CURE VIOLENCE GLOBAL
CITY OF ANNAPOLIS
ASSESSMENT
AUGUST 8-12, 2022

OBJECTIVE OF ASSESSMENT VISIT

The Cure Violence Global (CVG) Training & Technical Assistance Team conducts assessment visits to determine if local political will and capacity exists to implement the CVG model. The assessment visits are conducted by engaging stakeholders, community organizations, and individuals to familiarize them with the CVG model, to review data to determine potential target areas, develop partnerships, meet with possible workers, and develop potential program structures for future implementation. Specifically, the assessment seeks to determine the following:

1. Is there a governmental or non-governmental agency with the capacity and will to implement the CVG model with fidelity?

2. Does official and unofficial data exist about violent incidents to focus, monitor, and measure the implementation of the model?

3. Does official and unofficial data exist about the nature of violent incidents to determine if the CVG model is appropriate?

4. Does official and unofficial data exist to create criteria to identify the highest risk target population for focusing implementation?

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

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

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

Due to the COVID pandemic, CVG adapted the assessment process to include several virtual meetings to minimize the number of “in person” meetings required to complete the assessment.

CVG worked closely with the City of Annapolis, and Anne Arundel County Department of Health over the course of several months to complete the assessment through the four distinct phases which included (1) CVG 101 Informational meetings for a broad range of stakeholders including government agencies, service providers, and community-based organizations, (2) Smaller stakeholder meetings with a subset of attendees of the CVG 101 presentations; (3) In person visit to Annapolis, MD which took place August 8-12, and then the (4) Determination of next steps with the submission of the assessment report. The schedule of the “In person visit” included:

Monday August 8th Agenda:

I. 9:30am - 10:30am Stakeholder Session: Officials (Mayor's Office, CE's Office, Legislators)
II. 11:00am - 12:00pm Introductory Session: Cure Violence 101 Hybrid
III. 12:00pm - 12:30pm Partner Social
IV. 1:00pm - 5:30pm Neighborhood Tours 30-60 minutes max per site (five sites)
1:00 pm - 2: 00 pm Clay Street
2:00 pm - 2:45 pm Newtowne
3:00 pm - 3:45 pm Robinwood
4:00 pm - 4:45 pm Eastport
5:00 pm - 5:30 pm Bay Ridge Gardens

Tuesday August 9th Agenda:

I. 10:30am - 11:30am Stakeholder Session: County Agencies (MHA, AACPS, DSS)
II. 12:00pm - 1:00pm Stakeholder Session: Gun Violence Intervention Team (GVIT)
III. 1:00pm - 2:30pm Stakeholder Session: City Agencies (NAM, LEAD, OCS)
IV. 2:30pm - 3:30pm TBD
V. 3:30pm - 4:00pm Stakeholder Session: Annapolis Office of Emergency Management

Wednesday August 10th Agenda:

I. 9:00am - 10:00am Stakeholder Session: Police Departments
II. 10:00am - 11:00am Stakeholder Session: Partnership for Children, Youth and Families
III. 11:00am-12:00pm Lunch
IV. 12:00pm - 1:00pm Stakeholder Session: Housing Authority of the City of Annapolis
V. 1:00pm - 2:00pm Stakeholder Session: Annapolis Recreation and Parks Department
VI. 2:00pm - 3:00pm Back-up Stakeholder Session
Open to all partners who are unable to attend their stakeholder session.
VII. 3:00pm - 3:30pm Annapolis Allstars
VIII. 3:30pm - 4:00pm Bay Ridge Gardens Management 4:30pm - 5:30pm Stakeholder Session: Healthy Families and Community Development

Thursday August 11th Agenda:

I. 9:30am - 10:00 am Stakeholder Session: Faith-based Leaders
II. 10:00am - 11:00am Stakeholder Session: Charting Careers
III. 11:00am - 11:30am Stakeholder Session: Small City Big Dreams
IV. 11:30am - 12:00pm Stakeholder Session: H20 4 L.I.F.E Clubhouse
V. 12:00pm - 1:00pm LUNCH
VI. 1:00pm - 1:30pm Stakeholder Session: Newtowne CDC
VII. 1:30pm - 2:00pm Stakeholder Session: Street Angel Project
VIII. 2:00 pm - 2:30 pm Stakeholder Session: We Care & Friends
IX. 2:30pm - 3:00pm Stakeholder Session: Seeds4Success
X. 3:00pm - 3:30pm Stakeholder Session: People Builders
XI. 3:30pm - 4:00pm Stakeholder Session: Community Action Agency

CURE VIOLENCE GLOBAL BACKGROUND

For more than 20 years, Cure Violence Global has successfully worked to reduce violence in some of the most violent communities in the United States and around the world, advancing a new health paradigm on violence and a scientific approach to preventing it. This approach is grounded in an understanding that violence exhibits hallmarks of an infectious disease. It behaves with a contagious nature; it is acquired and biologically processed, perpetuated through social norms and peer reinforcement, and can be prevented using disease control methodology.

Like an epidemic disease, violence clusters and spreads geographically (Slutkin, 2013; Zeoli, Pizarro, Grady, & Melde, 2012). Many types of violence are transmitted between individuals, including child abuse (Widom, 1999), community violence (Bingenheimer, 2005; Spano, Rivera, & Bolland, 2010), intimate partner violence (Ehrensaft, Cohen, & Brown, 2003), and suicide (Gould & Kramer, 2001; Gould & Lake, 2013). Furthermore, violence can transmute -- exposure to one form of violence increases not only the likelihood of engaging in that type of violence, but others as well. For instance, exposure to community violence has been shown to increase one's risk of perpetrating domestic violence (Abramsky, et al., 2011) and exposure to war violence one's risk of engaging in community violence (MacManus, et al., 2013).

Research further demonstrates a transactional relationship between suicide and other forms of violence, with a history of violence increasing one’s risk of suicide and a history of suicidality increasing the propensity for engaging in other types of violence (Van Dulmen et al., 2013).

The Cure Violence Global model is based on the World Health Organization’s epidemic control approach for stopping the spread of infectious diseases such as AIDS, cholera, and tuberculosis. The model advances a prevention methodology to identify and detect violent events; interrupt, intervene and reduce risk of their occurrence; and change the behaviors and norms that perpetuate violence.

This method begins with epidemiological analysis of the clusters involved and transmission dynamics, and uses several new categories of paraprofessional health workers to interrupt transmission to stop the spread and to change norms around the use of violence. Central to this approach is the use of workers viewed as trustworthy and credible by the population being served. This is best accomplished by hiring workers who are from the same community and have had similar life experiences (i.e., community health workers). Workers are trained as disease control workers, similar to tuberculosis workers, and receive extensive training in methods of mediation, behavior change, and norm change.

Cure Violence Global has extensive experience bringing its health-based violence prevention model to scale in Chicago and working with implementation partners to bring the model to scale in other cities.

The model is currently being implemented in more than 50 sites in 25 cities in 10 countries (currently, Mexico, Honduras, El Salvador, Colombia, Argentina, Trinidad and Tobago, South Africa, Canada, Syria, the West Bank, and the United States). While many cities have multiple program sites, the largest scaling of the model to date has occurred in New York, which began as one program site in Brooklyn and has now expanded to more than 30 Cure Violence program sites in nine cities throughout the state. This expansion was made possible in part through the success of the initial seed program, which was found to be high effective at reducing violence in an independent evaluation. The evaluation's findings provided policymakers with the evidence needed to support the program, which now receives more than $20 million in annual funding from state and local governments.

For a number of reasons, model adaptation is eminently scalable. As it has evolved, the Cure Violence approach to model adaptation and diffusion lends itself to replication and scalability. Because Cure Violence has developed an approach rather than a program, per se, and does not typically implement the model directly, it develops extensive training materials and protocols to guide each implementation and adaptation and has a robust training and technical assistance initiative to oversee model implementation nationally. Cure Violence's replication approach calls for the identification of and collaboration with local partner organizations that have the capacity, credibility, and desire to operate a local program, with Cure Violence providing start- up training, ongoing technical assistance, a peer learning network, and process evaluation to ensure fidelity to the approach.

As noted, the Cure Violence Global model is derived from epidemiological disease control methods. Three main strategies are used in reversing infectious epidemic processes: (1) detecting and interrupting ongoing and potentially new infectious events; (2) determining who are most likely to cause further infectious events from the infected population and then reducing their likelihood of developing disease and/or subsequently transmitting; and (3) changing the underlying social and behavioral norms, or environmental conditions, that directly relate to the spread of the infection (Nelson and Williams, 2007; Heymann, 2008).

The Cure Violence Global method begins by examining the clusters involved and transmission dynamics, and uses several new types of disease control workers -- including violence interrupters and outreach behavior change agents -- to interrupt transmission (or the contagion), to stop the spread of the violence disease, and to change underlying norms. Workers are trained similarly to tuberculosis or HIV/AIDS workers to help find cases and ensure that persons are sufficiently rendered noninfectious (albeit in the case of tuberculosis through the use of antimicrobial agents) (Slutkin, et al., 2006). However, tuberculosis outreach workers also require the use of persuasion (e.g., for taking medications) to ensure that effective change is occurring. Cure Violence Global disease control workers are trained in modern methods of persuasion, behavior change, and community norm change — all of which are essential for limiting the spread of outbreaks of violence. The principles underpinning the approach derive from current knowledge of social psychology and brain research, just as the principles for controlling other infectious diseases stem from understanding their underlying mechanisms and patterns of flow.

One of these principles involves employing persons from the same "in-group" as change agents, which reduces defiance and engenders trust, credibility, and access. A number of cognitive processes are sensitive to group membership and for assessing "us" or "them" (Mathur, Harada, Lipke, & Chiao, 2010; Bruneau, Dufour, & Saxe, 2012), and determining whether someone is working in your own interest or not. Behavior change is enhanced through the use of credible messengers, as well as ensuring that the new behaviors are acceptable, doable (i.e., potential barriers to engaging in the behaviors are mitigated), and feel right socially. Messages need to be constructed to include new information about the behavior and new skills to be practiced and to trigger positive rather than negative reactions from peers.

Changing norms is done most effectively by bringing some of these practices to scale, and by questioning existing norms and proscribing new norms at population levels. As thoughts, behavioral scripts, and norms are transmissible, new scripts and norms are developed and a new set of behaviors becomes the norm.

Interruption is essential; however, brain processes, including preexisting emotional dysregulation as well as continued peer pressures to belong, remain problems if unattended to or untreated.

In community violence implementation sites, trained health workers called violence interrupters and outreach workers (in some adaptation these positions are combined) prevent violence by identifying and mediating potentially lethal conflicts in the community (violence detection and interruption), and following up to ensure that the conflict does not reignite. Whenever a shooting happens, trained workers immediately mobilize in the community and at the hospital to cool down emotions and prevent retaliations – working with the victims, friends and family of the victim, and anyone else connected with the event. Workers also identify ongoing conflicts by talking to key people in the community about ongoing disputes, recent arrests, recent prison releases, and other situations and use mediation techniques to resolve them peacefully. Workers follow up with conflicts for as long as needed, sometimes for months, to ensure that the conflict does not become violent.

Outreach Workers also work intensively with a caseload (15 - 20) of the highest risk individuals to decrease the use of violence (behavior change of highest risk) by establishing contact, meeting them where they are at, developing trusting relationships, talking to them about the consequences of engaging in violence, teaching alternative responses to violence triggers, and helping them to obtain the social services and community resources they need such as job training, employment, and drug treatment, to shift their violent trajectory.

Finally, workers engage leaders in the community as well as community residents, local business owners, faith leaders, service providers, and at-risk individuals, promulgating the message that violence should not be viewed as normal but as a behavior that can be changed (norm change). Whenever a shooting occurs, workers organize a public response during which dozens of community members voice their objection to the shooting. Workers also coordinate with existing and establish new block clubs, tenant councils, and neighborhood associations to build social cohesion and promote community safety. And, they distribute materials and host events to convey the message that violence is not acceptable.

The Cure Violence Global model has undergone 11 independent evaluations to date, all of which have reported statistically significant reductions in violence. A John Jay College of Criminal Justice evaluation of two New York City neighborhoods operating Cure Violence programs from 2014 to 2016 found steeper declines in acts of gun violence and increases in the expression of pro- social norms compared with similar neighborhoods not operating Cure Violence programs. The study found reductions across all measures, including a 63% reduction in shootings in one community, a 50% reduction in gunshot wounds in the other, less support for the use of violence, and greater confidence in police. An evaluation in three Philadelphia Police Service Areas found that the Cure Violence program was associated with a 30% reduction in the rate of shootings. A 2014 evaluation of two Chicago Cure Violence program neighborhoods showed a 31% reduction in homicides and a 19% reduction in shootings in targeted districts. A 2009 Northwestern University evaluation found that the model was associated with 16-34% reductions in shootings and 46-100% reductions in retaliatory homicides. A 2012 Johns Hopkins University evaluation found that Safe Streets, Cure Violence's partner in Baltimore, reduced killings up to 56%, and shootings up to 44%. In a study released by Arizona State University in 2018, the adaptation of the Cure Violence model in East Port of Spain, Trinidad found "Based on a series of quasi-experimental designs using three independent data sets maintained and updated by different entities…found that the Cure Violence intervention was associated with significant and substantial reductions in violence."

ASSESSMENT FINDINGS

Cure Violence Global was able to determine that city of Annapolis and Anne Arundel County Department of Health have the capacity to successfully implement the CVG model. Below are brief descriptions of the findings of the assessment for each element which is required to implement the CVG model successfully.

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

Yes, CVG was able to determine during the assessment process that city of Annapolis and Anne Arundel County Department of Health have the capacity and political will to implement the CVG model with fidelity. City of Annapolis and Anne Arundel County Department of Health established a multi-agency Cure Violence Steering Committee which met on a weekly basis to fully support the assessment process.

Members of the steering committee invested considerable amount of time and resources to the process and have demonstrated the highest levels of capacity to organize, convene, and work with the diverse set of government, community, and individual stakeholders required to implement the CVG model.

The Cure Violence Steering Committee members and affiliations are below:

Cate Pettit	Office of the Mayor
Adetola Ajayi	Office of the Mayor
Dr. Nilesh Kalyanaraman	Anne Arundel County Department of Health
Tonii Gedin	Anne Arundel County Department of Health
Isabella Young	Anne Arundel County Department of Health

If city of Annapolis and Anne Arundel County Department of Health decides to move forward with the implementation of the CVG program, it has the capacity to serve as the administrator or "Implementation Partner." As the Implementation Partner, the city and or Anne Arundel County Department of Health would be responsible for subcontracting to a community-based organization, collaboration with other City and County departments, and coordination of CVG training and technical assistance. CVG would also strongly recommend that the Cure Violence Steering Committee continue to meet regularly to ensure successful collaboration and coordination of violence prevention efforts as well as add additional members from other agencies.

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

Yes, CVG was able to determine that City of Annapolis/Anne Arundel County Department of Health exceeds the data requirement for the CVG model to be successful. Anne Arundel county Department of Health provided data for the assessment which demonstrated the ability to capture, focus, monitor measure, and ultimately report on the impact of the CVG model at the community level. The available data identifies chronic "hot spots" to the level of area where shootings and killings have persisted for several years to focus the intervention.

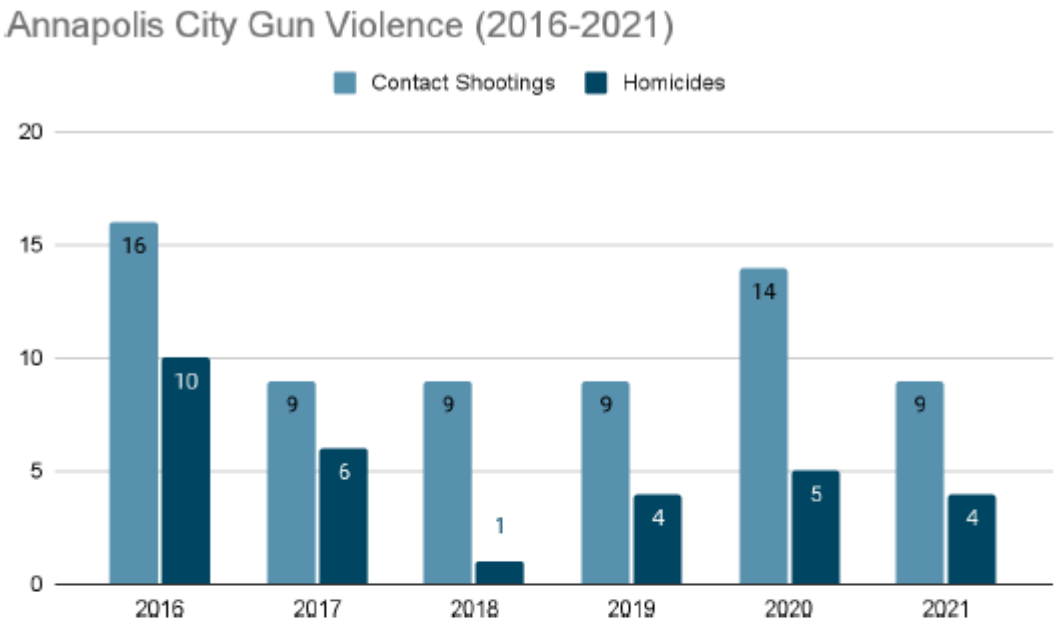
Annapolis City GV Data

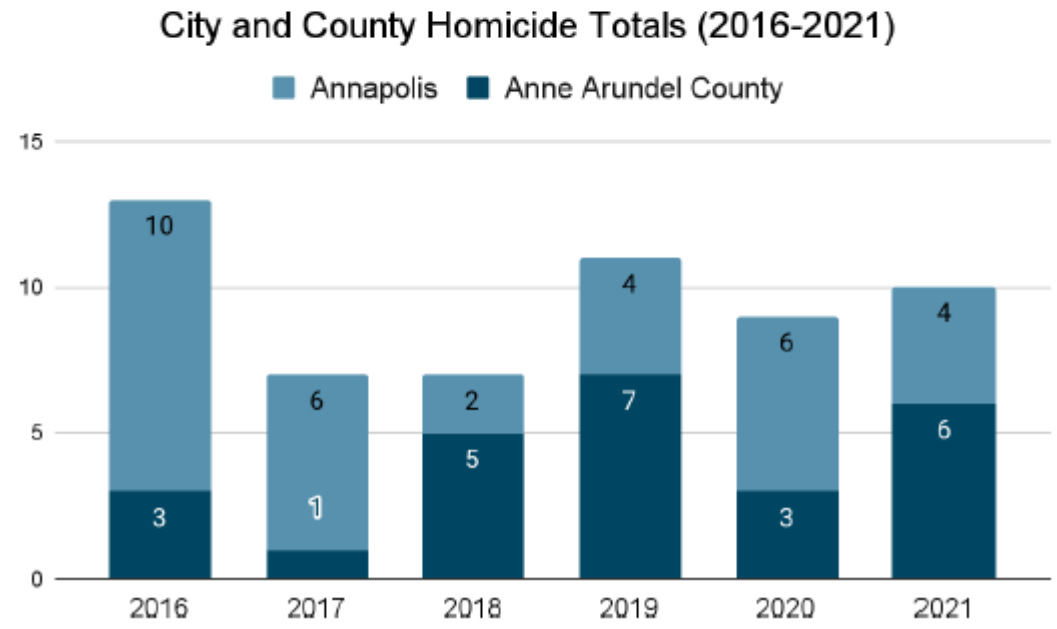
Source: Annapolis Police Department incident report data (2016-current).

➔ See also: [GVIT Data Dashboard](#).

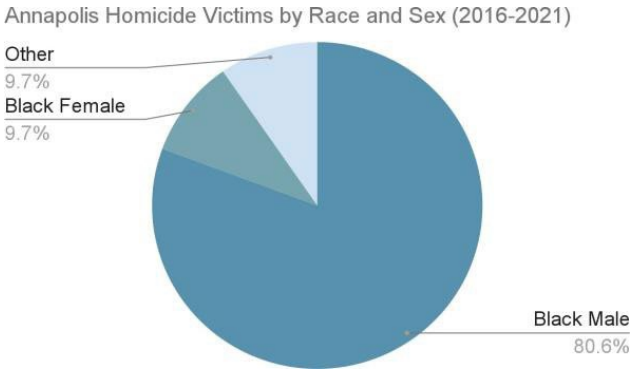
➔ Note: Annapolis county zip codes are included with the city in city/county comparisons.

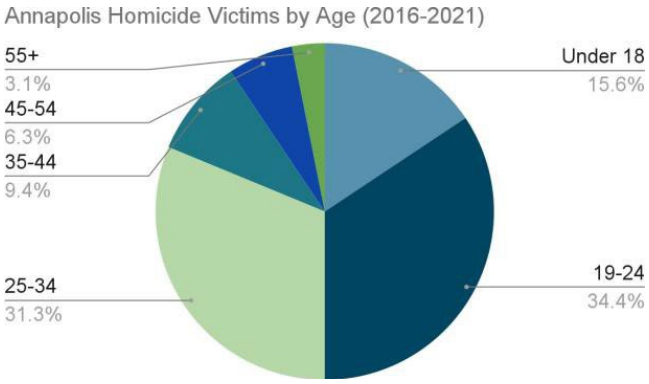
Trends Overtime

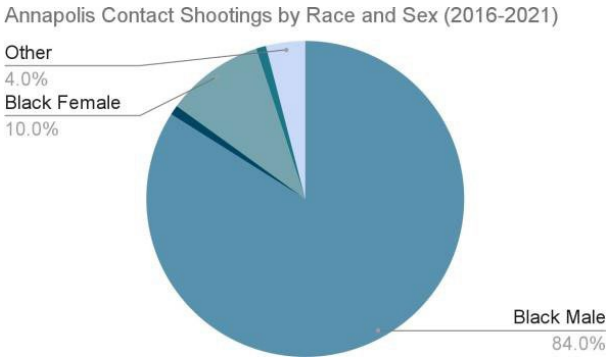


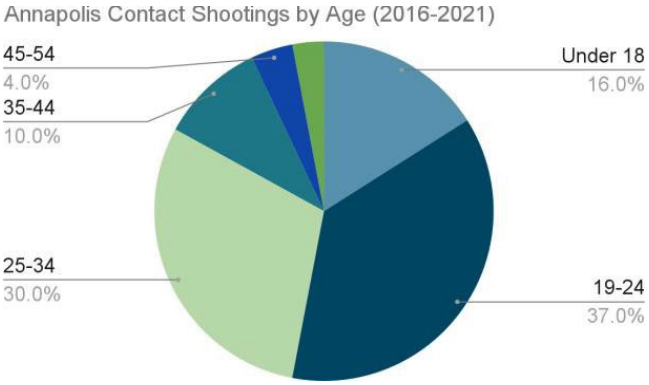


Demographics









The wards with the greatest quantities of gun homicides and contact shootings are Ward 6 and Ward 4, respectively. In order of incidents, the neighborhoods with the greatest quantity are Eastport, Robin Wood, Bay Ridge Gardens and Newtowne Drive (mapped contact shooting and homicide incidents, 2019-2022 YTD).

Each year on average there are 25 reported shots fired in the city (annual average of reported shots fired, 2016-2021). Most of these were reported in Wards 2, 3 and 5.

As can be seen in data there are clear "hot spot" areas. The concentration of Homicides and Aggravated assaults have persisted in these "hot spot" areas for all the years that data was reviewed for the assessment. All conversations during the assessment process confirmed that those "hot spot" areas are the areas with the most persistent violence.

The specific target areas inside city of Annapolis and Anne Arundel County Department of Health which are being recommended to implement the CVG model are Eastport, Clay Street, Robin Wood, Newtowne Drive and Bay Ridge Gardens.

According to data reviewed, conversations held with stakeholders from the areas, and the drives/ride-a- longs throughout in the target area during the assessment it has been determined that the dynamics of the "hot spots" are appropriate and consistent with other areas where the CVG model has been implemented. These dynamics included the existence of individuals and groups associated with violence (gangs, crews, clicks, etc.), high levels of social and economic inequity, illegal drug activity, and high levels of robberies and other crimes.

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

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

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

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

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

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

CVG was able to meet with several individuals and organizations including Charting Careers, Small City Big Dreams, Street Angel Project, We Care & Friends, People Builders, H2O-4 Life, Healthy Families and Community Development Network, Partnerships for Children, Youth and Families, Annapolis Allstars as well as city agencies such as Police department, LEAD, NAM, OCS, Office of Emergency Management, Housing Authority of the city of Annapolis and GVIT including county agencies MHA, DSS, Parks and Recreation Police department which have demonstrated great concern and commitment to the community throughout the course of the assessment process in City of Annapolis. They have a wide range area of work which included some violence prevention, health-based programming, community engagement, legal services, large and small activities for the community, provision of supportive services, mental health services, re-entry work, life skills, sporting activities for youth, mentorship programs, food, and clothing distribution.

As an example, one organization which CVG was able to spend time with during the assessment process was We Care & Friends. We Care & Friends mission is "dedicated to supporting the building blocks to create strong families and communities in areas affected by drugs, poverty, and crime in Maryland." It is our charge to display leadership in a manner that will cultivate skills, enhance talent and present positive role models to young people..." said Shelton Willett." CVG was able to observe that We Care & Friends has a mission in alignment with the CVG model, has strong ties to the community, appear to be viewed as credible, would potentially be able to assist in the recruitment of potential target areas, willing to hire individuals with criminal backgrounds, history of work with high-risk youth, and organizational experience in program implementation. The concern about We Care & Friends as well as the other Community-Based Organizations (Small City Big Dreams, People Builders Consultants, H2O-4 Life) would be the financial oversight of the program with federal dollars, however, We Care & Friends did express that they have received money that required reporting outcomes to city previously.

It is not uncommon that organizations with the best relationships with the highest risk in the target area do not have the full capacity to provide fiscal oversight. Additional support for administration may be needed to bolster existing candidate organizations. In CVG's experience that can be achieved through a fiscal agent or housing the program in larger organization. Some cities have worked with organizations like the Urban League to serve as the fiscal agent.

Other cities have decided to "house" the program in a health department or similar institution. In this instance, the managers, violence interrupters, and outreach workers are state/county employees and implement the model as such as part of an existing department or division. Hiring practices and other HR considerations must be mapped out clearly to ensure that no barriers are put in place which preclude hiring staff that meet the criteria.

If City of Annapolis and Anne Arundel County Department of Health decides to move forward with CVG model, CVG will work with them to provide sample "Requests for Proposal" which can be included in any local procurement procedures to make the decision which community-based partner is selected to implement the program, as well as if the city of Annapolis and Anne Arundel County Department of Health decides to keep the program "in-house" CVG will work with helping to identify the managers, violence interrupters and outreach workers.

Hospital Based Program

In many cities CVG either works directly or closely with hospital-based violence intervention programs that work to use this unique point of intervention to prevent retaliation, re-injury, and provide individuals with necessary resources. As part of the assessment process CVG was able to meet with staff from hospital, (Barry Meisenburg, Mike Renoll, and Andrew McGlone) and was advised by them that the Level 1 gunshot wounded victims (GSW) go to Shock Trauma unit in Baltimore and that it would not make sense to have a hospital responder program due to the extremely low volume of GSW. They reported that if a community-based program is established in Annapolis, they would pass along the information of the contact person at the Shock Trauma unit in Baltimore. With that said, the staff also reported that they would still be on-board with working with community-based Cure Violence team once it is assembled as needed bases.

The CVG hospital responder program is deployed immediately upon a patient's arrival in the emergency room, medical staff contacts the responder (via call, text, etc.) and the responder arrives at the patient's emergency room bedside within the hour as serves as part of the treatment team. Hospital Responders are "Credible messengers" from the community, similar backgrounds to trauma victims, much like the Violence Interrupters and Outreach Workers. They are trained in crisis intervention, trauma-informed care, and de-escalation. They provide immediate intervention to prevent retaliatory violence from family, friends, or the victim. They use persuasive dialogue and motivational interviewing techniques, capitalizing on this potential turning point, to encourage the victim to set a new course. Additionally, they coordinate with the community-based violence prevention programming to ensure follow up and prevention of further violent events. If the local hospital is interested in implementing the CVG Hospital Responders Program, a series of planning meetings would be required to determine the specific protocols internal to the hospital, recruitment and hiring, and coordination with the community-based violence prevention programming.

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

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

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

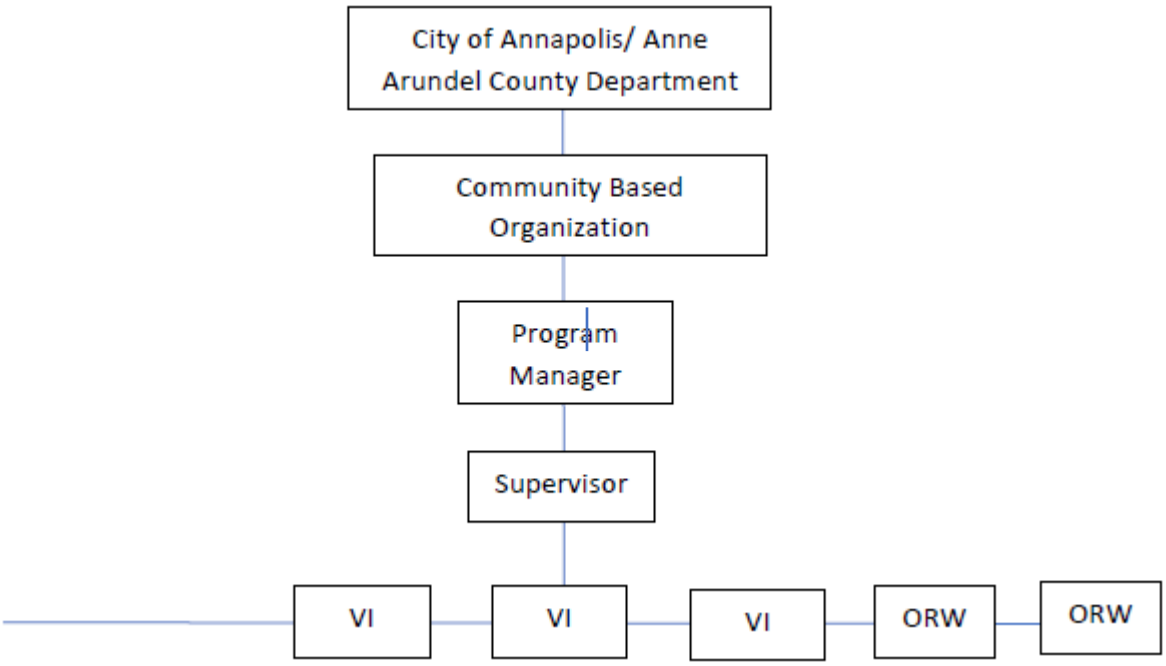
CVG was able to meet with individuals from the "hot spot" communities who clearly fit the profile to fulfill the role of violence interrupters and outreach workers during the in-person site visit in August 2022. CVG is confident that if the city of Annapolis and Anne Arundel County Department of Health moves forward with the model, the selected community-based partner or if he city keeps the program "in-house" will be able to recruit workers who fit the profile to serve as Violence Interrupters and Outreach Workers for city of Annapolis area with specific relationships to reach the highest risk in the Robin Wood, Clay Street, Eastport, Newtowne and Bay Ridge Gardens communities.

(7) Determine initial program recommendations for program size, budget, and ongoing training and technical assistance plan from CVG.

Program Size

Based on the size and the scope of the violence in potential target areas, CVG recommends implementing 2-4 programs of 6-8 staff per program to cover the target areas of Robin Wood, Clay Street, Eastport, Newtowne and Bay Ridge Gardens. This would be considered a "Large" size program due to the amount of recommended programing sites (4). This staffing pattern would include one program manager, one supervisor, three Violence Interrupters and two Outreach Workers. The estimated budget for setting up a program of this size and scope is $564,750.00 a year per individual program site for implementation for a total of $2,259,000 for all four program sites.

Staffing Pattern + Implementation Structure



Sample 1 Year Budget

Below is a sample line-item budget based on other programs which have successfully implemented the CVG model. Local costs and factors will need be considered to finalize the program budget.

LINE ITEMS	YEAR 1
SALARIES (5VI @ 40K;2 OW@; 1 Supervisor @ 50k; Program Manager @ 50K)	**$380,000**
FRINGE (20%)	**$76,750**
UNIFORMS	**$2,000**
COMMUNITY EVENTS	**$20,000**
PARTICIPANT ACTIVITIES/SUPPORT SERVICES	**$20,000**
TRANSPORTATION/TRAVEL	**$4,000**
RENT	**$12,000**
UTILITIES	**$5,000**
MOBILE PHONE SERVICE	**$5,000**
OFFICE SUPPLIES	**$15,000**
PUB ED MATERIAL	**$25,000**
TOTAL	**$564,750**

Cure Violence Technical Assistance Plan

Cure Violence Global proposes the following training and technical assistance (TTA) to ensure the successful implementation of the model in City of Annapolis. The TTA will include (1) assistance with the request for proposal process (RFP) to select a community-based partner to implement the CVG

model, (2) provision of the "onboarding training" for the community based partner and governmental agencies, (3) facilitation of panel interviews to recruit and select the best candidates to serve as front line staff, (4) facilitation of program manager/supervisor training for the management of the community based site, (5) facilitation of Violence Interruption and Reduction Training (VIRT) for outreach workers and violence interrupters, (6) access and use of the Database (which includes weekly data

reports), (7) participation in weekly monitoring phone calls, (8) three booster trainings/site visits, and 24 hour a day 7 days a week emergency assistance. A brief description of each is below:

(1) Assistance with Request for Proposal (RFP) Process:

CVG will provide examples of RFPs used by other cities to select the Community Based Partner. The sample RFP can be adapted to local procurement laws and processes. The RFP review committee and eventually the hiring panel should include community members and leaders identified during the assessment.

(2) On-Board Training:

Two-day onboarding training for community-based partner and governmental oversight agency The two-day Onboarding Training is designed to equip the governmental oversight and community-

based partner with the necessary information and skill associated with the successful implementation of the CVG model. All critical implementation issues are addressed, and specific action plans are developed for the first three to six months of programming.

(3) Recruitment and Hiring of Staff:

To ensure uniform recruitment and hiring practices. The CVG model uses hiring panels to hire all violence interrupters and outreach workers which include representatives from the implementing agency

(i.e., CVC and representatives from health department), community-based partner organizations (CBO), local faith leaders, community residents, and law enforcement, to ensure that the best candidates are selected for each target area. These following are tools which are used to ensure the best candidates are recruited and selected:

(A) The prescreening checklist to ensure that sufficient background work has been done with the potential candidate to determine that they are suitable to serve as a staff member and have a reliable personal support system.

(B) The panel briefing form to assist in educating all members of the panel on the goals and objectives of the hiring panel and their participation to ensure that the strongest candidates are selected (with the least likelihood of relapse).

(C) The implementation of uniform interview questions and scorecards for each staff position to ensure that the selection of a worker is predicated on their possessing the necessary skillset to implement the model successfully.

(D) The use of a panel tracking form designed to ensure the appropriate individuals and institutions are included in the hiring panels.

(4) 40-hour Program Management Training:

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

(5) 40-hour Violence Interruption and Risk Reduction Training (VIRT):

The Violence Interruption and Reduction Training (VIRT) has been developed for outreach workers, violence interrupters, and other administrative staff. It includes a mix of presentation of core concepts and skill development through demonstration and practice. The curriculum is focused on four core areas:

1) Introduction to interruption and outreach, including roles and responsibilities with an emphasis on boundaries and professional conduct; 2) Identifying, engaging and building relationships with participants and prospective participants, assisting participants to change their thinking and behavior as it relates to reducing risk for injury/re-injury and/or involvement in violence; 3) Preventing the initiation of violence or retaliatory acts when violence occurs through mediation and conflict resolution; and 4). Working with key members of the community, including residents, faith leaders and service providers through public education, responses to violence and community building activities.

(6) 16-hour Database Training:

The database training is designed to equip the site with the necessary skills to use Cure

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

(7) Weekly Program Monitoring Meetings (with data reports):

Ongoing support will be provided through monthly conference calls with the site and representatives of the City of Annapolis. These calls will include analysis and review of the weekly data reports. Cure Violence Global TTA staff will also be available to provide immediate crisis response assistance in addition to the scheduled calls, as needed.

(8) Quarterly Booster Training/Site Certification visits:

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

(9) 24/7 Emergency Assistance

The cost of the Training and Technical Assistance is estimated at 15-20% of overall program budget. A scope of work with associated costs of each item and a draft timeline can be provided if the city decides to move forward with the model.

CONCLUSION

Cure Violence Global would like to acknowledge the tremendous support and assistance of the City of Annapolis staff, Anne Arundel County Department of Health staff and the Cure Violence Steering Committee in completing the assessment process. It would not have been possible without the group's tenacity and dedication. CVG strongly believes that there is an opportunity for the model to make a substantial contribution to the City of Annapolis/Anne Arundel County Department of Health overall efforts to reduce violence. CVG will meet with Cure Violence Steering Committee of Annapolis to review the findings of this report and answer any remaining questions.