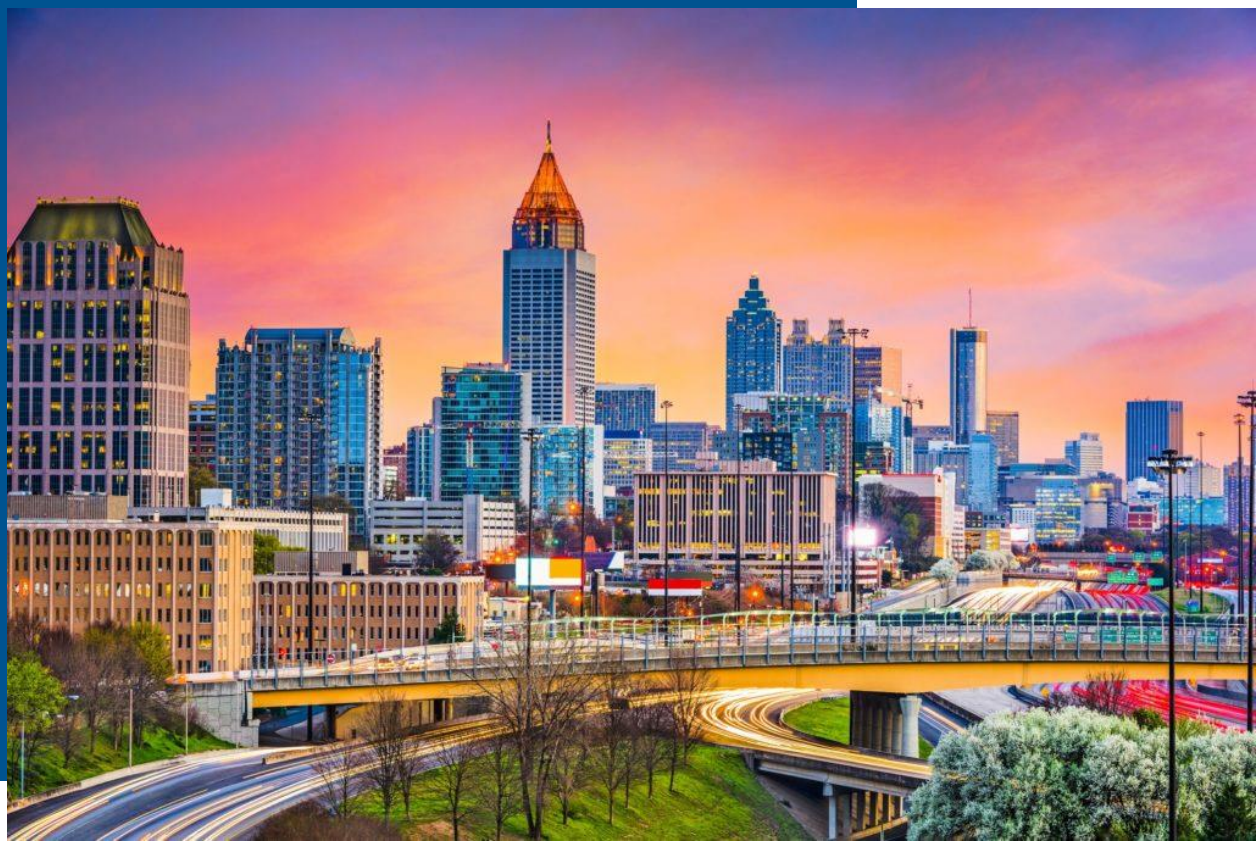

Strategies for
Policing
Innovation

PIVOT ATLANTA

Program to Interrupt Violence thru Outreach and Treatment

FINAL REPORT

September 2021

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ARS
APPLIED RESEARCH SERVICES, INC.

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"Gun violence is a leading cause of premature death in the U.S. Guns kill more than 38,000 people and cause nearly 85,000 injuries each year."

– American Public Health Association

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EXECUTIVE SUMMARY

The Atlanta SPI project provided an opportunity for a multi-disciplinary team to come together to reduce gun violence and retaliatory gun violence through the *Program to Interrupt Violence through Outreach and Treatment* (PIVOT) taskforce and program. This was the first such attempt of this type involving the Atlanta Police Department (APD) and Grady Hospital. The project involved three prongs. The first prong was the delivery of wraparound services and intense follow-up to victims of gunshot wounds through the PIVOT program managed by a dedicated social worker at Grady Hospital. The second prong involved rapid response to shootings and intensive community policing efforts by two dedicated APD PIVOT program officers. The final prong was data sharing which was to include the sharing of APD and Grady Hospital data, implementation of the Cardiff Model, and the creation of hotspot maps to better target areas of violence.

At Grady Memorial Hospital the PIVOT program screened 1,136 shooting patients for eligibility for participation in the program and enrolled 35% (44) of those determined eligible into either the intervention or control group (125 total eligible). Just under one-third were enrolled into intervention programming, thirteen persons. These PIVOT participants received varying wrap around services that included education, employment, mental health, and substance use services along with mentorship from the Community Resource Coordinator funded through this grant.

Two PIVOT officers were deployed into three target neighborhoods with high rates of gun violence, and 272 shifts were logged wherein they engaged in intensive community policing efforts to build trust and repair fractured relations between the community and police. The PIVOT Officers responded within 24 hours of shooting 32 times during the project period. They intervened on 12 occasions to conflicts within the target neighborhood and were able to bring successful resolution in half of those instances. The Officers indicated that three of the twelve had the potential to escalate to a shooting. The officers also helped refer 23 individuals to Atlanta Victims Assistance, which employs victim advocates that are embedded within the Atlanta Police Department.

To build community relationships, the PIVOT Officers in 42% of their shifts interacted with other agencies, organizations, service providers, and/or a PIVOT partner. They participated in food distribution, attended 28 community forums, and contacted code enforcement 53 times in direct response to resident or officer concerns about derelict properties. While community surveys at the start of the project found resident concerns about the responsiveness of the police to the community and their concerns, all community partners interviewed strongly expressed that the PIVOT officers had a positive effect on the community and that their work helped break down barriers, change perceptions, and increase trust in the police.

While he PIVOT program fell short of its original target goals, it greatly succeeded in providing leaders and funders with a clearer picture of what the community needed and what could better meet those needs. A direct result of this was the implementation of a Trauma Recovery Center at Grady Memorial Hospital to continue the hospital-based portion of the project, and funding to implement Cure Violence to provide the rapid response in

the community through interrupters/credible messengers. Cure Violence and the Trauma Recovery Center now work in partnership to bring needed supports and services to gunshot victims and their families.

The program also found success in the lessons learned in implementing a project of this scale with an inter-disciplinary team, which may help other jurisdictions better understand where and how the PIVOT model might be more feasibly implemented. Some key lessons were setting an appropriate social worker/client ratio, preparing the team for the role of the research partner and the importance of fidelity and data collection, staff and management that embrace the ideal of community policing, creating a taskforce atmosphere of respect that encourages the merging of multi-disciplinary viewpoints, and the importance of community involvement in the implementation of initiatives such as the Cardiff Model.

PIVOT Program Recommendations/Lessons Learned

Multi-Disciplinary Taskforce

- Create atmosphere of respect
- Merging of viewpoints
- Multi-disciplinary leadership
- Clearly defined roles/responsibilities

Research Component

- Prepare team for integration of research partner & importance of the role of research
- Consider using a non-HVIP hospital as control group
- Get key leaders involved that can assist with data acquisition

Cardiff Implementation

- Ensure community input
- Share data with community
- Law enforcement agreement to take support role (not suppression)

Community Policing

- Ensure strategy has commitment of leadership
- Flexibility to maximize efforts
- Staff and management that embrace alternative side of policing

Hospital-Based Violence Intervention Program

- Ample staffing to support a reasonable social worker/patient ratio
- Automated system to identify prospective participants for program screening
- Direct management of social work staff by a HVIP operative
- Explore engagement strategies to get participants involved in services
- Services for entire family (when needed)

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TARGETED PROBLEM: GUN VIOLENCE

Gun violence is a serious public health issue in the United States (US). The Centers for Disease Control (CDC) report that there were close to 40,000 firearm related deaths in the US in 2019 alone (retrieved from: https://www.cdc.gov/violenceprevention/firearms/fastfact.html). This equates to 109 people dying from a firearm related injury every single day. In addition to firearm deaths, there are thousands more people that suffer non-fatal firearm-related injuries. But survivors may suffer long-term effects of their injury including serious physical and mental health issues. The effects are typically also borne by the families of the injured, and safety concerns as a result of shootings can impact entire communities.

While calculating the entirety of personal and vicarious damage of violence may never be possible, the economic cost of violence in the U.S. consists of many variables (e.g., missed wages, treatment, prosecution and incapacitation, loss of productivity, pain and suffering, decreased quality of life) that equate to billions of dollars spent every year. Based on McCollister and colleagues' (2010) estimated economic value of violence in 2008 U.S. dollars, Table 1 shows the 2018 approximate costs for murder, aggravated assault, and robbery. Together, this violence cost the public billions of dollars every year.

Table 1. National Institutes of Health Study: Per-Offense Costs in 2008 Dollars and 2018 Estimate

Offense Type	Victim Cost	Offender Cost	Justice System Cost	Intangible Cost	Total Adjusted Cost	2018 National UCR Count*	Amount To 2018 Costs Est.
Murder	$ 737,517	$ 148,555	$ 392,352	$ 8,442,000	$ 8,982,907	16,214	$ 173,355,053,018
Agg. Assault	$ 8,700	$ 2,126	$ 8,641	$ 95,023	$ 107,020	807,410	$ 102,846,260,096
Robbery	$ 3,299	$ 4,272	$ 13,827	$ 22,575	$ 42,310	282,061	$ 14,204,158,167
							$ 290,405,471,281

* Retrieved from: https://ucr.fbi.gov/crime-in-the-u.s/2018/crime-in-the-u.s.-2018/topic-pages/tables/table-1

Using the cost estimates produced by DeLisi and colleagues (2010) (who argue they include more offender-relevant variables in their monetization procedures), the price tag significantly increases to approximately half-a-billion dollars spent on these three crimes in 2018.

Neither estimates include the expense to hospitals, which results in millions more dollars lost (Peek-Asa, Butcher, & Cavanaugh, 2017; Gani, Sakran, & Canner, 2006). Further, these costs are only calculated for the known incidents; alternative data suggests around half of violent victimizations go unreported to the police (Morgan & Kena, 2018). These data are from the National Crime Victimization Survey (NCVS), collected from a nationally representative sample of U.S. households regarding nonfatal crimes. For more information, visit: https://www.icpsr.umich.edu/icpsrweb/NACJD/NCVS/) For instance, violent victimizations increased 28% from 2015 to 2018, to a current rate over 23 victims per 1,000 U.S. resident (Morgan & Oudekerk, 2019).

Research has long established that serious violent crime is more likely to occur among small groups of individuals in certain geographical enclaves compared to others (Leovy, 2015; Kennedy, Brown, Brown, & Flemming, 1996). For instance, Southern states typically have higher rates of homicide than the rest of the U.S. Recently released UCR data (2018) puts the national violent crime rate at 380.6 per 100,000

Table 2. Violent Crime Rate per 100K capita

	2015	2016	2017	2018
National Average	384.6	397.1	394.9	380.6
Northeast	321.2	317.1	306.2	292.7
Midwest	358.0	378.4	379.4	361.4
South	405.6	404.7	424.4	403.9
West	397.9	418.4	425.6	423.2

people. Table 2 shows that the Northeast and Midwest fall below that average while the rate in the South is consistently higher.

In addition, violence rates are regularly observed to be greater in urban areas compared to rural regions (Lee, Maume, Ousey, 2003). Further, within an urban area it can be further traced to communities (Shaw & McKay, 1942). In fact, about half of crime stems from around 6% of people and 3% of neighborhoods (Weisburd, 2015; Wolfgang, Figlio, & Sellin, 1972); this is particularly true for nonfatal shootings (Papachristos, Wildenman, & Roberto, 2014).

Areas most blighted by violence share additional, comparable characteristics. Impoverished communities are at greater risk of experiencing serious violence than middle and upper-class neighborhoods (Parker & Pruitt, 2000; Williams & Flewelling, 1988). Areas with higher rates of unemployment, racial segregation, family disruptions, and mobility have been shown to struggle with high crime rates (Bursik & Grasmick, 1993; Sampson, Raudenbush & Earls, 1997; Shaw & McKay, 1942) and the highest homicide rates are observed in cities (Meithe & Meier, 1994; Ousey, 2000; Peterson & Krivo, 1993; Shihadeh & Steffensmeier, 1994). The presence of group or gang activity (Cronin et al., 2007) in neighborhoods is also predictive of higher homicide rates (Laurikkala, 2011; Lee, 2011) as violence and gun use become normalized (Anderson, 1999). Given the outlined importance of locations, the next sections describe the project setting.

Gun Violence In Georgia

As the 8th most populated state, Georgia (GA) is home to over 10.6 million people living within 59,000k square miles. With a diverse landscape, high and growing annual Gross Domestic Product (Retrieved from: https://countryeconomy.com/gdp/georgia) and a strong connection of infrastructure and global access, Georgia has been regularly listed among the top 10 fastest growing states (Retrieved from: https://www.census.gov/newsroom/press-releases/2018/estimates-cities.html#table1) It also has a busy criminal justice system. On average, each year there are nearly half-a-million arrests, 52,000 inmates housed in the state's prisons, and 230,000 individuals on correctional supervision. These offenders drive an annual violent crime rate that has historically matched the national average (FBI, 2018).

Table 3. Atlanta Police Department – Five Year Change in Violence/Gun Offenses

	2012	2016	5 Year Rate of Change
Violent Crime Count	6,027	5,121	-15%
With a Firearm	2,209	2,329	+5%
Firearm Seizures	1,547	1,836	+19%
Firearms Stolen	828	1,016	+23%
Shots Fired Incidents	7,276	10,765	+48%
Shooting Victims	373	587	+57%

The Georgia violent crime rates are largely driven by cities with populations over 100,000. The U.S. Office of Management and Budget lists the metro-Atlanta area as one of the most populated urban area in the world with approximately six million residents. About 35 people move to Atlanta every day, with even more flocking to the suburban sprawl; consequently, population growth will rise by nearly three million more residents over the next thirty years. (Retrieved from: https://atlantaregional.org/news/press-releases/metro-atlanta-population-to-grow-by-2-9-million-and-reach-8-6-million-by-2050-atlanta-regional-commission-forecasts-show/) According to Uniform Crime Report (UCR) data, violent crime occurs five time more often in metro-Atlanta than anywhere else in the state.

City of Atlanta

The Atlanta Regional Commission defines the metropolitan area by 10 counties (Fulton, Dekalb, Gwinnett, Rockdale, Henry, Clayton, Fayette, Douglas, Cobb and Cherokee counties). In the past decade, there have been over two million arrests made by local law enforcement in metro-Atlanta (The most recent arrest data available were used to count arrests from July 31, 2009 – July 31, 2019). A third of those were for serious crimes and 13%

were violent felony arrests. The 71,000 violent-felony arrests averaged 3 charges each, and 12% were gun-related. In the Atlanta area, offenders are known to commit crime in multiple jurisdictions. On average, violent offenders have been arrested by five agencies.

Table 3 displays data from the Atlanta Police Department's RMS data system. While it reflects a 15% decrease in violent crime counts (reported crimes) between 2012 and 2016, increases are seen in terms of firearms. During the five-year period, the City saw a 48% increase in shots fired incidents, and a 57% increase in shooting victims. It's important to note that not all shootings are reported to the police, so the actual incident counts are almost certainly even higher than those reflected here.

In 2016, the ten most affected zip codes experienced a 117% increase in gunshot victims. While these ten zip codes only represent one-third of the zip codes that encompass the City of Atlanta, a full 90% of all gunshot victims reported to the Atlanta Police Department (APD) were shot in one of those ten zip codes. Nearly half of all gun-related crimes occur in the 30310 and 30318 zip codes. The communities within these parts of the city are 91% and 60% African American, meaning that a disproportional concentration of gun violence is hurting specific persons. In the past decade, 92% of gunshot victims reported to APD have been African American.

Data from Grady Hospital, Atlanta's premier Level I trauma center, reflects parallel data to APD. Per the Grady Trauma Registry, in 2015 Grady treated 529 victims of intentional gun violence, 91% of whom were African American males. The highest patient volume came from the same zip codes identified by APD, 30310 and 30318. Grady Health System financials reflect extraordinary cost expenditures to treat these patients, calculated at up to $2.7 million for one person with serious gunshot wounds. It is important to note that the Registry only captures those patients admitted to the hospital. Those receiving treatment as outpatients are not included, thus underestimating the true scope of gun violence treated through the Grady Health System.

In 2015 Grady Hospital and the DeKalb County Police Department partnered to implement the Cardiff Model. An interesting finding from this partnership is that 76% of all violent injuries treated at Grady are unknown to APD. This represents a significant and important gap in APD's data on violence as compared to actual levels of violence occurring within Atlanta.

LITERATURE REVIEW

Gun Violence Summary

Gun violence constitutes a widespread, difficult to control problem in America. Multiple studies demonstrate the negative effects of gun violence on communities, local economies, and individuals. These studies have found that a few achievable means of lowering gun violence have been identified, such as increasing jail bonds, implementing youth programs, and group/gang-focused prevention efforts for youthful offenders and parolee forums for adult offenders. Much of this research has been conducted in large cities with high crime rates such as Chicago, Minneapolis, St. Louis, Atlanta, Detroit, and Indianapolis. The positive results of gun violence prevention and control efforts in these large cities suggest that these methods may well be successful in other municipalities. In Atlanta and the five-county metropolitan Atlanta area specifically, general crime has been decreasing for years but certain violent crimes, specifically Aggravated Assault, Homicide, and offenses involving use of a firearm have all increased (analysis of 2016 – 2021 Georgia and Atlanta crime data, conducted by ARS in August 2021, for this report). These increases predate the current Coronavirus pandemic, having been observed as early as 2016.

To further gun violence prevention efforts, it would be helpful to implement increased jail bonds for gun-related arrests, prevention and suppression programs for youths, and gang/group or parolee forums for preventing recidivism. Implementing large scale programs such as Pulling America's Communities Together (PACT) may also be helpful in gun violence prevention efforts. PACT was established in 1993, implemented in Atlanta in 1995-2000 and "identified homicide, gun violence, and juvenile crime as major community concerns in Atlanta" (Kellerman et al., 2006). PACT had four objectives to help reduce gun violence: reducing illegal demand for firearms; reducing illegal supply of firearms; reducing illegal carrying of firearms; and rehabilitating juvenile gun offenders (Kellerman et al., 2006). These goals benefitted from the help of Federal, State, and local law enforcement and juvenile justice agencies. Throughout the six years that PACT was implemented in Atlanta "The number of homicides in Atlanta fell by 27 percent. The 134 homicides recorded in 2000 were the lowest number in the city in 30 years" (Kellerman et al., 2006). More recently however, the consistent declines in homicide incidents in Atlanta began reversing in 2017, and have been increasing steadily since that time.

Hospital-linked Violence Intervention Programs

Our review of the current literature on hospital-based violence intervention programs (HVIPs) reveals that although cycles of violence and reinjury feature prominently in adult populations throughout the US, study outcomes are mixed and a clear consensus regarding the efficacy of HVIPs has not been reached as of this report (Aboutanos et al 2011; Affinati et al, 2016; Cooper et al 2006; Purtle et al, 2013; Zun et al 2006; Zun et al 2004; Shibru et al 2007; Becker et al 2004). The monetary costs of firearm

injury are considerable; a study by Peek-Asa et al (2017) of hospital admissions for firearm injuries between 2003 and 2013 accounted for an annual average admissions cost of $622 million dollars. Fully 60% of these admissions were for assaults, and 70% of injuries with a known weapon type were from handguns. While there exist extensive bodies of literature on HVIPs, much of the scholarship around these interventions addresses instances of domestic violence (Norton, 1997; Berger et al, 2002; Coben, 2002); there is limited empirical data on HVIPs in relation to victims of gun victimization (Juillard et al, 2016; Affinati et al, 2016).

Few extant studies successfully document effective interventions in this area of focus. Of the existing literature on adult-centered HVIPs, some studies illustrate the increased risk of firearm-related reinjury compared to the general population, highlighting the importance of HVIPs in helping curb gun victimization among vulnerable populations, particularly, unemployed, uninsured, African American males (de Anda et al, 2018; Rowhani-Rahbar et al, 2015). Others highlight how HVIP programs decrease recidivism rates of HVIP participants (DeVos et al, 1996; Bell et al, 2018; Julliard et al, 2016). Other studies reveal the complex interplay between trauma and victimization while underscoring the importance of trauma-informed approaches to HVIPs and other violence prevention programs (Corbin et al, 2011; Corbin et al, 2013). Other studies suggest employing gang leaders in violence reduction programs ("credible messengers") as they are able to engage hard to reach target populations (Amandes, 1979). Additionally, studies of HVIPs that focus on adult victims of gun violence feature HVIPs as social service providers, finding increased hospital service utilization and decreases in reinjury among victims of gun violence following participation in the HVIPs (Chong et al, 2015; Cooper et al, 2000; Smith et al, 2012). While a systematic review of HVIPs (Affinatti et al, 2016) could not recommend adult-focused HVIPs due to a lack of data and other methodological issues in the studies they identified, another recent review found HVIPs to be promising as regards their effectiveness and cost-effectiveness in five randomized controlled trials (Purtle et al, 2017).

The Program to Interrupt Violence through Outreach and Treatment (PIVOT) program serves to contribute evidentiary support to the existing body of HVIP literature by providing ongoing, rigorous evaluation methods that can provide useful and necessary data to test the hypothesis that HVIPs are, in fact, both efficacious and cost-effective. Evidence of efficacy will legitimate further funding for such program development and ensure that healthcare services sufficiently meet patient needs.

Victim-Offender Overlap

There exists significant overlap between those who are responsible for and who are victims of gun-related violence (Averdijk et al, 2016; Berg, 2011; Fagan et al, 1987; Felson et al, 2018; Hass, 2017; Jennings et al, 2010; Klevens et al, 2002; Maldonado-Molina et al, 2010; Muftic et al, 2013; Mulford et al, 2018; Posick, 2015; Reingle et al, 2012; Rivara et al, 1995; Smith, 2007; Zimmerman and Posick, 2017). The relationship between victimization and offending is well documented and accepted by scholars. Although in this literature the victim-offender overlap is predominately centered around

sexual offenses (Siegel et al, 2003; Swanston et al, 2003; Iratzoqui, 2018), a growing body of literature exists concerning the victim-offender overlap in relation to homicide (Averdijk et al, 2016; Berg, 2011; Fagan et al, 1987; Felson et al, 2018). Studies on the relationship between homicide and offending generally provide evidence that victimization is a risk factor for delinquent behavior and adult offending (Cops, 2014; Chang et al., 2003; Daday et al., 2005). Recent studies have suggested that, among violent offenders, elevated risk of victimization was explained by routine activities theory as delinquent behavior and peer associations predict risks for both offending and victimization (Felson et al, 2018; Hass, 2017; Jennings et al, 2010; Klevens et al, 2002; Maldonado-Molina et al, 2010).

This victim/perpetrator overlap appears to be most pronounced in gang-related violent encounters. A growing body of empirical studies has established the association between gang membership and victimization (Pyrooz et al, 2014; Taylor et al, 2008; Taylor et al, 2007; van Gelder, et al 2015; Watkins, 2018). A study of gang violence in fifteen cities across four states (Wu, 2016) found that gang membership increases the odds of victimization. This is largely attributed to the "code of the street" - the informal rules that govern interpersonal violence among poor inner-city youths that serve to increase the likelihood of violent victimization. Similarly, a study by Pyrooz et al (2014) revealed that gang members were more than twice as likely as non-gang members to be both victims and offenders.

Although there remains a lack of consensus on the cause of the victim-offender overlap, scholars postulate that various demographic variables such as sex (Fagan et al, 1987; Zaykowski, 2013), schooling commitment (Nadel et al, 1996) parental involvement (Hartinger-Saunders et al, 2012; Li et al, 2019), peer influences (Cops, 2014; Durant et al, 1994; Papachristos et al, 2015), substance use (Begle, 2011; Berg, 2015) and decreased regulation of self-control (Ren et al, 2017) in both victims and offenders increase the magnitude of the relation between victimization and offending. Most notably, other studies revealed the role that age plays on victimization and offending. Adolescents and young adults were reported as being both the usual victims and offenders of violence (Cops, 2014; Durant et al, 1994; Papachristos et al, 2015). Further, studies such as Nadel et al (1996), Begle (2011), Berg (2015), Hartinger-Saunders (2012) and Li et al (2019) reported that substance use, lower school commitment and low attachment to parents and increased peer influences notably predicted violent offending rather than victimization, with older teenagers more likely to report being victims than younger adolescents.

In addition to the above-cited studies conducted in the United States, scholars across the globe have documented evidence for the victim-offender overlap, particularly when it comes to violent crimes. Evidence from countries such as South Africa, Sweden, Colombia, China, Poland and the Caribbean illustrate the prevalence of victimization among offenders and vice versa (Heber, 2014; Hinsberger et al, 2016; Klevens et al, 2002; Li et al, 2019; Ren et al, 2017; Souverein et al, 2016; Wang and Beckman, 2019; Xavier, 2014). These studies demonstrate that the population of victims and that of offenders overlap significantly, to the extent that it was by-and-large comprised of the same group of individuals (Klevens et al, 2002; Posick, C. (2013). Other studies highlight the fact that violent offenders are at increased risk of being victimized themselves when compared with the general population (Heber,

2014; Hinsberger et al, 2016). Bringing together global evidence of the victim-offender overlap, these international studies shed light on multiple types of experiences of the victim-offender overlap that shape the emergence of this distinct group.

COMMUNITY OUTREACH AND COLLABORATION

While gun violence is not a new issue in the City of Atlanta, the pervasiveness of the problem and its rapid growth have been of great concern to the community and community stakeholders for quite some time. The Atlanta Smart Policing Initiative (SPI) project sought to bring the criminal justice system, medical service providers, and community resources together to address gun violence using a collaborative approach that supports individuals and communities. The expressed goal of the SPI collaborative project was to reduce and prevent firearm related re-injury and retaliation. A 2015 study from Washington State (Rowhani-Rahbar et al, 2015) linked patient hospital records with criminal history to determine the risk of both firearm re-victimization and future arrested based on one firearm related hospitalization. They found persons with a firearm-related hospitalization were more likely to be readmitted with a firearm related injury and to be arrested for a non-firearm nonviolent offense. Patients admitted to the hospital with a previous arrest history for a violent or firearm-related crime were at even higher risk. Data such as this highlighted the need for collaborative efforts between criminal justice and public health to work together to address the problem of gun violence.

The Atlanta SPI brought about the Program to Interrupt Violence thru Outreach and Treatment (PIVOT). PIVOT was a coordinated effort between Grady Hospital (the premier Level 1 trauma center in the region) and the Atlanta Police Department (APD), in combination with supportive services from community service providers. PIVOT embraced a coordinated public health model of violence prevention which acknowledges that gun violence can operate like an epidemic through social interactions and personal networks (Green et al, 2017). The goal of the public health model of violence prevention is to interrupt the retaliatory contagion that can occur following a single violent event. Hospital-based violence prevention programs have shown promise in reducing future contact with the criminal justice system and/or reducing the likelihood of violent trauma re-victimization through the connection to services and/or peer mentor programs.

Atlanta SPI PIVOT Approach – Three Components

The PIVOT collaborative approach involved three components to address firearm related violence: wrap-around services with intensive follow-up, community policing, and data sharing. A Social Ecological Model was employed that involves individual, community, and policy level approaches to the issue of gun violence. Changes at the individual and community levels can have a direct effect on policy, demonstrating program efficacy with a sound multi-organizational approach.

Component 1 – Wrap-Around Services With Intense Follow-Up

The first component was modeled after hospital and street-based violence interruption programs whereby culturally competent and respected individuals of the community (often with violent or criminal pasts) calm tensions and provide intensive mentorship to individuals at risk of being involved in violence. Programs such as Cure Violence, CeaseFire, Youth Alive-Caught in the Crossfire, and The Wrap-Around Project and others are part of a national network of hospital-based violence intervention programs that work to prevent violent injuries before they occur. These programs involve case

management and mentorship that connect gunshot victims to a wide range of services including follow-up medical care, employment services and mental health treatment. There is mounting evidence as to the effectiveness of such programs. For example, the New York Times reported that since implementation of the Cure Violence program in the Queensbridge Housing in Queens New York that the neighborhood had gone more than a year without a shooting (Dwyer, 2017).

The PIVOT program aimed to bring violence interruption into the hospital setting through the hiring of a Community Resource Coordinator (CRC). The CRC was a culturally competent emergency department social worker on staff at Grady Hospital. This person was tasked with facilitating mentorship and follow-up with clients. Prior to implementation of PIVOT, emergency department (ED) staff involved social work staff for all firearm related injuries. Serious injuries required a personal consult by social work staff, whereas less serious injuries could be handled through a phone call after release. Social workers engaged with patients to develop plans to meet their medical and social needs after release. The CRC brought to these patients an extra layer of support, mentorship, follow-up, and the identification of needs post-release.

The CRC met with gunshot wound (GSW) patients in the hospital to review eligibility and to introduce them to the PIVOT program. Phone calls were utilized for the process if persons had already been discharged prior to the CRC making contact at the hospital. A randomized system was used whereby eligible persons were identified either as prospective intervention or control group participants. Control group participants still received contact by the CRC and were provided with a community resource guide with information on organizations that the patient could access independently for needed supports and services.

Persons enrolling in the intervention group received detailed assessments to ensure a comprehensive case plan was created, intensive support, direct connection to resources, as well as regular follow-up from the CRC. The design of the CRC role was based upon the interrupter model used in cities like Chicago and Baltimore.

Component 2 – Community Policing

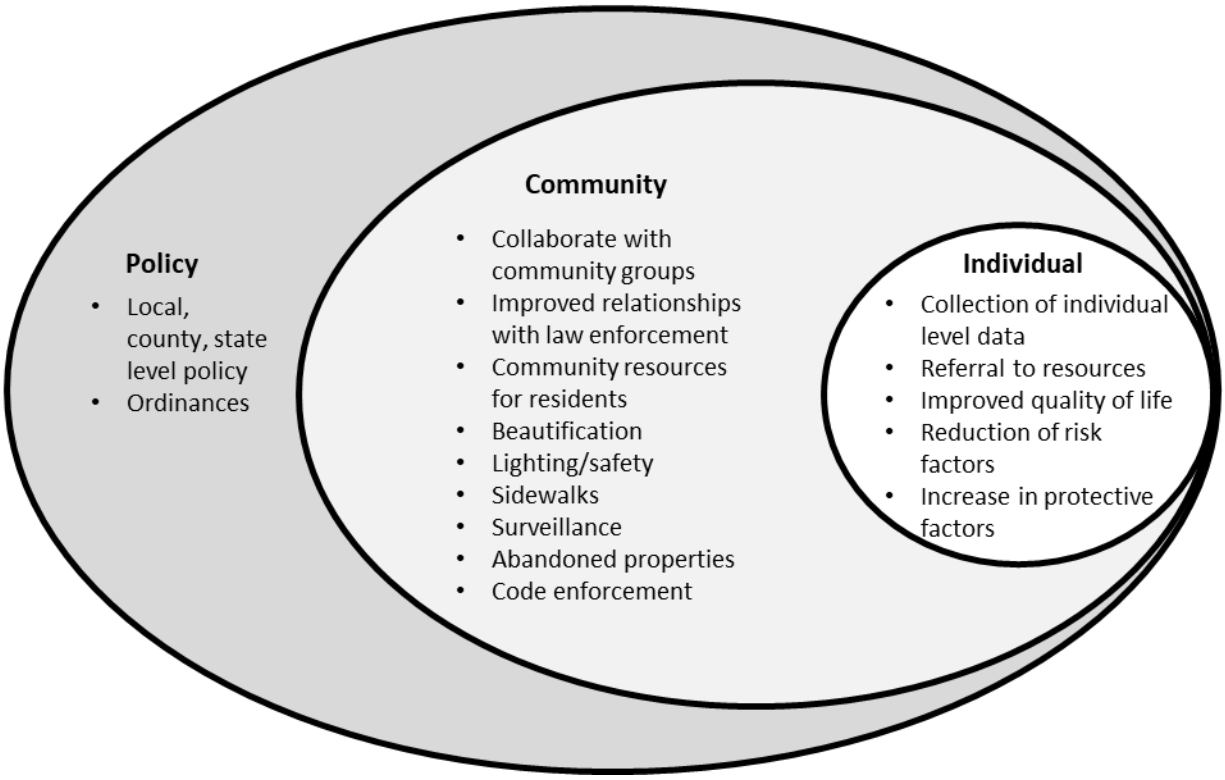
Community Policing involved utilizing police officers in target communities to foster a change in attitudes towards law enforcement, as well as to increase citizen participation in solving gun crime. While APD had already invested in the development of community-oriented policing in the city, the SPI project afforded the opportunity to provide intensely focused community policing efforts in a small area for an extended period of time to maximize the benefits of the community policing model. The component involved what were called PIVOT officers – two Atlanta Police Officers specially assigned to target neighborhoods identified as disproportionately impacted by gun violence (the Fairburn Heights, Mechanicsville, and Pittsburgh neighborhoods). Officers concentrated their efforts in these neighborhoods and focused on community interactions to build trust in the community and to promote self-efficacy among community members to spark change. In addition, the vision included officers serving as rapid responders to the scenes of gun violence and meeting with victims at the hospital, as well as working closely with the CRC and other service providers to ensure that gunshot wound victims remained connected to the services they needed.

Component 3 – Data Sharing

The final component of the module was facilitated by the Violence Prevention Coordinator (VPC) at Grady Hospital. Anonymized violent injury data was to be shared by Grady Hospital with the APD Crime Analysis Unit and the research partners Applied Research Services (ARS) in order to create hotspot maps to aid in efforts to reduce gun violence.

The Social Ecological Model (depicted in Figure 1, below) best describes the approach taken. Firearm-related violence was approached at the individual level though hospital-assessed violence interruption by means of service provision and intensive mentorship/follow-up. The collection of individual violent injury data during ED encounters also aimed to address intervention and prevention at the individual level by capturing specific data points regarding the injury. The hotspot maps and interventions resulting from shared individual-level violent injury data were to address firearm-related crime and injury at the community and policy level, with the goal of decreasing future violent related injuries within the hotspot communities. APD's community policing unit focused on the community level of the social ecological model through outreach and relationship building with community residents.

Figure 1. Firearm Violence Addressed Through Individual, Community and Policy Level Approaches



Formative Evaluation

This section covers the formative steps taken to implement the Atlanta SPI strategy. The PIVOT program idea entailed planning, collaboration, and piloting. Formative evaluation provides a better understanding of what it takes to implement a new program, in part by examining program expectations vs. the realities of implementation.

The Atlanta SPI project was the result of coordination efforts by Georgia's Criminal Justice Coordinating Council (CJCC) in 2016 to bring together representatives from Grady Hospital and the Atlanta Police Department. Rising gun violence impacts both agencies and both had prevention efforts in place, but were not yet working in a collaborative fashion. Grady doctors were particularly concerned about persons making repeat visits for gunshot wounds, as well as retaliatory gun violence. Grady Hospital was working with the DeKalb County Police Department on a Cardiff Model grant to share hospital and law enforcement data in order to create hot spot maps to identify areas most impacted by gun violence, but the effort did not include the Atlanta Police Department. The idea was to bring these agencies together to see if there was mutual interest in collaborating to address gun violence and applying jointly for an SPI grant. The "Grady Gun Violence Initiative" was a team of persons primarily from Grady Hospital, CJCC, and the Atlanta Police Department that were meeting regularly to discuss issues related to gun violence reduction and grant opportunities to help support and expand the team's efforts. Guests and other attendees from organizations such as the Annie E. Casey Foundation and the Georgia Department of Public Health (GDPH) also attended meetings intermittently.

Year One – *October 2016 to September 2017*

The Atlanta SPI grant was awarded in October of 2016. At this time the SPI collaborative team (referred to as the Taskforce) focused on developing a team that would specifically be focused on implementing the PIVOT program. The core collaborative team included APD, Grady Hospital, ARS, and CJCC. Emory School of Medicine faculty, Morehouse School of Medicine faculty, residents and students, and Grady employed EMTs, nurses and social workers also had varying level of involvement in different aspects of the initiative. As the PIVOT program was implemented, other partners were also brought to the table on occasion, including the Annie E. Casey Foundation, Chris 180, and representatives from the Neighborhood Planning Unit V (NPU-V).

One of the first tasks of year one of the project involved the creation of the Strategic Action Plan (SAP) to lay out a detailed roadmap of what the team would accomplish during the study period, how, by whom, the data that needed to be collected, and how progress would be measured. Drafting of the SAP went into early 2017. Once approved, work then began in getting Institutional Review Board (IRB) approval for the project, data use agreements, Memoranda of Understanding, contracts, charters, hiring of staff, as well as the onboarding and training of all PIVOT staff (nurses, physicians, hospital leadership, PIVOT Officers, CRC). Other tasks planned for year one included creation of a service provider network and a community resources guide, completion of preliminary analysis of Grady Hospital data to develop a screening tool and to define the current rate of hospital firearm-related recidivism. This data was also to be shared with APD, so they could combine the data to create hot spot maps for the team (per the Cardiff Model). While taskforce members eagerly began work on all of these steps in year one, these start-up activities ran into many unexpected delays along the way.

By the spring of 2017 the team was still experiencing delays with Grady's ability to hire new personnel due to obstacles caused by the leadership and management structure in the social services department. There were also delays obtaining data required by the IRB from the Information Technology Department (IT). APD experienced delays with the hiring of PIVOT staff as their legal office advised of unexpected steps to maneuver, including the need for sub-awards to be approved by the Mayor before hiring could commence.

The summer of 2017 concluded and PIVOT Officers had still not yet been assigned. APD was still waiting for the grant to be finalized. The department decided to speed up the process such that they would transfer existing officers to the PIVOT role. Data acquisition continued to be an issue with data sharing agreements for Grady to share data with APD still being processed by legal staff, and ARS was still awaiting finalization of the data sharing process in order to begin obtaining hospital data.

Year one ended without a CRC on staff due to leadership hiring miscommunications. In addition, the grant was also still held up within the City of Atlanta approval process, which prevented APD from assigning officers to the PIVOT project. While the Atlanta City Council had approved the grant, additional signatures were still needed from the Mayor's office. In addition, the research team was still without hospital data. More than three months after ARS submitted their data request to IT, Grady was still trying to clarify the request, establishing a point of contact within their unit, and setting up lines of communication.

Another hitch also slowed efforts in year one. There was a desire by Grady Hospital staff to deviate from the original grant proposal plan of having the CRC conduct the hands-on work with the intervention group. There was concern that the caseload would be too great for a single CRC and that violence interrupters should be included in the violence prevention model to assist in enrollments and to work directly in the affected communities. The conceptualization and planning of this idea consumed much of the taskforce's time and energy in year one. In the end, funding for Cure Violence and credible messengers was received later in the grant period, but it was not part of the SPI project.

Funding for an additional social worker for the project was discussed by the taskforce. A Victims of Crime Act (VOCA) grant application was supposed to be submitted requesting funds for a second social worker. Grady staff attempted the application process twice but a completed VOCA grant application was never submitted.

While year one hit some unexpected bumps, snags and delays, some other opportunities were present that helped press the taskforce forward in their work. One example is that the BJA director personally connected directly with Chief Shields of APD to ensure that leadership had a strong understanding of the SPI strategy and goals. In addition, several members of the team participated in the National Network of Hospital-based Violence Intervention Programs Conference. The information learned was well-received, networking occurred, and key information was shared with the Taskforce as a whole.

Year Two – *October 2017 to September 2018*

It was expected that year two would begin with the deployment of PIVOT officers in the target neighborhoods, as well as with piloting of the PIVOT program with the CRC embedded within Grady Hospital. It was expected that tweaks would be made after the three-month pilot and that the PIVOT program would be fully live in its official form by January of 2018. Unfortunately, the delays of year one continued in year two, pushing back launch of the pilot. In January of 2018, data had still not been provided by Grady Hospital to the research team nor to APD. This prevented development of screening tools which were necessary for the identification of appropriate patients for the PIVOT program, delaying start of the pilot. The Phase II IRB process ended up being lengthier than expected as well, which would have delayed the start of the pilot project even if all had been ready to launch.

The CRC was officially brought on board at the start of year two and in January was in the process of meeting with community organizations to create a network of service providers to ensure continuity

of care for patients enrolled in the PIVOT program. APD identified two officers that would serve as PIVOT officers, but as of January they were still working on a Special Order which outlined the duties of PIVOT officers. Departmental approval of the Special Order through the Accreditation Unit and ultimately the signature of the Chief was also needed in order for the officers to officially become PIVOT officers.

By March of 2018 the PIVOT officers were in place in the target communities and Taskforce meetings focused on discussions about moving forward with the planned three-month PIVOT pilot. In addition, a PIVOT resource guide had been developed and printed that would be given to both intervention and control group participants. The guide provided resources in both Atlanta counties (Fulton and DeKalb). The team decided to begin with a "pilot of the pilot" with a mock of the planned process to identify areas of refinement. Medical students were recruited to serve as mock patients so that the CRC could gauge how long it took to complete surveys and consents, as well as to share feedback about how the process felt and to document questions/concerns they might have if they were actually a gunshot victim interacting with the CRC. By June the actual pilot was completed, tweaks were made, and the program was fully operational at Grady.

By July the CRC had made contact with 18 eligible patients at the hospital and two had consented to participate. The PIVOT officers were working to engage the target communities, but were finding residents to not be particularly responsive. They reported that only older residents were responsive to talking with them. The Taskforce repeatedly expressed concerns about the officers wearing full uniforms as PIVOT officers. Requests were made to allow them to engage in street clothes but departmental policy would not permit this. In addition, one of the target neighborhoods was changed. The Fairburn Heights community was replaced with the Thomasville neighborhood because it was busier and had a higher volume of activity. The officers were strictly serving in a community policing capacity as internal concerns about case interference prevented the officers from serving as rapid responders to both the scene of shootings as well as hospital interactions with victims. PIVOT officers had begun logging post-shift data to an online data collection tool to collect information on specific officer activities and interactions.

Year two ended with the PIVOT program functioning at both the hospital and police levels. The concept of interrupters had been tabled and the taskforce was focused on the program at hand and how to improve, expand, and promote PIVOT. The team, which had been weary from the successive delays, seemed much more energized as the year ended and the program was fully operational.

Year Three – *October 2018 to September 2019*

Year three was to be a year of program operation and data collection/sharing to explore the impact of Cardiff Model hot spot maps, as well as the impact of CRC services on PIVOT participants. It was expected that relationships between law enforcement and the target communities would improve through the connections built between the PIVOT officers and community members. Steps were also to be taken in year three towards sustainability.

Halfway through year three, hot spot maps had still not been created due to national legal issues related to the release of hospital data to police agencies. In addition, only five persons had become PIVOT intervention group participants. Recruitment was proving to be much more complicated than anticipated due to a myriad of reasons including a time-intensive manual system of eligible patient

identification which led to delays in the CRC making initial contact, the CRCs business hour schedule which wasn't consistent with when most gunshot wound victims enter the hospital, patient distrust, as well as complications contacting persons post-release because of inaccurate or changing contact information. By the end of year three, a total of 38 persons were enrolled in the PIVOT program – nine in the treatment group and 29 in the control group. These numbers were grossly lower than expectations going into the grant.

In year three, the taskforce found themselves trying to address enrollment complications, as well as the struggles that the PIVOT officers were having making the deep level connections in the community that had been anticipated and that were likely required to achieve any degree of lasting success. Monthly meetings focused on how to overcome these issues and propel the program and services forward to those in need. These efforts, while well intentioned, highlighted the challenges of bringing together different disciplines with vastly different perspectives; healthcare, law enforcement, social work, and research. While all taskforce members were committed to the goal at hand of reducing gun violence, there were clearly struggles to see the problems outside of one's own lens. As a result, coming together with a unified vision remained a difficult challenge.

Year Four – *October 2019 to September 2020*

In year four, the PIVOT program continued to operate with a grant extension. Funding for the CRC ran out in February of 2020, ending PIVOT program recruitment and services. Shortly thereafter, Grady Hospital opened their Trauma Recovery Center, which provides a one-stop-shop for connection to services for persons that have experienced firearm violence, domestic violence, human sex trafficking or sexual assault. The Trauma Recovery Center was a direct result of the PIVOT project that incorporated the lessons learned to better meet the needs of the target population. APD PIVOT officer funding also ran out in early 2020, but officers continued logging their efforts in the target communities through the end of September.

Year Five - *October 2020 to September 2021*

In year five the focus of the initiative shifted away from PIVOT and moved towards expansion of law enforcement efforts. The main goal was implementation of the Cardiff Model within the Atlanta Police Department. The earlier data sharing issues had been resolved and courts ruled that data could be shared through state Public Health Departments. Unfortunately these efforts did not succeed, partially thwarted by the COVID-19 pandemic and civil unrest within the city, which coincided and interfered with implementation efforts. APD resources and priorities had changed, and there was no longer a willingness to engage in Cardiff efforts.

Formative Evaluation: Conclusions

The formative process of the PIVOT taskforce was fraught with delays that are typical when multiple, large bureaucratic agencies are involved in a single collaborative initiative. The taskforce met regularly and worked together to overcome obstacles, but ultimately miscommunications within large organizations, legal delays, and delays due to a lack of manpower/resources were the main culprits. It would be expected that other organizations starting a similar initiative would likely encounter similar, unexpected bureaucratic delays. The delays in obtaining data from Grady Hospital in order to create

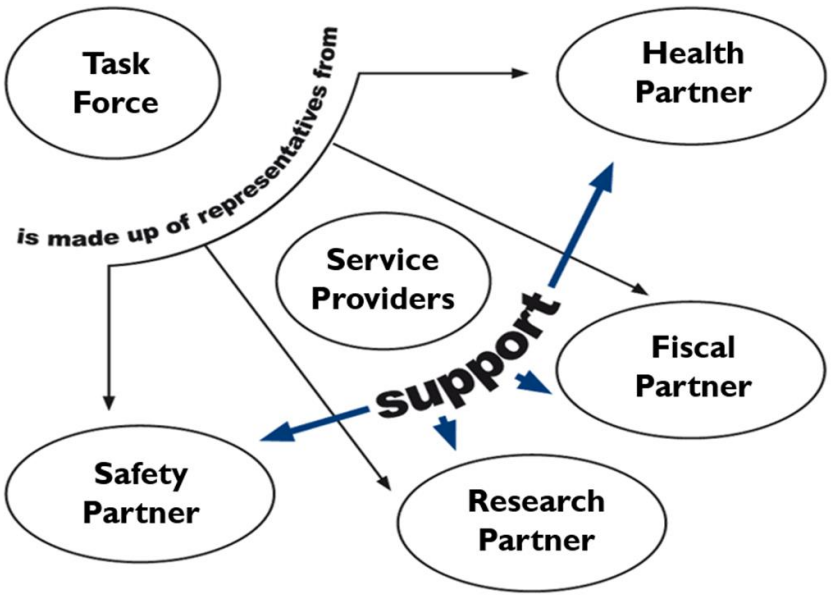
the screener and launch the pilot were more extensive than expected. Perhaps a recommendation to others undertaking such a project would be to involve IT leadership in the process from the outset, and/or to create a process to prioritize taskforce needs. Ultimately the taskforce data request was not handled as a priority and many months were spent waiting for needed data to launch the project, and inter-project hospital data was delayed by over a year. Data is clearly needed for such an under-taking and cooperation and timeliness from the data legs of all agencies involved is necessary for a smooth process to occur.

Another key lesson gleaned from the formative evaluation concerned the amount of time required to not only respond to all of the delays and requests for paperwork, but to also manage the regular day-to-day operations of PIVOT once it was operational. A member of the injury prevention team at Grady was given management of PIVOT as one of their many duties. They were managing many other projects and found it difficult to keep up with the demands of PIVOT. In addition, they did not have managerial authority over the PIVOT staff at the hospital (CRC), which put them strictly in the role of a liaison providing information or requests to those with management authority. The project would have benefitted from a full-time person within Grady assigned to manage PIVOT. Managerial authority over PIVOT hospital staff would have created a clear line of communication and accountability.

SPI Community Partners and Stakeholder Involvement

The SPI collaborative involved bringing together partners from several sectors for the common purpose of reducing firearm related re-injury and retaliation. Prior to submitting the SPI grant application, Grady Hospital already had in place a collaborative team of agencies concerned about gun violence that was meeting and strategizing ways to reduce gun violence in Atlanta. The PIVOT grant allowed for the team to restructure in such a way as to better reach and serve the community. As shown in figure 2 below, the PIVOT taskforce was comprised of representatives of Grady Hospital (health partner), APD (safety partner), ARS (research partners), CJCC (fiscal partner), and an array of service providers that provide direct care and support to victims of gun violence and their families.

Figure 2. Taskforce Structure



The taskforce met every month and the regular attendees were the health, safety, fiscal and research partners. Service providers had open invitations to attend meetings, but typically only came when specifically invited to share information on specific topics or initiatives underway. Other visitors from different levels of the health and safety partner would also attend meetings at various times. For example, while the PIVOT officers attended all meetings, sometimes higher-ranking superiors would also attend to provide updates or to learn about or contribute to the strategic maneuverings of taskforce activities. Often residents, medical students, public health administration students, and staff from psychiatric services would attend meetings to provide specific supports and/or to learn. Members of the NPU-V that supports the target communities were also invited to attend.

Service providers were not a big part of the taskforce meetings, but that does not imply that they were not critical to the implementation of the PIVOT program. Taskforce meetings provided a forum to discuss strategy, data, bureaucratic processes, public promotion, and sustainability. Many service providers did attend, often at the invitation of the CRC, to talk about program offerings, to share perspectives, discuss concerns or positive developments in their service communities, or to share ideas. However, the service provider role was mainly rooted in the actual provision of services to PIVOT participants. The real value added was that service providers could serve the complex needs of participants within the community to address individual needs. The taskforce did not in any way interfere with the necessary work of their service provider partners. One particular provider that collaborated with the taskforce was a group called Chris 180 based in the target neighborhoods. They provided resource information to the CRC, and also communicated regularly with APD about events such as community clean-ups and rallies where the PIVOT officers could get involved with the community at the grassroots level to build rapport and trust.

While some service providers already had relationships with the taskforce prior to the start of the PIVOT program, it was mainly the CRC who brought providers to PIVOT. Service providers brought to the initiative were part of the Community Provider Network (CPN). When the CRC was hired, the PIVOT program was still awaiting data to create screeners so his first few months of work were solely dedicated to the creation of the CPN. These activities continued throughout his tenure. The CRC was already doing social work in the Atlanta area and had close contacts at many social services agencies in the area. The CRC advised that he began efforts to build the provider network with known contacts. A form was used to document these efforts as well as the services that each provider could provide (next page). The CRC's goal was to bring services to the initiative that could provide a continuum of care for participants.

After exhausting personal contacts, the CRC began researching organizations and networking with others familiar with the social service make-up of Atlanta to target organizations that would fit the needs of the PIVOT collaborative. Building relationships was often a slow process requiring numerous meetings and phone calls. The CRC advised that building the network in the beginning was challenging as there was no "face" to the PIVOT program. The program had not yet begun so the CRC was unable to talk about the specific needs of PIVOT participants, nor the volume of persons that would be seeking services. Solicitation involved talking in generalities. While an added challenge, the CRC advised that all of the agencies that joined the network already provided services to this vulnerable population, so they fully understood the complexities and were still willing to provide service and assistance. The CRC estimated that the Community Resource Network consisted of about 60 agencies by the conclusion of the project. All agreed to provide services to participants, although not all providers had been directly

called upon to do so. The CRC estimated that the majority of service referrals were made to less than a dozen organizations that served the most immediate mental health and medical service needs of PIVOT participants.

Efforts to build service provider partnerships rested primarily with the CRC. While the CRC reportedly enjoyed building the network and felt that a network was established to address most participants needs/potential needs, there was frustration expressed that the task was bigger than a one-person job. The CRC felt that the expertise and connections of other taskforce members should have been utilized to host network meetings and to deal with obtaining partnership MOUs. Such activities were not within the scope of the CRC's training, and took time that could have been spent recruiting and servicing PIVOT participants. Despite the challenges, the CRC developed a Community Provider Network providing a continuum of care services. Figure 3, below, depicts the Community Resource Network Data form used during the recruitment and engagement process.

Figure 3. Community Resource Network Data Sheet

Agency Overview Describe the services/support your offer to clients List the criteria clients have to meet in order to receive services.	**Services**	**Eligibility Criteria**	**Ineligibility Criteria**
PIVOT Support What are some ways you think your agency can collaborate with PIVOT and serve PIVOT clients?	**1.** **2.** **3.**		
Challenges/Barriers What are the barriers and challenges you see to collaboration?	**Streamlining Referrals:**		
	Reserving Space:		
	Sharing Client Data:		
Next Steps What steps within your organization are you going to take to formalize a partnership with PIVOT?	**Staff/Leaders you need to engage:**		
	Forms/Paper work that needs to be completed:		
	Process you will propose for PIVOT clients:		

PIVOT

Agency Name: _____ **Agency Contact(s):** _____

STRATEGIES EMPLOYED

The Program to Interrupt Violence thru Outreach and Treatment (PIVOT) developed out of the need to provide effective interventions that prevent firearm related injury patients from repeat injury and hospitalization and addresses the underlying trauma that results from being a victim of violence, regardless of potential contributory conduct. APD leadership from the Community-Oriented Policing services (COPs), Tactical Crime Analysis, and Gang Unit were searching for an innovative and data-driven approach to curbing gun violence in Atlanta's communities, as was leadership from Grady Hosptial. PIVOT brought both agencies together to address a common cause.

PIVOT was a unique program to Atlanta that linked hospital-based services, social services within the community, and the criminal justice system. The program was designed as a collaborative effort between hospital personal providing direct patient care and APD, responding to violent injury "hot spots" within communities. The program was based at Grady Memorial Hospital as the largest hospital in the state and one of the busiest level 1 trauma centers in the country, where the majority of firearm-related injuries were received and managed.

PIVOT was envisioned as a collaborative with APD via a deidentified data sharing approach that allowed Community-Oriented Police services to engage within communities most affected by higher rates of firearm-related injuries. The PIVOT mission was to provide novel wraparound social services to high-risk patients who present with a firearm related injury, with the goal of reducing repeat violent injury and mitigating retaliatory violence within the community.

The principle function of PIVOT was to create a meaningful and culturally competent connection between patients of firearm related-injuries and a Grady-based social worker. Cultural competency, or the understanding and respect for a victim's background, is necessary in developing intervention strategies to prevent re-injury that are based on trust and mentorship. The social worker developed case plans based on interviews with the patient, identifying individual intervention components with the objective being to reduce the risk of future violent injury. As individual risk factors were identified and strategies developed, patients were connected to existing supportive services in the Atlanta communities and the surrounding metro areas served by Grady Hospital, with an overall goal of mitigating repeat violent injuries. The goal of PIVOT was to leverage established social services within the community by linking patients to these services, allowing comprehensive treatment for PIVOT participants including mental health, education, employment, substance abuse treatment, housing, life skills, and social and community engagement. The hospital-based social worker was to provide intensive mentorship as the patient connected with these resources, encouraging follow-up visits and working towards the meeting of individual case plan goals.

Logic Model

The PIVOT program was designed around the logic model which can be found on the next page. The model involves the creation of a collaborative team working together to achieve goals related to the reduction of gun violence and repeat victimization. The model relies upon three key parts working together – hospital-based intervention, community-oriented policing, and data and information sharing. Immediate goals of this approach include a coordinated response to violence prevention efforts between Grady Hospital and APD as well as receipt of directed services by victims of gun violence. Long-term goals include marked reductions in: firearm-related hospitalizations, gunshot victims, and repeat victimization.

PIVOT (Program to Interrupt Violence thru Outreach & Treatment) Logic Model

GOAL: To reduce the prevalence of gun violence in the City of Atlanta through a coordinated public health approach that focuses on the provision of mentorship and community resources and the application of innovative violence prevention strategies by law enforcement.

Inputs
• Community Resource Coordinator, Human Services at Grady Hospital • Social Workers (10% of time), Human Services at Grady Hospital • VOCA funded social worker, Human Services at Grady Hospital • Violence Prevention Coordinator, Trauma Unit at Grady Hospital • 2 COPs Officers Atlanta Police Department • Tactical Data Analysis Unit, Atlanta Police Department • Emory Faculty and Medical Students • Applied Research Services • CNA Subject Matter Experts

Outputs
Activities
1. Regular hot spot mapping of APD incident and Grady violent injury data 2. Develop screening tool 3. Triage gunshot wound victims in hospital for program participation. 4. Connect GSW victims to services and manage cases 5. Rapid response by COPs officers following a shooting. 6. COPS investigate nature of conflict 7. LE employs individual based responses to cool tempers and intervene in escalating conflicts 8. COPS officers hold community forums 9. APD and Grady staff Assigned to PIVOT Coordinating efforts 10. Impact and Evaluation plan by ARS 11. IRB approved 12. Participation in BJA National SPI Meetings, webinars and site visit, and consultation calls 13. Published program evaluation

Outcomes – Impact
Short-term
• Identify Community Services • Enrollment of GSW victims in PIVOT • Treatment and Mentoring of GSW victims • Targeted rapid response in the community by COPs officers following a shooting • Understanding of the extent and nature of conflicts in the targeted communities by APD • Focused violence prevention efforts by APD and Social Workers • Coordinated violence reduction response from Grady and APD • Identify issues with police community relations
Medium-term
• Empower at risk individuals to derail the cycle of violence • Expand the program to various neighborhoods • Identify neighborhood conditions that facilitate violence
Long-term
• Reduce firearm related hospitalizations • Reduce the number of gunshot victims • Reduce repeat victimization • Foster healthy community police relations • Reduce neighborhood conditions that facilitate violence • Add to the evidence of the impact of hospital base violence intervention programs • Shift attitudes of health providers and law enforcement officials to view violence as a public health issue

External Factors: *Economy, poverty, city development, laws and regulations, federal constraints on meetings and travel, changing federal priorities, turnover at SPI site, changing priorities of SPI partners,*

Assumptions: *Gushot wound precipitates change, vilence can spread like a disease, SPI goals and objectives correlated/in tune with contemporary needs and interests of local police agencies, CNA and SMEs have correct expertise and rapport with SPI sites, grant resources and support are appropriate and effective. Collaboration from apartment complex management.*

The PIVOT program was envisioned as a collaborative venture whereby groups invested in reducing gun violence come together to find a common vision of gun violence and prevention; essentially, embracing violence as a public health issue. This shift in attitude was at the core of the strategy. The vision was for the team to work together to make decisions, and for policy-level staff to serve on the collaborative to enable direction at the managerial level as well as to create a culture of change agency-wide.

The main PIVOT strategies were, for the most part, implemented and maintained through the life of the initiative. Some tweaks and changes were necessary over the course of the project. These modifications will be discussed in the sections below. In terms of replication, it's important to note that the project required a willingness by the team to be adaptable to unexpected developments and situations. While other collaborative teams may not encounter the same bumps, one of the key lessons learned was for the team to stay abreast of process issues so that adjustments could be made in a timely manner. The research partner played an active role in monitoring implementation and encouraged the team to address problems and challenges as they were observed. However, the research partner was simply one part of the collaborative team. While recommendations could be made to modify steps as the initiative moved forward, there was no authority to do so and many recommendations were not heeded by the collaborative team. The resultant strategy is reflective of a collaborative approach with the team making decisions in line with the majority and/or dominant lines of thought.

Also note that the team received training and technical assistance (TTA) from CNA during the process. They, in essence, served as an unseen collaborative partner from the grant award through the piloting of the PIVOT program process. Their suggestions and influence are felt in the final strategies employed, although they are not mentioned directly as they did not serve as integrated collaborative team members.

The PIVOT strategy involves a three-pronged approach: hospital-based violence intervention, community oriented policing, and information and data sharing. Each prong will be discussed, including process evaluation findings to highlight challenges encountered, and steps taken to address the challenges. It is hoped that process findings can be used to help other jurisdictions involved in replication efforts create plans and strategies to address what were unanticipated issues for the PIVOT taskforce.

1. Hospital-Based Violence Intervention

The hospital-based intervention piece was originally envisioned as a program led by a culturally competent Grady Hospital social worker that assessed patients coming to the hospital with an intentional firearm injury. It was expected that the social worker would triage patients based on the hotspot data feedback provided from APD and other risk factors identified during the grant's problem identification phase. Patients shot in one of the hotspot areas would be assessed for their risk of being involved in further violence and their need for social or counseling services. Additionally, it was expected that a Community Resource Coordinator would also be hired to inventory available services in each of the hotspot areas that APD identifies. The Community Resource Coordinator was to establish relationships with neighborhood organizations and begin organizing hotspot communities against gun violence. The Community Resource Coordinator position was to be funded through a separate VOCA grant, but the taskforce never submitted a grant application

In the end, funding was only available for one social worker to handle both responsibilities, and they were known as a Community Resource Coordinator (CRC). In addition, hotspot data was not factored into the process (reasons for this will be discussed in the information and data sharing section of this chapter). The intervention kept to the key tenets of identifying and targeting persons with gunshot wound injuries and the provision of services to meet the medical and social needs of participants.

Trends were identified in patients who presented at Grady Hospital from 2013-2016 with a firearm-related injury. Understanding the historic risk profile of patients presenting with firearm-related injuries allowed for development of a clinically relevant risk profile stratification, allowing identification of the most common characteristics of those patients who are victims of firearm-related violence. The identified risk stratification was used to create a screening tool for victims of firearm-related injuries seen at Grady for participation in the PIVOT program (form to left). This ensured that appropriate persons were identified and that parameters were set that would ensure adequate numbers of persons eligible for both the intervention and control groups.

Patient Eligibility Screener

To be completed for all persons who present with a gunshot wound at Grady

Patient Initials_____ MRN(s): _____/_____
Arrival Date & Time:_____ Screener's Initials:_____
EMS Service_____

Patient is **Eligible** if **both** apply:

☐ 1). ***Injured*** in a target zip code **OR** ***Lives*** in a target zip code

Injured	***Lives***
☐ Zip Code Unknown	☐ Zip Code Unknown
☐ 30318	☐ 30318
☐ 30310	☐ 30310
☐ 30315	☐ 30315
☐ 30331	☐ 30331
☐ 30311	☐ 30311
☐ 30354	☐ 30354

☐ 2). And scores at least 3 of the following (check all that apply):

- ☐ Male
- ☐ Younger than 26 years old_____
- ☐ Black or African American
- ☐ Presented at Grady between 9pm and 9am
- ☐ Under the influence of drugs or alcohol
- ☐ Expresses volatile anger or desire to retaliate
- ☐ Previously shot _____ _____

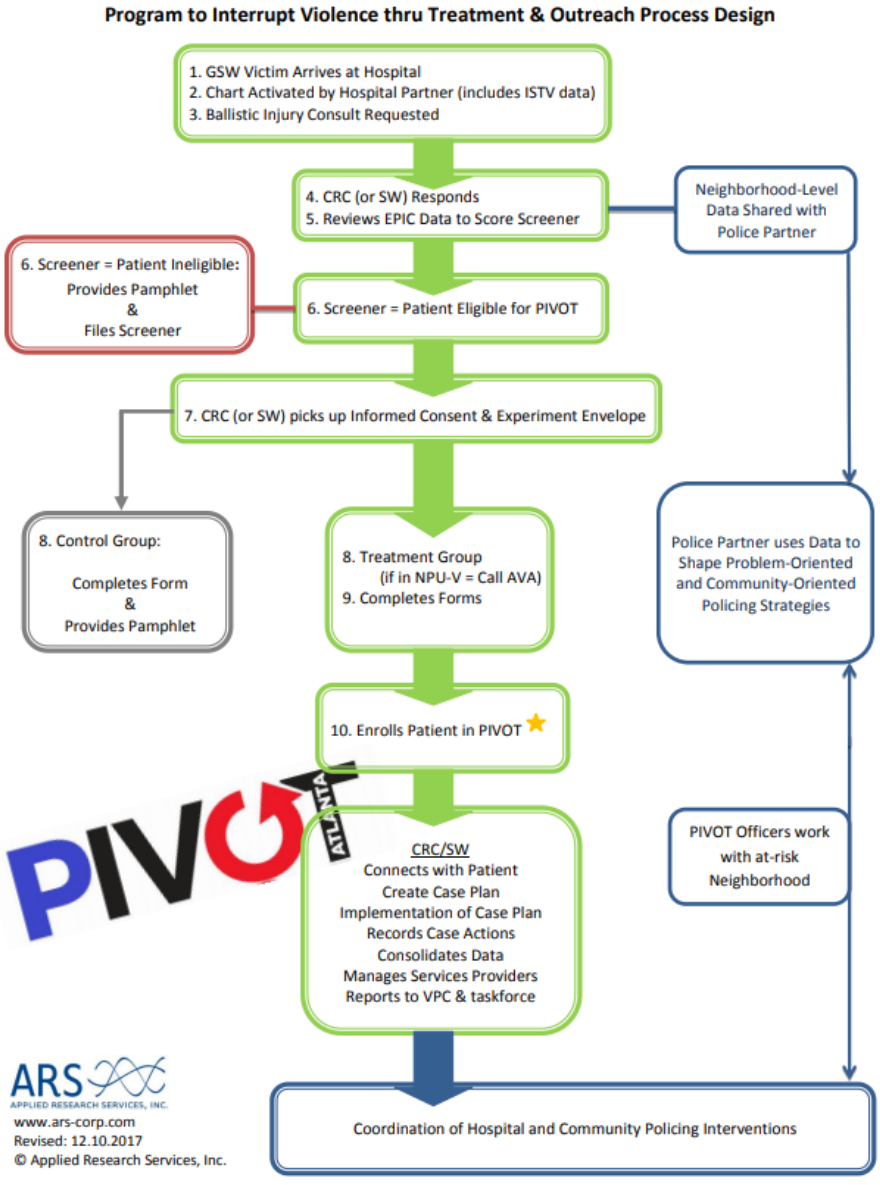
Notes:

Patient is **Ineligible** if **any** of the following (check all that apply, regardless of results):

- ☐ Self-inflicted injury
- ☐ Minor (17 years old or younger)
- ☐ Over 35 years of age _____
- ☐ Not English speaking
- ☐ Not cognitively independent/requires a guardian due to impair
- ☐ Injured during sexual assault
- ☐ Injured due to domestic violence
- ☐ Injured due to child abuse
- ☐ Is a prisoner/in custody of a law enforcement officer
- ☐ Zip codes of injury and residence outside of target areas _____ _____
  Res Inj

The graphic on the next page provides a flowchart of the PIVOT program intervention process. The process entails a gunshot wound victim arriving at the hospital. A social worker visits all persons that enter the emergency department with a GSW to do a quick assessment of patient needs post-release. Information about the contact is entered into the EPICS database. The CRC worked during regular business hours. Typically the CRC would start their day by reviewing EPICS information on GSW patients that entered the hospital the previous day (or over the weekend) and a screener form was completed

to determine if the person was eligible for the PIVOT program. A list of ineligible criteria was first considered. Persons that met one or more of these issues could not enter the program. Exclusionary criteria included a self-inflicted injury, being a minor under 17 years of age, and being a prisoner/in custody of law enforcement (see screener above). Eligibility required the victim to either live or have been injured in one of three zip codes, but was expanded after the pilot to six zip codes to enlarge the eligibility pool (30318, 30310, 30315, 30331, 30311, or 30354). To maximize efforts, these were the same zip codes where the APD PIVOT officers focused their work. If the person met the geographic requirements, at least three of the following also needed to apply: male, Black/African American, under 26 years of age, intoxicated, vengeful, or repeat gunshot wound victim. If these criteria were met, the patient then went through a randomization process which involved randomly selecting an envelope with a consent form and information as to whether this patient was in the treatment or control group (one in four intervention ratio). Once eligibility was established, the CRC would visit with patients and introduce the PIVOT program and solicit participation.



Control group eligible persons were introduced to the PIVOT program and were provided with a guide of community provider information. In order to officially be included in the control group, participants had to be enrolled, which entailed the completion of consent forms to be tracked for the project, completion of a survey, and completion of screening instruments. No direct services were provided to the control group. They received the resource guide advising them of local service providers, but they needed to rely on their own initiative to seek needed services.

Intervention group participants were introduced to the PIVOT program and typically given a copy of the community resource guide as well. However, the intervention group was also informed that if they enrolled in the program that they would receive direct assistance for program placement as well as mentoring from the CRC. Enrollment involved the signing of consent forms as well as assessments used to create an individualized case plan. The CRC advised that it typically took a series of three visits in order to gain enough trust from both the treatment and control groups before a conversation about enrollment could take place. Over the course of the visits the CRC would ask how he could serve the families and provide information on the hospital, victim assistance services, or even help communicate needs and questions to medical staff. The CRC characterized GSW patients and their families as very guarded and suspicious. It took time to build trust before persons would even consider enrollment. The CRC advised that often even after three visits persons were still apprehensive and sometimes more visits were needed. In some cases, it required the involvement of a parent or grandparent that believed the patient needed the services offered to finally garner agreement to participate.

Persons enrolled into the intervention group received the same enrollment package as the control group, but their assessment instruments were combined with a detailed bio/social/psychological/spiritual tool to identify key areas of need. A tiered treatment system (see Tiers of Service document in the Appendix) was employed whereby persons were prioritized for service intensity by their level of need. All of these pieces of information were combined into a detailed case plan created specifically to meet individual needs. Tier level determined the length of PIVOT program engagement, which ranged from six to 12 months.

In addition to the recruitment, assessment, and direct hands-on service connection for the PIVOT participants, the CRC was also responsible for building a community network of service providers that could support an array of participant needs. The CRC had a few months to get started on this task prior to the start of the PIVOT pilot and patient recruitment activities, but once the PIVOT program began, network activities and enlistment was completed in combination with other responsibilities. The CRC focused on building a resource network in the following areas: education/training, employment, financial, health care, shelter/housing, clothing/food, legal services, and transportation. The network was open to ancillary services, but the focus was to develop resources in these key sectors.

A resource guide was created with contact information for each service provider divided by service type and county (Fulton, DeKalb). This guide was given to both intervention and control group participants. The CRC advised that they gave the guide to all persons on their first interaction with

them. Persons whose eligibility was not clear on the first visit also received the resource guide. Issuance of the resource guide was a standard part of the initial visit to build trust and to demonstrate value in the PIVOT program and interactions with the CRC.

The CRC built relationships with the providers in the network to help facilitate the placement of persons into program and services. The goal was to achieve priority status for PIVOT participants whereby wait lists could be avoided, but this was not ultimately achieved. However, the CRC reported no problems getting persons into most programs and was able to quickly secure services to meet needs. Housing and treatment beds were the two main areas where service delays sometimes occurred.

In addition to building a network of service providers for PIVOT participant access, the CRC also sought to connect the network to create a more cohesive and robust working group to better serve participants. Three provider meetings were held to bring the network together to discuss issues, learn more about the services each agency offers, as well as to brainstorm ways to better coordinate service delivery. The CRC ultimately wanted to make the network meetings a more regular occurrence (perhaps monthly or every other month), but the other demands of the job limited the feasibility of doing so. Regular meetings notwithstanding, a network of providers was built to meet the needs of participants in an array of key service areas.

Process Evaluation

The research team expected to answer an array of detailed process evaluation questions including the optimal level of service for successful outcomes, as well as to obtain information regarding any observed differences between participants and controls that were successful and those that were not. However, the program failed to garner the level of participation needed in order to examine such issues. While the PIVOT program was fully operational for about 18 months (law enforcement efforts extended longer), the program did not meet expectations in terms of enrollment numbers, hampering our ability to examine such issues. However, many process issues were noted during the implementation process which contributed to the program's ultimate inability to reach expected benchmarks. These issues and solutions (when available) are included to assist in replication planning efforts.

Program Vision

While taskforce members contributed to the SPI grant proposal and all players expressed unity with the vision for the PIVOT program, the vision seemed to become somewhat amorphous and diffuse once the grant funds were issued. The medical arm of the taskforce became focused on the idea of violence interrupters and wanted to integrate them into the PIVOT framework. This seemed to cause an early divide and tensions within the team that were never fully reconciled (discussed more later through analysis of Wilder Collaboration Factors Inventory surveys and interviews). The early divide seemed to keep each partner operating within their silos (i.e. healthcare, law enforcement) and kept the group as

a whole from finding the expected level of common ground and a unified vision. Team members regularly operated within their own lens/perspective and struggled to bridge gaps between competing perspectives. They operated more or less separately as medical professionals, law enforcements professionals, and social work professionals addressing gun violence from their own professional perspective rather than as a unified group combining perspectives and finding common ground to address gun violence. This lack of alliance between members led to pervasive fractures and tensions within the group.

Program Staffing

Implementation of the PIVOT model hit many bumps along the way. One of the first issues was that funding could only be secured for one social worker to do the work of PIVOT within Grady. It had been expected that two persons would be managing responsibilities. Grady twice attempted VOCA grant applications to obtain funding for a social worker whose main responsibility would be building the provider network, but an application was never submitted. While one person was able to maintain the tenets of the program, it was done so on a much smaller scale than was needed to fully evaluate the impact of the program on gun violence in the target zip codes. Consistent feedback from the taskforce and the CRC was that the hospital-based portion of the PIVOT program needed more than one social worker to function optimally. One person was not able to assess all persons entering the hospital with a gunshot wound for program eligibility as well as recruit, provide intensive supports and service connections, and develop and maintain a community provider network to support the program. Simply put, it appears that more staff were needed to carry out PIVOT responsibilities. The CRC advised that an average social work caseload would be no more than 30 high-risk persons. Future efforts would do well to estimate the volume of enrollees expected and hire social work staff accordingly.

The PIVOT CRC worked Monday through Friday during regular business hours, which meant that they were not present at the hospital when many patients with gunshot wounds arrived at the hospital. Persons with serious injuries were admitted to the hospital and program recruitment visits could occur the next day (excluding weekends). But persons with less serious injuries were often treated and released during hours when the CRC was not present to conduct an in-hospital introduction to the PIVOT program and its benefits. The CRC advised that persons were much more receptive to the program when approached while they were still in the hospital. Cold calls made once persons had exited were rarely returned, yet many gunshot wound victims were exiting the hospital while the CRC was not present. Thus for many, the primary mode of introduction to PIVOT was through cold calls.

The research team had planned to use data from Grady to determine the hours when most GSW victims arrived at the hospital for treatment to set the CRC schedule. However, there were major delays obtaining this data and the CRC was hired before it was acquired and analyzed. The CRC was hired by Grady to work during regular business hours. After data acquisition and throughout the program's operation the research team recommended that the CRC hours be changed to ensure coverage during

the peak evening hours and weekends when persons with GSWs were most apt to arrive at the hospital. The CRC was not in favor of changing his hours and Grady management were not receptive to changing the CRC schedule, thus no changes were made.

There was talk of having the social workers that are already required to conduct consults with GSW patients in the emergency department prior to discharge introduce the PIVOT program. However, there were complications with determining eligibility on-the-fly, as well as concerns about adding responsibilities to persons with already demanding jobs. There was also talk of Emergency Department social work staff providing PIVOT resource guides and the CRC's business card to all GSW victims so that the eligible persons would at least possibly recognize the program name when the CRC reached out to them. However, it's unclear if any of these plans were enacted. It would be recommended that any site implementing a program like PIVOT make data-driven decisions about staffing hours to ensure coverage during peak patient admission hours.

CRC Role

The CRC was the face and functioning arm of the PIVOT program's hospital-based efforts. The research team encountered much push-back from the CRC, and in many taskforce meetings the CRC openly admitted to not liking and to not always following the established and agreed-upon research protocols. One of the main frustrations of the CRC was the control group; they felt bound by their role as a social worker to help all of those in need. The medical team on the taskforce seemed sympathetic to the CRC concerns as they were also practitioners called to serve all those in need. The CRC was especially frustrated that some of the control group enrollees were more motivated to change and desirous of support and services than were many persons in the intervention group. They felt obligated to help those in need and openly admitted that some service connection and mentoring conversations occurred with the control group. The extent of servicing of control group participants is not clear, as these interactions are not documented. Clearly an important component to an RCT design is having strict adherence to protocols. Research team efforts to gain compliance and understanding of the reasons behind the protocols were not well-received. Future efforts could employ comparison sites to serve as controls. If internal controls are desired (as used in this project), it would be recommended that any social work staff be made aware of the research protocol and commitments be gained prior to hiring to comply with said protocols. Consequences for not following protocols may also prove useful. This issue also perhaps speaks to larger issues of players not fully understanding the role of others on the team (which will be discussed later).

The CRC also voiced concerns about the PVIOT partnership with the police and the potential to damage his reputation in the target communities. While the CRC openly said that he liked the PIVOT officers and believed they were well-suited for their roles in the community, there were fears of being connected to the police in general and that having a negative impact on his ability to work with the target population. The CRC felt his effectiveness would be greatly diminished if persons felt he was

working in any way with the police. For this reason he took great strides to distance himself from the PIVOT officers as much as possible. He interacted with them during taskforce meetings, but said he did not interact with the officers outside of such meetings. The validity of the CRC's concerns are unknown, but his stance did thwart a part of the PIVOT program design which included having the CRC and officers liaise to build relationships and trust within the target communities. Future endeavors of this nature would do well to address such concerns early and to find ways to build bridges between the social worker, police, and community.

A part of the evaluation plan included shadowing the CRC to document fidelity to protocols as well as to note process issues. Four shadowing observation events occurred. Three observations were conducted by a doctoral candidate with extensive training as a qualitative field researcher, the fourth by a highly skilled investigator with more than 20 years of field research experience. The CRC accommodated the visits, but went to supervisors to express concerns about the shadowing experience interrupting the therapeutic experience and his ability to build rapport, and subsequently asked that they stop.

In April of 2019, the Injury Prevention Coordinator at Grady relayed feedback from the CRC and suggested that the process had not been helpful to the CRC and recommended that shadowing be stopped. No further field observations were conducted. Unfortunately, this type of project relies to a great extent on the collection of qualitative and field data to understand program complexities and nuances. Ceasing field work prevented the research team from understanding and documenting these issues, and prevented the research team from engaging in collaborative problem-solving. Many of the findings presented throughout this report are the opinions of the CRC as to why the PIVOT program did not function as expected, and many recommendations are based upon those opinions. Most of the CRC's opinions cannot be corroborated with data, field research, or documented observations by the research team. While this does not negate said opinions, is it important to note that confirmation by the research team is often lacking.

In lieu of these developments with shadowing, the research team recommended that the taskforce assign a committee to take charge of the process evaluation to ensure that the needed level of data was collected. It was suggested that a process evaluation team be elected by the taskforce to take charge of the process evaluation. The program coordinator suggested including all partners, agencies and personnel in the evaluation process. In the end, the taskforce did not take action and most process evaluation data was lost to a lack of observations and data collection.

Enrollment Process

The PIVOT enrollment process was fraught with issues. The first issue to surface involved problems in determining program eligibility. First, the CRC had to manually scroll through EPICS hospital lists of persons coming to the hospital for treatment and search for those with a gunshot wound. In other

words, there wasn't a flag to identify the target population. Part of the project plan involved creating flags and alerts within Grady's EPICS database, but this did not materialize. The CRC had to scroll through hospital patients by entry date and complaint (the CRC demonstrated this process for researchers during a shadowing). Once GSW victims were located, multiple screens in EPICS had to be searched in order to answer the eligibility screener questions. Often after an intense search of multiple screens, the necessary information was not located to determine eligibility. As an example, address information for both the incident location and patient address were missing or incomplete.

The CRC advised that they relied upon the social worker notes in EPIC as they tended to contain more detailed information about issues such as whether the person was in police custody, language barriers and the suspected/actual domestic abuse or sexual abuse related to the injuries. However, even social work notes were often lacking the data needed to determine eligibility. This required the CRC to meet with "potential" participants and ask questions to determine eligibly, using limited CRC resources, often to learn that persons didn't meet eligibility criteria. A flag or better system of eligibility identification would have saved much CRC time and effort, which could have resulted in time being used for other PIVOT responsibilities (the research team learned that such identification flags in the database were implemented with the opening of the Trauma Recovery Center).

In addition, many persons that did meet eligibility requirements lacked needed contact information in EPICS. Phone numbers were often missing or were incorrect and the CRC was unable to contact discharged patients to inform them about their eligibility for the PIVOT program. Some social workers would log multiple contact numbers to include family members, which greatly assisted the CRC in making contact after discharge. Unfortunately, most patient files lacked such information. Potential participants were therefore often lost due to missing/incorrect contact data.

Even in situations in which contact information was available, the CRC still struggled to contact potential participants. While a phone number may work to leave an initial voice message, or to even make contact with a potential participant or family member, the numbers often were no longer in service when secondary contact was made. "Burner phones" and a constant changing of contact numbers was a hallmark of much of the target population. This greatly impeded recruitment efforts both for persons whom exited prior to a CRC visit, as well as those with whom the CRC had made contact, but that nonetheless exited Grady prior to enrollment. Once they left the hospital, the ability to make contact by phone was a consistent and pervasive obstacle.

The CRC estimated that 20-25% of persons were already discharged from Grady prior to making initial contact. Invalid contact information was an issue, but even when he had a valid number, challenges were expressed garnering participation on the phone. The CRC said that most persons did not answer the phone nor return his messages, were reluctant to talk to him if they did pick-up, were very suspicious and untrusting, and some openly said they didn't believe that he wasn't from law enforcement. The CRC characterized recruitment by phone as incredibly challenging and said that persons were much more receptive to the PIVOT program when it was introduced to them at the

hospital. Not a single intervention group participant was successfully recruited who had been discharged from the hospital prior to the CRC making the initial in-person contact.

The system of determining intervention and control participants was also not without issues. An RCT system was set up whereby the Injury Prevention Coordinator would pair eligible participant names with consent packages that would determine if persons were in the intervention or control group. This was logged to track which groups persons fell into. This system ran into failings when the coordinator was offsite or indisposed; the CRC did not know whether persons were in the intervention or control group, leading to delays in visits, or in initial contacts where the CRC did not know a person's status and could not present the full array of benefits of the program as control group participants would not be eligible for such benefits. After a shadowing visit in March of 2019, it was suggested by the observer that an odd/even system of MRNs be utilized whereby the CRC would know immediately which group the person fell into. Analysis by the research team determined that this system would result in sufficient numbers of intervention/control participants, but for unknown reasons the process was not changed.

Enrollment efforts were also stymied by a simple reluctance on the part of the target population to participate. Suspicion and distrust apparently ran deep among potential participants. Many didn't want assistance or think that they needed help. There was a general disregard of the program by many potential participants. The CRC advised that often it was pressure from a parent or grandparent that convinced a person to participate. Under these circumstances of distrust and skepticism, the CRC advised that it took many visits to court someone to participate in the program. He typically employed a three-contact process in an effort to garner trust. The first visit typically involved providing a get-well card with his business card, the PIVOT resource guide, and a brief introduction to himself and the PIVOT program. The visit usually concluded with a promise to visit again soon. Usually within a day or two the CRC again checked in on the person and inquired about immediate needs. If rapport developed naturally during this visit, then a third visit was made a day or two later and the person was officially presented with the PIVOT program and an offer to participate. If rapport was not developed during the second visit, more visits were made to gain trust before official recruitment began.

Gaining trust and a willingness to participate in the program proved to involve much more time than anticipated. The three-contact model involved the CRC devoting time not only to multiple visits, but to investing the level of time needed to build trust. Oftentimes persons were released before the lines of trust were strong, which greatly impeded the CRC's recruitment abilities. In addition, building trust did not equate to an interest in participation. Often persons would engage in mentoring-type conversations with the CRC, with no accompanying desire to change or to avail themselves of program services. While the CRC saw the need for participation and service acquisition, potential participants often did not share this view.

Another challenge to program enrollment was that many of the GSW patients presenting at Grady lived/were injured in neighboring DeKalb County and were thus not eligible for the program. At the

start of implementation concerns were expressed by the CRC about an adequate number of study participants. Analysis on the numbers of persons with gunshot wounds presenting at Grady was completed to develop the screening criteria to ensure an appropriate sample size. After the pilot, the research team conducted secondary analysis and the number of eligible Fulton County zip codes was expanded, which enlarged the pool of GSW patients eligible for PIVOT participation.

Enrollment in the PIVOT program involved the completion of an enrollment package that contained several screeners and survey questions to learn more about participants. The CRC expressed concerns about the consent forms and some of the questions required, in particular questions related to police and gang involvement. He felt these questions made participants uncomfortable and potentially interfered with the hard-earned trust that was developed over the series of introductory visits. While the forms ultimately were not changed, the CRC remained steadfast in his feelings that the forms had a negative impact during the early, vulnerable moments when the CRC was working to build trust and establish himself as a mentor. He felt that asking about police and gang activities had an erosive effect on these critical efforts.

The CRC utilized a bio/psycho/social/spiritual intake form to identify participants needs. This assessment served as the basis of the participant's case plan. During the early phases of enrollment, the CRC felt that a system of need prioritization was required so that high and low risk participants could be identified, parsed, and time divided appropriately to ensure those at most risk received the highest level of his time and attention. The CRC created a tiered system of care whereby the number of identified needs would place persons into one of three tiers. Persons in Tier I had the lowest levels of need; Tier III the greatest level of need. The CRC prioritized his time investment in each participant based upon their tier, with Tier III receiving the most attention and hands-on interaction time. This unfortunately did not always pan out as often persons in Tier III who were most at need were not receptive to the time and services of the CRC. While the Tier system was a well-intentioned and responsive way to divide limited CRC time, in the end the CRC's time was spent with participants that returned calls and were willing to engage, irrespective of their assigned tier level.

PIVOT Participants

Participants completed an enrollment packet and were informed that PIVOT participation involved intensive hands-on service connection and mentorship. While persons may have been well-intentioned when they enrolled in the program, the CRC reported the loss of contact with participants to be a serious challenge. Sometimes participants simply would stop returning calls, but often participants changed phone numbers without providing the information to the CRC. This left the CRC with no way to make contact. While email addresses were obtained from persons willing to provide it, the CRC advised that it was not an effective way to contact participants – they did not respond to emails. When possible the CRC would reach out to family members with whom he had gotten contact information,

but often they changed phone numbers as well. Loss of contact was a pervasive issue which greatly impacted the CRC's ability to provide intensive mentorship, as well as to connect persons to services.

The CRC expressed that the position was designed to be hospital-based, but it was his feeling that the role needed to include funding to also go into the community for face-to-face contact. Going to participant homes during times when contact was lost to reconnect was seen as essential to keeping participants engaged and to ensure that needed services were received. The CRC did not receive reimbursement for gas or mileage as the position was expected to operate strictly from Grady. There were many occasions when he felt it necessary to visit participant homes, which he did at his own expense.

Another issue was a lack of follow-through by participants to obtain services from service provider partners. The CRC advised that he would set up appointments (often even getting premier slots sought by many), that were never attended. The CRC set up an elaborate system of reminder texts and phone calls leading up to the appointment to ensure that persons attended. But despite his best efforts, persons often did not show up as scheduled. This was a stressor on the CRC's job as much time and effort was expended to ensure persons connected to services, and it was also a stressor on providers who were unable to schedule others in need for time slots that went unused. The CRC advised that the level of no-shows caused friction with some community partners with whom he collaborated. A goal of the program was to secure PIVOT time slots (i.e. Tuesdays at 1pm) which would always be available to program participants and would ensure speedy provider connections. However the level of no-shows to appointments nipped this possibility. Providers were not willing to reserve a slot when persons were not apt to appear as scheduled. Had community contacts been reimbursed, he felt that his time would have been well spent taking the most high-risk participants to appointments to ensure attendance and receipt of needed services.

The CRC felt that at least some of the lack of follow-through was related to fear, uncertainty, and a lack of know-how. Participants were young men without much life experience that did not typically embrace or have the means to engage with service sectors such as medical care and counseling services. There was suspicion and mistrust due in large part to a lack of familiarity. In addition, many of the participants lacked basic things like identification and social security cards in order to gain employment. He characterized much of their resistance to attend such appointments as based in fear. Participants would not voice fear, but he advised that if you took them to the appointments and walked them through it, they were compliant and usually happy to obtain needed services. Left to do such things on their own typically resulted in a failure to launch. The CRC felt that much hands-on attention was required to usher participants through channels that were new, scary, and where there was mistrust. The CRC felt hands-on case management was a necessary part of the position due to the clientele being served. The CRC argued that adapting the role to the needs of participants would involve more hands-on assistance to actually take them to appointments, help them find jobs and walk them through all steps of the application process, as well as intensive mentoring. This would necessitate a smaller caseload, much time away from the hospital working with participants in the community, as

well as a need to reimburse for expenses such as gas, mileage, and things like application fees that participants could not afford.

Exit surveys were expected to be fertile ground for information about how the program served PIVOT participants and areas ripe for improvement. Unfortunately exit surveys were obtained from very few program participants and weren't provided to the research team. The earlier discussed loss of participant contact was the main culprit. Participants did not exit the program because their needs had been met and they successfully discharged. Most participants exited the program by losing contact with the CRC who could no longer track them down to continue service connection and mentorship. The research team had considered offering incentives to conduct a focus group with PIVOT participants, but without valid contact information there was no way to invite participation.

The CRC advised that the community provider network developed spanned the continuum of care and was able to meet the needs of participants in most areas. Persons typically did not avail themselves of the services available, but they were there if they chose to engage. However, the CRC noted three areas where participant need existed that he failed to find within the community. The first was access to free medical supplies. GSW victims often had injuries requiring regular medical supplies such as catheters, which are costly and outside the ability of many persons to afford. Another challenge was connecting participants to quality housing options. While emergency housing could be secured, the CRC advised that efforts to connect with options for quality long-term housing had not borne fruit. He advised that conversations with other service providers illuminated a dearth of options which was reflective of a larger community problem and something that required community solutions. Lastly, he cited a lack of quality family counseling options. The CRC said that the impacts of gun violence (as well as other systemic issues) was felt by the family as a whole. Family counseling was therefore needed by the entire family unit, but such options were very limited. This was noted as an important priority area that the CRC felt needed to be addressed in order to provide the healing and skills needed to successfully navigate the impact of the trauma and other issues which kept participants and their families stuck in unhealthy cycles and kept them vulnerable to future gun violence.

2. Community Oriented Policing

The community oriented policing strategy involved APD hiring two community policing officers with SPI funds. These officers were to serve as a rapid response team in the immediate aftermath of a shooting to cool tempers, gather information about the context of the shooting, and rally community leaders to prevent retaliatory violence – if such a threat existed. The plan was that officers would liaise closely with Grady's CRC, working to build relationships and trust with community leaders. Their goals after a shooting were two-fold: first, to be a deterring presence in a community in the immediate aftermath of a shooting and once the victim is released from the hospital; and second, to assure community members that APD will do everything possible to bring justice to the victim.

One of the officers was to be cross-trained with the Gang Unit and to serve as a rapid responder to the Grady ED to gather information from families and victims. Their role was to build trust and rapport with victims' families so they would be more willing to speak with law enforcement during the investigative process.

ARS was to work with APD to identify target neighborhoods to concentrate APD efforts. Hotspot maps created by combining APD and Grady data were to be integrated into the methodology to assist APD in further targeting their community efforts.

The actual implementation of the community-oriented piece was much different than envisioned and as described above. The assignment of officers to the project was delayed significantly due to changes needed in APD standard operating policy in order to designate PIVOT officers. This process took much longer than expected and required legal review as well as approval by the Chief of Police and the Mayor's office. Eventually the needed signatures were acquired and two dedicated officers were assigned to serve as PIVOT officers. Three neighborhoods were selected for targeted efforts. One of those neighborhoods changed during the project to include a larger, more responsive geographic area. Once operational, the community policing leg quickly ran into problems with internal APD policies and procedures, as well as a disconnect from the CRC. The rapid response team model which involved interacting with victims and families both at Grady hospital and in the community did not materialize as planned, nor did efforts ensue between APD and the CRC.

Despite the numerous obstacles enumerated above, a community policing strategy emerged and remained relatively consistent throughout the project. The strategy involved no arrests – the officers were tasked with building trust and improving relationships between the police and target communities. Rapid response within the community and hospital did not occur as expected, nor did collaborative efforts between the police and CRC. The police instead focused their efforts on public interaction in the target areas in the form of talking with neighbors, providing contact information for victims' advocates, providing PIVOT service provider resource guides, and engaging with the public in organized events in the target communities (such as community clean-ups, library card drives, rallies, food drives, and youth events). While they did not serve as rapid responders after shootings as envisioned, they did engage with the community after shootings to listen to residents, gather information for investigators, and generally help to restore a sense of calm and stability to the community. They also often met with the families of shooting victims to provide information on the Atlanta Victim Advocate (AVA) program that helps support crime victims and their families. They made weekly appearances at the local community center and schools, and welcomed invitations from community leaders to interact with the target neighborhoods as needed to build trust and put a positive face on the police. In short, these officers responded to community needs. For example, the head of security at a large apartment complex would ask the officers to regularly meet with residents so they could ask questions, and sometimes requested interactions with individual families needing things such as advice on domestic violence situations or to talk with troubled youth. During work on other projects in the target neighborhoods by the research team, it wasn't uncommon for persons to

make reference to the PIVOT officers by name and to refer to them as “our community police officers” or “police liaisons that support the community.”

The PIVOT officers also received training in collective efficacy, and in the summer of 2019, CJCC developed a detailed collective efficacy plan for officers. The goal was to build trust in the target neighborhoods through collective efficacy efforts which were expected to involve about 50% of officer time. These efforts were off to a strong start with the PIVOT officers and CJCC meeting monthly for updates and progress reports. Unfortunately the COVID-19 pandemic impeded these efforts in early 2020 as the officers were forced to engage in other public safety priorities.

Process Evaluation

The community policing strategy changed greatly from the original vision and the reasons for these deviations are varied. One of the earliest barriers to emerge concerned bureaucratic processes which delayed by more than a year the hiring/assignment of officers to the PIVOT project. Changes in SOP, legal reviews, and even the Mayor’s signature were needed in order to appoint staff to the project. In addition, there was also staff turnover, both at the officer level and leadership of the PIVOT officers. The original two PIVOT officers were reassigned and replaced with a new team early on. Leadership over the PIVOT officers (Major) also changed four times over the course of the project, further leading to confusion about roles and responsibilities. Leadership varied in the degree to which they embraced the PIVOT mission and tactics. For example, while officers were not assigned to arrest in the target areas, one supervisor instructed officers to do pullovers which was in stark contrast to the community policing face that was implemented under the previous supervisor. While turnover and promotions are a normal part of business as usual in a large police agency, the PIVOT program espoused a non-traditional role for law enforcement which was not universally supported by each of the changes in leadership. PIVOT was a very small unit that served an area plagued with violence and crime; the non-traditional PIVOT approach was innovative and very much outside the scope of experience of incoming leadership. Stability in leadership may have brought more continuity to APD’s PIVOT efforts.

A change in one of the target neighborhoods was required early in the initiative. Of the three selected communities, one of the neighborhoods (Fairburn Heights) was a concern to the officers. The community was very small, and officers said that they were unable to find public gathering spaces within the community in which to interact with people. In addition, residents and businesses were not receptive to their efforts to communicate and work together. The research team selected another community to serve as the third target site with a disproportionate amount of gun violence that had a larger population (Pittsburgh). The new site was close to the Mechanicsville site and both communities were already involved in overlapping work through the Annie E. Casey Foundation, with NPU-V doing healing circles. The officers found this community to be a better fit and much more receptive to their efforts. As a result, they were able to quickly start building relationships within the Pittsburgh community.

Documenting the efforts of PIVOT officers was a challenging task for the research team. Most of the work of the PIVOT officers was done off-record, with officers interacting on an ad hoc basis between the three communities. To best understand the daily interactions of the PIVOT officers, an end-of shift report was created. The report was created in Survey Monkey and officers simply logged into a link each night and were able to use a simple form of drop down menus and click boxes to quickly capture their daily activities. The research team did not want to add burdensome work on officers, and therefore the rapid form allowed them to click and register their activities in under five minutes.

The design of the community officers was to have the PIVOT officers serve as a rapid response team after shootings. They were to gather information about the shooting, help to settle tensions and tempers and to rally the community. Rapid responses were also to extend to the Grady ED, where information could be gathered from families of the victim. Rapid response never materialized as envisioned, primarily due to APDs own internal operations. The gun violence unit has its own protocols, practices, and intelligence systems. They did not want PIVOT officers to interfere with active investigations. There was also concern that having multiple officers could confuse victims. In addition, there was much pushback from Grady doctors about having police officers in the emergency room.

After much back and forth, rapid response duties were changed and PIVOT officer work focused primarily in a community policing capacity to make connections with the community and to build trust and alliances. Officers did also sometimes engage in a reduced rapid responder capacity within the community after shootings to listen to resident concerns and to help reduce tensions. They also met with some families of those that had been shot and provided information for Atlanta Victims Assistance (AVA). AVA provides support to victims of crime and their families through court advocacy and the provision/connection to needed services for victims of violent crime.

Another piece of the initiative that did not take shape as planned was the expected coordinated efforts by the CRC and the PIVOT officers to build relationships and trust within the community. While the PIVOT officers were willing to cooperate and work together, the CRC was not. The CRC said that he supported the efforts of the police in the target neighborhoods and felt that the officers assigned as PIVOT officers were well-suited to the task at hand, but he was apprehensive of being personally associated with police efforts. He described the level of distrust between the community as so high that being associated with the police could negatively impact his ability to effectively navigate and complete his work responsibilities. Apparently, the CRC feared that his reputation would be sullied by association with APD, which would risk losing the trust of the community based upon perceptions and the actions of APD. The CRC would not interact with officers within the community and virtually no networking or information-sharing between the CRC and PIVOT officers occurred outside of taskforce meetings.

Hotspot maps were expected to be a large piece of the focusing and directing of the initiative to areas most negatively impacted by gun violence. Officers were expected to specifically target areas found to

be most vulnerable on hotspot maps, but this never materialized. This will be discussed more in the next section.

While the PIVOT officers were primarily assigned to the target neighborhoods, they were often pulled away from PIVOT duties and placed on special assignments for weeks at a time. For example, the officers were required to serve on teams providing Super Bowl-related security in 2019 for several weeks when Atlanta hosted the game. It's unclear the impact these temporary reassignments had on their trust-building efforts, but during interviews with partners of the police efforts in the target neighborhoods, two of the persons interviewed mentioned officer absences due to other agency assignments as pervasive and they expressed concern that the agency did not better prioritize their work in the community.

The taskforce envisioned that the PIVOT officers would be able to conduct their duties without having to don official APD uniforms. The idea was for community officers to have more of a community-friendly appearance by wearing street clothes, or at the very least, a less formal version of the APD uniform. APD policies however prevented PIVOT officers from wearing anything other than the formal officer uniforms. Departmental policies requires that officers on duty always be ready to respond to calls. As PIVOT officers, they were considered regular on-duty officers and could be called to support other officers, if needed. For this reason, they were always required to wear their formal uniforms. The officers themselves and the taskforce were frustrated and felt that the officers could serve the target neighborhoods better if they looked less like police officers and were able to blend in a bit more as they carried out their duties.

3. Information and Data Sharing

The third component of the planned implementation of the PIVOT approach was data sharing. The data sharing model relied on the merging of APD violent crime data with anonymized violent injury data collected in emergency rooms, the production of hotspot maps from that data, and the use of those maps to develop community-level interventions that reduce violent injury/crime. The success of this part of the approach is based on the Cardiff Model for Violence Prevention developed in Cardiff, Wales, in the United Kingdom. After initial merging of data, the original Cardiff project observed that 53% of violent injuries reported in the emergency room were not reported to law enforcement. Following inception and implementation of hot spot identification and communication of data to law enforcement, Cardiff observed a 50% decrease in violent injuries in hospitals, 42% decrease in admissions and violent crime reported to police, and a £7m savings in violence related healthcare expenditures in 2007. This data sharing model was to be facilitated by the Violence Prevention Coordinator at Grady Hospital, who would pass secure anonymized data to the APD's Crime Analysis Unit. Violent injury data, including mechanism of injury, weapon used, date, time, and location, is collected from patients by nurses in the emergency department using the violent injury screen in EPICS.

The anonymized data was to be shared securely with APD and Applied Research Services, Inc. (ARS) to create hotspot maps combining APD and hospital data.

Unfortunately this component never occurred. The planned sharing of hospital data was met with national legal challenges which put the effort on hold. The hospital and data team at APD awaited resolution of this issue in the courts, and data was not exchanged. This issue was later resolved with state public health agencies becoming the data storehouse for mapping purposes. A year five extension was specifically geared towards this effort and realization of the Cardiff Model in Atlanta. This effort was hindered due to the global COVID-19 pandemic and civil unrest that characterized the summer of 2020 in Atlanta. The Atlanta Police Department therefore had other pressing priorities and were no longer interested in adoption of the Cardiff Model. Efforts were made to secure another police department serving Atlanta in these efforts. The Metropolitan Atlanta Rapid Transit Authority (MARTA) PD (the police department that services the public transportation network throughout the city) and Georgia State University PD which is located in metro Atlanta were both approached, but neither agreed to participate. To date the Cardiff Model has not been implemented in Atlanta (Fulton County).

Gears shifted in year five with the failures to gain agreement to implement Cardiff, and instead efforts turned to generating community interest in the Cardiff Model as well as how to effectively onboard interested agencies. As will be discussed later in the report, a focus group was conducted with residents of the target communities to gauge support for implantation of the Cardiff Model, as well as to gain a better understanding of how the Cardiff model could be most effectively presented to the community to garner understanding of the model as well as support. In addition, an onboarding packet was compiled as well as an onboarding call with the Albany, Georgia Police Department and representatives from the local hospital, Phoebe Putney. The purpose of this call was to prepare both agencies for submission of a SPI application while noting the resultant questions and issues which could help with improvements to the onboarding packet. Additional objectives were to recruit new Cardiff partnerships and to serve others that might be newly engaging in Cardiff efforts about potential challenges to assist in planning efforts.

DATA AND INTELLIGENCE

The success of the Atlanta SPI initiative relied heavily upon data and intelligence. To keep the collaboration informed and to share relevant data an intelligence, a Google drive was set up for the taskforce. Access was only available by the core taskforce members. This practice began in September of 2016 when funding was announced to the group. While there were struggles obtaining many pieces of needed data, the SPI effort pushed forward. Data was used from multiple sources to identify target participants and communities. In addition, data collection efforts included surveys, interviews and shadowing. Training was also an important component of the initiative to ensure evidence-based practices (EBPs) were integrated into all aspects of the project. Each of these areas will be discussed in turn, below.

Identifying Target Participants: Recurrent Firearm Violence Profile

Data and Methods

To understand the population most likely affected by recurring or retaliatory gun violence in Atlanta, longitudinal analyses were used to compute a risk profile. The graphic below illustrates the sources of data used in this analysis. The Atlanta SPI historical cohort (N=4,058) was defined as any shooting victim

who presented to Grady Memorial Hospital or the Atlanta Police Department between 2013 and 2016. Self-harm, accidents (ruled by both agencies), and deaths were excluded to produce a population of nonfatal intentional firearm violence victimizations. It was the goal of PIVOT to reduce violence by serving this population.

Qualifying firearm violence encounters were captured by 54 applicable ICD9 and ICD10 hospital E-codes or police incident reports. The sample from Grady Hospital included 4,442 cases from the charting system and 2,469 from the Trauma Registry. The sample from APD included 2,309 cases from the agency's records management system. Each system maintains an agency-specific identifying key(s) to each person's episodic information. A series of probabilistic matchings were programed to delineate unique person-based records and link them with all related identification numbers to clean duplicate cases within and between the tables.

Next, all related records for those individuals were extracted from the two Grady databases and five types of criminal justice system data housed in separate databases by APD, Georgia Bureau of Investigation (GBI) Crime Information Center (GCIC), the Georgia Department of Corrections (GDC), and the Georgia Department of Supervision (GDCS). The data were triangulated to develop a comprehensive dataset. That dataset was used to develop the profile of an individual prior to a new shooting, felony violent or gun-related incident.

Table 4. PIVOT Historical Cohort Descriptive Statistics (N=4,058)

	Min	Max	Mean/%	S.D.
Repeat Shooting or Retaliation	0	1	28%	.45
Male	0	1	90%	.31
Nonwhite	0	1	94%	.23
Age	0	78	30	11.73
Evening/Early Morning Hours	0	1	51%	.50
Target Zip Codes	0	1	33%	.47
Prior Mental Health Problem	0	1	8%	.27
Prior Abuse Indicated	0	1	33%	.47
Prior Other Injury	0	1	48%	.50
Prior Illegal Drug User	0	1	54%	.50
Prior Tobacco User	0	1	54%	.50
Prior Alcohol Problem	0	1	16%	.37
Prior Criminal History				
Any Arrest	0	73	3.61	5.99
Felony Arrest	0	39	1.73	3.20
Misdemeanor Arrest	0	55	1.88	3.40
Violent Arrest	0	1	29%	.45
Property Arrest	0	1	34%	.47
Drug Arrest	0	1	29%	.46
Gun Charge	0	1	11%	.32
Parole/Probation Violation	0	1	23%	.42
On Parole/Probation	0	1	30%	.46
Incarceration	0	1	11%	.31
Verified Gang Member	0	1	3%	.16
New Arrests				
Any Arrest	0	13	12%	.32
Felony Offense	0	7	9%	.29
Misdemeanor Offense	0	8	7%	.25
Violent Crime	0	1	3%	.17
Property Crime	0	1	4%	.19
Drug Crime	0	1	4%	.19
Gun Charge	0	1	3%	17
Supervision Violation	0	1	6%	.23

Repeat Gun Violence in the Historical Cohort

Of the more than 4,000 shooting victims, 28% experienced another nonfatal intentional firearm violence victimization or committed a violent or firearm offense (nearly half of which occurred within a year of the first shooting). Table 4 above displays the Atlanta SPI historical cohort descriptive

statistics. The mean is shown as an average number or percentage and the standard deviation (s.d.) is a degree of variation. Shooting victims were primarily male, nonwhite and averaged 30 years old. Half were shot between 9pm and 9am and a third in the zip codes identified as hot spots of gun violence.

Approximately 8% had prior mental health problems like schizophrenia or bipolar disorder. A third were exposed to verbal, physical, or emotional abuse. Nearly half had experienced another type of injury, such as a serious car wreck or broken bones. The majority had used tobacco or illegal drugs previously, known either through self-report, treatment, or an associated arrest.

Sixteen percent of the shooting victims had a known alcohol problem to the point where they suffered from alcohol poisoning, were diagnosed with a drinking problem, or had been arrested for driving while drunk. In fact, most of these individuals were in previous contact with the Georgia justice system, averaging four prior arrests, two each for felonies and misdemeanor crimes. Approximately a third had a violent, property, and/or drug arrest event, with 11% of those arrests including a gun and 23% a parole or probation violation charge. Overall, 30% of the shooting victims had been on probation or parole supervision and 11% had been incarcerated. Verification of 3% gang membership is related to the Georgia street gang activity charge and APD or GDC investigations.

At-risk for Repeat or Retaliatory Gun Violence

Individuals who are at risk of repeat or retaliatory shooting exhibit significant differences in their descriptions compared to shooting victims who are not at risk. The second and third columns in Table 5 (next page) show the characteristic percentages per group. The last two columns list the measures of association test findings for those groups' characteristics. The Chi-square value represents the index of difference, with larger numbers representing larger disparities between the groups. Significantly different levels are denoted as ***($p<.001$). All characteristics are significantly different between groups except for those who are nonwhite, have a prior alcohol problem, and were shot during early morning or evening hours.

At-risk individuals are often male, nonwhite, and young adults (18 to 35 years old). Over two-thirds were either residing or shot in the target zip codes (30318, 30315, 30310, 30331, 30311, 30354). Prior mental health issues were documented among 10% of at-risk individuals. Nearly half had experienced prior abuse and had another type of injury. Drug and tobacco use were prevalent at 71% and 68% respectively, and, 17% had an alcohol problem.

Indeed, a large majority of the at-risk individuals had a criminal history. Felony and misdemeanor arrests were both present in their pasts. They had 43% prior violence, 51% property, and 41% drug arrests. Among their arrest charges, 22% committed a gun crime and 34% had one or more parole or probation violations. About half had been on parole or probation supervision and nearly a quarter served a prison sentence. In general, the most significant differences between those at risk and those who are not at risk are related to illegal behaviors – drug use and criminal justice involvement. This victim/offender overlap supports the call for the hospital and police to collaborate on violence reduction efforts. Those efforts can be supported by further understanding the extent to which certain characteristics are associates with risk of recurrent victimization or offending.

Table 5. At-risk Profile Descriptive Statistics

	At-Risk Group		Difference	
Profile Measures	Yes (n=1,129)	No (n=2,889)	Chi^2	Sig.
Male	96%	87%	59.11	***
Nonwhite	95%	94%	1.55	
18- 35 years old	72%	63%	30.94	***
Evening/Early Morning Hours	53%	50%	3.58	
Target Zip Codes	38%	31%	20.88	***
Prior Mental Health Problem	10%	7%	11.58	***
Prior Abuse Indicated	41%	30%	41.22	***
Prior Other Injury	57%	45%	47.37	***
Prior Illegal Drug User	71%	48%	182.98	***
Prior Tobacco User	68%	48%	129.45	***
Prior Alcohol Problem	17%	15%	3.48	
Prior Any Arrest	74%	48%	222.04	***
Prior Felony Arrest	64%	36%	263.74	***
Prior Misdemeanor Arrest	61%	42%	115.56	***
Prior Violent Arrest	43%	23%	148.16	***
Prior Property Arrest	51%	27%	199.73	***
Prior Drug Arrest	41%	25%	101.76	***
Prior Gun Charge	22%	7%	173.60	***
Prior Par/Prob Violation	34%	8%	111.13	***
Prior Parole/Probation Episode	46%	24%	180.01	***
Prior Incarceration	21%	7%	162.02	***
Verified Gang Member	6%	1%	75.00	***

How likely is a shooting victim to be shot again or engage in retaliatory behavior?

Table 6 depicts the individual odds ratios for characteristics found among those shooting victims at-risk of a recurring violent event. The odds were calculated based on a variation of each factor occurring within risk – a bivariate association. Factors are not adjusted for any overlapping explained variance of other factors. The correct interpretation of these odds is compared to the absence of that factor, not the presence of another. For example, males are three times more likely to be at risk than females.

Not surprisingly given findings in the professional literature, the strongest independent relationship with risk is gang membership. Gang members victimized by gun violence are five times more likely to be shot again or to retaliate. Similarly, risk is three times more likely among those who have a prior arrest, prior felony arrest, a prior arrest with a gun or were incarcerated.

The odds of risk are more than doubled for individuals who use illegal drugs or tobacco. Risk is twice as likely among those who had a misdemeanor, violent, property or drug arrest, with property arrestees having the highest odds. Compared to persons not on parole or probation supervision and who did not get arrested for a supervision violation, risk of repeat gun violence is two to two-and-a-half times higher.

Young adults and those with mental health issues have over one-and-a-half times higher likelihood of risk. Odds are also increased among nonwhites, those associated with the target hot spot zip codes, and who have an alcohol problem. It is also important to understand how the recurrent event is related to subsequent offending patterns.

What are the offending patterns after recurrent events?

Table 7 shows the offending patterns for individuals who incurred a second shooting victimization or exhibited retaliatory shooting behavior. Nearly half were arrested again, a third for a felony. Their new arrest types were 11% violent, 13% property, and 14% drug. Those arrests include probation or probation violation charges among 20%, and 10% had a gun-related charge.

Patient Eligibility Screener

The dataset was used to create a patient eligibility screener that would ensure a study group of sufficient size to create both an intervention and control group of adequate proportions for study purposes. Detailed analysis of demographics and clinical

Table 6. Risk Factor Strength (N=1,129)

Profile Measures	Independent Odds Ratio
Male	3.12
Nonwhite	1.21
18- 35 years old	1.53
Evening/Early Morning Hours	1.14
Target Zip Codes	1.40
Prior Mental Health Problem	1.52
Prior Abuse Indicated	1.60
Prior Other Injury	1.62
Prior Illegal Drug User	2.73
Prior Tobacco User	2.29
Prior Alcohol Problem	1.19
Prior Any Arrest	3.08
Prior Felony Arrest	3.19
Prior Misdemeanor Arrest	2.14
Prior Violent Arrest	2.36
Prior Property Arrest	2.74
Prior Drug Arrest	2.10
Prior Gun Charge	3.57
Prior Par/Prob Violation Charge	2.28
Prior Parole/Probation Episode	2.65
Prior Incarceration	3.51
Verified Gang Member	5.15

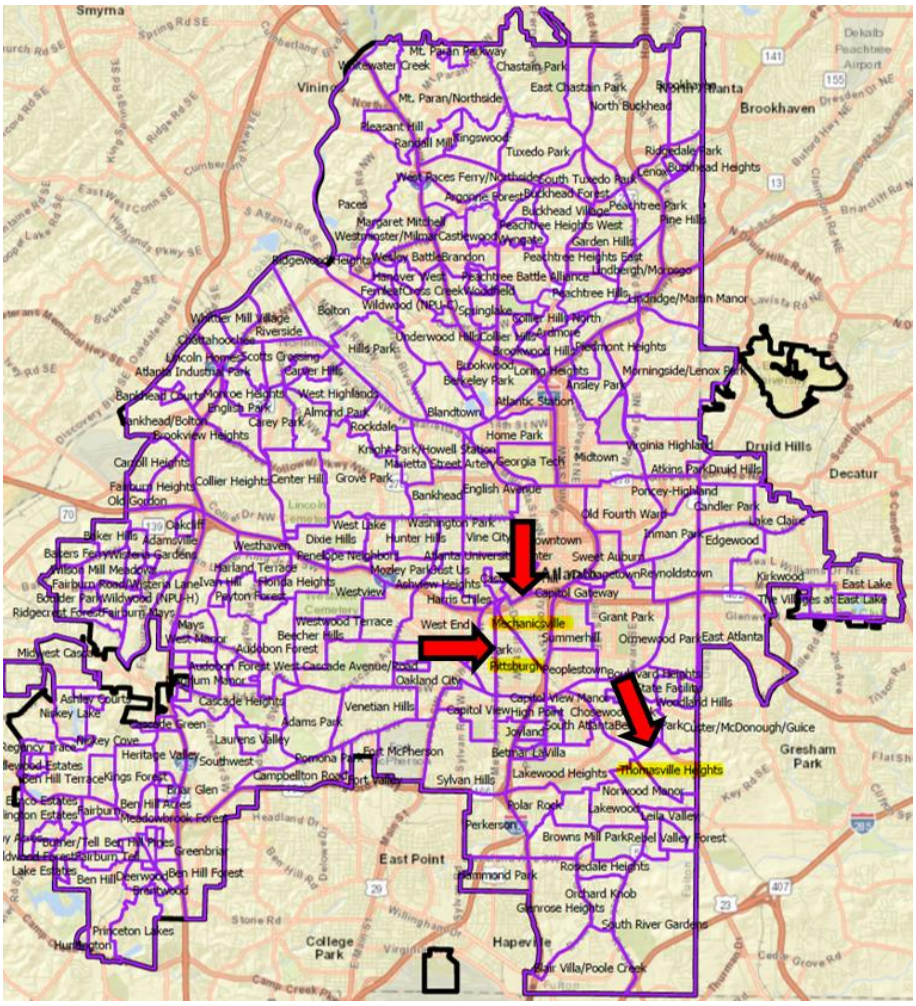
Table 7. Repeat Gun Violence Offending Patterns

N=1,129	Mean/%	S.D.
Any Arrest	42%	.49
Felony Arrest	33%	.47
Misdemeanor Arrest	23%	.42
Violent Arrest	11%	.31
Property Arrest	13%	.34
Drug Arrest	14%	.34
Par/Prob Violation Charge	20%	.40
Gun Charge	10%	.30

presentation factors were conducted to create a patient eligibility screening measure. The change in target neighborhoods warranted a zip code change, which slightly expanded PIVOT patient eligibility.

Identifying Target Communities

An analysis of Atlanta communities was conducted to select three to serve as target neighborhoods for the SPI initiative. The goal was to select communities that have high rates of gun crimes and shootings. Three neighborhoods were initially selected – Mechanicsville, Thomasville Heights and Fairburn Heights. Due to the small geographic area and struggles encountered by the PIVOT officers in engaging the community, Fairburn Heights was replaced with the Pittsburgh community in July of 2018. The map below shows the three target areas relative to all Atlanta neighborhoods. Each is discussed in detail below.



Mechanicsville is located in Intown Atlanta (Zip codes: 30310, 30312 and 30315). It has a population of 3,731 people living in a mostly apartment or linked home structures. It is primarily located in Atlanta Police Department (APD) Zone 3; however includes beats 101, 303, 304 and 501. The associated Neighborhood Planning Unit (NPU) is "V", along with 5 other neighborhoods.

APD reporting data show 43 serious gun crimes occurred last year at a rate of 1.15 per 100 residents. This neighborhood was chosen due to its high rate of violence and calls for shootings, as well as increase in firearm victimization. In 2016, 6 people were injured by gun violence within the 0.614 square city miles. In a year's time that count increased to 20. It has incredibly high crime and safety rates compared to the national rates per 100,000 people and shares a higher ratio of individuals at risk for violence.

Crime and Safety Rates (per 100k residents)[1]

Crime	Mechanicsville	Nationwide
Assault	1,413	283
Robbery	1,028	136
Burglary	1,413	500
Theft	4,856	2,043
Motor Theft	1,953	284

Quality of Life[2]

Measures	NPU V	Atlanta
Park access	83.5%	54%
Retail access	76%	95%
Transit access	98%	79%
Mean travel time (mins)	33	26
Jobs to labor force ratio	0.7	1.16
Walkability (out of 100)	57	46
Low food access	20%	4%
Vehicle crashes per 1k	16.4	15.3
Violent crimes per 1k	24.9	11.5
Property crimes per 1k	113.5	73

Landmarks and Institutions[3]

Education

- Dunbar Elementary
- Mechanicsville Branch of the Atlanta-Fulton Public Library System

Neighborhood Associations

- The Mechanicsville Civic Association
- The Citizens Associations of Mechanicsville

Recreational Areas

- Rosa L. Burney Park Religious Institutions

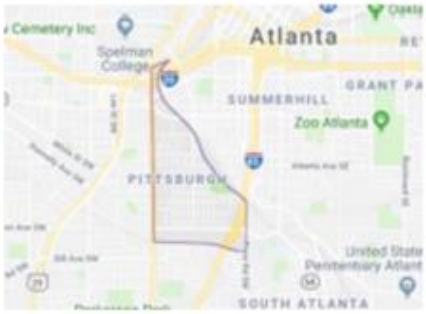
Religious Institutions

- Central Presbyterian Church (nearby)

Demographics

Measure	Mechanicsville[3]	NPU V[4]	City of Atlanta
Population	~3,731	12,055	425,931
Age	28% under 18	Mean = 29.8yr 29% <18yo 34% yrs 20 – 39 9% > 65yo	Mean = 33yr 19% <18yo 37% yrs 20 – 39 11% >65yo
Racial Composition		89% Black/AA 3% Other 6% White 1% Asian	52% Black/AA 4% Other 40% White 4% Asian
Housing Tenure		74% renters	57% renters
Housing Occupancy		33% vacant	21% vacant
Unemployment Rates		24%	12%
Median HH Income	$34,539	$20,858	$46,146
% Below Poverty Line		45%	24%
College Educated		18%	46%

[1] Niche. (2017). Living in Mechanicsville. Retrieved from https://www.niche.com/places-to-live/n/mechanicsville-atlanta-ga/
[2] Georgia Tech. (2010). Atlanta's Neighborhood Quality of Life & Health Project: Neighborhood Planning Unit V. Retrieved from http://cspav.gatech.edu/NQOLH/About_NPUs/V/
[3] City Data. (2018). Mechanicsville neighborhood in Atlanta, Georgia (GA), 30310, 30312, 30315 detailed profile. Retrieved from city-data.com
[4] City of Atlanta (2010). 2010 Census Summary Report: Neighborhood Planning Unit V. Retrieved from http://www.atlantaga.gov/Home/ShowDocument?id=3897



Pittsburgh is located in Intown Atlanta (Zip codes: 30310 and 30315). It has a population of 3,658 people living in primarily single-family home structures. It mostly falls into Atlanta Police Department (APD) Zone 3; beats 101, 302, 303, 304, and 305. The associated Neighborhood Planning Unit (NPU) is "V", along with five other neighborhoods.

Within the 0.833 square city miles, APD data show 248 serious gun crimes occurred in the past five years, at a rate of 6.78 per 100 residents. Those have resulted in 58 shooting victimizations, one of the highest individual counts in the city. Indeed, the crime rates are double and triple the national estimates. Thus, this neighborhood was chosen because it accounts for such a large percentage of gun crimes and shootings in Atlanta and easily accessible from one of the other target areas. It also is challenged by social risk factors.

Crime and Safety Rates (per 100k residents)[5]

Crime	Pittsburg	Nationwide
Assault	1,725	283
Robbery	1,089	136
Burglary	1,664	500
Theft	4,175	2,043
Vehicle Theft	2,027	284

Quality of Life[3]

Measures	NPU V	Atlanta
Park access	83.5%	54%
Retail access	75.8%	95%
Transit access	98.3%	79%
Mean travel time (mins)	33.3	26
Jobs to labor force ratio	0.7	1.16
Walkability (out of 100)	57	46
Low food access	20.2%	4%
Vehicle crashes per 1k	16.4	15.3
Violent crimes per 1k	24.9	11.5
Property crimes per 1k	113.5	73

Demographics

Measure	Pittsburg[6]	NPU V[4]	City of Atlanta
Population	~3,658	12,055	425,931
Age	22% under 18	Mean = 29.8yr 29% <18yo 34% yrs 20 – 39 9% > 65yo	Mean = 33yr 19% <18yo 37% yrs 20 – 39 11% >65yo
Racial Composition		89% Black/AA 3% Other 6% White 1% Asian	52% Black/AA 4% Other 40% White 4% Asian
Housing Tenure		74% renters	57% renters
Housing Occupancy		33% vacant	21% vacant
Unemployment Rates		24%	12%
Median HH Income	$25,412	$20,858	$46,146
% Below Poverty Line		45%	24%
College Educated		18%	46%

Landmarks and Institutions[1]

Education

- Gideons Elementary
- Evangeline Booth College
- Salvation Army Center for Officer Training

Neighborhood Associations

- Pittsburgh Improvement Association

Recreational Areas

- Pittman Park
- Welch Street Park

Religious Institutions

- Rice Memorial Presbyterian
- New Hope Church of God in Christ
- Jars of Clay Outreach
- Ariel Bowen Memorial United Methodist
- Antioch Baptist
- Iconium Baptist
- Sunny Side Baptist
- Bethany Baptist
- Greater Mount Pleasant Baptist
- Greater New Harvest Baptist
- Mount Mariah Primitive Baptist
- St John Ame
- Victory House
- New Mt Calvary Baptist
- Rize Community

[5] City Data. (2018). Pittsburgh neighborhood in Atlanta, Georgia (GA), 30310, 30315 detailed profile. Retrieved from city-data.com
[6] Niche. (2018). Living in Pittsburgh. Retrieved from niche.com

Thomasville Heights is located in Southwest Atlanta (Zip code 30315). It has a population of 3,621 people living in a mix of single family and apartment home structures. It is primarily located in Atlanta Police Department (APD) Zone 3; beats 305, 308, and 607. The associated Neighborhood Planning Unit (NPU) is "Z", along with 12 other neighborhoods.

This neighborhood was chosen because it is similar to the other target areas in crime trends, population, and size (0.599 square city miles); however, it is outside of ShotSpotter range. Like Pittsburgh, 9 people were shot within Thomasville Heights last year. Although the number of gun crimes has decreased in recent years, it is still remarkably high at .83 per 100 residents last year and overall victimizations have increased.

Crime and Safety Rates (per 100k residents)[7]

Crime	Thomasville Heights	Nationwide
Assault	586	283
Robbery	322	136
Burglary	439	500
Theft	659	2,043
Vehicle Theft	366	284

Quality of Life[3]

Measures	NPU Z	Atlanta
Park access	51%	54%
Retail access	34%	95%
Transit access	76%	79%
Mean travel time (mins)	32	26
Jobs to labor force ratio	1.4	1.16
Walkability (out of 100)	25	46
Low food access	8%	4%
Vehicle crashes per 1k	9.6	15.3
Violent crimes per 1k	17.6	11.5
Property crimes per 1k	71	73

Landmarks and Institutions[3]

Education

- Dobbs Elementary School
- Thomasville Heights Elementary School
- Mt Nebo Christian Academy
- Long Middle School
- Price Middle School
- Early College High School at Carver
- South Atlanta School of Health and Medical Science
- Thomasville Heights Branch Library

Recreational Areas

- Thomasville Resource Center
- Mt Nebo Health Fitness Center

Religious Institutions

- Mt Carmel AM E Church
- Faith Apostolic Holiness Church
- First Mt Selah Baptist Church
- Faith Temple of Praise Hlnss
- House of God

Demographics

Measure	Thomasville H[8]	NPU Z[9]	City of Atlanta
Population	~3,621	18,771	425,931
Age	29% under 18	Mean = 29yr 33% < 18yo 27% = 20 - 39yo 8% > 65yo	Mean = 33yr 19% <18yo 37% yrs 20 – 39 11% >65yo
Racial Composition		95% Black/AA 5% White 0% Asian 0% Other	52% Black/AA 4% Other 40% White 4% Asian
Housing Tenure		59% renters	57% renters
Housing Occupancy		20% vacant	21% vacant
Unemployment Rates		22%	12
Median HH Income	$23,889	$26,354	$46,146
% Below Poverty Line		36%	24%
College Educated		10%	46%

[7] City Data. (2018). Thomasville Heights neighborhood in Atlanta, Georgia (GA), , 30315 detailed profile. Retrieved from city-data.com
[8] Niche. (2018). Living in Thomasville Heights. Retrieved from niche.com
[9] City of Atlanta (2010). 2010 Census Summary Report: Neighborhood Planning Unit Z. Retrieved from http://www.atlantaga.gov/Home/ShowDocument?id=3897

Shooting Hotspot Maps

Shooting hotspot maps were an anticipated key piece of the SPI initiative (adoption of Cardiff Model) that unfortunately never transpired. The project instead remained focused on the three target neighborhoods described above. While the expected hotspot maps that combined both APD and Grady data did not occur, APD did provide their own hotspot maps of shootings which were used for planning purposes, were used by the PIVOT officers to confirm what was being heard from neighborhood residents, and were used during taskforce discussions.

Community Resident Surveys

It was a goal of PIVOT to reduce gun violence in high-victimization neighborhoods, so understanding community perceptions of the problem was especially important. A community assessment was conducted to explore the experiences and perceptions of residents in the PIVOT target neighborhood as it might relate to program efforts. The goal during collection of resident surveys was to conduct a comparison of thoughts/opinions before and after implementation of the PIVOT program to understand program effectiveness. The expectation was that if the program was effective, that it would have a positive impact on community perceptions of safety and the police. In the end, the decision was made not to conduct post-surveys. The initiative pieces did not come together in an appreciable way where it was expected that perceptions would have changed in community members as a whole. Instead, interviews were conducted with persons that partnered with the PIVOT officers in the target communities to assess their impressions on the impact of the work on community perceptions.

The survey was restricted to Mechanicsville, Pittsburgh and Thomasville Heights, where there are approximately 11,000 residents living within two square miles. These neighborhoods fall within two Atlanta zip codes with high violence rates – 30310 and 30315. The city neighborhoods are organized into 26 Neighborhood Planning Units (NPUs) named for each letter of the alphabet. Mechanicsville and Pittsburgh are assigned to “NPU-V” and Thomasville Heights is located in “NPU-Z”. Those two NPUs have a respective 45% and 36% of their residents living below the poverty level, while comparatively the percentage of people living below the poverty line in the City of Atlanta is approximately 24%. Relatedly, these neighborhoods can also be described as having a higher proportion of younger residents, higher unemployment, more renters, as well as lower rates of educational attainment and reduced access to healthy food. These are measures known to be associated with increased crime rates. Naturally, these neighborhoods were chosen because of high firearm violence rates. The following sections describe the survey methods and results.

Methods

A total of 163 surveys were collected from August to October 2018. The questionnaire developed by the PIVOT best practices committee and approved by the Emory University Institutional Review Board, included over 70 data points. Certified survey administrators were recruited from Emory University, Georgia State University, and the greater Atlanta community. The administrators were trained in how to obtain informed consent and to conduct the survey. The survey was designed to measure six subjects: 1) respondent demographics, 2) contact with police, 3) gun familiarity 4) personal and vicarious exposures to violence and deviance, 5) fear of crime, 6) quality of life, 7) perceptions of informal social control, and 8) judgements of the police. Two open-ended questions were also included to collect qualitative data on the participants' ideas on community improvement. The survey was verified to possess readability on an eighth-grade level and took respondents approximately five minutes to complete. Study participants were community members residing in three Atlanta neighborhoods (Mechanicsville = 49, Pittsburgh = 42, and Thomasville Heights = 72). A nonprobability, convenience sampling technique was used to collect survey data. The sample was selected in two stages: face-to-face and impersonally.


PIVOT ATLANTA
Program to Interrupt Violence thru Outreach and Treatment

A Unique Volunteer Opportunity Awaits You!

Are you interested in furthering your research experience, building a network of professionals, strengthening your leadership skills, and implementing new ideas within our learning and development community?

If so, PIVOT Atlanta has an incredible opportunity for you! PIVOT Atlanta is a collaborative violence reduction program between Grady Memorial Hospital and the Atlanta Police Department that aims to interrupt violence through outreach and treatment.

To reduce violence in the City of Atlanta, we need dedicated volunteers like you to conduct community-based survey research in three local neighborhoods: Mechanicsville, Pittsburgh, and Thomasville Heights.

What Should You Expect?

- Hands-on field research experience
- Networking with biomedical, police and criminology practitioners and researchers
- You can receive a letter of commendation for future employment and educational purposes
- You will get the opportunity to interface with community members and make an impact on our city!

To find out more, please join us on July 26th at 11am, Grady room 1C114.

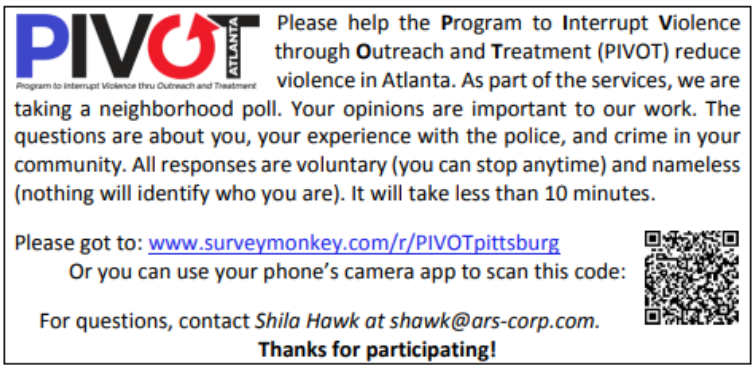
RSVP to tatenda.mangurenje@emory.edu
Assistant researcher: Tatenda Mangurenje, Ph.D. Candidate
Principal researcher: Shila Hawk, Ph.D.

ARS
APPLIED RESEARCH SERVICES, INC.

First, trained survey administrators went to the neighborhoods wearing lanyards identifying them as PIVOT researchers and solicitated responses from community centers, including churches, shopping centers and apartment complexes. Survey administrators first received permission from community centers. Following initial contact and permission, survey administrators returned to community centers

to conduct surveys at their locations one day a week. Community centers, consisting of shopping centers, businesses, and public parks, were surveyed on Mondays, Thursdays and Fridays in Mechanicsville, Thomasville Heights and Pittsburgh, respectively, for approximately three hours a day ranging from 10am – 3pm. Churches in all communities were surveyed on Sundays. Churches were surveyed just once due to the expectation that the same participants were expected to return each week. Approximately 400 community members were personally asked to complete the survey. In addition, 200 mail-in surveys were placed on mailboxes in the communities. The overall response rate was approximately 28%.

The survey was administered using a multi-option simplification approach. Individuals were asked to take the full one-page front and back page questionnaire (a copy of the survey can be found in the Appendix). If the participant indicated their inability to read, survey administrators collected data via an individual interview. Among participants hesitant to respond due to time constraints or other factors, a truncated single-page survey was provided. For those who had no time but wanted to participate, a webpage link to an online version was provide for electronic submission at their convenience.


PIVOT ATLANTA
Program to Interrupt Violence thru Outreach and Treatment

Please help the **P**rogram to **I**nterrupt **V**iolence through **O**utreach and **T**reatment (PIVOT) reduce violence in Atlanta. As part of the services, we are taking a neighborhood poll. Your opinions are important to our work. The questions are about you, your experience with the police, and crime in your community. All responses are voluntary (you can stop anytime) and nameless (nothing will identify who you are). It will take less than 10 minutes.

Please got to: www.surveymonkey.com/r/PIVOTpittsburg
Or you can use your phone's camera app to scan this code:

For questions, contact *Shila Hawk at shawk@ars-corp.com.*
Thanks for participating!

Community members who agreed to participate were also offered the online link to distribute the survey to friends and family members who reside in those neighborhoods. The mail-in version was the last approach. To ensure anonymity, participants were given addressed, stamped envelopes in which to return surveys to the research partner. All collected data were then entered into an electronic database on a secure server.

Key Findings

Table 8 on the following pages outlines all of the information collected from each data field. Key findings are discussed below the table.

Table 8. Community Survey Results (N=163)

☑ **Check all that apply. Are you….?**

41% Male	1% Hispanic	60% Single	6% Unemployed
51% Female	79% Black/AA	17% Married	7% Employed Part Time
	3% White	3% Divorced	34% Employed Full Time
37% a Home Renter	3% Asian	3% Widowed	15% Disabled/Retired
12% a Home Owner	4% Other: Multi, Israel, etc.	3% Other: engaged, relationship	6% Other: self, student,

☑ **Check the response that most applies**

In your community, how often do you….?	**Never**	**Rarely**	**Usually**	**Always**
hear gunshots	10%	25%	25%	38%
feel unsafe	19%	29%	26%	19%
feel stressed	20%	25%	21%	13%
have trouble sleeping	23%	30%	19%	10%
see the police	7%	18%	27%	40%
talk with the police	41%	30%	12%	10%
hear loud verbal arguing	16%	20%	27%	18%
see physical fighting	17%	29%	21%	14%
see drug use	20%	22%	20%	19%
see gang activity	20%	27%	16%	17%
feel like you need to carry a gun for protection	26%	19%	17%	31%
How often do you worry about … in your community?	Never	Rarely	Usually	Always
being a victim of a crime	31%	31%	19%	15%
your home being broken into	29%	25%	16%	12%
Being hurt by someone	33%	29%	12%	9%
being mugged	33%	29%	10%	10%
being shot	39%	26%	15%	13%
a loved one being a victim of a crime	25%	32%	19%	19%
being stopped by the police	31%	31%	15%	18%
In your community, how often are … a problem?	Never	Rarely	Usually	Always
gangs	31%	25%	22%	22%
gun use	18%	25%	25%	26%
illegal drugs	18%	22%	24%	31%
physical fighting / assault	14%	29%	22%	16%
drinking / loitering	11%	18%	24%	29%
trash / litter	7%	15%	24%	36%
vandalism / graffiti	15%	25%	15%	26%
poverty	11%	15%	21%	34%
unsupervised youths	10%	15%	17%	39%
How often do your neighbors…?	Never	Rarely	Usually	Always
watch out for each other	9%	26%	33%	26%
obey the police	10%	25%	33%	24%
call the police when they need help	5%	21%	28%	25%
call the police to report a crime witnessed	14%	25%	31%	22%
do something about crime in their neighborhood	15%	28%	19%	17%
work to clean up their neighborhood	16%	23%	24%	17%
worry about being shot	17%	25%	22%	28%

Please Turn Over

Quality of life *is based on health, safety, relationships, and personal satisfaction.* Thinking about your *quality of life* on a scale of 1 (low) to 10 (high), **how do you rate your community**? 108 missing data (66%). 55 valid, 1-4 = 18 (33%), 5-10 = 37 (66%)

Please Circle One:

(low) 1 2 3 4 5 6 7 8 9 10 (high)

☑ **Check the response that most applies**

How often do the police…?	**Never**	**Rarely**	**Usually**	**Always**
treat people fairly	15%	32%	31%	12%
treat people respectfully	14%	31%	31%	14%
respond to community concerns	11%	29%	25%	14%
act trustworthy	18%	26%	31%	14%
take care of crime problems	15%	29%	22%	11%
explain their decisions	23%	33%	18%	13%
listen to people	18%	32%	23%	15%
respond to people's needs	14%	29%	23%	10%
do a good job	15%	33%	28%	12%

Have you ever…?	**Yes**	**No**	
had any contact with the police in your community in the past 12 months?	31%	47%	
been shot?	9%	79%	
had a loved one who was shot?	31%	58%	
had someone do something to you that was against the law	35%	53%	
If yes, were you physically hurt or scared that you might be?	19%	29%	
If yes, did it involve a gun?	12%	34%	
If yes, did you report it to the police?	18%	32%	
received a traffic ticket?	26%	50%	
been arrested for a misdemeanor?	24%	53%	Arr? 34%
been arrested for a felony?	17%	61%	13 Y, 7 N
had a family member who was arrested?	39%	51%	
been arrested in the past 12 months?	10%	67%	
been hungry but could not get food	27%	63%	

Please Describe Yourself

How old are you? ___19-91___years old. ų = 39 s.d. = 13.5 (1/2 <36)

How many people live in your home? 1 (10%), 2 (13%), 3 (18%), 4 (16%), 5 (7%)….up to 9

How many years have you lived in this community? _____years >5 yrs 39% , <2yr 12%

How do you feel about your neighborhood? 26% like your neighborhood 43% want to improve it 21% want to move

What is the highest level of school that you completed?
10% Some High School 36% High School Diploma/GED 7% Post High School Education, No Degree/Certification
9% Associates Degree or Technical Certification 9% Bachelor's Degree (BA/BS) 3% Master's Degree or Higher

Do you have health insurance? 50% Yes 25% No

Do you or anyone in your household own any firearms for sport or protection?
3% Yes, for sport 21% Yes, for protection 7% Yes, for both 52% No, neither

What does your community need to improve overall safety and reduce crime?

_____

24hrs security watch or more outreach programs for middle + high schools	1
Be more consistent and involved.	1
Better enforcement/not scared	1
Better fellowship	1
Better lighting	1
Better people who really care	1
Better street lights more police presence and respond when asked! Community street cleaning programs (litter).	1
Call the police	1
Catch all the unneeded people of the street	1
Check visitors. 24 hr security - figure out who are the problem. Work w/ community leaders.	1
Clean up some of the areas nearby that are drug infested.	1
Clean up the drug activity and prostitution	1
Come together more	2
Drugs & Traffic	1
Everything	4
EVERYTHING	1
Everything positive	1
Everything!!	1
Families, things to do	1
Fighting, killing, shooting, gang bangers	1
Gang and gun violence. Stop prostitutes from working the street	1
Get all the bad seeds out, gate the community.	1
Get rid of all these teenagers that committing these crimes, guns break-in loitering.	1
Get rid of the gang, education	1
Give jobs	1
Give kids something to do	1
Government funding	1
Gun control	1
Gun violence.	1
Have a place for young teens to attend.	1
Have more churches, community youth involvement in the community!! I believe active constituency will reduce the crime rate!	1
Have more police patrol.	1
Housing	1
I would like to see the drugs, homeless and prostitution moved from the neighborhood. Don't like that the kids are exposed to this everyday on their way to school.	1
I'm not sure	1

Infrastructure from within; motivating the poor to build a better community; guaranteed wage 300 for all per month so the poor and homeless; creative affordable housing for the homeless.	1
Jesus God	1
Jobs	2
Less drug dealers and gang bangers	1
Less drug use	1
Love and respect each other	1
Maybe organizations or after school programs for the youth	1
Maybe some help w/addressing poverty. Activities for kids.	1
Money	1
More activities for our children	1
More activities. More opportunities in the community as far as rec-ball.	1
More babies	1
More games for kids	1
More jobs and after school programs for teens: more enforcement making parents responsible for their teens where abouts.	1
More parents involved	1
More police	3
More police presence	1
More police presence.	1
Move rut the bad seeds! Period.	1
N/A	2
Need clean up more	1
Need every damn thing. Get these gangs out of here. Get these young people something to do. Its babies having babies and fathers are gone. Its not right	1
Need help on everything, special with young peoples	1
Neighborhood/Neighbor watch, secured protection, more security	1
Nicer police and the community to come together instead of being against each other	1
No	2
No guns, more jobs for felonies, health insurance	1
Nothing	1
Patrols	1
Police are corrupt - start there!!!	1
Police awareness. Visual	1
Police officers stopping people for no reason	1
Police on the beat	1
police presence	1
Police response time	1
Police to visit more often	1
Policing needs to come back to the community.	1
REBUILD	1

Rebuild homes, provide jobs in the neighborhood.	1
REMOVE GUNS	1
Safety	1
Safety and arguing	1
Safety, stealing, kids everywhere unattended to.	1
Some funds for our kids to have something to do to keep the crime rates down.	1
Some retail units need to be removed.	1
Something	1
Speeding through stop signs! More kids at play SLOW DOWN in lawn signs to remind drivers. Police been doing great job reducing crime in area.	1
Stay to themselves	1
Stick together. Less Police!	2
Stop being lazy eating donuts all day	1
Stop killing and gun violence	1
Support	1
The main problem is that there are many gang violence and gun violence.	1
The police.	1
There's not enough room for this answer.	1
They need to come together as one and we can work everything out. They for self, they don't look out for each other. If I got something, they'll kill me for it, even if its a dollar more.	1
We need people to stay in the rent office first	1
Where I stay I don't see anything bad. All I see is good things.	1
Work on the homeless issue and police responsiveness — this would necessitate more police	1
Yes	1

Is there anything else you think we should know about you or your community?

_____

Activities	1
Decreased crime.	1
DESTRUCTION IS ON A CONSTANT RISE	1
Don't care, don't show any concern. Poorly supervised.	1
EVERYTHING	1
Gentrification is destroying it.	1
Good community - not so good people	1
Have more programs for single family homes with jobs + want a better leadership.	1
Help the youth or young adults in the community give them something to do.	1
I have tried but it's up to people	1
I knew moving to Pittsburg would have its challenges, I didn't realize they would come from the police. They use it as their playground for those who seek action from the boredom of regular patrolling.	1
Illegal drug activity	1

Improved slowly	1
It could be safe if the community works together.	1
It needs a lot of help	1
It really is a great place	1
It start at home. That should be our phrase!!!	1
It's a lot of arguing sometimes	1
It's not a bad community. No getting mugged.	1
Its crazy	1
Lot of Pz	1
Make more programs for the people so they can come together	1
More trash receptacles would improve the trash/litter problem along Ralph David Abernathy Blvd.	1
My community needs to be reviewed and torn down.	1
N/A	3
Need Road Sweet	1
Needs to be clean-up	1
No	1
No	16
NO	1
No thank you!	1
No, can you fix the regular housing around here	1
No.	1
none	1
Not that I can think of.	1
Nothing	1
Nothing really make it better	1
Police need to stop harassing the kids	1
Repair - maintenance issues.	1
That it developing. Those who are not in a position to elevate, would look at resources to do so	1
That will be all :)	1
That's all	1
The community is over 135 years old and has a nice history are matter how it looks now. We need to build on that legacy.	1
The people who live here are amazing and caring and kind, and dealing w/poverty which is what is causing most of the issues. I would love to see the issue of poverty being addressed w/work in the community, activities for kids. And community gatherings.	1
They need help	1

This community needs to help keep as many long term residents in there homes while also inviting to potential new residents. Abandoned homes are no longer good, but pushing out long term residents is not the answer.	1
Very family oriented at times more community outreach for both teens and young adults to help keep the community safe and more clean.	1
Violent	1
We need help! Drugs everywhere!	1
We need more programs to teach people parenting skills so they can control they're teens	1
Would love to be apart of the solution!!	1
Yes, better family relations with each other.	1

Survey participants were fairly evenly divided between males and females between the ages of 19 and 91, averaging 39 years old (half were 35 years old or younger). Respondents were primarily Black/African American (79%), high school graduates (90%), and single (60%). Less than half were employed. While not all survey participants reported their housing status, of those that did, most were renters. The majority of households included four or fewer members.

About one third of respondents had interacted with a police officer in the past year, some of which were for an arrest (10%). In fact, 34% have been previously arrested, with about a quarter for a misdemeanor offense and 17% for felony crimes. Arrests among family members were reported as more common than personal arrests, at 39%. Overall, people see the police quite often (67%) but do not commonly talk to them (22%), nor think their neighbors obey them (57%).

Participants were asked about their familiarity with firearms. A sizable proportion of those surveyed had been shot (9%), had a loved one who was shot (31%), or were victimized by someone with a gun (12%). Approximately two-thirds often hear gunshots and 45% feel they need a gun for safety. Nearly half own a gun, and just over half think guns are a problem in their neighborhood. While 28% always/usually worry about being shot, they believe half of their neighbors worry about being shot. Relatedly, 35% of all participants self-reported to having been victimized, with 19% getting injured and 18% that did not report the incident to the police. One-third of those surveyed frequently see gang activity and 44% think it is a problem. Observing drug use was also frequently reported (39%), as well as described as a problem (55%).

Being victimized or exposed to violence is related to people's fear of crime. Respondents were asked how much they worry. When it comes to sleeping and general feelings of unsafety, the residents reported that they always/usually struggle at 29% and 45% respectively. When asked about their worries, they commonly fear being victimized (34%) or mugged (20%). One-third also often worry about being stopped by the police.

Fear of crime is often correlated with quality of life, which presents a challenge in these communities. Residents often hear fighting (45%), see problematic loitering (53%), are upset by trash/litter (60%) and unsupervised youths (56%). These conditions can erode a neighborhood's sense of informal social control or perceived willingness for neighbors to band together to solve problems. Forty percent don't think that neighbors watch out for one another, and just under half don't believe neighbors call the police for help or to report witnessed crime.

Participants responded to questions related to their perceptions of police legitimacy in their neighborhoods. Almost half of participants said that the police never or rarely do a good job, and only one-third of respondents believe police are typically responsive to personal or community needs. An average of 40% of participants (range 45% to 31%) believe the police are always/usually procedurally just (fair, respectful, trustworthy, listen and explain decisions). Lastly, the majority of residents want to improve their community or move, and a quarter say they currently like it.

The fill-in section of the survey produced significant qualitative data for analysis. When asked what they think their communities need to do to improve overall safety and reduce crime, the majority of participants reported that their communities needed "everything." Specifically, they want increased police presence and responsiveness. Guns were of special concern as it relates to their safety and killings. They added that they needed a reduction in gang violence and drug crimes, as well as increases in community services, activities, or programming for youths.

Other themes include physical and/or structural issues, such as needing better lighting, more street cleaning, and effective neighborhood watch programs. When asked if there is anything else that they would like for us to know about themselves or their communities, the majority of participants reported that although they recognized that their communities have problems, mainly related to gang and drug violence, they believe that that the communities are made up of good people that need help.

Study Limitations

The main limitation to this survey is its relatively small sample size. This sample is only a very small proportion of the entire population of these communities. One of the main limitations related to sample size was that participants did not respond in large numbers to the online survey, thus limiting our access to the study population. Another possible sample size limitation was due to access. Access to community members was limited due to the relatively small number of public spaces such as community centers, shopping areas and businesses. In instances where community centers such as churches were present, their congregations were made up largely of people who no longer reside in the neighborhoods. Therefore, a larger sample would enable better generalizability of the survey's findings. The second limitation to this survey may be due to the self-report nature of the study. As such, selective memory and exaggeration may have biased the observed results. Lastly, the survey may also be limited by the use of a nonprobability, convenience sampling method. The sample of community members for this survey was chosen for convenience and may not be representative of the total

population in these communities. A larger sample would therefore likely have resulted in a greater degree of generalizability of the survey's findings.

Wilder Collaboration Factors Inventory

Interagency collaboration involves a complex dance of agencies, agency practices, policies, perspectives, and personalities. The success of a collaborative team is determined by how well the team can navigate these differences and find common ground to meet shared goals and objectives. The Wilder Collaboration Factors Inventory (WCFI) is an assessment tool that empowers collaborative teams to examine their functioning in 20 key areas. The tool provides a snapshot of the collaboration at a moment in time and is intended to be administered at multiple points in time. Collaborative teams are always subject to the ebbs and flows of each agency and the persons on the team. Changes in staff or agency policy can impact the collaborative, as can factors such as changes in the political climate, partners leaving or joining the collaborative team, current events that impact opinions, changes within the community, and shifts in trust between team members, just to name a few.

The WCFI does not address specific collaborative problems. For example, the assessment will not advise that many members are angry that leadership decided to spend money on a public awareness campaign that had not been first approved by the collaborative team. Instead, it provides scores for questions in areas shown to be important to collaborative health. In the situation above, the WCFI might reflect lowered scores in areas such as "multiple layers of decision-making," "mutual respect, understanding and trust," or perhaps "skilled leadership." The purpose of the WCFI is for the team to use the assessment scores to provide insight into potential weaknesses and problems. The team should discuss and address low scoring areas and find solutions that strengthen the collaborative.

The WCFI consists of forty questions grouped into 20 factors. Each factor represents an area that research has found to be important to successful collaborative teams. The factors look at critical aspects of the collaborative including the environment, membership, process/structure, communication, purpose and resources.

Respondents answer each of the 40 questions using a 5-point Likert-type scale selecting "Strongly Disagree," "Disagree," "Neutral/No Opinion," "Agree," or "Strongly Agree." Responses can be averaged to determine individual question averages, factor averages, as well as an overall collaborative average score. These scores help the collaborative team identify strengths and weaknesses. Typically factor scores of 1.0-2.9 are considered weaknesses in need of attention, and scores of 4.0-5.0 are categorized as collaborative strengths. Scores between 3.0-3.9 are considered borderline and areas that should be discussed and put into the context of the team dynamic. For example, a score of 3.5 on Skilled Leadership may be considered a strength if the collaborative is new, it's leaders are recent additions to their respective organizations and are still in the learning stages of their roles within their organization and the collaborative. However, a 3.5 score for a long-standing collaborative with seasoned leadership

may well indicate a relative weakness. Examining factor scores over multiple administrations is especially useful to see if the score has fallen or increased over time. Team discussion of borderline factors determines if there are concerns or fractures in the collaborative that need to be addressed to strengthen the group. Ultimately, the true value of the WCFI comes from using the results to address weaknesses and improve the collaborative over time.

WCFI Results

The WCFI was distributed in six waves between 2017 and 2019 (twice annually). Table 8 shows the scores for each question at each assessment point. These scores represent a snapshot of the strengths and weaknesses of the collaborative at each point in time. Score variation between the administrations reflect things such as changes within the partnering entities, leadership changes, or changes within the community or the political landscape that may have impacted the collaborative.

Table 9 shows the average percentage of respondents that agree in each factor area. When averaging the agree scores across assessment waves, the factors with the highest level of agreement have been:

- Establishment of informal relationships and communication links
- Favorable political and social climate
- Shared vision
- Unique purpose
- Skilled leadership
- Concrete, attainable goals and objectives
- Collaborative group seen as a legitimate leader in the community
- Members share a stake in both process and outcome

The factors showing the lowest levels of agreement are:

- Sufficient funds, staff, materials and time
- Multiple layers of participation
- Development of clear roles and policy guidelines
- History of collaboration or cooperation in the community
- Open and frequent communication
- Adaptability

These strengths and weaknesses paint a picture of a collaborative team with a shared purpose, vision and goals that is seen as leader in the community, has built relationships, has skilled leaders on the team and is doing their work in a favorable political climate. However, the assessment also indicates that the group has issues internally with communication, adaptability, layers of agency participation, clear roles/policy, a lack of sufficient funds, staff, materials, and/or time, and challenges with community cooperation.

During each wave, an overall average score was calculated which can be seen to the right. This table shows some fluctuation with averages showing marginal changes over the course of the project. Of some concern is that the project ended with the lowest agreeability scores of all six waves. As shown in Table 8, there were drops in the percentage of agreeability for every factor between waves 5 and 6. The largest decreases were observed for the following items:

WCFI Wave	Avg. Score
Wave I	3.95
Wave II	4.04
Wave III	3.70
Wave IV	3.85
Wave V	3.97
Wave VI	3.53

- Sufficient funds, staff, materials, and time (-42%)
- Appropriate pace of development (-40%)
- Mutual respect, understanding, and trust (-39%)
- Development of clear roles and policy guidelines (-39%)
- Appropriate cross section of members (-36%)
- Adaptability (-34%)
- Collaborative Group seen as a legitimate leader in the community (-32%)

Interestingly, one of the factors that saw a large drop in agreement was one of the factors that had been consistently high throughout the survey period (Collaborative group seen as a legitimate leader in the community). Three of the other factors seeing large drops in agreement however had consistently demonstrated low levels of agreement.

The research team provided detailed summaries of the WCFI findings to the collaborative team after each administration. The findings were reviewed by the team, but were not used as a discussion tool to address areas of weakness; the results were used more or less as "nice to know" information. The collaborative ended the 6th survey wave with an average 3.53 overall score.

While WCFI results were not utilized to the extent that they perhaps could have been; the process evaluation and interviews with team members provide additional insight into collaborative weaknesses identified through the WCFI process. For example, one key area expressed in the interviews was concern that the work of the PIVOT team was thwarted because more staff was needed. There were calls for more social workers, more PIVOT officers, as well as a full-time project coordinator to oversee all aspects of the project. This feedback was likely represented in the low scores found in the "Sufficient funds, staff, material, and time" factor. Interviews also pointed to dissatisfaction surrounding the roles and responsibilities of collaborative team members and calls for org charts, detailed roles/responsibilities, and a defined managerial hierarchy. Concerns such as these are likely reflected in the "Development of clear roles and policy guidelines" factor, and may also be woven into others such as "Mutual Respect, understanding, and trust" or perhaps the "Skilled leadership" factors.

Table 8. WCFI Results (2017-2019)

PIVOT Task Force Opinions: Waves Comparison Table	Mar. 2017 (N = 8)		Oct. 2017 (N = 7)		Mar. 2018 (N = 14)		Nov. 2018 (N = 10)		May 2019 (N=10)		Dec. 2019 (N=8)	
WCFI Item	**Avg.**	**%Agree**	**Avg.**	**%Agree**	**Avg.**	**%Agree**	**Avg.**	**%Agree**	**Avg.**	**%Agree**	**Avg.**	**%Agree**
1. Agencies in our community have a history of working together.	3.29	43%	3.57	60%	3.64	50%	3.44	77%	4.00	90%	3.45	55%
2. Trying to solve problems through collaboration has been common in this community.	3.14	43%	3.86	60%	3.50	49%	3.44	65%	3.40	70%	3.64	64%
3. Leaders in this community who are not part of this collaborative seem hopeful about what we can accomplish.	4.00	86%	4.14	66%	3.86	60%	4.33	100%	4.20	80%	3.73	82%
4. Others who are not part of the collaborative would generally agree that those involved are the "right" organizations to make this work.	3.57	71%	4.43	80%	3.86	66%	4.33	100%	3.90	80%	3.64	55%
5. The political and social climate seems to be "right" for starting a collaborative like this one.	3.14	43%	4.29	80%	4.50	90%	4.56	93%	4.70	100%	4.73	100%
6. The time is right for this collaborative project.	4.43	100%	4.86	97%	4.64	93%	4.44	93%	4.70	100%	4.91	100%
7. People involved in our collaboration always trust one another.	4.14	86%	3.71	60%	3.00	40%	2.78	52%	3.50	70%	2.27	9%
8. I have a lot of respect for the other people involved in this collaboration.	4.71	100%	4.57	91%	4.00	70%	4.00	97%	4.30	90%	3.82	64%
9. The people involved in our collaboration represent a cross-section of those who have a stake in what we are trying to accomplish.	4.43	100%	4.86	97%	4.00	69%	4.44	93%	4.30	90%	4.18	100%
10. All the organizations that we need to be members of this collaborative group have become members of the group.	3.00	29%	2.71	34%	3.50	54%	3.33	67%	3.50	60%	2.91	27%
11. My organization will benefit from being involved in this collaboration.	4.29	86%	4.86	97%	4.50	90%	4.56	93%	4.60	100%	4.55	91%
12. People involved in our collaboration are willing to compromise on important aspects of our project.	3.71	71%	3.86	51%	3.50	44%	3.56	78%	3.80	70%	2.73	27%
13. The organizations that belong to our collaborative invest the right amount of time in our collaborative efforts.	4.14	100%	2.86	34%	3.64	54%	3.67	73%	4.10	90%	3.18	55%

14. Everyone who is a member of our collaborative group wants this project to succeed.	4.86	100%	4.71	94%	4.21	81%	4.44	93%	4.90	100%	4.09	73%
15. The level of commitment among the collaboration participants is high.	4.86	100%	4.00	66%	4.00	73%	4.11	92%	4.10	90%	3.36	73%
16. When the collaborative group makes major decisions, there is always enough time for members to take information back to their organizations and make decisions.	3.71	71%	3.29	51%	3.50	47%	3.56	75%	3.80	80%	3.55	64%
17. Each of the people who participate in decisions in this group can speak for the entire organization they represent, not just a part.	3.00	43%	2.57	14%	3.07	30%	3.56	88%	3.20	50%	2.91	36%
18. There is a lot of flexibility when decisions are made; people are open to discussing different options.	3.86	86%	4.00	74%	3.36	41%	3.78	76%	4.20	80%	3.27	64%
19. People in this collaborative group are open to different approaches to how we can do our work. They are willing to consider different ways of working.	4.14	86%	4.00	66%	3.43	47%	3.67	70%	3.90	80%	3.18	55%
20. People in this collaborative group have a clear sense of their roles and responsibilities.	3.57	57%	3.57	51%	3.50	56%	3.33	67%	3.80	80%	3.27	45%
21. There is a clear process for making decisions among the partners in this collaboration.	3.29	43%	3.29	40%	3.07	30%	3.44	68%	3.80	80%	3.27	36%
22. This collaboration is able to adapt to changing conditions, such as fewer funds than expected, changing political climate, or changes in leadership.	3.43	57%	3.86	63%	3.43	36%	4.11	92%	3.80	70%	3.27	36%
23. This group has the ability to survive even if it had to make major changes in its plans or add some new members in order to reach its goals.	4.00	100%	4.43	89%	3.43	41%	4.11	92%	3.70	70%	3.36	36%
24. This collaborative group has tried to take on the right amount of work at the right pace.	4.00	100%	4.00	74%	3.57	53%	3.67	73%	3.90	80%	3.36	55%
25. We are currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to the collaborative project.	4.00	100%	3.71	63%	3.57	51%	3.44	77%	4.10	90%	3.27	36%
26. People in this collaboration communicate openly with one another.	4.00	86%	4.00	66%	3.07	41%	3.56	91%	3.30	50%	3.09	45%
27. I am informed as often as I should be about what goes on in the collaboration.	3.57	57%	3.71	63%	3.43	59%	3.44	81%	3.70	70%	3.09	45%
28. The people who lead this collaborative group communicate well with the members.	4.29	100%	4.14	77%	3.14	44%	4.33	92%	3.70	70%	3.09	36%
29. Communication among the people in this collaborative group happens both at formal meetings and in informal ways.	4.57	100%	4.86	97%	4.21	77%	3.89	91%	3.60	90%	4.00	82%
30. I personally have informal conversations about the project with others who are involved with this collaborative group.	4.29	86%	4.86	97%	4.14	74%	3.78	85%	4.00	100%	4.00	82%
31. I have a clear understanding of what our collaborative is trying to accomplish.	4.43	100%	4.71	94%	4.21	74%	4.33	100%	4.20	90%	4.09	73%
32. People in our collaborative group know and understand our goals.	3.71	71%	4.14	77%	3.71	49%	3.78	76%	4.10	90%	3.64	64%
33. People in our collaborative group have established reasonable goals.	4.00	86%	4.57	91%	4.07	76%	3.89	86%	4.20	100%	3.55	64%
34. The people in this collaborative group are dedicated to the idea that we can make this project work.	4.57	100%	4.71	94%	4.29	84%	4.22	95%	4.50	100%	4.27	82%
35. My ideas about what we want to accomplish with this collaboration seem to be the same as the ideas of others.	3.86	71%	4.00	74%	3.57	46%	3.89	86%	4.30	100%	3.82	64%
36. What we are trying to accomplish with our collaborative project would be difficult for any single organization to accomplish by itself.	4.86	100%	4.86	97%	4.29	74%	4.78	100%	4.70	80%	4.73	91%

37. No other organization in the community is trying to do exactly what we are trying to do.	4.29	71%	4.71	86%	4.29	77%	4.67	93%	4.40	80%	3.82	45%
38. Our collaborative group has adequate funds to do what it wants to accomplish.	2.43	14%	2.71	26%	2.50	11%	2.56	52%	3.10	60%	2.27	9%
39. Our collaborative group has adequate "people power" to do what it wants to accomplish.	3.14	57%	3.29	51%	2.93	26%	3.11	71%	2.80	60%	2.91	27%
40. The people in leadership positions for this collaboration have good skills for working with other people and organizations.	4.14	100%	4.43	80%	3.86	71%	3.67	88%	4.10	70%	4.10	70%

Table 9. PIVOT Task Force Factors: Waves Comparison Table

	Wave I %Agree	Wave II %Agree	Wave III %Agree	Wave IV %Agree	Wave V %Agree	Wave V I %Agree
History of collaboration or cooperation in the community	43%	60%	50%	71%	80%	59%
Collaborative Group seen as a legitimate leader in the community	79%	73%	63%	100%	100%	68%
Favorable political and social climate	72%	89%	92%	93%	80%	100%
Mutual respect, understanding, and trust	93%	76%	55%	75%	75%	36%
Appropriate cross section of members	65%	66%	62%	80%	100%	64%
Members see collaboration as in their self-interest	79%	74%	67%	86%	70%	59%
Members share a stake in both process and outcome	100%	65%	69%	86%	93%	67%
Multiple layers of participation	57%	33%	39%	82%	65%	50%
Flexibility	86%	70%	44%	73%	80%	59%
Development of clear roles and policy guidelines	50%	46%	43%	68%	80%	41%
Adaptability	79%	76%	39%	92%	70%	36%
Appropriate pace of development	100%	69%	52%	75%	85%	45%
Open and frequent communication	81%	69%	48%	88%	63%	42%
Established informal relationships and communication links	93%	97%	76%	88%	95%	82%
Concrete, attainable goals and objectives	86%	87%	66%	87%	93%	67%
Shared vision	86%	84%	65%	91%	100%	73%
Unique purpose	86%	92%	76%	97%	80%	68%
Sufficient funds, staff, materials, and time	36%	39%	19%	62%	60%	18%
Skilled leadership	100%	80%	71%	88%	88%	70%

Taskforce Committees

The taskforce developed a number of committees to focus on specific topic areas, with the objective being to better hone the work of the taskforce. The research team did not participate in committee meetings, but made requests on a quarterly basis for the committees to provide agendas, materials

collected, materials produced, actions taken, decisions made, and barriers encountered so that committee activities could be documented and tracked for the process evaluation. Almost no information was transferred to the research team in response to these many requests, and as a result such efforts were abandoned.

Interviews

Interviews were conducted with persons peripherally associated with the PIVOT program (called PIVOT non-operatives). These persons had knowledge of the PIVOT program and could provide perspectives from the outside looking in. Interviews were also conducted with persons directly involved with the PIVOT program (called PIVOT operatives) that could potentially provide internal viewpoints and assessments of program strengths and weaknesses.

Methods

As a part of a larger mixed methods PIVOT research project, this analysis draws on semi-structured open-ended interviews conducted with seven PIVOT non-operatives and five PIVOT operatives in Atlanta, Georgia (n=13). Study participants were identified through a combination of purposeful and convenience sampling. A semi-structured interview guide was developed by the research team and emphasis was placed on addressing factors that variously facilitated and obstructed PIVOT operations. Research procedures were approved by the Emory University Institutional Review Board (IRB) prior to study initiation.

Data Analysis

Data analysis was guided by the principles of grounded theory by eliciting key themes from the interview data (Corbin & Strauss, 1990). A grounded theory approach was utilized for this project because of the emphasis on process and discovering how individual participants think through their roles in relation to PIVOT, the overall operations of the program, and its implications for gun violence reduction in Atlanta. As such, codes were used to organize key themes that were derived inductively from the interviews.

Limitations

The main limitation of this study was our sample size. Although we were able to gather a representative active-PIVOT member sample, we were unable to recruit large numbers of non-PIVOT members. However, although the number of interview participants is lower than anticipated, the broader perspective that participants provided on the interview questions nonetheless offered valuable insights. Given that the study participants were actively involved with PIVOT (either directly or indirectly), the group was diverse in perspective as well as in length of involvement with the PIVOT

program. As such, the project findings are reflective and representative of many of the members of PIVOT at large.

Summary: PIVOT Non-Operative Interviews

ARS invited non-operative PIVOT staff to participate in interviews and share opinions and ideas. Between June and October of 2019, 27 persons were sent email requests to participate in these interviews. Persons were sent up to three invitations to prompt engagement. Most of the persons solicited for participation were from various arms of either the Grady Health System or the Atlanta Police Department. These persons were not involved in the day-to-day operations of PIVOT, but had participated in some level of informational training about the initiative, may have participated in initiative planning activities, and might therefore have an external view of its operations. Two persons declined to participate, and five persons accepted the invitation and scheduled an interview with ARS staff. It's unclear why the remaining 20 persons did not respond.

All but one of the persons interviewed were employed through Grady Health System. Interviews lasted an average of 45 minutes. While not directly involved in delivery of the PIVOT program, all persons expressed a solid understanding of how the program worked, as well as knowledge of prior research on hospital-based violence prevention programs. When asked who they felt was most impacted by firearm violence, almost all cited the literature indicating that young black males are disproportionately impacted by firearm violence, and older white males by suicide by firearms. However, most also believed that the impact of firearm violence reached much deeper. They cited the families of both perpetrators and victims as being adversely affected, entire communities that live in fear due to the pervasiveness of the firearm culture, and first responders who directly experience the impact of firearm violence in the performance of the job responsibilities (vicarious trauma).

Anti-Violence Programs

Interviewees were asked if they believed that anti-violence programs are generally effective in improving public health. Most were already familiar with the research and literature in this area and advised that hospital-based anti-violence programs have much potential if implemented correctly. A few also expressed concern that while effective, there are still other societal and communal layers of the violence problem that also need correcting in the communities most negatively impacted by violence.

Participants were asked to share their thoughts on the role their agency should play to reduce violence, as well as the other agencies that should be involved in such efforts. Everyone believed that their agency had a role to play in reducing gun violence. Those employed by Grady believed that preventing violence was a public health issue. They cited the challenges of dealing with the aftermath of violence at the hospital and the potential benefits to the physical and emotional health of individuals and communities with reduced rates of violence. Other agencies cited as also needing to play a role in

violence reduction included: law enforcement, the state department of public health, local fire departments, state and local educational authorities, state/county/city community leaders, and churches. Most felt that the roots of violence were deep and that it was a problem that needed to be addressed at all levels; a single agency approach could not stem the tide.

In terms of their actual role in working with victims/perpetrators of violence, interviewees varied widely from having no direct interaction with such persons to having direct contact with them, either on the scene or in the hospital. Contact with such persons varied from never to several times per day. None of those interviewed said that they routinely collect data about shootings or the persons involved. When asked to share any patterns that they've noted through their work with persons impacted by firearm violence, the prevalence of young black male victims was frequently cited. Some persons reported seeing "frequent flyers" in that it's not uncommon to see the same persons more than once for gunshot wounds. It was also noted that most victims do not want to talk about what happened and that persons typically give very vague information about the shooting incident. Another person noted that it appears that most often the violence is the result of an argument, although most persons will simply tell you that they were at the wrong place at the wrong time. Interviewees were also asked if they ever deal with persons vicariously impacted by firearm violence. All indicated that they had. Some cited interacting with the families of the gunshot victims, and others talked about interacting with healthcare providers and community members that are vicariously impacted by seeing firearm violence and its results. One person commented on the "culture of hardening" among healthcare workers that are vicariously impacted by firearm violence on a daily basis; there was concern that healthcare workers are adversely affected but that the impact is not taken into consideration through programming, services or supports. In addition, it was noted several times that there is very little support for the vicarious victims of violence.

In terms of documentation of firearm violence, none of those interviewed indicated participating in any systematic data collection outside of the electronic medical record (EMR). One person thought it was possible that persons admitted to the hospital for a firearm-related injury might be logged into Grady's trauma registry.

For those with direct interactions with victims/perpetrators, questions were asked about follow-up for victims of firearm violence as well as mechanisms in place to refer these persons to other institutions to ensure their range of needs are met. Two persons advised that referrals may be made to behavioral health outpatient services if signs of sleep disturbances or hyper-arousal are noted, and a direct call might be placed to the PIVOT social worker if it is thought that someone is in dire need of assistance. It was noted that persons may receive resources through social work consultations as well, but those interviewed were not privy to what occurred in those sessions. None of those interviewed advised that it was within their scope of practice to follow up with persons after they exit the hospital to ensure that needs were being met. It was noted that if a victim of firearm violence received a psychiatric referral, they would likely receive a follow-up from the hospital system related specifically to that.

When asked if their agency appropriately identifies, tracks and refers firearm victims to services, one person advised that their agency does not provide direct consumer services. The other persons felt that their agency was not doing an adequate job in these areas. These persons felt that their agency lacked a strong referral-making process and patient/victim tracking system, and that there was a lack of prioritization and funding for such services within their agency. Many gaps outside of participants' agencies were also noted, including:

- lack of affordable housing in the community to fill patient needs
- a disjointed social service system that makes it difficult to connect persons to services even if resources are available
- a perception among agencies that "someone else is doing it" which lets them off the hook
- a general lack of necessary wrap-around services
- lack of educational opportunities
- lack of employment opportunities
- failure in allocation of VOCA funds to make strong connections for patients to needed services
- a lack of behavioral health follow-up
- lack of identification of many traumatic injuries (i.e. PTSD) that have a lasting impact on persons when not properly treated
- a funding tilt towards criminalization instead of social services
- a failure to treat historic trauma (i.e. childhood trauma)
- Failure to address persons who have been through the systems available and still did not get what they needed to heal/prosper (referred to as "drivers of violence")
- lack of patient navigators and social workers in the communities most impacted by violence
- lack of training for legal system personnel about the impact of mental health problems
- lack of support from leadership to focus training/resources on the problems surrounding violence
- changes in agency policy needed
- legislative changes to recognize the community-based health worker model
- policy changes that make violence prevention services from social workers medically reimbursable
- laws impacting access to certain types of weapons can be changed
- an overall legislative shift towards violence reduction efforts, and
- permitting the allocation of Medicaid dollars in Georgia for violence reduction activities.

PIVOT Program

When asked about PIVOT specifically, most persons advised that they had been aware of the initiative since before its actual inception. Aside from attending meetings and staying abreast of PIVOT activities, none of the persons interviewed said that their department works directly with PIVOT. When asked to comment on the effectiveness of PIVOT, most said that they felt the program had much promise based upon the efforts of similar programs, but that its actual effectiveness remained to be seen. Most

mentioned that PIVOT was a research-based initiative and expected that there would be data to show the level of effectiveness at the end of the grant period.

In terms of PIVOT program improvements, participants shared many ideas. One of the main areas of concern was funding with persons believing that the initiative was under-funded to function as robustly as needed. Nearly all expressed concern that PIVOT only had one social worker that was expected to both recruit and support patients, as well as build a community network. One person also expressed concern that the program was not taking proper care of the secondary trauma impacting the PIVOT social worker. A few expressed concern about the limited geographical catchment area, which did not open the program to all patients entering the hospital with gunshot wounds. One person was concerned that other national programs similar to PIVOT not only have more social work staff, but they also support the entire family unit impacted by the violence; they felt that PIVOT could benefit by expanding services to the family. There was also concern that PIVOT lacked street-level outreach workers which were seen as essential to truly understanding client needs and challenges in the community. One person also felt that PIVOT should have gotten nurses involved. They felt that nurses are more trusted than doctors and sometimes social workers, and are seen as a respected source of advice; nurses could have been effective gauges of patient need and advocates for PIVOT programming. Two persons also expressed concern about the research component and felt that it was negatively impacting buy-in from staff. They stated that randomizing patients into intervention and control groups had served to delegitimize the program within Grady. They believed that healthcare staff are not energized by PIVOT because so many are not receiving services that need them. It was noted that some other hospitals have stopped using control groups for such types of studies and instead use other hospitals admitting similar patients without violence reduction programs as the control group. When asked if the relationship between PIVOT and the interviewee's agency is sustainable, most noted that they hoped for sustainability but there were concerns about funding and the impact that leadership changes may have on what has been built.

Lastly, participants were asked to comment on national concerns about the disconnect between law enforcement and hospitals. Sixty percent of respondents said that they are not in a role where they personally experience this phenomenon, but they were aware of the concerns. Those that had experienced this disconnect felt that it was inherently due to the very different roles that law enforcement and medical personnel hold. They felt that patients would not feel comfortable or safe receiving care if they felt that hospital staff were in any way connected to the police. They understood the challenges this placed on law enforcement, but they believed it was essential for patient care that the two entities be separate.

PIVOT Operative Interviews

ARS invited persons directly involved with PIVOT program operations (called PIVOT Operatives) to participate in interviews and share opinions and ideas. Between June and October of 2019, 14 persons were sent email requests to participate, with up to three invitations being sent if persons were not responsive to the previous request. Persons served roles with the Grady Health System, the Atlanta

Police Department, or other governmental/non-profit agencies directly involved in PIVOT activities. Half of those contacted (seven) agreed to be interviewed; the reasons others did not respond are unknown.

All but one of the persons interviewed represented a division of the Grady Health System or the Atlanta Police Department. All persons had attended PIVOT taskforce meetings, and over half had been involved with the initiative since inception. All persons were very familiar with the program's mission and were in full support of PIVOT's aim to bring healthcare and law enforcement efforts together to reduce gun violence. PIVOT Operative interviews averaged about one hour in length.

Everyone expressed strong beliefs that each taskforce partner was committed to the PIVOT mission and that all involved wanted to see the initiative succeed. However, many noted that relations at taskforce meetings were often tense. Much of this tension was attributed to the fact that the key partners came from different worlds (healthcare vs. law enforcement vs. social work vs. research vs. non-profit) and that each partner brings different perspectives on the key issues. There was concern that some of these perspectives (especially those of non-healthcare players) were not given equal weight and consideration by taskforce leadership, and that the PIVOT partnership was not yet speaking with one voice. However, there was optimism that as the group worked together, common ground would be found.

Interactions With Those Impacted By Firearm Violence

Participants were asked if it was more common to interact with perpetrators or victims of firearm violence through their daily work. Two persons advised that they do not have direct patient/client interactions. Two said that they primarily worked with victims, and three advised that they typically don't know if the victims they serve might also be perpetrators. They said that victim vs. perpetrator distinction didn't factor into how they did business; they treated all persons adversely impacted by gun violence the same. When asked how often interactions with victims/perpetrators of gun violence occurred, responses ranged from about three to four times per day, to weekly or monthly. For those persons with direct contact with persons involved in shootings, they were asked if they typically have routine questions or data they collect from these interactions. None followed a prescribed protocol, and one person said that they never ask about the incident. The others typically asked questions related to getting services such as inquiring about connection to services from a victim's advocate, but not asking questions directly related to the shooting incident itself. Respondents said that when persons voluntarily shared any information about reasons for the shooting (which was rare), they most often simply said that they were at the wrong place at the wrong time.

When asked to describe any patterns/commonalities among persons impacted by firearm violence, the most common response was that young black males are the most adversely impacted. Several added that they tend to live in areas with high crime and poverty rates, and that many have absent fathers. One person added that they almost never see a father visit victims at the hospital. Typically it's mothers, grandmothers and girlfriends that are there to offer support. A few also noted that firearm victims tended to be mistrustful of both the police and the healthcare system in general, often have

had involvement in the criminal lifestyle, often smoke, are prone to drink or use drugs, and are often resistant to returning for medical follow-up appointments/treatment after release from the hospital.

Respondents were asked if they have contact with persons vicariously affected by firearm violence. Two persons said they do not have such interactions, but the other five respondents said they do have such interactions and all cited having varying levels of interaction with the families of firearm victims. Family interactions varied, with some efforts devoted to answering questions and providing information, and others trying to foster support from the families to support the needs of the victim. One person cited healthcare personnel and law enforcement as vicariously affected by firearm violence and as two groups that they interact with regularly. Several noted that there is not enough support for vicarious victims of firearm violence. One person noted that it is not uncommon for vicarious victims of firearm violence to indicate that they themselves have been the victim of firearm violence. There was much concern for the societal/familial complexity of firearm violence and the unaddressed layers of trauma within impacted families and communities.

PIVOT Program

Respondents were asked to share how PIVOT attracts participants and to discuss any campaigns or promotional activities spreading word of the program among the target population. Many persons excitedly talked about efforts resulting in recognition by the Georgia Senate, and a segment on National Public Radio (NPR) about the program. A few also mentioned posters and other promotional materials that were displayed at Grady during trauma awareness month, as well as some lectures conducted at the hospital on ballistic violence. One person mentioned passing out to potential stakeholders a one-pager about PIVOT created by ARS. The majority of program promotion was credited to the program social worker (CRC), who screens patients presenting with gunshot wounds and personally visits them to talk about the PIVOT program and assess how it can help meet their needs. Several noted that the PIVOT officers had been asking for materials to promote the program within the target communities since inception, and that to date APD had not provided them with anything. Such materials were seen as necessary in order to reach deeper into the communities most in need to let persons know that help was available. There was also concern expressed that some portion of persons eligible for PIVOT are not being solicited for participation because a manual (rather than automated) identification system was used which was prone to error, and that there are community stakeholders that would likely engage as partners in PIVOT that are also not aware of the program; these deficiencies were seen as impacting both the efficacy and sustainability of the program.

Those interviewed were asked to talk about the types of resources provided by PIVOT, how well the services are delivered, and any gaps. Persons all credited the PIVOT CRC with connecting persons to resources and believed that he built relationships with many community providers that could assist with some of the major participant needs – education, counseling services, and connection to a victim's advocate that could assist with victim's compensation. A few thought the social worker might also have resources for jobs and housing, but they were unsure. Several service gaps were identified which included PTSD treatment, adequate mental health services and follow-up for those with severe mental illnesses, support groups appropriate to the PIVOT population, access to free medical supplies (i.e.

ostomy bags, diabetic supplies), and petty cash to allow the CRC to assist patients with things such as obtaining identification and social security cards. Most persons also said that more staff was needed to effectively run the PIVOT program. Additional social workers were seen as necessary to more promptly screen and begin patient engagement, and also to provide more intensive follow-up to ensure that services are obtained and that new needs have not surfaced. In addition, it was felt that the social worker's weekday schedule precluded triaged and released patients from receiving PIVOT information prior to release. Having full coverage 24 hours per day would better ensure that all eligible persons were introduced to PIVOT during their time in the hospital.

When discussing gaps, most interviews included conversation about patient engagement. Persons were very concerned that even if the program had every service that a patient could possibly need, there would still be issues with patients actually engaging in those services. Respondents felt that much of the target population lacked a desire/ability to engage in the program in a meaningful way to create change. Respondents were not clear on the personal/societal dynamics which led to this phenomenon, but they were very concerned that until persons engaged in services, the amassed resources are inconsequential. Interviewees commented on a lack of engagement not only in social programming and mental health treatment, but also in medical treatment, with many persons failing to even attend prescribed physical therapy or follow-up medical appointments. There was frustration and sadness that persons were suffering when there was cost-free help at their disposal to get them on the road to wellness and success. Patient commitment was seen as an essential component for the success of the PIVOT program. While there was no clarity on how to improve engagement and commitment, most thought the issue needed to be addressed if PIVOT was to have maximal impact reducing gun violence.

Respondents were asked to share the benefits of working with the PIVOT target population as well as the challenges. The benefits primarily centered around the concept of being able to help bring needed support, services and hope to a segment of the population greatly in need. Several mentioned that they knew they were doing good through the PIVOT program and it felt good to offer persons a second chance. The challenges to working with this population included a general lack of engagement by many to take advantage of the array of help and services at their disposal through the program. Many found the target population to lack accountability and reliability, which impeded efforts to help. In addition, concerns about the culture of distrust for law enforcement was seen as a barrier to community efforts by the police, as well as an obstacle to increased collaboration between law enforcement and healthcare in general.

When asked if PIVOT adequately identifies and tracks persons affected by firearm violence and refers them to appropriate services, all persons agreed but felt that there was much room for improvement. Areas for improvement included the identification of cases – there were concerns about the manual process of identifying cases when an automated system of pulling gunshot cases out of the Grady database could hasten the process. A few persons expressed concern about the selection criteria and felt that the PIVOT area (zip codes) should be expanded, and one person felt that minors should be able to participate with parental approval. Several persons were concerned that patients weren't being referred to the volume of services needed to reduce risk, but there was also an acknowledgement that the social worker is hindered by low engagement and that the only useful referrals are the ones that

result in client follow-through. Most persons were not sure how well clients were tracked, but there was some concern that tracking was likely lacking. Lastly, there was concern that persons triaged and released from the hospital were those at greatest risk for retaliatory violence, yet they are the persons least likely to be introduced to the PIVOT program because the social worker only works weekday business hours. It was acknowledged that efforts were made to contact these persons after release, but the social worker admitted that such contacts were typically fruitless.

Persons were asked to share their expectations going into PIVOT and whether things had turned out the way they expected. While one person reported going into the project with no expectations, the others went in expecting to be able to work together with a multi-disciplinary team to reduce gun violence in Atlanta. A few also had expectations around improving police/community relationships in high gun violence areas. About half felt that their expectations had been met, and the other half felt that their expectations had at least been somewhat met. These persons said that the team had encountered unexpected obstacles and challenges which had slowed progress, but they felt that there had been positive motion forward and that the project still held much potential. In addition, all respondents felt that their agency's PIVOT partnership was sustainable.

Respondents were asked to talk about the ways in which they see PIVOT being an effective gun violence reduction program and ways in which they didn't see it being effective. Most pointed to the research component which will ultimately determine whether the program is effective. However, some felt that at a minimum, the program successfully brought together healthcare and law enforcement to address a problem that plagues both disciplines. In terms of the program not being effective at reducing gun violence, a few expressed concerns that there were tensions between taskforce members which impacted morale and the general ability of the team to be effective. There were also some concerns that the program was under-staffed and that the program needed more full-time social work staff in order to reach the number of persons required to have a discernable impact on gun violence in a city as large as Atlanta. There were also concerns that there were issues outside the control of the taskforce negatively impacting gun violence, such as inadequate mental health services, communities with untreated trauma, a lack of quality housing, poverty, addiction, and lax gun laws. Persons seemed to be cautiously optimistic, while also resolute that there was not one program that could solve all of the societal ills contributing to gun violence.

Recommendations for Improvement

Suggestions to improve PIVOT included:

- **More social workers to carry out the work of screening, engaging, over-seeing and following-up with PIVOT participants.** Most persons felt that more social workers were needed that could cover shifts around the clock, and ensure clients received at least weekly check-ins. There were also concerns that the current PIVOT program engages persons that are admitted to the hospital – those with the most severe injuries and the lowest level of retaliation. Persons triaged and released from the hospital quickly were deemed those with the highest retaliation risk, but those least likely to be enrolled in the program because they exit the hospital before they can be screened and visited by the PIVOT social worker. Having persons at Grady around the clock

that could reach-out to these triaged high-risk cases was seen as imperative to achieving PIVOT goals.

- **An automated screening or flagging system to more quickly identify eligible patients was greatly desired over the manual process where the social worker must visit multiple lists and computer screens to determine eligibility.** Interviewees felt the methods currently used to determine eligibility are prone to error. Using automated data in the official health record was viewed as more reliable, and would provide an instant list of eligible patients which would save time which could then be devoted to patient interactions. An automated case tracking system was seen as essential to better gauge patient/social worker interactions, services received, and to provide a reliable tally of how much case management time is needed to effectively manage a PIVOT case.

- **More PIVOT officers that can engage more neighborhoods adversely impacted by gun violence.** In addition to more officers, there was a strong desire to see more PIVOT outreach and activities in the target communities and other affected areas with all partners involved, including the PIVOT officers (i.e. a Grady health fair, PIVOT-sponsored playground restoration). There were also strong concerns among most partners about officers driving marked cars, wearing uniforms, and carrying full police gear. There was a sense that such an overtly enforcement-type persona negatively impacts the ability of officers to build trust and foster communication.

- **Creation and adherence to an organizational chart that clearly defines roles, responsibilities, and managerial hierarchy.** Many said that roles/responsibilities were not clear, and that partners regularly over-stepped into the area of others. There were many concerns expressed over numerous "disrespectful" taskforce exchanges, and too many persons playing the "Chief" and trying to take charge of the initiative which caused confusion and lowered morale. In addition, a few felt that an executive board should be making high-level decisions about PIVOT. This board would include true decision makers such as the CEO of Grady and the Chief of Police for APD. The taskforce would report issues and problems from the ground, and then the board would provide the taskforce with action directives. Many felt that PIVOT sustainability required an authoritative body, clearly defined roles for each partner, and accountability from the authoritative body to promote an air of cooperation and unity within the taskforce.

- **Work to bring the team together to speak with one voice.** Many different disciplines had been brought to the table – law enforcement, healthcare, social work, research – and the worlds were not seen as having fully meshed in that each discipline was still seeing the tasks through their own lens. There was a strong sense that the team needed to better understand each other's worlds and listen and respect the challenges each player faced in order to come together to view and address gun violence through a more unified lens.

- **Bring on a full-time PIVOT program coordinator.** Many were troubled about the challenges that had been posed by staff turnover, and fears about how such turnover could impact PIVOT once the grant has ended. PIVOT has a part-time coordinator which cannot on-board all new

partners when there is turnover. Such responsibilities were often completed voluntarily by taskforce partners, which likely led to inconsistencies in messaging. A full-time program coordinator could be tasked with such on-boarding responsibilities to ensure that all partners receive consistent information and directives. In addition, many felt that the program coordinator should also serve as the direct line of authority over the PIVOT social worker (or social workers as it was felt that more than one was needed). The thought was that the coordinator could provide oversight to ensure that daily activities were achieving PIVOT goals, and would allow for the quick redirection of staff activities and implementation of protocol changes to ensure program success.

Of note is that the first two suggestions for improvement have already seen movement. There were calls for more social workers to conduct assessments and service delivery to those impacted by gun violence. Grady now has the Trauma Recovery Center where currently a staff of four social workers serve those seeking services and referrals. In addition, the automated screening/flagging system suggested was also implemented in coordination with the needs of the Trauma Recovery Center. There are now flags built into the EPIC system that identify eligible patients.

Shadowing

The research team shadowed the CRC on four occasions: July 10, 2018, January 22nd and 30th, 2019, and March 18, 2019. The first three occasions were made with one member of the research staff, while the final visit by a different team member. The purpose of the shadowing visits was to document CRC processes for fidelity, log data such as average patient interaction times, and to identify unexpected bottlenecks and problems with the implementation model for redress.

Methods

As a part of a larger mixed-methods PIVOT research project, this analysis included qualitative field observations. Research staff scheduled field observations directly with the CRC (unplanned visits were not conducted due to the variability in the CRC schedule which had him at different areas of the hospital as well as off-site meetings with community providers). While an official data collection instrument was not utilized for the visits, the field researchers were well-versed with PIVOT processes and carefully documented pertinent information, interaction times, and problems.

Two accomplished and highly skilled qualitative field researchers were dispatched to shadow the CRC. One researcher was a doctoral candidate with extensive training as a qualitative field researcher, and the other a highly skilled field researcher with more than 20 years of experience.

Data Analysis

Notes from CRC observations were combined into a single summary tallying interactions. The focus was on better understanding the field realities and challenges of the CRC role, as well as documenting fidelity issues, challenges, and key data points such as the average length of time it takes to complete an eligibility screening measure.

Limitations

The main limitation of the shadowing portion of this study was the limited number of times that research staff was able to observe the CRC interactions. Only four shadowing sessions occurred. Three shadowing events were under three hours in length. The CRC expressed concern that the presence of research staff impeded his ability to effectively do his job and the CRC subsequently requested to end shadowing.

Shadowing Summary

All shadowing of the CRC occurred at Grady Hospital. Researchers met the CRC in the morning. Three of the observations lasted less than three hours, with one lasting a total of six hours.

Two visits began with patient visits, and two of the observations began with the CRC reviewing EPIC data to determine patients that had entered the hospital with a GSW since the last check of the system. The latter two visits allowed researchers to see the patient screener process. This process was lengthy and often searches of the database did not yield the necessary information to determine if persons were eligible or not. On one of the shadowing visits, 22 persons were identified as having entered the hospital with a GSW. Of these, 15 did not meet the enrollment criteria (more than half because they did not live/reside within the target zip codes, and the others for a mix of age, custody, self-inflicted, and time-of-day factors). Three persons met the enrollment criteria, but there wasn't enough information available to determine the eligibility of four persons. Of the potential seven persons (three eligible and four where the CRC needed to meet the person to gain more information), two had already been discharged. The screening process of these persons in total took just over three hours; some screeners were completed quickly (with an estimated time of five minutes or less), while others involved more than 30 minutes of searching through multiple screens to collect the needed information. The individual process of each screener was not recorded as the CRC was simultaneously explaining the process to the observer and it wasn't clear if that may have impacted processing time. It was expected that such measurements would be taken on future observations (which did not occur).

On one of the observations, the coordinator was not present, which prevented the CRC from learning whether patients were eligible for the intervention or control group. The CRC advised it wasn't an uncommon occurrence and that he often had to make initial visits not knowing which group prospective persons fell into.

During the four shadowing episodes, 23 persons were identified as eligible for PIVOT (or potentially eligible because EPIC was missing the information needed to make the final determination). Three had already been discharged from the hospital. Attempts to make contact with the remaining 21 persons were made. Some were asleep, in surgery, in comas, or otherwise indisposed. Contact was made with 12 persons where the researchers could observe the CRC interact in the initial contact with prospective patients. Of those interactions, three persons ended up not being eligible for participation; they were simply given resource guides and the PIVOT program was not discussed. The researchers were able to observe nine PIVOT introduction meetings, and each was unique. The CRC advised that the first contact typically lasts about 10 minutes and is simply a quick meet and greet to let the patient and their family know that there is someone they can reach out to if they need support, to provide his contact information, and to begin building rapport and trust.

The nine interactions observed varied greatly. Sometimes family members were present, other times the patient was alone. The ability of patients to interact varied as well, with some in severe pain and not interested in conversation, and others on medications that impaired their ability to communicate effectively. In all but one interaction, the patients and/or their families expressed clear apprehension and suspicion about the CRC and his purpose. Two specifically asked if he was with the police. The interactions were short, lasting between six and eleven minutes. In one observation, it was learned through conversation with family members that a potential participant was ineligible because they resided and were shot outside the target zip codes. The patient was in a coma and the family was very emotional and latched on to the CRC as a representative of Grady with many questions (outside of PIVOT) and seemed desperate for conversation and understanding. The CRC stepped outside of PIVOT responsibilities and thirty minutes were spent talking to the family, providing comfort, and giving them a resource guide and suggesting agencies that can provide supports to the patient upon release. In all patient interactions observed, the CRC exhibited care and concern and made great strides to put patients and families at ease and to build trust and rapport.

The CRC was observed attempting phone contact with two of the eligible persons that had already been released. In one case the phone number in EPIC went to a disconnected phone. For the second person, a message was left on voicemail. The EPIC record of the second person also contained a secondary phone number for a family member. This number was called and it turned out to be the sister of the victim. A ten-minute conversation ensued in which the CRC told the sister about the PIVOT program and asked that she please encourage the brother to return the call. The sister was leery to engage at first and thought that the CRC was with the police department. She seemed to relax as she learned that her brother could be eligible for services and relayed her own experiences having been shot herself several years earlier and the many needs she had during that time. The call ended with the sister saying that she would ask her brother to return the CRC's call.

No observations were made of second or subsequent patient interactions. There were no observations made of program enrollments, the assessment process, or any interactions with patients once enrolled in the program.

The CRC went to supervisors to express concerns about being shadowed and asked that there be no further observations. He felt that having persons with him on visits interfered with his ability to build rapport and that they hampered the therapeutic experience. In April of 2019, the Injury Prevention Coordinator at Grady recommended that shadowing be stopped. No further field observations were conducted. Ceasing field work prevented the research team from understanding and documenting both the nuances and complexities PIVOT processes with patients and inhibited collaborative problem-solving.

The research team strongly recommended that the taskforce assign a committee to take charge of the process evaluation to ensure program fidelity as well as to collect data needed for program evaluation. The program coordinator suggested including all partners, agencies and personnel in the evaluation process. In the end, the taskforce did not take action. The result is that process data was lost and program fidelity questions cannot be answered. Most of the reporting and recommendations on the PIVOT program surrounding CRC duties are reflective of CRC opinions only and cannot be corroborated through direct observation nor data by the research team.

Recommendations

The research team made several recommendations to the taskforce based upon the four observations that were made. These were as follows:

- Streamline identification of the intervention and control group by using a system of odd/even MRN numbers instead of the envelope system, which requires the presence of the program coordinator.
- Reevaluate inclusion of the PTSD assessment in the enrollment packet. Depending on when one is enrolled, this assessment is likely measuring PTSD that happened prior to one's GSW. According to the DSM-5, a PTSD diagnosis requires the presence of symptomatic criteria for more than one month after the event.
- Work with the social work team in the emergency room to get as many contact numbers as possible for persons entering with gunshot wounds. Contact numbers of family members would be very helpful for persons discharged before release, as the CRC reported that many of the numbers recorded are invalid or belong to phones that have already been deactivated by the time he is able to reach out. The research team observed one such situation where the number in EPIC was no longer active. The CRC also talked about the important role that family engagement plays and how it's often family members that help shepherd eligible (but reluctant) persons into the program.
- During conversation the CRC said that there were about 30 providers in the PIVOT community provider network to date, and they were working on finding more. It is recommended that the

CRC connect with the Prisoner Re-Entry Initiative (PRI) community coordinator based out of the Fulton County Department of Community Supervision office. This person was tasked with building a network of community providers to serve the needs of persons returning from prison and has built a database of over 500 service agencies willing to work with the high-risk population in Fulton County.

Since the shadowing was halted, the research team felt it was important to get feedback on the PIVOT process directly from the CRC. Instead of including the CRC in the general PIVOT Operative interviews, a separate interview was conducted with the CRC that specifically targeted issues related to his role and solicited suggestions for improvement. What follows is a summary of that interview, which occurred shortly before the CRC position ended.

Interview with Grady PIVOT CRC Conducted 2/18/20

This interview lasted just over three hours. The CRC was a cooperative and willing participant and advised that he was looking forward to the interview as he thought that he had valuable information to share to help the program improve.

Identification of prospective patients

The identification system originally relied upon the Emergency Department (ED) Social Worker case lists. It was thought that social workers must meet with everyone that comes through the ED with a GSW, but it was later learned that they only meet with Level I and II cases. While this probably captures the majority of cases, it does leave out the Level III cases. To address this gap, he added review of the Medical Student logs as well, which would include the Level III GSW cases.

The CRC was unclear how many cases were missed by relying upon the Social Work information alone, but felt that they were capturing at least 90% of cases that way. He said that the social worker notes tended to provide a good level of information and he felt that the data was accurate and reliable. The Level III cases that were not on the social work list he said tended to be minor and represented persons who were in and out of the ED rather quickly.

Screening process:

1. All the GSW cases for the previous day(s) were reviewed on the social worker and medical student ED lists.
2. All GSW cases on these lists were reviewed through EPIC to answer the screener questions (age, zip codes).
3. Cases that were determined to be eligible were given to the Injury Prevention Coordinator for randomization for control/intervention group status.
4. Cases for which eligibility was unclear were visited in the hospital or otherwise contacted by the CRC to determine eligibility.

An issue the CRC often faced was insufficient data to determine eligibility. There was often missing data in EPIC, or things such an address which was a known homeless shelter or treatment center (not a permanent address).

EPIC does not contain the address where the incident occurred. Sometimes the social worker would add this information to the system, but it was not standard information collected. If a person did not live in the target area, the only way to determine if they were an eligible case was to go speak to the person and ascertain where the person was shot. This was cited as a very time-consuming task. If the person had already left the hospital, the CRC was often never able to determine eligibility. He said that persons rarely called him back in such instances when he had not made an initial, personal contact at the hospital. If the person was still at the hospital, he brought them a PIVOT resource guide and inquired about the missing information to determine eligibility.

The CRC found the randomization process to be cumbersome. If the coordinator was not present to randomize the cases, he was not able to go onto the floors making contacts with any knowledge about intervention/control status. A simpler system was desired and proposed, whereby status could be determined immediately. Perhaps an odd/even numbered patient ID system or another way that verified eligibility instantly.

The CRC was also concerned about what he characterized as the low number of persons that met the program criteria. He felt that the target area should have been expanded to include more zip codes (particularly some in the most crime-heavy neighborhoods of DeKalb County).

The CRC felt that one downfall of the identification process was that there was no way to easily search EPIC for GSW cases. He felt that updating reporting features to permit such searches would have ensured that all eligible persons were captured.

The CRC also expressed much frustration that many persons in the control group wanted to engage in treatment. He was very frustrated that the most motivated individuals in the study ended up in the control group. He felt it was a disservice to identify persons for treatment and then exclude them from receiving treatment services simply because of “the luck of the draw”.

The CRC also felt that more persons needed to be involved in the screening of persons. He advised that he himself had screened more than a thousand people. Of those, a few hundred were found to be eligible. He said that numbers that large were too much for one person to manage, especially since screening was less than a quarter of his job. He said that an intern did help him with some screenings and enrollments. He considered their assistance to be “some relief” but not necessarily “help.” He said that the most time-consuming part of his job was managing the patient caseload and the intern could provide no assistance there. He felt that “help” would have been able to assist him where needed, not to just take one task off his hands. He believed that another person should have been on staff and that they could have perhaps divided the caseload by zip code.

Randomized Control Trial (RCT)

The CRC was not a fan of the RCT protocol. He understood it was necessary for the research project, but felt that the process left many persons needing services out of the eligibility pool. He said that the

original protocol involved one of four persons being selected for the intervention group which delayed efforts to build a strong pool of candidates for services. He was glad that the taskforce listened to his concerns and changed to a "one to two" RCT system. He was also glad that the enrollment criteria was expanded to include more zip codes, but still felt like the criteria was too limiting and that even more zip codes should have been added. His main suggestion to boost enrollment was to add DeKalb County zip codes to the criteria, as he felt that a good portion of persons in need of services lived in DeKalb County.

The CRC felt that only having one person to manage the RCT process was a disadvantage, especially since he said there were many instances where the coordinator was in meetings, had a day off, or was otherwise not available to determine eligibility when he needed the information. He said that there were already delays in assessing eligibility when patients entered over the weekend, so adding other stressors to the system meant losing potential patients.

The CRC estimated that about 20-25% of persons were not screened because they had already been discharged before eligibility had been assessed and the RCT completed. While he said that he still contacted eligible persons that had been discharged, he said that he almost never received a response from them. He advised that it was critical that contact be made within Grady to begin building rapport and to help increase the chances that his calls would be answered upon release. He said that persons were much more receptive to talking to him and to learning about PIVOT when it occurred at the hospital. While he acknowledged that the coordinator's ability to conduct RCTs wasn't the only factor impacting his ability to contact patients before discharge, he cited it as on one of the top three reasons.

Enrollment Process

The CRC said that he typically employed a three-contact process for enrollments (both intervention & control).

1st contact: The CRC provided a sympathy/get well card with a business card and a resource guide. He would have a short conversation with the person letting them know that he will serve as their advocate. He would let them know that he only works with GSW victims and that he understands that they often need special care and attention and that he will help them navigate the process, staff, and life after the hospital. The length of these conversations depends upon their level of engagement (often on high doses of pain meds), and the reception received (welcomed, suspicious), as well as the reaction of any family/friends that may also be in the room. He said about 80% of the time, this initial contact lasts 5-15 minutes. The other 20% of the time things go longer, often because family members have questions and want to engage.

After the visit he then talks with staff and the floor social worker. He wants to learn if there is anything unique about this patient, do they have any special challenges, or is there any other info that would be helpful to connecting them to services. He also wants to get an estimate of when they will be released, which helps him to determine when his next two visits will occur.

The CRC felt that having the initial contact occur in the hospital sent the message that "in my darkest moment people came to see me." He said that it wasn't uncommon for persons to be in the hospital

with no loved ones around them either because they lacked transportation, or they could not afford to lose time at work. He felt that having initial contact in the hospital helped more quickly build rapport with these persons and made them feel like someone cared. Persons that had already exited before he was able to make a first contact were subsequently called. Although he said that most would not return his calls, and those that he was able to engage with did not trust him and were disinterested in what he had to say. In-person contacts were much more successful.

2nd contact: The CRC said that the 2nd visit varied according to the patient and their needs. Sometimes he is just doing a second check-in to remind the person that he is their advocate and to see if they need anything. Other times he has engagements with patients or families with lots of questions. He tries to provide information on the psychological effects of trauma and the need for self-care. He said that he sometimes asks if patients are having trouble sleeping, or are having nightmares. If they are, he lets them know those are side-effects of a major life trauma and assures them it is normal, but that self-care is needed. He also likes to engage family/friends and ask if they have eaten or slept and remind them that the trauma impacts everyone around the victim and that they also need to exercise good self-care.

If the patient/family members are receptive, he also spends time talking to them about normalizing after the trauma and talks about what they may experience when they go back home. He feels that it's important to give the client what they need, and to educate them on trauma if the person is receptive to the information.

CRC said that he also likes to mention assistance with victim's compensation applications. He felt like that was a "carrot" to engage people, something that had value to them. Most persons had no idea they could apply for financial assistance, and most really wanted to pursue this avenue. He lets them know that if they enroll that he can connect them to persons that can provide direct assistance. He said that the second visit is typically around 30 minutes. If the first visit was very short, this visit may be a bit longer.

When asked how many persons receive a second visit, he said that about 80% of the persons he visits once are still in the hospital as expected for the second visit. Some that he calls that have exited the hospital already will be back for follow-up appointments and he tries to see if he can meet up with them on those visits for the second contact. He feels like face-to-face contacts work better than over the phone, so he always attempts to make face to face contact when possible.

3rd contact: This is the visit when he brings the enrollment packet and tries to encourage the participant to enroll in the program (intervention or control). At this point some degree of trust has been built and he has a bit of a relationship with the patient and their family. Often he'll also bring up himself being a credible messenger if that hasn't come up already. He then has them sign the consent forms and begins doing the assessment instruments. He estimated that he is able to complete the entire battery of enrollment components about 80% of the time. In the other 20%, another visit is needed to complete the assessments. Persons often tire or they are interrupted so they can leave for other medical procedures. He said that a full enrollment typically takes 45 minutes, but it's not uncommon to for the process to take up to 90 minutes.

He said that about 10-15% of enrollment packets were done outside of the hospital room, but were completed at Grady during follow-up visits at the clinic.

The CRC said that he would like to do a 4th visit while the person is in the hospital to get them more engaged with treatment upon release, but he advised that most persons leave within a day or two of enrollment.

The CRC said that his enrollment packet included the following:

- Consent form
- Survey
- Depression screener
- Anxiety screener
- PTSD screener
- ACES
- Suicide support questionnaire

The CRC felt that the enrollment package was too large. He understood the need for the consent form, but felt that the survey was much too long and asked too many questions that made participants uncomfortable. He was especially opposed to the questions involving police and gang involvement. He advised that on many of his contacts persons were suspicious that he was with the police and not Grady, so asking such questions put further doubt in their mind and often changed the tone of the interaction. He thought the depression, anxiety and ACES were useful assessments. He questioned the validity of the PTSD questions so early after one was shot and felt that the suicide questionnaire could be handled through conversation instead of structured questions.

The CRC also expressed frustration that the taskforce had instructed him to get social media contact information during the intake process as another avenue of contacting persons. He felt this was intrusive and a privacy violation. He advised that he would not share such information and felt that asking persons to do so would negatively impact rapport. He also thought asking for one's email address was also inappropriate. He said that the PIVOT population was young and a generation that texts or talks on the phone (not email). He felt that communication should happen via those two methods. He felt that asking for any other mode of communication impacted the trust that he was working so hard to build.

Control Group

The CRC was asked how he handled the control group in terms of enrollment and services. He advised that the enrollment process was done exactly the same as with the intervention group. He said that his slant while "courting" the participant was somewhat different however. Instead of talking about customizing services, he instead said that he could help connect them to persons that could help them get their GED and victim's compensation. He said that he mainly took the "I" out of the conversation,

since he himself would not be making the connections. But he would put them in contact with agencies where they could get services if they had the initiative to do so.

He was very frustrated with the control group and said that many of his most motivated persons were in the control group. These persons were ready to change and wanted help and he was expected to turn a blind eye and not provide the services that they needed. It went against his beliefs and training as a social worker. In addition to getting calls from participants wanting assistance, he also received calls from family members that wanted to engage and get help for their loved one. He said that he was really frustrated to not be able to help, and he said that the families and participants in turn were also frustrated with him. He didn't think the situation went smoothly at all.

When asked what he thought could have been done differently with the control group, he felt that someone else should have been put in charge of enrolling them into the program – preferably someone that wasn't a social worker. He stated that social work is a small world and that people talk about their social worker. He felt that not being able to help the control group had damaged his reputation. Persons wanted more than he was able to give them. He wanted to help but was prevented from doing so, but the control group participants and their families don't see that. They just see another person who didn't do anything to help. That hurt him personally and professionally. He felt that it made more sense to have the experienced social worker working with the intervention group and that an administrative specialist could have served in that role for the control group. He wasn't sure if persons would sign up for the program under their direction, but he felt that they could better set the tone and provide the bare minimum of assistance. He felt like a failure because he did not help these people and felt that someone needed to service the control group that did not have the same mindset as he does as a social worker.

The CRC was asked if perhaps gift cards would have been a good carrot for the control group. Instead of promising the group services, they could be offered a gift card to complete assessments, given a resource guide, and then given another gift card if they complete exit assessments. He felt that was a good option to both encourage participation and to take the pressure off the person administering the program to provide services. He repeatedly advised that he felt that he had failed the control group and that his reputation in the at-risk communities had been hurt by not meeting the needs of the control group participants. He strongly felt that a different approach needed to be taken if this were to be done again. He felt that a social worker's credibility was critical to their ability to serve, and that should be taken into account should this type of project be done again.

Intervention Group

When persons were brought into the intervention group, he said that he reviewed the screeners for some background information but that a thorough case plan/treatment plan was developed. It included a detailed bio/psycho/social/spiritual intake, some questions about the incident that led them to their GSW, mental health history questions, and educational goals. There were eight total "need" areas or domains. Based upon the number of needs identified, persons fell into one of three "Tiers." Tier I participants had the lowest number of needs, and Tier III had the highest.

Persons in Tier I were considered low risk of retaliation/re-injury. Their case plans were the simplest and typically could be completed within three months. These persons had one or less need area identified and most often received a referral for help completing their VOCA paperwork, and sometimes referral to outside providers for assistance with things such as assistance with Medicaid or Social security paperwork, and connections to food pantries and organizations to help with rent, utilities and other basic life type services.

Tier II clients were at medium risk of retaliation/re-injury and typically had 2-3 need areas identified. These persons typically received assistance for about six months. They received the same types of services as the Tier I clients, but also tended to require more connection to service agencies to address larger life issues. In addition, the CRC took a more hands-on role in directly connecting these persons to the service providers (whereas the Tier I persons were primarily just given the resources and had to rely on their own initiative to obtain services).

Tier III clients exhibit more than three need areas and are considered at high risk for retaliation/re-injury. They receive services comparable to Tier II clients with the addition of more hands-on navigation assistance to ensure that they successfully connect to the providers needed. The CRC said that he usually spends upwards of a year with these persons to ensure that they have been connected to providers that can service all of their need domains.

The CRC advised that one of the main obstacles he faced in connecting persons to services was low follow-through. Even when he would schedule appointments for the client and remind them the day before or even the day of their appointment, persons often didn't follow through. This not only meant that the person was not receiving needed treatment/services, but it also caused friction between the CRC and the providers that had agreed to work with him. He said that in the end, to ensure that providers continued to work with him and give priority to PIVOT clients, and to ensure that persons got needed services, he ended up having to take a more hands-on approach and actually had to take many persons to their appointments. He advised that this was a time-consuming process, but persons in turn were actually getting services, and he was able to use the time together with the clients to mentor them and discuss other relevant life issues. He felt this was an essential task to ensuring that those most at risk received what they needed. However, he felt like the taskforce was unaware of the lengths he was going to in order to ensure client needs were met. He advised that the taskforce was only concerned about the number of participants brought into the program and not the quality of care that they received once in the program. He cited one day when he spent about six hours picking up a client, sitting with him at the social security office to ensure that he got his application completed and submitted for a social security card, and then driving him back home. He was unable to find employment without it, which had kept him teetering on the edge of going back to his old (criminal) lifestyle. He felt that the time spent getting this person situated for employment success, in addition to the time he spent mentoring him while they were together, were invaluable yet unrecognized as having any value by the taskforce.

The CRC strongly felt that his position required case management. He said that the population served were high risk young adults that are notoriously known for low levels of engagement. He felt that in

order to get buy-in, follow-through, and any provision of services, that some hand-holding was required for most PIVOT clients. He felt that due to the level of hands-on interaction required with each client, that there was a clear need to fund multiple persons to carry out the work. He felt that you could simply sit back and schedule an appointment or tell a person to schedule it themselves. But that if the expectation was that services would actually be received, then most participants required a case manager to hold them accountable, take them to appointments, and ensure that they were actually connected to the help that they need. He also noted that many persons have never navigated the system themselves and that pride is an invisible barrier. Persons would rather say they forgot or play tough like they don't need help rather than admit that they are scared. Taking persons to at least their first appointment helps to show them the ropes and break down the fear – they have been through it once, they have the confidence to do it again on their own.

Another issue related to this was that the CRC advised that he was not reimbursed for engaging in these services. He did not receive compensation for gas or mileage. While he did these actions because he believed it was in the best interest of the client, he felt that others may not be as inclined to use their own resources for such purposes and that any future iteration of this project should include compensation for such case management expenses.

When asked to talk about case plans, the CRC felt that he had a good process in place for identifying needs and connecting participants to services. While clients may not always engage in services, he felt that the network was established that could meet all of the need domains. One item noted was that having a case plan template at the start of the project would have been useful, as well as a database structured around said case plan. CRC advised that he did not have a database or other means to permanently record case plans or case plan progress.

The CRC noted that paperwork was an issue and that it was difficult to keep up with all of the information that he was asked to track. He felt that it would have made more sense for there to be an operational database for him to enter things such as case plans and case activities – databases that collected what was needed for the evaluation, in addition to serving his needs as the CRC. Entering data into a survey monkey file did not assist him in conducting his job but instead took time away from his duties.

When talking about service connection, the CRC said that it was typically pretty easy for him to get appointments for clients. He estimated that he ran into roadblocks that delayed services in less than 15% of cases. While he was able to get appointments for clients, the bigger issue was actually getting them to follow through with the appointment. He said his no-show rate when he simply scheduled and informed clients was quite high.

The CRC was asked how many providers he used on a regular basis. He said that he had built a "good-sized network" of providers to serve PIVOT clients, but that he mostly used the same core providers because they were reputable, truly wanted to work with this population, and provided quality services. He said that Atlanta Tech, Mercy Care, and Atlanta Victim's Assistance (AVA) were the top three providers that he utilized. He estimated that there were probably only about 6-8 other providers that he used on a regular basis.

In terms of missing services in his network, he felt that there were two areas needing more attention. He advised that he did not have a connection to free medical supplies. He had several clients that would have benefited from this resource as their injuries or other ailments left them needing medical supplies on a regular basis and they could not afford them. They often had to re-use supplies or go without. He said he had tried to find connections in this area but failed. He also advised that it was difficult to find agencies that could provide quality family counseling services. He had strong connections for individual counseling, but that family counseling, while not often requested, was difficult to find for free/reduced cost.

The CRC was asked if his clients ever reached out for help for persons other than themselves – did they ask for assistance for family or friends? He said that hadn't been an issue, except in situations where the family had been directly impacted by the GSW event. In one case the victim was shot in front of his girlfriend, and in another situation other family members saw the shooting occur. In one case the shooter was a girlfriend's brother. These cases led to much trauma not only for the victim, but for their families as well. While they did not ask for help for these persons, the CRC saw how it impacted the client to be around persons not receiving treatment for their own trauma. He felt that it would be beneficial if PIVOT had a mechanism to provide case management services for all those impacted by GSWs, not just the direct victim that is shot.

Weekly Activities

The CRC was asked to estimate how much of his time was spent in various activities each week. He advised that there was much variation in each week, but provided a rough estimate of a typical week and how much time is engaged in each major activity group.

Estimated time per week on each activity per week:

Screeners	9%
Rounds in hospital (visit potential clients/glean info from staff)	16%
Enrollment process	7%
Home visits (typically with potential clients that left hospital before enrolling)	3%
Community meetings	3%
Case plan coordination	50%
One-on-one meetings with service network providers (includes potential providers)	3%
Control group responsibilities (responding to calls from clients and family members)	3%
Advocacy with hospital staff	4%
Professional development/CEUs	1%
Staff meetings	1%

Intake vs. Exit Survey

The CRC advised that the same survey was done at both intake and exit. He said that the surveys were provided by the research team. He said that the surveys had changed during the fall of 2019. He said that his bio/psycho/social/spiritual assessment has some overlap with the intake/exit survey. Few exit surveys were collected due to clients falling out of care.

Exit Survey Administration

The CRC advised that the exit process was a challenge as most persons had fallen out of touch prior to what he considered the conclusion of their case. The control group were the most troublesome as there was no real need for them to stay in touch with the CRC since they weren't receiving services. He said that he has lost touch with about half of the control group and cannot complete an exit survey with them. In addition, there is no "carrot" for the control group to agree to an exit survey. They have gotten nothing out of the deal except for a resource sheet.

Client contact/follow-up

CRC advised that maintaining contact with clients has been a major challenge. They are constantly changing their numbers and getting new phones. He said that family members seem to change numbers just as frequently, which makes it a struggle to maintain any connection with persons or their extended contact group. He said that he always tries to get contact information for parents and grandparents but their phones are shut off about as often as the participants. He noted that many of the participants fail to even come for follow-up medical appointments, so it should not be surprising that they fail to prioritize his services.

He estimated that he has been able to maintain regular contact with about half of the intervention and control group participants. Sometimes that is due to their responsiveness in providing updated contact info when it changes, other times it is due to a family member that keeps the lines of communications open. He estimated that less than 25% of participants maintained the same phone number during their time in the program (3-12 months). He estimated that those whose numbers had changed, that they had changed numbers a minimum of three times. He advised that this habit was a mixed blessing. Sometimes they were changing numbers and living off of burner phones due to limited finances. Other times changing numbers was good as it disconnected them from old acquaintances and their old lifestyle. He said that he never told participants to not change numbers, but simply to call or text him and keep him in the loop when they did so to ensure he could get in touch with them.

The interviewer tried to get a sense of how many attempts were made before CRC successfully connected with participants. The CRC wasn't able to give a response and said that it varied so widely that there was no "average" attempt. On occasion he got someone on the first try, other times he spent hours trying to track down a person for whom their phone was no longer in service.

This line of questioning led to a conversation about the apparent general lack of motivation that most of the program participants exhibited. He advised that many didn't really see a need to change their lives, even after being shot. Or, they thought they should change, but they just weren't ready to do what was needed. Some participants only joined the program because their mothers or grandmothers strong-armed them into it. They saw the need for change more than the participants. While this may have gotten them to enroll, it unfortunately did not get them to engage.

The interviewer asked if the CRC had any suggestions to increase motivation in the client base. He did not. Interviewer inquired about incorporation of motivational interviewing (MI) into the process to help increase buy-in, and application during moments when low motivation was exhibited. The CRC was very much in favor of incorporating MI. He felt that official training in MI was necessary to ensure that practitioner did it correctly for maximum effect. The Interviewer also inquired about any type of programming CRC might be aware of, such as Motivation 4 Change that might lend itself to this population. He was not aware of anything, but did think that MI could be useful to increasing engagement.

Service Completion

The CRC was asked how he determines when a client has received all the help they need and therefore when it would be appropriate to end the service period. CRC advised that he uses a general timeframe based upon a person's Tier, which would generally indicate services for three, six, or 12 months. He said that unfortunately most of the persons referred for services have fallen out of contact with him. He said they were the higher risk persons and they stopped communicating and he has struggled to find alternate ways to reach them. At this point he said he can simply confirm that connections to services were made on his end, but cannot comment on the level of services that the clients actually received.

Community Provider Network

The CRC was asked to describe the community provider network that he had built. He advised that he had many contacts from previous employment and that he pulled on his connections to get things started. He said he the used the United Way and NPU functions to get more connections to keep serving participants. He said that the more community meetings he attended, the more connections he kept making. He scheduled one-on-one meetings with providers to learn more about their services and to see if they would be a fit for PIVOT participants. He said that he hosted a few informal community meetings to help build his network and for providers to be able to network amongst themselves, since they are all serving similar populations and rely upon providers to fill gaps.

He felt that overall he built a network that could meet the needs of the PIVOT clients. He felt that two holes remained – access to free medical supplies and family counseling. Other than that, he felt that he had sufficient connections to meet client needs. He felt that the AVAs and Mercy Care were the two most needed services and that both were always accommodating to see PIVOT clients. He also felt that

housing was needed, but felt that was a city-wide problem and didn't think it was so much a matter of finding providers to fill the gap as it was that the community needed to build such resources, as they did not exist.

The CRC expressed frustration that he did not receive any assistance building a community network and said that he's a social worker and admitted that network building was not something he was trained to do. He felt that the hospital staff or taskforce should have played a role. He felt that he did well to bring providers to the table, but that others with experience he lacked should have taken care of hosting meetings and developing MOUs. He said he had no experience or training in this area and felt that his time would have been better spent recruiting and servicing clients.

Other Feedback

The CRC was asked to provide any other feedback that wasn't covered during the interview. He first advised that there needs to be more than one person in his position. He said that he was asked to wear too many hats and that the workload for each was too much. He felt that the taskforce only viewed him as bringing in participants ("numbers") but did not have any idea about all of his other responsibilities. He felt that the role would be more "balanced" if there was more than one social worker handling cases, and if other staff from Grady managed aspects of the position such as community networking and MOUs.

The CRC acknowledged that he had been assigned an intern and felt that there was some value in having their assistance. However, they mostly just screened cases, as they weren't qualified to do other aspects of his job.

There was more concern about the control cases expressed and concern about his reputation as a social worker being tarnished by dissatisfaction among those in the control group who wanted assistance. He felt that the staff managing intervention and control cases should be different. Perhaps the control group should be managed by a non-social worker that would not be frustrated simply providing resources cards.

CRC was also concerned about his own self-care and felt that the job took a strong toll emotionally. He felt that the taskforce was unsympathetic to that aspect of the position and said that in the end he had to take leave to ensure he got self-care.

The CRC felt very misunderstood by the taskforce and did not feel like a valued part of the team. He felt alone as the only representative of social work on the team. The other players were primarily medical staff and law enforcement. While he respected their positions, he did not feel that they understood his role and thus his contributions were not valued. CRC was asked if he felt that he had a strong grasp of the day-to-day responsibilities of the other players – did he know what the law enforcement officers, doctors, researchers and hospital administrators did on a daily basis for the project? He said that he did not and that maybe the issue was just that the team didn't really understand each other's roles. It was possible that other players may have felt the same way he did. Being that the project had such a large focus on the "numbers" though, he thought he likely got the

brunt of things. Lastly, he said that he wished that the taskforce had treated each other respectfully. He felt there was a lot of back-stabbing and just general distrust and disrespect among many of the taskforce members. He thought that the initiative would have been more successful if people had worked together better and treated each other respectfully.

Cardiff Focus Group and On-Boarding

The original fifth year extension of the SPI project was dedicated to Cardiff expansion efforts in Atlanta. After exhaustive efforts to engage the target Atlanta police department, Cardiff efforts remained at a standstill. The City of Atlanta was unresponsive, apparently disinterested in participation. To be fair, some of these efforts occurred during the climate of the COVID-19 pandemic, civil unrest, community calls to defund the police, and diminished personnel capacity in police departments nationwide, which may have played a role in the indifferent response to Cardiff Model expansion efforts at this time. To continue efforts and not risk damage to relationships with the target departments during these unprecedented times, a change of scope was submitted in the summer of 2021 to refocus Cardiff efforts.

The new strategy was two-fold and would address both community perspectives as well as continued law enforcement engagement. The community piece involved conducting a focus group with the NPU-V community safety group to collect insights from community members disproportionately impacted by gun violence. The goal was to learn perspectives about the Cardiff Model and its perceived applicability to efforts to combat violence in their community. The law enforcement piece involved the development of implementation and onboarding packets that could be used for future agencies looking to implement the Cardiff Model, as well as a Zoom meeting where these materials could be presented to a team looking to apply for Cardiff funding and to answer team questions (and record key issues from this interaction to assist with future interactions with teams looking to implement the Cardiff Model). Both efforts leave the United States Injury Prevention Partnership (USIPP) with information and tools useful for future Cardiff expansion efforts.

Cardiff Community Perspectives: Focus Group

A focus group was conducted on August 9, 2021 from 1pm to 2:30pm at the Cure Violence headquarters in South Atlanta. Members active in the Neighborhood Planning Unit V (NPU-V) were invited to participate and share their opinions on the Cardiff model and its perceived usefulness in their community violence prevention efforts.

The city of Atlanta is divided into 25 NPUs, with each serving as a citizen advisory council to the Mayor and City Council. NPU-V is comprised of the Adair Park, Mechanicsville, Peoplestown, Pittsburgh, and Summerhill neighborhoods, which have disproportionately high rates of violent crime in the city. Eight NPU-V members attended the focus group. During introductions and throughout the course of the focus group, it was clear that the participants are very actively involved in their community and had

much personal knowledge about historical crime/violence prevention, suppression, and restorative efforts throughout NPU-V.

Focus Group Design

The focus group employed a market-research design. Participants were asked to read a three-page summary of the Cardiff Model created by the Centers for Disease Control, and they then watched a short video about the Cardiff Model created by the United States Injury Prevention Partnership (USIPP) in Atlanta. These items were presented as "advertisements" for the Cardiff Model, and after presentation participants were asked to rate how useful they thought the Cardiff Model would be in violence prevention efforts in their community. They were also asked to talk about their thoughts on health agencies and law enforcement agencies working together to reduce violence in their community.

Next, participants were told that they would receive a more in-depth overview of the Cardiff Model and local efforts, essentially a longer "advertisement" about the Cardiff Model provided by a member of the local Atlanta USIPP. They were then provided with an opportunity to ask questions and were again asked about the perceived usefulness of the model for violence prevention in their community.

Summary of Findings

The focus group first explored the reviews of the Cardiff Model using the three-page review from the CDC, as well as the Atlanta USIPP video. Persons responded hesitantly to the materials. Two persons felt that the materials would be useful to their community, but all other respondents felt that it would "maybe be useful." There was much conversation about what persons would want and need from the Cardiff Model, as well as terms of engagement. The main theme was that the materials reviewed gave them a sense of what the model could provide, but not the level of detail they needed to fully embrace it as a strategy that would bring benefits to their community.

The group supported the idea of law enforcement and health agencies working together to address violence. The community is home to Cure Violence Atlanta, an organization that embraces viewing violence as a public health issue – a disease that can be treated and cured. While the group wasn't clear from the materials exactly how the Cardiff Model worked, they had experience with the concept of health agencies working to combat violence and were not adverse to expanding such partnerships if they saw a clear benefit to the community. Many felt that if more people saw violence as a public health issue that it would bring new resources to the community to help. Violence as a public health issue was seen as something that members of the general public who are not disproportionately affected by violence would find palatable.

Participants had very clear ideas of what their community needed to address violence, and what it didn't need. Some of the key themes that emerged were:

- Past partnerships with the police have not met community expectations. Participants talked about frustrations about police coming in with a "suppression" mentality, which is not what they wanted. Several persons talked about not wanting the police to come in and lock people up, but instead to work with the community and families to find solutions to violence. There were also several references to the police trying to "bully" the community partnership into doing things their way, as well as complaints about police leadership turnover which impedes the community's ability to build strong, enduring relationships with the department.

- Some expressed concern that the Cardiff Model did not include lawmakers and key decision makers in the community. Resources are needed to address the problem of violence and without lawmakers and those with control of the purse strings, there was concern that the Cardiff Model could not achieve much.

- There was agreement that the Cardiff Model could not operate in a bubble. It needed to be combined with other community efforts such as those of Cure Violence and other organizations that respond to victims, families, and address the trauma within the community as a whole. Persons felt that the partnership needed to include more than just law enforcement and health agencies. "Everyone has to be a part of the solution."

- There was much talk about trauma and its impact on the community. Some felt that a "trauma response" was needed to fully effect change. "We're spinning our wheels if we ignore the impact of trauma."

- Many felt that a missing piece in the Cardiff Model was the community itself. One person said that a map of where violence was occurring wasn't needed for people that live in the community. They can tell you where those things are happening – they live in the middle of it and see and hear it every day. While specific suggestions for how to include the community weren't provided, many in the group felt it was necessary for the Model to be optimally effective.

- In addition to including the community, there was some wariness of outsiders coming in and telling the community what their problems were and how to solve them. Participants talked about having seen many so-called experts come and go. They stressed that the residents are the ones that stay. They are the ones impacted every day. Residents need to have a say in the initiative and need to be involved since they are the ones impacted by violence in their community, not the experts.

- Several persons talked about the efforts of Cure Violence, who respond to the scene of violent crime and are there to support and provide services to those impacted. They are known by residents and are respected responders. These persons felt that the Cardiff Model needed to include a piece that had persons on the ground like Cure Violence to collect information and to

offer services. They felt such efforts were needed to effectively address violence in a community where it was so deeply entrenched.

- There were concerns about community malaise and a related, tacit acceptance of the current state of affairs after so many failed initiatives to create change. One person said "People in the community have become numb to violence and all the things that go with it – trash all over the streets, streetlights out, shootings, drugs being used and sold in the streets … " Many talked about violence and crime having become normalized. While they weren't against implementation of the Cardiff Model, the thought was that there needed to be reengagement and hope brought back to the community before such efforts could have a lasting impact.

The next step in the process was for a USIPP representative to provide a more detailed overview of the Cardiff Model in Atlanta using a PowerPoint presentation. Afterwards, the floor was opened to questions. There were many questions, but also much conversation amongst the participants about the model and what they liked and didn't like about it. The key item that participants liked about the Model was the inclusion of public health in perhaps a new capacity. One person said that the Model might help them reach a new audience that doesn't already see violence as a public health issue, and another felt that bringing new experts to share that message was useful to work already happening in the community.

Several key themes emerged, all focused on data:

- In this community that has many initiatives operating currently/previously, there is a lot of data being collected. There is clearly frustration and questions as to whether all of the data collection is actually benefitting the community.
- Respondents felt that data was being collected and kept in silos and that organizations weren't working together to do anything meaningful with the data.
- One person talked about a recent data collection project conducted by Morehouse College. They asked, "Was it really necessary? We've got too many data collection systems going on. No one's putting them together or communicating with each other."
- There was again concern about whether Cardiff data was useful to those that live in the community – residents already know where the violence is occurring, as they live through it every day.
- There was concern by some that trauma data was not part of the Cardiff equation. The sentiment was that trauma was at the core of much of the community's issues and that a trauma-informed response that included data on trauma was needed to successfully address violence.
- There were concerns that groups come in and collect data that the citizens of the community never see. There was a strong call for data to be accessible to residents.

At the conclusion of the focus group, participants were asked to again think about the usefulness of the Cardiff Model at addressing violence in their community after having heard the second, much more in-depth presentation on the model. It was a fifty-fifty split with half of persons saying that the Cardiff Model would be useful, and half saying it would maybe be useful to violence prevention efforts.

In line with conversation where respondents pointed to the significant data that Cure Violence already collects, they were then asked to rate the usefulness of the Cardiff Model if its maps included data points from law enforcement, health agencies, and Cure Violence. This changed opinions slightly, with 62% (5 persons) voting that the Cardiff Model would be useful and 38% (4 persons) voting that it would maybe be useful in violence prevention efforts.

Key Findings – Transferrable to Other Sites

The focus group provided a good deal of information that will be useful to future Cardiff Model efforts in the NPU-V communities. Community members were advised that areas that have not received the level of intervention that they have may differ (this community has been the focus of many prevention, service, and research initiatives), but the session provided several key take-aways valuable to presenting the Cardiff Model to other similar communities where many initiatives have been tried/are ongoing:

- Community members stressed the importance of Cardiff Model implementation being done on the community's terms, not the terms of outsiders. They have become disillusioned with persons from outside the community coming in and telling them what was best for them and what needed to be done. They wanted a role in management of the process and say in what was best for the community.

- There was apprehension about past partnerships with the police. There was room at the table for law enforcement, but community members wanted them to be open to taking on a different role than they were used to; talk to the community and find out what they need from law enforcement. In this community, they reported that law enforcement defaulted to a suppression approach even when the community requested that they play a support role.

- Share data! Community members had heard a lot of promises from organizations that they would share data with community members, yet most of those promises did not materialize. There was a strong desire for data to be shared with community members in a format and on a timetable agreeable to the community.

- In a community that has experienced a lot of interventions, there is suspicion about what a new model can bring to the table. There is also suspicion about broken promises as were experienced in the past. Be careful to involve the community and build bonds of trust. Understand what the community needs, what has been tried before, and what the model can bring that is unique. Keep the needs of the community first and foremost.

- The three-page summary of the Cardiff Model created by the Centers for Disease Control in combination with the short video about the Cardiff Model created by the United States Injury

Prevention Partnership (USIPP) in Atlanta did not provide the level of information that community members felt was needed to fully understand the Cardiff model. Community members wanted to not only understand the model itself, but also to understand how it would directly and specifically provide benefits to the community. The group had clearly seen many presentations on different initiatives targeting their community. What they wanted was a clear, concise description of how the model benefitted the community, how the community would be involved in implementation (partnership and a voice at the table), how the model would impact other efforts in place that had community support (such as Cure Violence), as well as how the community would receive information and data from the initiative. Presentations to future communities would benefit from crafting the Cardiff message around these needs to best provide residents the information most important to them.

Cardiff Law Enforcement Engagement: Onboarding Zoom Meeting

On August 6, 2021 a Cardiff Translation onboarding event was conducted virtually via Zoom with the Albany (Georgia) Police Department (Albany PD). Present on the call were representatives from the Albany Police Department (the Chief, crime analyst, planning manager, and a high-ranking supervisory officer), Phoebe Putney (PP) Hospital (Director of Inclusion, and a Communication and Engagement Specialist), a representative from the Georgia Department of Public Health (DPH), a representative from the Criminal Justice Coordinating Council, a member of the ARS research team, and two persons from Grady Hospital representing the Cardiff Model implementation team (one of these persons also represented the United States Injury Prevention Partnership – USIPP).

The purpose of the meeting was to initiate the foundational work needed for Albany PD to implement the Cardiff Model and submit an SPI application next year to fund the programming identified through the partnership. In addition to serving as an instructional call for Albany PD, the call was also a learning experience for the Cardiff team on onboarding new members. What questions arise? What supports do the police and health agency need? What kind of concerns are expressed? This call was designed to help the team better prepare and support Cardiff onboarding.

Summary of the Meeting

Overall, the meeting went very smoothly. It was led by Jasmine Moore of Grady Hospital in Atlanta, who is also serves as a representative of USIPP of Atlanta. Participants of the call were already familiar with the Cardiff Model so the facilitator focused on reviewing the onboarding process. A copy of the USIPP onboarding packet was emailed to all participants before the call.

There were some questions about the data sharing agreement and the DPH representative was able to address these issues. A particular concern was about the time period of data that needed to be shared, as the hospital was not sure that their data was collected in a way that would provide much of the pre-implementation data needed. There were also questions about mapping, and the DPH representative advised that their agency handled this for the agencies. The team was told that mapping can occur on

the timeframe that works best for them (monthly, quarterly, etc.) – they will work with agencies to provide the maps in a way that best serves the team.

The Albany PD crime analyst expressed some concerns about providing victim impact data and said this wasn't possible unless cases were pulled individually (not a feasible strategy). One of the PP representatives expressed concerns about challenges they would also have pulling historical data out of their system.

Albany PD was not clear on the software that the department was using to track demographic data. The Chief advised that they had to check with their vendor.

There was a conversation that an MOU was needed between Albany PD and PP.

Conversation shifted to next steps wherein Jasmine reviewed key issues around the data sharing agreement process which begins at DPH and then moves to the Albany PD. Albany PD advised that they will need to go through their City Attorney for review.

Participants on the call were invited to attend the monthly Atlanta USIPP meetings, which occur on the third Thursday of the month, as well as the National USIPP calls that occur every other month.

The floor was then opened for all participants to ask questions about any steps in the process. Participants were encouraged to think about what they want to learn from the Cardiff Model as well as to consider data structure and capacity.

A question was asked about the Cardiff Model and crime solvability. Jasmine explained that the Model does not help in that respect. It helps agencies identify needs and gaps. The data is used to plug in services and help solve issues in areas the maps show to be plagued with violence. Several points were made including that Cardiff is a preventative approach that does not increase crime rate statistics, it's a public health approach with partnerships that help agencies better leverage help to communities in need, and that the model should have a bottom-up, rather than top-down approach.

Albany PD inquired about whether other partners should be involved as their scope of services is limited to policing/public safety. They felt that other partners such as the local Safety Commission should be involved as they allocate money for community issues. Albany PD wants to identify community partners for the project to help bring services needed to the areas that will be shown on the maps created. It was felt that violence is the result of a culmination of other unaddressed social issues within the community. Not addressing those issues constitutes a disservice to the community.

The Chief very much wants information on lessons learned and best practices from other jurisdictions to review for application to Albany.

There was conversation about viewing violence as a public health issue and consideration of other agencies that could be pulled into the partnership other than just PP. PP suggested churches get involved and felt that they could bring much to the affected communities.

Jasmine talked about providing the partnership information on collective efficacy and a pin exercise where residents place pins on a map to indicate troublesome areas. These will provide the group with

steps others have taken and will give them areas to consider moving forward. In addition, it was said that Albany will need to start their own community safety partnership.

A participant in the meeting had attended the Georgia Association of Community Hospitals meeting and said that Cardiff was mentioned there.

Next steps include DPH and the Albany PD crime analyst connecting to talk about data, as well as the need for formalized agreements which need to be reviewed by the Albany Chief of Police as well as the City Attorney. The planning and research representative at Albany PD said that they will monitor data to see if benchmarks are hit. The Community Engagement representative from PP talked about a desire to do a warm-up session. The call concluded with PP and Albany PD agreeing to get together to work out the remaining details.

Lessons Learned

The purpose of the virtual meeting was twofold: 1) to initiate the foundational work needed for Albany PD to start implementing the Cardiff Model and submit an SPI application to support the implementation and, 2) to learn how to improve the process for future onboarding efforts. Goal number one was met and the Albany team is taking next steps with engaging with DPH on a data sharing agreement and is participating in USIPP meeting for technical assistance to prepare for implementation and the submission of a grant proposal. Several opportunities to improve the onboarding process were also learned that can help support future Cardiff efforts both locally and beyond, as follows:

1. There was much conversation about data, specifically the level of detail needed and the availability of historical data. The DPH representative did a great job responding to these questions, but it's clear that more conversations between DPH and the data persons from PP and Albany PD are still needed in order to get a better sense of the data availability past and present.

   Recommendation: Develop a one-page summary sheet for inclusion in the implementation packet clearly outlining data expectations so that partnering agencies come to the onboarding meeting with a better sense of what is required. The document may not answer all questions, but the data representatives on the call seemed to be operating from a place of unfamiliarity about what data was needed. Better knowledge before the call would allow for more focused data-related conversations during the onboarding process.

2. There were questions about the maps that would be produced and a lack of knowledge that DPH handled mapping duties. It also seemed that some persons on the call weren't clear about the maps in general.

   Recommendation: Consider opening the onboarding meeting with a short summary of Cardiff so that everyone on the call has at least a baseline knowledge of what is happening. Anyone brought in at the last minute would at least be operating during the onboarding process with some knowledge base. Infographics of the Cardiff process that could quickly convey the process

would be useful, as would examples of maps and other visuals of Cardiff outputs (available in the informational packets as well as presented visually at the meeting for discussion).

3. The Chief of Police on the call specifically asked for documentation of lessons learned and best practices from other sites.

   Recommendation: Best practices documentation was a planned piece of the implementation packet and the Chief's request confirms the importance of their inclusion. Sharing documentation from other sites' best practices and lessons learned would be valuable tools for start-up sites. If sites agree to serve as contacts, it would be ideal that these materials provide persons and contact details so that sites can easily contact each other to better share detailed information about first-hand experiences and answer questions.

4. The partners were told on the call that they need to create their own community safety partnership, and much talk occurred between the partners about who to bring into the partnership to best serve the needs of the community.

   Recommendation: Develop a one-page document outlining the types of services providers and agencies typically invited to participate in a community safety partnership. Who do other Cardiff Model communities partner with? What sorts of needs should the partnership expect in order to identify relevant partners? Albany is a unique, close-knit community with many church outreach efforts to address community needs and an established collaborative network of agencies working together to assist in prisoner reentry efforts. Many communities will not have this already-established structure and may struggle in such efforts. A starting point about who to have at the table for the community safety partnership is a valuable tool.

5. The onboarding packet is still in development, but a draft was sent to call participants about an hour before the call. This is understandable as the document was still being edited for review, but the small window of time did not allow for review prior to the call. It is unclear if participants received an implementation packet.

   Recommendation: Once the onboarding packet is finalized, the document should be sent to participants well in advance of the onboarding call to allow for ample time to review and discuss. This may provide clarity so that some questions don't need to be asked on the call, and may also open other doors of inquiry.

Training

Training opportunities were integrated into the Atlanta SPI. One of the main training experiences came through a peer exchange program with the San Francisco Hospital-based Violence Interruption Program wherein taskforce members were invited to observe operations. In addition, a training was

also provided to the CRC, PIVOT officers, and other members of the Atlanta Police Department to encourage the use of trauma-informed responses. Training was also provided to the taskforce on collective efficacy which was the basis of a detailed collective efficacy plan for law enforcement efforts in the target communities. All training opportunities are discussed in more detail below.

Hospital-based Violence Interruption Program Peer-Exchange Training

The Atlanta SPI team participated in Hospital-based Violence Interruption Program Peer-exchange (HVIP) Training. This involved several key team members visiting the HVIP team in San Francisco for three days in January of 2018 for direct observation of their program in operation, mentoring, and the sharing of lessons learned, best practices, and implementation recommendations. The Atlanta HVIP program was unique in that it was developed in coordination with the police department. While the San Francisco HVIP wasn't an exact program match, the experience provided the team with much information about program challenges and flow.

The primary goals of the Atlanta team were (1) to observe the day-to-day functioning of an HVIP and (2) query launch and longitudinal practices with regard to staffing, training, collaboration with a secondary (post-hospital implementation) external source of violence interrupters, and information sharing across agencies that will benefit clients and communities. Learning how the San Francisco HVIP captures, stores, and monitors data was also of special interest, as were process documentation practices and the logging of best practices for post-grant sustainability. Such knowledge was used as a template in PIVOT planning and development.

Trauma Informed Criminal Justice Training

The Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes that the majority of people who have behavioral health issues and are involved with the justice system have significant histories of trauma and exposure to personal and community violence. Involvement with the justice system can further exacerbate trauma for these individuals. Traumatic events can include physical and sexual abuse, neglect, bullying, community-based violence, disaster, terrorism, and war. These experiences can: challenge a person's capacity for recovery, pose significant barriers to accessing services, and result in an increased risk of interacting with the criminal justice system.

SPI Training and Technical Assistance (TTA) funds were sought to bring the trauma-informed care approach to the SPI initiative. It was recognized that persons with gunshot wounds likely have histories of trauma and acknowledged the role that trauma can play in people's lives. Trauma-informed criminal justice responses can help to avoid re-traumatizing individuals. This increases safety for all, decreases the chance of an individual returning to criminal behavior, and supports the recovery of justice-involved women and men with serious mental illness. Partnerships across systems can also help link individuals

to trauma-informed services and treatment. As PIVOT works with people who have been physically assaulted and with victims of or witnesses to community violence and are at risk of system-induced trauma and re-traumatization, the training was expected to increase PIVOT officers' capacity to successfully execute the program's objectives.

The training also introduces the Adverse Childhood Experiences (ACE) study and the influence this ongoing study has had on our understanding of the multitudinous, long-term effects of trauma. The ACE factors were measured on the personal surveys completed by program eligible individuals.

The GAINS Center developed the SAMHSA training with the objective of increasing awareness of trauma, its causes, and effects among a broad range of criminal justice professionals. SAMHSA identifies the specific objectives of the training, entitled "How Being Trauma-Informed Improves Criminal Justice System Responses," as follows:

- Increase understanding and awareness of the impact of trauma
- Develop trauma-informed responses
- Provide strategies for developing and implementing trauma-informed policies

The training curriculum selected provides a basic but solid understanding of trauma, specifically referencing SAMHSA's "three Es" definition of trauma – Events, Experiences, and Effects. The training is interactive, engaging, and tailored for criminal justice professionals.

Training was scheduled on October 24, 2018 from 9am to 3pm at Atlanta Police Headquarters. Two certified trainers with degrees in clinical psychology and criminal justice, who have been working with criminal justice professionals for over twenty years on issues such as trauma and trauma-informed care tailoring the training to PIVOT conducted the class of 20. The PIVOT officers and CRC were present in training, as were officers from the gang unit, gun reduction unit and community-oriented policing unit that cover Atlanta Zones 1 and 3 (which have the highest violent crime rates) participated.

The application of PIVOT officers working in communities as prescribed by our SPI is likely to be perceived as unprecedented by collaborators and partners within the department. This training served as an essential piece to ensure understanding and support for PIVOT officers across law enforcement roles. This training was instrumental for the introduction of trauma-informed care into the Atlanta Police Department, as PIVOT officers were able to directly translate their training to their peers. In addition, a brief presentation on PIVOT was facilitated at this training which allowed officers to view their training within the context of a program happening in their own city, department, zones, and beats. Many officers in attendance were not familiar with the PIVOT program.

The training was very well received by those in attendance. The trainers commented on the very high level of participation from the group as well as their willingness to share personal stories and examples, which greatly enriched the classroom experience. Officers were very receptive to the concept of

adopting trauma-informed policing strategies and many were able to relate their own personal experiences with trauma to the importance of adhering to the recommendations. Officer post-training surveys supported these findings as officers reported strong agreement in the usefulness of the class and their ability to respond in a trauma-informed way. An article about the training appeared in the fall 2018 SPI newsletter.

Collective Efficacy Training

Training on collective efficacy was made available to the PIVOT taskforce. There was much interest and a call was held with Craig Uchida on April 22, 2019 to learn more. An official training on collective efficacy was conducted by Craig Uchida and Shellie Solomon on June 26, 2019 for taskforce members. The training was very well received and a collective efficacy planning meeting was conducted on July 24, 2019. The meeting was facilitated by CJCC and was attended by representatives from APD, Grady Hospital, and ARS. The meeting focused on how to implement the learnings from the June training. How could the group move community members to action? What resources are available to officers to support collective efficacy efforts? What could the group do to support and promote such efforts within the community?

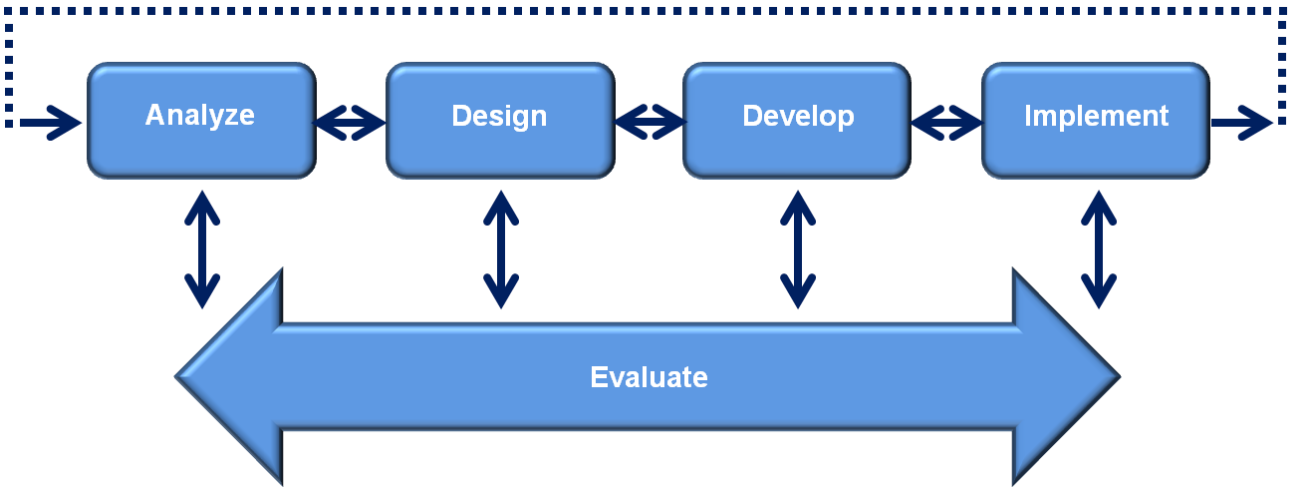
Another meeting was held on August 21, 2019 where CJCC provided a formalized collective efficacy plan and reviewed what was required of the PIVOT officers (copy of plan in the Appendix). CJCC met with the officers monthly to review the plan and discuss progress until they felt that the officers had the support of APD leadership to continue their efforts independently. In addition, ARS conducted analysis on APD calls-for-service data and created knock and talk lists so that the officers could personally meet with persons regularly in contact with the police to report incidents.

CJCC was pleased with these efforts and felt that the officers were gaining momentum in the target communities. Unfortunately the COVID-19 pandemic hit and collective efficacy went to the back burner in early 2020 as the police had to change focus to more pressing issues. It is hoped that implementation of the plan developed by CJCC can serve as a model for APD for future collective efficacy efforts in the target communities and beyond.

Process Reviews: Continuous Quality Improvement Efforts

The Atlanta SPI employed a continuous quality improvement model (CQI) to facilitate evaluation feedback being translated into program monitoring and improvement efforts. This involved the PIVOT taskforce working together with a clear aim and understanding. CQI involves evaluation at all steps of the process to identify processes not congruent with expected outcomes. While the idea of CQI was

embraced by taskforce members, the process did not always function smoothly or produce results that kept quality in check.



The CQI process was successful in addressing some concerns and demonstrated that the taskforce team had the ability to respond and find consensus. For example, when there was concern about one of the target neighborhoods not engaging with the PIVOT officers, the research team found viable substitutes and the team agreed upon a replacement relatively easily. However, such success did not always occur. Several factors contributed to the erosion of CQI efficacy.

Some of the CQI breakdown occurred due to a lack of data. For example, transmission of data from Grady Hospital were severely delayed, which prevented the team from understanding issues as they arose. The CRC stopped field observations, so the research team lost the ability to assess issues on the ground to bring to the team for consideration. The CRC logged very little data about his day-to-day interactions, which prevented a complete understanding of field activities and interactions. The CRC himself brought problems to the table, but they were issues of his choosing and not driven by process data. The research team asked the taskforce to assign a subcommittee to oversee the collection of process evaluation data, but this was never done. The PIVOT officers rarely brought issues to the table as they worked to address issues within their own command structure at APD. Other taskforce members sometimes brought up issues related to the PIVOT officers and APD, but it was rare that the officers themselves brought items to the taskforce as they were instead brought to their commanders and handled within APD.

Turnover also contributed to issues. The turnover of taskforce members meant that trust had to be built each time new members came on board. As an example, leadership over the PIVOT officers at APD changed many times and led to a revolving door of sorts with different supervisors making appearances at meetings that were not well versed on the PIVOT project nor taskforce processes or protocols.

Other problems occurred when issues were brought to the attention of the team and members were not able to look at the problem through a unified lens and instead saw the problems through the eye of healthcare, or the eye of law enforcement, or the eye of social work. There were many very tense team discussions where members walked away feeling disrespected and/or misunderstood. Such diverse perspectives often kept the team from easily finding common ground and solutions.

The taskforce had subcommittees that addressed specific PIVOT-related issues. Those conversations and the decisions made by the subcommittees were not routinely discussed at the larger taskforce meetings and research staff did not attend those meetings. Requests by the data team for quarterly updates on subcommittee activities were not honored. It is unclear the extent to which CQI factored into subcommittee activities.

This discussion does not imply that the taskforce did not employ a CQI process. CQI was an important component to maximizing efforts amongst such a diverse group representing not only different agencies, but different sectors of public service and private firms and therefore vastly different perspectives. However, it's important to note that the CQI process was not without limitations or problems. While CQI was effective for some issues, it greatly missed the mark on others.

ANALYSIS AND EVALUATION

ARS proposed a very detailed process and impact evaluation plan for the SPI project. As discussed in the previous chapter, the process evaluation was less robust than expected due to many factors including expected data not being provided/logged, as well as the requested ceasing of field observations. Despite these limitations, the process evaluation still provided much context and insight into the challenges of the PIVOT initiative. The historical cohort analysis provided insight into the volume and complexities of the target population. Community surveys highlighted the depth of communal issues and concerns surrounding crime, violence, and police relations. The limited shadowing experiences provided a glimpse into challenges with the eligibility identification process as well as challenges engaging participants in the program. The Wilder surveys and PIVOT and non-PIVOT operative interviews provide insight into the strengths and weaknesses of the taskforce and the PIVOT initiative as a whole.

The impact evaluation mirrors the process evaluation in many respects. A carefully crafted research plan was designed that ultimately was not fulfilled due to factors outside of the control of the research team. The evaluation was designed to explore two levels of impact – individual and community (crime problem). ARS planned to employ an experimental design to determine the degree to which the program provided measurable improvements in participant outcomes when compared to eligible patients who do not participate in the program. Pre- and post-patient screening tools, hospital visits, and criminal records were to be examined, as well as an analysis of complex factors driving violent crime in the target areas. Data from the treatment area was to be matched to proximal and comparison neighborhoods. Multivariate analyses at both the person and community levels was expected, as were survival analysis models to measure the number of days of program success (program start to adverse event or no adverse event).

Two main culprits stymied the ability to complete the impact evaluation as expected – a lack of data and a very small sample size. At the end of the 18-month study period, the PIVOT program only enrolled 13 persons in the intervention group and 31 in the control group. These numbers were much too small to draw the expected conclusions about program success. The research team also struggled to obtain data from Grady Hospital. As of this writing, the final data request made to Grady more than a year ago has still not been fulfilled, and this data has yet to be provided. Despite these impediments, the study still has impact findings, just not of the nature planned. The Atlanta SPI project provides a broad view of impact that helped to illuminate the immense challenges of bringing together a multi-disciplinary team used to working in silos with the expectation of finding a common vision, the important role of data and the challenges with acquisition, as well as strategies and ideas that might be more effective. The evaluation addresses the impact of the Atlanta SPI on individual-level care and the crime problem using the data source available. While the expected roads to evaluation were not taken, data can nonetheless be used to highlight some important impact results.

Impact – Individual-Level Care

The project yielded several sources of individual-level care data including: a profile of persons screened for participation, the CRC's end of shift report data, as well as the CRC's patient tracking log. Each of these will be discussed below. It is important to note that data was requested from Grady to compare post-release hospitalization data for the intervention and control group, as well as data on all GSW entries into the hospital during the study period. As of this writing, the research request remains in the queue at Grady Hospital and data has not been provided.

GSW Victims Screened for Participation

In August of 2020 the research team received data from Grady Hospital on all persons that had received a PIVOT screener during program operation (See Table 10). The 18-month program resulted in 1,136 shooting patient screenings (validated by the program coordinator). One-third occurred in the second half of 2018, and 65% in 2019. The total number of persons presenting at Grady Hospital with a GSW during this time period is unknown (data not provided), so the actual percentage of all GSW victims that were screened cannot be calculated.

Among patients with known residential zip codes, fully half of the cases were within APD's jurisdiction, and 28% resided in one of the target area zip codes. The average patient was 31 years old (std. dev. = 11) at the time the screener was completed. Just under one-third of persons screened (31%) were between the ages of 18 to 25, which was considered the prime at-risk range. Twenty-eight percent were over age 35, which automatically made them ineligible for the PIVOT program. A disproportionately high number of Black or African American (90%) persons and males (87%) were shooting victims.

Shooting patients screened were equally as likely to present in the day or evening hour, and over half entered the hospital between the CRC's working hours (9am to 5pm). One-quarter of the victims arrived at Grady during the nighttime to early morning hours, which is linked to an increased likelihood of recurrent firearm violence. Displays of volatile or angry and retaliatory expressions, being under the influence of drugs or alcohol, and involvement in a prior shooting were also linked to increased risk, and were less discernable from hospital records at the time of most screenings (5%). Thirteen percent were found to have multiple Grady Hospital records.

In total, 125 persons or 11% of those screened were fully eligible for PIVOT participation. A randomization of one to four was used. Thirteen persons were enrolled in the intervention group (10%) and 31 in the control group, equating to an overall enrollment of 35% of the screened eligible population. This is in line with other HVIP studies which have had enrollment rates of 31% and 20% respectively (Chong et al (2015); Aboutanos et al (2011)).

Table 10. Screener Captured Firearm Violence Patients					
Cases = 1,136	**N/%**	**Min**	**Max**	**Mean/%**	**S.D.**
2018 (6 months)	1,135	0	1	35%	.48
2019 (12 months)	1,135	0	1	65%	.48
Multiple MRNs	1,136	0	1	13%	.34
APD Jurisdiction (Fulton Co.)[1]	1,116	0	1	50%	.50
30318[1]	1,116	0	1	5%	.22
30310[1]	1,116	0	1	6%	.24
30315[1]	1,116	0	1	5%	.22
30331[1,2]	1,116	0	1	6%	.24
30311[1,2]	1,116	0	1	2%	.15
30354[1,2]	1,116	0	1	4%	.20
Underage (<18 years old)	1,090	0	1	4%	.21
Over age 35	1,090	0	1	28%	.45
White/Caucasian	1,130	0	1	7%	.25
Other or Multiracial	1,130	0	1	5%	.22
Presented AM	1,117	0	1	46%	.50
Presented PM	1,117	0	1	52%	.50
Presented CRC 9am – 5pm[1]	1,117	0	1	55%	.50
Patient is Eligible if Both apply:					
1) Injured or Lives in **Unknown or Target Zip Codes**	1,136	0	1	66%	.48
2) And scores 3 of the following					
Male	1,135	0	1	87%	.34
Age 18-25	1,090	0	1	31%	.46
Black or African American	1,110	0	1	90%	.30
Presented 9pm – 9am[1]	1,117	0	1	25%	.43
Concerning Expressions	1136	0	1	2%	.14
Charted as High/Intoxicated	1136	0	1	.3%	.05
Previously Shot[3]	1,136	0	1	2%	.42
Total (Eligibility #2) Score	1,136	0	5	2.68	.82
Scored at least 3 on Group #2	1,136	0	1	61%	.49

All Eligible	1,136	0	1	41%	.50
Any Ineligibility	1,136	0	1	89%	.32
Eligibility/Potential Enrollee	1,136	0	1	11%	.31

[1]Of valid cases
[2]Added/changed after pilot
[3]Confirmed medical history/ GMH charted (patient reported to provider or provider previously treated) or formerly screened during study period

CRC End of Shift Report

To better understand CRC daily activities and patient interaction, the CRC completed a short end-of-shift survey where daily activities were logged. The survey was designed to take about five minutes to complete and was completed online through a Survey Monkey link. Questions involved logging the number of patient screenings and enrollments completed each day, reasons eligible patients were not enrolled, the number/type of patient contacts, follow-ups completed, as well as community resource-building activities.

Over the course of the project, 118 entries were made. Thirty-nine percent of entries were not entered on the same day they were dated; some entries were made up to four days later. The CRC did not share internal logs of activity, so it's unclear if the lag time in entries may reflect some lost data points.

Logged patient screenings ranged from 0 to 34 per day, with an average of five screenings completed per shift. Of the 77 persons logged as being screened as eligible, the CRC logged making initial contact with 27 of these persons, 12 were noted as having already been discharged from the hospital, and five were in ICU and contact was not feasible on the day of screening (the contact status of the remaining 33 eligible persons was not logged in the database). The CRC logged interacting with zero to four eligible patients per day.

One hundred and forty-six bedside contacts were logged, along with 18 contacts during follow-up appointments at Grady. Fifty-six offsite meetings with patients were logged, but the location and nature of those contacts is not known. In conversation during shadowings the CRC mentioned sometimes visiting with persons at home that had fallen out of contact, as well as personally going to appointments with enrollees (such as the social security office or an initial mental health screening). It is assumed that visits such as these are captured in the 56 logged offsite meetings. The CRC spent much time contacting participants by telephone, with 312 phone contacts recorded.

The CRC logged attendance at 57 offsite meetings with community partners/potential partners. Twenty-one of those interactions indicated that a new partner was brought into the PIVOT community network.

While it is likely that the end-of-shift log does not capture the totality of the CRC's interactions, the log still reflects much time spent screening patients for program eligibility (average of five persons

screened per day) and much contact with the CRC and prospective/actual program participants. The CRC logged 146 bedside visits, 56 offsite patient interactions and more than 300 phone contacts.

CRC Patient Tracking Log

The CRC provided the research team with a copy of his internal patient tracking spreadsheet for the 13 intervention group participants. The spreadsheet provided program entry and exit dates, information on the Tier level, identified needs, connection date to services, status of services (on-going or complete), as well as an exit note from the CRC as the project closed. The spreadsheet does not provide any detail as to who provided the services, the specific types of services provided, how often services were received, nor any notes about whether the service met the needs of the patient. There was no comparison information on assessed Tier level or needs for the control group.

Of the 13 people enrolled, endnotes indicated that one person was now deceased and one was incarcerated. Three participants were listed as Tier 1 (lowest risk) and ten at Tier 3 (highest risk). No intervention group participants fell into Tier II.

All persons listed as Tier I were shown to have only one domain need, and all were for mental health. All are shown as having been connected to mental health services about a week after program entry. One person completed services within eight months, one is listed as receiving on-going mental health services, and there is no notation about service completion for the third. The person whose completion date is unknown was also shown to have received food and utility assistance. The Tier 1 participants were in the program from five to eight months, with two listed as "Patient fell out of care" as the reason for their program exit.

Of the ten persons in Tier III, one had three areas of need, one had six areas of need, and the others each had four areas of need identified. All Tier III participants were identified as having employment, mental health and life skills needs. Eight also had education as an identified need, two had substance abuse needs, and one had a housing need.

The patient with needs in all six areas was shown as having been connected to services in each area, and was engaging in on-going services in the areas of education, employment and housing. This person was in the program the longest at 14 months, and the CRC noted that in February of 2019 that the participant was working and planned to get a GED from Atlanta Tech.

All persons with a need for mental health services were shown as having been connected to services. One person was shown to have ended services, and three of the Tier III participants were shown as still receiving services on an ongoing basis. All but one of the persons with an education need were shown to have obtained services, with two listed as receiving ongoing educational services. The two persons with substance abuse needs were shown as having received services, with one reflecting a date for completion of services.

Eight of the ten persons with an identified life skills need received services; only one person is shown as having completed life skills services; the status of the others is unknown. Only two of the 10 persons with employment needs was listed as having obtained services, yet three are indicated as receiving

ongoing services. The person with a housing need was shown to have obtained services and was listed as receiving ongoing services in this area. In addition to the major service domains, some participants were also noted as needing assistance with utilities, food assistance, assistance accessing specialized medical care, and help obtaining social security benefits.

The Tier III participants were in the program for between four and 14 months, with an average of seven months. Two of the ten Tier III participants were listed as "Patient fell out of care." The CRC notes indicated that one person was employed and connected to mental health services, one was connected to mental health treatment, and two persons were unemployed but receiving some mental health treatment.

In sum, of the 13 intervention group participants:

- 6 participants received education services
- 2 participants received employment services
- 13 participants received mental health services
- 2 received substance abuse services
- 8 received life skills services
- 1 received housing services
- 4 received "other" services

Impact – Community/Crime Problem

Community impact data for this project is problematic. The premise of law enforcement involvement was that they would serve as a rapid response team in the immediate aftermath of a shooting to gather information about the context of the shooting and rally the community to prevent retaliatory violence. Rapid response services were also to occur directly at Grady to gather information from families and victims to assist with the investigative process. PIVOT officers were to serve as a deterrent to retaliatory violence (immediately after the shooting as well as after release of the victim back to the community), and were to assure the community justice for the victim. As discussed in the report, the police role changed greatly upon implementation and essentially the PIVOT officers became APD ambassadors to the community charged with improving relations and building trust between the target communities and the police.

Measuring changes in crime rates, gun crimes and shootings is not an appropriate analytic strategy, as the resulting PIVOT law enforcement intervention did not directly address gun crime. The focus became improving soured community relations and building trust. In addition, the PIVOT program within Grady only served 13 persons, so measurable community-wide impacts would not be expected to result from serving such a small sample of victims of gun violence. In addition, hotspot maps combining law

enforcement and hospital data, which were to be an important tool for targeting police intervention and services never materialized. For these reasons, comparisons of gun violence data are not provided pre- and post-PIVOT implementation. Community surveys were also not conducted post-PIVOT, as the intervention did not reach the community as expected. Any changes in community attitudes about crime were not expected to be attributable to the PIVOT program.

Two sources of community impact data are available. Officers logged their daily activities in an end-of-shift survey each night, which provides a look at the depth of services provided to the community. In addition, interviews were conducted with some of the key partners that the PIVOT officers worked with in the community. While official crime data would not be a reliable measure the PIVOT officer intervention, partners serving alongside officers in the community were seen as a strong qualitative gauge of impact.

PIVOT Officer End-of-Shift Reports

Between June 1, 2018 – October 8, 2020, the PIVOT officers logged 272 shifts in PIVOT designated "at-risk" or target neighborhoods. Of note is that funding for the PIVOT officers ended in early 2020, but the Major over the target neighborhoods had the officers continue their work in the community. These efforts continued until October when the Major and the officers were reassigned by the department. Mechanicsville was the most frequented community and was visited in 87% of logged shifts. Pittsburgh was visited in just under two-thirds of shifts (65%), and officers logged time in the Thomasville Heights community on 46% of their PIVOT shifts. One-third of shifts included visits to all three communities, and another third included visits to two of the three target communities.

Logs indicate that shootings occurred in the target neighborhoods 32 times when officers on duty or within the 24 hours prior to their shift, with most shootings occurring either outside of a residence or on the street/sidewalk. While on patrol, officers reported seeing/hearing about conflict on 20 shifts. They personally intervened on 12 occasions and were able to bring about a successful resolution in half of those instances. In four situations officers referred persons to services. Officers opined that they thought three of the 12 (25%) situations had the potential to escalate to a shooting had there not been officer intervention.

PIVOT officers reported that they had contact with either the Gun Reduction Taskforce, an Investigator, or the Gang Unit in 17% of their logged shifts. Those interactions involved the exchange of information with either the PIVOT officers being asked for information, and/or them being given information on investigations or activities afoot. There was no record of the officers working together to talk to victims or witnesses. While officers did not work in concert with investigative units, it was noted that 23 referrals were made to the Atlanta Victims Advocate. From notes, it appears as though these exchanges occurred during supportive (not investigatory) visits with shooting victims and/or their families. Officers logged 10 interactions where they spoke with a witness of shooting. It's unclear how/why the interactions occurred, but it's likely these occurred during officer "knock and talk" efforts wherein they

went door-to-door in areas after a shooting to gather information and to help quell community frustration and to calm tensions.

Forty-two percent of PIVOT officer shifts involved interaction with other agencies, organizations, service providers, and/or a PIVOT partner. Notes indicate regular weekly interaction with food distribution at a community elementary school and a local recreation center. In addition, one-third of PIVOT officer shifts involved briefings, education and/or outreach efforts. Officers logged attendance at 28 community forums and made 53 contacts with code enforcement in direct response to resident or officer concerns about derelict properties.

Officers cited 92 shifts where community contacts were made unrelated to shootings/conflicts. These appear to be contacts specifically geared towards building communal relationships and trust. Officers also logged various other community activities such as passing out Crimestopper cards, safety flyers, participating in career days and talking to local students, handing out gift cards for groceries, handing out toiletry bags, as well as participating in community clean-up events and local National Night Out events.

Qualitative Impact Interviews

Evaluating the impact of preventative efforts relying only on quantitative data misses advances that are not easily calculable, such as changes in attitudes and beliefs that are not measurable through official crime statistics. For this reason, efforts were made to learn more about such gains through personal interviews with persons/agencies that partnered with the police in the target communities. These interviews yielded valuable information that could not be detected through official data channels.

The PIVOT officers worked with many community partners, with the intensity of those partnerships and the regularity of activities varying widely. ARS wanted to target the partners that officers worked with most closely, the partnerships that were thought to have the highest chance of impacting the community at large. ARS selected the four groups with which the officers regularly worked and emailed them a short message asking if they would be willing to answer a few questions about their partnership with the Atlanta Police Department. Three persons enthusiastically responded that they would be happy to share their feedback, and phone interviews were subsequently scheduled. One person did not respond to multiple email requests. It was later learned that they had very recently left the agency and that their email was not providing notice of their departure. The partners interviewed were from a school, a library, and a large apartment complex located in the target neighborhoods. A list of five questions was used to guide and structure all of the interviews, which lasted 15 to 35 minutes each.

The types of activities that the officers engaged in varied by community partner, but typically involved both structured and unstructured activities. Structured activities involved things such as giving

presentations, responding to community complaints/concerns, assisting with a library card drive, and helping to set up/distribute food to needy families. Unstructured activities typically involved engagement and interaction with community members and children. While the partners all expressed great appreciation for the assistance with structured activities, all felt that the real power came from the unstructured activities where the PIVOT officers and community members could talk, laugh, bond, and build trust. One person said "I see pops of magic happening when kids and parents interact with the officer. They see that he's a good guy. He really cares. It chips away at their negative view of the police."

All persons interviewed felt strongly that their partnership with the police had positive effects on the community. One person felt that having the police engage directly with the community in a positive way helped to "humanize the police." Another person said that their partnership allowed the police and community youth to interact, and they felt it was critical that the kids see a positive side to the police to build trust and to encourage them to take their lives in a positive direction. Yet another person said "Officer Blackmon is a part of the community and our family…he is a positive force for our children and families. He talks to people. He offers support. He's a positive ambassador for the police department."

When asked if the collaborative efforts between the police had an impact on reducing community violence, one person said they believed the interactions had a positive effect on the community, they weren't sure the reach of the impact that the partnership was having. The other two answered with a resounding "yes!" The officers on the PIVOT project were described as role models and trusted by many children and families in the community. They were also described as resources where people could get and share critical information. One person shared that officers often worked with women and children in domestic violence situations to connect them to safety resources. The officers were also credited with providing gang prevention information and providing real-world information on the impact of gangs on gang members and the community as a whole. Officers were present when the local school went on lockdown due to gunfire from a nearby gang conflict. They were able to help the children feel safe and to better understand the negative impact of gangs.

When asked how their partnership with the police department could be improved, several suggestions were provided, but the central theme revolved around expansion. The partners believed that more of the officers' time and attention would allow them to have an even greater impact on the community. The apartment complex representative said that they would love to see the officers on the property two or three times per week to be present when citizens have questions or needs, to validate that the police are truly a partner with the community to create a safer place, and to interact and bond with the children to help steer them from the negative paths that many will take due to the environmental pressures of living in a high-crime area. In addition, expanding community efforts that allowed for more officers to engage in community activities was also seen as helpful.

Another suggestion was provided which revolved around police response times. There was grave concern that the good work the officers are doing in the community can potentially be negated by the poor response times of the department as a whole when citizens need them. One person noted response times of over an hour. They said, "People call and it takes the cops an hour or longer to respond. That breaks down the trust that Officers Blackmon and Walker have built. You gotta come when we need you. People get so frustrated they don't even call. If we say there are gunshots or someone is being beat, we need the police faster than an hour. The shooter is long gone. The victim is dead. It's too late. I think the community officers combined with response times that make people feel safer would go a long way to changing things here."

The general sense from the interviews was that the partnerships were: valued, effective at breaking down barriers and changing perceptions and increasing trust in the police, successful at helping children to develop bonds and to see the police as positive forces in the community, served as a tool with the potential to help reduce violence, and needed to facilitate change in the target neighborhoods. Below is additional feedback to provide more context:

"The community is in a really bad way. There is so much violence. So many guns. It's unreal. Whatever the police can do to build trust with this community is important. We really need the police to be a part of the solution."

"Officer Blackmon is a familiar face. People recognize him in the community. They call him the food panty officer. They ask for him. They look forward to his being on the property…he is faithful. He serves this community and he's loyal. We know we can count on him. "

"This community needs community police officers. Having them here helps break down walls. People start to think that maybe not all cops are bad. They feel safer, seen, heard. We need police response times to validate that."

"Having officers involved in community events has been very beneficial. People get to engage directly with them in a positive way. It helps humanize the police."

"We're at the heart of Black Lives Matter and police unrest in the city. Rayshard Brooks' children went to our school. Secoria Turner went to our school. So did five parents that worked at the Wendy's that burned down. Relations with the police aren't good. There is so much tension and anger. But Officer Blackmon's presence provides a different view. Not all cops kill black children. As a black officer he is able to really talk to our kids and show them policing in a different light. Policing isn't all about chasing people and guns; it involves giving back to the community and serving. He not only says it, he lives it. Officer Blackmon is part of the healing process in this community, and this community really needs healing."

During the Cardiff Model focus group in August of 2021, the PIVOT officers were mentioned several times (no PIVOT-related questions were asked; the feedback came organically in conversation where residents talked about police relations and effective violence reduction initiatives in their community). One person talked about the PIVOT officers that had been regular fixtures at the local recreation center and talked about how useful it was in building trust between youth and the police. They talked about the officers being friendly, accessible, and going out of their way to be a trusted place where kids and families could share problems and get support. This person lamented the loss of the officers and felt that direct outreach in the community like that made a palpable difference. The loss of the PIVOT officers was also mentioned by another person in the focus group who felt that APD had made a big mistake by reassigning the officers after they had made so many in-roads in the community and were helping to improve police-community relations.

INTEGRATION AND SUSTAINABILITY

Sustainability of the PIVOT program was a primary goal of the taskforce. The partners acknowledged that gun violence and repeat gun violence were serious problems that needed to be addressed. The time was seemingly right to address this issue, confirmed by WCFI survey results. Agencies were concerned, poised and ready to come together when funding for the Atlanta SPI project was approved. The collaborative team dedicated much time and effort to implementation and refinement of the PIVOT program and processes. Ultimately though, the team succumbed to the challenges and complications of a multi-disciplinary team. The team wasn't able to see the issue of gun violence through a unified lens. Agencies accustomed to working in silos on this issue (e.g., public health, law enforcement, social work, community service providers, researchers) had a hard time landing on common ground, and ultimately the PIVOT program ended with the expiration of funding.

Dissention began early in the planning process with doctors and others on the taskforce wanting to insert violence interrupters into the PIVOT initiative to support the work of the CRC. Funding was lacking to support this addition and ultimately forced a recourse back to the original plan, but this early dissention and fracture in the taskforce led to many others over the course of the project. Ultimately the hospital-based portion of the PIVOT program was not staffed in a way to screen and provide services to a sizeable numbers of participants. Furthermore, the PIVOT officers never became the rapid-response team envisioned due to departmental push-back by investigators fearful of interference with active investigations. Finally, there was a lack of adherence to many of the research protocols, and the taskforce began to splinter rather than come together as an integrated unit.

Despite the dissolution of PIVOT, the experience laid a solid foundation for continued gun violence prevention efforts in Atlanta. PIVOT is a story of learning lessons. The Atlanta SPI project opened the door to two initiatives that would follow and pick up where PIVOT left off. The desire for violence interrupters/credible messengers was shared by community members in the PIVOT target neighborhoods of Mechanicsville and Pittsburgh, which are within the Neighborhood Planning unit V (NPU-V). It was through the partnership with the Community Safety Committee in NPU-V and PIVOT that funding was obtained from an OJJDP grant to partially fund cure Violence in NPU-V. This grant along with funding from the Kendeda Fund and the Annie E. Casey Foundation allowed for a full implementation of Cure Violence and violence interrupters/credible messengers in NPU-V. Cure Violence has taken the envisioned role of the police as rapid responders to the scene of gun violence; credible messengers now fill that role by responding to shootings and work on building better relationships with the community.

The City of Atlanta has embraced the work of Cure Violence and other non-law enforcement resources for crime prevention efforts. The Mayor has committed $5 million dollars to expand community based violence intervention and prevention work, which includes the expansion of the Cure Violence initiative to other neighborhoods outside of NPU-V. The pandemic and civil unrest have exacerbated the issues

of capacity and manpower for APD to dedicate personnel to prevention efforts. This highlights an opportunity for organizations like Cure Violence or other violence prevention or intervention programs to help stem the tide of violence when many law enforcement agencies are facing staffing issues or community backlash to increased enforcement strategies.

While Cure Violence has filled the gap and is providing rapid response to violence interventions, Grady Hospital has shifted internal efforts to meet patient needs away from a singular CRC to create a Trauma Recovery Center (TRC) with a team of six full-time staff (1 coordinator, 4 clinicians, and a data analyst) and one part-time clinician. The TRC provides assessments and wrap around services to meet the needs of patients following victimization of a violent crime. The TRC has a strong focus on mental health services and the identification and treatment of trauma. The TRC also partners with Cure Violence credible messengers to legitimize services as well as to aid in the penetration of the community with the delivery of needed services. Grady Hospital ultimately wants inclusion of credible messengers to be at GSW victims' bedside in the hospital, so that relationships and trust can be built before persons are released and return to the community to decrease future gun victimization/retaliatory violence, as well as to increase engagement in treatment and services through the TRC. This step is currently a work-in-progress as legal issues are hashed out. The goal is that case management be conducted by Cure Violence staff, (to include motivation and mentoring), and the Trauma Recovery Center be the hub and provider of all mental health supports needed to ensure comprehensive healing and success.

PIVOT provided fertile ground for the Atlanta SPI to learn, and to ultimately create a more workable strategy for combating gun violence. Cure Violence and the new Trauma Recovery Center at Grady Hospital continue the work begun by PIVOT. Having learned from the trials and tribulations of PIVOT, the new programs are better able to navigate these now chartered waters and therefore to be more responsive and nimble in their efforts to meet the needs of individuals and the community at large to address gun violence.

SUMMARY AND CONCLUSIONS

The Atlanta SPI project provided an opportunity for a multi-disciplinary team to come together to reduce gun violence. This was the first such attempt involving the Atlanta Police Department and Grady Hospital and the experience wasn't without growing pains. The project involved three prongs. The first prong was the delivery of wraparound services and intense follow-up to victims of gunshot wounds through the PIVOT program managed by a dedicated social worker. The second prong involved rapid response and intensive community policing efforts through two dedicated PIVOT program officers. The final prong was data sharing, which was to include the sharing of APD and Grady Hospital data, implementation of the Cardiff Model, and the creation of hotspot maps to better target areas of violence.

At Grady Memorial Hospital the PIVOT program screened 1,136 shooting patients for eligibility for participation in the program and enrolled 35% (44) of those determined eligible (125 total). Of those enrolled, thirteen received intervention programming, which is nearly a third of all those enrolled. PIVOT participants received varying wrap around services that included education, employment, mental health, and substance use services along with mentorship from the Community Resource Coordinator funded through this grant.

Two PIVOT officers were deployed into three target neighborhoods with high rates of gun violence, and 272 shifts were logged wherein they engaged in intensive community policing efforts to build trust and repair fractured relations between the community and police. The PIVOT Officers responded within 24 hours of shooting 32 times during the project period. They intervened on 12 occasions to conflicts within the target neighborhood and were able to bring successful resolution in half of those instances. The Officers indicated that three of the twelve had the potential to escalate to a shooting. The officers also helped refer 23 individuals to Atlanta Victims Assistance, which employs victim advocates that are embedded within the Atlanta Police Department.

To build community relationships, the PIVOT Officers in 42% of their shifts interacted with other agencies, organizations, service providers, and/or a PIVOT partner. They participated in food distribution, attended 28 community forums, and contacted code enforcement 53 times in direct response to resident or officer concerns about derelict properties. While community surveys at the start of the project found resident concerns about the responsiveness of the police to the community and their concerns, all community partners interviewed strongly expressed that the PIVOT Officers had a positive effect on the community and that their work helped break down barriers, change perceptions, and increase trust in the police.

Due to legal wrangling's and later failed attempts to regain commitment, the data sharing component of the project was not implemented, but a focus group was conducted with community members to gauge interest and support for implementation of the Cardiff Model. The focus group provided valuable insight into key community needs in a partnership, including a strong desire to have input into

implementation, a sharing of data, and an appeal for the police to play a supportive role (not suppression).

While the PIVOT program did not emerge as expected and missed some intended goals, it succeeded in providing leaders and funders with a clearer picture of what the community needed and what could better meet those needs. A direct result of this was the implementation of a Trauma Recovery Center at Grady Memorial Hospital to continue the hospital-based portion of the project. The Center is currently staffed by a team of four full-time clinicians providing vital services to all victims of crime, with a focus on mental health and trauma treatment. Funding was also secured to implement Cure Violence to provide the rapid response in the community through interrupters/credible messengers. Cure Violence and the Trauma Recovery Center now work in partnership to bring needed supports and services to gunshot victims and their families.

While the PIVOT model did not take residence in Atlanta, that's not to say that the program couldn't find success elsewhere. Some of the key lessons learned are provided here for other jurisdictions where the PIVOT model might be more feasibly implemented.

Key Lessons: Multi-Disciplinary Taskforce

Bringing together a multi-disciplinary team proved to be very challenging. We recommend that much time and care be given during the formative process of crafting and launching the multi-disciplinary team to help create an atmosphere where the sharing of ideas and opinions can be done respectfully, and where a merging of interdisciplinary viewpoints is encouraged. Leadership representing the disciplines involved can lend credibility and help foster understanding and team building. Roles and responsibilities should be clearly defined.

Key Lessons: Research Component

While the research partner was a formalized member of the team, there were many struggles to obtain data and cooperation. We recommend that future teams/taskforces be prepared to have an integrated research team member and be versed on the value of process and fidelity data, and how to use the data to make decisions. Due to the continual struggle with control group compliance, future endeavors may want to consider using data of gunshot wound victims from a similar hospital without a hospital-based violence intervention program. In addition, having key leadership involved in obtaining data from their respective agencies could be a valuable tool to avoid the many data delays and failures to obtain data encountered throughout the project.

Key Lessons: Hospital-based Violence Intervention Program

The hospital-based part of the PIVOT program involved the identification, recruitment, and connection to services by a hospital social worker. Recommendations for future endeavors include ample staffing in order to assess and deliver services, including setting and adhering to an acceptable patient-social worker ratio. Ensuring staffing around the clock would ensure that there was always staff onsite to make the initial program contact while the patient was still at the hospital, which proved to be a much

more effective tactic than cold calls after release. In addition, an automated alert or flag system of gunshot wound admissions would assist in the efficient identification of prospective program participants. Direct management by a PIVOT operative would also improve the flow of communication and ensure answerability to taskforce leadership.

Engagement of participants was an unintended hurdle. While the CRC had access to a bank of agencies willing to provide services, most participants did not avail themselves to the bevy of services at their disposal. CRC training in motivational interviewing techniques and implementation of other tactics geared towards engagement could be helpful in facilitating commitment and change talk. Further, engagement and connection of the entire family unit (when needed) in wraparound services could potentially help bring stability, healing, and increased chances of success.

Key Lessons: Community Policing

It is recommended that future community policing efforts of this nature begin with a strategy that police leadership is willing and able to commit to implementing at all levels and over an extended period of time. In addition, implementation should include on-the-fly flexibility to be responsive and maximize efforts, as well as full commitment to the initiative so that officers are not pulled in multiple directions and are left confused about departmental priorities. Due to the nature of community policing, which requires a much different mindset and approach than traditional policing, careful attention should be placed on the selection of command staff and officers alike. Persons should be well-trained and embrace an alternate side of policing with a commitment to serving the community in a nontraditional way.

Key Lessons: Cardiff Model Implementation

Implementation of the Cardiff Model did not occur as expected. A focus group was conducted with residents of NPU-V to learn more about community support for the Cardiff model. Several key lessons were learned including a strong desire for community input into the process, prioritizing the needs of the community, as well as the importance of sharing data. There was also a powerful appeal for law enforcement to play a support role instead of a suppression role. Lastly, residents did not find the official Cardiff Model marketing materials presented to provide the level of information desired and felt that the materials needed to specify the benefits of implementation to the community, how the community would be involved in implementation, how the model impacts other efforts that the community supports, as well as to outline how the community will receive data. Residents were clearly tired of agencies telling them what they needed to do – they wanted a voice and to be actively involved with implementation.

PIVOT Program Recommendations/Lessons Learned

Multi-Disciplinary Taskforce

- Create atmosphere of respect
- Merging of viewpoints
- Multi-disciplinary leadership
- Clearly defined roles/responsibilities

Research Component

- Prepare team for integration of research partner & importance of the role of research
- Consider using a non-HVIP hospital as control group
- Get key leaders involved that can assist with data acquisition

Cardiff Implementation

- Ensure community input
- Share data with community
- Law enforcement agreement to take support role (not suppression)

Community Policing

- Ensure strategy has commitment of leadership
- Flexibility to maximize efforts
- Staff and management that embrace alternative side of policing

Hospital-Based Violence Intervention Program

- Ample staffing to support a reasonable social worker/patient ratio
- Automated system to identify prospective participants for program screening
- Direct management of social work staff by a HVIP operative
- Explore engagement strategies to get participants involved in services
- Services for entire family (when needed)

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Appendix

- Atlanta SPI Risk Profile
- Participant Survey
- APD Officers' Action Data Points
- Community Survey Informed Consent
- Community Survey
- Control Group Informed Consent
- Eligibility Screener
- Exit Interview Topics
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Recurrent Firearm Violence Risk Profile: Historical Cohort Analyses

To understand the population most likely affected by recurring or retaliatory gun violence in Atlanta, longitudinal analyses were used to compute a risk profile by Applied Research Services (ARS). The Atlanta SPI historical cohort (N=4,058) was defined as any shooting victim encountered by Grady Memorial Hospital (GMH) or the Atlanta Police Department (APD) 2013 – 2016. Self-harm, accidents (ruled by both agencies), and deaths were excluded to produce a population of nonfatal intentional firearm violence victimizations. It is the goal of PIVOT to reduce violence by serving this population.

Qualifying firearm violence encounters 2013 – 2016 were captured by 54 applicable ICD9 and ICD10 hospital E-codes or police incident reports. The sample from GMH included 4,442 cases from the charting system and 2,469 from the Trauma Registry. The sample from APD included 2,309 cases from the agency's records management system. Each organization maintains an agency specific identifying key(s) to individual's episodic information. A series of probabilistic matchings were programed to delineate unique person-based records and link them with all related identification numbers to clean duplicate cases within and between the tables.

Next, all related lifetime records for those individuals were extracted from the two GMH databases and five types of criminal justice system data housed in separate databases by the Atlanta Police Department (APD), Georgia Bureau of Investigation (GBI) Crime Information Center (GCIC), the Georgia Department of Corrections (GDC), and the Georgia Department of Supervision (GDCS). While the criminal justice databases include over 40 years of data, it is a limitation that the GMH cases were truncated to 7.7 years due to an operational system migration.

Those data were triangulated to develop a comprehensive dataset. That dataset was used to develop the profile of an individual prior to a new shooting, violent felony, or gun-related incident.

Table 1. PIVOT Historical Cohort Descriptive Statistics

(N = 4,058)	Min	Max	Mean/%	S.D.
Repeat Shooting or Retaliation	0	1	28%	0.45
Male	0	1	90%	0.31
Nonwhite	0	1	94%	0.23
Age	0	78	30	11.73
Evening/Early Morning Hours	0	1	51%	0.50
Target Zip Codes	0	1	33%	0.47
Prior Mental Health Problem	0	1	8%	0.27
Prior Abuse Indicated	0	1	33%	0.47
Prior Other Injury	0	1	48%	0.50
Prior Illegal Drug User	0	1	54%	0.50
Prior Tobacco User	0	1	54%	0.50
Prior Alcohol Problem	0	1	16%	0.37
Prior Criminal History				
Any Arrest	0	73	3.61	5.99
Felony Arrest	0	39	1.73	3.20
Misdemeanor Arrest	0	55	1.88	3.40
Violent Arrest	0	1	29%	0.45
Property Arrest	0	1	34%	0.47
Drug Arrest	0	1	29%	0.46
Gun Charge	0	1	11%	0.32
Parole/Probation Violation	0	1	23%	0.42
On Parole/Probation	0	1	30%	0.46
Incarceration	0	1	11%	0.31
Verified Gang Member	0	1	3%	0.16
New Arrests				
Any Arrest	0	13	12%	0.32
Felony Offense	0	7	9%	0.29
Misdemeanor Offense	0	8	7%	0.25
Violent Crime	0	1	3%	0.17
Property Crime	0	1	4%	0.19
Drug Crime	0	1	4%	0.19
Gun Charge	0	1	3%	17
Supervision Violation	0	1	6%	0.23

Repeat Gun Violence in the Historical Cohort

Of the more than 4,000 shooting victims in the 4-year study, 28% experienced repeat firearm victimization or committed a violent or firearm offense (nearly half of which occurred within a year of the first shooting). Specifically, we know that GMH had to treat over 550 patients for a second gunshot. Other descriptive statistics of the Atlanta SPI historical cohort are displayed in Table 1. The mean is shown as an average number or percentage. The standard deviation (S.D.) is a degree of mean variation.

Shooting victims were primarily male, nonwhite, and averaged 30 years old. Half were shot between 9pm and 9am and a third in the zip codes identified as hot spots of gun violence. Approximately 8% of the victims had prior mental health problems like schizophrenia or bipolar disorder. A third were exposed to verbal, physical, or emotional abuse. Nearly half had experienced another type of injury, such as a serious car wreck or broken bones. The majority had used tobacco or illegal drugs previously, known either through self-report, treatment, or an associated arrest.

Sixteen percent of the shooting victims had a known alcohol problem to the point where they suffered from poisoning, were diagnosed with a drinking problem, or had been arrested for driving while drunk. In fact, most of these individuals were in previous contact with the Georgia justice system, averaging 4 prior arrests, 2 for felonies and 2 for misdemeanor crimes. Roughly a third had a violent, property, and/or drug arrest episode, with 11% of those arrests involving a gun and 23% a parole or probation violation charge. Overall, 30% of the cohort had a prior probation or parole supervision episode and 11% had been previously incarcerated. Verification of 3% gang memberships is related to the Georgia street gang activity charge and APD or GDC investigations.

At-risk for Repeat Gun Violence

Individuals who are at risk of repeat or retaliatory shooting exhibit significant differences in their descriptions compared to shooting victims who are not at risk. The second and third columns in Table 2 show the characteristic percentages per group. The last two columns list the measures of association test findings for those groups' characteristics. The Chi-square is the level of difference, with larger numbers representing bigger disparities between the groups. All characteristics are significantly (***p<.001) different except for those who are nonwhite, have a prior alcohol problem, and were shot during early morning or evening hours.

At-risk individuals are often male, nonwhite, and young adults (18 to 35 years old). Over 2/3 were either residing or shot in the target zip codes (i.e., 30318, 30315, 30310, 30331, 30311, 30354). Prior mental health issues were documented among 10% of at-risk individuals. Nearly half had experienced prior abuse and had another type of injury. Drug and tobacco use were prevalent at 71% and 68% respectively; and, 17% had an alcohol problem.

Table 2. At-risk Profile Descriptive Statistics

	At-Risk Group		Difference	
Profile Measures	Yes (1,129)	No (2,889)	Chi^2	Sig.
Male	96%	87%	59.11***	
Nonwhite	95%	94%	1.55	
18- 35 years old	72%	63%	30.94***	
Evening/Early Morning Hours	53%	50%	3.58	
Target Zip Codes	38%	31%	20.88***	
Prior Mental Health Problem	10%	7%	11.58***	
Prior Abuse Indicated	41%	30%	41.22***	
Prior Other Injury	57%	45%	47.37***	
Prior Illegal Drug User	71%	48%	182.98***	
Prior Tobacco User	68%	48%	129.45***	
Prior Alcohol Problem	17%	15%	3.48	
Prior Any Arrest	74%	48%	222.04***	
Prior Felony Arrest	64%	36%	263.74***	
Prior Misdemeanor Arrest	61%	42%	115.56***	
Prior Violent Arrest	43%	23%	148.16***	
Prior Property Arrest	51%	27%	199.73***	
Prior Drug Arrest	41%	25%	101.76***	
Prior Gun Charge	22%	7%	173.60***	
Prior Par/Prob Violation	34%	8%	111.13***	
Prior Parole/Probation Episode	46%	24%	180.01***	
Prior Incarceration	21%	7%	162.02***	
Verified Gang Member	6%	1%	75.00***	

Indeed, a large majority of the at-risk individuals had a criminal history, both for misdemeanors and felonies. They had 43% prior violence, 51% property, and 41% drug arrests. Among their arrest charges, 22% committed a gun crime and 34% a parole or probation violation. About half had been on parole or probation supervision and nearly a quarter served a prison sentence.

In general, the most significant differences between those at risk and those who are not are related to illegal behaviors – illegal drug use and criminal justice involvement. This victim/offender overlap supports the call for the hospital and police to collaborate on violence reduction efforts. Those efforts can be supported by further understanding the extent to which certain characteristics are associated with risk of recurrent victimization or offending.

How likely is a shooting victim to be shot again or to engage in retaliatory behavior?

Table 3 shows the individual odds ratios for characteristics found among those shooting victims at-risk of a recurring violent event. The odds were calculated based on a variation of each factor occurring within risk – a bivariate association. Factors are not adjusted for any overlapping explained variance of other factors. The correct interpretation of these odds is compared to the absence of that factor, not the presence of another. For example, males are three times more likely to be at risk than females.

Table 3. Risk Factor Strength (N =1,129)

Profile Measures	Independent Risk Ratio
Male	3.12
Nonwhite	1.21
18- 35 years old	1.53
Evening/Early Morning Hours	1.14
Target Zip Codes	1.40
Prior Mental Health Problem	1.52
Prior Abuse Indicated	1.60
Prior Other Injury	1.62
Prior Illegal Drug User	2.73
Prior Tobacco User	2.29
Prior Alcohol Problem	1.19
Prior Any Arrest	3.08
Prior Felony Arrest	3.19
Prior Misdemeanor Arrest	2.14
Prior Violent Arrest	2.36
Prior Property Arrest	2.74
Prior Drug Arrest	2.10
Prior Gun Charge	3.57
Prior Par/Prob Violation Charge	2.28
Prior Parole/Probation Episode	2.65
Verified Gang Member	3.51
Prior Incarceration	5.15

The strongest independent relationship with risk is gang membership. Gang members victimized by gun violence are five times more likely to be shot again or retaliate. Similarly, risk is three times more likely among those who have a prior arrest, prior felony arrest, a prior arrest with a gun or were incarcerated.

The odds of risk are more than doubled for individuals who use illegal drugs or tobacco. Risk is twice as likely among those who had a misdemeanor, violent, property or drug arrest, with property arrestees having the highest odds. Compared to persons not on parole or probation supervision and who did not get arrested for a supervision violation, risk of repeat gun violence is two to two and half times higher.

Young adults and those with mental health issues have over one and half times higher likelihood of risk. Odds are also increased among nonwhites, those associated with the target hot spot zip codes, and who have an alcohol problem. It is also important to understand how the recurrent event is related to subsequent offending patterns.

What are the offending patterns after recurrent event?

Table 4 shows the offending patterns for individuals who incurred a second shooting victimization or exhibited retaliatory shooting behavior. Nearly half were arrested again, a third for a felony. Their new arrest types were 11% violent, 13% property, 14% drug. Those arrests include probation or probation violation charges among 20% and 10% had a gun offense charge.

Table 4. Repeat Gun Violence Offending Patterns

N=1,129	Mean/%	S.D.
Any Arrest	42%	.49
Felony Arrest	33%	.47
Misdemeanor Arrest	23%	.42
Violent Arrest	11%	.31
Property Arrest	13%	.34
Drug Arrest	14%	.34
Par/Prob Violation Charge	20%	.40
Gun Charge	10%	.30

PIVOT ATLANTA
Program to Interrupt Violence thru Outreach and Treatment

Please tell us about yourself, your experiences, & your neighborhood

The goal of this study is to provide better care to patients injured by gunfire. Your info will be kept private and will not identify you. No answers will be shared with anyone outside of the study team. You do not have to fill this out. You can skip any questions. The more you tell us, the more we can help you and others like you. Thank you for your help. If you have any concerns, contact the *Community Resource Coordinator: Aric Johnson, (470)585-8021 or ajohnson15@gmh.edu.*

Date:_____ Participant #_____ Start Time:_____ End Time:_____

☑ all your answers. Are you….?				
☐ male	☐ female			
☐ Hispanic	☐ Black/AA	☐ White	☐ Asian	☐ other
☐ single	☐ married	☐ other_____		
☐ younger than 25		☐ 25 or older		
☐ unemployed	☐ employed part time	☐ employed full time		

☑ all your answers. Do you ….?			
☐ rent your home		☐ own your home	
☐ live alone	☐ live with your parent	☐ live with other relatives	☐ live with partner/spouse
☐ live with friend/roommate	☐ live with your kids	☐ live with other_____	
☐ like your neighborhood	☐ want to move		
☐ use tobacco		☐ drink alcohol more than 3 times week	
☐ know where to buy drugs		☐ know someone who has been shot	

☑ all your answers. Do you have ….?	No	Yes
a high school diploma/GED	☐	☐
health insurance	☐	☐
someone you look up to	☐	☐
someone you can go to for help	☐	☐
close family members that have been arrested	☐	☐
Is that person a parent	☐	☐
Is that person a sibling	☐	☐
close family members who have been to prison	☐	☐
Is that person a parent	☐	☐
Is that person a sibling	☐	☐

☑ all your answers. How many of your friends…?	None	1 or 2	Several	All
have been shot	☐	☐	☐	☐
carry a gun	☐	☐	☐	☐
have been arrested	☐	☐	☐	☐
have been to prison	☐	☐	☐	☐
use drugs	☐	☐	☐	☐
sell drugs	☐	☐	☐	☐
have been in a gang	☐	☐	☐	☐
have been in a physical fight	☐	☐	☐	☐

PLEASE TURN OVER

☑ all your answers. Have you ever….?	No	Yes
been shot before this incident	☐	☐
joined a gang	☐	☐
had an injury that knocked you out (blackout)	☐	☐
caused an injury that knocked someone out (blackout)	☐	☐
thought about hurting the person who shot you	☐	☐
been a victim of a crime before	☐	☐
was it a violent crime	☐	☐
did you get help	☐	☐
were the police involved	☐	☐
did they arrest the offender	☐	☐
been to an ER before	☐	☐
were you the one hurt	☐	☐
been asked to join a gang	☐	☐
used drugs	☐	☐
traded drugs for money	☐	☐
had to defend yourself with a gun	☐	☐
been hungry but could not get food	☐	☐

☑ all your answers. How often do you….?	Never	Rarely	Monthly	Weekly	Daily
play sports	☐	☐	☐	☐	☐
fight because of social media	☐	☐	☐	☐	☐
hangout with family	☐	☐	☐	☐	☐
sleep away from home	☐	☐	☐	☐	☐
hear gunshots in your neighborhood	☐	☐	☐	☐	☐
feel safe	☐	☐	☐	☐	☐
feel stressed	☐	☐	☐	☐	☐
have trouble sleeping	☐	☐	☐	☐	☐
see the police	☐	☐	☐	☐	☐
talk with the police	☐	☐	☐	☐	☐
worry about being a victim of crime	☐	☐	☐	☐	☐
worry about a loved one being a victim of a crime	☐	☐	☐	☐	☐
worry about being shot again	☐	☐	☐	☐	☐
see someone get hurt	☐	☐	☐	☐	☐
feel like you need to carry a gun for protection	☐	☐	☐	☐	☐
get hit by someone angry at you	☐	☐	☐	☐	☐
hit someone out of anger	☐	☐	☐	☐	☐

☑ all your answers. In your community, how often are the following a problem…?	Never	Rarely	Monthly	Weekly	Daily
Gangs	☐	☐	☐	☐	☐
Gun use	☐	☐	☐	☐	☐
Illegal drugs	☐	☐	☐	☐	☐
Physical fighting / assault	☐	☐	☐	☐	☐
Drinking / loitering	☐	☐	☐	☐	☐
Trash / litter	☐	☐	☐	☐	☐
Vandalism / graffiti	☐	☐	☐	☐	☐

Homeless people	☐	☐	☐	☐	☐
Youths "hanging around"	☐	☐	☐	☐	☐

NEXT PAGE PLEASE

☑ all your answers. How often do the police…?	Never	Rarely	Often	Always
treat people fairly	☐	☐	☐	☐
treat people respectfully	☐	☐	☐	☐
respond to community concerns	☐	☐	☐	☐
act trustworthy	☐	☐	☐	☐
take care of crime problems	☐	☐	☐	☐
explain their decisions	☐	☐	☐	☐
listen to people	☐	☐	☐	☐
respond to peoples' needs	☐	☐	☐	☐
do a good job	☐	☐	☐	☐
☑ all your answers. How often should people…?	Never	Rarely	Often	Always
watch out for each other	☐	☐	☐	☐
obey the police	☐	☐	☐	☐
call the police when they need help	☐	☐	☐	☐
call the police to report a crime witnessed	☐	☐	☐	☐
do something about crime in their neighborhood	☐	☐	☐	☐
work to clean up their neighborhood	☐	☐	☐	☐
help stop violence	☐	☐	☐	☐
☑ all your answers. How often do you…?	Never	Rarely	Often	Always
talk through disagreements	☐	☐	☐	☐
think about the results of your actions	☐	☐	☐	☐
think about how you affect others	☐	☐	☐	☐
try to problem solve	☐	☐	☐	☐
put others first	☐	☐	☐	☐
think your family is supportive of you	☐	☐	☐	☐
think friends are supportive of you	☐	☐	☐	☐
get advice about problems from family	☐	☐	☐	☐
get advice about problems from friends	☐	☐	☐	☐

What type of services would be helpful to you?_____

_____

Thank you!

PIVOT ATLANTA
Program to Interrupt Violence thru Outreach and Treatment

Officers' Actionable Data Points

- Number of visits to each PIVOT community
- Number of interactions with Community Liaison Officers, beat officers, crime analysts and serve as liaisons between the department and the target communities to prevent crime and foster community relationships
- Number collaborative partnerships between the Police Department and the citizens within the target communities alongside the Crime Prevention Inspectors
- Number PIVOT meetings attended
- Number rapid responses to gun violence in target communities to cool tempers and connect with victims
- Number consults with the Tactical Crime Analysis Unit and Code Enforcement to coordinate PVIOT interventions
- Number liaises with the Gun Reduction Task Force of the Targeted Enforcement Unit in APD's Special Enforcement Section as the task force identifies family, friends, or associates of gunshot victims to further their investigation
- Number times provide feedback about target community interactions with investigators and general information COPS officers may gather from residents about incidents
- Number community forums in PIVOT targeted communities to facilitate conversations regarding police-community relations, crime, and other relevant issues
- Number times identified interactions and observations in the PIVOT targeted areas opportunities to enhance relationship between the public and the police, reduce gun violence, and connect residents to needed services
- Number times worked with the PIVOT Community Research Coordinator at Grady Hospital or other designated violence reduction staff to identify community resources for PIVOT participants and the communities at large
- Number of program tasks that were completed during the reporting period that are directly linked to grant funding Number of briefings or outreach to the public/community about evidence-based practices
- Number of times met with the research partner
- Number of police canvasses in target communities
- Number of directed police patrols in target communities
- Number and type of data sharing/communications between Grady & APD
- Changes in perceptions of the police Number of witness statements successfully obtained
- Number of tips or pieces of intel collected via community conversations about retaliatory gun violence

INFORMED CONSENT FOR SOCIAL SCIENCE RESEARCH

Title:	"PIVOT: Community Survey"
Contact:	Dr. Shila Hawk, Applied Research Services, Inc. 3265 Cains Hill PL NW, Atlanta, GA 30305 (404) 881-1120 x101, (404) 881-8998 fax shawk@ars-corp.com, www.ars-corp.com
Sponsor:	Bureau of Justice Assistance, Strategies for Policing Innovation

Purpose:
You are invited to take part in a research study. The purpose of the study is to understand community relations with the police and area crime at the beginning of a new program designed to reduce gun violence.

Procedures:
If you decide to participate, you will be asked to provide anonymous survey feedback. All information will be collected, handled, and protected by a trained researcher. Your participation is appreciated.

Risks:
In this study, you will not have any more risks than you would in a normal day of life.

Benefits:
Participation in this study will not benefit you personally. We hope to gain information that will help reduce crime by improving criminal justice policies and practices. Research findings will be available to anyone upon request.

Voluntary Participation and Withdrawal:
Participation in research is voluntary – you do not have to contribute. The survey is self- administered, so you can skip any question and/or can stop participating at any time.

Confidentiality:
All data will be kept secure and private to the extent allowed by law. Only the research team and members of the Emory Institutional Review Board may have access to the information you provide. The information you provide will be stored in a locked filing cabinet housed in a private office at Applied Research Services. All participants taking the survey will be assigned a numeric identifier as no names will be collected/attached to the data. Data may also be shared with those who make sure the study is done correctly if requested. Examples included the Emory Institutional Review Board. The information provided will be entered into a locked electronic filing cabinet and paper versions shredded. No information that might point to a participant will appear when the study is presented or results are published. The findings will be summarized and reported in group form. Participation in this study will not benefit them personally. However, we hope to gain information that will help reduce crime by improving public health and criminal justice practices.

Contact Persons:
Contact Dr. Shila Hawk (see above) if you have questions about this study or concerns about your rights as a participant.

Copy of Consent Form to Subject:
We are not asking you to sign a consent form. This assures that information about you is kept private and confidential. Instead, the researcher will give you a copy of this form and a business card.

PIVOT ATLANTA

Program to Interrupt Violence thru Outreach and Treatment

The following questions are about your experiences with law enforcement and crime in your community. All responses voluntary and anonymous, so please do not put your name on this sheet. The survey should take approximately 10 minutes to complete. If you have any questions or concerns about this survey, feel free to contact Dr. Hawk at shawk@ars-corp.com or 404.881.1120, x101. Thank you for your time and feedback!

Circle the response that most applies

***Please describe the police in your community:* To what extent…**	**Never**	**Rarely**	**Usually**	**Always**
…do officers treat people fairly?	1	2	3	4
…are officers respectful?	1	2	3	4
…are officers responsive to community concerns?	1	2	3	4
…do you trust your local police agency?	1	2	3	4
…are you satisfied with the overall performance of your local police department?	1	2	3	4
…are police effective at addressing crime?	1	2	3	4
…do officers sufficiently explain their decisions?	1	2	3	4
…are police responsive to peoples' needs?	1	2	3	4

Please describe how common the following are in your community:	**Not Common**	**Somewhat Not Common**	**Somewhat Common**	**Very Common**
Drug use	1	2	3	4
Physical fighting or assault	1	2	3	4
Hearing gun shots	1	2	3	4
People carrying guns	1	2	3	4
People shot	1	2	3	4
Police Sirens				
Seeing an ambulance				

Please describe how you feel in your community:	**Never**	**Rarely**	**Often**	**Everyday**
How often do you worry about being a victim of crime?	1	2	3	4
How often do you worry about your home being broken into?	1	2	3	4
How often do you worry about being mugged?	1	2	3	4
How often do you worry about being shot?	1	2	3	4
How often do you worry about a loved one being the victim of a violent crime?	1	2	3	4

How much of a problem are the following in your community?	**Not a Problem**	**A Small Problem**	**A Problem**	**A Big Problem**
Gangs	1	2	3	4
Gun use	1	2	3	4
Illegal drugs	1	2	3	4
Trash dumping/littering	1	2	3	4
Physical fighting/assault	1	2	3	4
Poverty	1	2	3	4
Unsupervised children	1	2	3	4
Vandalism/graffiti	1	2	3	4
Youths "hanging around"	1	2	3	4
Any other specific problem? please describe:				

Please continue on the back

PIVOT ATLANTA

Program to Interrupt Violence thru Outreach and Treatment

Please describe how true you feel the following statements are:	Not True	Somewhat Not True	Somewhat True	Very True
Disobeying the police is seldom justified.	1	2	3	4
The youth in this community engage in violent activity.	1	2	3	4
Neighbors in this community watch out for each other.	1	2	3	4
I would not hesitate to call the police for assistance.	1	2	3	4
I would not hesitate to call the police to report a crime I witnessed.	1	2	3	4
I am satisfied with police services in this community.	1	2	3	4
Many youths in this community have witnessed violence.	1	2	3	4
Living in my community is stressful.	1	2	3	4

Please check a response:	Yes	No
Have you had any contact with the police in your community in the past 12 months?	◯	◯
Have you ever been shot?	◯	◯
Has a loved one ever been shot?	◯	◯
Have you ever been the victim of a crime?	◯	◯
If yes, was it a violent crime?	◯	◯
If yes, did the crime involve a gun?	◯	◯
Have you ever received a traffic citation?	◯	◯
Have you ever been arrested for a misdemeanor?	◯	◯
Have you ever been arrested for a felony?	◯	◯
Have any family members been arrested?	◯	◯
Have you been arrested in the past 12 months?	◯	◯
Do you have any children under 18 years old living with you?	◯	◯

Please describe yourself:

☐Male ☐Female

How long have you lived in this community? _____years

Do you ☐Own or ☐Rent your home?

What is your age? _____ years old

(Check all that apply)

☐American Indian or Alaska Native

☐Asian

☐Black or African American

☐Hispanic

☐Native Hawaiian or Other Pacific Islander

☐White

Current marital status? ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Thank you!

Emory University and Grady Health System
Consent to be a Research Subject / HIPAA Authorization

Title: **Evaluation of PIVOT (Program to Interrupt Violence thru Outreach and Treatment) Atlanta**

Principal Investigator: Diane E. S. Payne, MD, MPT

Sponsor: Bureau of Justice Assistance, Grant No. 2016-WY-B-X-K001

What is this?
You are invited to be in a study. It is for noninvasive treatment. *This form is about collecting research-relevant data only. You do not need to do anything other than agree to share your information. Take your time to read it and ask questions.*

About the study:
We want to know more about firearm-related injuries in Atlanta. In addition to receiving a pamphlet about local services and support, we would like to know about you. We must get information about victims of firearm violence to complete the study and possibility help reduce injuries. About 300 people will be in this study. It is your choice to participate. Studies only include people who want to be in them. You can stop at anytime. Your records will be kept private. You will not be charged any money to participate – it is free. It is your choice to participate and this choice will not change your medical care or benefits. Your doctor will continue to treat you. Before you decide:

- Please carefully read this form or have it read to you
- Please listen to the study staff explain the study to you
- Please ask questions about anything that is not clear

You can have a copy of this consent form. Take your time thinking about if you want to participate. You can talk to your family or friends first. Do not sign this consent form unless you had a chance to ask questions and understand the answers. By signing this, you ***will not*** give up any legal rights.

What is the purpose of this study? This study is to learn more about factors that can help decrease firearm violence. The Bureau of Justice Assistance (BJA) pays for the study. We hope to use the findings of this study to prevent injury in the future.

What will I be asked to do? You will be asked to take a survey for information about yourself and your injury. In six months you may be contacted to see how things have changed for you. You decide what information to share. If any questions make you too uncomfortable to answer, you can skip them.

Who owns my study information? If you join this study, you will be donating your study information. Only study staff only will see your program records. Study reporting will not identify any one person. On the back of this page is more about keeping your data safe.

Will I benefit directly from the study? This study is not designed to benefit you directly. We want to learn more about how to help others in the future. You will not be given money for being in this study. You will receive a guide to free services to improve your wellbeing.

What if I want to stop later? You have the right to leave a study at any time without penalty. The researchers also have the right to stop your participation without your consent for any reason. This may happen if they believe it is in your best interest.

How will you protect my private information that you collect in this study? All data will be kept secure and private to the extent allowed by law. A study number will be used, in place of your name, on study records. Your name and other personal information will be deleted after from your study records. Identifying data will not be shared outside the study.

Data collection papers will be kept in a locked filing cabinet at Grady until data are entered into the electronic system. Then the papers will shredded. The electronic data will be encrypted and accessed only by study personnel. Those people will be required to sign security data-use agreements.

The results of everyone in this study will be discussed in group format with the research community to advance science and health. No information that might point to a participant will appear when the study is discussed or results are published. It is extremely unlikely that anyone would be able to identify you from the information we share because of this study.

Certificate of Confidentiality
There is a Certificate of Confidentiality from the National Institutes of Health for this Study. The Certificate of Confidentiality helps us to keep others from learning that you participated in this study. Emory will rely on the Certificate of Confidentiality to refuse to give out study information that identifies you. For example, if Emory received a subpoena for study records, it would not give out information that identifies you.

The Certificate of Confidentiality does not stop you or someone else, like a family member, from giving out information about you being in this study. For example, if you tell your insurance company that you are in this study, *and* you agree to give them research information, then the researchers cannot use the Certificate to withhold your information. This means you and your family also need to protect your own privacy. Your insurance does not need to know about you being in this study.

The Certificate does not stop Emory from making the following disclosures about you:
- Giving state public health officials information about certain infectious diseases,
- Giving law officials information about abuse of a child, elderly person, or disabled person.
- Giving out information to prevent harm to you or others.
- Giving the study sponsor or funders information about the study, including information for an audit or evaluation.

Caring for you is our goal. We will do everything we can to protect information about you and your role in this study. Please ask the study staff if you have any questions about your rights.

Medical Record
All patients seen in the Grady Health System have a medical record. This is where your protected medical health records are stored. Anyone who has access to your medical records will be able to have access to that information. Study data may be pulled from that system. Note that data collected from people in this study will not be entered into that system. Laws like the HIPAA privacy rule will protect the confidentiality of your medical records AND study information. In special cases, state and federal laws may not protect the research information from disclosure.

We will take reasonable steps to keep copies of this consent form out of the Grady Health System's medical records system. If we are not successful in keeping these forms out, despite our efforts, we will take steps to remove them. If they cannot be removed, we will take steps to limit access to them.

Authorization to Use and Disclose Protected Health Information

The privacy of your health information is important to us. We call your health information that identifies you, your "protected health information" or "PHI." To protect your PHI, we will follow all federal and state privacy laws. That includes Health Insurance Portability and Accountability Act and regulations (HIPAA). We refer to these laws as the "Privacy Rules." Next we let you know how we will use and share your PHI for the study.

Protected Health Information (PHI) that may be used or shared for the research study includes:

- Medical information about you including your medical history and social history
- Results of exams, procedures, assessments, and tests you have before and during the study period
- Information related to your injury in regards to place, time, and type of weapon

The purpose of sharing your PHI with the research team is to learn how helping people can reduce the risk of violent injury. PHI may be used and shared to make sure the study team is following this consent authorization.

The research team may consist of people that help conduct or carry out the study. That may include data monitors, contract research organizations, Institutional Review Boards (IRBs), and other study sites. If you leave the study, we may use your PHI to determine your health, vital status, or contact information.

People Who will Use/Disclose Your PHI:

The following people and groups may use and disclose your PHI in connection with the research study:

- The Principal Investigator and research team will use/disclose your PHI to do the research and program work.
- The following people and groups will use your PHI to make sure the research is done ethically and safely:
  - Emory and Grady Health System offices that are part of the Human Research Participant Protection Program and those that are involved in study administration and billing. These include the Emory IRB, the Grady Research Oversight Committee, the Emory Research and Healthcare Compliance Offices, and the Emory Office for Clinical Research.
- Sometimes a Principal Investigator or other researchers move to a different institution. If this happens, your PHI may be shared with that new institution and their oversight offices. PHI will be shared securely and under a legal agreement to ensure it continues to be used under the terms of this consent and HIPAA authorization.

We will have to use and disclose your PHI when we are required to do so by law. This includes laws that require us to report child abuse or abuse of elderly or disabled adults.

Authorization to Use PHI is Required to Participate: By signing this form, you give us permission to use and share your PHI as described in this document. You do not have to sign this form that authorizes the use and disclosure of your PHI.

Expiration of Your Authorization: Your PHI will be used until this research study ends.

Revoking Your Authorization:

If you sign this form, at any time later you may revoke (take back) your permission to use your information. If you want to do this, you must contact Erika Ortega at 404-778-1550 or the Principle Investigator. At that point, the researchers would not collect any more of your PHI. However, they may use or disclose the information you already gave them, so they can follow the law. They may do it protect your safety or make sure that the study was done properly and the data is correct as well. If you revoke your authorization, you will not be able to stay in the study.

To maintain the integrity of this research study, you will not have access to your study-related PHI until the study ends. When the study ends, your request to access to your PHI will be granted. Your designated record set is data that includes medical information or billing records that your health care providers use to make decisions about you. If it is necessary for your health care, your health information will be provided to your doctor.

We will remove identifying information from your study PHI. Once we do this, the remaining information will not be subject to the Privacy Rules. Information without identifiers may be used or disclosed with other people or organizations for purposes besides this study. For example, the study sponsor, BJA, may request de-identified or aggregate data related to the study findings.

Contact Information

Contact the Emory University study coordinator or the Grady Community Resource Coordinatorif you have any questions about this study or your part in it, Weekdays between 8 am and 4 pm:

Research Education & Clinical Research Coordinator: Erika Ortega, (404)778-1550 or erika.ortega@emory.edu

Contact the Emory University Institutional Review Board at 404-712-0720 or 877-503-9797 or irb@emory.edu:

- if you have questions about your rights as a research participant.
- if you have questions, concerns or complaints about the research.
- You may also let the IRB know about your experience as a research participant through our Research Participant Survey at http://www.surveymonkey.com/s/6ZDMW75.

If you are a patient receiving care from the Grady Health System and have a question about your rights, you may contact the Office of Research Administration at research@gmh.edu.

Consent and Authorization:

TO BE FILLED OUT BY STUDY PARTICIPANT ONLY

Signing below indicates you agree to the above conditions of the study. By signing this consent and authorization form, you will not give up any of your legal rights. It is voluntary to be in the study. Thank you for considering this offer.

_____

Name of Subject

_____ _____ _____

Signature of Subject (18 or older and able to consent) **Date** **Time**

TO BE FILLED OUT BY STUDY TEAM ONLY

_____

Name of Person Conducting Informed Consent Discussion

_____ _____ _____

Signature of Person Conducting Informed Consent Discussion **Date** **Time**

PIVOT ATLANTA
Program to Interrupt Violence thru Outreach and Treatment

Patient Eligibility Screener

To be completed for all persons who present with a gunshot wound at Grady

MRN: _____ Date:_____

Screener's Name:_____

Patient is **Ineligible** if **any** of the following (check all that apply, regardless of results):

- ☐ Self inflicted injury
- ☐ Minor (17 years old or younger)
- ☐ Over 35 years of age
- ☐ Not English speaking
- ☐ Not cognitively independent/requires a guardian due to impair
- ☐ Injured during sexual assault
- ☐ Injured due to domestic violence
- ☐ Injured due to child abuse
- ☐ Is a prisoner/in custody of a law enforcement officer

Patient is **Eligible** if **all 3** apply:

- ☐ 1). Injured or lives in a target zip code:
  - ☐ Zip Code Unknown
  - ☐ 30318
  - ☐ 30310
  - ☐ 30315
- ☐ 2). Available for follow-up contacts (provided contact information)
- ☐ 3). And scores at least 3 of the following (check all that apply):
  - ☐ Male
  - ☐ Younger than 26 years old
  - ☐ Black or African American
  - ☐ Presented at Grady between 9pm and 9am
  - ☐ Under the influence of drugs or alcohol
  - ☐ Expresses volatile anger or desire to retaliate
  - ☐ Previously shot

PIVOT ATLANTA
Program to Interrupt Violence thru Outreach and Treatment

Participant Exit Interview Topics

Life history

- background: childhood, adolescents, adulthood
- family history, role & social support
- neighborhood description and dislikes
- education & employment
- religious/spiritual life
- intimate relationships/social bonds

Program

- program affect
- accomplishment from/since
- challenges during/after
- other changes since injury
- self/life perceptions difference
- life goals/happiness

PIVOT (Program to Interrupt Violence thru Outreach & Treatment) Logic Model

GOAL: To reduce the prevalence of gun violence in the City of Atlanta through a coordinated public health approach that focuses on the provision of mentorship and community resources and the application of innovative violence prevention strategies by law enforcement.

Inputs
• Community Resource Coordinator, Human Services at Grady Hospital • Social Workers (10% of time), Human Services at Grady Hospital • VOCA funded social worker, Human Services at Grady Hospital • Violence Prevention Coordinator, Trauma Unit at Grady Hospital • 2 COPs Officers Atlanta Police Department • Tactical Data Analysis Unit, Atlanta Police Department • Emory Faculty and Medical Students • Applied Research Services • CNA Subject Matter Experts

Outputs
Activities
1. Regular hot spot mapping of APD incident and Grady violent injury data 2. Develop screening tool 3. Triage gunshot wound victims in hospital for program participation. 4. Connect GSW victims to services and manage cases 5. Rapid response by COPs officers following a shooting. 6. COPS investigate nature of conflict 7. LE employs individual based responses to cool tempers and intervene in escalating conflicts 8. COPS officers hold community forums 9. APD and Grady staff Assigned to PIVOT Coordinating efforts 10. Impact and Evaluation plan by ARS 11. IRB approved 12. Participation in BJA National SPI Meetings, webinars and site visit, and consultation calls 13. Published program evaluation

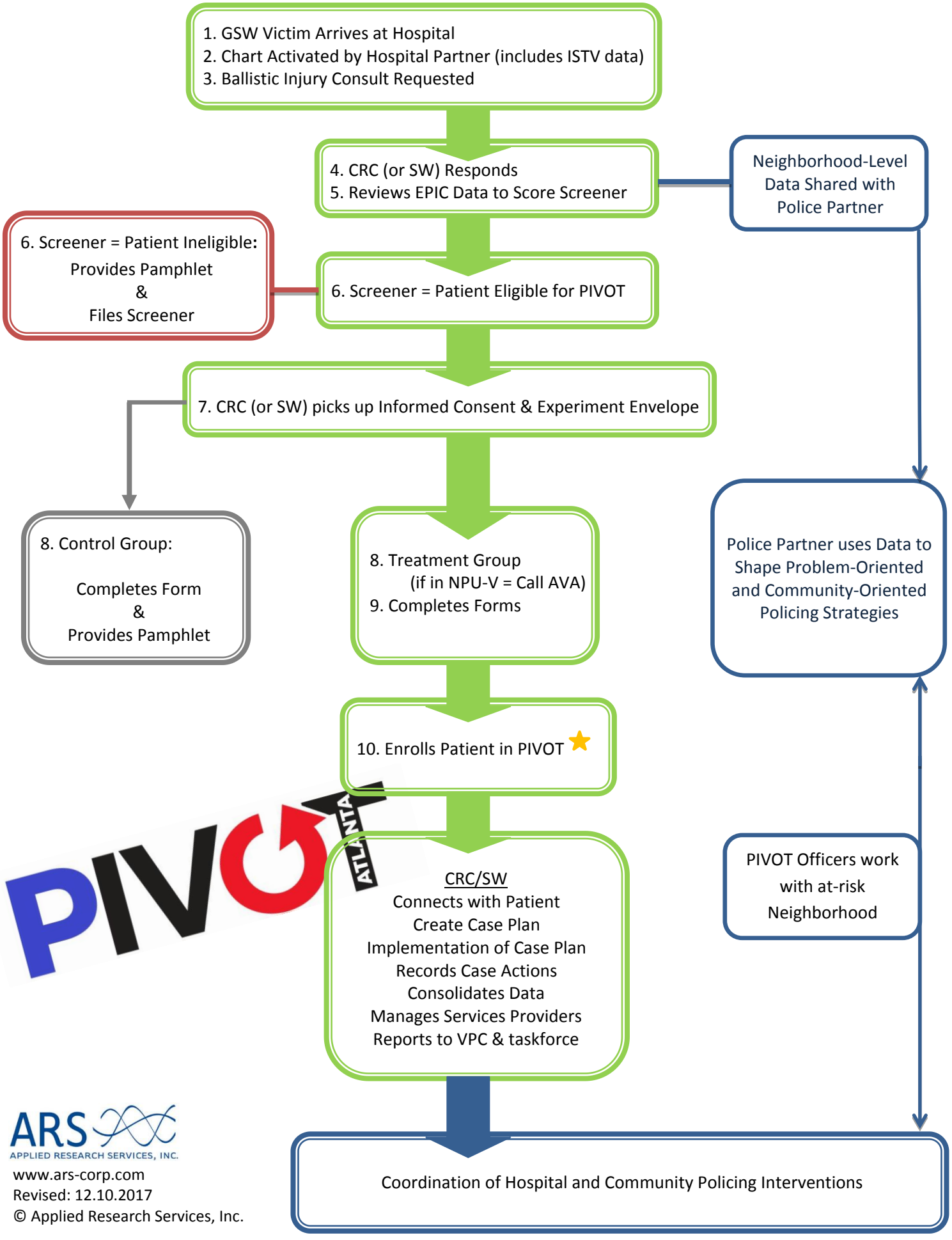
Outcomes – Impact
Short-term
• Identify Community Services • Enrollment of GSW victims in PIVOT • Treatment and Mentoring of GSW victims • Targeted rapid response in the community by COPs officers following a shooting • Understanding of the extent and nature of conflicts in the targeted communities by APD • Focused violence prevention efforts by APD and Social Workers • Coordinated violence reduction response from Grady and APD • Identify issues with police community relations
Medium-term
• Empower at risk individuals to derail the cycle of violence • Expand the program to various neighborhoods • Identify neighborhood conditions that facilitate violence
Long-term
• Reduce firearm related hospitalizations • Reduce the number of gunshot victims • Reduce repeat victimization • Foster healthy community police relations • Reduce neighborhood conditions that facilitate violence • Add to the evidence of the impact of hospital base violence intervention programs • Shift attitudes of health providers and law enforcement officials to view violence as a public health issue

***External Factors**: Economy, poverty, city development, laws and regulations, federal constraints on meetings and travel, changing federal priorities, turnover at SPI site, changing priorities of SPI partners,*

***Assumptions:** Gushot wound precipitates change, vilence can spread like a disease, SPI goals and objectives correlated/in tune with contemporary needs and interests of local police agencies, CNA and SMEs have correct expertise and rapport with SPI sites, grant resources and support are appropriate and effective. Collaboration from apartment complex management.*

Last Revised: June 19, 2017

Program to Interrupt Violence thru Treatment & Outreach Process Design



ARS
APPLIED RESEARCH SERVICES, INC.

www.ars-corp.com
Revised: 12.10.2017

Emory University and Grady Health System
Consent to be a Research Subject / HIPAA Authorization

Title: **Evaluation of PIVOT (Program to Interrupt Violence thru Outreach and Treatment) Atlanta**

Principal Investigator: Diane E. S. Payne, MD, MPT

Sponsor: Bureau of Justice Assistance, Grant No. 2016-WY-B-X-K001

What is this? You are invited to be in a study. It is for noninvasive treatment. *This form is about the study. Below tells you what you need to know to decide if you want to enroll. Take your time to read it and ask questions.*

About the study:
You are invited to be in a study. We want to know if this program can lower firearm-related injuries in Atlanta. The program helps people injured by firearm violence get local services and support. Those services may keep you from being hurt again. We must get information about members and their services to find out if the program works. About 300 people will be in this study. It is your choice to participate. Studies only include people who want to be in them. You can stop at anytime. Your records will be kept private. You will not be charged any money to participate – it is free. It is your choice to participate and this choice will not change your medical care or benefits. Your doctor will continue to treat you. Before you decide:

- Please carefully read this form or have it read to you
- Please listen to the study staff explain the study to you
- Please ask questions about anything that is not clear

You can have a copy of this consent form. Take your time thinking about if you want to participate. You can talk to your family or friends first. Do not sign this consent form unless you had a chance to ask questions and understand the answers. By signing this, you ***will not*** give up any legal rights.

What is the purpose of this study? This study is to learn more about how to help decrease firearm violence. The Bureau of Justice Assistance (BJA) pays for the study. We hope to use the findings to prevent injury in the future.

What will I be asked to do? You will be asked for information about yourself, your injury, and about being in the program. You will be matched to a service expert. They will ask you to take a survey. They might ask will ask for other information about yourself and your injury to further understand your needs. You decide what information to share. If any questions make you too uncomfortable to answer, you can skip them. They will use that information to create a plan to help you and guide you to the services that may benefit you. Services could be for housing, a job, education, counseling, and more. While in the program, you can expect to hear from your service expert often until your case plan is closed. Feel free to talk to them whenever you like. You can decide if meetings are at the hospital or somewhere else. The program will last as long as you need the planned services. This will all be free for you. As part of the study, we will keep track of how you are doing in the program. At the end, you will be asked about the program.

Who owns my study information? If you join this study, you will be donating your study information. If you leave the study, data that was already collected may be still be used for this study. Only study staff only will see your program records. Study reporting will not identify any one person. On the back of this page is more about keeping your data safe.

Will I benefit directly from the study? This study is designed to benefit you as a victim of violence. We also want to learn how to help others. You will not get any money. You will receive free services to improve your wellbeing.

What are my other options? If you decide not to enter this study, there are still services available to help you. You will be given a community resource guide that lists local services. You do not have to be in this study to get that guide.

What if I want to stop later? You have the right to leave a study at any time without penalty. The researchers also have the right to stop your participation without your consent for any reason. This may happen if they believe it is in your best interest.

How will you protect my private information that you collect in this study? All data will be kept secure and private to the extent allowed by law. A study number will be used in place of your name on study records. Your name and other personal information will be deleted after from your study records. Identifying data will not be shared outside the study.

Data collection papers will be kept in a locked filing cabinet at Grady until data are entered into the electronic system. Then the papers will shredded. The electronic data will be encrypted and accessed only by study personnel. Those people will be required to sign security data-use agreements.

The results of everyone in this study will be discussed in group format with the research community to advance science and health. No information that might point to a participant will appear when the study is discussed or results are published. It is extremely unlikely that anyone would be able to identify you from the information we share because of this study.

Certificate of Confidentiality
There is a Certificate of Confidentiality from the National Institutes of Health for this Study. The Certificate of Confidentiality helps us to keep others from learning that you participated in this study. Emory will rely on the Certificate of Confidentiality to refuse to give out study information that identifies you. For example, if Emory received a subpoena for study records, it would not give out information that identifies you.

The Certificate of Confidentiality does not stop you or someone else, like a family member, from giving out information about you being in this study. For example, if you tell your insurance company that you are in this study, *and* you agree to give them research information, then the researchers cannot use the Certificate to withhold your information. This means you and your family also need to protect your own privacy. Your insurance does not need to know about you being in this study. The Certificate does not stop Emory from making the following disclosures about you:

- Giving state public health officials information about certain infectious diseases,
- Giving law officials information about abuse of a child, elderly person, or disabled person.
- Giving out information to prevent harm to you or others.
- Giving the study sponsor or funders information about the study, including information for an audit or evaluation.

Caring for you is our goal. We will do everything we can to protect information about you and your role in this study. Please ask the study staff if you have any questions about your rights.

Medical Record
All patients seen in the Grady Health System have a medical record. This is where your protected medical health records are stored. Anyone who has access to your medical records will be able to have access to that information. Study data may be pulled from that system. Note that data collected from people in this study will not be entered into that system. Laws like the HIPAA privacy rule will protect the confidentiality of your medical records AND study information. In special cases, state and federal laws may not protect the research information from disclosure. We will take reasonable steps to keep copies of this consent form out of the Grady Health System's medical records system. If we are not successful in keeping these forms out, despite our efforts, we will take steps to remove them. If they cannot be removed, we will take steps to limit access to them.

Authorization to Use and Disclose Protected Health Information

The privacy of your health information is important to us. We call your health information that identifies you, your "protected health information" or "PHI." To protect your PHI, we will follow all federal and state privacy laws. That includes Health Insurance Portability and Accountability Act and regulations (HIPAA). We refer to these laws as the "Privacy Rules." Next we let you know how we will use and share your PHI for the study.

Protected Health Information (PHI) that may be used or shared for the research study includes:

- Medical information about you including your medical history and social history
- Results of exams, procedures, assessments, and tests you have before and during the study period
- Information related to your injury in regards to place, time, and type of weapon

The purpose of sharing your PHI with the research team is to learn how helping people can reduce the risk of violent injury. PHI may be used and shared to make sure the study team is following this consent authorization.

The research team may consist of people that help conduct or carry out the study. That may include data monitors, contract research organizations, Institutional Review Boards (IRBs), and other study sites. If you leave the study, we may use your PHI to determine your health, vital status, or contact information.

People Who will Use/Disclose Your PHI:
The following people and groups may use and disclose your PHI in connection with the research study:

- The Principal Investigator and research team will use/disclose your PHI to do the research and program work.
- The following people and groups will use your PHI to make sure the research is done ethically and safely:
  - Emory and Grady Health System offices that are part of the Human Research Participant Protection Program and those that are involved in study administration. These include the Emory IRB, the Grady Research Oversight Committee, the Emory Research and Healthcare Compliance Offices, and the Emory Office for Clinical Research.
- Sometimes a Principal Investigator or other researchers move to a different institution. If this happens, your PHI may be shared with that new institution and their oversight offices. PHI will be shared securely and under a legal agreement to ensure it continues to be used under the terms of this consent and HIPAA authorization.

We will have to use and disclose your PHI when we are required to do so by law. This includes laws that require us to report child abuse or abuse of elderly or disabled adults.

Authorization to Use PHI is Required to Participate:
By signing this form, you give us permission to use and share your PHI as described in this document. You do not have to sign this form that authorizes the use and disclosure of your PHI. If you do not sign this form, then you may not participate in the research study but you may still receive non-research related resources.

Expiration of Your Authorization: Your PHI will be used until this research study ends.

Revoking Your Authorization:
If you sign this form, at any time later you may revoke (take back) your permission to use your information. If you want to do this, you must contact Erika Ortega at 404-778-1550 or the Principle Investigator. At that point, the researchers would not collect any more of your PHI. However, they may use or disclose the information you already gave them, so they can follow the law. They may do it protect your safety or make sure that the study was done properly and the data is correct as well. If you revoke your authorization, you will not be able to stay in the study.

To maintain the integrity of this research study, you will not have access to your study-related PHI until the study ends. When the study ends, your request to access to your PHI will be granted. Your designated record set is data that includes medical information or billing records that your health care providers use to make decisions about you. If it is necessary for your health care, your health information will be provided to your doctor.

We will remove identifying information from your study PHI. Once we do this, the remaining information will not be subject to the Privacy Rules. Information without identifiers may be used or disclosed with other people or organizations for purposes besides this study. For example, the study sponsor, BJA, may request de-identified or aggregate data related to the study findings.

Contact Information

Contact the Emory University study coordinator or the Grady Community Resource Coordinatorif you have any questions about this study or your part in it, Weekdays between 8 am and 4 pm:

Research Education & Clinical Research Coordinator: Erika Ortega, (404)778-1550 or erika.ortega@emory.edu
Community Resource Coordinator: Aric Johnson, (470)585-8021 or ajohnson15@gmh.edu

Contact the Emory University Institutional Review Board at 404-712-0720 or 877-503-9797 or irb@emory.edu:

- if you have questions about your rights as a research participant.
- if you have questions, concerns or complaints about the research.
- You may also let the IRB know about your experience as a research participant through our Research Participant Survey at http://www.surveymonkey.com/s/6ZDMW75.

If you are a patient receiving care from the Grady Health System and have a question about your rights, you may contact the Office of Research Administration at research@gmh.edu.

Consent and Authorization:

TO BE FILLED OUT BY STUDY PARTICIPANT ONLY

Signing below indicates you agree to the above conditions of the study. By signing this consent and authorization form, you will not give up any of your legal rights. It is voluntary to be in the study. Thank you for considering this offer.

_____

Name of Subject

_____ _____

Signature of Subject (18 or older and able to consent) **Date Time**

TO BE FILLED OUT BY STUDY TEAM ONLY

_____

Name of Person Conducting Informed Consent Discussion

_____ _____

Signature of Person Conducting Informed Consent Discussion **Date Time**

PIVOT ATLANTA

Program to Interrupt Violence thru Outreach and Treatment

Problem

The amount of crime related to gun violence has increased in the City of Atlanta. In fact, gunshot victimizations known to the police have grown by 65% in recent years, and hospital data suggests many victimizations go unreported. Not only does it cost billions to treat and investigate gun violence, a victim's likelihood of being shot again increases significantly. Preliminary analyses suggest nearly half of all gunshot-wound patients seen at Atlanta's premiere trauma center are revictimized by gun violence. The consequences of this problem are visible not only to victims, but also the communities at large. Therefore, physicians were seeking an intervention that prevents firearm-related injuries, and addresses the underlying trauma of violence. Simultaneously, police leadership was also searching for an innovative and data-driven approach to curb gun violence in Atlanta's communities. Research shows both public service agencies can indeed limit gun violence, suggesting there is an overlap between the criminal justice system and health arenas that demanded a collaborative response.

Response

The Bureau of Justice Assistance Smart Policing Initiative is sponsoring such a collaborative response between Grady Memorial Hospital and the Atlanta Police Department with Applied Research Services serving as an embedded research partner and evaluator. Hospital based violence prevention programs have shown promise in reducing the likelihood of violent trauma revictimization, as well as an individual's future contact with the criminal justice system through service previsions provisions). Similarly, research shows policing initiatives, such as problem-oriented, hot-spots, and broken-windows policing, can effectively reduce crime within at risk communities. Taken together and in consideration that gun violence can spread like an epidemic through social interactions and personal networks, a coordinated public health model was initiated – PIVOT.

Solution

This *Program to Interrupt Violence thru Outreach and Treatment* aims to interrupt the contagion of violence that can occur following a single violent event. The project focuses on preventing repeat gunshot victimization and retaliatory violence through the combination of three major components: wraparound social services with intensive follow-up, community policing, and data sharing. Victims of gun violence seen by Grady will be assessed for program eligibility based on their risk of subsequent victimization or offending. Program participants will receive direct staff support to obtain services for a variety of needs, such as assistance with crisis intervention, mentoring, housing, and employment. PIVOT will also draw upon focused data-driven strategies used by law enforcement to reduce the burden of violence within Atlanta communities. Their multifaceted role involves the Community Oriented Policing Section, Tactical Analyses Unit, and Gangs Unit. PIVOT dedicated Officers will work specifically in targeted neighborhoods to build trust with citizens, increase their participation in solving gun crime, and address issues that put both an individual and a neighborhood at risk of further violence. For more information, contact our Violence Prevention Coordinator, Jasmine Moore, at jusher@gmh.edu

This project was supported by Grant No. 2016-WY-B-X-K001, awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the Office of Sex Offenders Sentencing Monitoring, Apprehending, Registering, and Tracking. Points of view or opinions in this document are that of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

November 1, 2018

Atlanta Strategies for Policing Innovation Grant Pretest Community Survey

Introduction

It is a goal of PIVOT to reduce gun violence in high-victimization neighborhoods, so community perceptions of the problem is important to understand. A community assessment was conducted to understand the experiences and perceptions of residents in the PIVOT target neighborhood as it might relate to program efforts. It will be important to compare the before and after results to understand program effectiveness. We hope, if the program is effective, that it will have a positive impact on community perceptions of safety and the police.

The survey was restricted to Mechanicsville, Pittsburgh and Thomasville Heights, where there are approximately 11,000 residents living within 2 square miles. These neighborhoods fall within two zip codes with high violence rates in Atlanta – 30310 and 30315. The city neighborhoods are organized into 26 Neighborhood Planning Units (NPU) and named for each letter of the alphabet. Mechanicsville and Pittsburgh are assigned to "NPU-V" and Thomasville Heights is located in "NPU-Z". Those two NPUs have a respective 45% and 36% of their residents living below the poverty, while comparatively the percentage of people living below the poverty line in the City of Atlanta is approximately 24%. Related, these neighborhoods can also be described as having more youths, unemployment, and renters, as well as less education and less access to food. These are measures known to be associated with increased crime rates. Naturally, these neighborhoods were chosen because of high firearm violence rates. The following sections describe the survey methods and results.

Methods

A total of 163 surveys were collected from August to October 2018. The questionnaire developed by the PIVOT best practices committee and approved by the Emory University Institutional Review Board, included over 70 data points. Certified survey administrators were recruited from Emory University, Georgia State University, and the greater Atlanta community. The administrators were trained in how to consent and conduct the survey. The survey was designed to measure six subjects: 1) respondent demographics, 2) contact with police, 3) gun familiarity 4) personal and vicarious exposures to violence and deviance, 5) fear of crime, 6) quality of life, 7) perceptions of informal social control, and 8) judgements of the police. Two open ended questions were also included to collect qualitative data on the participants' ideas on community improvement. The survey was verified readability on an eighth-grade level and took approximately 5 minutes to complete. Study participants were community members residing in three Atlanta neighborhoods (Mechanicsville = 49, Pittsburgh = 42, and Thomasville Heights = 72). A nonprobability, convenience sampling technique was used to collect survey data. The sample was selected in two stages: face-to-face and impersonally.

First, trained survey administrators went to the neighborhoods and solicitated responses from community centers, including churches, shopping centers and apartment complexes. Survey administrators first received permission from community centers. Following initial contact and permission, survey administrators returned to community centers to conduct surveys at their locations one day a week. Community centers, consisting of shopping centers, businesses and public parks, were surveyed on Mondays, Thursdays and Fridays in Mechanicsville, Thomasville Heights and Pittsburgh, respectively, for approximately 3 hours a day ranging from 10am – 3pm. Churches in all communities were surveyed on Sundays. Churches were surveyed just once due to the expectation that the same participants were expected to return each week. Approximately 400 community members were personally asked to take the survey. Second, 200 mail-in surveys were placed on mailboxes in the communities. The overall response rate was approximately 28%.

The survey was administered using a multi-option simplification approach. Individuals were asked to take the full one page back-and-front questionnaire. If the participant indicated their inability to read, survey administrators collected data interview style. Among participants hesitant to respond due to time constraints or other factors, a truncated single-page survey was provided. For those who had no time but wanted to participate, a webpage link to an online version was provide for electronic submission at their convenience.

Community members who agreed to participate were also offered the online link to distribute to friends and family members who reside in those neighborhoods. The mail-in version was the last approach. To ensure anonymity, participants were given readdressed, stamped envelopes in which to return to the research partner. All collected data were then entered into an electronic database on a secured server.

Key Findings

Table 1 shows the sample description. The first section includes demographic information. Survey participants were mixed (fe)male between the ages of 19 and 91, averaging 39 years old (half 35 years or younger). Respondents were primarily black/African Americans (79%), high school graduates (90%) and single (60%). Less than half were employed. While not all survey participants reported their housing status, most were renters. The majority of households included 4 or fewer members. More people have lived in the neighborhood for over five years than those who move there within the prior two. Only 50% had health insurance.

Table 1 also shows the resident's contact with police. About a third had interacted with an officer in the past year, some of which were for an arrest (10%). In fact, 34% have been previously arrested, with about a quarter for a misdemeanor offense and 17% for felony crimes. Arrests among family members were reported more common than personal arrests at 39%. Overall, people see the police quite often (67%) but do not commonly talk to them (22%), nor think their neighbors obey them (57%).

Next, participants responded to questions about their familiarity with firearms. A proportion of those surveyed had been shot (9%), have a loved one who was shot (31%), or were victimized by someone with a gun (12%). Approximately 2/3 often hear gunshots and feel they need a gun for safety. Nearly half own a gun, but 3/4 think guns are a problem in their neighborhood. While half worry about being shot, they believe 75% of their neighbors worry about it. Interconnected, Table 2 (on the next page) displays responses about personal and vicarious exposure to violence and deviance. Thirty-five percent of all participants self-reported to having been victimized, with 19% who got hurt and 18% that did not

Table 1. Sample Descriptive Statistics

Item	Values	Mean/%
Age	Range 19-91	39 (s.d. 13.5)
Sex	Female	51%
Race		
	Black/African American	79%
	Other (Asian, Hispanic, White)	11%
Marital Status		
	Single	60%
	Married	17%
	Divorced/ Widowed	6%
	Other	3%
Employment Status		
	Unemployed	6%
	Employed part-time	7%
	Employed full-time	34%
	Disabled/retired	15%
	Other	6%
Housing Status		
	Renter	37%
	Home owner	12%
	Living with <5 people	57%
	<2 years Tenure	12%
	>5 years Tenure	39%
Highest Level of School Completed		
	Some high school	10%
	High school diploma/GED	36%
	HS education without degree	7%
	Associates or Technical Degree	9%
	Bachelor's Degree or Higher	12%
Have Health Insurance		50%
Police Contact		
	In last year	31%
	Any arrest	34%
	In last year	10%
	Misdemeanor	24%
	Felony	17%
	Family member arrested	39%
	Often see the police	67%
	Often talk with police	22%
	Think neighbors obey police	57%
Firearm Familiarity		
	Been shot	9%
	Loved one shot	31%
	Victimized with gun	12%
	Often hear gunshots	63%
	Feel need a gun for safety	67%
	Own a gun	48%
	Guns problem in neigh.	76%
	Ever worry about being shot	54%
	Think neighbors fear being shot	75%

report the incident to the police. A quarter of those surveyed often see people fighting in their neighborhood and most (67%) deemed it a community problem. They also frequently see gang activity (60%) and think it is a problem (69%). Seeing drug use was also reported (61%) as well as describing it as a problem (76%).

Being victimized or exposed to violence is related to people's fear of crime. Respondents were asked how much they worry. When it comes to sleeping and general feelings of unsafety, the residents struggled at 29% and 25% respectively. When asked about often they worry, they commonly fear being victimized (38%) or mugged (49%) more reported. Currently in the neighborhoods, the most fear seems to be related to interaction with the police (64%).

Fear of crime is often correlated with quality of life which is a challenge for these communities. They often hear fighting (65%), see problematic loitering (71%), are upset by trash/litter (68%) and are challenged by unsupervised youths (71%). These conditions can erode a neighbor's sense of informal social control, or perceived willingness for neighbors to band together to solve problems. More than half of the residents reported not believing their neighbors watch out for one another (59%), call the police for help or to report a witnessed crime (53%) or try to clean up the neighborhood (41%).

Participants responded to questions related to their perceptions of police legitimacy in their neighborhoods. More than half of all participants did not believe that the police are often doing a good job and merely a third believes police are responsive to personal or community needs. Only 22% of participants reported believing that the police are procedurally just (fair, respectful, trustworthy, listen and explain decisions). Lastly, the majority of residents want to improve their community and a quarter say they currently like it.

Table 2. Sample Descriptive Statistics, cont.

Measure	Values	Mean/%
Personal and Vicarious Exposure to Violence		
	Victimized	35%
	Were hurt	19%
	Reported it to police	18%
	Often see affray	25%
	Affray/assault a problem	67%
	See gang activity	60%
	Gangs are a problem in neigh.	69%
	See drug use	61%
	Illegal drugs a problem	76%
Fear of crime		
	Often cannot sleep	29%
	Often feel unsafe	25%
	Often worry about being a victim	38%
	Ever worry about being mugged	49%
	Ever worry about police	64%
Quality of Life		
	Often hear verbal fighting	65%
	Drinking/loitering often a problem	71%
	Trash/Litter often a problem	68%
	Vandalism/graffiti a problem	66%
	Unsupervised youths a problem	71%
	Poverty often a problem	70%
Informal Social Control….Neighbors often:		
	Watch for others	59%
	Call police for help	53%
	Call as witness	53%
	Clean up neighborhood	41%
Police Legitimacy…Police often:		
	Do a good job	40%
	Treat people fairly	43%
	Treat people respectfully	45%
	Respond to community needs	39%
	Act trustworthy	45%
	Take care of problems	33%
	Explain their decisions	31%
	Listen to people	38%
	Respond to people's needs	33%
Commitment		
	Like neighborhood	26%
	Want to move	21%
	Want to improve	43%

The fill-in section of the survey produced some qualitative data for analysis. When asked what they think their communities need to do to improve overall safety and reduce crime, the majority of participants reported that their communities needed "everything." Specifically, they want increased police presence and responsiveness. Guns were of special concern as it relates to their safety and killings. They added that they needed a reduction in gang violence and drug crimes, as well as increases in community services, activities, or programming for youths.

Other themes include physical disorder issues, such needing better lighting, street cleaning, and neighborhood watch programs. When asked if there is anything else that they would like for us to know about themselves or their communities, the majority of participants reported that although they recognized that their communities have problems, mainly those related to gang and drug violence, they believe that that the communities are made up of good people that need help.

Study Limitations

The main limitation to this survey is due to its sample size. This sample is only a very small proportion of the entire population of these communities. One of the main sample size limitations was that participants did not respond to the online survey, thus limiting our access to the study population. Another possible sample size limitation was due to access. Access to community members was limited due to the limited number of public spaces such as community centers, shopping areas and businesses. In instances where community centers such as churches were present, their congregations were made up of people who no longer reside in the neighborhoods. Therefore, a larger sample would enable better generalizability of the survey's findings. The second limitation to this survey may be due to the self-reported nature of the study. As such, selective memory and exaggeration may have biased the observed results. Lastly, the survey may also be limited by the use of a nonprobability, convenience sampling method. The sample of community members for this survey was chosen for convenience and may not be representative of the total population in these communities. A larger sample would therefore enable better generalizability of the survey's findings.

Conclusions

This community survey of 163 adults in three Atlanta neighborhoods (Mechanicsville, Pittsburgh and Thomasville Heights) over seven weeks asked community members a number of questions about their experiences with victimization, law enforcement and their perceptions on crime in their neighborhoods. Our analysis of the survey data identifies key points about public attitudes toward the experiences with victimization, law enforcement and their perceptions on crime in their neighborhoods that will inform how the PIVOT program can strengthen police-community relations.

On the basis of these findings, several conclusions concerning violence in these neighborhoods can be drawn. The findings of this survey indicate that community members experienced high rates of personal and/or vicarious exposures to violence; police working in the neighborhoods are reported to not be procedural; and furthermore, quality of life in these communities is reported to be low. The two foremost reported problems that routinely negatively affect the community are: gang and gun violence. Additionally, the lack of activities for children and youth as well as the absence of policing were also listed as negatively impacting quality of life in the community.

The following questions are about you, your experience with law enforcement, and crime in your community. All responses voluntary and anonymous, so **please do not put your name on this sheet**. The survey should take approximately 10 minutes to complete. If you have any questions or concerns about this survey, feel free to contact Applied Research Services, Inc.:

Dr. Hawk at shawk@ars-corp.com or 404.881.1120, x101

☑ **Check the response that most applies**

Thank you for your time and feedback!

Are you….?

☐ Male	☐ Female		☐ a Home Renter	☐ a Home Owner
☐ Hispanic	☐ Black/AA	☐ White	☐ Asian	☐ Other_____
☐ Single	☐ Married	☐ Divorced	☐ Widowed	☐ Other_____
☐ Unemployed	☐ Employed Part Time	☐ Employed Full Time	☐ Exempt	☐ Other_____

How often do you….?	**Never**	**Rarely**	**Usually**	**Always**
hear gunshots in your neighborhood	☐	☐	☐	☐
feel safe	☐	☐	☐	☐
feel stressed	☐	☐	☐	☐
have trouble sleeping	☐	☐	☐	☐
see the police	☐	☐	☐	☐
talk with the police	☐	☐	☐	☐
see physical fighting or assault	☐	☐	☐	☐
see drug use	☐	☐	☐	☐
see gang activity	☐	☐	☐	☐
feel like you need to carry a gun for protection	☐	☐	☐	☐

How often you worry about … in your community?	**Never**	**Rarely**	**Usually**	**Always**
being a victim of a crime	☐	☐	☐	☐
your home being broken into	☐	☐	☐	☐
being mugged	☐	☐	☐	☐
being shot	☐	☐	☐	☐
a loved one being a victim of a violent crime	☐	☐	☐	☐
being stopped by the police	☐	☐	☐	☐

In your community, how often are … a problem?	**Never**	**Rarely**	**Usually**	**Always**
Gangs	☐	☐	☐	☐
Gun use	☐	☐	☐	☐
Illegal drugs	☐	☐	☐	☐
Physical fighting / assault	☐	☐	☐	☐
Drinking / loitering	☐	☐	☐	☐
Trash / litter	☐	☐	☐	☐
Vandalism / graffiti	☐	☐	☐	☐
Poverty	☐	☐	☐	☐
Unsupervised Youths	☐	☐	☐	☐

How often should people…?	**Never**	**Rarely**	**Often**	**Always**
watch out for each other	☐	☐	☐	☐
obey the police	☐	☐	☐	☐
call the police when they need help	☐	☐	☐	☐
call the police to report a crime witnessed	☐	☐	☐	☐
do something about crime in their neighborhood	☐	☐	☐	☐
work to clean up their neighborhood	☐	☐	☐	☐
help stop violence	☐	☐	☐	☐

Please Turn Over

PIVOT ATLANTA
Program to Interrupt Violence thru Outreach and Treatment

Please Circle One: From 1 (not a problem) to 10 (an extreme problem), how would you rate the **quality of life** in your community?

(not a problem) 1 2 3 4 5 6 7 8 9 10 (an extreme problem)

☑ **Check the response that most applies**

Please describe the police in your community: How often do the police…?	**Never**	**Rarely**	**Usually**	**Always**
treat people fairly	☐	☐	☐	☐
treat people respectfully	☐	☐	☐	☐
respond to community concerns	☐	☐	☐	☐
act trustworthy	☐	☐	☐	☐
take care of crime problems	☐	☐	☐	☐
explain their decisions	☐	☐	☐	☐
listen to people	☐	☐	☐	☐
respond to people's needs	☐	☐	☐	☐
do a good job	☐	☐	☐	☐

Have you…?	**Yes**	**No**
had any contact with the police in your community in the past 12 months?	☐	☐
ever been shot?	☐	☐
had a loved one ever been shot?	☐	☐
ever been the victim of a crime?	☐	☐
If yes, was it a violent crime?	☐	☐
If yes, did the crime involve a gun?	☐	☐
ever received a traffic citation?	☐	☐
ever been arrested for a misdemeanor?	☐	☐
ever been arrested for a felony?	☐	☐
any family members been arrested?	☐	☐
been arrested in the past 12 months?	☐	☐
been hungry but could not get food	☐	☐

Please Describe Yourself

How many years old are you? _____years old

How many people live in your home? _____ people

How many years have you lived in your current community? _____years

How do you feel about your neighborhood? ☐ like your neighborhood ☐ want to move

What is your highest level of formal education?

☐ No High School ☐ High School Diploma/GED ☐ Post High School Education, No Degree/Certification

☐ Associates Degree or Technical Certification ☐ Bachelor's degree (BA/BS) ☐ Master's degree or higher

Do you have health insurance? ☐ Yes ☐ No

Do you or anyone in your household own any firearms for sport or protection?

☐ Yes, for sport ☐ Yes, for protection ☐ Yes, for both ☐ No, neither

What type of services would be helpful to your community?_____

_____

Is there anything else you think we should know about you or your community? _____

_____

Thank you!

PIVOT ATLANTA
Program to Interrupt Violence thru Outreach and Treatment

Please tell us about yourself, your experiences, and your neighborhood. This information will be used to adjust the program and track its progress. No individual answers will be shared with anyone outside of the research team. There are X questions which should take approximately X minutes of your time. There is no penalty for not completing this survey; it is voluntary. You are free to skip any questions you deem problematic. All participation is greatly appreciated and important for tailoring the program. If you have any questions or concerns about this survey and/or the study, feel free to contact the *Community Resource Coordinator*: Aric Johnson, (470)585-8021 or ajohnson15@gmh.edu. Thank you for your input!

Date:_____

Participant #_____

Circle the answer(s) that most applies

Please describe yourself:

What is your gender?	Male	Female
Your race/ethnicity?	Hispanic White Asian	Black or African American Indian or Alaska Native Native Hawaiian or Other Pacific Islander
Your age group?	18-19 years old 25-29 years old	20-24 years old 30-35 years old
Circle everyone you live with.	Parent(s) Grandparent Other relative Group home/shelter Romantic Partner	Sibling(s) Foster family Non-relative other Friend General roommate
Is your home rented?	Yes	No
Are you married?	Yes	No
Do you like your neighborhood?	Yes	No
If no, are you trying to move?	Yes	No
Did you graduate high school?	Yes	No
If no, what was the last grade you completed:	_____	
If no, do you want to get a GED?	Yes	No
Do you have a job?		
If yes, is it…	Part time	Full time
Do you smoke?	Yes	No
Do you have insurance	Yes	No

To what extent…	**Never**	**Rarely**	**Usually**	**Always**
Do you think about retaliating against the person who shot you?	1	2	3	4
Do you worry about being a victim of crime again?	1	2	3	4
Do you worry about being shot again?	1	2	3	4
Do you worry about a loved one being the victim of a violent crime?	1	2	3	4

PLEASE TURN OVER

Please circle your answer

Please describe how common the following are in your community:	***Not Common***	***Not so Common***	***Somewhat Common***	***Very Common***
Gangs	1	2	3	4
Gun use	1	2	3	4
Illegal drugs	1	2	3	4
Physical fighting / assault	1	2	3	4
Drunkenness	1	2	3	4
Trash dumping / littering	1	2	3	4
Poor people	1	2	3	4
Vandalism / graffiti	1	2	3	4
Youths "hanging around"	1	2	3	4

Is it stressful to live in your community?	Yes	No
Have you ever been the victim of a crime before being shot?	Yes	No
If yes, was it a violent crime?	Yes	No
Have any family members been arrested?	Yes	No
Have any family members been to prison?	Yes	No
If yes, was it a parent?	Yes	No
If yes, was it a sibling?	Yes	No

Are any of your friends in a gang?	Yes	No
Have you ever been asked to join a gang?	Yes	No
Do any of your friends regularly carry a gun?	Yes	No
Do you ever carry a gun?	Yes	No
Do you have access to a gun if you wanted one?	Yes	No
Do you have any friends that have been shot?	Yes	No
Do you hear gunshots a lot?	Yes	No
Has anyone ever threatened to shoot you?	Yes	No
Have you ever been shot?	Yes	No

Do any of your friends regularly use drugs?	Yes	No
Do any of your friends sell drugs?	Yes	No
Can you buy drugs at school if you want them?	Yes	No
Do you know where to buy drugs in your neighborhood?	Yes	No
Do you regularly use drugs?	Yes	No
Have you ever traded drugs for money?	Yes	No

What type of services would be helpful to you?_____

_____

Please circle the most appropriate response to rate how you functioned during conflicts.

DURING A CONFLICT, how often did/do you…

1. Discuss the issue calmly?
   1= Never 2=Rarely 3=Sometimes 4=Often

2. Talk through a disagreement?
   1= Never 2=Rarely 3=Sometimes 4=Often

3. Identify and express your feelings in a constructive manner?
   1= Never 2=Rarely 3=Sometimes 4=Often

4. Pay attention to your self-talk?
   1= Never 2=Rarely 3=Sometimes 4=Often

5. Think about the consequences of your actions?
   1= Never 2=Rarely 3=Sometimes 4=Often

6. Think about the impact of your behavior on others?
   1= Never 2=Rarely 3=Sometimes 4=Often

7. Think before you speak or act?
   1= Never 2=Rarely 3=Sometimes 4=Often

IN GENERAL, how often did/do you…

8. Feel safe, secure and emotionally stable?
   1= Never 2=Rarely 3=Sometimes 4=Often

9. Feel able to take care of your own needs?
   1= Never 2=Rarely 3=Sometimes 4=Often

10. Feel good about yourself?
    1= Never 2=Rarely 3=Sometimes 4=Often

11. Think that you have options and resources?
    1= Never 2=Rarely 3=Sometimes 4=Often

12. Based on your experience, how have the police treated you or those close to you?
    1. Very bad/Mistreated 2. Okay 3. Good 4. Very Good

13. If you, your family or friends called the police for assistance (911), How do you think the Police would treat you?
    1. Very bad/Mistreated 2. Okay 3. Good 4. Very Good

14. Would you tell the police about a crime if you knew about it and they asked you?
    1. Never 2. Probably not 3. Probably 4. Most definitely

15. How would you describe your experience with the police?
1. Terrible 2. Okay 3. Good 4. Very Good

16. I believe I can find support through the police.
1. Never 2. Probably not 3. Probably 4. Most definitely

17. I think I can find support through the court system.
1. Never 2. Probably not 3. Probably 4. Most Definitely

18. How often does crime/violence occur in your neighborhood?
1. Never 2. Not Often 3. Occasionally 4. Very Frequently

19. I believe I can do something about the crime in my neighborhood.
1. Never 2. Probably not 3. Probably 4. Most definitely

20. I think I can help stop violence with other youth.
1. Never 2. Probably not 3. Probably 4. Most Definitely

21. I believe it is important for people to improve their own neighborhood.
1. Never 2. Probably not 3. Probably 4. Most Definitely

22. I believe there is hope for decreasing violence.
1. Never 2. Probably not 3. Probably 4. Most Definitely

23. Do you know the phrase "Stop Snitchin"? Yes No

24. Do you agree with the phrase "Stop Snitchin"? Yes No (please explain)
_____
_____
_____

25. If you experienced violence tomorrow how would you deal with it? (please explain)
_____
_____
_____

26. What ideas do you have about how violence can be reduced in your community? (please explain)
_____
_____
_____

Thank you!

The following questions are to be completed after the program has been completed.

27. How has your view on violence changed since you started the program?
1. More Negative 2. Stayed the same 3. Less Positive 4. More Positive

28. How has your view on police changed since you started the program?
1. More Negative 2. Stayed the same 3. Less Positive 4. More Positive

29. Would you recommend the program to others?
1. Never 2. Probably not 3. Probably 4. Most Definitely

30. What did you like about the program? (please explain)

_____
_____
_____

31. Is there anything you didn't like about the program? (please explain)

_____
_____
_____

Additional comments about the program and/or how we could improve:
_____
_____
_____

Thank you!

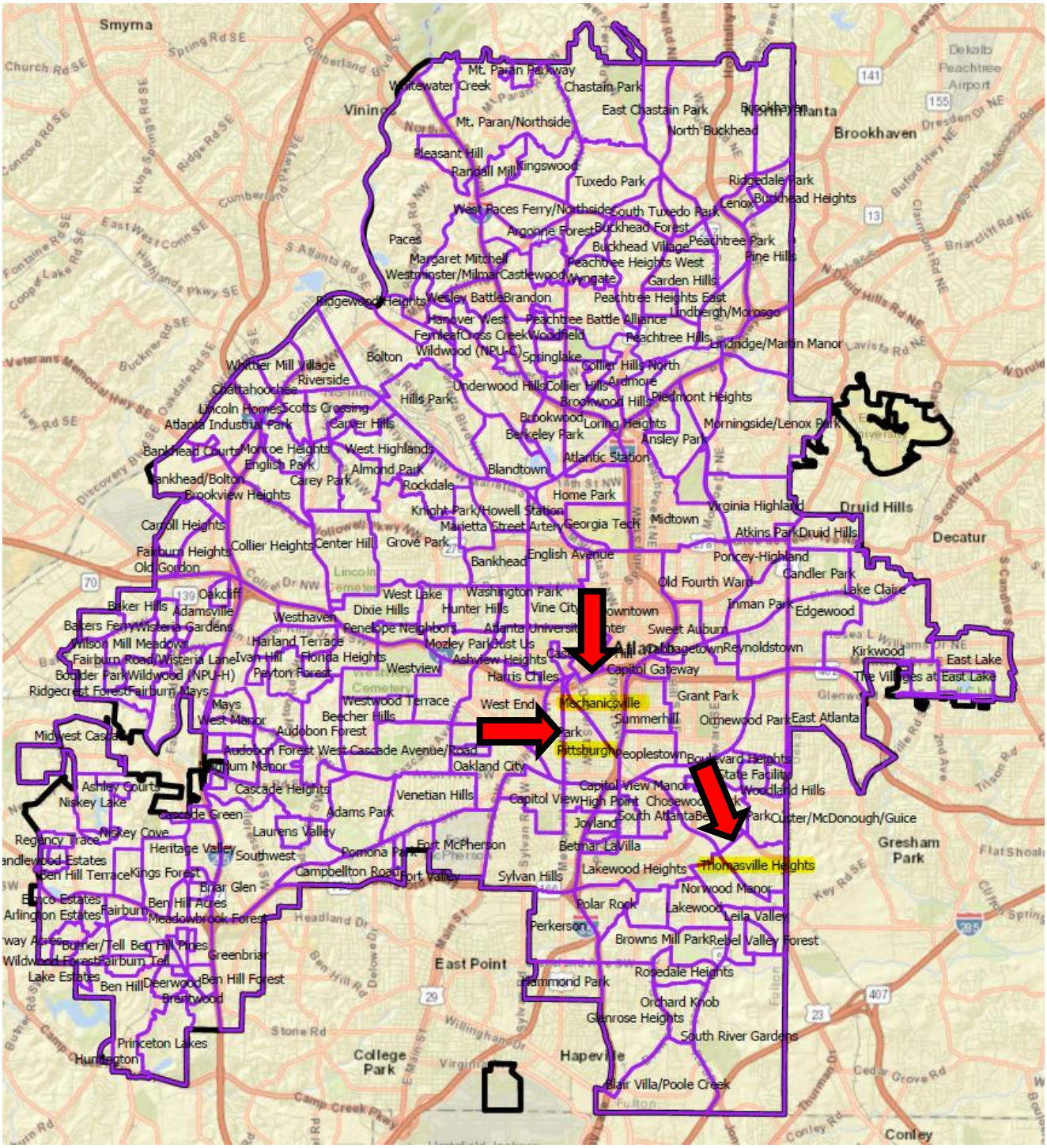
PIVOT ATLANTA
Program to Interrupt Violence thru Outreach and Treatment

ARS
APPLIED RESEARCH SERVICES, INC.

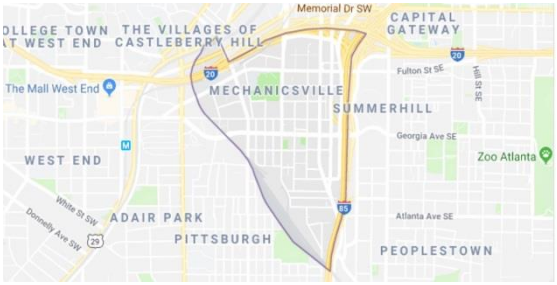
Target Neighborhoods

Zip Codes 30310 & 30315
Atlanta Police Department Zones 1 & 3
Populations < 4k in < 1sq mi area

Last Revised: July 1, 2018



Mechanicsville is located in Intown Atlanta (Zip codes: 30310, 30312 and 30315). It has a population of 3,731 people living in a mostly apartment or linked home structures. It is primarily located in Atlanta Police Department (APD) Zone 3; however includes beats 101, 303, 304 and 501. The associated Neighborhood Planning Unit (NPU) is "V", along with 5 other neighborhoods.



APD reporting data show 43 serious gun crimes occurred last year at a rate of 1.15 per 100 residents. This neighborhood was chosen due to its high rate of violence and calls for shootings, as well as increase in firearm victimization. In 2016, 6 people were injured by gun violence within the 0.614 square city miles. In a year's time that count increased to 20. It has incredibly high crime and safety rates compared to the national rates per 100,000 people and shares a higher ratio of individuals at risk for violence.

Crime and Safety Rates (per 100k residents)[1]

Crime	Mechanicsville	Nationwide
Assault	1,413	283
Robbery	1,028	136
Burglary	1,413	500
Theft	4,856	2,043
Motor Theft	1,953	284

Quality of Life[2]

Measures	NPU V	Atlanta
Park access	83.5%	54%
Retail access	76%	95%
Transit access	98%	79%
Mean travel time (mins)	33	26
Jobs to labor force ratio	0.7	1.16
Walkability (out of 100)	57	46
Low food access	20%	4%
Vehicle crashes per 1k	16.4	15.3
Violent crimes per 1k	24.9	11.5
Property crimes per 1k	113.5	73

Landmarks and Institutions[3]

Education

- Dunbar Elementary
- Mechanicsville Branch of the Atlanta-Fulton Public Library System

Neighborhood Associations

- The Mechanicsville Civic Association
- The Citizens Associations of Mechanicsville

Recreational Areas

- Rosa L. Burney Park Religious Institutions

Religious Institutions

- Central Presbyterian Church (nearby)

Demographics

Measure	Mechanicsville[3]	NPU V[4]	City of Atlanta
Population	~3,731	12,055	425,931
Age	28% under 18	Mean = 29.8yr 29% <18yo 34% yrs 20 – 39 9% > 65yo	Mean = 33yr 19% <18yo 37% yrs 20 – 39 11% >65yo
Racial Composition		89% Black/AA 3% Other 6% White 1% Asian	52% Black/AA 4% Other 40% White 4% Asian
Housing Tenure		74% renters	57% renters
Housing Occupancy		33% vacant	21% vacant
Unemployment Rates		24%	12%
Median HH Income	$34,539	$20,858	$46,146
% Below Poverty Line		45%	24%
College Educated		18%	46%

[1] Niche. (2017). Living in Mechanicsville. Retrieved from https://www.niche.com/places-to-live/n/mechanicsville-atlanta-ga/
[2] Georgia Tech. (2010). Atlanta's Neighborhood Quality of Life & Health Project: Neighborhood Planning Unit V. Retrieved from http://cspav.gatech.edu/NQOLH/About_NPUs/V/
[3] City Data. (2018). Mechanicsville neighborhood in Atlanta, Georgia (GA), 30310, 30312, 30315 detailed profile. Retrieved from city-data.com
[4] City of Atlanta (2010). 2010 Census Summary Report: Neighborhood Planning Unit V. Retrieved from http://www.atlantaga.gov/Home/ShowDocument?id=3897

Pittsburgh is located in Intown Atlanta (Zip codes: 30310 and 30315). It has a population of 3,658 people living in primarily single-family home structures. It mostly falls into Atlanta Police Department (APD) Zone 3; beats 101, 302, 303, 304, and 305. The associated Neighborhood Planning Unit (NPU) is "V", along with five other neighborhoods.

Within the 0.833 square city miles, APD data show 248 serious gun crimes occurred in the past five years, at a rate of 6.78 per 100 residents. Those have resulted in 58 shooting victimizations, one of the highest individual counts in the city. Indeed, the crime rates are double and triple the national estimates. Thus, this neighborhood was chosen because it accounts for such a large percentage of gun crimes and shootings in Atlanta and easily accessible from one of the other target areas. It also is challenged by social risk factors.

Crime and Safety Rates (per 100k residents)[5]

Crime	Pittsburg	Nationwide
Assault	1,725	283
Robbery	1,089	136
Burglary	1,664	500
Theft	4,175	2,043
Vehicle Theft	2,027	284

Quality of Life[3]

Measures	NPU V	Atlanta
Park access	83.5%	54%
Retail access	75.8%	95%
Transit access	98.3%	79%
Mean travel time (mins)	33.3	26
Jobs to labor force ratio	0.7	1.16
Walkability (out of 100)	57	46
Low food access	20.2%	4%
Vehicle crashes per 1k	16.4	15.3
Violent crimes per 1k	24.9	11.5
Property crimes per 1k	113.5	73

Demographics

Measure	Pittsburg[6]	NPU V[4]	City of Atlanta
Population	~3,658	12,055	425,931
Age	22% under 18	Mean = 29.8yr 29% <18yo 34% yrs 20 – 39 9% > 65yo	Mean = 33yr 19% <18yo 37% yrs 20 – 39 11% >65yo
Racial Composition		89% Black/AA 3% Other 6% White 1% Asian	52% Black/AA 4% Other 40% White 4% Asian
Housing Tenure		74% renters	57% renters
Housing Occupancy		33% vacant	21% vacant
Unemployment Rates		24%	12%
Median HH Income	$25,412	$20,858	$46,146
% Below Poverty Line		45%	24%
College Educated		18%	46%

Landmarks and Institutions[3]

Education

- Gideons Elementary
- Evangeline Booth College
- Salvation Army Center for Officer Training

Neighborhood Associations

- Pittsburgh Improvement Association

Recreational Areas

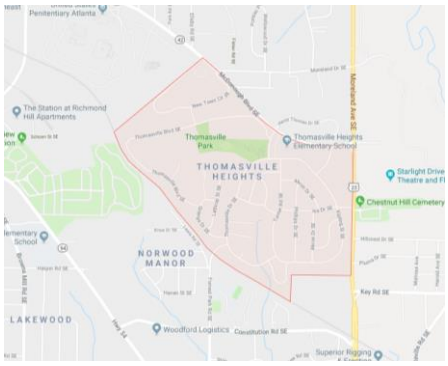
- Pittman Park
- Welch Street Park

Religious Institutions

- Rice Memorial Presbyterian
- New Hope Church of God in Christ
- Jars of Clay Outreach
- Ariel Bowen Memorial United Methodist
- Antioch Baptist
- Iconium Baptist
- Sunny Side Baptist
- Bethany Baptist
- Greater Mount Pleasant Baptist
- Greater New Harvest Baptist
- Mount Mariah Primitive Baptist
- St John Ame
- Victory House
- New Mt Calvary Baptist
- Rize Community

[5] City Data. (2018). Pittsburgh neighborhood in Atlanta, Georgia (GA), 30310, 30315 detailed profile. Retrieved from city-data.com
[6] Niche. (2018). Living in Pittsburgh. Retrieved from niche.com

Thomasville Heights is located in Southwest Atlanta (Zip code 30315). It has a population of 3,621 people living in a mix of single family and apartment home structures. It is primarily located in Atlanta Police Department (APD) Zone 3; beats 305, 308, and 607. The associated Neighborhood Planning Unit (NPU) is "Z", along with 12 other neighborhoods.



This neighborhood was chosen because it is similar to the other target areas in crime trends, population, and size (0.599 square city miles); however, it is outside of ShotSpotter range. Like Pittsburgh, 9 people were shot within Thomasville Heights last year. Although the number of gun crimes has decreased in recent years, it is still remarkably high at .83 per 100 residents last year and overall victimizations have increased.

Crime and Safety Rates (per 100k residents)[7]

Crime	Thomasville Heights	Nationwide
Assault	586	283
Robbery	322	136
Burglary	439	500
Theft	659	2,043
Vehicle Theft	366	284

Quality of Life[3]

Measures	NPU Z	Atlanta
Park access	51%	54%
Retail access	34%	95%
Transit access	76%	79%
Mean travel time (mins)	32	26
Jobs to labor force ratio	1.4	1.16
Walkability (out of 100)	25	46
Low food access	8%	4%
Vehicle crashes per 1k	9.6	15.3
Violent crimes per 1k	17.6	11.5
Property crimes per 1k	71	73

Landmarks and Institutions[3]

Education

- Dobbs Elementary School
- Thomasville Heights Elementary School
- Mt Nebo Christian Academy
- Long Middle School
- Price Middle School
- Early College High School at Carver
- South Atlanta School of Health and Medical Science
- Thomasville Heights Branch Library

Recreational Areas

- Thomasville Resource Center
- Mt Nebo Health Fitness Center

Religious Institutions

- Mt Carmel AM E Church
- Faith Apostolic Holiness Church
- First Mt Selah Baptist Church
- Faith Temple of Praise Hlnss
- House of God

Demographics

Measure	Thomasville H[8]	NPU Z[9]	City of Atlanta
Population	~3,621	18,771	425,931
Age	29% under 18	Mean = 29yr 33% < 18yo 27% = 20 - 39yo 8% > 65yo	Mean = 33yr 19% <18yo 37% yrs 20 – 39 11% >65yo
Racial Composition		95% Black/AA 5% White 0% Asian 0% Other	52% Black/AA 4% Other 40% White 4% Asian
Housing Tenure		59% renters	57% renters
Housing Occupancy		20% vacant	21% vacant
Unemployment Rates		22%	12
Median HH Income	$23,889	$26,354	$46,146
% Below Poverty Line		36%	24%
College Educated		10%	46%

[7] City Data. (2018). Thomasville Heights neighborhood in Atlanta, Georgia (GA), , 30315 detailed profile. Retrieved from city-data.com
[8] Niche. (2018). Living in Thomasville Heights. Retrieved from niche.com
[9] City of Atlanta (2010). 2010 Census Summary Report: Neighborhood Planning Unit Z. Retrieved from http://www.atlantaga.gov/Home/ShowDocument?id=3897

Atlanta Police Department Policy Manual		Special Order
Effective Date: January X, 2018		APD.SO.18.0X PIVOT Officers
Applicable To: All employees		
Approval Authority: Chief Erika Shields		
Signature: Signed by ES		Date Signed: X/X/18

1. PURPOSE

To establish the duties and responsibilities of the COPS Officers assigned to the PIVOT Grant.

2. POLICY

2.1 It is the policy of the Atlanta Police Department to establish proactive community partnerships and exemplify principles established in the Community Oriented Policing model.

2.2 The COPS shall maintain proper oversight to ensure that proactive community partnerships and personalized strategies are developed and tailored for the unique needs of each community to reduce crime and improve the quality of life.

3. RESPONSIBILITIES

3.1 Responsibilities of the Organization

3.1.1 The COPS Commander shall be responsible for coordinating the administering of the PIVOT Grant. The COPS Commander shall work closely with and serve as a liaison for the police department and the community groups, social organizations, business groups, civic organizations, schools, and other organized groups who participate in the PIVOT Grant. (CALEA 6th ed. Standard 45.2.1)

3.1.2 The COPS Major shall monitor the implementation of this directive.

4. ACTION

4.1 PIVOT Officers responsibilities include but are not limited to:

a. Officers assigned to COPS shall adhere to the policy and procedures as they pertain to them in this directive at all times;

b. PIVOT officers will work only with PIVOT communities;

c. Interact with Community Liaison Officers, beat officers, crime analysts and serve as liaisons between the department and the target communities to prevent crime and foster community relationships;

d. Build collaborative partnerships between the Police Department and the citizens within the target communities alongside the Crime Prevention Inspectors;

e. Participate in monthly PIVOT task force meetings, ad hoc grant meetings as needed, and be responsive to PIVOT task force members;

f. Provide timely response to gun violence in target communities where an incident of gun violence has occurred;

g. Work with Applied Research Services as the designed research partner for the Strategies for Policing Innovation grant process and impact evaluation, providing timely information, collecting data, and meeting as needed;

h. Consult with the Tactical Crime Analysis Unit and Code Enforcement to coordinate PIVOT interventions;

i. Liaise with the Gun Reduction Task Force of the Targeted Enforcement Unit in APD's Special Enforcement Section as the task force identifies family, friends, or associates of gunshot victims to further their investigation;

j. Provide feedback about target community interactions with investigators and general information COPS officers may gather from residents about incidents;

k. Conduct community forums in PIVOT targeted communities to facilitate conversations regarding police-community relations, crime, and other relevant issues;

l. Identify through community forums, interactions, and observations in the PIVOT targeted areas opportunities to enhance relationship between the public and the police, reduce gun violence, and connect residents to needed services;

m. Work with the PIVOT Community Research Coordinator at Grady Hospital or other designated violence reduction staff to identify community resources for PIVOT participants and the communities at large;

n. Should the program hire community violence interrupters, PIVOT officers will need to guide the targeted community violence prevention efforts of those individuals through information gather from the Gun Reduction Task Force investigations;

o. Complete other functions as directed by his or her supervisor.

5. DEFINITIONS

5.1 PIVOT Grant: This *Program to Interrupt Violence thru Outreach and Treatment* aims to interrupt the contagion of violence that can occur following a single violent event. The project focuses on preventing repeat gunshot victimization and retaliatory violence through the combination of three major components: wraparound social services with intensive follow-up, community policing, and data sharing. Victims of gun violence seen by Grady will be assessed for program eligibility

based on their risk of subsequent victimization or offending. Program participants will receive direct staff support to obtain services for a variety of needs, such as assistance with crisis intervention, mentoring, housing, and employment. PIVOT will also draw upon focused data-driven strategies used by law enforcement to reduce the burden of violence within Atlanta communities. Their multifaceted role involves the Community Oriented Policing Section, Tactical Analyses Unit, and Gangs Unit. PIVOT dedicated Officers will work specifically in targeted neighborhoods to build trust with citizens, increase their participation in solving gun crime, and address issues that put both an individual and a neighborhood at risk of further violence.

The Bureau of Justice Assistance Strategies for Policing Initiation is sponsoring a collaborative response to firearm violence in Atlanta between Grady Memorial Hospital and the Atlanta Police Department, with Applied Research Services serving as an embedded research partner and evaluator. Hospital based violence prevention programs have shown promise in reducing the likelihood of violent trauma revictimization, as well as an individual's future contact with the criminal justice system through service previsions provisions). Similarly, research shows policing initiatives, such as problem-oriented, hot-spots, and broken-windows policing, can effectively reduce crime within at risk communities. Taken together and in consideration that gun violence can spread like an epidemic through social interactions and personal networks, a coordinated public health model was initiated ─ PIVOT.

6. CANCELLATIONS

N/A

7. REFERENCES

APD.SOP.7030 Community Oriented Policing Section (COPS)

Commission on Accreditation for Law Enforcement Agencies (CALEA) 6th ed. Standards; 45.1.1, 45.1.2, and 45.2.1.

Tiers of Services

Tier 1: Low risk of retaliation and re-injury based on gathered information during the assessment. Little to no need for Case Management due to the client meeting or exceeding in 4 or more of the intervention domain areas listed below. These clients receive advocacy, help with Victims of Crime paperwork and referrals to outside agencies. These clients are also recommended for Mental Health counseling. These patients typically will only need up to 3 months of Case Management.

Tier 2: Medium risk of retaliation and re-injury based on gathered information during the assessment. These clients need Case Management due to multiple needs (1-3) of the intervention domain area being identified during the assessment. These clients receive advocacy, help with Victims of Crime paperwork, and referrals to outside agencies as well as receiving help navigating successfully throughout the domain areas. These patients typically will only need up to 6 months of Case Management.

Tier 3: High risk of retaliation and re-injury based on gathered information during the assessment such as involvement in multiple systems, gangs, drug trade in addition to them expressing multiple needs (3-5) of the intervention domain area. These clients will require Case Management and they will receive advocacy, help with Victims of Crime paperwork, and referrals to outside agencies as well as receiving help navigating successfully throughout the domain areas. These patients will need at minimum 6 months to a 1 year of Case Management, but it could take longer.

Intervention Domains

Domain: Mental Health				
	Tier One	**Tier Two**	**Tier Three**	**Tier Four**
Specific Need	Reduce PTSD symptoms	Reduce Depression symptoms	Reduce Anxiety symptoms	Reduction in substance abuse
Assessment Tool	PCL-5 Checklist and Injured Trauma Survivor Screen	PHQ-9 screening	GAD-7 screening	Dast-10 screening
Intervention	Individual/Group counseling	Individual/Group counseling	Individual/Group counseling	Individual/Group counseling
Outcome Evaluation	Patient will score lower on PCL-5 Checklist.	Patient will score lower on PHQ-9 screening.	Patient will score lower on GAD-7 screening.	Patient will score lower on Dast-10 screening.

Domain: Employment			
	Tier One	**Tier Two**	**Tier Three**
Specific Need	Obtain employment	Increase job readiness	Move patients from being underemployment to gainful employment
Assessment Tool	Questionnaire via Intake Needs Assessment	Questionnaire via Intake Needs Assessment	Questionnaire via Intake Needs Assessment & Current annual income
Intervention	Assist patients with creating resumes for job readiness.	Educate patients on interviewing skills	Educate patients on different career industries, including those with higher wage-earning opportunities.

	Educating patients on how to complete online and in person job applications.		
Outcome Evaluation	Number of Job interviews		Pay increase at current position, or new job with higher annual salary

Domain: Education			
	Tier One	**Tier Two**	**Tier Three**
Specific Need	General Education Development (GED)	Graduating High School	Advanced education or trade school
Assessment Tool	Questionnaire via Intake Needs Assessment	Questionnaire via Intake Needs Assessment	Questionnaire via Intake Needs Assessment
Intervention	Enrollment in GED Program	Assist with high school enrollment Partner with School Counselors/Social Workers to ensure patients are on course for high school graduation. Enroll patients in tutoring/summer school and other programs to assist with make-up credits	Assist patients with completing college or trade school admission applications. Provide educational resources for college entrance exams (i.e. SAT, ACT)
Outcome Evaluation	Percentage of GED program completed at 1-year post enrollment (Completed Credits/Total Credits needed)	Percentage of patients graduated from high school at 1-year post enrollment	Percentage of patients enrolled in post-secondary education or trade school 1-year post enrollment

Domain: Housing			
	Tier One	**Tier Two**	**Tier Three**
Specific Need	Patient needs to obtain stable housing.	Patient needs to obtain safe housing	
Assessment Tool	Housing needs assessment (VI-SPADT).	Housing needs assessment (VI-SPADT).	
Intervention	Enroll patient in housing program. Educate patient on finances and creating a household budget	Assist patients with moving to safer neighborhoods Partnering with community-based organizations for referrals and assistance with moving costs.	
Outcome Evaluation	Patient housed at end of 1-year enrollment.	Patient moved to new neighborhood post 1-year program enrollment.	

Domain: Life Skills			
	Tier One	**Tier Two**	**Tier Three**
Specific Need	Learning to appropriately manage anger	Positive conflict resolution skills	
Assessment Tool	Anger Management questionnaire.	Anger Management questionnaire.	
Intervention	Provide education on anger management tools and resources Participation in anger management group therapy	Provide education on healthy conflict resolution skills	
Outcome Evaluation	Post-test program evaluation on anger management coping mechanisms Reduction in the number of violent responses 1-year post program enrollment	Post-test program evaluation on positive conflict resolution skills. Reduction in the number of violent responses 1-year post program enrollment	