

Disparity Impact Statement: Victims of Retaliatory Violence

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Janelle Duda-Banwar, PhD jmdgci@rit.edu
Assistant Research Professor, Center for Public Safety Initiatives

Irshad Altheimer, PhD ixagci@rit.edu
Director, Center for Public Safety Initiatives
Associate Professor, Department of Criminal Justice

INTRODUCTION

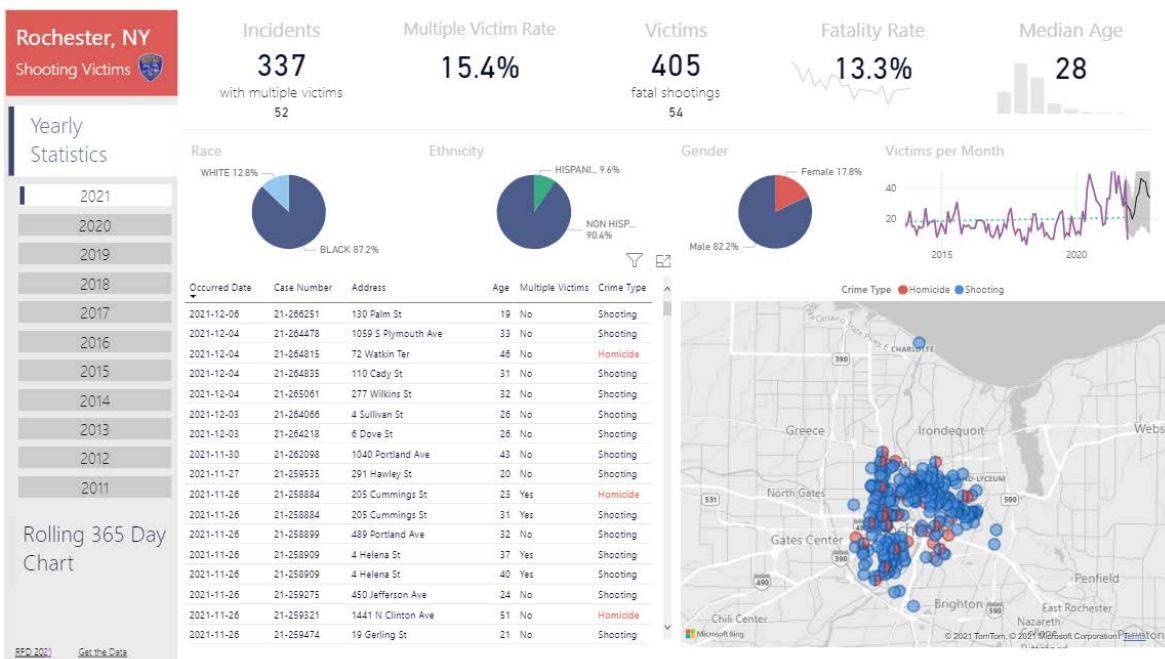
The Center for Public Safety Initiatives was recently awarded a grant by the Greater Rochester Health Foundation to develop a coordinated services hub for victims of retaliatory violence. This paper is the first in a series of working papers that will provide information related to this project. The focus of this paper is an explanation as to why this topic is important and a description of who is disparately impact by violence. Thus, a disparity impact statement (DIS) was developed to better understand the problem of retaliatory gun violence in Rochester, NY. The DIS format was adapted from SAMHSA in order to concisely and succinctly identify the population, describe the disparity, outline the planned intervention AKA quality improvement plan, and ensure that cultural health is central to the effort.

DESCRIPTION: POPULATION AND DISPARITY

By the end of December 2021, Rochester experienced 349 shooting incidents involving 419 victims. In 2020, there were 335 shooting victims involved in 267 shooting incidents. Based on these recent years of data, Rochester has a shooting victim rate of nearly 200 shooting victims/100,000.

Similar to urban communities across the U.S., Rochester has experienced a recent uptick in violence, specifically, gun violence. While the increase is alarming, not everyone has the same likelihood of being a victim of community violence. The majority of gun violence victims are male (82%) and Black (87%). The median age is 28 years old; in previous years it has hovered around 26 years old. While the media highlight young people involved in gun violence (e.g., [Freile, Bell, & Cleveland](#), November 2021), people in their 30s are consistently involved in violence as well. Yet, the focus continues to be on youth violence and subsequent youth violence interventions. There is a need to prevent youth violence, but while doing so, it is critical that services and interventions are also adopted and funded that serve individuals older than 25 years old. If we exclude this population, than we are ignoring HALF of the victims of gun violence in this community, which is more than 200 people in just 2021. Homicide is the leading cause of death for black males, 1-44 years old in the US, while for white males, homicide ranks 4th leading cause of death for males 1-18 years old and 5th leading cause for males 19-44 years. Gun violence disproportionately affects Black men, their families, and their communities.

Below is a screenshot of the Shooting Victims dashboard updated by RPD Crime Analyst Staff in December 2021. The vast majority of shootings are non-fatal; during the first 11 months of 2021, there were at least 351 shooting victims that survived. These individuals likely have service needs, which may range from a safe place to stay, support to process the traumatic event and develop coping skills, dispute mediation, or even assistance on leaving a gang (part of the mediation process).



From the CERV Project¹ we identified some key information about local victims of retaliatory violence and their service needs. For this analysis, we identified victims who showed up to RGH for treatment of a violent injury due to retaliatory violence (identified through a risk assessment tool).

- 75% were treated and released, the remaining were hospitalized
- More than half were released within 4 hours, this includes those with gunshot wound injuries
- 67% are Black, 17% white, and 16% Latino
- 70% are male
- Nearly one-third received prior treatment for violent victimization at a local Rochester hospital, it is likely that even more were previously victimized, but did not receive medical treatment
- Of those eligible for CERV, about 40% were treated for a blunt injury, 40% for a stab wound, and 20% for gunshot wound
- The most frequently provided service was “safe housing”, followed by transportation (in many cases this was transportation to a safe place, using air fare, ride share, or bus fare), followed by supplies (e.g., food, toiletries, etc.)

Interviews with victims and their loved ones revealed feeling unwelcome at institutions, particularly medical facilities, as described by a mother:

It almost seemed like he was victimized again when he got there because it started seeming like the nurses and everyone once they found out he got shot they started acting like they were scared to come in the room. Like the whole treatment just kind of went in another direction where most of the time people come to the hospital they're treating them and showing some kind of compassion, well in his place it got to the point where they looked at him like he was a gang member.

¹ For more information on Community Engagement to Reduce Victimization (CERV), please see CERV Working Paper

This kind of treatment points to a wider culture of exclusion from these traditional systems for this population. The victims know they are feared and, they, themselves are often scared in the aftermath, but they are patched up and discharged without any connection or warm hand-off to any service providers, outside of medical follow-up (which only happens sometimes). Victims and their loved ones quickly learn that services broadcast as being available to them, actually are not. Thus, the only intervention is medical intervention, which we know is not enough to prevent future violence, including retaliation.

Medical intervention should not be ignored, demoted, or pushed aside. Keeping people alive and with fewer long-term complications should continue to be a priority that receives investment². However, medical care is just one of many needs that these victims have, yet these other needs (e.g., emotional, basic needs, safety, etc.) go unaddressed. The lack of investment for decades in comprehensive wrap-around services has contributed to where we are now.

There are major gaps and shortcomings in health and human service systems when it comes to supporting victims of violence and intervening to prevent further victimization. These include:

1. low rates of post-discharge safety plans and referrals to follow-up and community services for violence victims who present at local emergency departments
2. Inadequate coordination of wrap-around services after discharge, and in some cases eligibility exclusions and other systemic barriers that prevent victims from accessing critical services, and
3. Lack of trauma-informed (including culturally relevant) responses and services that effectively address symptoms of trauma in victims as well as family members or other surrogates.

While this work is heavily planning focused, we anticipate piloting this process with 5-10 cases once processes have been developed and agreed upon. Piloting a small number of cases will allow for careful review and consideration of each step, quick identification of gaps, and following cases in real time. We will select cases based on diverse factors so that we do not just test one type of case. For example, we will plan to include the three main injury types (blunt trauma, stab wound, gunshot wound) and both younger and older individuals. The full coordination will then be built out from this pilot.

QUALITY IMPROVEMENT PLAN

To address these gaps, steps need to be taken to create a comprehensive victim services project. The overall goal of this project will to improve comprehensive services for victims of violence. The aim of this project is to put an end to the current fractured system of care for this population through planning and piloting a service hub that provides comprehensive coordination of multi-tiered, multi-agency services for victims of violence and their surrogates. Services will address needs that are more immediate (e.g., follow-up medical care, dispute mediation, safe housing) as well as prolonged (e.g., other medical and behavioral health, employment and social services). The project should involve collaboration of several key stakeholders including Jordan Health Center, Monroe County Systems Integration, the City of

² There is still more work to be done in the medical sector, with CERV victims describing little access to painkillers when experiencing severe pain. As described by one of our CERV participants, *“No and I didn’t receive no pain medication, nothing, no after care instructions, that’s what I’m saying, I don’t feel they take care of people. I got stabbed four times and basically was like oh you’re stitched up, time to go home.”*

Rochester, the ROC Against Gun Violence Coalition, Ubuntu Village Works, Rise Up Rochester, SNUG and other community organizations.

A major part of the planning period will be to develop and finalize a quality improvement plan that can then be evaluated. This includes identification of indicators to not only determine success, but to also better understand and therefore respond to the victims' and community's needs. Building on CPSI's prior work in this area, below we list several activities that we believe will build towards a comprehensive and practical Quality Improvement Plan for serving this population.

- Identify stakeholders and convene regular meetings
- Develop a process across systems and stakeholders to: (1) triage, (2) provide a warm hand-off, (3) conduct dispute mediation (4) provide ongoing services, e.g., case management and (5) follow-up to address violence victims needs
- Leverage United Way's Systems Integration Project (SIP) to collaborate and coordinate across stakeholders focused on this population
- Identify trauma-informed work already being done in the community, at both the individual (e.g., trauma-informed counseling/support groups) and community level (e.g., service providers trained in trauma-informed approaches), and create a service provider list and work towards a best practices list
- Describe the current state of community violence prevention programming in the community (both funded and unfunded)
- Gather feedback from street outreach works/front line staff throughout the project
- Stay connected to and potentially influence NYS Department of Health's exploration of the use of Medicaid funds to bill for Violence Prevention Activities
- Build on Jordan Health's reputation in the community and intimate expertise with the local Rochester population to improve victim engagement, understand medical and behavioral health needs of victims, and best practice to improve retention
- Develop data sharing protocol across systems
- Develop and track data indicators across systems, at both the individual AND community level
- Engage the Public Health Department to declare violence as a public health issue and allocate resources to address the issue
- Incorporate engagement and service provision for loved ones/surrogates of violence victims
- Conduct regular check-ins with United Way's SIP community advisory council/board
- Make this work available and accessible to the community:
 - Through dissemination of CPSI working papers,
 - Post resources and materials online
 - Check-in with surrogates and victims to determine best way to share information
 - Leverage RIT and/or city and/or foundation community resources (communications grad student?) to develop a website that exists in perpetuity that hosts this information
- Pilot the Service Hub process with 5-10 cases
- Assess pilot and gradually move toward full project implementation
- Once we get to full implementation, additional activities will be identified (including data audits, dissemination of findings, and new provider onboarding)

ALIGNMENT WITH CLAS STANDARDS

This work will align with the Culturally and Linguistically Appropriate Services (CLAS) Standards developed by the Office of Minority Health within the Department of Health and Human Services. The National CLAS standards were created with the aim to, “improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly [diverse communities](#).” Fifteen standards were developed that flow from three main areas: governance, leadership, and workforce; communication and language assistance; and engagement, continuous improvement, and accountability; plus the principal standard: “Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.”³

While this is an organizational framework, we intend to use the standards to guide the work of the Services Hub for Violence Victims.

Governance, Leadership and Workforce: while stakeholders will be identified based on their employment position within institutions (i.e., decision makers), we will also recruit individuals directly impacted by gun violence who are representative of the population. Therefore, the project will recruit from community-based organizations that employ black and Latino males. Their role will include sharing their own experience with systems and providers, make suggestions for improvement, and challenge decision-makers’ assumptions, to name a few. These individuals will be compensated for their time.

Communication and Language Assistance: A comprehensive assessment will be conducted to identify what kinds of language assistance is offered from the participating service providers. The findings will be shared with the stakeholders and made public. Stakeholders with identified gaps will receive support from the group and guidance on how to make tangible change in their organizations.

Engagement, Continuous Improvement, and Accountability: We will ensure that as we conduct assessments of existing services, prospective services, etc., the focus is not only be on what the services are, but also how culturally and linguistically appropriate the services are. Demographic data will be tracked and reported out when possible, and when not possible, a description as to why the data are not available will be provided. Ongoing assessment of community assets and needs will be conducted throughout this project as they relate to gun violence reduction.

And we will close with the Principal Standard: *Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs:* As the Violence Victims Services Hub is developed and shifts into pilot phase, feedback will be sought directly from the clients themselves. Pilot participants will be asked about their experience and treatment in general, but they will also be asked specific questions that link directly back to the CLAS Standards. The process will be modified based on this feedback.

³ While these standards were developed with a focus on healthcare settings, they have also been adapted for behavioral health. OMH and SAMHSA collaborated to build on the National CLAS Standards to develop the [Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care \(Behavioral Health Guide\)](#). This is worth reviewing as well.