**CURE VIOLENCE GLOBAL**
**FORSYTH COUNTY AND CITY OF WINSTON-SALEM ASSESSMENT**
**JANUARY 10TH 2022**

## OBJECTIVE OF ASSESSMENT VISIT

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

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

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

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

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

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

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

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

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

CVG worked closely with the Forsyth County and City of Winston-Salem over the course of four months to complete the assessment through the four distinct phases which included (1) CVG 101 Informational meetings for a broad range of stakeholders including government agencies, hospitals, service providers, and community-based organizations (virtual), (2) Smaller stakeholder meetings with a subset of attendees of the CVG 101 presentations (virtual); (3) In person visit to Forsyth County which took place in December of 2021, and then the (4) Determination of next steps with the submission of the assessment report. The schedule of the "In person visit" included:

**Tuesday December 7th Agenda:**

i. 9:00am – Vehicle tour with Commissioner El Amin/Shontell start at County Managers office to survey the target areas.
ii. 11:00am – Meeting with Novant hospital at Novant 3rd floor.
iii. 2:00pm – Health Department meeting.
iv. 5:00pm– Aric and Rock will do ride along with Effiguan Muhammad/10,000 Fearless.

**Wednesday December 8th Agenda:**

i. 9:00am- Meeting with Winston-Salem State University
ii. 11am – Meeting with Neighbors for Better Neighborhoods
iii. 12pm- Meeting with Wake Forest Baptist hospital
iv. 5pm- Aric and Rock will do ride along with Artemus "Papa"/Enough is Enough

**Thursday December 9th Agenda**

I. 9:00am- Meeting with Urban Strategies
II. 11am- Steering Committee meeting.
III. 5pm- Aric and Rock will do ride along with Artemus "Papa"/Enough is Enough.

**CURE VIOLENCE GLOBAL BACKGROUND**

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

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

The Cure Violence Global model is based on the World Health Organization's epidemic control approach for stopping the spread of infectious diseases such as AIDS, cholera, and tuberculosis. The model advances a prevention methodology to identify and detect violent events; interrupt, intervene and reduce risk of their occurrence; and change the behaviors and norms that perpetuate violence.
This method begins with epidemiological analysis of the clusters involved and transmission dynamics, and uses several new categories of paraprofessional health workers to interrupt transmission to stop the spread and to change norms around the use of violence. Central to this approach is the use of workers viewed as trustworthy and credible by the population being served. This is best accomplished by hiring workers who are from the same community and have had similar life experiences (i.e.,

community health workers). Workers are trained as disease control workers, similar to tuberculosis workers, and receive extensive training in methods of mediation, behavior change, and norm change. Cure Violence Global has extensive experience bringing its health-based violence prevention model to scale in Chicago and working with implementation partners to bring the model to scale in other cities.

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

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

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

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

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

Changing norms is done most effectively by bringing some of these practices to scale, and by questioning existing norms and proscribing new norms at population levels. As thoughts, behavioral scripts, and norms are transmissible, new scripts and norms are developed and a new set of behaviors becomes the norm. Interruption is essential; however, brain processes, including preexisting emotional dysregulation as well as continued peer pressures to belong, remain problems if unattended to or untreated.

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

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

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

The Cure Violence Global model has undergone 11 independent evaluations to date, all of which have reported statistically significant reductions in violence. A John Jay College of Criminal Justice evaluation of two New York City neighborhoods operating Cure Violence programs from 2014 to 2016 found steeper declines in acts of gun violence and increases in the expression of pro- social norms compared with similar neighborhoods not operating Cure Violence programs. The study found reductions across all measures, including a 63% reduction in shootings in one community, a 50% reduction in gunshot

wounds in the other, less support for the use of violence, and greater confidence in police. An evaluation in three Philadelphia Police Service Areas found that the Cure Violence program was associated with a 30% reduction in the rate of shootings. A 2014 evaluation of two Chicago Cure Violence program neighborhoods showed a 31% reduction in homicides and a 19% reduction in shootings in targeted districts. A 2009 Northwestern University evaluation found that the model was associated with 16-34% reductions in shootings and 46-100% reductions in retaliatory homicides. A 2012 Johns Hopkins University evaluation found that Safe Streets, Cure Violence's partner in Baltimore, reduced killings up to 56%, and shootings up to 44%. In a study released by Arizona State University in 2018, the adaptation of the Cure Violence model in East Port of Spain, Trinidad found "Based on a series of quasi-experimental designs using three independent data sets maintained and updated by different entities…found that the Cure Violence intervention was associated with significant and substantial reductions in violence."

**ASSESSMENT FINDINGS**

Cure Violence Global was able to determine that Forsyth County and the City of Winston-Salem have the capacity to successfully implement the CVG model. Below are brief descriptions of the findings of the assessment for each element which is required to implement the CVG model successfully.

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

Yes, CVG was able to determine during the assessment process that Forsyth County and the City of Winston-Salem have the capacity and political will to implement the CVG model with fidelity. Forsyth County established a multi-agency Cure Violence Steering Committee which met on a weekly basis to fully support the assessment process. Members of the steering committee invested considerable amount of time and resources to the process and have demonstrated the highest levels of capacity to organize, convene, and work with the diverse set of government, community, and individual stakeholders required to implement the CVG model. The Forsyth County has also identified potential sources of funding from the American Recovery Plan.

The Cure Violence Steering Committee members and affiliations are below:

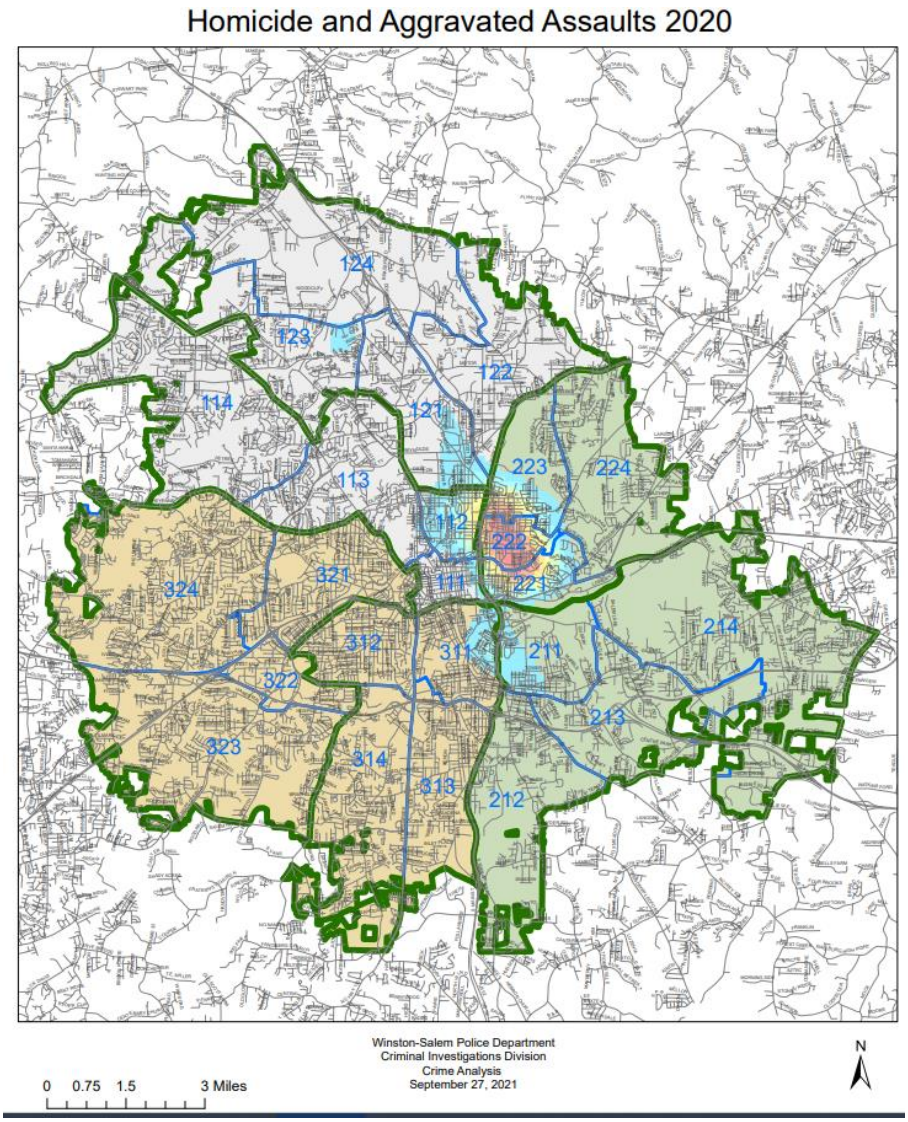
| | |
|---|---|
| Tricia McManus | WSFC School |
| William Penn | Assistant Chief WSPD |
| Rocky Joyner | Chief Deputy FCSO |
| Stan Clarkson | Chief Court Counselor Juvenile Justice |
| Judge Denise Hartsfield | District Court Judge |
| Fleming El-Amin | County Commissioner |
| Tonya McDaniel | County Commissioner |
| Shontell Robinson | Deputy County Manager |
| Dr. Jack Monell | Professor Justice Studies WSSU |
| James Taylor | City Councilman |
| Patrice Toney | Assistant City Manager |
| Sherri Cook | Judicial District Manager Adult Probation |
| Patrick Ellington | District Attorney Office |
| Kevin Acuna | District Attorney Office |
| Rich Smith | JCPC Support |
| Kimberly Busse | Forsyth County |
| Dr. Lucas Paul Neff | Atrium Health Wake Forest Baptist |
| Dr. Martha Sieber | Novant |
| Jennifer Martin | DA office |
| AC Miles | Assistant Chief WSPD |
| Bobby Kimbrough | Sheriff |
| Valene McMasters | District Court Judge |

If Forsyth County and the City of Winston-Salem decide to move forward with the implementation of the CVG program, the County has the capacity to serve as the administrator or "Implementation Partner." As the Implementation Partner, the County would be responsible for subcontracting to a community-based organization, collaboration with other City and County departments, and coordination of CVG training and technical assistance. CVG would also strongly recommend that the Cure Violence Steering Committee continue to meet regularly to ensure successful collaboration and coordination of violence prevention efforts.

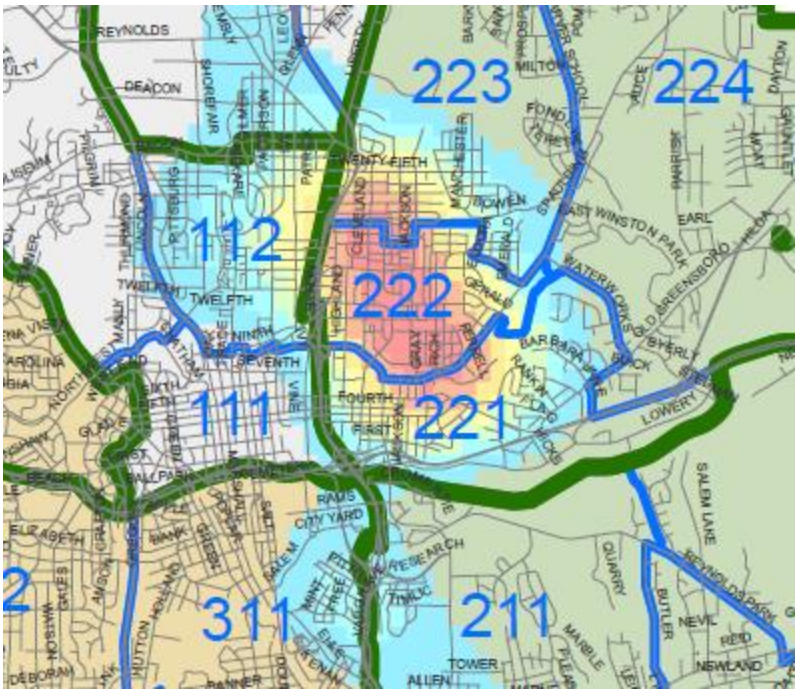
**(2) Does official and unofficial data exist about violent incidents to focus, monitor, and measure the implementation of the model?**

Yes, CVG was able to determine that Forsyth County and the City of Winston-Salem exceeds the data requirement for the CVG model to be successful. WSPD and the Forsyth County Sheriff's office provided data for the assessment which demonstrated the ability to capture, focus, monitor measure, and ultimately report on the impact of the CVG model at the community level. The available data identifies chronic “hot spots” to the level of area where shootings and killings have persisted for several years to focus the intervention.

Homicide and Aggravated Assaults 2020 (source WSPD):




As can be seen in data there is clear “hot spot” in area of 222. The concentration of Homicides and Aggravated assaults have persisted in 222 for all the years that data was reviewed for the assessment. All conversations during the assessment process confirmed that the area 222 was the area with the most persistent violence.




The specific target areas inside of area 222 which are being recommended to implement the CVG model are Rolling Hills, Piedmont Circle, and Cleveland Ave homes.

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

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

Yes, the data CVG was able to review the data provided by WSPD and the Forsyth County Sheriff's during the assessment process which demonstrated the nature of the violent incidents is consistent with other areas where the CVG model has been implemented. Meaning, that the shootings and homicides take place in mostly public spaces in the community between individuals and groups who are in conflict for

various reasons ranging from sale of narcotics to interpersonal conflicts (often fueled by social media) to other “on the spot” transactional disputes.

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

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

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

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

CVG was able to meet with several individuals and organizations including Enough is Enough, 10,000 Fearless, Neighbors for Better Neighborhoods, Public Health Department, Winston-Salem State

University, and Urban Strategies which have demonstrated great concern and commitment to the community throughout the course of the assessment process in Forsyth County and the City of Winston-Salem. They have a wide range area of work which included some violence prevention, health-based programming, community engagement, legal services, large and small activities for the community, provision of supportive services, mental health services, re-entry work, life skills, sporting activities for youth, mentorship programs, food, and clothing distribution.

As an example, one organization which CVG was able to spend time with during the assessment process was Enough is Enough. Enough is Enough mission is to "Empower youth with love and unity while taking back our community. It is our charge to display leadership in a manner that will cultivate skills, enhance talent and present positive role models to young people..." said the founder Artemus Peterson AKA "Papa." CVG was able to observe that Enough is Enough has a mission in alignment with the CVG model, has strong ties to the community, appear to be viewed as credible, would potentially be able to assist in the recruitment of potential target areas, willing to hire individuals with criminal backgrounds, history of work with high-risk youth, and organizational experience in program implementation. The concern about Enough is Enough would be the financial oversight of the program with federal dollars.

It is not uncommon that organizations with the best relationships with the highest risk in the target area do not have the full capacity to provide fiscal oversight. Additional support for administration may be needed to bolster existing candidate organizations. In CVG's experience that can be achieved through a fiscal agent or housing the program in larger organization. Some cities have worked with organizations like the Urban League to serve as the fiscal agent. One potential example of would be the Neighbors for Better Neighborhoods, which met some of the criteria and could potentially be a good fit to house the program as the fiscal agent to provide financial oversight to a smaller community-based organization.

Other cities have decided to "house" the program in a health department or similar institution. In this instance, the managers, violence interrupters, and outreach workers are state/county employees and implement the model as such as part of an existing department or division. Hiring practices and other HR considerations must be mapped out clearly to ensure that no barriers are put in place which preclude hiring staff that meet the criteria. It is also important to consider how the health department is viewed by the community and is it accessible during the typical hours of operation of the CVG model (evenings, nights, and weekends).

During the assessment visit, it was determined that the Health Department could make sense to implement the program if no local CBO meets the fiscal oversight criteria. It has facilities in the target area, appears to have good relationships with the community, as a health department has a mission which is in sync with CVG, and willing to hire and work with individuals with criminal histories/come from the groups in conflict in target area. The conversations with other community stakeholders confirmed that it could make sense for the health department to potentially serve as the partner for implementation.

If Forsyth County and the City of Winston-Salem decides to move forward with CVG model, CVG will work with the County to provide sample "Requests for Proposal" which can be included in any local procurement procedures to make the decision which community-based partner is selected to implement the program or assist in mapping out how it can be positioned in a health department (no RFP/RFQ is required in this instance).

**Hospital Based Program**

In many cities CVG either works directly or closely with hospital-based violence intervention programs that work to use this unique point of intervention to prevent retaliation, re-injury, and provide individuals with necessary resources. As part of the assessment process CVG was able to meet with staff from Novant and Wake Forest Baptist hospitals.

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

After meeting with hospital staff at both hospitals Novant and Wake Forest Baptist, CVG staff felt very confident that a full Cure Violence Hospital responder program could be implemented at Wake Forest Baptist which primarily receives the Gun Shot Wounds (GSW) from the area. Additional coordination could be planned for the cases which are received at Novant. Currently the hospitals provide substance abuse assessments, but do not have violence prevention programming to address the additional needs of the GSW victims. The responders would be able would be able to directly coordinate efforts with the community-based program for cases that are associated with the 222 area.

After the initial conversations, CVG recommends a staffing pattern of 3-4 Hospital responders with a supervisor would be able to provide the coverage necessary for Forsyth County and the City of Winston-Salem. If the hospitals are interested in implementing the CVG Hospital Responders Program, a series of planning meetings would be required to determine the specific protocols internal to the hospital, recruitment and hiring, and coordination with the community-based violence prevention programming.

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

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

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

CVG was able to meet with individuals from the "hot spot" communities who clearly fit the profile to fulfill the role of violence interrupters and outreach workers during the in-person site visit in December 2021. CVG is confident that if the county and city move forward with the model, the selected community-based

partner will be able to recruit workers who fit the profile to serve as Violence Interrupters and Outreach Workers for 222 area with specific relationships to reach the highest risk in the Rolling Hills, Piedmont Circle, and Cleveland Ave homes.

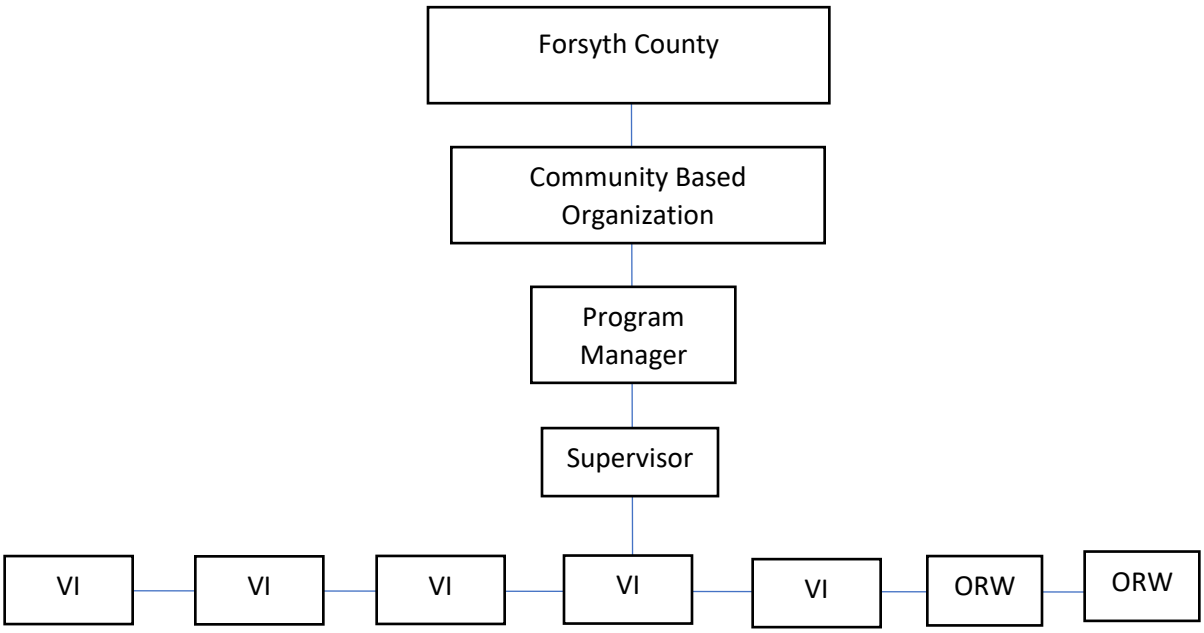
**(7) Determine initial program recommendations for program size, budget, and ongoing training and technical assistance plan from CVG**

**Program Size**

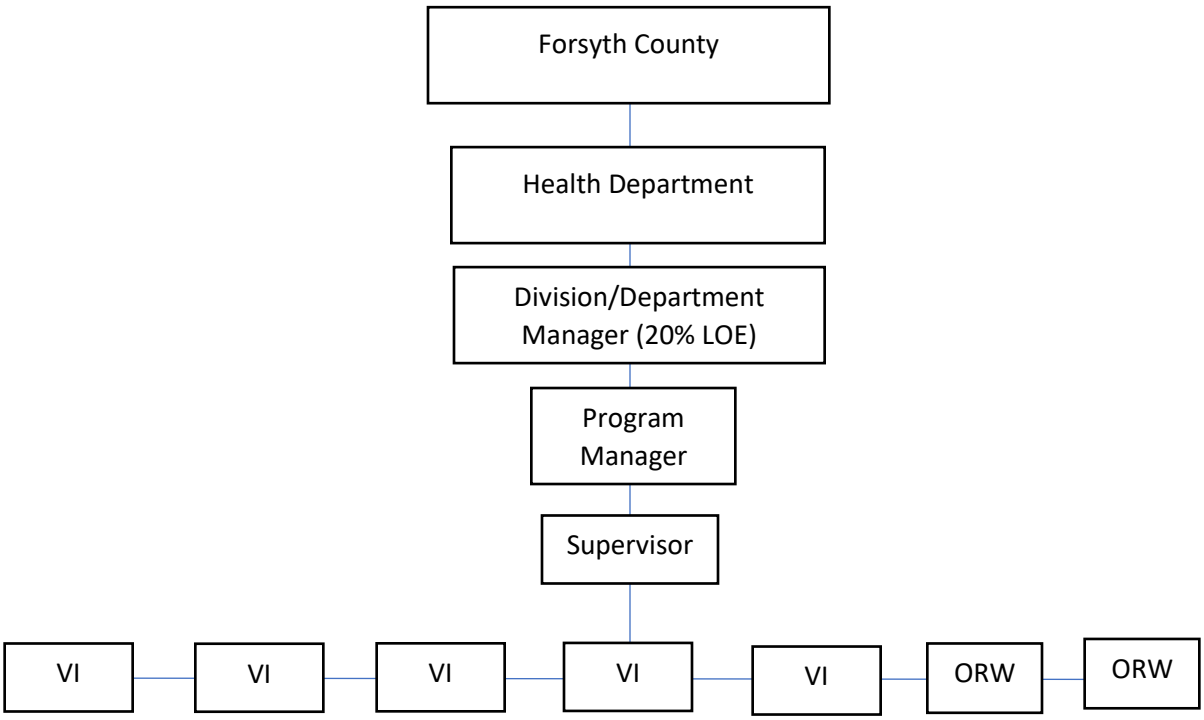
Based on the size and the scope of the violence in potential target areas, CVG recommends a program of 8-9 staff to cover the 222 area. This would be considered a "medium" size program. This staffing pattern would include one program manager, one supervisor, five Violence Interrupters and two Outreach Workers. The estimated budget for setting up a program of this size and scope is $ 564,750 to $614,750 a year for implementation depending on where the program is positioned. Forsyth County has identified America Recovery Plan as dollars to fund the program which will be administered by the County and subcontracted to a community-based organization to implement.

**Staffing Pattern + Implementation Structure**

Example 1: Community Based Organization Implementation




Example 2: Health Department Implementation




**Sample 1 Year Budgets**

Below are three sample line-item budget based on other programs which have successfully implemented the CVG model (one for CBO, one for Health Department, and one for the hospital response program). Local costs and factors will need be considered to finalize the program budgets.

Sample 1 (CBO)

| LINE ITEMS | YEAR 1 |
|---|---|
| **SALARIES** (5VI @ 40K;2 OW@ 40K; 1 Supervisor @ 50k; Program Manager @ 50K) | **$380,000** |
| **FRINGE (20%)** | **$76,750** |
| **UNIFORMS** | **$2,000** |
| **COMMUNITY EVENTS** | **$20,000** |
| **PARTICIPANT ACTIVITIES/SUPPORT SERVICES** | **$20,000** |
| **TRANSPORTATION/TRAVEL** | **$4,000** |

| | |
|---|---|
| **RENT** | **$12,000** |
| **UTILITIES** | **$5,000** |
| **MOBILE PHONE SERVICE** | **$5,000** |
| **OFFICE SUPPLIES** | **$15,000** |
| **PUB ED MATERIAL** | **$25,000** |
| **TOTAL** | **$564,750** |

Sample 2 (Health Department)

| **LINE ITEMS** | **YEAR 1** |
|---|---|
| **Health Department Costs** (20% LOE of Department/Division Manager) | **$50,000** |
| **SALARIES** (5VI @ 40K;2 OW@ 40K; 1 Supervisor @ 50k; Program Manager @ 50K) | **$380,000** |
| **FRINGE (20%)** | **$76,750** |
| **UNIFORMS** | **$2,000** |
| **COMMUNITY EVENTS** | **$20,000** |
| **PARTICIPANT ACTIVITIES/SUPPORT SERVICES** | **$20,000** |
| **TRANSPORTATION/TRAVEL** | **$4,000** |
| **RENT** | **$12,000** |
| **UTILITIES** | **$5,000** |
| **MOBILE PHONE SERVICE** | **$5,000** |
| **OFFICE SUPPLIES** | **$15,000** |
| **PUB ED MATERIAL** | **$25,000** |
| **TOTAL** | **$614,750** |

Sample 3 (Hospital Response Program)

| LINE ITEMS | YEAR 1 |
|---|---|
| **SALARIES** (3 Hospital Responders @ 40K; 1 Supervisor @ 50k) | **$170,000** |
| **FRINGE (20%)** | **$34,000** |
| **UNIFORMS** | **$1,000** |
| **TRANSPORTATION/TRAVEL** | **$5,000** |
| **MOBILE PHONE SERVICE** | **$5,000** |
| **OFFICE SUPPLIES** | **$15,000** |
| **TOTAL** | **$230,000** |

**Cure Violence Technical Assistance Plan**

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

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

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

(2) On-Board Training:

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

(3) Recruitment and Hiring of Staff:

*To ensure uniform recruitment and hiring practices. The CVG model uses hiring panels to hire all violence interrupters and outreach workers which include representatives from the implementing agency (i.e., CVC and representatives from health department), community-based partner organizations (CBO), local faith leaders, community residents, and law enforcement, to ensure that the best candidates are selected for each target area. These following are tools which are used to ensure the best candidates are recruited and selected:*

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

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

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

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

(4) 40-hour Program Management Training:

*The Management Training is conducted to impart management-level staff with critical knowledge, skills, strategies, and insights specific to managing a health intervention, frontline staff (Violence Interrupters & Outreach workers), strategic recruitment and deployment of staff, building a strong team, creating a positive work environment, enforcing accountability, mobilizing the community and shifting community norms that perpetuate violence. This training is designed to prepare management for providing oversight*

*of the day-to-day operations, including potential programmatic challenges, strategic planning and the use of data to guide the work and problem solving based upon nearly 20 years of programmatic experience, current staff and community dynamics.*

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

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

(6) 16-hour Database Training:

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

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

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

(8) Quarterly Booster Training/Site Certification visits:

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

(9) 24/7 Emergency Assistance

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

**CONCLUSION**

Cure Violence Global would like to acknowledge the tremendous support and assistance of the Forsyth County staff and the Cure Violence Steering Committee in completing the assessment process. It would not have been possible without the group's tenacity and dedication. CVG strongly believes that there is an opportunity for the model to make a substantial contribution to the Forsyth County and the City of Winston-Salem overall efforts to reduce violence. CVG will meet with Cure Violence Steering Committee on January 12th, 2022, to review the findings of this report and answer any remaining questions.