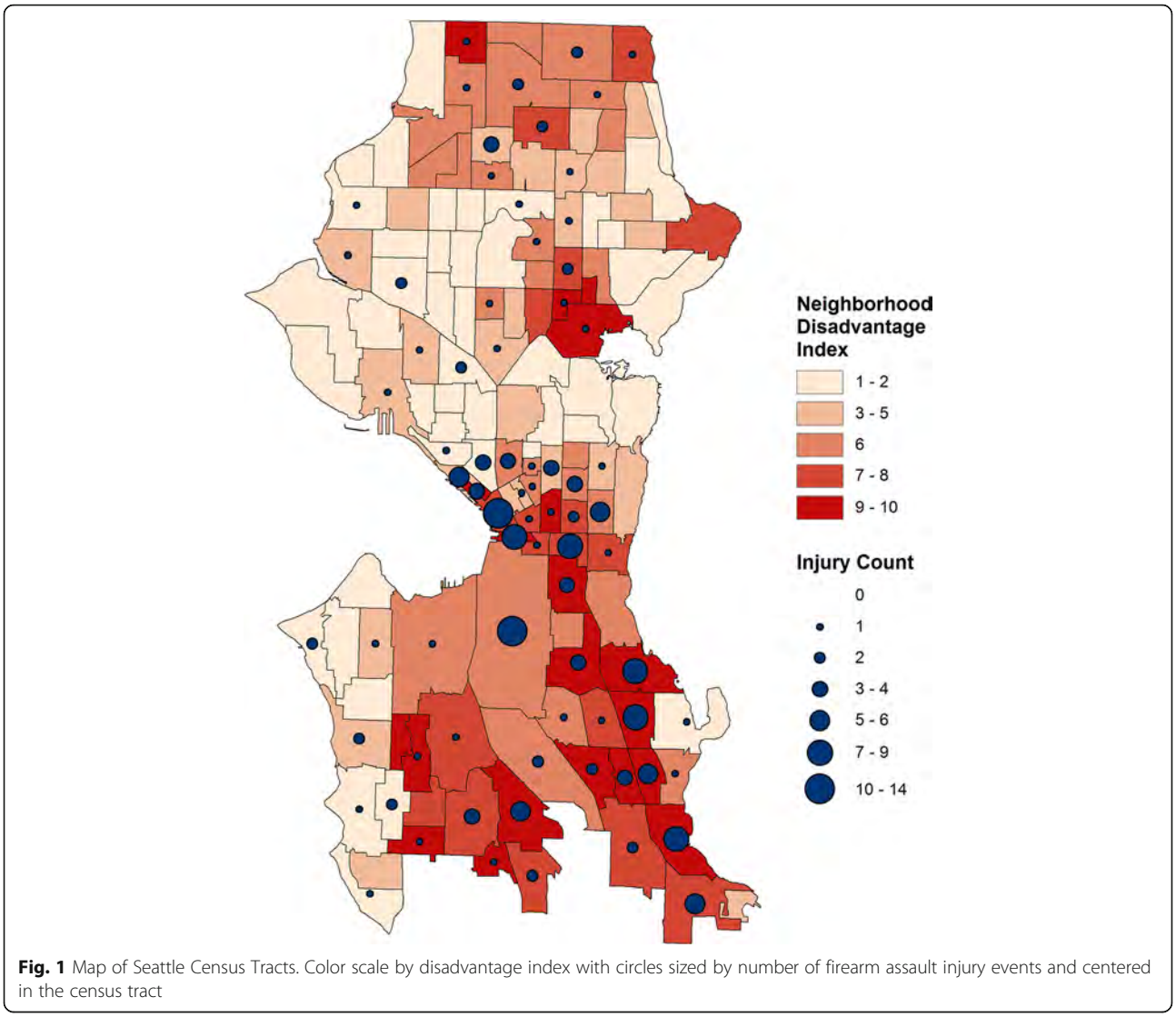

Fig. 1 Map of Seattle Census Tracts. Color scale by disadvantage index with circles sized by number of firearm assault injury events and centered in the census tract

In the BYM2 spatial model, higher neighborhood disadvantage was associated with more firearm injuries, but the results were somewhat attenuated. For two census tracts that differed by 1 decile of neighborhood disadvantage, the number of firearm injuries was expected to be higher by 21.0% (95% credible interval: 10.5, 32.8%) in the group with higher neighborhood disadvantage. However, even after accounting for spatial structure by contiguous neighbors, there was still considerable residual spatial dependence with 53.3% (95% credible interval: 17.0, 87.3%) of the model variance being spatial. This suggests the presence of residual confounding by location. As a sensitivity analysis, another BYM2 model was fit without including the neighborhood disadvantage index to compare the proportion of the variance that was explained by including a measure of disadvantage in the model. When examining the spatial dependence of firearm assault injuries without the disadvantage index, 75.2% (95% credible interval: 37.1, 95.2%) of the model variance was spatial.

In visually inspecting the association between neighborhood disadvantage index and firearm injury (Fig. 2), we observed areas with high neighborhood disadvantage and low firearm injury count. Several of these data points were from the Delridge neighborhood district, specifically in the community reporting areas of High Point and Highland Park (Fig. 3).

Discussion

This study demonstrates the importance of considering the geographic context when studying social determinants of firearm violence. Geographic analysis of crime has been prominent in Seattle with micro-place analysis of crime examining street segments (Weisburd et al., 2004). Even when considering larger areas such as census tracts and examining firearm violence specifically,

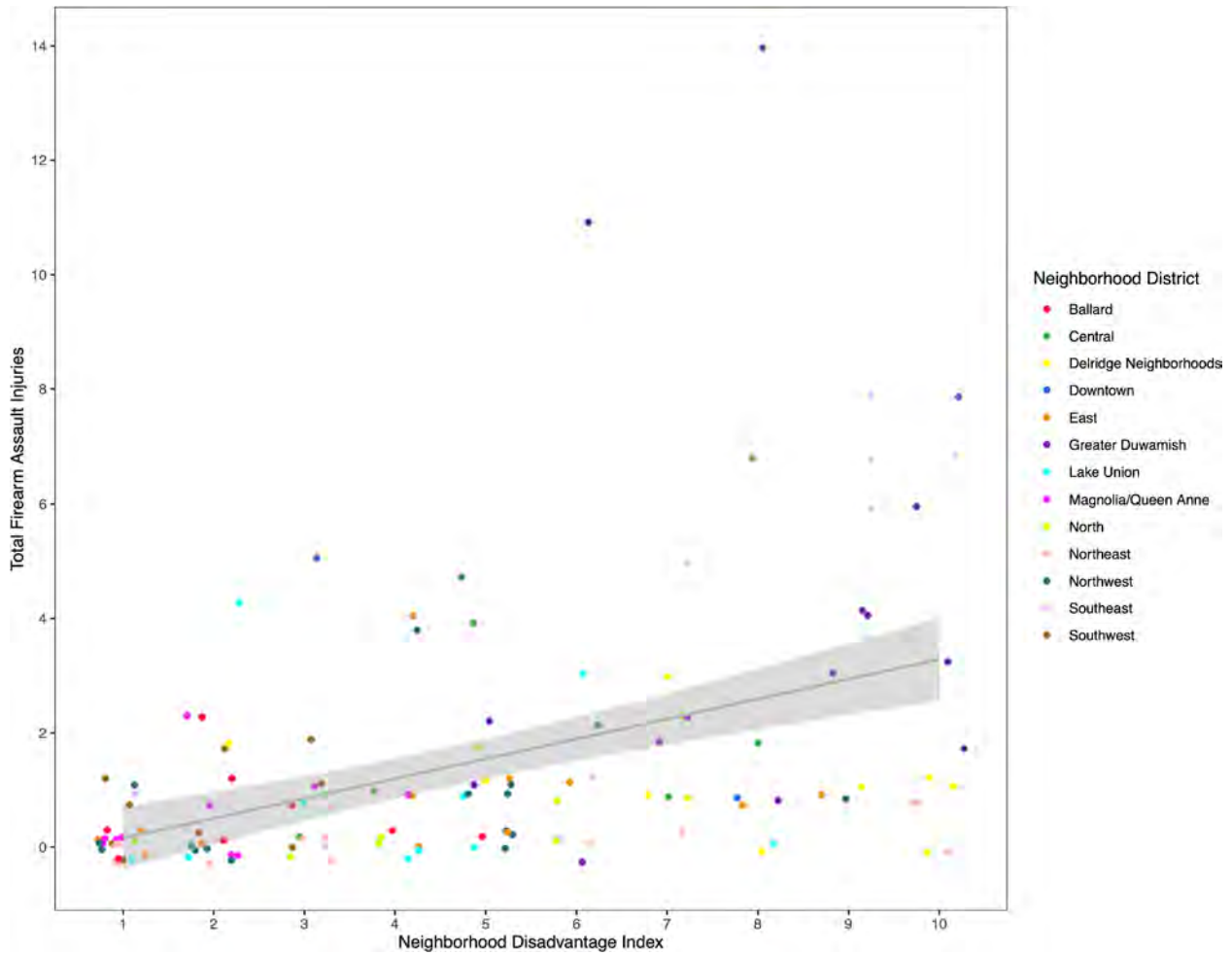

Fig. 2 Scatterplot of neighborhood disadvantage index and firearm assault injuries of the census tract. Linear fit line for exploratory characterization, color denotes Neighborhood District name

we found a similar clustered pattern where a few areas contributed to the majority of events. When examining the association of neighborhood deprivation with firearm injuries, neighborhood disadvantage had a significant association in both the non-spatial and spatial models, though the results were attenuated when space was included. Firearm injury research should investigate spatial clustering when performing analyses as independence may not be able to be assumed even after adjusting for socioeconomic factors. This is particularly important for studying interpersonal outcomes, such as assault, where social proximity may be as important as geographic distance (Papachristos et al., 2015).

In using firearm injury location data as opposed to residence location, we were able to determine that where an injury occurs is related to the neighborhood's deprivation; however, even after accounting for the influence of neighboring tracts, a large proportion of the variance was spatial. Together these results suggest that areas with high firearm injury rates tend to cluster together and the influence of injuries in neighboring tracts has an effect on the outcome of firearm injuries in a location above and beyond the census tract's level of deprivation. Future investigations should explore other potential explanatory variables that might be able to explain some of this residual variability and explore why proximate tracts have similar firearm injury rates even after accounting for the effect of neighborhood deprivation.

There may be other contextual factors that affect firearm injuries in these locations including environmental factors such as greenspace and vacant lots (Bogar & Beyer, 2016, Branas et al., 2016, Moyer et al., 2018). Neighboring census-tracts may also be similar in other characteristics associated with firearm violence such as education (Goin et al., 2018), gun ownership (Monuteaux et al., 2015), and alcohol outlet density (Furr-Holden et al. 2019; Mair et al. 2013). These factors may

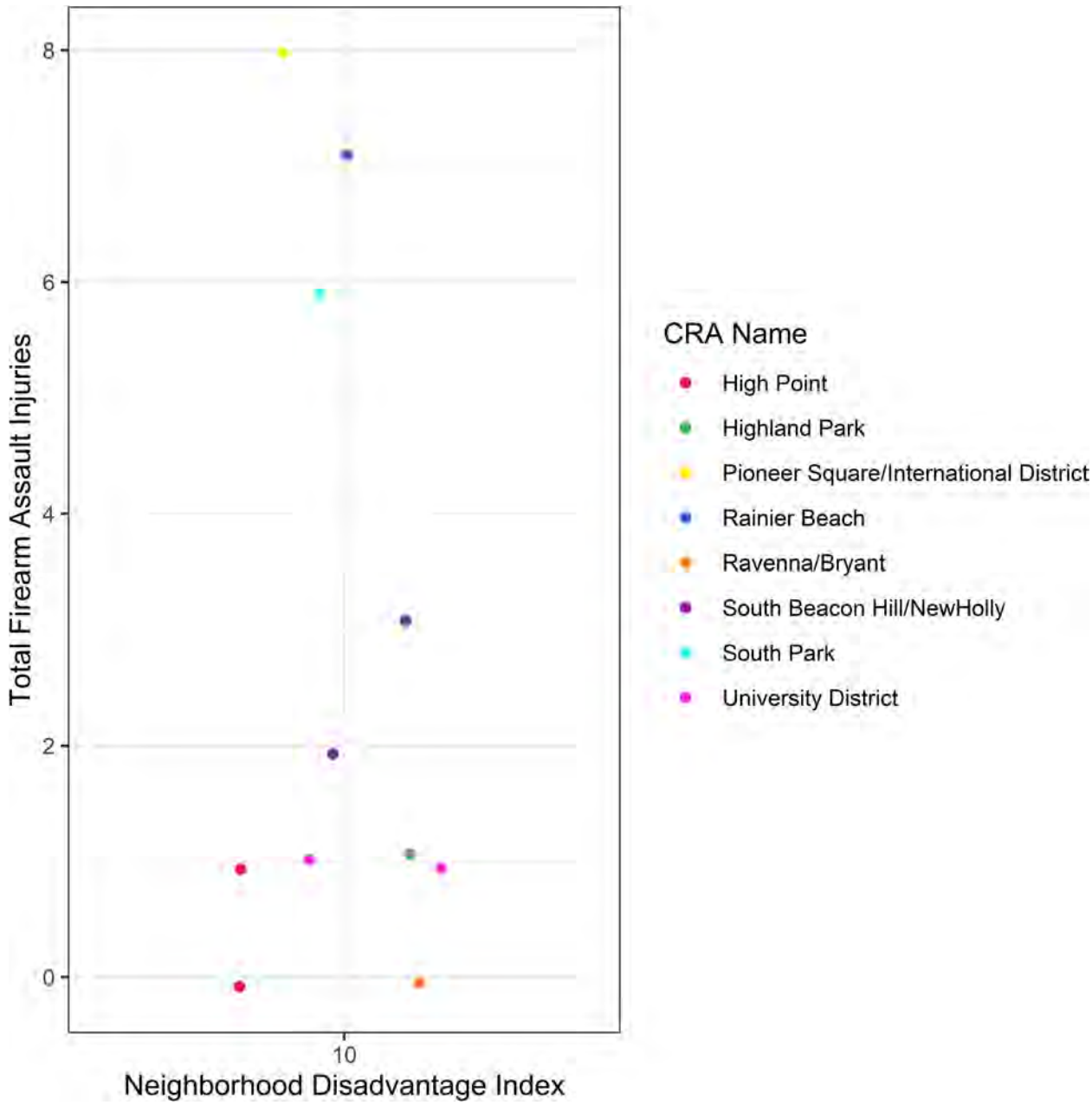

Fig. 3 Firearm assault injury count for census tracts with a neighborhood disadvantage index of 10. Color denotes the Community Reporting Area (CRA) name

be potential confounders in the relationship between neighborhood disadvantage and firearm injury or could be part of the pathway from neighborhood disadvantage to firearm violence, perpetuating a cycle of disadvantage and firearm violence. These potential feedback effects could be explored in future work.

We observed areas with high disadvantage and low firearm injury suggesting future research should examine potential protective factors or resiliency at a neighborhood level such as social cohesion and capital (Lochner et al., 2003; Sampson et al., 1997). These were noted in communities of working-class families with historical ties to employment opportunities, Highland Park which is located near Boeing Field and the Industrial District, and redevelopment. High Point was originally developed during World War II as government housing. From 2003 to 2010, Seattle Housing Authority redeveloped the area into a mixed-income neighborhood with attention to environmental sustainability and community engagement. In Duval County, Florida, areas with high

neighborhood deprivation but low firearm injury were also noted to have been targeted by community revitalization efforts (Abaza et al., 2020). Further work examining neighborhoods with high deprivation and low firearm injury may provide additional information on protective factors that could be strengthened by community organizations. Community revitalization efforts that impact neighborhood disadvantage may also reduce firearm injuries. Community revitalization may be impacting the built-environment and increasing social capital, strengthening informal social controls (Sampson et al., 1997).

The findings from the current study can be used to assist in strategic planning of firearm prevention efforts. In 2009, the Seattle Youth Violence Prevention Initiative was initiated to reduce youth violence and included various programming for at-risk youth ages 12–17 as well as street outreach services (City of Seattle Office of City Auditor, 2015). This initiative was unable to be evaluated due to lack of defined goals and data management systems (City of Seattle Office of City Auditor, 2014). Firearm prevention programs may consider integrating neighborhood disadvantage reduction as a part of primary prevention.

Limitations

The NaNDA measure of neighborhood disadvantage features items commonly seen in the violence and health literature (Clarke et al., 2014). However, this index may not fully capture the structural context of deprivation associated with firearm violence. This study used residential population of each census tract as the population offset. However, notably in urban areas, the population at risk may greatly fluctuate in different timings throughout the day based on routine activities such as school, work, transportation hubs, and nightlife (Walker et al., 2014). An area may have a large number of non-residents that may differ in sociodemographic characteristics who spend time in the census tract. The current analysis includes all assault injuries; however, there may be important distinctions depending on type of assault such as domestic violence and gang violence. Future research should examine if the association of neighborhood disadvantage and firearm injury differs by these intents.

Additionally, the reliance on administrative boundaries such as census tract for which these data are available, may not capture the identity of a neighborhood. Geographic level is an important consideration (Hipp, 2007; Schnell et al., 2017; Mair et al., 2020) and other units of aggregation were considered such as census block group. However, with the number of firearm assault injury events, we believed aggregating smaller than the census tract may produce spurious findings due to the high proportion of zero incidence tracts at smaller geographic levels (Wakefield, 2004). Though we believe census tract was the relevant scale to represent the neighborhood context, more research understanding how certain theories of violence operate at different spatial scales is needed (Boessen & Hipp, 2015). In addition to the implications of these findings on community prevention efforts, the study highlights the need for available measurements at the neighborhood level of such protective factors, potential confounders, and modifiers. Measurements of income inequality, racial segregation and discrimination, gun ownership, and social capital and cohesion at smaller-scale geographies may further elucidate the relationship between neighborhood disadvantage and firearm injury.

The current study was an ecological analysis with exposure and outcome measured close together or concurrently in time, neighborhood deprivation measures from 2013 to 2017 and firearm injury from 2016 to 2018. Future research should consider additional time periods of neighborhood deprivation that could have differing effects on firearm injury or demonstrate different pathways such as the effect of lifetime of experience, historical deprivation (Benns et al., 2020; Jacoby et al., 2018), and neighborhood changes, including gentrification (Schnake-Mahl et al., 2020). In a prior study examining the effects of gentrification on crime in Seattle from 1982 to 2000, it was not found to be statistically significantly associated with violent crime (Kreager, Lyons, & Hays, 2011). However, as gentrification was observed to change from the small-scale investments in the 1980s to larger corporate investors and urban renewal programs in the 1990s, neighborhood changes in the recent decades may by qualitatively different and could influence firearm violence.

Lastly, this study features findings from one city. The firearm homicide rate in Seattle and King County decreased from 2007 to 2010, and by 2016 increased to the rate observed in 2000 (Public Health — Seattle & King County, 2019). According to data from the King County Prosecuting Attorney's Office, in 2017, there was an increase in firearm homicides and non-fatal injuries across the county while 2018 showed decreases that more closely resembled 2016 (King County Prosecuting Attorney's Office, 2019). The results may not be generalizable to other cities but adds to the previous literature of neighborhood disadvantage and firearm violence in urban areas.

Conclusion

Firearm injuries depict geographic patterns that are associated with neighborhood disadvantage in Seattle, WA. Despite prior research on neighborhood disadvantage and violence, fewer studies have examined the association between neighborhood disadvantage and fatal and non-fatal firearm assault violence using data on

injury location. As spatial methods techniques advance and become more accessible, these methodological considerations could have implications for findings and therefore, prevention recommendations.

In addition to using spatial analysis to identify areas with high burden of violence, the association of neighborhood disadvantage with firearm assault injury should consider addressing and evaluating programs and practices that remedy concentrated disadvantage as reducing neighborhood deprivation could reduce firearm injuries as well. Community-level programs and practices can consider unique opportunities for place-based firearm injury and violence prevention that would otherwise be lost or misallocated. However, as neighborhood disadvantage is not the only spatial measure affecting firearm violence, future research should consider other neighborhood contextual factors that could serve as risk or protective factors.

Abbreviations

GVA: Gun Violence Archive; NaNDA: National Neighborhood Data Archive; IID: independent and identically distributed; ICAR: Intrinsic Conditional Auto-Regressive; BYM2: Re-parameterized Besag-York-Mollie

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Not Applicable.

Availability of data and material

Part of the data analyzed for this study are publicly available on Gun Violence Archive (https://www.gunviolencearchive.org/). Part of the data analyzed for this study are not publicly available due to the restrictions placed by data stewards.

Authors' contributions

KD conducted the analysis, interpreted the results, and drafted the manuscript. EG interpreted the results and revised the manuscript. BM contributed to the conception of the study and provided revisions for the manuscript. AF oversaw data collection and provided revisions for the manuscript. FR contributed to the conception of the study and provided revisions for the manuscript. AR designed the study, oversaw the analysis, obtained funding for the study, and provided revisions for the manuscript. All authors read and approved the final manuscript.

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Ethics approval and consent to participate

This study was approved by the University of Washington Human Subjects Division (Institutional Review Board; STUDY00000852).

Consent for publication

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Competing interests

The authors declare that they have no competing interests.

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Understanding situational factors and conditions contributing to suicide among Black youth and young adults

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ABSTRACT

In 1897, sociologist Émile Durkheim published in his book the first body of research on the social causes of suicide. His research challenged the notion that suicide potential factors are limited to psychological or emotional conditions and found a link between suicide and an individual's social connectedness to one's society as a member of a collective group. Since this early work, there has been limited research focusing on suicidality and conditions that undermine the sense of belongingness to one's society. The current study examines suicidality among inner-city Black adolescents and young adults, the link to the social problem of discrimination, and the unique ways that it may behaviorally manifest in this population. This systematic review explores high-risk behaviors through a culturally sensitive framework that can be conceptualized as signs of suicide risk, intent, and behavior among this population. Further, the authors expand on the traditional method of suicide; the act of intentionally killing oneself, to examine the cultural function of a proposed form of suicide, victim-precipitated homicide, whereby individuals unconsciously or consciously aid in their own death through self-destructive behavior or violent confrontation (Chance et al., 1998; Parent & Verdun-Jones, 1998). A goal of this review is to shift away from the original view of victim-precipitated homicide which focused on the victim and instead examine the factors that perpetuate the psychological conditions that propels the behavior. The aim of this review is to shed light on cultural and situational forces that facilitate the risk of self-harm in Black adolescents and young adults. More importantly, this review also explores the need for improvements in the screening, detection, and prevention of suicidality that may be identified as high-risk or aggressive behaviors that result in violent death among this population.

1. Introduction

In its most basic form, suicide has been defined as the purposeful killing of oneself and conceptualized as the end result of a complex interaction involving neurobiological, psychological, social, and cultural factors that impact an individual (Parent & Verdun-Jones, 1998). According to the American Foundation for Suicide Prevention (2020), suicide increased from 14 individuals out of 100,000 in 2017 to 14.2 individuals out of 100,000 committing suicide in 2018 and is the 10th leading cause of death in the United States. Although suicidal behaviors have been studied for many years, less is known about risk factors for suicide among some racial and ethnic minorities (Cheref et al., 2015). Suicide has become a rising concern within the Black community in particular (Burr et al., 1999; Chance et al., 1998; Crosby & Molock, 2006; Ramchand et al., 2008) although the rates of classified suicides among Black individuals are relatively low in comparison to many other racial/ethnic groups (American Foundation for Suicide Prevention, 2019; McKenzie et al., 2003). Notwithstanding this fact, the rate of suicide has increased over the past decade. In a recent study, researchers found that the suicide rate among Black children between 5 and 11 years

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old doubled between 1993 and 2012 relative to their White counterparts whose rates declined during the same period (Bridge et al., 2015). Moreover, suicide among the Black population overall increased from a rate of 6.61 to 6.69 per 100,000 individuals (American Foundation for Suicide Prevention, 2020), which urge a broader understanding of suicide in this population (American Foundation for Suicide Prevention, 2019; Anderson, 1999; Bridge et al., 2015; Price & Khubchandani, 2019). We also propose to move beyond the traditional symptomatic lens and consider the psychological features of suicide through a social-cultural lens for Black youth and young adults. In doing so, one can then consider the psychological impact of discrimination juxtaposed with the culturally specific stigma of mental health, particularly for Black individuals, which discourages traditional methods of suicide. In response, we propose that elements of the idea of "victim precipitated homicide" in the context of behaviors not normally associated with suicide may be reexamined. Exploring these less typically associated suicidal behaviors may be of critical importance when discussing a culture that tends to avoid acknowledging the need for mental health treatment and the guilt and stigma of intentionally killing oneself.

Traditionally, in order to label a death as suicide, it must be deliberate and done to oneself with the intention to cause death (Claassen et al., 2010). For racial minority youth, a broader conceptualization of suicide is needed relative to conventional ways of thinking. The term "victim precipitated homicide" is a broader concept of suicide that refers to a victim unconsciously encouraging their own death by having a violent confrontation with the alleged murderer (Chance et al., 1998). Victim-precipitated homicide can be perpetuated deliberately, rather than unconsciously, and an individual can play an intentional role in causing their own death (Parent & Verdun-Jones, 1998), suggesting there could be some point for intervention by the mental health community. It should be noted that the authors acknowledge the problematic nature of this terminology and recognize the view that victim precipitation theory functions as a sort of victim blaming, as argued by some scholars (Eigenberg & Garland, 2008). It is not our intention to perpetuate victim blaming ideology, as our goal is not to advocate for assigning responsibility to any individual for their own victimization. Instead, we are proposing that clinicians recognize the larger external, situational and cultural conditions as well as bias that make it difficult for Black youth and young adults to be viewed as needing help and/or to recognize that 'help-seeking' is an option.

The research literature points to many psychosocial risk factors for suicide including mental health, stigma, discrimination/social circumstances, religious views, and chronic trauma exposure (Cheref et al., 2015; McKenzie, 2012; Parent & Verdun-Jones, 1998). However, these factors may require a more unique, culturally sensitive conceptualization of suicide that take the realities of a Black inner-city youth and young adults' environment into consideration (Cheref et al., 2015; McKenzie, 2012; Parent & Verdun-Jones, 1998). Additionally, the collective history of discrimination for Blacks as a group factors into the discussion regarding suicide risk, and both the desire for and access to mental healthcare (Goodwill et al., 2019).

With respect to access to help, it has been documented that the healthcare system within the United States disproportionately underserves minorities (Berchick et al., 2019). Further, there is also a long-standing stigma associated with seeking mental health treatment within communities of color (Conner et al., 2009; Keating & Robertson, 2004; Ward & Heidrich, 2009). This is especially the case for Black communities who have historically been found to internalize this stigma, and also are disproportionately pathologized by mental healthcare systems (Conner et al., 2009; Keating & Robertson, 2004; Ward & Heidrich, 2009). Moreover, Black people are not likely to receive quality care when mental health treatment is sought out given the long-standing disparities within the healthcare delivery system. In other words, Black people are less likely to seek mental healthcare, in part because of the healthcare field's inadequate attention and care to the unique needs of this community, which results in an internalized and culturally driven aversion to mental healthcare (Alvidrez et al., 2008; Mills, 2012; Wahby et al., 2019).

Sue and Sue (2016) noted that mental health professionals (MHPs) and the psychology field contribute to the status quo of oppression in several ways: (a) there is a lack of sufficient multicultural content in education and training of MHPs to adequately prepare providers to serve and understand diverse group; (b) there is biased and inaccurate information in the mental health literature to properly identify what might be normal or abnormal for diverse groups; and (c) there is a failure to treat social problems (or tailor the scope of services to the client's life experiences of oppression). Given this information, it is proposed by the current authors that providers may tend to mischaracterize behavior of Black youth because they misunderstand what is normative. Further, a behavior that might otherwise lead to a classification as a "danger to self or others" in a White individual is missed altogether or mischaracterized as merely outward directed aggression.

In agreement with Sue and Sue (2016), we set out to challenge the traditional way of thinking about suicide and ask the reader to do the same. We propose that the psychological features of suicide potential for Black youth and young adults are more of a slow suicide pathway in the face of racial/ethnic discrimination that creates existential anger, anxiety (e.g., unable to manage the imperfect or unjust world), depression (e.g., unable to manage the emotional heaviness of hurt and harm), or other mental health concerns that impair insight or judgment to recognize there is a problem and/or see options beyond self-harm. The longstanding reality of stigmatizing individuals with mental illness and the cultural pressure to be strong (and not weak) uniquely compromises Black youths' health and well-being as well as put them at risk for suicide by way of victim-precipitated homicide.

Suicide is not unique to any one cultural group albeit the rate of prevalence varies by racial and ethnic groups. The authors of the current article propose, however, that the typology of suicide is different for racial and ethnic minorities due to the psychological stressor of discrimination and the cultural norms, beliefs, and attitudes centered around mental health. Black people, in particular, have a unique relationship in America given the institutional laws, policies, and practices specifically designed to oppress them since their arrival to the United States over four hundred years ago. Thus, we propose that the enduring, perpetual nature of oppression is a unique stressor and risk factor for Black youth and young adults to understand in the context of suicide potential.

The purpose of this systematic review is to expand our understanding of how suicide risk, intent, and behavior are exhibited by Black adolescents and young adults. First, the methodological approach for this review of the literature is presented. Then, a critical overview of the relevant research on suicide among Black adolescents and young adults is provided. This overview is organized into four domains that represent what is currently known about suicide by Black youth and young adults: (a) social factor of discrimination, (b) post-mortem interpretations of Black suicide risk and (c) function or intent of "victim-precipitated homicide" as a form of suicide. An expanded definition of "victim-precipitated homicide" is proposed and used as a framework to facilitate the understanding of suicidality among Black adolescents and young adults. Lastly, (d) an argument is made that a more culturally relevant lens could help improve screening and detection, and subsequently aid in the development of more effective prevention strategies in order to reduce premature violent death in young Black adults and adolescents.

2. Methods

2.1. Search and exclusion process

For the purpose of this systematic review, a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) model was utilized to reduce the risk of bias throughout the selection process (Moher et al., 2009). For the sources to be considered for eligibility, they

must have met the following criteria: (a) examine suicide risk, intent, and behavior and (b) discuss suicide among Black adolescents and young adults.

To obtain sources for this systematic review, sources were identified through an electronic literature search utilizing *PsycINFO*, *Google Scholar*, the *Criminal Justice Database*, *MEDLINE database in the National Library of Medicine*, *National Institute of Health using Entrez PubMed*, *Embase*, *Cochrane Central Register of Controlled Trials*, *Cumulative Index of Nursing and Allied Health Literature*, *Social Sciences Citation Index*, *Science Citation Index*, *Art and Humanities Citation Index*, and *Conference Proceedings Citation Index*. Articles in the English language were identified and all duplicate sources across databases were eliminated. Boolean search terms and operators included: *African American*, *minority*, and *Black* along with the lexical forms of *victim-precipitation*, *suicide*, *behavior*, *plan*, *ideation*, and *youth* to identify specific articles. For the purpose of this review, the majority of the following search strings comprised of: *African American* and *victim-precipitation*; *African American*, *youth*, and *suicide*; *Black*, *minority*, and *victim-precipitation*; *Black*, *youth*, and *victim-precipitation*; *Black*, *youth*, and *suicide*; *Black*, *youth*, *suicide*, and *ideation*; and *minority*, *youth*, and *victim-precipitation*.

2.2. Inclusion and exclusion criteria

For a source to be included within this review, they must have been published between 1950 and 2019. Sources from both peer-reviewed and non-peer-reviewed journals were included in this review. For inclusion, studies must have addressed suicidal ideation, suicide attempts, risk factors related to suicide, victim precipitation, "suicide by cop," or completed suicides related to Black youth and young adults. If the article addressed these components within their main research questions, reported findings, or were included as an essential variable, they were deemed eligible for this systematic review.

However, theses, dissertations, book chapters, books, and studies that were not in English or within the publication date range were not included within this systematic review. Any source that did not specifically mention or focus on the Black population with relevant information regarding suicidality or risk factors were excluded from this review. It is important to note that over the past 50 years published psychological research highlighting race has been rare (e.g., overall, less than 5% of articles from social, developmental, and cognitive psychology journals), and is due to systemic and implicit biases during the publication process when the topic of race is raised in research (Roberts et al., 2020). Unfortunately, this also contributes to the dearth of research on

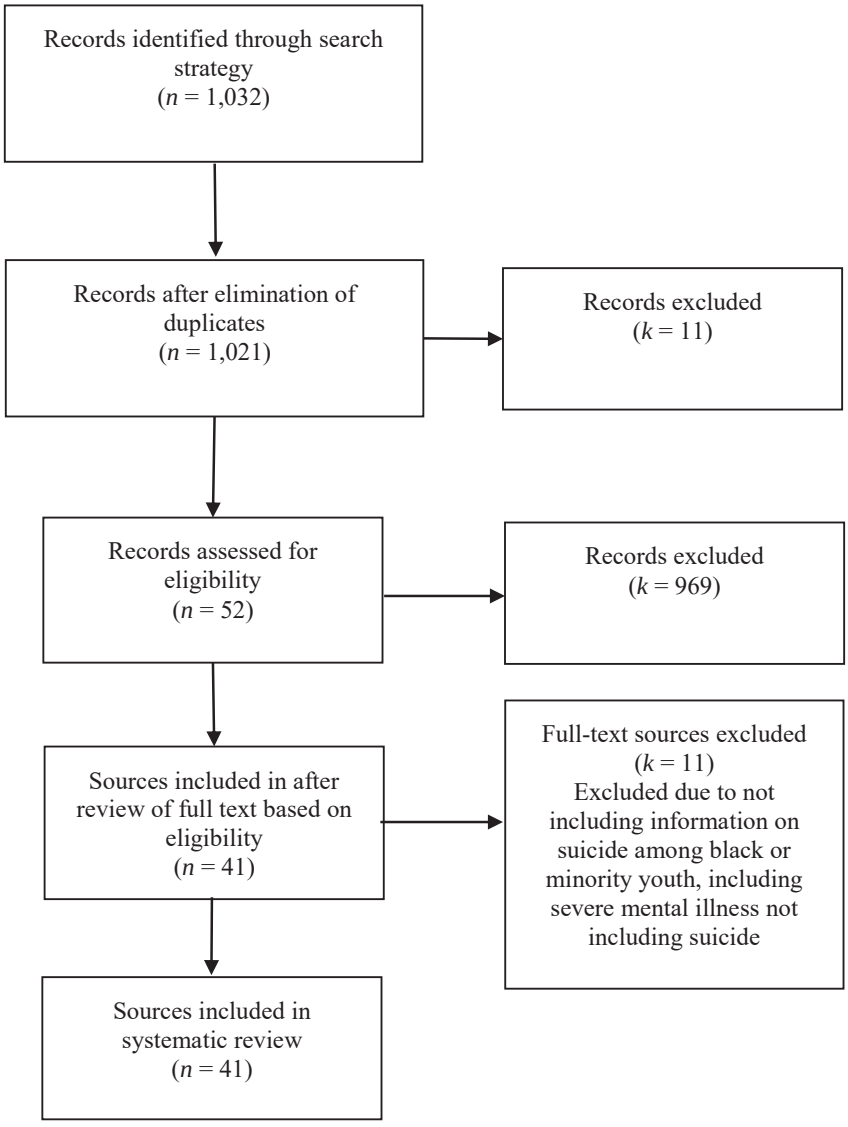

Fig. 1. PRISMA flow diagram.
Note: The above figure provides a layout of the selection of the article and reports included within this review adapted from Moher et al.' (2009) PRISMA diagram.

the Black population.

2.3. Assessment of relevance and evaluation of quality

A step-by-step process was utilized by the authors to select articles for review (see Fig. 1). Once articles were selected through the aforementioned screening process, the remaining full text articles were read to identify whether they fully met inclusion criteria. The authors met to discuss any discrepancies and confirm agreement of the final selection of articles. Overall, there were 41 sources that warranted inclusion in this systematic review, including 39 empirical articles and two reports.

3. Results

3.1. The social factor of discrimination as a risk factor

3.1.1. Psychological effects

One could define the aim of discrimination is to restrict resources and opportunities from individuals from specific groups based on their social identity (i.e., age, gender, race, ethnicity, sexual orientation, religion, ableness). It is then not surprising that discrimination creates marginalization, unfair treatment, stress, and the loss of self-agency and connectedness to the world. For Black youth specifically, discriminatory practices that limit their opportunities and create race-related stress include marginalization or limited resources (Goodwill et al., 2019; Neblett et al., 2006), harsher sanctions in school for behavioral problems relative to their White counterparts (Prelow et al., 2004; Society for Research in Child Development, 2009), as well as being the victim of, or witness to police brutality (Allen & Solomon, 2016). Being treated unfairly because of one's race can be psychologically harmful and can lead to lethal violence towards one's self (Burr et al., 1999; Cheref et al., 2015). Moreover, the mindset of anger, rage, and/or hopelessness in response to discrimination and inequities can be accelerating risk factors for suicidal ideation and behavior, especially for Black males (Walker et al., 2017).

In a study conducted by Goodwill et al. (2019), a significant relationship was found between depressive symptoms and suicidal ideation among Black males who experience everyday forms of racial discrimination. Although the study was conducted with an adult population, the findings have implications for the developmental trajectory of adolescents who experience race-related stress. In fact, Patcher et al. (2018) found that depression and anxiety were associated with discrimination among African American and Afro Caribbean youth. Furthermore, Chance et al. (1998) suggested that the race-based stress of discrimination can lead youth to internalize these frustrations and fall into self-destructive behavior.

In many ways the connection between stress and discrimination is not fully understood for Black individuals because research is limited on sociocultural risk factors for suicide. However, stress has been consistently cited in the literature as a risk factor for adolescent suicide. For example, many studies have identified interpersonal losses such as the death of loved ones, break-ups, or peer rejection, while others emphasize the stress of academic demands and family (Amitai & Apter, 2012; Spirito & Esposito-Smythers, 2006). It stands to reason that stress-inducing sociocultural risk factors are present as racial discrimination creates bidirectional conditions that shape the way racial minority youth are treated and, in turn, how they eventually begin to see themselves and their place in the world (Chance et al., 1998). Historically, being a racial minority in the United States has meant living with some level of pain or stress due to institutional systems of oppression that hinder achievement opportunities and educational advancement (Chance et al., 1998).

3.1.2. Mental health stigma

Fox et al. (2018) provided the Mental Illness Stigma Framework (MISF) to conceptualize the processes that lead individuals to either refuse to seek help or the healthcare system's refusal to provide help. The authors described three mechanisms used by health care providers that can be used to explain differential and biased assessment/treatment in the mental health context when working with some racial/ethnic minorities: *Cognitive mechanism* whereby stereotypes, prejudices, and negative beliefs about individuals with mental illness are formed as part of social conditioning (e.g. dangerousness, weakness). These beliefs trigger the *affective mechanism* in which there are the emotional reactions stemming from the stereotypes, prejudices, and negative beliefs including fear, anger or pity. The affective reaction then facilitates the *behavioral mechanism* such that there are discriminatory behavioral reactions generated from stereotypes, prejudices, and negative beliefs, such as refusing to help individuals, avoiding them, segregating them, and providing unfair differential treatment. Fox et al. (2018) also noted research on the intersection of race whereby racial minorities are viewed as more dangerous and seen as needing more segregation in comparison to their white counterparts. In sum, we conclude as Fox et al. (2018) that research on mental health stigma and the health care system points to how racial minorities are discouraged from seeking help and in turn untreated mental health concerns are exacerbated.

3.2. Post-mortem interpretations of Black suicide risk

As early as the 1980s, externalizing behaviors were associated with suicide. For instance, in an early study by Apter et al. (1988), youth diagnosed with conduct disorder had higher suicide potential than their same age counterparts diagnosed with major depression. Higher levels of conduct disorder have also emerged as a significant predictor of suicidal ideation and attempts among youth in substance abuse treatment. Additionally, conduct disorder in conjunction with depression has positively predicted subsequent both suicidal ideation and plan (Chance et al., 1998; Ramchand et al., 2008). Moreover, research revealed that racial discrimination is associated with depression, violence, suicide, and other types of maladaptive externalizing behaviors among Black individuals (Hope et al., 2015).

Failing to consider conduct-related behaviors as possible psychological effects of racial discrimination may undermine the detection of suicide risk among marginalized, racial minority youth. Further, through a sociocultural lens, it is suggested that symptoms of anger, rage, and/or hopelessness can manifest itself among Black youth and young adults in overt and covert self-harming behaviors (Chance et al., 1998). It should be noted that among marginalized, racial/minority youth, behaviors that are seen as aggressive and antisocial often result in their own violent deaths but are not yet classified as suicides, even though the death is reflective of self-destructive, high-risk behavior that has many of the theoretical underpinnings of suicidality. For instance, two of the current authors (DP and KC) worked with court involved Black youth and recall youth who have dared someone to shoot them in the midst of an argument and later reported feeling hopeless and no longer cared if they lived or died. The lack of identification of suicide may be due to implicit bias (Snowden, 2003), which leads mental health practitioners to normalize high-risk and violent behavior with Black clients that would raise a red flag to them if the same behaviors were reported by a White client (Fadus et al., 2019).

3.3. Function or intent of "victim-precipitated homicide"

Discrimination is a unique risk factor for racial and ethnic minorities as an external force that creates stressors, mental health challenges, and undermines self-agency to navigate the world. We also propose that mental health stigma and the taboo of suicide are cultural dynamics within racial and ethnic minority groups that can lead some to engage in high-risk conflict that can result in death to remove their psychosocial "pain" as opposed to a traditional form of suicide, thereby avoiding the cultural shame of having a mental illness or being seen as 'weak.' Homicide can be self-inflicted as the victim may have purposefully put

themselves in harm's way (Muftic & Hunt, 2012). These homicides may appear subtle but are rather obvious expressions of risk-taking behavior intended to be self-destructive and classified as a "passive" suicide (Chance et al., 1998; Muftic & Hunt, 2012).

In "victim-precipitated homicides," the victim provokes their own death in a way. When attempting to control feelings of worthlessness and aggressive impulses, youth may turn to suicidal behavior as well as engage in risky behaviors resulting in death not typically classified as suicides (Chance et al., 1998; Crosby & Molock, 2006). As such, these events could be understood as suicides disguised as other forms of reckless behavior. We acknowledge it is difficult to always know the victim's mindset about death and suicidality ex-post facto and many types of high-risk behaviors can be conceptualized in this manner. Nonetheless, we argue that not all, but some particular culturally specific forms of risky behavior could be conceptualized as suicidal risk or intent, especially among inner-city Black adolescents and young adults. For instance, brandishing weapons, confronting rival gangs alone, returning to known target areas when they could have sought safe refuge instead. The problem in the mental health field is providers may not consider how violent behavior that threatens one's own safety may be a subtle attempt to die or bring about one's demise. Interestingly, when compared with White individuals, completed suicides by Black individuals were more likely to have originated from violent behaviors related to homicides and were less likely to be methods typically viewed of suicide like self-inflicted gun-shot wounds or overdoses (Chance et al., 1998; Copes et al., 2002; Johnson et al., 2019).

A specific type of homicide called "crime-precipitated homicide" is an extension of "victim-precipitated homicide." This is best defined as the victim being "killed while participating in illegal behavior" (Copes et al., 2002), although the degree to which the victim plays a role in their own demise can vary. For example, death can be the result of one failing to take precautions either verbally or physically, which, in turn, can provoke violence. An individual who is focused on self-destruction that engages in criminal behavior can easily accomplish their goal of death through interaction with law enforcement, also known as "suicide-by-cop" (Johnson et al., 2019; Klinger, 2001). Through the aforementioned methods, suicidal individuals from certain cultural groups, more specifically Black youth and young adults, are able to facilitate their own killing in a manner that shields one from the burden of the guilt and stigma associated with the traditional methods of suicide (Goldston et al., 2008). This also is based on the premise that certain racial/ethnic minorities frown upon suicide and "mental health" problems viewing them as culturally unacceptable and as a sign of weakness (Klinger, 2001; Mills, 2012).

Additionally, Crosby and Molock (2006) used Spaights and Simpson's (1986) frustration-aggression hypothesis to explain the rising suicide rate for Black males who may externalize their aggressive impulses and have higher rates of violent crimes, such as homicides (Crosby & Molock, 2006). If one includes homicides on a continuum with suicidal behavior, rates of self-inflicted deaths for Blacks increase exponentially, possibly because they are over-burdened by poverty, unemployment, and other sociocultural factors which contribute to violence (Chance et al., 1998; Crosby & Molock, 2006). These factors taken together help explain a linkage between some of the homicides in marginalized Black communities and suicides.

3.4. Culturally responsive approach to screening and intervention

While victim-precipitated homicide is not yet a recognized as a form of suicide, it is a distinct category of lethal violence that needs further empirical study. As noted previously in the body of this paper, however, such framing must not overlook the situational conditions of racial discrimination and cultural factors unique to Black youth and young adults that are barriers to seeking and utilizing help. Further, suicide and homicide are closely related through self-injurious risky behavior. Partaking in aggressive and antisocial behaviors as a male youth is a strong predictor of suicide, while homicide is the seventh cause of death for Black individuals (Heron, 2019; Ramchand et al., 2008). The sociocultural understanding of suicide and possible less overt means of suicide could be obscured by homicides that happen as a result of crime and conflict in urban neighborhoods.

A culturally responsive approach is needed in the screening of suicide risk among Black youth and young adults. Victim-precipitated homicide or crime-precipitated homicide are not clinical terms nor do the terms capture the primary problems connected to suicide among this population. However, a conceptual framework that appreciates the situational conditions and cultural phenomena to understand suicide is important when working with marginalized, minority youth and young adults with severe externalizing behavioral problems. Not only are situational conditions such as racial discrimination and mental health stigma historically grounded and culturally relevant, but they also help to establish how risk-taking and aggressive behavior may in fact be self-destructive and, at times, can be classified as suicidality if its function is to die while avoiding the shame of suicide or it is too daunting to overcome mental health stigma. Issues of aggression, rage, and risky behaviors accompanied by reported feelings of hopelessness and an empty fatalistic view of the future, which at times is a response to neighborhood conditions and race-related discrimination/stress, may be red flags for suicide risk and is gleaned in the literature (Chu et al., 2013).

4. Recommendations

We propose that a culturally sensitive protocol to assess harm to self must be grounded in best practices and include research-based indicators of emotional disturbance (i.e., depression, helplessness, anxiety), ideation, plan, access to weapons, and prior attempts. Building on best practices in accordance with Sue and Sue (2016), the current authors note it is important to assess stressors in the person's life that might be fueling the intense feelings, including the experience of being a racial minority and the degree to which safety and the ability to trust are intact or threatened as a result. In this context, we propose hopelessness and isolation are important to assess, particularly in the context of community violence, marginalization, and discrimination to understand the impact of sociocultural conditions and the source of the crisis.

Other culturally relevant factors to assess include understanding how the individual experiences acts of discrimination and explore feelings, thoughts, capacity to connect to others, and a sense of loss of control based on lived experiences. It is also important to assess how the individual generally copes, views help, and seeks help, in order to gauge the strategies employed by the individual to deal with stress as well as any potential feelings of guilt, shame, and/or stigma that might be a barrier to utilizing mental health treatment, as suggested by much of the research regarding help seeking behaviors among minority populations (Sheehan et al., 2018). Cultural and community influences are also important to determine. More specifically, we propose the assessment should also include inquiries about support systems that encourage and/or discourage behavioral health treatment. Lastly, it is important to assess the individual's lifestyle and elicit responses to understand the type, severity, and self-reported reasons for engaging in any reckless, aggressive, or self-destructive behaviors. It might also be important to consider risk for crime-precipitated homicide type of action if the motivations for the behavior are to avert from emotional pain and there is guilt and stigma associated with more traditional methods of suicide.

Similar to screening for suicide risk, interventions should be culturally responsive. Initial intervention efforts would ideally employ traditional best practice approaches of crisis management to reduce imminent harm. Once the individual is more stabilized, we propose that is important to address issues that give rise to suicidal thoughts and/or reckless behavior due to emotional pain likely to result in death. In a cultural context, this might include strengthening the family functioning or support networks. Additionally, it is important to treat the mental

health concerns that result from the impact of racial discrimination to improve the person's overall functioning. The treatment focus can include: (a) creating the space to process discriminatory events; (b) helping to understand the impact of discrimination on the individual; (c) building the coping capacity to manage the impact of racial discrimination and how to handle discriminatory situations; (d) helping to identify areas of control or ways to contribute to racial change and engage in acts of empowerment; (e) figure out ways to overcome the stigma associated with mental health treatment; (f) helping to promote a healthy sense of self shaped by fact-based information regarding the individual's history; and (g) problem-solve how to foster a sense of safety without the use of violence or self-destructive behavior. As such, trauma-informed care also might be needed. Furthermore, we suggest it would be beneficial to expand the individual's support network to include community interveners (e.g., mentors, outreach workers, advocates) who specialize in disrupting interpersonal conflicts and community violence. Black youth and young adults who feel hopeless or traumatized by their environmental conditions and discrimination can benefit from this type of support to learn how to problem-solve and navigate the conditions around them (Walker et al., 2017).

5. Conclusion

There is a dearth of literature examining suicide through a framework of victim-precipitated homicide despite its potential connection in some communities as laid out by the authors in this paper. Limited research is available on this topic, with one of three main articles being released in the past ten years and the other two being significantly older. Overall, the existing literature does not touch upon non-explicit suicidal or "at risk" actions pertaining to victim-precipitated homicide. It is suggested that suicide risk assessments should be standardized to include marginalized, racial/ethnic minorities with the awareness that cultural differences often make it less likely that individuals from these groups would disclose suicidal ideation as mental health stigma is prevalent (Chu et al., 2013).

Additionally, there needs to be complete recognition and acknowledgement of various minority groups with significant attention paid towards cultural issues when assessing for suicidal thoughts and behaviors (Goldston et al., 2008). Chu et al. (2013) found that the Cultural Assessment of Risk for Suicide (CARS) is a valid measure of cultural suicide risk factors. The CARS is the first measure to operationalize a systematic model accounting for cultural competency across multiple cultural identities in suicide risk assessment efforts. To help with identifying specific risks across various cultural groups, the measure was developed through the use of the Cultural Theory and Model of Suicide. Moreover, the measure provides a broader generalization of minority stress that CARS may assess suicide risk factors related to cultural contexts that are applicable for the general population. Nonetheless, further research on suicidality among minorities, particularly Black youth and young adults, and an expanded, modernized victim precipitated homicide framework is required moving forward.

5.1. Limitations and future directions

Throughout this systematic review, the authors noted a lack of research on concepts that consider situational conditions that are culturally relevant phenomena to understand suicide when focusing on the young Black population. Most of the existing research on suicide focuses primarily on White and adult individuals. This made it difficult for the authors to locate information about suicide among Black youth and young adults. Given the limited research, it is essential to note the importance of the need for more research in this area.

Furthermore, it is important to focus research on mental health stigma to understand the barriers and meanings to acknowledging and seeking mental health treatment among racial and ethnic minorities. Along similar lines, research to understand the creation of stigmatizing attitudes and behaviors among healthcare providers is equally important to address racial disparities in treatment among racial and ethnic minorities.

Based on the limited research that was reviewed, there is evidence that demonstrates the need for early interventions and research on this topic, specifically for Black youth within urban areas. As many researchers have noted, there is a significant connection between violence and the development of depression (Robinson et al., 2011). To understand more about this connection and to prevent "victim-precipitated homicide," or situational precipitants that propel suicide, more research is needed to develop the appropriate interventions and identify specific risks that can help determine when interventions need to be implemented. Research is also needed to understand the views on suicide from racial and ethnic minorities within an ecological framework to better understand the continuum from suicide to homicide and the cultural nuances for culturally responsive screening and interventions.

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APPENDIX C3

Perspectives and Voices from Connecticut Youth

1. Comments shared by Sean Reeves, Sr., Co-Founder, S.P.O.R.T. Academy
2. Hartford Communities That Care (HCTC) Youth Leaders' Problem-Solving Framework
3. Letter from Representative Robyn Porter, 94th Assembly District; Member, Juvenile Justice Policy and Oversight Committee

Youth Comments
Provided by Sean Reeves, Sr., Co-Founder, S.P.O.R.T. Academy

These comments were shared by youth in New Haven, CT, who may have entered or worked at the Hazel Street Community Garden in Newhallville or attended one of the S.P.O.R.T. Academy Chess giveaway events when asked about the problems they face daily.

- *Neighborhood youth are behind and do not understand the work in class (high school).*
- *Youths project that the embarrassment of being made fun of in class for not knowing the work makes them decide to skip class and/or act out to get into trouble and leave class.*
- *"Skipping school is the only option not to be made fun of."*
- *"My Mom doesn't understand, If I am forced to go to school I am bullied and made fun of."*
- *"I act up at school or "make trouble" in the hallways so it takes the attention away from me not being able to do the schoolwork."*
- *There is nothing for us kids to do.*
- *No opportunities to make money. No jobs for young kids.*
- *No safe places to hang out.*
- *Peer pressure is real!*
- *"I have home issues – My mom be out all night sometimes with her friends really late and I stay up waiting for her to come home, so that I know she is safe."*
- *"I don't get much sleep at night, so I get in trouble for falling asleep in school."*
- *Youth expressed having challenges at home with being sexually abused and or afraid of the violence that takes place inside of the home.*
- *Youth expressed issues such as: "If I like a girl on the other side of town. I know I am taking a chance to be shot and killed just to see her. So, I have to carry a gun and be ready to shoot or be shot just going from one side of town to the other. This shouldn't be."*
- *No sports opportunities.*
- *No gyms to go to for basketball.*
- *No basketball courts that are safe.*
- *There are a lot of neighborhood issues – people don't like each other and at odds with each other. Territory issues.*
- *No entertainment – so stealing cars, riding dirt bikes and ATVs through the city is fun.*
- *No one cares about us.*
- *No enjoyment.*
- *No social activities.*
- *I never been out of New Haven.*

The Greater Hartford Youth Leadership Academy at Hartford Communities That Care (HCTC) helped develop and still uses the problem-solving framework illustrated on the following pages. Youth have used this approach to study their exposure to gun violence – and to build recommendations for preventing gun violence.

Adjusting to the pandemic, HCTC's Raising Youth Voices podcast series and region-wide youth summit meetings have kept up the momentum of youth leadership development using the Zoom platform and other video tools.

The program link is **hartfordctc.org**

Youth Summit Teams' 2019 Recommendations

Following Up with Rep. John Larson, Rep. Rosa DeLauro, and Sen. Chris Murphy

May 30, 2019

A Synopsis of Hartford Youth Gun Violence Research:

The Youth Leadership Academy Violence/Trauma, Poverty, and Education Teams'

2019 Recommendations

The Greater Hartford Youth Leadership Academy at Hartford Communities That Care (HCTC) on May 23, 2019 presented its latest set of recommendations to Rep. John Larson and his congressional colleagues. The work grew out of an analysis of root causes and local conditions related to high rates of gun violence, poverty, and chronic student absenteeism in Hartford. As highlighted by this synopsis, the youth followed a four-stage problem-solving process created by their predecessors, in conjunction with the Community Anti-Drug Coalitions of America (CADCA).

The 2019 recommendations were part of the program at the May 18, 2019, "Raising Youth Voices" Summit, which also featured discussions of the additional issues of teen pregnancy, entrepreneurship and financial/business skills development, and the importance of positive role-model mentoring.

Earlier, as detailed in a March 26, 2018 news release containing the full text of last year's recommendations for Alleviating Poverty, Equalizing Education, and Preventing Violence and Trauma, the youth joined forces with the March For Our Lives movement last year to bring an urban violence perspective to the recurring issue of school shootings tragedies. Those recommendations were presented in 2018 to the Hartford City Council and to the State and congressional delegations as part of March For Our Lives protests in Washington, D.C., and Newtown, CT.

Youth leadership development in these efforts is dedicated to "raising youth voices" by acquainting them with the processes of gathering and communicating evidence based research – activities that will stand the youth in good stead later in high school, in college, in careers, and in their civic involvement.

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Youth Summit Problem-Solving Teams

Facing a Problem by Asking "But Why?" and "Why Here?"

The Problem

_____

Data:
_____

(Root Cause)

But why?

1) _____

2) _____

Data:
_____

(Local Conditions)

But why here?

1a)

1b)

2a)

2b)

(Recommendations)

Strategies/ Interventions

Provide Information:

Enhance Skills:

Provide Support:

Enhance Access/Reduce Barriers:

Change Consequences:

Change Physical Design:

Modify/change policies:

Note:

These stages reflect the problem-solving process used by the Greater Hartford Youth Leadership Academy teams in their preparation for the May 18 Youth Summit. The process is adapted from the Community Anti-Drug Coalitions of America (CADCA). Samples from the Violence and Trauma, Poverty, and Education Teams' activities are on the following pages.

C357

Youth Summit Violence & Trauma Team 1

Facing a Problem by Asking "But Why?" and "Why Here?"

The Problem

High Rate of Gun Violence in Hartford

Data:
Hartford averages 120+ Shooting Victims Every Year *(Hartford Police Department)*

(Root Cause)

But why?

1) Easy Access to Weapons

Data:
In the U.S., there are more guns than autos, and more stores to buy guns than there are coffee shops. *(CAGV)*

(Local Conditions)

But why here?

1a) Involvement in Drug Trade

1b) Untreated Trauma among Violence Victims

Data:
More than half of untreated gunshot victims are shot again within five years – and 20 percent of those are killed (American College of Surgeons, 2017)

(Recommendations)

Strategies/ Interventions

Provide Information:

Create a massive, broad-reaching public awareness campaign to prevent and reduce gun violence

Provide Support:

1a) Deliver support services to peers and families impacted by violence

1b) Enhance access to treatment for victims and their families

Modify/change policies:

(1) Enact gun reforms that discourage interstate straw purchases of illegal guns

Key Question:

How can we prevent survivors from being re-victimized?

More than half of gunshot victims are shot again; 20 percent of those are killed (American College of Surgeons)

C358

Youth Summit Violence & Trauma Team 1

Facing a Problem by Asking "But Why?" and "Why Here?"

The Problem

High rates of gun violence in Hartford

Data:
Concentrated poverty and trauma in urban communities

(Root Cause)

But why?

1) School-to-Prison Pipeline

Data:
Average reading proficiency of Hartford students, Grades 3-8, is less than half the statewide average

(Local Conditions)

But why here?

1) Black boys as young as 10 are stereotyped as less innocent (and viewed as older) than their peers

Data:
Black males born in 2001 had a 32 percent chance of going to prison in their lifetimes

(Recommendations)

Strategies/ Interventions

Provide Information:

Publicize positive youth resources such as recreation, clubs, workshops, and leadership programs

Enhance Skills:

1) Hire new teacher role models for students of color – and train existing staff

1) Create and sustain parent support groups and student mentoring programs

Modify/change policies:

(1) Recognize best practices of schools with restorative justice programs – and limited law enforcement use in schools

Note:

This sample illustrates the problem-solving process used by the three Greater Hartford Youth Leadership Academy teams in their preparation for the May 18 Youth Summit. The process is adapted from the Community Anti-Drug Coalitions of America (CADCA).

C359

Youth Summit Poverty Team 2

Facing a Problem by Asking "But Why?" and "Why Here?"

The Problem	(Root Cause) But why?	(Local Conditions) But why here?	(Recommendations) Strategies/ Interventions
High Rate of Poverty in Hartford Data: 33.9 percent of Hartford residents live below the poverty rate.	1) Zero, Low or Stagnant Incomes Data: 31 percent of residents have not worked in more than a year.	1a) High Cost of Renting Homes 1b) Limited job opportunities Data: Homeownership rate in Hartford is 26 percent	Enhance Skills: *1b) Expand workforce and career training opportunities for youth and adults* Enhance Access/Reduce Barriers *1b) Invest in the creation and support of local entrepreneurs* Provide Support: *1a) Increase affordable housing opportunities for low-income residents* Modify/change policies: *1) Increase the minimum wage* *1b) Invest in high-quality child care and preschool for the children of job trainees and workers*

Key Question:

What earnings will cover food, housing, and childcare?

73 percent of Hartford residents are struggling to meet basic needs, unable to cover the state's high cost of living (NE and Central CT United Way)

C360

Youth Summit Poverty Team 2

Facing a Problem by Asking "But Why?" and "Why Here?"

The Problem

High Rate of Poverty in Hartford

Data:
33.9 percent of Hartford residents live below the poverty rate.

(Root Cause)

But why?

1) Unemployed and Part-Time Workers, and Single-Parent Families Can't Get Ahead

Data:
The 7.8 percent unemployment rate in Hartford is the highest in the state.

(Local Conditions)

But why here?

1a) The cost of living and working is a stretch for most Hartford households

1b) One-third of families do not have enough food

Data:
73 percent of Hartford households struggle to meet basic needs*

(Recommendations)

Strategies/ Interventions

Provide Information

1a) Develop and sponsor income creation and job opportunity workshops to help build residents' assets and wealth

Enhance Access/Reduce Barriers

1b) Recognize and support merchants who sell healthy, fresh, and affordable food

Provide Support:

1b) Link restaurants, grocery stores, and farmers to afterschool programs, schools, and food pantries

Modify/change policies:

1) Expand the Earned Income Tax Credit

1) Give families lee way to apply for government assistance – and promote availability of benefits (SNAP, WIC)

Note:

* The regional ALICE data reflect Asset Limited, Income Constrained, Employed households; those that earn more than the federal poverty level but less than the cost of living (for housing, child care, food, transportation, and health care, etc.). Hartford has the largest percentage (73%) and highest number of combined ALICE and poverty-level households in the region (45,845).

C361

Youth Summit Education Team 3

Facing a Problem by Asking "But Why?" and "Why Here?"

The Problem

Chronic Absenteeism in Hartford Schools

Data:
Statewide, 10.7 percent of students are chronically absent; the rate in Hartford is 39 percent

(Root Cause)

But why?

1) Lack of Engaging and Meaningful Instruction

Data:
Gaps in Hartford students' reading and math scores; lack of tutors, social work, and guidance staff; overall disparities compared to CT

(Local Conditions)

But why here?

1a) Teachers can't relate to students' exposure to trauma

1b) Poor school climate and unsafe school

Data:
Overwhelmingly white teacher corps in heavily minority school district; 29 percent High School dropout rate

(Recommendations)

Strategies/ Interventions

Provide Information:
Implement a city-wide campaign showing the lifetime value of education

Enhance Skills:
1a) Train teachers on the impact of trauma and high levels of stress on academics

Change Consequences:
1b) Ensure fair and effective disciplinary practices and in-school suspension; offer extracurricular activities that motivate students to stay in school

Modify/Change Policies:
Ensure hiring and training of teachers who reflect – and can connect with – students

Note:

State data from the Smarter Balance Assessment Consortium (SBAC) compare reading and math performance between Hartford schools and schools district- and state-wide. A separate test, the SAT, focuses on high school students' college readiness. On both tests, an extremely low percentage of Hartford students score at the "proficient" level.

C362

Youth Summit Education Team 3

Facing a Problem by Asking "But Why?" and "Why Here?"

The Problem

Absenteeism in Hartford Schools

Data:
Statewide, 10.7 percent of students are chronically absent; the rate in Hartford is 39 percent

(Root Cause)

But why?

1) Mental Distress and Trauma

Data:
See Crime, Violence, and PTSD Statistics

(Local Conditions)

But why here?

1a) High rates of peer, home, and community violence

1b) Academic failure due to out-of-school discipline practices

Data:
See school district data on student suspension and expulsion.

(Recommendations)

Strategies/ Interventions

Provide Information:

1) Educate parents, teachers, and students on the impact of trauma and high stress levels, through PSAs, town halls, and assemblies – and public leaders' advocacy

Enhance Skills:

1a) Offer trauma training to the business and faith communities – and families – to gain understanding and volunteer support

Change Physical Design:

1b) Ensure safe routes to school (well-lit and monitored by caring adults)

Modify/Change Policies:

1b) Adjust school discipline to hardships interfering with family and student success

Note:

With more than 100 shootings per year – for two decades – thousands of Hartford residents are victim, family member, loved one, friend, and community sufferers of trauma ... which is lifelong and often untreated.

State of Connecticut
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CHAIR
LABOR AND PUBLIC EMPLOYEES COMMITTEE

MEMBER
APPROPRIATIONS COMMITTEE
JUDICIARY COMMITTEE

December 21, 2021

Dear Dr. Violano:

As a voting member of the Juvenile Justice Policy and Oversight Committee (JJPOC), co-chair of the JJPOC Education Subcommittee, the co-chair of the Labor and Public Employees Committee, and member of the Appropriations and Judiciary committees, I have championed several key pieces of legislation that support restorative justice with tools that foster respect, dignity, and equitable treatment. My focus has been and continues to be concentrating our efforts to reduce and prevent crime, gun, and gang violence by implementing alternatives to incarceration with the long-term objective of creating policies that address the root causes by means of restoration, not incarceration.

Undoubtedly, I do believe in order to accomplish this goal and to have the outcomes that we all desire we MUST have those closest to the problems at the table so that as we seek solutions, we will have the valuable (and oftentimes missed) input of those directly impacted. There is so much power and revelation in story. That is why I felt compelled to share the following with the Gun Violence Intervention and Prevention Advisory Committee, and why I counted it all joy when I received an invitation from Trel Morrison who heads a program called *Daniel's Company Youth Leadership Mentoring Program* to attend and listen to a group of youth regarding their views and thoughts on the spike in gun violence occurring specifically here in New Haven.

The Youth Forum was held at Wilbur Cross High School in New Haven, CT and came at a very crucial moment in time. The following is what was captured from the student-led dialogue showcasing the perspectives of some highly discerning youth who attended the forum. The youth who participated were sophomores, juniors, and seniors from multiple schools throughout the district. The following information identifies what they see as the existing problems contributing to increases in gun and community violence in the state and offers a variety of solutions and needs assessment that can help to mitigate gun and community violence in Connecticut.

Problem

- Poverty
- Lack of mental health services ***
- Loopholes in gun laws/requirements
- Wealth gap
- School to prison pipeline and industrial complex
- All systems interconnected
- Affecting kids from young age and desensitizing them
- Violence starts to feel normal
- Militarization of police
- School Resource Officers and metal detectors in schools
- Criminalization of youth
- Taught not to share emotions
- Numb to violence

Need

- Sustainability
- Meeting basic needs/Accessibility
- Better communication skills
- Social supports
- Attack problem at its root
- Nurturing in education
- People from community involved with youth
- Stability
- Places for kids to go
- Programs to support kids who are affected by gun violence
- More community conversations
- Increase awareness of resources/supports
- Change the conversation

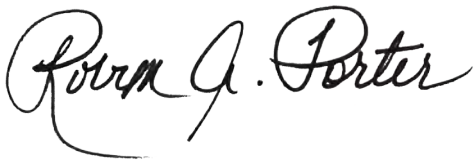
Solutions

- Background checks
- Tracking guns
- Better regulations on guns
- Police interactions
- More accessible resources to meet needs
- Pay teachers more
- Address issues at its root
- Incentives for community members to stay
- Address systemic issues
- Multiple youth centers to support everyone
- Minimize weapons carried by police
- Remove metal detectors

- Adopt new practices and approaches. Stop using approaches from the past, it's not working-outdated
- Stop criminalizing students before they even commit a crime
- Youth Town Hall: Food & breakout rooms led by youth
- Centralized platform to access youth resources (i.e., Therapists)
- Social Workers should initiate community meetings
- Create culture of family/community within school

In closing, it is my fervent hope and prayer that what has been shared here from the mouths of our youth will not fall on deaf ears but will be instrumental in developing a strategic plan to effectively and equitably address the on-going issue of gun violence and crime in our communities. Truly, it is time for us to put our resources and money to work in a way that invests in our youth-at-risk, restoring them to what I affectionately refer to as our "youth-at-promise."

Respectfully submitted,



Representative Robyn A. Porter, 94th District