GUN VIOLENCE IMPACTED FAMILIES PROGRAM EVALUATION

Multnomah County, Oregon

AUTHORS

Taylor Geyton, PhD
Primary Investigator
Jingyi Luan, BA
Senior Research Assistant
Mykia Hernandez-Richardson, BA
Senior Research Assistant
Jasmin Alvarez
Research Assistant
Sade Robinson
Research Assistant

Scholarship-Praxis on Health and the Embodiment of Resistance and Equity

RESEARCH TEAM BIOGRAPHIES AND CONTRIBUTIONS

Dr. Taylor Geyton (Senior Researcher/PI)

Dr. Taylor Geyton (She/her) is an Assistant Professor in the School of Social Work at Portland State University. She is a Black woman from Baltimore, MD, and a first-generation college graduate. She completed her doctoral studies at Morgan State University in Baltimore, MD in 2021. During her studies, she was awarded the Council for Racial, Ethnic, and Cultural Diversity Doctoral Student Award in 2020 for her dissertation titled *Shattered Resilience: The Identity Formation of Black Women Activists.*

Dr. Geyton is a dedicated researcher committed to exploring the intersections of resistance, activism, and health equity among marginalized populations. She employs critical theoretical approaches and liberatory perspectives to gain a deep understanding of the systemic barriers faced by underrepresented communities. She operates a private therapy practice and has over 13 years of experience working in mental health with Black youth families and adults in Baltimore Maryland and Portland Oregon. Through qualitative and quantitative methodologies, Dr. Geyton's research ad practice highlights the unique challenges faced by marginalized individuals and communities in pursuit of mental health. Dr. Geyton strives to amplify their voices, advocate for their rights, and develop actionable solutions to advance health equity.

Dr. Geyton is the Primary Investigator (PI) and Lead Researcher for this project. In this role she facilitated training and guidance of all research assistants. Dr. Geyton took the lead on all aspects of the project including the drafting of the report.

Jingyi Luan (Senior Research Assistant)

Jingyi Luan (She/Her) is a Master of Social Work candidate at Portland State University, interning at the PSU's SHAC Counseling Department as a therapist and a research assistant at SHPERE Research Lab. She is an international student from Beijing, China, who has been studying in the U.S. for the past 13 years. She is a first-generation college student and graduated from the University of Nevada, Las Vegas, with a bachelor's in communication studies and minored in human services. She is also a member of the National Society of Collegiate Scholars.

As a researcher, Jingyi is interested in Intercultural Communications in clinical settings in order to provide advanced culturally diverse care to her clients. Jingyi bases her work on Critical Race Theory, Post-Colonialism, Liberation Psychology, and Intersectionality Theory to provide a robust understanding of various social events. Jingyi is passionate about understanding the "Asian" experience in different parts of the world, how colonization impacts racial development, and the importance of building critical consciousness and activating cross-racial solidarity. Jingyi is interested in pursuing a Ph.D. program in clinical psychology after getting her M.A. in social work; she is dedicated to providing mental health services and research studies to uplift marginalized communities.

Jingyi assisted with every facet of the project and provided supplemental information for the background section. Jingyi's status as an MSW in her advanced year gave her invaluable insight into the clinical implications of the findings. Jingyi assisted with the trial scoping review methods and with developing the scoping review protocol. Jingyi also assisted with the facilitation of the stakeholder focus group, cleaned the transcript for analysis, and she assisted with the analysis and interpretation of the qualitative data.

Mykia Hernandez-Richardson (Senior Research Assistant)

Mykia Hernandez-Richards (she/her) is a Master of Social Work candidate at Portland State University. She is a Black and Mexican woman from Portland, Oregon, and is a first-generation high school graduate and college student. Mykia is an alumnus of the University of Oregon where she double majored in Ethnic Studies and Women, Gender, and Sexuality Studies to obtain her Bachelor of Arts.

As a researcher, Mykia bases her work on Black Feminist Theory and structural approaches. Mykia is passionate about highlighting alternative expressions of Black womanhood and how societal and structural inequities in meaning-making limit dominant expressions of Black womanhood in American cultural production. With that, Mykia is motivated to use her education and expertise to limit the fungibility of Black women and expand dominant expressions of Black womanhood. She is passionate about expressions of Black

womanhood in cultural productions because she is a mother of two and wants her daughters to be able to see multiple versions of what a Black woman can be.

Mykia assisted with the trial scoping review of this project as well as to the qualitative process analyses. Mykia completed two participants interviews and cleaned the transcripts for analysis. Mykia also contributed to the themes and findings of the scoping review. Mykia was a co-facilitator of the focus group for stakeholders. Mykia also conducted two qualitative process interviews and cleaned the transcripts for analysis.

Jasmin Alvarez (Research Assistant)

Jasmin Alvarez is a Mexican American undergraduate student at Portland State University pursuing a B.S. in Anthropology with a minor in Indigenous Studies. She aspires to facilitate meaningful research that is led by, in constant collaboration with, and serves local communities. Working in the public sector, Jasmin could see first-hand the need for data and culturally relevant research to promote equitable allocation of resources and services. Jasmin is interested in the intersection between Mexican Indigenous affairs, community-based participatory research, and successful advocacy efforts within the public sector. Jasmin intends to continue to a graduate program to focus on Mexican Indigenous affairs and community-based participatory action research.

Jasmin assisted greatly with the scoping review screening and extraction process. Jasmin also contributed to the findings regarding outcomes of exposure to gun violence.

Sade Robinson (Research Assistant)

Sade Robinson is a first-generation African American woman scholar earning her bachelor’s degree in social work from Portland State University. Sade is an emerging researcher with interests in equity, and medical research. As a 2024 McNair scholar Sade is conducting original research on the experiences of Black women in academia as they relate to retention and well-being. Upon graduation in the spring of 2024, she intends to pursue equity research as her full-time career, dedicating her work to improving the experiences of marginalized and underrepresented communities.

Sade assisted with the process and interpretation of scoping review results, specifically the synthesis of common intervention characteristics.

SUMMARY

The Multnomah County Behavioral Health Division's Gun Violence Impacted Families Behavioral Health Response Team (GVIF) aims to provide mental health services for those at risk of or impacted by Gun violence through a community-based approach. Community violence is a significant public health crisis with extensive implications for mental, emotional, behavioral and social health outcomes among youth and families. (Ahmad et al., 2017; Dinizulu et al., 2020). People with multiple minoritized social identities, including race, gender, class, sexual orientation, and disabilities, have greater chances of being victims of community violence and "polyvictimization" (Gaylord-Harden et al., 2020). Therefore, this evaluative report will discuss the literature on gun violence interventions with Youth and families, provide an equity analysis and impact estimates over a five-year trajectory for GVIF, discuss the qualitative process analysis with first-hand accounts according to stakeholder s and service users, and posit a list of outcomes assessments to be implemented with program participants in order to track and record progress. The yields of these analyses are recommendations to the GVIF program pertaining to workforce expansion, training and cultural considerations, and the implementation of assessments.

ABBREVIATIONS

GVIF- Gun Violence Impacted Families Behavioral Health Response Team
NCS- Non-Culturally Specific
UnkCS- Unknown Cultural Specificity
AfrAm-African American
AfRef-African Immigrant/Refugee
Latine/SS-Latine/Spanish Speaking
Unk-Unknown

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INTRODUCTION

Organization of the report

Following an introductory chapter on the proposed evaluation including the subject, purpose, and process of the evaluation, a description of the methodologies employed, limitations, and the activities carried out in the award period is provided. The remainder of the report will present the findings organized according to the evaluation criteria and research questions, followed by implications and recommendations at the end of each section.

Evaluation Proposal

The Multnomah County Behavioral Health Division's Gun Violence Impacted Families Behavioral Health Response Team (GVIF) aims to provide mental health services for those at risk of or impacted by Gun violence through a community-based approach. The program is funded from the Multnomah County General Fund as well as through county allocated federal American Rescue Plan Dollars.

The objective of this evaluation was to assess the impact, relevance, and processes of the GVIF, and to develop recommendations for improvement and sustainability based on empirical evidence.

The Program evaluation includes: 1) desk review of the project documents and a scoping review on gun-violence and effective mental health response practices; 2) quantitative equity analysis that estimates the impacts of the BHRT Mental Health Program on racialized groups; 3) qualitative process evaluation that provides in-depth information about the impacts of the BHRTGIF Mental Health Program from the perspectives of the stakeholders and beneficiaries; and 4) review and compilation of assessment and intervention modalities for working with gun violence impacted families.

Evaluation process

The evaluation period was from February 2023 through March 2024, with the field work performed in June and October.

The scoping review was completed using Covidence software with the first literature search occurring in April 2023, and the final literature search occurring in February 2024.

The quantitative equity analysis included data provided by GVIF in August 2023, Data from the Multnomah County District Attorney's office From 2019-2023, Data from the OHSU Gin Violence Prevention Research Center from 2018-2023 and the US Census, the analysis was completed using IBM's SPSS software.

The qualitative process evaluation entailed one focus group of seven stakeholders identified by GVIF as well as two interviews with service users and their families identified by GVIF. The focus group took place at Portland State University School of Social Work in June 2023. It was attended by seven stakeholders, three research assistants, and one senior researcher. The interviews were completed in October 2023 by a graduate research assistant. See appendices for interview protocols.

Assessment and evaluation tools were identified through a review of the literature extracted during the scoping review process. Instruments were sorted into categories based on their function; Mental Health Screenings, Needs Assessments, Risks Assessments, Culturally Informed Assessments, and Community Assessments.

BACKGROUND

Youth Exposure to Community Violence

Community violence is a significant public health crisis (Dinizulu et al., 2020). Unfortunately, many American youth have consistent daily exposure to community violence. According to Dinizulu et al. (2020), 50-96% of children and adolescents who live in major urban areas have experienced exposure to various crimes, poverty, and violence in their neighborhoods. Community violence exposure includes witnessing, experiencing, or learning of any act that intends to cause physical harm against someone in the community(Tache et al., 2018). According to the US Department of Justice Programs, in 2019, more than 60% of youth in America were exposed to or victims of community violence. The US has the highest gun violence rate in the world, along with imprisonment, police spending, and medical disparities. Each year, over 40,000 people die from gunshot wounds, and over 100,000 are injured by gun-related violence. The burdens of community violence, especially gun violence, disproportionately affect marginalized and minoritized communities, especially African American youth, and adolescents (Armstrong & Carlson, 2019; S. Buggs et al., 2023). Research shows that gun violence ranks as the third leading cause of death among young people aged 15 to 24 in the US. However, it is the second leading cause of death for Black girls and young women and the primary leading cause for Black boys and young men. Despite Black youth making up only less than 1% of the population, they accounted for 18% of gun-related homicides (Buggs et al., 2022).

People with multiple minoritized social identities, including race, gender, class, sexual orientation, and disabilities, have greater chances of being victims of community violence and "polyvictimization" (Gaylord-Harden et al., 2020). Intersectional identities shape how trauma is experienced by people who are the victims of community violence. In the context of gun violence, individual, collective, and cultural responses arise. Individual trauma is the result of specific traumatic events that have impacted an individual through direct victimizaton or indirectly such as through the witnessing of abuse or the loss of a loved one. Collective traumas are traumatic events that have affected a group of people who belong to the same cultural group. These adverse events negatively affect each person within the collective and create bonds between each group member. Cultural trauma is the process that interprets and shapes a group's shared memories of trauma as a part of their collective cultural identity (Gaylord-Harden et al., 2020).

Individually, people who experience gun violence are at high risk of adverse mental and physical health. For example, survivors of gun-related injuries are at higher risk of developing Post-traumatic Stress Disorder (PTSD) and related symptoms than people who only experienced non-assaultive injuries such as car accidents (Brandolino et al., 2024). Moreover, PTSD is estimated to impact 20% of patients with gunshot wounds, and those patients are more likely to develop other symptoms such as; chronic pain, substance use, alcohol abuse, decreased daily physical functions, and overall reduced quality of life (Kagawa et al., 2020; Voisin DR et al., 2014; Voith et al., 2023). Trauma symptoms experienced by youth exposed to community violence include a combination of externalized and internalized events. Youth have been noted to have difficulty sleeping, increased aggression, sexualized behaviors, difficulty in interpersonal relationships, poor educational outcomes, and isolation from others after witnessing community violence. These are externalized manifestations of the trauma endured through community violence exposure. Internalized symptoms include low self-esteem, depression, anxiety, and fear. Studies show that more often, children and adolescents demonstrate externalized symptoms as a result of community violence exposure (Collins et al., 2013; Galovski et al., 2018; Tache et al., 2018; Voisin et al., 2015). Collins et al. (2013) proposed that many of the externalized presentations of trauma are motivated by feelings of fear, anxiety, depression, physiological hyperarousal, intrusive and frightening thoughts, feelings and images, and emotional numbness due to repeated exposures. According to Galovski et al. (2018), frequency, intensity, and duration of violent exposure make a difference in the manifestation of traumatic symptoms. Youth who are chronically exposed to violent environments will develop a sense of helplessness, hopelessness, and futurelessness. Some children believe they will not reach adulthood; this makes them more vulnerable and increases self-blame and retaliation (Collins et al., 2013).

Gun violence also impacts the places where the traumatic event took place; resulting in community/collective trauma (Buggs et al., 2022). Communities of color are disproportionately represented among gun violence statistics; at the community level, intersectional forces of oppression result in cyclical

violence that influences the community sense of safety (Armstrong & Carlson, 2019; Buggs et al., 2022). The symptoms within communities that indicate community/collective trauma include excessive police force, high incarnation rate, metal fences, intense security checkups at schools, sidewalk memorials, poor local economy, increased fast-food restaurants instead of fresh produce, disrupted social/interpersonal relations, and intergenerational trauma(S. A. L. Buggs et al., 2022). Notably many of these markers are evidence of socioeconomic disparity. Galovski et al. (2018) found that financial resources impact mental health outcomes following exposure to violence and that previous exposure is a risk factor for poor mental health outcomes. This, coupled with the understanding that communities experiencing social and economic inequities are disproportionately plagued with gun violence, is demonstrative of the conditions in which traumatic responses to repeated exposure to community violence can emerge (Santilli A et al., 2017). Moreover, Black youth are nine times more likely to attend schools that are located in neighborhoods with a recent gun-related homicide which may increase the likelihood of youth to carry firearms themselves and lead to higher death and injury rates (Buggs et al., 2022).

According to Armstrong & Carlson (2019), Cultural Trauma is formed through societal ideologies on race, gender, and class, social institutions, social support regarding resources within each community, and the responsiveness of legal and political systems. The effects of the corruption portrayed in the media have shown predominantly African Americans as victims of police corruption. Police brutality may also contribute to complex trauma for racial and ethnic minorities who are targets of multiple traumas, including but not limited to police brutality (Bor et al., 2018). The possibility of police misconduct and corruption increases in communities that are economically challenged and where the residents are ethnic minorities (Robinson & Seim, 2018). Circo et al. (2019) identified that youth also feared the police and potentially were victimized by the police. They found low satisfaction with police activity among individuals who endorsed a fear of victimization and varied responses among individuals who endorsed a history of victimization (Circo et al., 2019). Themes of racial pride and neighborhood cohesion emerged as protective factors for adolescents who are exposed to community violence in that where those elements are present they have fewer internalized and externalized symptoms of trauma (DiClemente CM & Richards MH, 2022).

Gun Violence in Multnomah County

Gun related incidents across Multnomah County increased 217% from 2019-2022 (*Board Updated on County Departments' Efforts to Combat Gun Violence*, 2023). Much of the data surrounding the increase in these events is reported the Multnomah County District Attorney's (DA) office, and specifically references the cases that were issued and prosecuted by the DA. The issue of gun violence in Multnomah county historically has been tied to drug and gang activity since the 1980's (Boland, 2007). Initiatives for prevention and intervention through legislation, policing, and community-based advocacy such as the Oregon Ceasefire implemented in 1994 have had minor impacts on crime and violence throughout the city however those results have been inconsistent (Yurk et al., 2001)(Yurk et. Al, 2001). Moreover, notably absent from the programs from a regulatory point of view are interventions that address the families, youth, and communities that are impacted by gun violence through culturally informed and specific methods. This is especially relevant given the development of mistrust between minoritized communities and police.

EVALUATION OBJECTIVE AND SCOPE

The project documents along with the scoping review on gun-violence exposed youth and mental health responses will provide the foundation on which focus group and interview questions with stakeholders and service users is developed, and will seek to answer the following research questions:

1. What are the overarching aims, key characteristics, and outcomes of community-based interventions designed to support families affected by community-based gun violence in the United States?
2. What are the overarching aims, key characteristics, and outcomes of *culturally specific* community-based interventions designed to support families affected by community-based gun violence in the United States?
3. What biopsychosocial, spiritual, and behavioral outcomes are experienced by youth exposed to community-based gun violence in the United States?
4. What *culturally specific* biopsychosocial, spiritual, and behavioral outcomes are experienced by Black, Latine, and African Immigrant youth exposed to community-based gun violence in the United States?

The quantitative equity analysis will be organized according to cultural specificity where applicable and will provide insight into the impact of GVIF on minoritized populations within Multnomah County to answer the research questions:

1. How does racial/cultural diversity, inclusion, and access to behavioral health services within GVIF compare to the broader demographics of Multnomah County, Oregon, among communities affected by gun violence?
2. What is the impact of GVIF on racialized groups impacted by GV in Multnomah County, Oregon.

The process evaluation includes feedback from stakeholders through focus groups and from service users through one-on-one interviews. The results of this thematic analysis will be presented according to the themes identified in the transcripts of the focus groups and interviews and will answer the research question:

1. What are the perceived benefits and deficits of the Gun Violence Impacted Families Behavioral Health Response Team (GVIF) program from the qualitative perspectives of stakeholders and service users, and how do these perceptions inform opportunities for program enhancement and community support.

Finally, the review of assessments and interventions for working with families impacted by gun-violence will be accomplished through an additional extraction item in the scoping review process. This review will be presented according to the function of the assessments identified and will answer the research question:

1. What evaluative and diagnostic assessments might GVIF employ to support individuals and communities affected by gun violence, considering factors such as cultural competence, trauma sensitivity, and alignment with program goals.

METHODOLOGY AND LIMITATIONS

Scoping Review

The scoping review was completed using Covidence software. Before completing the larger review, a trial review was conducted using Microsoft excel. Through the trial review themes and indicators for data extraction were identified.

This review included primary studies that evaluate the effectiveness of gun violence-focused programs, including randomized controlled trials, quasi-experimental studies, and observational studies. Studies published in the English language from 2013 to the present were considered. The review also included studies that focus on individuals affected by gun violence, including victims and individuals at risk of involvement. The review included studies that evaluate the effectiveness of gun violence-focused programs, including prevention programs, intervention programs, and rehabilitation programs. The programs must have had a specific focus on addressing gun-related violence.

The primary outcomes of interest identified through the trial review were reductions in gun-related activities among participants, reductions in neighborhood gun-related violence, including but not limited to homicide, assault, robbery, and illicit firearm activities, mental and behavioral health indicators such as endorsing symptoms of PTSD or delinquency, culturally specific outcomes regarding mental and behavioral health, assessment instruments to be used, community efficacy, peer-to-peer service delivery, changes in exposure to gun violence, recidivism rates, and reports of feelings of neighborhood safety.

Databases and Terms Searched

PubMed, PsycINFO, SocINDEX, and Web of Science were queried to gather relevant literature. The search strategy for each database was tailored according to the parameters indicated and encompassed a combination of keywords and subject headings pertinent to the research focus. The adaptation of the strategy for each database is crucial for maximizing the relevance of the retrieved literature. The primary areas of interest include gun and community violence exposure, gun and community violence prevention, gun and community violence interventions, and violence rehabilitation programs.

Search Terms. A set of search terms and key keywords were employed to optimize the search strategy and were developed through the manual trial of the scoping review. These include:

- Youth Gun Violence
- Community Violence
- Gun Violence Prevention
- Gun Violence Intervention
- Gun Violence Rehabilitation
- Gun Violence Mental Health
- Gun Violence Trauma
- Gun Violence AND Community

The utilization of these terms aimed to capture a comprehensive range of literature addressing various aspects of youth and gun violence intervention, prevention, and rehabilitation efforts. The combination of both subject headings and keywords enhances the sensitivity and specificity of the searches, ensuring a thorough exploration of the available literature on the specified topics.

Inclusion and Exclusion Criteria

Inclusion criteria encompass randomized controlled trials, controlled trials, surveys, observational studies, qualitative research, and evaluative studies. The specified topics include gun violence exclusively, mental health interventions, behavioral health interventions, culturally specific interventions (Latine, Black, Immigrant/Refugee, African especially Somalian), scales and assessment tools, statistics/outcomes of exposure, risks and protective factors, program/intervention protocols, gangs and gang involvement, and co-morbidities.

Exclusion criteria pertain to systematic reviews, meta-analyses, content analyses, and policy analyses. Additionally, the excluded topics involve domestic violence, sexual violence, intimate partner violence, studies

focusing outside the United States, incarcerated or detained populations, research older than 10 years, policing-related studies, bullying, cyberbullying, sexual health/HIV, substance use and drug use, and non-gun violence.

PRISMA

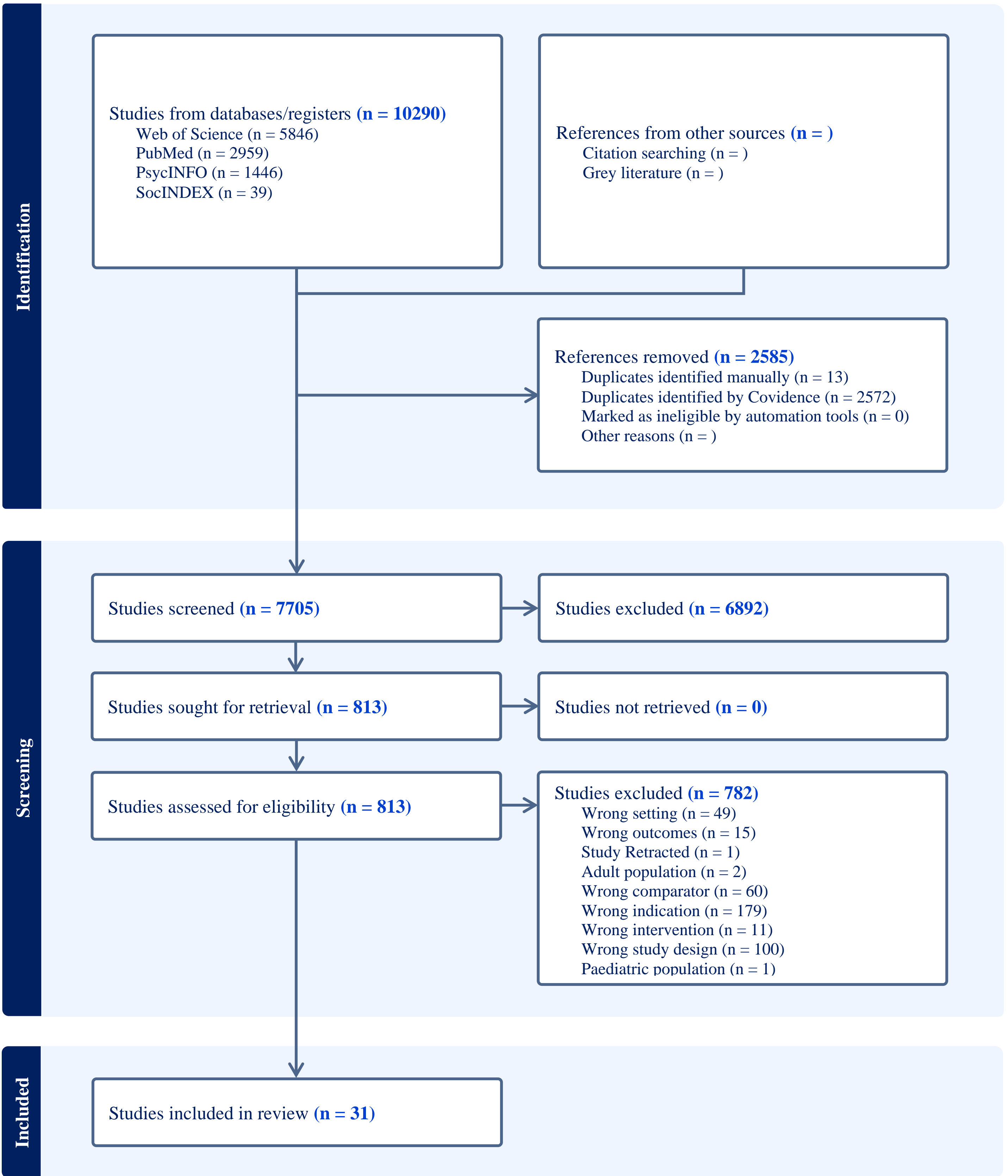
After entering the listed search terms into each database and applying filters to the indicated parameters 10290 references were imported to Covidence for screening as 10290 studies 13 duplicates were identified manually and 2572 duplicates were identified by Covidence.

The removal of duplicates left 7705 studies to screened against title and abstract. Titles and abstracts that did not meet the criteria were screened out yielding 6892 studies excluded.

The remaining 813 studies were assessed for full-text eligibility, which entailed a full review of the text for relevance. Full-text review resulted in 782 studies being excluded with the following breakdown of justifications; 339 studies were excluded due to "Full Text Not Available", 179 studies were excluded due to being about adjacent topics that were not the target of this review or having the "Wrong indication", 100 studies were excluded due to "Wrong study design", 60 studies were excluded due to "Wrong comparator", 49 studies were excluded due to "Wrong setting", 25 studies were excluded due to "Wrong patient population", 15 studies were excluded due to "Wrong outcomes" , 11 studies were excluded due to "Wrong intervention", 2 studies were excluded due to "Adult population", 1 study was excluded due to "Pediatrics population", 1 study was excluded due to "Study Retracted"

The exclusion of those studies left 31 studies included in the scoping review to inform and frame the assessment. The PRISMA diagram below depicts the inclusion and exclusion at each process.

Figure 1. Scoping Review PRISMA Report



Quantitative Equity Analysis

The Quantitative Equity Analysis was completed by the Senior Researcher, Dr. Taylor Geyton. The analysis utilized data collected from the Multnomah County District Attorney's Office regarding Cases issued involving a firearm, admissions to emergency departments in Multnomah County reported by the OHSU Gun Violence Prevention Center led by Dr. Kathleen Carlson, and deidentified program data provided by GVIF personnel on August 23, 2023. The analysis was carried out using a series of crosstabulations and probability calculations using IBM SPSS software in order to determine the potential impact of the program based on the estimated rates of Gun Violence in the County.

Qualitative Process Analysis

Recruitment and Data Collection

Stakeholder Focus Group. The stakeholder focus group was facilitated by One senior researcher, Dr. Taylor Geyton, two Graduate Research Assistants, Mykia Hernandez-Richardson, and Jingyi Luan, and two Undergraduate Research Assistants, Yoselin Aguirre, and Karisa Yuasa. Stakeholders were identified by GVIF personnel who provide the names and contact information to the research team. Stakeholders were emailed and invited to two different dates for the focus group at Portland State University. Stakeholders participated in once focus group at Portland State University on June 16th, 2023, from 11:00 am PDT to 12:30 pm PDT. Dr. Geyton provided the discussion questions to the group and redirected discussions as needed. Mykia was responsible for Memoing and taking notes throughout the process and making note of recurrent themes or observations about the content of the conversations. Jingyi was responsible for recording the behavior and body language of focus group participants throughout in order to add context to the content of the recorded transcripts. Yoselin and Karisa were responsible for capturing the audio recording of the focus group discussion and for using the automated software for transcription. All research assistants were tasked with asking clarifying questions.

Focus group participants were concerned with the possibility of GVIF losing funding and no longer existing, this concern made it difficult to keep the conversation focused on the process evaluation and leant to a rich discussion on the strengths and challenges of the program in its current state. Additionally, discussions about cultural specificity revealed the need for deeper process conversations that couldn't be had in one focus group. Some participants spoke with thick accents, and in lower tones than could be heard by the recording devices, this leant to inaudible points of the focus group interview that had to be inferred through memory or omitted altogether.

Service User Semi-Structured Interviews. In order to recruit families and youth for process interviews the research team provided fliers and contact information for program participants to reach out if they were interested in providing feedback about the program. The flyers and recruitment language were shared with the GVIF team on May 15th, 2023. After several weeks of not receiving any contact, the research team in collaboration with the GVIF team amended the recruitment process to allow the team to reach out to participants. The Portland State Institutional Review Board approved the amended recruitment process on July 21, 2023. The new process required GVIF to obtain consent to release information from their interested clients and then to provide the names and contact information so that the research team could reach out to them.

On October 3, 2023, GVIF provided a list of names for 10 participants and their families who had consented to be contacted and interviewed about their experiences with GVIF. Only 9 of the listen participants had accompanying contact information. On October 15th the PSU research team began outreach to the clients on the list. On November 8th the team requested a no-cost extension to allow time to interview families and analyze the results as very few families had responded to our efforts. Families with email preferences were contacted via email while those with phone numbers were contacted via phone. One participant was identified as Spanish speaking, as a result a research assistant fluent in Spanish was added to the research team, Jasmin Alvarez. Jasmin translated recruitment materials including consent forms and interview questions and submitted the translated forms through the institutional review board for approval. The IRB approved the forms and Jasmin's addition to the project on December 27, 2023.

Very few participants or families responded to the outreach efforts of the research team. Some responded declining the invitation to discuss their experiences while others did not respond at all. One youth

and one family member participated in process interviews with a graduate research assistant Mykia Hernandez-Richards On October 26, 2023. These interviews were held over the phone and audio recoded and transcribed using Otter.ai software.

Data Analysis

Transcripts from the focus group and all service user interviews were analyzed using thematic analysis and a combination of inductive and deductive coding. Deductive codes were identified through the scoping review process and included prevention, collective and community efficacy, peer mentorship, and interprofessional collaborations. Inductive codes were established through a blinded coding process completed by the Senior Researcher and a Senior Graduate Research Assistant; Dr. Taylor Geyton and Jingyi Luan. The Researchers met after coding each transcript to discuss the emergent themes and to make sense of these themes in the larger context of the GVIF program.

Codes were organized into larger themes and subthemes were identified during research team meetings. For triangulation and to bolster trustworthiness these interpretations were shared across the research team and discussed in team meetings where added nuance and context were considered. Finally, the notes, memos, and behavioral observations recorded during the focus group were used to triangulate the researchers' interpretations of the data and to add to the contextual understanding of the themes that emerged.

Review of Assessment Tools

Tools and outcome Measures were identified through the scoping review process. The extraction phase of the scoping review included an item where the tools and measures used in studies and evaluations of programs and initiative nationwide were recorded. Using these records the senior researcher, Dr. Taylor Geyton, compiled a list and categorized the tools according to their functions as either diagnostic or evaluative. Dr. Geyton then researched each assessment tool in order to write up a description and recommendation for use within GVIF.

EVALUATION FINDINGS

Scoping Review

The scoping review yielded a review of 31 Articles about youth and communities' exposure and experiences of Gun Violence in the US from 2013 through the present. The characteristics of these articles and a synthesis of the data they represent is presented here.

Location

Articles in this review were based in various cities across the united states. Among these, Chicago, Illinois, emerges as a prominent location with four studies focused on various neighborhoods within the city. Additionally, Boston, Massachusetts, and Flint, Michigan, each have two studies conducted within their respective cities. Other cities featured include Omaha, Nebraska; Phoenix, Arizona; Bridgeport and New Haven, Connecticut; Baltimore, Maryland; and a large midwestern city, though specific locations within these areas are not specified. Furthermore, the data encompasses broader regions such as California, Delaware, and the southeastern United States, without pinpointing specific cities or locales. One study extends its scope to a national level, covering six randomly selected cities across the United States, while another study's location remains unspecified within the USA. All locations were identified as urban environments and sustained disparity in socioeconomic status, over-representation among minoritized populations, and higher rates of unemployment and underemployment.

Sampling

Studies included were restricted to those including persons impacted by gun violence or community violence in the adolescent and young adult age range. Among the 31 studies examined, adolescents aged 12-17 years old comprised the largest proportion of participants, accounting for 45.2% of the studies. Young adults aged 18-25 years old constituted 25.8% of the studies, while adults aged 26 years and older represented 12.9%. Children aged 6-11 years old were involved in 25.8% of the studies. This reflects the interest and focus of the review on youth and young adults.

Regarding race and ethnicity, the largest proportion (35.5%) of the studies focused on individuals and communities identified as Black or African American. The next largest representation was studies that did not specify or included multiple races and ethnicities in their sample which were 32.3% of all studies included. One study had a primary sample target of Somali Refugees, this is a significant observation as available literature and research on this population is limited.

Study Designs

Articles included in this review employed various research methodologies and study designs, including secondary data analysis, longitudinal studies, cross-sectional studies, randomized controlled trials, qualitative research, program evaluations, and prevalence studies. These methodologies were employed across a range of topics and populations, such as children, families, neighborhoods, Black women, and survivors of traumatic events. Some studies focused on specific datasets or interventions, while others utilized comparative analyses or multiple case studies. Overall, there is a diversity of research approaches and designs used in empirical studies about youth and young adults and gun violence.

Randomized controlled trials and qualitative studies each represented 16.1% of the indicated methodologies, while longitudinal studies, cross-sectional studies, secondary analyses, and program evaluations each accounted for 9.7%. Finally, 26% of the articles utilized other methodologies, including combined fixed-effects and time-series design, diagnostic test validation, survey methods, text and opinion, prevalence study, comparative content analysis, and multiple case study designs.

Stated Purpose

Focus on Community Violence. Approximately 48.3% of the articles included for this review focused on understanding and addressing the impact of community violence on various demographic groups, particularly youth, and marginalized communities(Abdul-Adil & Suárez, 2022; Ahern et al., 2018; Ahmad et al., 2017; Assari et al., 2015; Aubel et al., 2023; Bagley et al., 2016; Borofsky et al., 2013; Bountress et al., 2021; Boyd et

al., 2022; Browning et al., 2014; Busby et al., 2013; Carreras et al., 2019; Gebo & Franklin, 2023; Griggs et al., 2019; Stritzel et al., 2021; Whipple et al., 2021).

Examination of Resilience and Coping Mechanisms. Notably 22.6% of the studies aimed to explore how individuals, particularly Black youth, navigated and coped with exposure to community violence. This includes investigating the role of familial and environmental factors in promoting resilience and mitigating negative mental health outcomes(Betancourt et al., 2015; Borofsky et al., 2013; Boyd et al., 2022; Bray et al., 2020; Browning et al., 2014; Carreras et al., 2019; Stevens-Watkins et al., 2014).

Impact on Mental Health and Well-being. About 32.2% of the studies included for review sought to understand the relationship between exposure to community violence and mental health outcomes, such as depression, anxiety, and post-traumatic stress symptoms (PTSS), among adolescents and young adults (Assari et al., 2015; Bagley et al., 2016; Borofsky et al., 2013; Boyd et al., 2022; Carreras et al., 2019; Gebo & Franklin, 2023; Griggs et al., 2019; Stevens-Watkins et al., 2014; Webb et al., 2014).

Evaluation of Intervention and Prevention Programs. Of the 31 Articles included 16% focused on evaluating the effectiveness of intervention programs, such as trauma-focused cognitive-behavioral therapy (TF-CBT) and after-school programs, in mitigating the negative effects of community violence and promoting positive outcomes among youth (Abdul-Adil & Suárez, 2022; A. M. Fox et al., 2015; Gebo & Franklin, 2023; Jeffries et al., 2019; Webb et al., 2014).

Exploration of Neighborhood Factors. Approximately 22.6% of the articles examined how neighborhood characteristics, such as safety perceptions, collective efficacy, and socio-economic status, influence exposure to community violence and its impact on individuals' well-being (Ahmad et al., 2017; Assari & Caldwell, 2017; Aubel et al., 2023; Boyd et al., 2022; Gibson et al., 2014; Stritzel et al., 2021; Whipple et al., 2021).

Policy Implications and Program Development. Fewer articles, 9.6% aimed to inform policy and program development by identifying effective strategies for preventing and addressing community violence, enhancing community resilience, and promoting positive youth development (Abdul-Adil & Suárez, 2022; Adams et al., 2021; Goldstick et al., 2017).

Methodological Advances. About 9.6% of included studies focused on methodological advancements, such as developing clinical screening tools for identifying individuals at risk of firearm violence and evaluating data sources for surveillance and research purposes (Adams et al., 2021; Goldstick et al., 2017; Whitehill et al., 2014).

Intersectionality and Cultural Factors. Finally, about 13% of the articles explored how factors such as race, ethnicity, gender, and culture intersect with experiences of community violence and influence individuals' coping strategies, mental health outcomes, and access to resources and support (Assari et al., 2015; Assari & Caldwell, 2017; Betancourt et al., 2015; Bulanda & McCrea, 2013; Busby et al., 2013; Carreras et al., 2019; Gibson et al., 2014; Griggs et al., 2019; Stevens-Watkins et al., 2014; Whipple et al., 2021).

Mental and Behavioral Health Outcomes of Exposure to Gun Violence

Of the 31 studies, 35.5% discussed mental health or culturally specific mental health outcomes. Mental health outcomes discussed include **anxiety** which was mentioned in 54.5% of all studies discussing mental health, **PTSD** was identified in 45.5%, **depression** was identified in 54.5%, **fear** was identified in 27.3%, and **self-esteem** was identified in 9%. Culturally specific mental health outcomes identified were a higher risk for Major Depressive Disorder in a study among African American males when neighborhoods were perceived as unsafe.

Behavioral health outcomes were discussed in 38.7% of all studies reviewed including culturally specific behavioral health outcomes. Of the studies that included behavioral health outcomes, 25% discussed **aggression**, including parent-child aggression, which affected **school engagement**. Other behavioral health outcomes present in the studies included **substance use**, **delinquency**, **gang affiliation**, **weapon carrying, sleep disturbance**, and **neighborhood engagement**. Culturally specific behavioral outcomes included impaired **interpersonal skills** and **John Henryism** (Stevens-Watkins et al., 2014).

Characteristics of Gun Violence Interventions

Numerous interventions to address and mitigate the impact of violence exposure on youth, families, and communities shared similarities in their approaches. Specifically, the importance of strong parent-child relationships and high levels of parental bonding was underscored. Additionally, school-based interventions predominated throughout much of the research. Notable interventions included after-school programs aimed at fostering constructive relationship skills, trauma-focused cognitive behavioral therapy (TF-CBT), model injury and violence prevention programs, and the integration of organizations into the community fabric. Furthermore, specific intervention programs were evaluated and discussed including a neighborhood trauma team network (NTTN) which was identified as a noteworthy intervention approach within this context.

Of the 31 articles included for review and extraction 38.7% involved interventions with youth impacted by community violence. Shared characteristics of interventions in community involvement, school-based interventions, family systems, Cognitive Behavioral Therapies, and advocacy. Many of the interventions included an amalgamation of several characteristics.

Community-Involved Interventions were present in 41.6% of the studies and included those that were community based which were characterized by implementation in the community rather than in a clinic or office setting; community-led, which involved community members directing and implementing the intervention; and community-centered, in which the interventions were based on the qualitatively expressed needs of the community and implemented in accordance with the community's stated desires (Abdul-Adil & Suárez, 2022; Bulanda & McCrea, 2013; A. M. Fox et al., 2015; Gebo & Franklin, 2023; Griggs et al., 2019). **School-based interventions** characterized 50% of the interventions identified. School-based interventions have high rates of implementation success with minoritized youth and are often a successful access point (Abdul-Adil & Suárez, 2022; Boyd et al., 2022; Bray et al., 2020; Bulanda & McCrea, 2013; Griggs et al., 2019; Whipple et al., 2021). **Family Systems Interventions** were characterized in 41.6% of interventions. This characteristic underscores the importance and relevance of family cohesion and family centered work in culturally adaptive and trauma informed interventions (Abdul-Adil & Suárez, 2022; Assari et al., 2015; Carreras et al., 2019; Griggs et al., 2019; Webb et al., 2014). **Cognitive Behavioral Therapies (CBT)** were discussed explicitly in 16.6 % of interventions reviewed (Abdul-Adil & Suárez, 2022; Webb et al., 2014). Other interventions that were characterized by elements of CBT such as emotional regulation, acceptance, behavioral activation, and social-emotional learning made up 25% of interventions overall (Bulanda & McCrea, 2013; Carreras et al., 2019; Griggs et al., 2019). Finally, **Advocacy-based interventions** appeared in 33% of interventions. Advocacy for and with youth, families, and communities impacted by community violence and gun violence have been indicated as effective engagement strategies that bolster participation and strengthen interventions (Abdul-Adil & Suárez, 2022; Bulanda & McCrea, 2013; Gebo & Franklin, 2023; Griggs et al., 2019).

Analysis

The following themes were developed from the results of the scoping review characterizing the published evidence of interventions in cities across the US as well as consistent characteristics of said interventions.

Impact and Vulnerabilities. This theme encompasses discussions on the mental health impact of gun violence, including anxiety, stress-related disorders, PTSD, and depressive symptoms. It also includes discussions on the

risk factors and vulnerabilities associated with exposure to gun violence, such as family structure, community environment, and individual characteristics.

Given the yields of the scoping review encompassing discussions on the impact and vulnerabilities of individuals, families, and communities, GVIF should emphasize community- and family-based therapeutic structures toward the development of social support and collective efficacy. Moreover, GVIF should continue to train clinicians and service providers in evidence-based mental and behavioral health interventions. Further, GVIF's focus on the family dynamic and on the importance of community incorporation is bolstered by this theme.

Intervention Strategies and Protective Factors. This theme focuses on intervention strategies aimed at mitigating the negative effects of gun violence. It includes discussions on providing access to mental health services, supporting families, adapting evidence-based practices, and promoting community engagement and collective efficacy. Additionally, it highlights protective factors such as school climate, parental bonding, and community support.

In discussing the accessibility of treatment, GVIF's community-based model offers services to families in the communities where they live and learn every day. This theme is especially relevant in that adaptation of evidence-based practices allows for client specific tailoring of treatment and approach. We recommend that GVIF sustain this practice as it expands on the accessibility of treatment as well. Finally, this theme encompasses social domains such as school, family, and community. GVIF would do well to position their services within each of these domains for the sake of community integration and accessibility.

Cultural Sensitivity and Community Collaboration. This theme underscores the importance of cultural and linguistic sensitivity in interventions, particularly for minority and refugee communities. It also emphasizes the need for collaboration with the community and leveraging community resources and partnerships for successful intervention implementation. Additionally, involving youth in intervention design and implementation is highlighted as a way to improve engagement and effectiveness.

Building from the previously identified themes, cultural specificity and community involvement are two characteristics that have demonstrated success working with youth who have experienced community-based gun violence. Given the disproportionalities extant in many minoritized communities and cultures within the US, and the unique ways that culture is influenced by social and environmental contexts, GVIF's culturally specific initiatives should take care to involve the community, and moreover to involve persons who are from the community as agents and providers.

Quantitative Equity Analysis

Public data on Gun Violence exposure and rates in Multnomah County is limited. The data presented here has been estimated based on the reports of the Multnomah County District Attorney's Office regarding cases issued involving gun violence, and a statewide firearm injury report from the OHSU Gun Violence Prevention Research Center led by Dr Kathleen Carlson, Ph.D.

Multnomah County District Attorney's Office

The provided tables below display the distribution of race, age group, and gender among cases issued by the Multnomah County District Attorney regarding gun violence incidents between 2020 and 2024. The counts are based on data provided by the DA's office.

Figure 2. Multnomah County DA Race Frequencies

Race

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Black	422	42.6	42.6	42.6
	White	401	40.5	40.5	83.0
	Hispanic	129	13.0	13.0	96.1
	Asian	30	3.0	3.0	99.1
	Native American	3	.3	.3	99.4
	Unknown	6	.6	.6	100.0
	Total	991	100.0	100.0	

The majority of cases, constituting 42.6% of the total, involve individuals identified as Black. Following closely, individuals identified as White account for 40.5% of the cases. Hispanic individuals represent 13.0% of the cases, while Asian individuals are involved in 3.0% of the cases. Native American individuals are identified in a small fraction, comprising only 0.3% of the cases. Cases where the race is unknown make up the remaining 0.6%.

Figure 3. Multnomah County DA Age Group Frequencies

Age Group

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0-17	7	.7	.7	.7
	18-25	313	31.6	31.6	32.3
	26-35	338	34.1	34.1	66.4
	36-45	196	19.8	19.8	86.2
	46-55	87	8.8	8.8	95.0
	56+	50	5.0	5.0	100.0
	Total	991	100.0	100.0	

The largest age group represented in the dataset is individuals aged 26-35, accounting for 34.1% of the total cases. Following closely, individuals aged 18-25 constitute 31.6% of the cases, making it the second-largest age group. The age group of 36-45 makes up 19.8% of the cases, while individuals aged 46-55 represent 8.8% of the cases. Those aged 56 and above contribute 5.0% of the total cases, indicating a smaller but notable presence. Notably, the youngest age group, 0-17, has the smallest representation with only 0.7% of the cases.

Figure 4. Multnomah County DA Gender Frequencies

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Female	80	8.1	8.1	8.1
	Male	911	91.9	91.9	100.0
	Total	991	100.0	100.0	

The overwhelming majority of cases involve male individuals, comprising 91.9% of the total cases. In contrast, female individuals are represented in a smaller proportion, accounting for only 8.1% of the cases.

Among individuals aged 0-17, the majority of cases involve White individuals, accounting for 57.1% of the cases within this age group, followed closely by Black individuals at 42.9%. No cases involve individuals of Hispanic, Asian, Native American, or unknown race within this age group.

In the 18-25 age group, Black individuals represent the largest proportion of cases at 47.9%, followed by White individuals at 27.2% and Hispanic individuals at 19.5%. A small percentage of cases involve Asian individuals (3.8%), while no cases involve Native American or individuals of unknown race in this age group.

For individuals aged 26-35, Black individuals continue to be prominently represented, accounting for 44.7% of cases within this age group. White individuals comprise 39.9% of the cases, while Hispanic individuals represent 13.0%. There are minimal cases involving Asian individuals (2.4%), and none involving Native American or individuals of unknown race.

In the 36-45 age group, Black and White individuals are the most prevalent, constituting 36.2% and 50.0% of cases, respectively. Hispanic individuals represent 8.2% of cases, while Asian individuals account for 4.1%. Native American individuals and cases with unknown race are minimal in this age group.

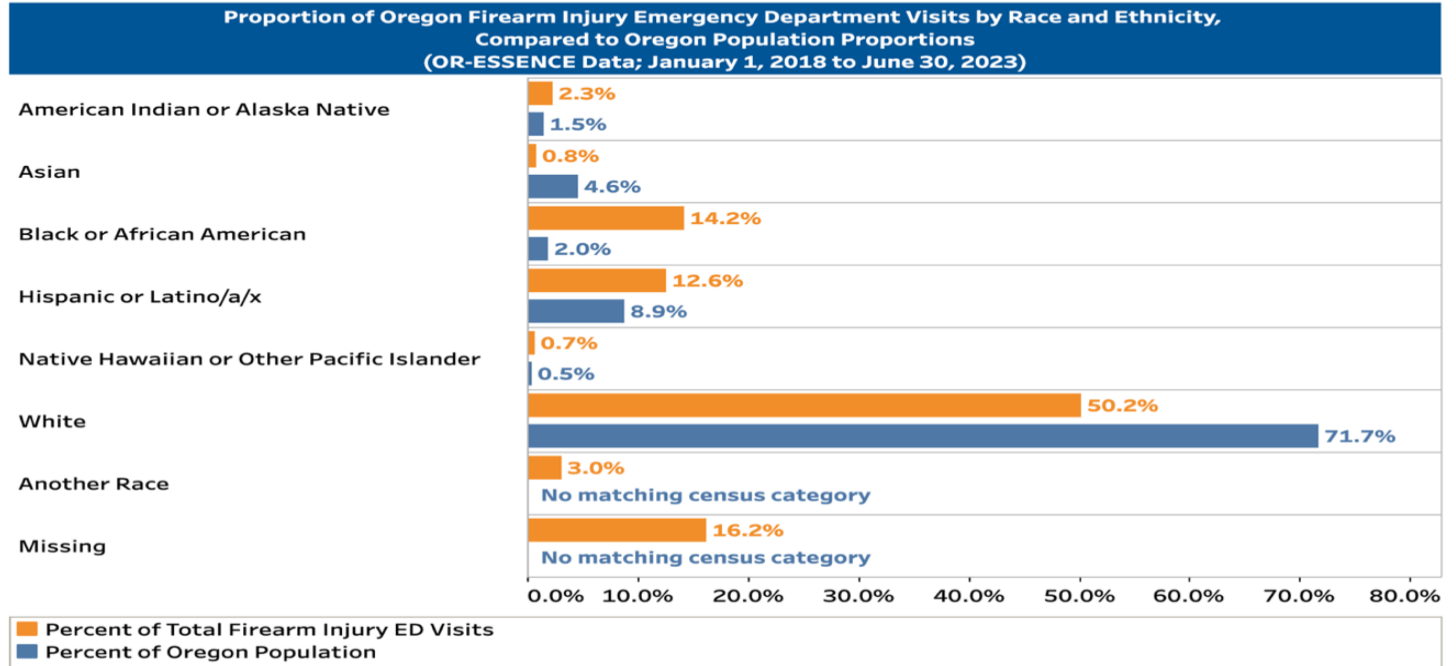
Individuals aged 46-55 are predominantly represented by White individuals (48.3%), followed by Black individuals (39.1%). Hispanic individuals comprise 9.2% of cases, while Asian individuals represent 2.3%. Native American individuals are minimally represented, and no cases involve individuals of unknown race in this age group.

Among individuals aged 56 and above, the majority of cases involve White individuals (74.0%), with Black individuals comprising 26.0% of cases. There are no cases involving individuals of Hispanic, Asian, Native American, or unknown race in this age group.

Statewide Firearm Injury Report

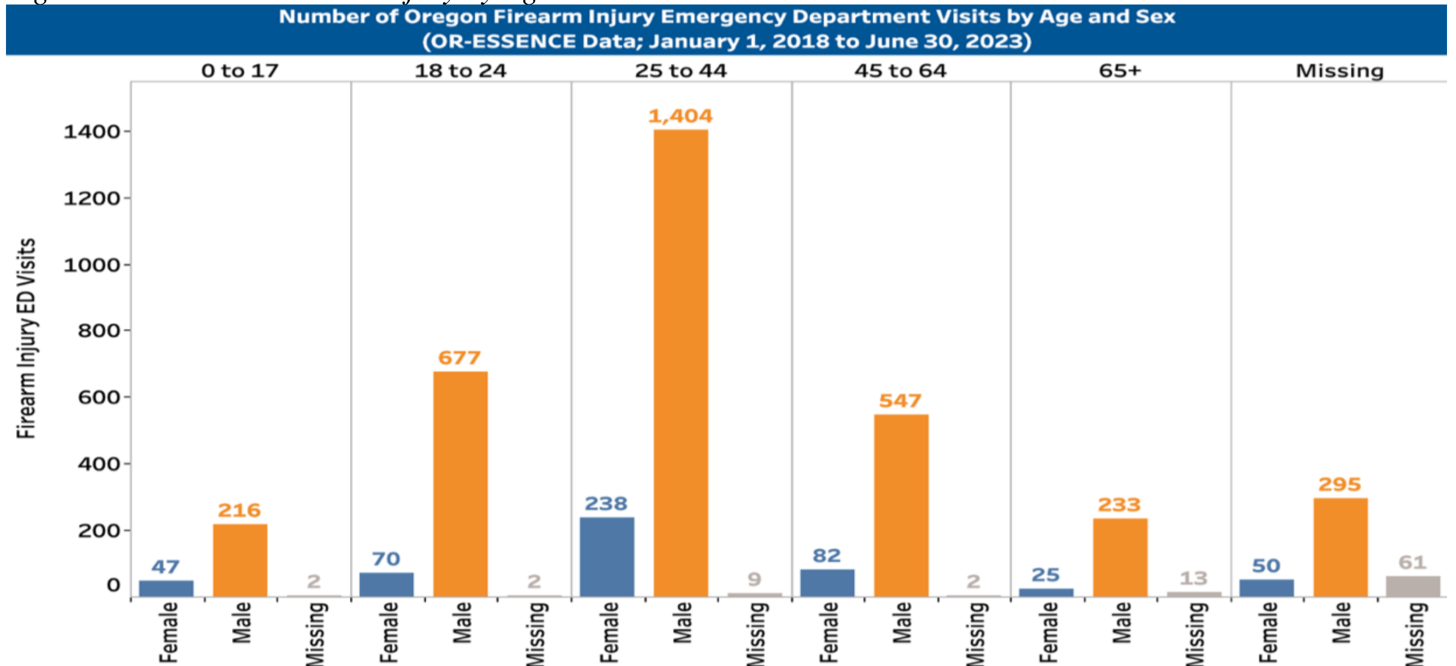
According to the Statewide firearm injury report, which includes gun violence injuries presented in emergency departments across the state of Oregon, between 2018 and 2023 there were 3,973 visits to emergency departments with gun related injuries. Multnomah county represented the county with the highest rates in state accounting for 31.2% of all cases presented at a rate of 151.9 per 100,000 residents.

Figure 5. Statewide Firearm Injury by Race and Ethnicity



The racial demographics of firearm related ED visits are depicted above. The graph above indicates that just over half of all ED visits related to firearm injury involved persons identified as white, while 16.2% of patients race was missing or unknown. Black people presenting with firearm injuries were 14.2% of the total firearm injury visits, Hispanic people were 12.6%. Those classified as “Another Race” were 3% while American Indian or Alaska Natives were 2.3% of all visits statewide. Asian and Native Hawaiian or Other Pacific Islanders were each less than 1% of the total visits at .8% and .7% respectively.

Figure 6. Statewide Firearm Injury by Age and Sex



Consistent with extant data regardng gun violence, males were 6.6 times more likely than females to visist the emergency department with firearm related injuries from January 2018 through June 2023. Additionaly, the highest represented age group among persons presenting to the meergency depratment with gun related injuries regardless of gender is 25-44.

GVIF

Between April 2022 and August 2023, 105 people were referred to receive services from GVIF. This sample is described below with reference to program status age and age group, This sample is described below with reference to program status age and age group, gender, and program designated cultural specificity.

Figure 7. GVIF Program Status Distribution

Program Status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Active	51	48.6	48.6	48.6
	Referred Out	21	20.0	20.0	68.6
	Waitlist	11	10.5	10.5	79.0
	Withdrawn	16	15.2	15.2	94.3
	Denied	3	2.9	2.9	97.1
	Closed	1	1.0	1.0	98.1
	TBD	2	1.9	1.9	100.0
	Total	105	100.0	100.0	

The table provides a comprehensive breakdown of the program status for GVIF referrals between April 2022 and August 2023. Within this dataset, program statuses are categorized into distinct categories, each with its own definition. Referrals classified as *Active* denote individuals currently engaged in the GVIF program, accounting for 51 instances or 48.6% of the total valid referrals. *Referred Out* referrals represent individuals directed to external programs or services, totaling 21 referrals or 20.0% of the valid referrals. *Waitlist* referrals indicate individuals placed on hold for future program participation, comprising 11 referrals or 10.5% of the total. Referrals categorized as *Withdrawn* reflect individuals who have opted out of the GVIF program, totaling 16 referrals or 15.2% of the valid referrals. *Denied* referrals signify instances where individuals were refused entry or participation in the program, accounting for 3 instances or 2.9% of the total. *Closed* referrals denote individuals who have successfully completed their participation in the GVIF program, totaling 1 referral or 1.0% of the valid referrals. *TBD* (To Be Determined) referrals represent instances where the program status is pending clarification, comprising 2 referrals or 1.9% of the total.

Figure 8. GVIF Age Group Distribution

Age Group

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0-17	65	61.9	61.9	61.9
	18-25	35	33.3	33.3	95.2
	26-35	1	1.0	1.0	96.2
	36-45	2	1.9	1.9	98.1
	46-55	2	1.9	1.9	100.0
	Total	105	100.0	100.0	

The data table presents the distribution of age groups among individuals involved in the Gun Violence Impacted Families (GVIF) program. Across a total of 105 valid referrals, participants are categorized based on their age range. The largest segment comprises individuals aged 0 to 17, representing 61.9% of the total referrals and highlighting the significant impact of gun violence on children and adolescents within families. Following closely, individuals aged 18 to 25 constitute 33.3% of the valid data, reflecting the challenges faced by young adults navigating the aftermath of gun violence. A single response falls within the age range of 26 to 35, while both the 36 to 45 and 46 to 55 age groups each account for 1.9% of the total referrals.

Figure 9. GVIF Gender Distribution

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	84	80.0	80.0	80.0
	Female	21	20.0	20.0	100.0
	Total	105	100.0	100.0	

The provided data table offers insights into the gender distribution among individuals participating in the Gun Violence Impacted Families (GVIF) program. A total of 105 valid referrals were recorded, each categorized based on the gender identity of the participant. The majority of participants, accounting for 84 referrals or 80.0% of the total valid referrals, identify as male. This significant representation underscores the impact of gun violence on men within affected families and communities. Female participants comprise a smaller yet significant portion, with 21 referrals accounting for 20.0% of the total valid data.

Figure 10. GVIF Active Adolescents Distribution

Active Adolescents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	N/A	23	21.9	45.1	45.1
	Active Adolescent (15-18)	28	26.7	54.9	100.0
	Total	51	48.6	100.0	
Missing	System	54	51.4		
Total		105	100.0		

Among the total of 105 valid referrals, 51 are accounted for, reflecting the status of active adolescents. Within this category, two distinct groups are identified: those for whom the specific age range (15-18) is not applicable (N/A), comprising 23 responses or 45.1% of the total valid responses, and those identified as active adolescents aged 15 to 18 years old, totaling 28 responses or 54.9% of the total valid data. This illustrates that more than half of the referrals received by GVIF are active participants aged 15 to 18 years old.

Regarding cultural specificity, GVIF has identified individuals as falling into the following categories. African Immigrant/Refugee, African American, Latino/e- Spanish Speaking, Unknown, and “Non-Culturally Specific”.

Figure 11. GVIF Culturally Specific Distribution

Culturally Specific

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	African Immigrant/Refugee	3	2.9	2.9	2.9
	African American	52	49.5	49.5	52.4
	Latine/Hispanic	40	38.1	38.1	90.5
	Unk	2	1.9	1.9	92.4
	"Non-Culturally Specific"	8	7.6	7.6	100.0
	Total	105	100.0	100.0	

The provided crosstabulation outlines the distribution of individuals referred to the Gun Violence Impacted Families (GVIF) program across various culturally specific groups. Out of 105 valid referrals, the majority of participants identified as African American, with 52 individuals representing 49.5% of the total

valid data. Additionally, 40 individuals (38.1% of valid referrals) were classified as Latine/Spanish Speaking. Three individuals (2.9% of valid referrals) were identified as African Immigrant/Refugee. Two individuals (1.9% of valid referrals) were categorized as Unknown, indicating unspecified or unknown cultural identities. Finally, eight individuals (7.6% of valid referrals) fell into the Non-Culturally Specific category, possibly representing individuals who do not identify with a specific cultural group or whose cultural identity is not relevant to the program's services. This breakdown provides valuable insights into the culturally diverse demographics served by the GVIF program, facilitating targeted outreach efforts and tailored support services for affected communities. The remainder of the equity analysis will be presented according to those nominal categories and will include the closest qualitative comparators available in larger national and state-wide data sets.

African American
Program Status

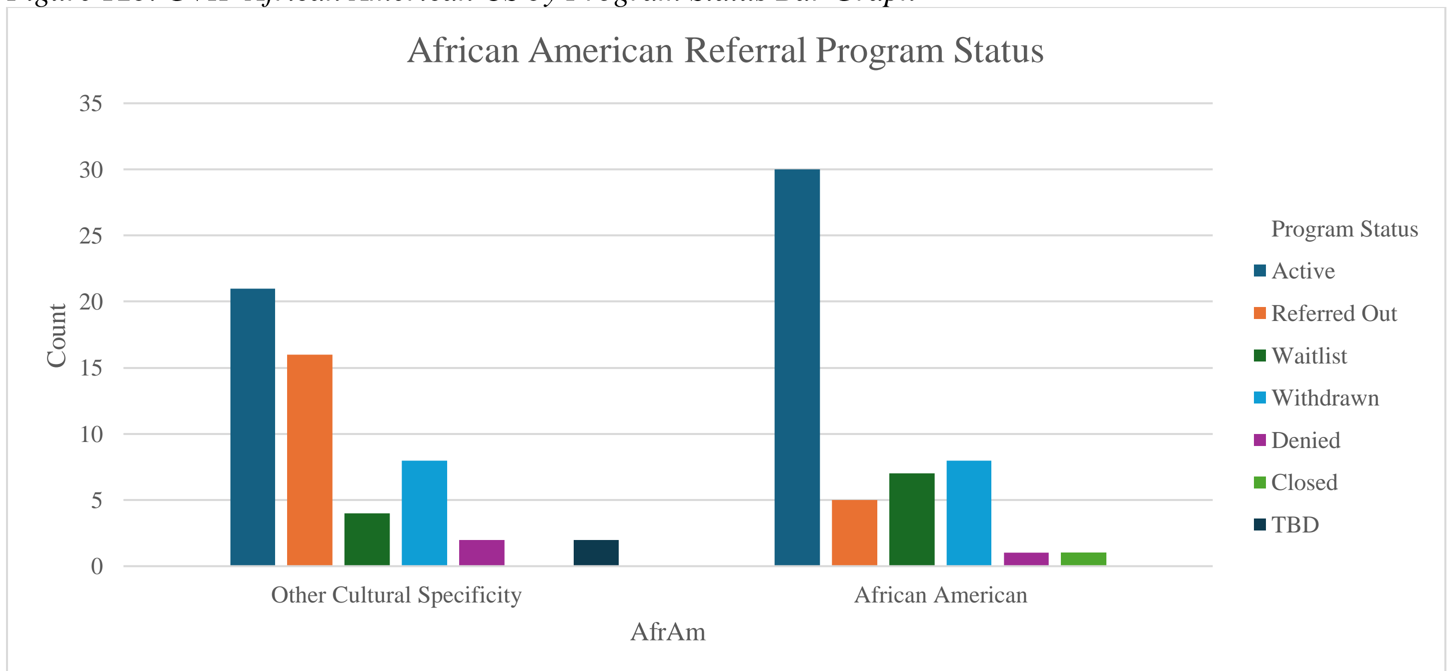
Figure 12a. GVIF African American CS by Program Status

AfrAm * Program Status Crosstabulation

			Program Status							Total
			Active	Referred Out	Waitlist	Withdrawn	Denied	Closed	TBD	
Cultural Specificity	Other Cultural Specificity	Count	21	16	4	8	2	0	2	53
		% of Total	20.0%	15.2%	3.8%	7.6%	1.9%	0.0%	1.9%	50.5%
	African American	Count	30	5	7	8	1	1	0	52
		% of Total	28.6%	4.8%	6.7%	7.6%	1.0%	1.0%	0.0%	49.5%
Total		Count	51	21	11	16	3	1	2	105
		% of Total	48.6%	20.0%	10.5%	15.2%	2.9%	1.0%	1.9%	100.0%

African Americans constituted a significant portion of referrals received by the Gun Violence Impacted Families (GVIF) program, comprising 49.5% of all referrals during the specified time period. Notably, African Americans represented a majority of individuals identified as having an active status within the program, accounting for 58.8% of all active participants. Conversely, they constituted a smaller proportion of individuals referred out for alternative services, comprising 23.8% of such cases. However, African Americans represented a substantial majority of individuals on the waitlist for services through GVIF, comprising 63.6% of individuals awaiting assistance. Furthermore, they were also represented among individuals denied services from GVIF, albeit to a lesser extent, accounting for 33.3% of such cases. It's noteworthy that the only case with a closed status within the program was that of an African American-identified individual, indicating the successful completion of services for this participant.

Figure 12b. GVIF African American CS by Program Status Bar Graph



The bar graph illustrates the distribution of African Americans across different program status designations within the Gun Violence Impacted Families (GVIF) program, comparing them to individuals from other cultural specificities. Among all program status designations, African Americans were most frequently designated as having an active program status, surpassing individuals from other cultural specificities. Conversely, African Americans were less frequently referred out, denied services, or designated as "to be determined" compared to individuals from other cultural specificities. This suggests a higher engagement and participation rate of African Americans within the GVIF program, indicating potential areas of success in service utilization and access. These insights underscore the importance of considering racial demographics in program evaluation and service provision within the context of gun violence impact.

Age and Gender

Age.

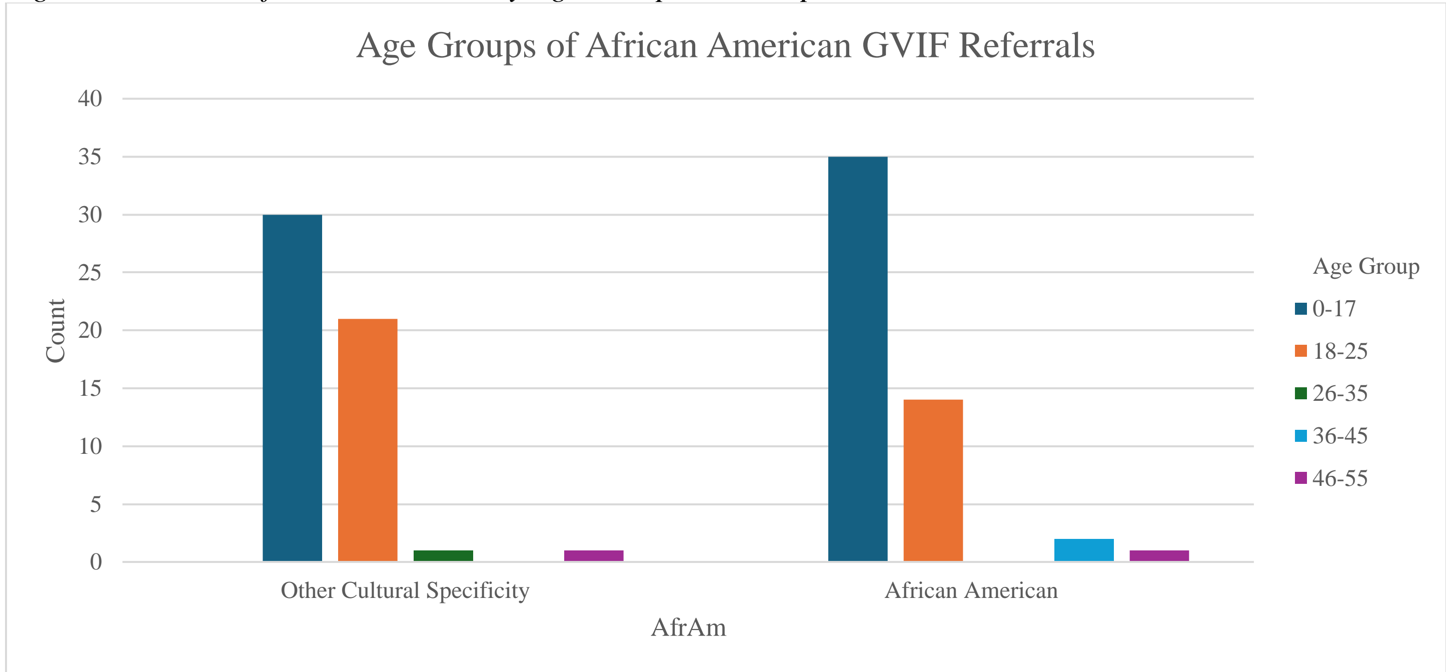
Figure 13a. GVIF African Americans by Age Group

AfrAm * Age Group Crosstabulation

			Age Group					Total
			0-17	18-25	26-35	36-45	46-55	
AfrAm	Other Cultural Specificity	Count	30	21	1	0	1	53
		% of Total	28.6%	20.0%	1.0%	0.0%	1.0%	50.5%
	African American	Count	35	14	0	2	1	52
		% of Total	33.3%	13.3%	0.0%	1.9%	1.0%	49.5%
Total		Count	65	35	1	2	2	105
		% of Total	61.9%	33.3%	1.0%	1.9%	1.9%	100.0%

The provided crosstabulation illustrates the distribution of African American individuals served by the Gun Violence Impacted Families (GVIF) program across different age groups. Among the 105 individuals served, African American participants were represented across multiple age categories. The largest proportion of referrals came from the 0-17 age group, comprising 65 individuals or 61.9% of the total valid data. This category encompasses children and adolescents actively engaged with the GVIF program. Additionally, African American individuals aged 18-25 accounted for 35 referrals, constituting 33.3% of the total valid data, representing young adults within the program. Moreover, there was one referral in the 26-35 age group, representing 1.0% of the total valid data, while the 36-45 and 46-55 age groups each accounted for two referrals, each representing 1.9% of the total valid data.

Figure 13b. GVIF African Americans by Age Groups Bar Graph



Consistent with other trends observed in the data, the bar graph reveals notable patterns in the distribution of African-American individuals across different age groups within the Gun Violence Impacted Families (GVIF) program. Specifically, African-Americans aged 0 to 17 outnumbered individuals of all other cultural specificities in the same age range. Conversely, there were fewer African-Americans aged 18 to 25 compared to individuals of other cultural specificities within this age bracket. Notably, there were no African-American referrals aged 26 to 35, indicating a distinct absence of individuals in this age group among African-American program participants. Furthermore, among individuals aged 36 to 45, African-Americans were the only group represented, highlighting a unique demographic composition within this age category in the sample.

Figure 14a. GVIF African Americans by Age and Program Status

African American Active Adolescents Crosstabulation

			Active Adolescents		Total
			N/A	Active Adolescent (15-18)	
AfrAm	Other Cultural Specificity	Count	11	10	21
		% of Total	21.6%	19.6%	41.2%
	African American	Count	12	18	30
		% of Total	23.5%	35.3%	58.8%
Total		Count	23	28	51
		% of Total	45.1%	54.9%	100.0%

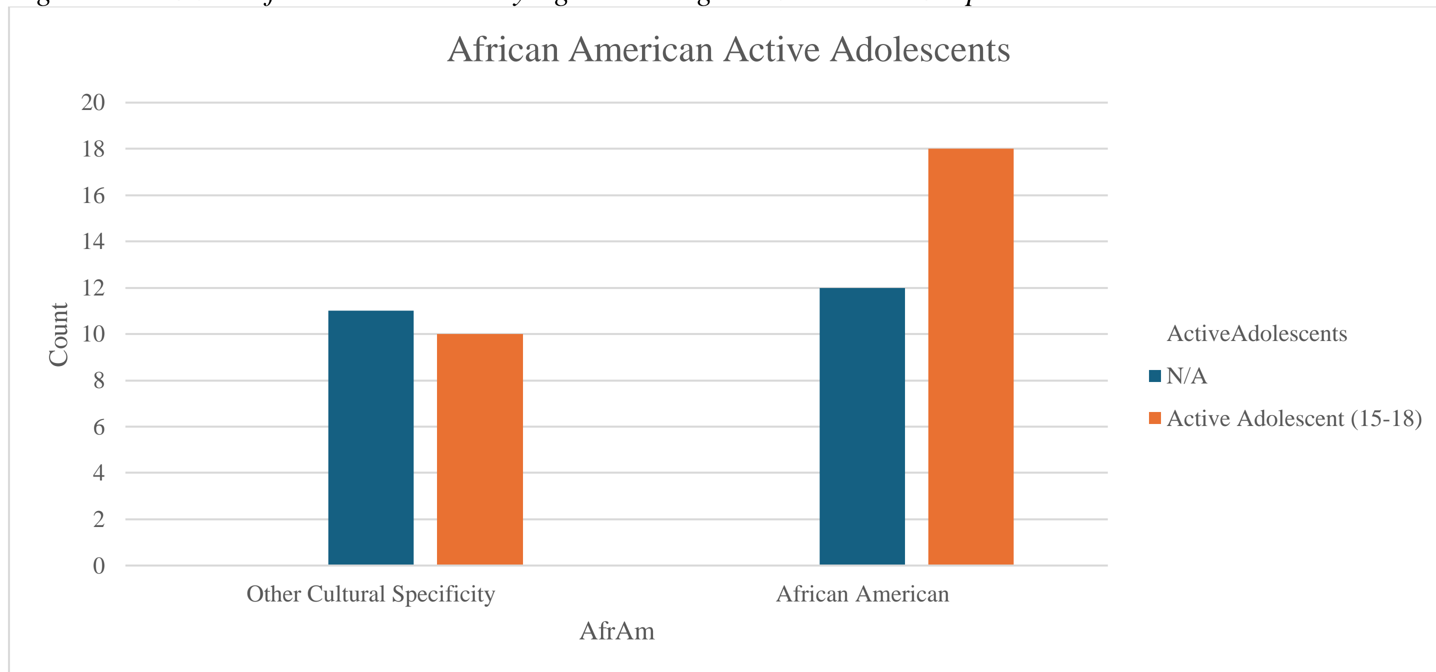
The crosstabulation illustrates the distribution of African American individuals within the Gun Violence Impacted Families (GVIF) program based on their active adolescent status. The data categorizes individuals into two groups: those designated as "Active Adolescent (15-18)" and those labeled as "N/A" (Not Applicable), indicating a status other than active adolescence.

Among the 51 total individuals served by the GVIF program, African American participants accounted for the majority, with 30 individuals representing 58.8% of the total. Within this demographic, a substantial

proportion (23.5%) were classified as "N/A," while the majority 35.3% were identified as "Active Adolescent (15-18)."

Similarly, individuals classified under the "Other Cultural Specificity" category exhibited variation in active adolescent status. Out of the 21 individuals in this group, 11 were designated as "N/A," representing 21.6% of the total, while 10 individuals (19.6%) fell under the "Active Adolescent (15-18)" category.

Figure 14b. GVIF African Americans by Age and Program Status Bar Graph



Among active adolescents African-Americans were 18 out of 28, which is 64.28%. African-American referrals, outnumbered other cultural specificities in this data sample. This trend holds true when looking at African-Americans age 15 to 18 with an active program status designation. Active adolescence in the African-American cultural specificity category outnumber all other persons.

Gender/Sex.

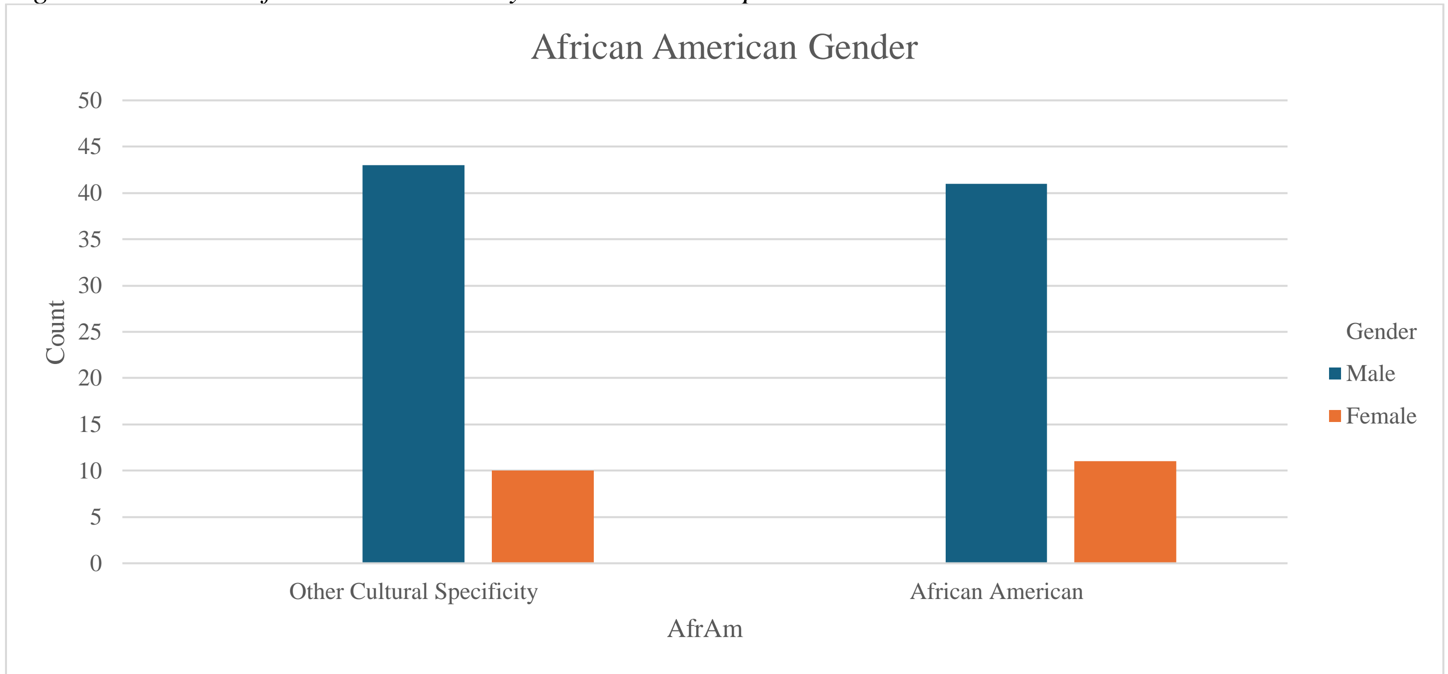
Figure 15a. GVIF African Americans by Gender

AfrAm * Gender Crosstabulation

			Gender		Total
			Male	Female	
AfrAm	Other Cultural Specificity	Count	43	10	53
		% of Total	41.0%	9.5%	50.5%
	African American	Count	41	11	52
		% of Total	39.0%	10.5%	49.5%
Total		Count	84	21	105
		% of Total	80.0%	20.0%	100.0%

The crosstabulation illustrates the distribution of African American individuals served by the Gun Violence Impacted Families (GVIF) program across gender categories. Among the total of 105 individuals served, the majority identified as male, with 84 referrals constituting 80.0% of the total valid data. In comparison, 21 referrals, representing 20.0% of the total, identified as female.

Figure 15b. GVIF African Americans by Gender Bar Graph



The bar graph illustrates the gender distribution of African American individuals served by the Gun Violence Impacted Families (GVIF) program and the gender distribution among other cultural specificities.

Within the African American demographic specifically, a similar pattern is observed. Of the 52 African American individuals served, 41 identified as male, accounting for 39.0% of the total, while 11 identified as female, comprising 10.5% of the total.

Latine/Spanish Speaking

Program Status

Latine or Spanish Speaking persons comprised 38.1% of all referrals during the review period and 29.4% of those with an active program status designated. This group made up 66.6% of all persons referred out for alternative services, 27.7% of persons who were placed on a waitlist, 31.25% of persons denied services, and 100% of persons with a status of TBD.

Figure 16a. GVIF Latines Program Status

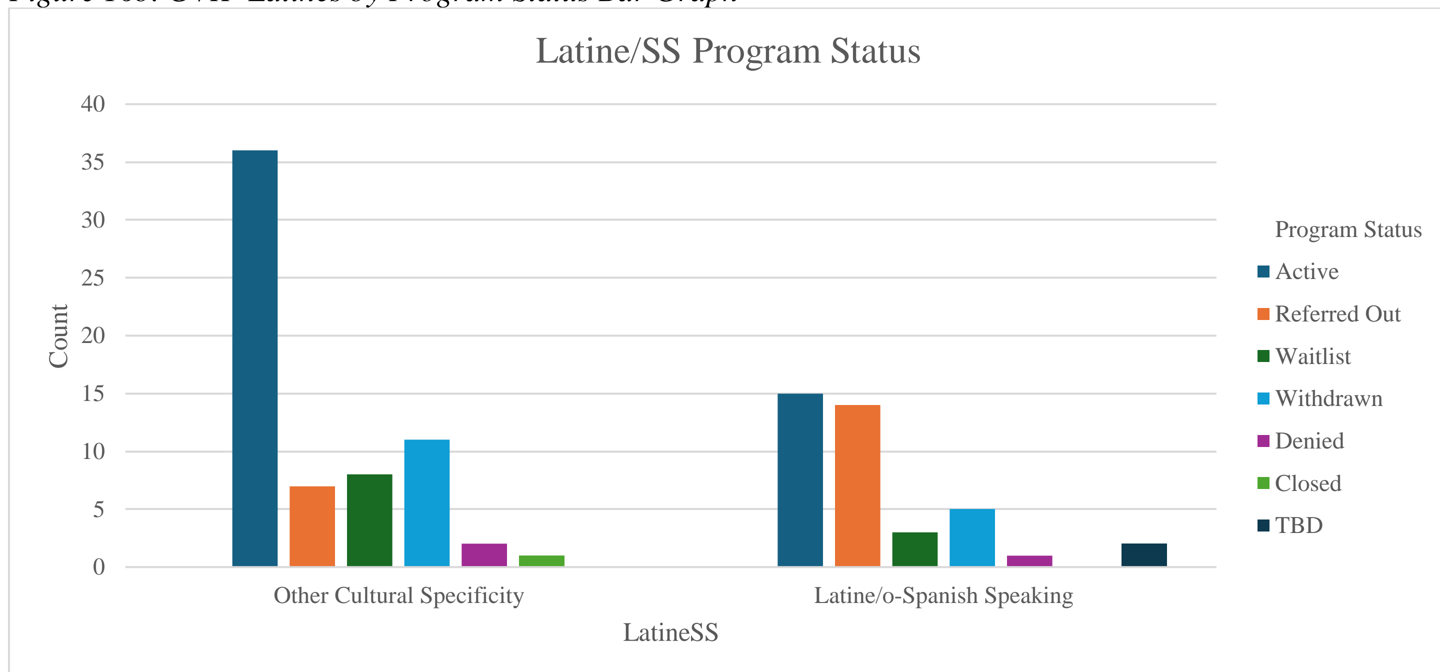
Latine/SS Program Status Crosstabulation

			Program Status							Total
			Active	Referred Out	Waitlist	Withdrawn	Denied	Closed	TBD	
LatineSS	Other Cultural Specificity	Count	36	7	8	11	2	1	0	65
		% of Total	34.3%	6.7%	7.6%	10.5%	1.9%	1.0%	0.0%	61.9%
	Latine/o-Spanish Speaking	Count	15	14	3	5	1	0	2	40
		% of Total	14.3%	13.3%	2.9%	4.8%	1.0%	0.0%	1.9%	38.1%
Total		Count	51	21	11	16	3	1	2	105
		% of Total	48.6%	20.0%	10.5%	15.2%	2.9%	1.0%	1.9%	100.0%

The crosstabulation provides insights into the distribution of Latine/Spanish-speaking individuals served by the Gun Violence Impacted Families (GVIF) program across various program statuses. Among the 105 total individuals served, the majority, comprising 65 individuals (61.9% of the total), are classified under the "Other Cultural Specificity" category. Within this group, individuals exhibit diverse program status distributions, with 34.3% categorized as Active, 6.7% as Referred Out, 7.6% as Waitlisted, 10.5% as Withdrawn, 1.9% as Denied, and 1.0% as Closed. Notably, none of the individuals in this category were designated as TBD (To Be Determined).

In contrast, the remaining 40 Latine/Spanish-speaking individuals (38.1% of the total) are classified under the "Latine/o-Spanish Speaking" category. Similar to the "Other Cultural Specificity" group, individuals in this category display varied program status distributions, with 14.3% classified as Active, 13.3% as Referred Out, 2.9% as Waitlisted, 4.8% as Withdrawn, 1.0% as Denied, and 1.9% as TBD.

Figure 16b. GVIF Latines by Program Status Bar Graph



The bar graph illustrates the program status distribution among Spanish-speaking individuals within the Gun Violence Impacted Families (GVIF) program, juxtaposed with individuals from other cultural specificities. Spanish-speaking persons exhibited an acceptance rate only marginally higher than those who were referred out. Moreover, referrals among this group were notably more frequent compared to other cultural specificities. Additionally, Spanish-speaking individuals comprised the only cases within the culturally specific group whose program status had yet to be determined.

Age and Gender

Age.

Figure 17a. GVIF Latines by Age Groups

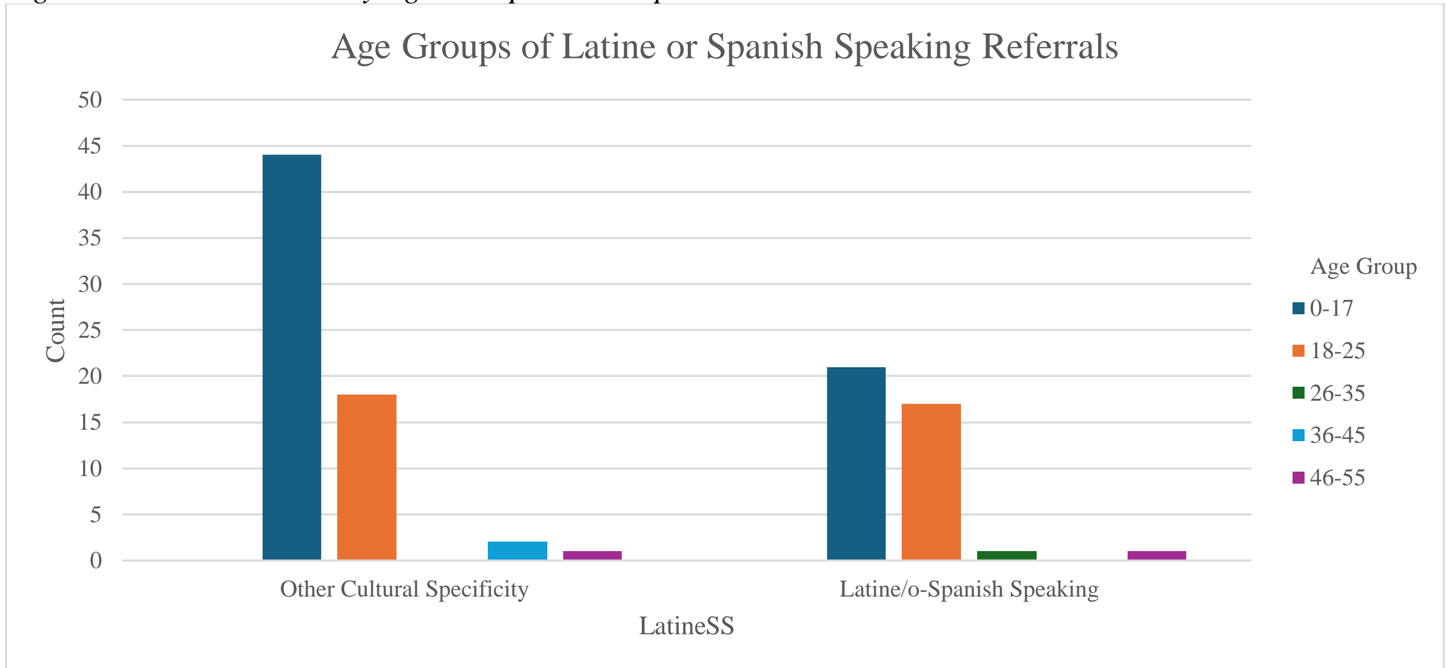
Latine/SS Age Group Crosstabulation

			Age Group					Total
			0-17	18-25	26-35	36-45	46-55	
LatineSS	Other Cultural Specificity	Count	44	18	0	2	1	65
		% of Total	41.9%	17.1%	0.0%	1.9%	1.0%	61.9%
	Latine/o-Spanish Speaking	Count	21	17	1	0	1	40
		% of Total	20.0%	16.2%	1.0%	0.0%	1.0%	38.1%
Total		Count	65	35	1	2	2	105
		% of Total	61.9%	33.3%	1.0%	1.9%	1.9%	100.0%

The crosstabulation reveals the distribution of Latine/Spanish-Speaking individuals within the Gun Violence Impacted Families (GVIF) program across different age groups. Among the 105 individuals served, the majority, comprising 61.9%, belong to the "Other Cultural Specificity" category, while the remaining 38.1% fall under the "Latine/o-Spanish Speaking" category. The data further highlights the distribution of individuals within each age group for both categories. Notably, individuals aged 0-17 represent the largest proportion in both groups, accounting for 41.9% and 20.0% in the "Other Cultural Specificity" and "Latine/o-Spanish Speaking" categories, respectively. Additionally, individuals aged 18-25 constitute a significant portion in both

groups, representing 17.1% and 16.2%, respectively. Interestingly, individuals aged 26-35 are only represented in the "Other Cultural Specificity" category, comprising 0.0% of the "Latine/o-Spanish Speaking" category.

Figure 17b. GVIF Latines by Age Groups Bar Graph



The majority of Latino or Spanish-speaking individuals who were referred fell between the ages of 0 to 25. Trends within this culturally specific groups are aligned with those seen across the sample and that the majority of persons fell in the 0 to 17 age range. Still, there's a notable difference between the number of 0 to 17-year-old who identified as Latino or Spanish, speaking compared with those of any other cultural specificity.

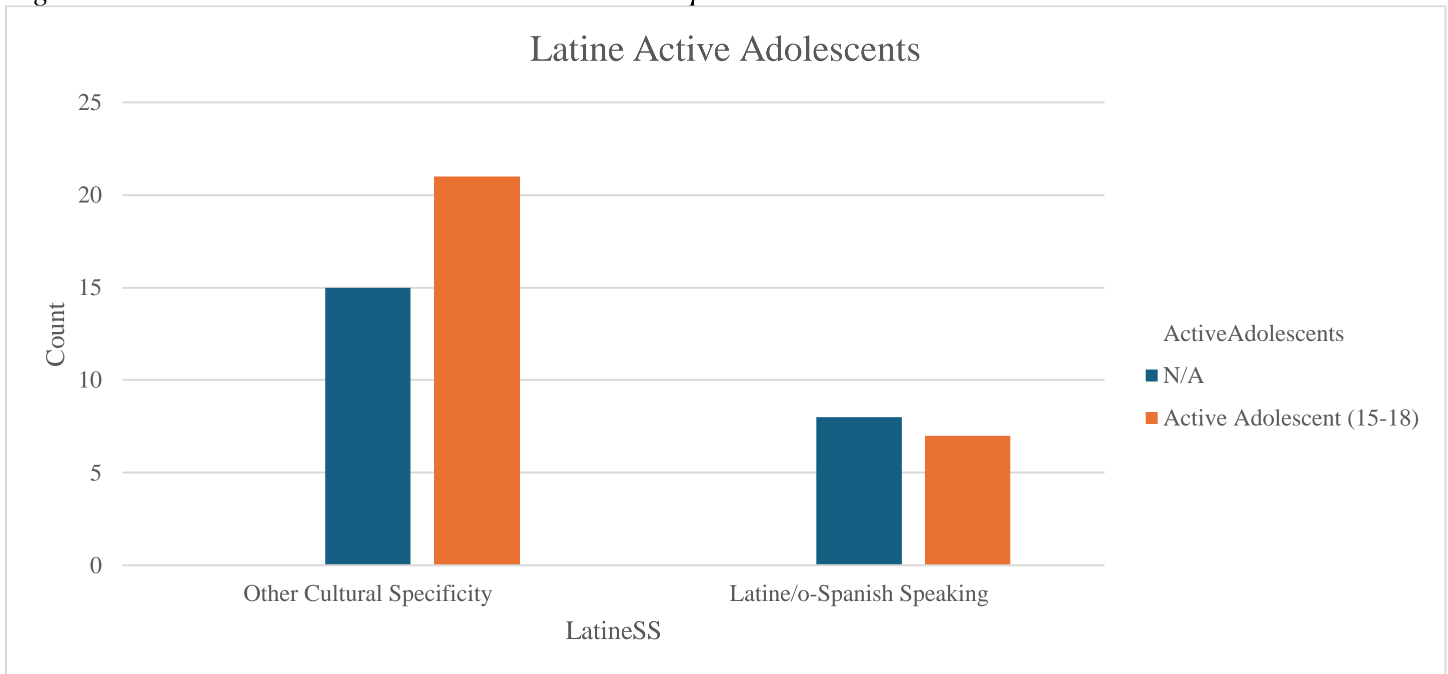
Figure 18a. GVIF Latine Active Adolescents

Latine/SS Active Adolescents Crosstabulation

			Active Adolescents		Total
			N/A	Active Adolescent (15-18)	
LatineSS	Other Cultural Specificity	Count	15	21	36
		% of Total	29.4%	41.2%	70.6%
	Latine/o-Spanish Speaking	Count	8	7	15
		% of Total	15.7%	13.7%	29.4%
Total		Count	23	28	51
		% of Total	45.1%	54.9%	100.0%

Among the 51 individuals categorized as having an "Active" program status, 70.6% of those classified under the "Other Cultural Specificity" category are identified as "Active Adolescent (15-18)", while 29.4% are categorized as "N/A" (Not Applicable). Similarly, among Latine/o-Spanish Speaking individuals, 41.2% are identified as "Active Adolescent (15-18)", while 15.7% are categorized as "N/A". represented across the entire data set.

Figure 18b. GVIF Latine Active Adolescents Bar Graph



The graph above depicts age distributions, according to cultural specificity. Among other culturally specific groups, active adolescence, aged 15 to 18 years old outnumber individuals who are either designated as inactive or are not within the age range. Conversely, among Latine or Spanish-speaking individuals, persons not aged 15 to 18 years old or indicated as having a non-active program status out number Active adolescents.

Gender/Sex.

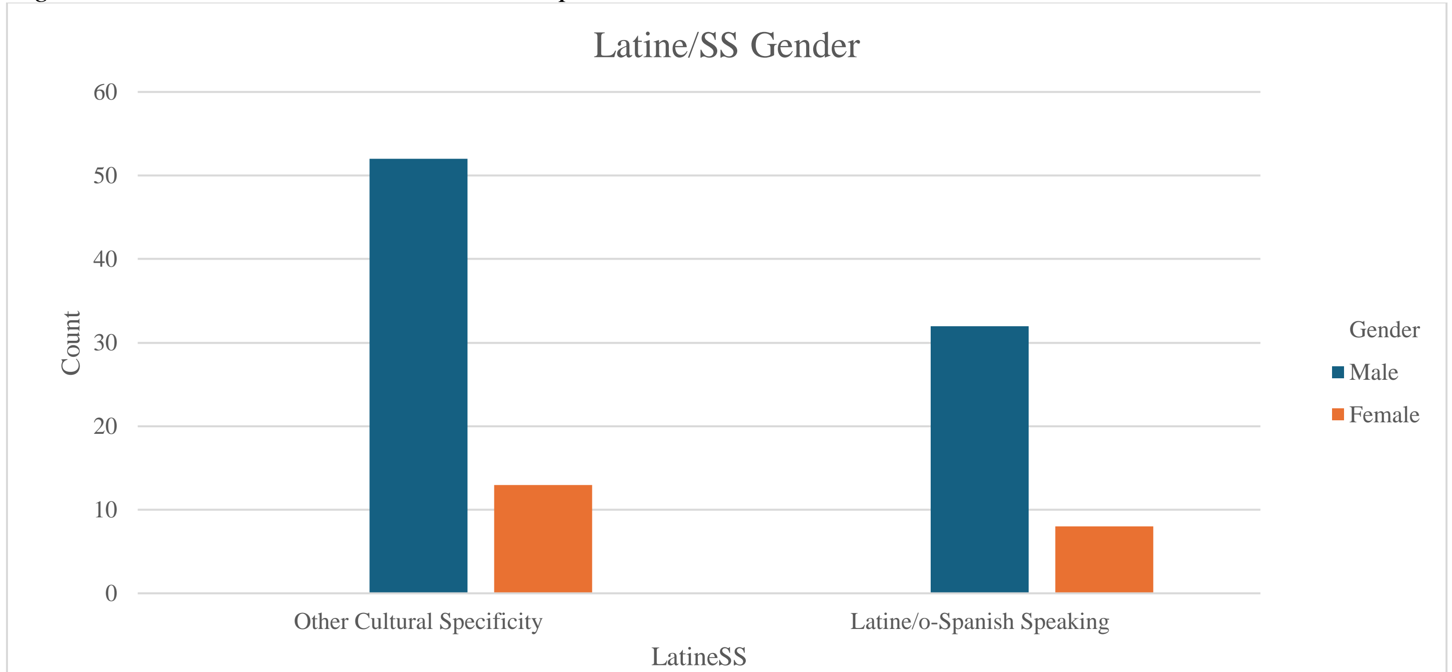
Figure 19a. GVIF Latines by Gender

Latine/SS Gender Crosstabulation

			Gender		Total
			Male	Female	
LatineSS	Other Cultural Specificity	Count	52	13	65
		% of Total	49.5%	12.4%	61.9%
	Latine/o-Spanish Speaking	Count	32	8	40
		% of Total	30.5%	7.6%	38.1%
Total		Count	84	21	105
		% of Total	80.0%	20.0%	100.0%

The crosstabulation provides insight into the gender distribution of Latine/Spanish-Speaking individuals within the Gun Violence Impacted Families (GVIF) program. Among the 105 individuals served, the majority, comprising 61.9%, are classified under the "Other Cultural Specificity" category, while the remaining 38.1% fall under the "Latine/o-Spanish Speaking" category. In terms of gender, males represent a higher proportion within both categories, accounting for 49.5% and 30.5% of individuals in the "Other Cultural Specificity" and "Latine/o-Spanish Speaking" categories, respectively. Conversely, females constitute a smaller proportion within both categories, representing 12.4% and 7.6% of individuals in the respective categories.

Figure 19b. GVIF Latines Gender Bar Graph



The graph above illustrates the gender distribution among Latino or Spanish-speaking, referrals, and other culturally specific groups. Specifically, among Latina or Spanish-speaking individuals. Moreover, of the 21 Women represented across all referrals, 8 identified as Latina or Spanish Speaking comprising 38% of all women referred to GVIF during the review period.

African Immigrants/Refugees

Program Status

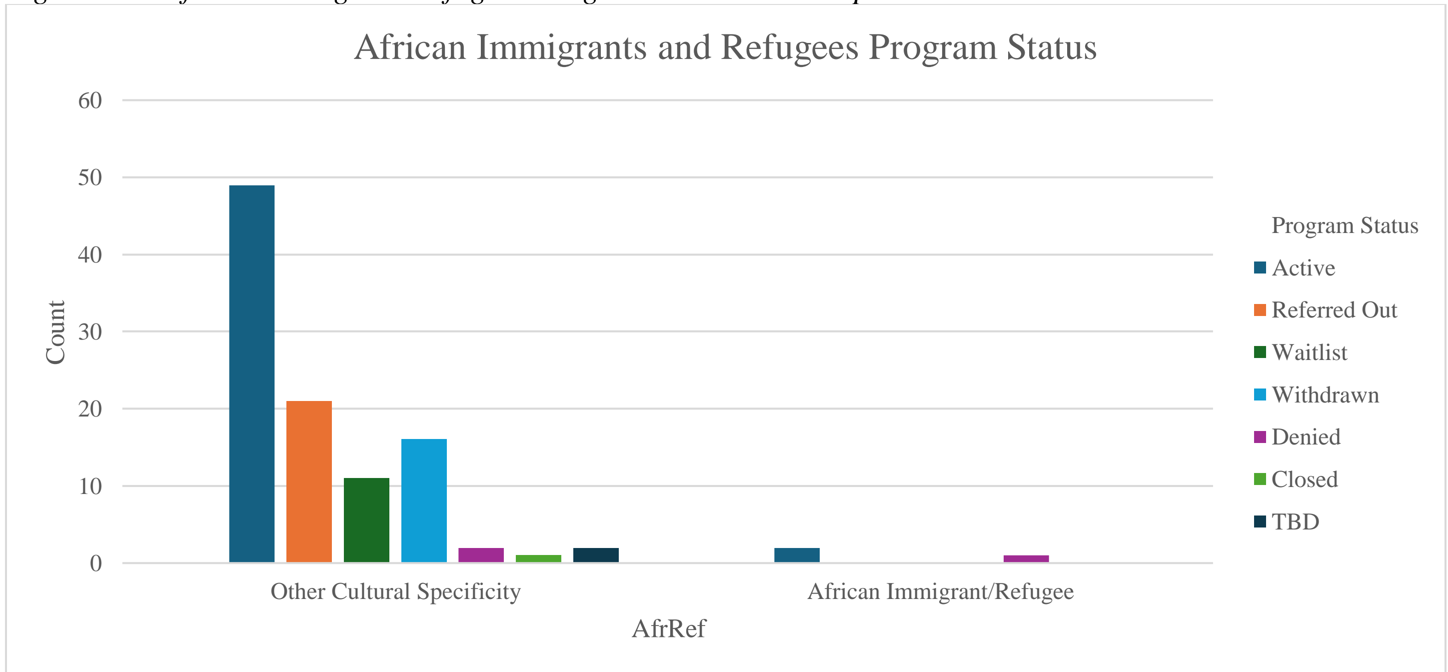
Figure 20a. GVIF African Immigrant/Refugees Program Status

African Immigrants and Refugees Program Status Crosstabulation

			Program Status							Total
			Active	Referred Out	Waitlist	Withdrawn	Denied	Closed	TBD	
AfrRef	Other Cultural Specificity	Count	49	21	11	16	2	1	2	102
		% of Total	46.7%	20.0%	10.5%	15.2%	1.9%	1.0%	1.9%	97.1%
	African Immigrant/Refugee	Count	2	0	0	0	1	0	0	3
		% of Total	1.9%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	2.9%
Total		Count	51	21	11	16	3	1	2	105
		% of Total	48.6%	20.0%	10.5%	15.2%	2.9%	1.0%	1.9%	100.0%

The African immigrant/refugee subgroup, specifically identified as "African Immigrant/Refugee," constitutes only 2.9% of the total individuals served. Within this subgroup, the majority are classified as "Active," accounting for 1.9% of the total, while a small percentage, representing 1.0%, are categorized as "Denied." Interestingly, no individuals within this subgroup were referred out, placed on the waitlist, or closed from the program.

Figure 20b. African Immigrant/Refugees Program Status Bar Graph



Persons identified as African immigrant Refugees made up 3.9% of all active cases and 33.3% of all denied cases. Most notable is that there were only three cases referred during the review period that had this cultural specificity.

Age and Gender

Age.

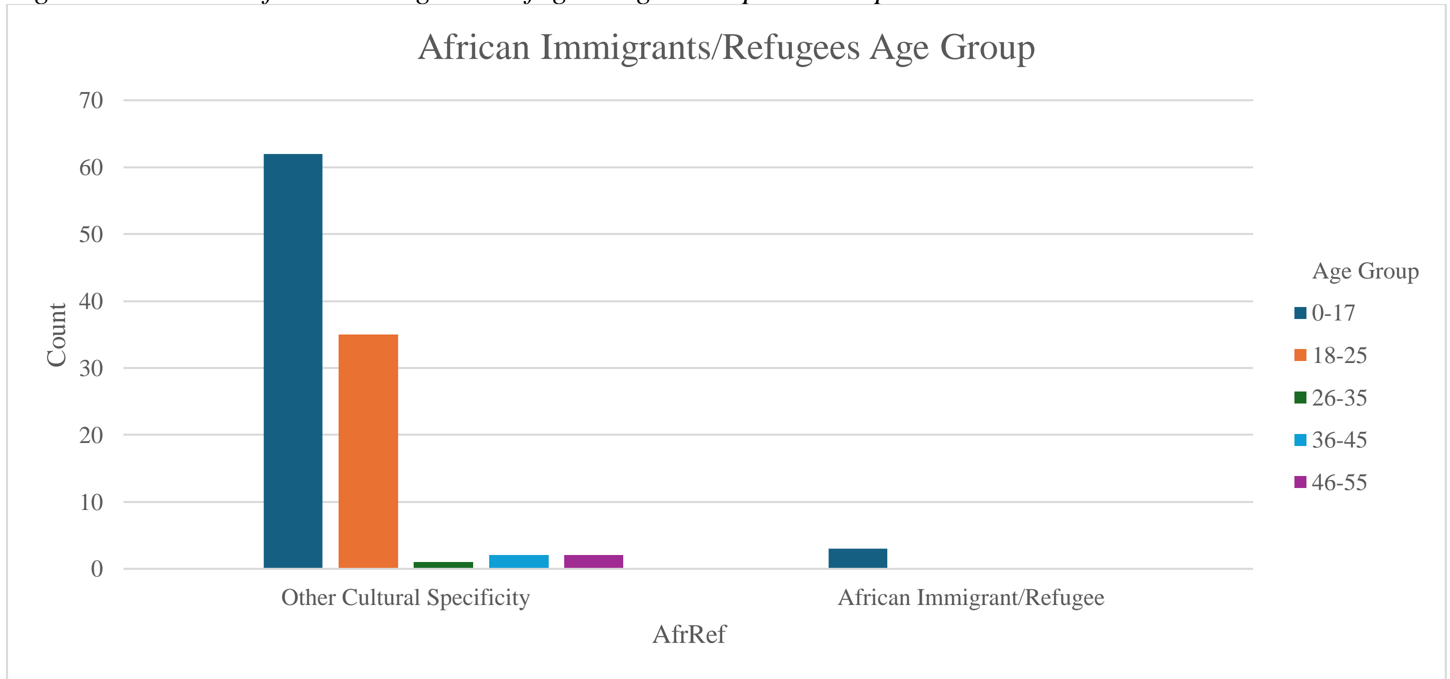
Figure 21a. GVIF African Immigrant/Refugees Age Group

AfrRef Age Group Crosstabulation

			Age Group					Total
			0-17	18-25	26-35	36-45	46-55	
AfrRef	Other Cultural Specificity	Count	62	35	1	2	2	102
		% of Total	59.0%	33.3%	1.0%	1.9%	1.9%	97.1%
	African Immigrant/Refugee	Count	3	0	0	0	0	3
		% of Total	2.9%	0.0%	0.0%	0.0%	0.0%	2.9%
Total		Count	65	35	1	2	2	105
		% of Total	61.9%	33.3%	1.0%	1.9%	1.9%	100.0%

All three cases of African Immigrant/Refugees were in the 0-17 age group. This demographic made up 4.6% of all 0–17-year-olds referred during the review period.

Figure 21b. GVIF African Immigrant/Refugees Age Group Bar Graph



The graph above depicts the only age group representation of this culturally specific demographic as the 0-17 year old group.

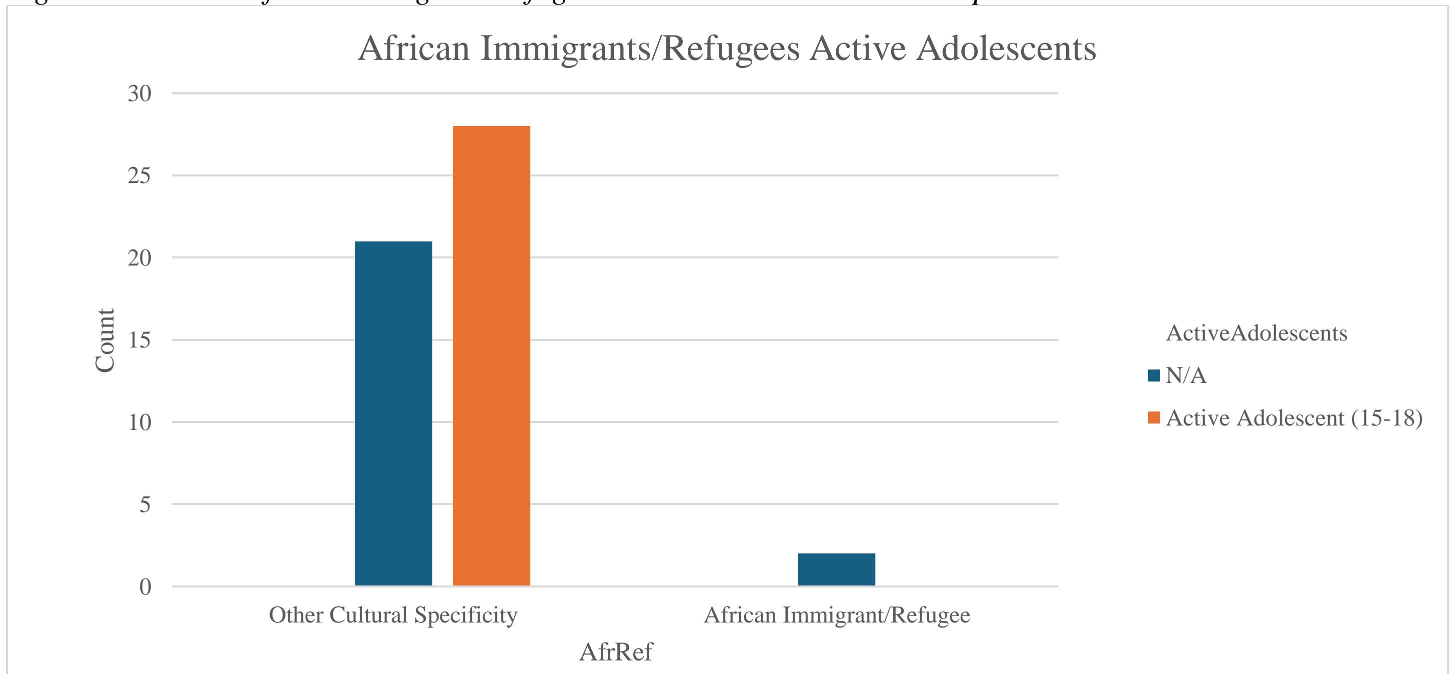
Figure 22a. GVIF African Immigrant/Refugees Active Adolescents

AfrRef ActiveAdolescents Crosstabulation

			Active Adolescents		Total
			N/A	Active Adolescent (15-18)	
AfrRef	Other Cultural Specificity	Count	21	28	49
		% of Total	41.2%	54.9%	96.1%
	African Immigrant/Refugee	Count	2	0	2
		% of Total	3.9%	0.0%	3.9%
Total		Count	23	28	51
		% of Total	45.1%	54.9%	100.0%

Inconsistent with the trends of cultural specificities, the two active participants within the African Immigrant/Refugee cultural specificity were not within the most prominently represented age category of adolescents age 15-18.

Figure 22b. GVIF African Immigrant/Refugees Active Adolescents Bar Graph



The bar chart above depicts that all of the “Active” African Immigrant Refugees did not fall between the ages of 15-18 years old.

Gender/Sex.

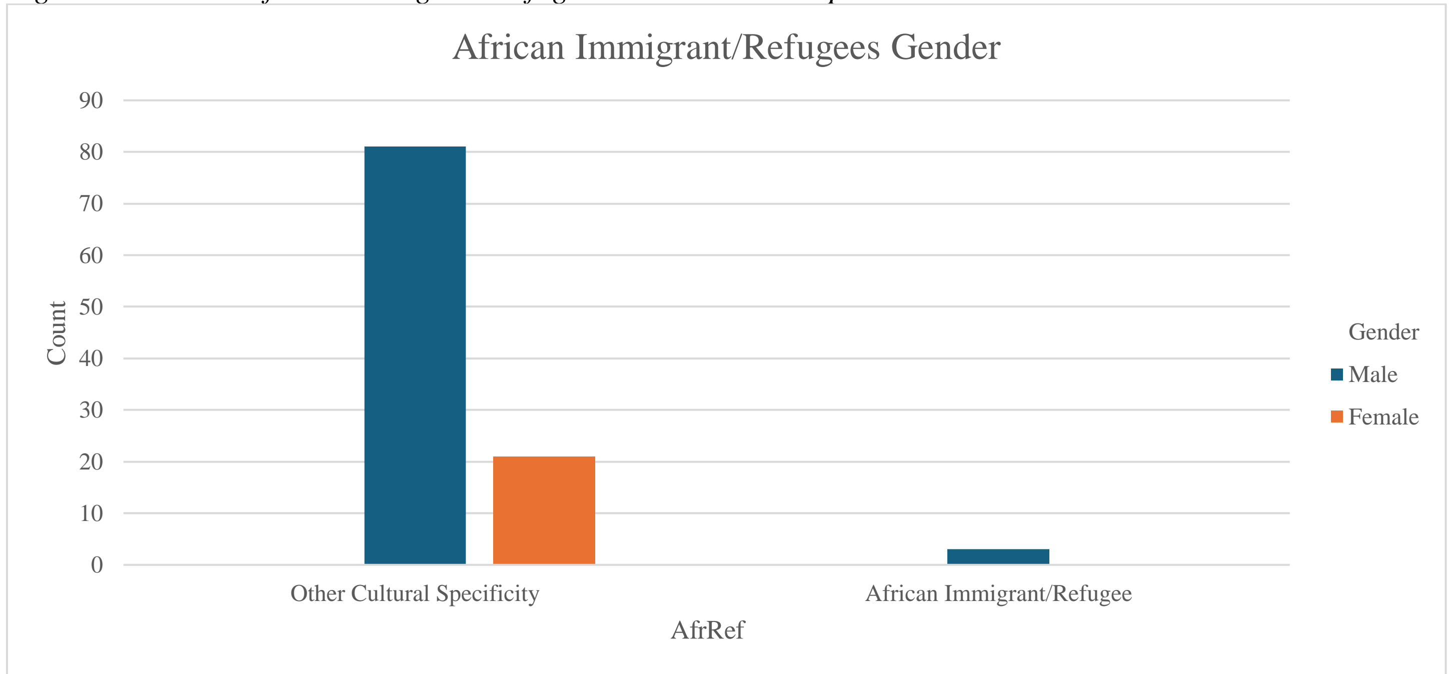
Figure 23a. GVIF African Immigrant/Refugees Gender

AfrRef * Gender Crosstabulation

			Gender		Total
			Male	Female	
AfrRef	Other Cultural Specificity	Count	81	21	102
		% of Total	77.1%	20.0%	97.1%
	African Immigrant/Refugee	Count	3	0	3
		% of Total	2.9%	0.0%	2.9%
Total		Count	84	21	105
		% of Total	80.0%	20.0%	100.0%

None of the referrals identified within the African Immigrants/Refugee subgroup were identified as female. Persons with this designation made up 2.9% of the total referrals and 3.6% of all male identified referrals.

Figure 23b. GVIF African Immigrant/Refugees Gender Bar Graph



The above graph is a depiction of the males who were identified as African Immigrants/Refugees compared with the gendered demographics of other culturally specific groups within the sample.

Unknown Cultural Specificity

Program Status

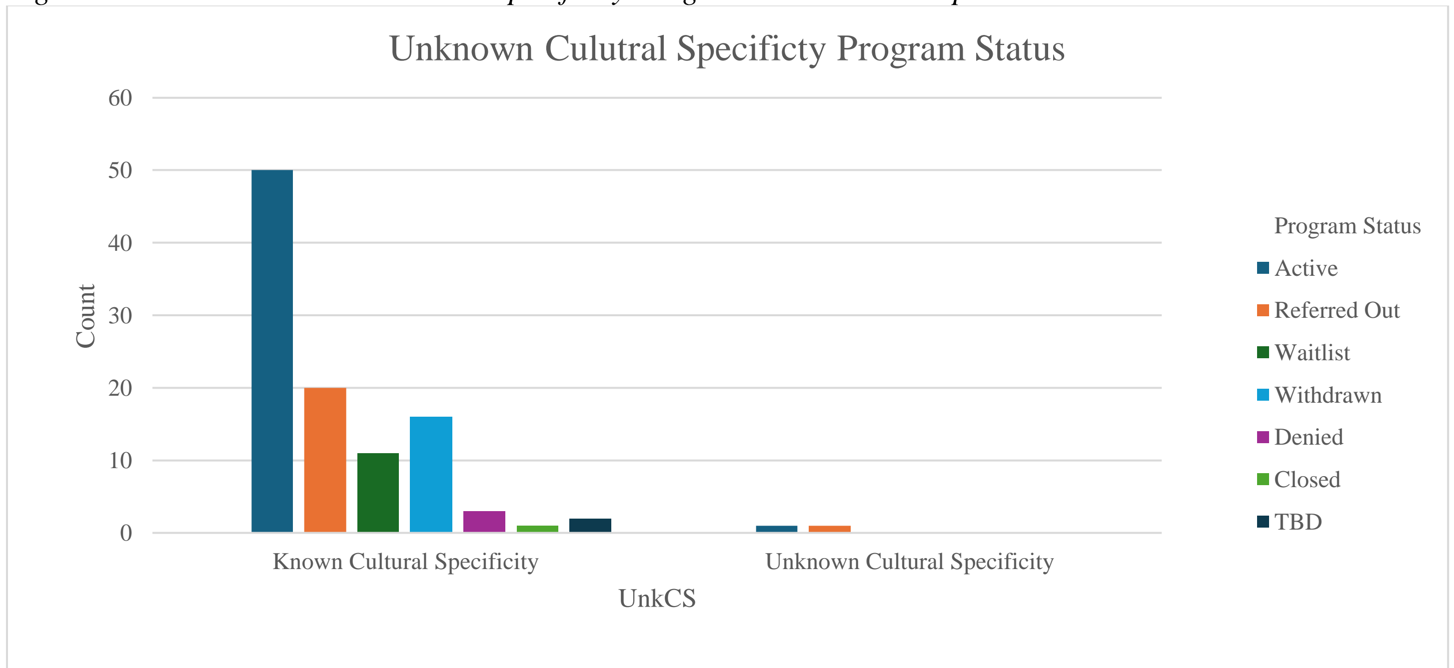
Figure 24a. GVIF Unknown Cultural Specificity Program Status

UnkCS * Program Status Crosstabulation

			Program Status							Total
			Active	Referred Out	Waitlist	Withdrawn	Denied	Closed	TBD	
UnkCS	Known Cultural Specificity	Count	50	20	11	16	3	1	2	103
		% of Total	47.6%	19.0%	10.5%	15.2%	2.9%	1.0%	1.9%	98.1%
	Unknown Cultural Specificity	Count	1	1	0	0	0	0	0	2
		% of Total	1.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.9%
Total		Count	51	21	11	16	3	1	2	105
		% of Total	48.6%	20.0%	10.5%	15.2%	2.9%	1.0%	1.9%	100.0%

The majority of individuals with Known Cultural Specificity are in the "Active" category, comprising 47.6% of the total count in this group. The least represented categories across both Known and Unknown Cultural Specificity are "Closed" and "TBD," each accounting for 1.0% of the total count. Unknown Cultural Specificity individuals constitute a small portion of the total count, with only 1.9% of the total population.

Figure 24b. GVIF Unknown Cultural Specificity Program Status Bar Graph



The bar graph illustrates the distribution of individuals with known and unknown cultural specificity across different program statuses. Among this group, the majority are categorized as "Active," representing approximately 47.6% of the total count within this subgroup. Conversely, other program statuses such as "Referred Out," "Waitlist," and "Withdrawn" have notably lower representation, each accounting for 1.0% or less of the total count. The graph emphasizes the prevalence of individuals with unknown cultural specificity in the "Active" category compared to other statuses, suggesting a potential area for further investigation or targeted intervention efforts to engage with this demographic more effectively within the program.

Age and Gender

Age.

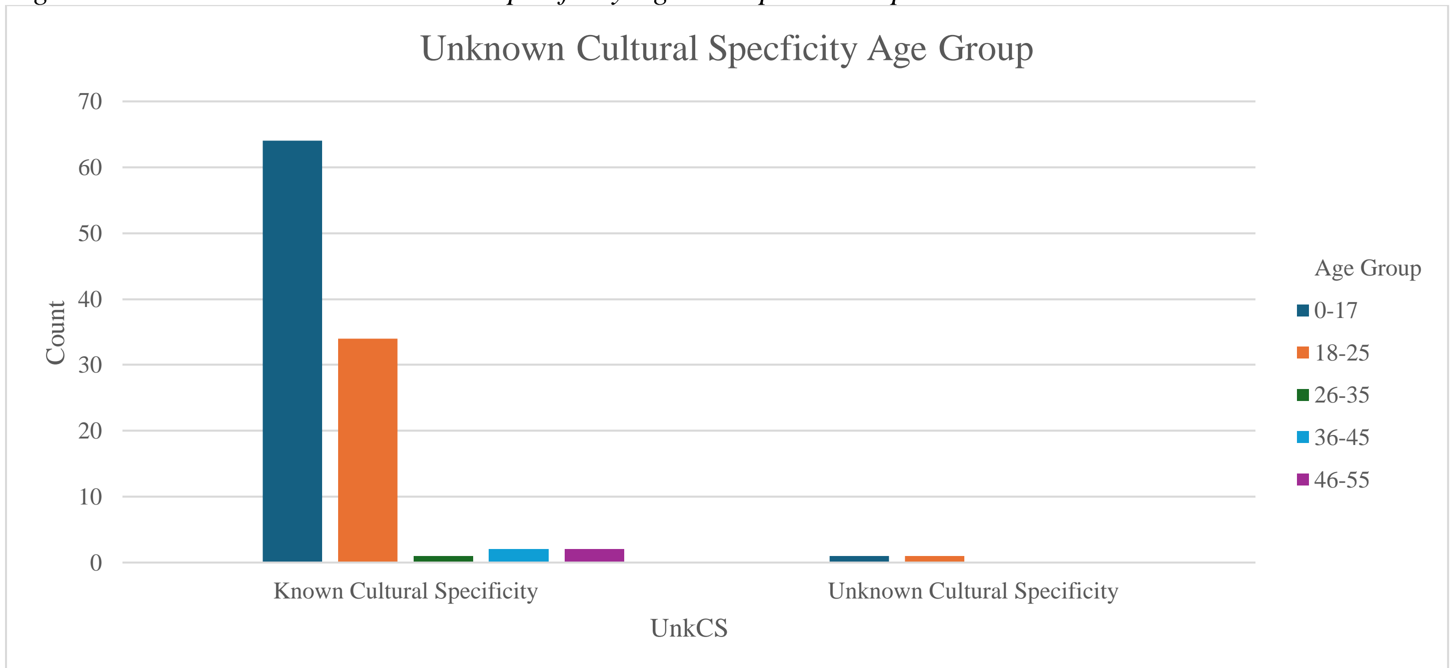
Figure 25a. GVIF Unknown Cultural Specificity Age Group

UnkCS * Age Group Crosstabulation

			Age Group					Total
			0-17	18-25	26-35	36-45	46-55	
UnkCS	Known Cultural Specificity	Count	64	34	1	2	2	103
		% of Total	61.0%	32.4%	1.0%	1.9%	1.9%	98.1%
	Unknown Cultural Specificity	Count	1	1	0	0	0	2
		% of Total	1.0%	1.0%	0.0%	0.0%	0.0%	1.9%
Total		Count	65	35	1	2	2	105
		% of Total	61.9%	33.3%	1.0%	1.9%	1.9%	100.0%

Within the unknown cultural specificity group, there is equal representation across the age groups of 0-17 and 18-25, each accounting for 1.0% of the total count within this subgroup. Known cultural specificity individuals are predominantly represented in the age group of 0-17, constituting 61.0% of the total count within this subgroup, followed by the age group of 18-25 with 32.4%. The remaining age groups (26-35, 36-45, 46-55) have minimal representation in both known and unknown cultural specificity categories.

Figure 25b. GVIF Unknown Cultural Specificity Age Group Bar Graph



The bar graph visually represents the distribution of individuals with unknown cultural specificity across different age groups. Within this subgroup, individuals are evenly distributed between the age groups of 0-17 and 18-25, with each age group accounting for 1.0% of the total count. Meanwhile, the graph emphasizes that individuals with known cultural specificity are predominantly represented in the age group of 0-17, comprising approximately 61.0% of the total count within this subgroup, followed by the age group of 18-25 with approximately 32.4%. The remaining age groups (26-35, 36-45, 46-55) have minimal representation among both known and unknown cultural specificity categories. This graphical representation underscores the relatively uniform distribution of individuals with unknown cultural specificity across younger age brackets and

highlights potential areas for targeted intervention or further investigation to better engage with this demographic within the program.

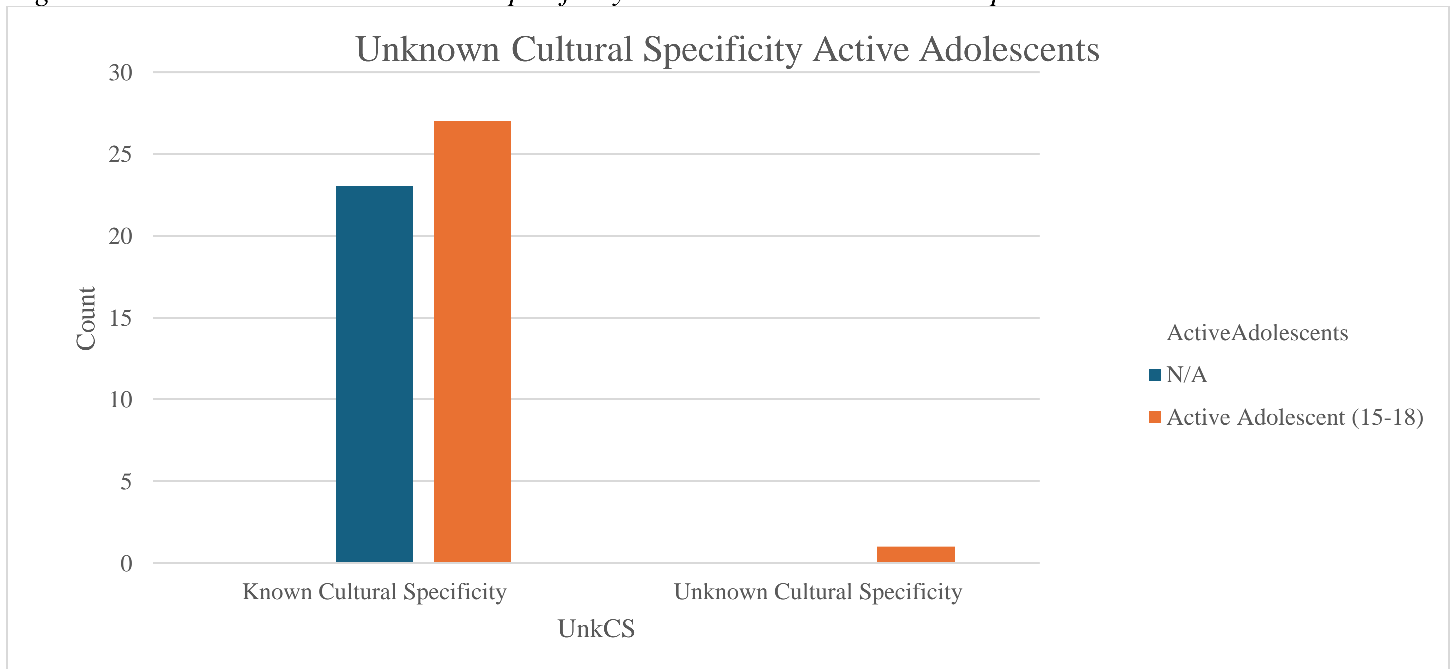
Figure 26a. GVIF Unknown Cultural Specificity Active Adolescents

UnkCS * ActiveAdolescents Crosstabulation

			Active Adolescents		Total
			N/A	Active Adolescent (15-18)	
UnkCS	Known Cultural Specificity	Count	23	27	50
		% of Total	45.1%	52.9%	98.0%
	Unknown Cultural Specificity	Count	0	1	1
		% of Total	0.0%	2.0%	2.0%
Total		Count	23	28	51
		% of Total	45.1%	54.9%	100.0%

Individuals with unknown cultural specificity represent a small proportion of the total population, comprising only 2.0%. Within the unknown cultural specificity group, there is one individual categorized as "Active Adolescent (15-18)," accounting for 2.0% of the total count within this subgroup. Known cultural specificity individuals are predominantly represented in the category of "Active Adolescent (15-18)," comprising 52.9% of the total count within this subgroup. The category "N/A" has no representation among individuals with unknown cultural specificity, indicating that all of them are classified as "Active Adolescent (15-18)."

Figure 26b. GVIF Unknown Cultural Specificity Active Adolescents Bar Graph



The bar graph visually represents the distribution of individuals with unknown cultural specificity across different categories of active adolescents. Within this subgroup, there is one individual categorized as "Active Adolescent (15-18)," accounting for 2.0% of the total count within this subgroup. Notably, there are no individuals categorized as "N/A" (Not Applicable) among those with unknown cultural specificity. Conversely, individuals with known cultural specificity are predominantly represented in the category of "Active Adolescent (15-18)," comprising approximately 52.9% of the total count within this subgroup. The graph underscores the representation of individuals with unknown cultural specificity within the "Active Adolescent (15-18)"

category, suggesting a potential area for further investigation or targeted engagement efforts to understand and address the needs of this demographic within the program.

Gender/Sex.

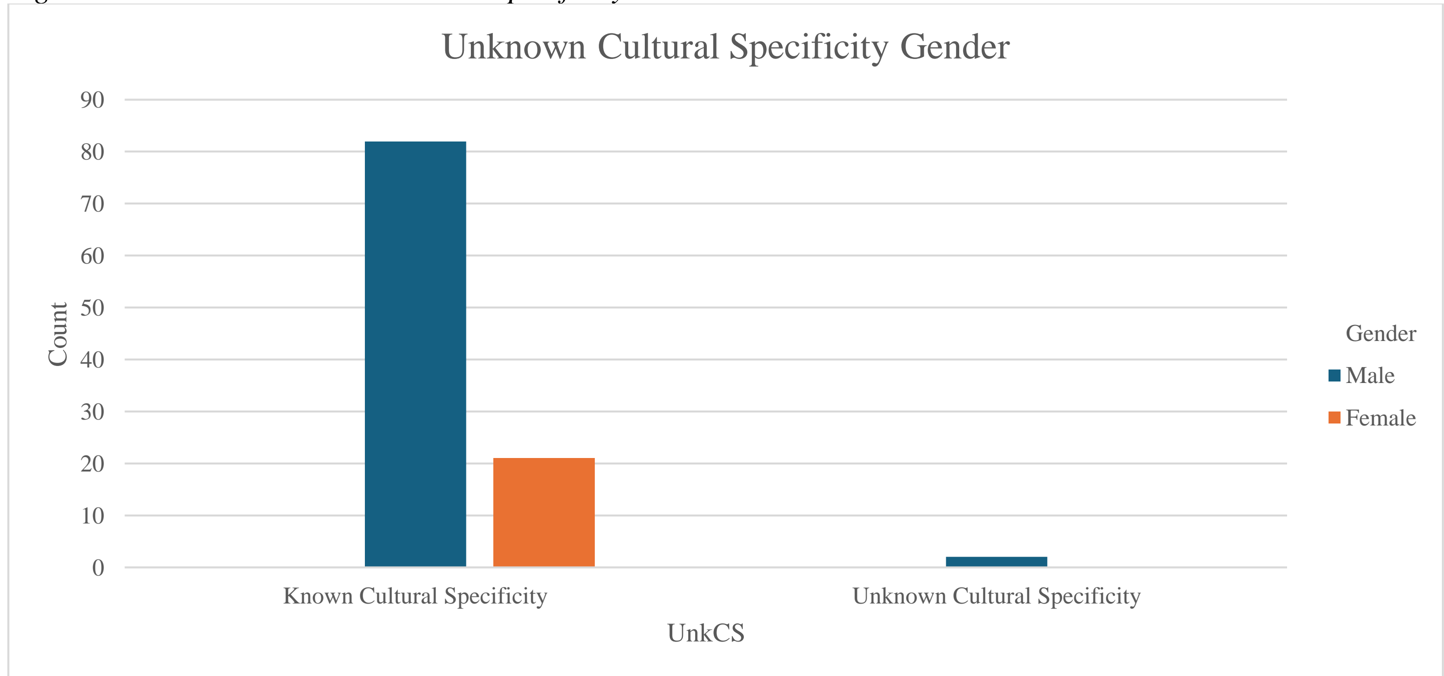
Figure 27a. GVIF Unknown Cultural Specificity Gender

UnkCS * Gender Crosstabulation

			Gender		Total
			Male	Female	
UnkCS	Known Cultural Specificity	Count	82	21	103
		% of Total	78.1%	20.0%	98.1%
	Unknown Cultural Specificity	Count	2	0	2
		% of Total	1.9%	0.0%	1.9%
Total		Count	84	21	105
		% of Total	80.0%	20.0%	100.0%

Within the unknown cultural specificity group, there are two individuals identified as male, accounting for 1.9% of the total count within this subgroup. There are no individuals identified as female within this group. Known cultural specificity individuals are predominantly male, comprising approximately 78.1% of the total count within this subgroup, while females constitute 20.0%. The total sample consists of 80.0% males and 20.0% females.

Figure 27b. GVIF Unknown Cultural Specificity Gender



The bar graph visually represents the distribution of individuals with unknown cultural specificity across different genders. Within this subgroup, there are two individuals identified as male, accounting for 1.9% of the total count within this subgroup. Notably, there are no individuals identified as female within this group. Conversely, individuals with known cultural specificity are predominantly male, comprising approximately 78.1% of the total count within this subgroup, while females constitute 20.0%. The graph underscores the representation of males among individuals with unknown cultural specificity, highlighting a potential gender disparity within this demographic. Further analysis may be warranted to understand the underlying factors contributing to this gender distribution and its implications for program engagement and outreach efforts.

"Non-Culturally Specific"

Program Status

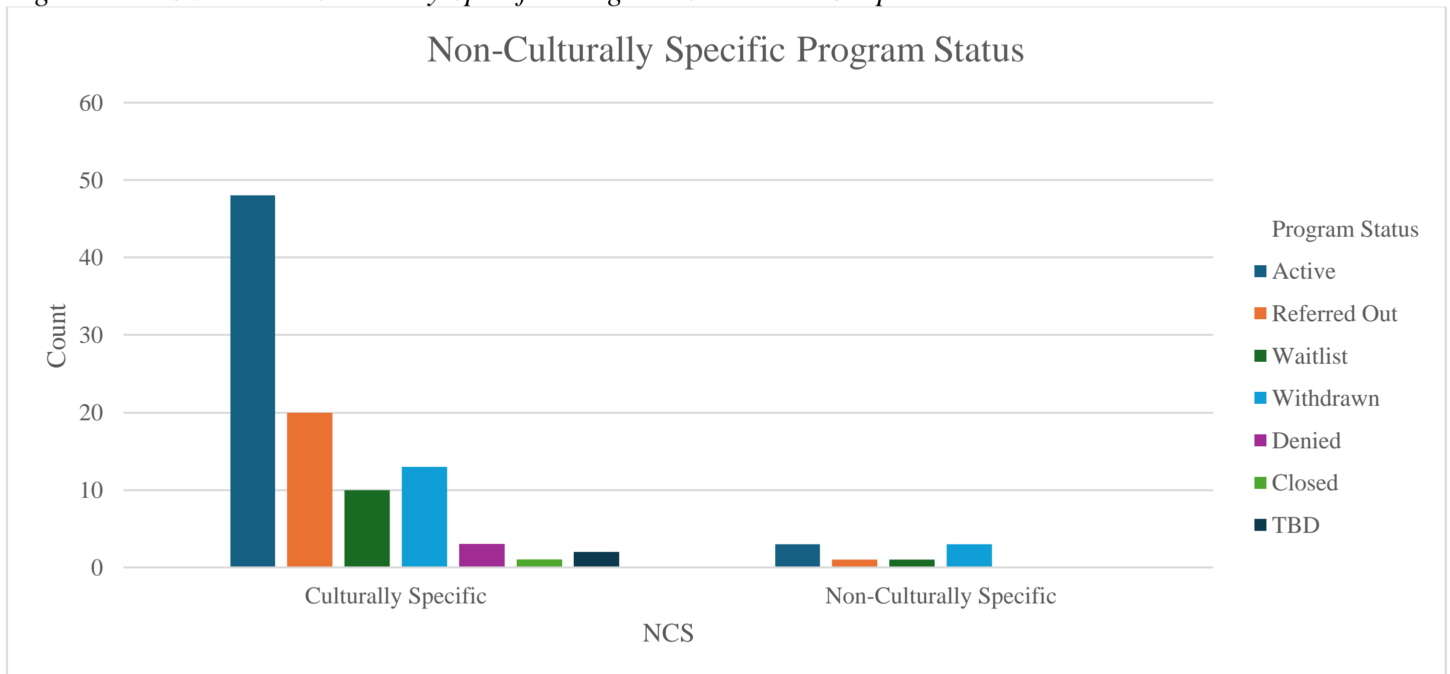
Figure 28a. GVIF Non-Culturally Specific Program Status

NCS * Program Status Crosstabulation

			Program Status							Total
			Active	Referred Out	Waitlist	Withdrawn	Denied	Closed	TBD	
NCS	Culturally Specific	Count	48	20	10	13	3	1	2	97
		% of Total	45.7%	19.0%	9.5%	12.4%	2.9%	1.0%	1.9%	92.4%
	Non-Culturally Specific	Count	3	1	1	3	0	0	0	8
		% of Total	2.9%	1.0%	1.0%	2.9%	0.0%	0.0%	0.0%	7.6%
Total		Count	51	21	11	16	3	1	2	105
		% of Total	48.6%	20.0%	10.5%	15.2%	2.9%	1.0%	1.9%	100.0%

Among individuals classified as Culturally Specific the majority are in the "Active" program status, accounting for 45.7% of the total count within this subgroup. The "Referred Out" and "Withdrawn" statuses also have notable representation among Culturally Specific individuals, each comprising 19.0% and 12.4% of the total count within this subgroup, respectively. Non-Culturally Specific (NCS) individuals are less prevalent across all program statuses, with the highest representation seen in the "Active" status at 2.9%. "Closed" and "TBD" statuses have minimal representation across both Culturally Specific and Non-Culturally Specific categories, each accounting for 1.0% or less of the total count within their respective groups. Overall, the majority of individuals are classified as Culturally Specific, constituting 92.4% of the total count, while Non-Culturally Specific individuals make up 7.6%.

Figure 28b. GVIF Non-Culturally Specific Program Status Bar Graph



The bar graph illustrates the distribution of individuals across various program statuses, categorized by their cultural specificity. Among Culturally Specific individuals, the majority are actively participating in the program, with 'Active' status representing the highest bar, followed by 'Referred Out' and 'Withdrawn.' In contrast, Non-Culturally Specific individuals show much lower representation across all program statuses, with

'Active' status being the most prevalent among them. Additionally, both groups exhibit minimal presence in statuses such as 'Closed' and 'TBD.' Overall, the graph highlights the disparity in program engagement between Culturally Specific and Non-Culturally Specific individuals, with Culturally Specific individuals showing higher involvement across multiple program statuses.

Age and Gender

Age.

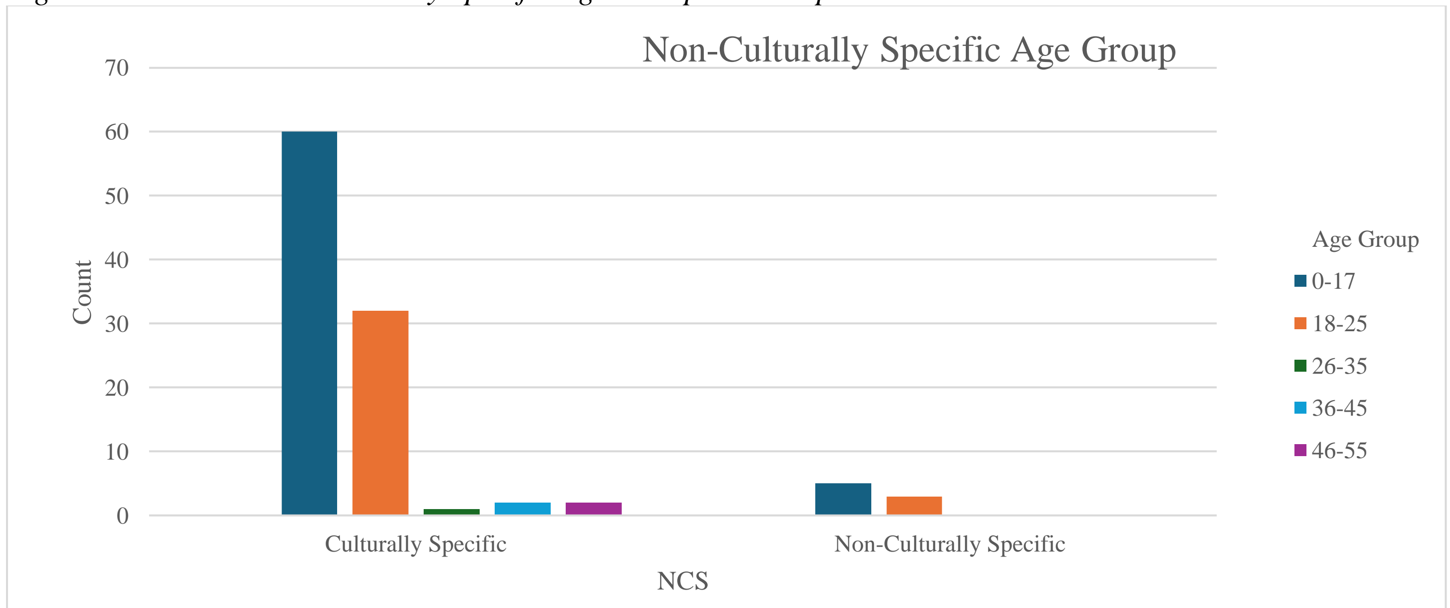
Figure 29a. GVIF Non-Culturally Specific Age Group

NCS * Age Group Crosstabulation

			Age Group					Total
			0-17	18-25	26-35	36-45	46-55	
NCS	Culturally Specific	Count	60	32	1	2	2	97
		% of Total	57.1%	30.5%	1.0%	1.9%	1.9%	92.4%
	Non-Culturally Specific	Count	5	3	0	0	0	8
		% of Total	4.8%	2.9%	0.0%	0.0%	0.0%	7.6%
Total		Count	65	35	1	2	2	105
		% of Total	61.9%	33.3%	1.0%	1.9%	1.9%	100.0%

Among individuals classified as Culturally Specific, the age group of 0-17 exhibits the highest representation, comprising 57.1% of the total count within this subgroup. The age group of 18-25 also has notable representation among Culturally Specific individuals, accounting for 30.5% of the total count within this subgroup. Non-Culturally Specific individuals are less prevalent across all age groups, with the highest representation seen in the age group of 0-17 at 4.8%. The remaining age groups (26-35, 36-45, 46-55) have minimal representation across both Culturally Specific and Non-Culturally Specific categories, each accounting for 1.9% or less of the total count within their respective groups. Overall, the majority of individuals are classified as Culturally Specific, constituting 92.4% of the total count, while Non-Culturally Specific individuals make up 7.6%.

Figure 29b. GVIF Non-Culturally Specific Age Group Bar Graph



The bar graph depicts the distribution of individuals across various age groups, classified by their cultural specificity. Among Culturally Specific individuals, the age group of 0-17 shows the highest

representation, with a substantial bar indicating 57.1% of the total count within this subgroup. Following closely, the age group of 18-25 also exhibits significant representation among Culturally Specific individuals, comprising 30.5% of the total count within this subgroup. Conversely, Non-Culturally Specific individuals are less prevalent across all age groups, with the highest representation observed in the 0-17 age group at 4.8%. Minimal representation is observed in the remaining age groups (26-35, 36-45, 46-55) for both Culturally Specific and Non-Culturally Specific categories. Overall, the graph highlights the disparity in age group distribution between Culturally Specific and Non-Culturally Specific individuals, with Culturally Specific individuals dominating across various age brackets.

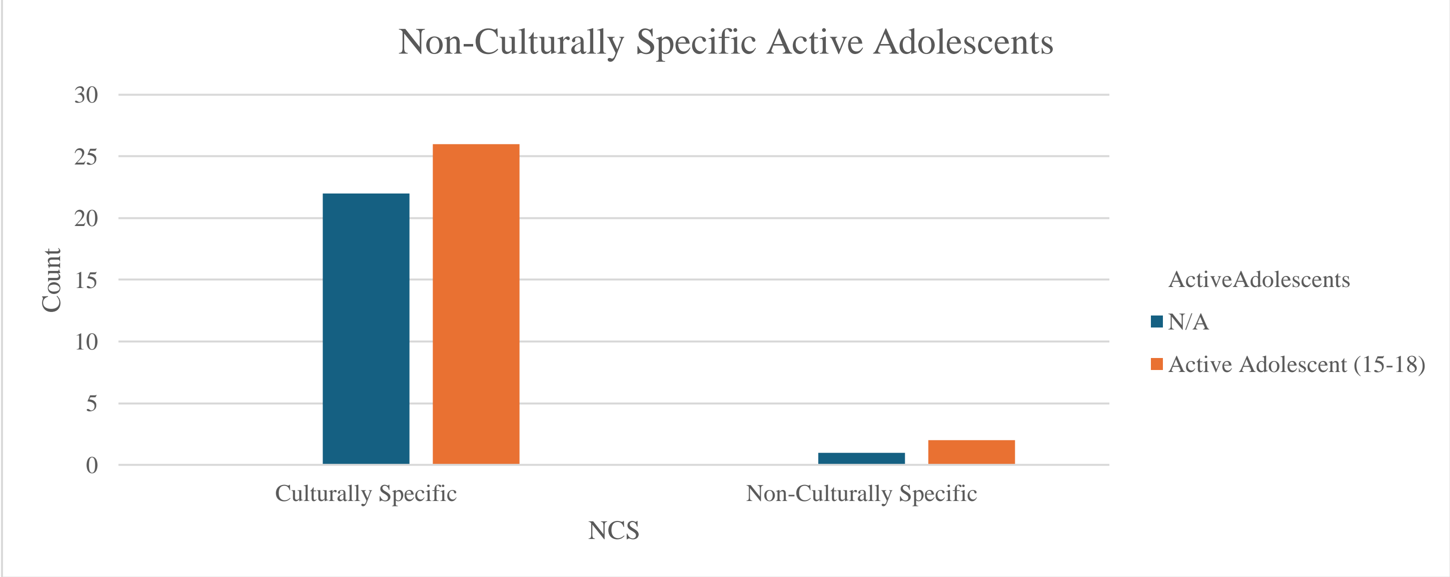
Figure 30a. GVIF Non-Culturally Specific Active Adolescents

NCS * Active Adolescents Crosstabulation

			Active Adolescents		Total
			N/A	Active Adolescent (15-18)	
NCS	Culturally Specific	Count	22	26	48
		% of Total	43.1%	51.0%	94.1%
	Non-Culturally Specific	Count	1	2	3
		% of Total	2.0%	3.9%	5.9%
Total		Count	23	28	51
		% of Total	45.1%	54.9%	100.0%

Among individuals classified as Culturally Specific, the majority fall into the category of "Active Adolescent (15-18)," representing 51.0% of the total count within this subgroup. A notable proportion of Culturally Specific individuals are categorized as "N/A" indicating that they are not a part of the Active Adolescent subgroup, accounting for 43.1% of the total count within this subgroup. Non-Culturally Specific (NCS) individuals also show representation in both categories, with the highest proportion falling into the "Active Adolescent (15-18)" category at 3.9%. Overall, the majority of individuals within the sample are classified as Culturally Specific, constituting 94.1% of the total count, while Non-Culturally Specific individuals make up 5.9%.

Figure 30b. GVIF Non-Culturally Specific Active Adolescents Bar Graph



The bar chart illustrates the distribution of individuals across two categories of active adolescents, further classified by their cultural specificity. Among individuals classified as Culturally Specific (NCS), the majority are categorized as 'Active Adolescent (15-18),' as depicted by the tallest bar, representing 51.0% of the total count within this subgroup. Additionally, a significant proportion of Culturally Specific individuals fall into the category of 'N/A,' indicated by the second tallest bar, accounting for 43.1% of the total count within this subgroup. Non-Culturally Specific (NCS) individuals also show representation in both categories, although to a lesser extent. The chart effectively highlights the disparity in active adolescent engagement between Culturally Specific and Non-Culturally Specific individuals, with Culturally Specific individuals dominating both categories.

Gender/Sex.

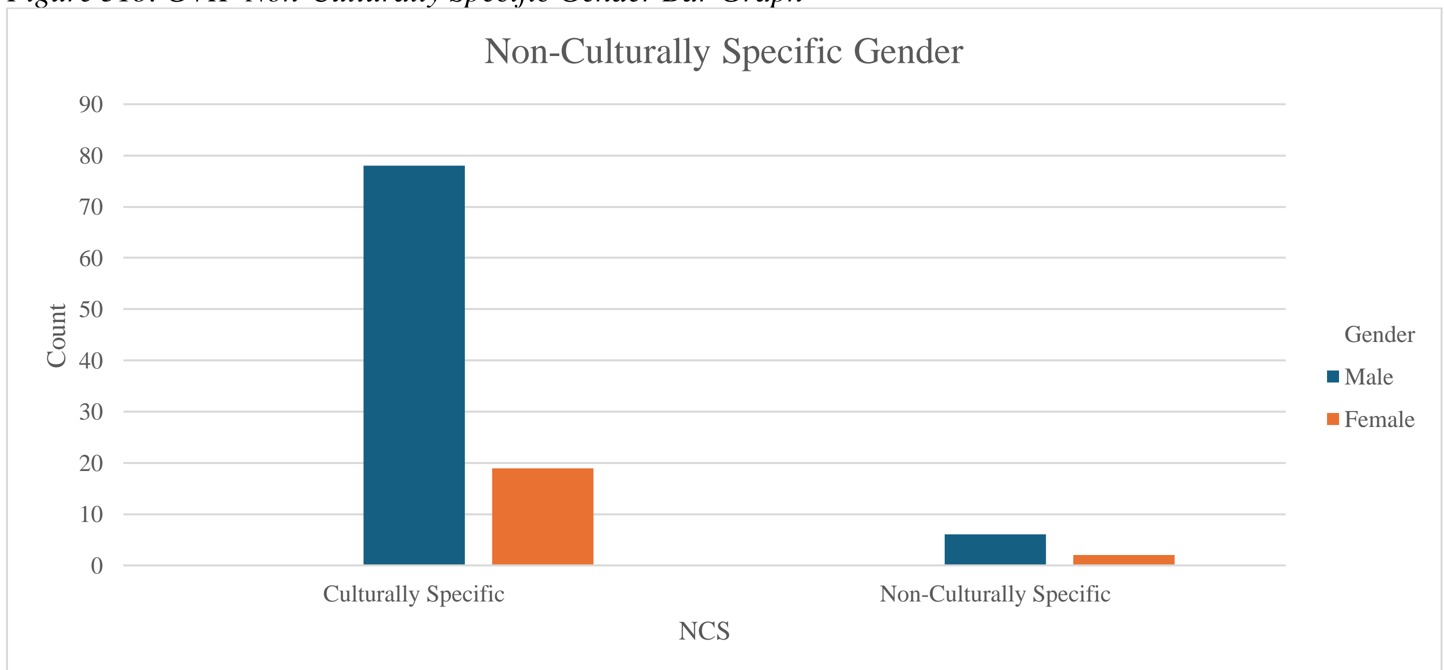
Figure 31a. GVIF Non-Culturally Specific Gender

NCS * Gender Crosstabulation

			Gender		Total
			Male	Female	
NCS	Culturally Specific	Count	78	19	97
		% of Total	74.3%	18.1%	92.4%
	Non-Culturally Specific	Count	6	2	8
		% of Total	5.7%	1.9%	7.6%
Total		Count	84	21	105
		% of Total	80.0%	20.0%	100.0%

Among individuals classified as Culturally Specific, the majority are male, accounting for 74.3% of the total count within this subgroup. Female representation among Culturally Specific individuals is notably lower, comprising 18.1% of the total count within this subgroup. Non-Culturally Specific (NCS) individuals also show male dominance, albeit to a lesser extent, with males representing 5.7% of the total count within this subgroup. Female representation among Non-Culturally Specific individuals is minimal, accounting for only 1.9% of the total count within this subgroup. Overall, the majority of individuals within the sample are classified as Culturally Specific, constituting 92.4% of the total count, while Non-Culturally Specific individuals make up 7.6%.

Figure 31b. GVIF Non-Culturally Specific Gender Bar Graph



The bar chart illustrates the distribution of individuals across two gender categories, further classified by their cultural specificity. Among individuals classified as Culturally Specific, the tallest bar represents males, accounting for 74.3% of the total count within this subgroup. A smaller bar adjacent to it represents females, comprising 18.1% of the total count within this subgroup. Non-Culturally Specific (NCS) individuals also show a similar pattern of male dominance, though to a lesser extent, with males representing 5.7% of the total count within this subgroup. The bar chart effectively highlights the gender disparity among both Culturally Specific and Non-Culturally Specific individuals, with males being more prevalent in both categories.

Equity Impact Estimates

Based on data from the US Census Bureau, the total population of Multnomah County in 2020 was reported to be 815,428 individuals. Additionally, according to the statewide firearm injury report spanning from 2018 to 2023, Multnomah County exhibited a firearm injury rate of 151.9 incidents per 100,000 individuals over this five-year period. Utilizing this information, we can estimate that approximately 1,237 individuals were impacted by firearm injuries in Multnomah County during this time frame. Subsequently, considering the data provided by GVIF, we estimate a five-year admission rate of 255 admissions out of 525 or 48.5%. To ascertain the likelihood of admission given an individual is impacted by a firearm injury, we computed the conditional probability. Dividing the number of admissions by the estimated number of impacted individuals, we find that approximately 20.6% of individuals impacted by firearm injuries over five years are likely to be admitted to the GVIF program.

According to the data provided by the Multnomah County District Attorney, there were 994 cases involving gun violence prosecuted between 2019 and 2024. Utilizing the total population of Multnomah County in 2020, reported to be 815,428 individuals by the US Census Bureau and the five-year admission estimate for GVIF of 48.5%, we calculated the probability of admission given an individual is represented in the DA's office related to gun violence to be approximately 48.49%. This suggests that around 48.49% of individuals impacted by gun violence in cases issued by the DA are likely to receive services from GVIF over a five-year period. Thus, it can be inferred that nearly half of the gun violence cases may have the potential to receive support through the GVIF program.

Qualitative Process Analysis

A thematic analysis of youth interviews, parent interviews, and a focus group discussion with GVIF stakeholders yielded five themes that inform the experiences of youth, families, and stakeholders with the GVIF process. These themes are named in no particular order in this section and accompanied by supportive direct quotes from respective sources.

Themes

Relational Connectedness from consumer to program. Stakeholders, youth, and their family members discussed the importance of relationships fostered with the program. Testimonies showed that trust in these relationships stemmed from endorsements by trusted professionals. Focus group discussions highlighted the process of building mutual trust between families and GVIF staff, evident across various narratives.

Relationships were evidenced as a primary reason that youth and families buy-in and align with GVIF as one stakeholder expressed "…our families don't trust anybody unless we bring them to the table." This sentiment, which is echoed throughout the focus group discussion, and interviews with the youth and their parent, suggests that trust in external entities or individuals is conditional upon the involvement or endorsement of someone who has already established rapport with the family. It implies that the community or organization plays a crucial role in facilitating trust and collaboration with others, particularly regarding their families. This statement underscores the importance of personal connections, community involvement, and endorsement in building trust and fostering meaningful relationships.

The endurance and longevity of the relationships built with GVIF are also described as a positive aspect of the program's operations. In a discussion about the difference between GVIF and other community-based services one stakeholder stated, "It's a healing process and they can continue this not just six to seven sessions and we're going to drop you off, it's a continuing relationship". It emphasizes the importance of continuity and ongoing support in the healing process, rather than a finite or time-limited intervention. The statement highlights the commitment to maintaining a long-term relationship and providing sustained support to individuals involved with GVIF.

> "So they, the therapists came to our parent meetings, they met our time, the parents time, so they came to them, and that's how they made the connection. So if we met on a Monday and opened it up for two, three referrals, we might have had five referrals because they met with the therapist in our meeting. So, you have to connect with us before you know to get our families and that happened."

This quote from a GVIF stakeholder emphasizes the process of inviting GVIF therapists into the community to facilitate introductions and rapport before youth enter the program. The description of this process further iterates the relevance and importance of rapport and relationship building within the community to facilitate trusting relationships between GVIF providers and the youth and families served.

Building Community Efficacy. GVIF's role in fostering community efficacy was highlighted consistently in interviews and focus groups. Community efficacy is foundationally supported through social cohesion. Social cohesion and collective efficacy were discussed across all points of data collection throughout this process. GVIF stakeholders discussed the tight-knit nature of the program itself as a positive promotion of social cohesion. Youth expressed similarly that "participation helps you make connections with other families who share similar experiences", and a parent shared "It's really good to be in a situation or setting with parents, who's experiencing the same as you in some shape, form, or fashion. You know, it's good to have each other to lean on in our time of need". These sentiments convey that the promotion of social cohesion among GVIF families and youth is beneficial for their experiences within the program as well as for building community efficacy.

Culturally Adaptive Programming. Culturally adaptive programming emerged as crucial from the qualitative data. Stakeholders stressed GVIF's deliberate hiring practices to match clinicians with clients' cultural needs. The program's success was linked to tailoring services to both cultural and individual circumstances, as noted by stakeholders, youth, and parents. The importance of community-based clinicians over outsiders was

consistently highlighted. Additionally, discussions among stakeholders emphasized the significance of incorporating religious connections into the programming.

GVIF's culturally targeted hiring practices for clinicians and staff that are aligned culturally with the participants and families that they serve is lauded as hallmark of their practice model among stakeholders.

> "And so, I know that the behavioral health team was looking to hire a person from the African communities to be able to address and start to work within communities to be able to start to address some of the issues around gun violence because it has such an impact."- Stakeholder Focus Group Participant

This approach acknowledges the importance of cultural representation and community involvement in addressing complex social issues such as gun violence, recognizing that individuals from affected communities have unique insights and perspectives that are essential for effective intervention and support.

Similarly, the adaptive nature of their service delivery and the considerations that GVIF makes regarding the circumstances of the youth and families in their care are noted as especially relevant to their programmatic success. For example, the parent of one youth in the program states "they have ways where they can do things where the, the two people that do not get along, to start the program separately, and then maybe down midway they can, you know, connect." This quote suggests that GVIF's strategy for facilitating connection and reconciliation between individuals who initially have conflicts or differences is effective. This approach recognizes the importance of starting the program separately to allow each person to engage in their treatment without the influence of the conflict. By providing space for individual reflection and growth, they can create opportunities for eventual connection and collaboration, potentially leading to resolution of conflicts or differences as the program progresses. Overall, this approach demonstrates a thoughtful and proactive approach to addressing interpersonal challenges and fostering positive outcomes through culturally adaptive engagement and connection.

The final subtheme, that emerged under the theme of culturally adaptive programming is the importance of representation. Among stakeholders the discussion of credible messengers spoke directly to the niched and specific ways that people from within the community can and do reach youth more effectively. These sentiments were fortified by reports from the youth,

> "I learned just how to just be a black man in general being around them. And they like you know, … they seemed like a lot of people with jobs and like, who got stuff going on with their life. That's what I learned to just be like one of them".

This quote speaks to the role models of Black men who demonstrated another way of life to which this youth can aspire. Additionally, it emphasizes the cultural relevance of racialized experiences within GVIF and among youth and families.

Family Care. Each contributor to the qualitative analysis highlighted a facet of family care that improved the program's effectiveness. This included aspects such as family inclusion, family safety, and family-centered work. For instance, one family member noted that GVIF facilitated positive experiences by increasing social connectedness and exposure to other families with similar experiences. And one youth identified that the program's inclusion of their family is impactful "…instead of just having the bad kids go, they invite the whole family. I like how they just include everybody that's in the household instead of just the one delinquent".

Subthemes of family care include role modeling, skill building, strategic treatment planning, and increasing social connectedness. These subthemes were evident across interviews and focus groups. For example, in speaking with a youth participant, the role models they interacted with were named as a primary motivator for their participation in the program and their choice to "…really look at how I'm living". The parent of a youth participant reported that their child was learning new skills in leadership and becoming a role model for other members of their family; "my child has adult siblings and younger siblings. So, it was a shock for the adult sibling, but impacted twice in two ways. So adult sibling is proud of the progress that he's done. And the younger siblings have someone they can look up to on a positive note".

Strategic treatment planning was evident in the ways that parents, youth, and stakeholders described the intentionality of treatment structures with GVIF. It is most notable in the narratives about how conflict is

handled among participants of the program. Strategic treatment planning is also evident in the process of clinical assignments in GVIF.

> "…and the young lady wanted a female therapist. Well, they didn't have any at the time, but they kept her abreast and the family communicated with until they got that therapist. So, it was communication weekly, next steps, where we're at, but they didn't just drop the ball. They continued with additional resources until they got a female therapist."

The strategy described by one stakeholder indicates great care and concern for how well youth involved with GVIF can relate with their providers. Given the emphasis on culturally adaptive, and relational treatment modalities this subtheme was especially poignant. Finally, increasing social connectedness was observed through the linking of families and youth to others within their communities in order to build up social supports. A parent's discussion of the impact of the program on her and her family described the integration of each of the subthemes aptly.

> "…it's good to know others has been through it. And it's good to exchange information and understand their process. Because when you look at someone else, and you see what they've gone through, how did they handle it? You know, that's also giving a parent tools where they can share with each other and build on that.".

Prevention. In service user interviews, the importance of prevention efforts in communities across Multnomah County were stressed. Youth and their family members expressed the desire for interventions to occur before issues arose, indicating a preference for proactive involvement.

> "Yes, the only thing that I feel about the program is, I think it needs to be put out there. The tools and the knowledge for our youth at an early age. You know, don't wait until they get in trouble. Do something beforehand, put it into schools, do something, put it on the radio, put it on multimedia. You know, these kids are always online."- GVIF Parent

This parent recognizes a need within the community for preventative efforts in tandem with the interventions provided with GVIF. Moreover, this quote illustrates the desire for families and those impacted to have access to and interface with services before the need is dire through the integration of services with schools, and media sources that are already a part of their daily lives. This perspective underscores the urgency of preventive measures and the need to reach young people where they are, highlighting the potential of widespread education and awareness initiatives to positively impact youth outcomes.

Review of Assessment Tools

Exposure to Violence Assessments:

Survey of Exposure to Community Violence (SECV; Richters & Staltzman, 1990). The Survey of Exposure to Community Violence (SECV; Richters & Stalzman, 1990) is a 54-item self-report survey that assesses the frequency of people's exposure to various threats in their neighborhoods. The survey has been used and validated in various abbreviated forms and with children, adolescent, and adult populations. On a 9-point Likert scale from 1 (never) to 9 (almost every day), respondents indicate how frequently they have experienced, witnessed, or heard about each type of violence (e.g., "How many times have you yourself been chased by gangs or individuals?" or "How many times have you seen someone else get chased by gangs or older kids?"). If respondents say that they experienced the event more than once, they answer follow-up questions about where it took place (near home, in the home, near school, in school, or other) and when it last happened (about a week ago, about a month ago, about 3 months ago, about 6 months ago, about 9 months ago, about a year ago, between 1 and 2 years ago, between 3 and 5 years ago, or more than 5 years ago). If respondents witnessed the event, they answer questions about whom it happened to (adult stranger, adult acquaintance, adult friend, young stranger, young acquaintance, young friend, parent, brother/sister, other relative, or don't know).

Community Experiences Questionnaire (CEQ; Schwartz & Proctor, 2000). The Community Experiences Questionnaire is a 25-item abbreviated version of the SECV developed by Schwartz & Proctor (2000) and validated for use with children and adults. On a 4-point Likert scale from 1 (never) to 4 (lots of times), respondents rate statements to indicate how often they have been exposed to violence. The CEQ has two subscales: the 11-item Exposure Through Victimization Scale ("How many times has somebody hit, punched, or slapped you?"), and the 14-item Witnessing Violence Scale ("How many times have you seen or heard gunshots?"). Researchers calculate Exposure to Community Violence and Exposure Through Victimization scores by averaging respondents' ratings for each subscale.

Exposure to Violence Questionnaire (EVQ). The Exposure to Violence Questionnaire (EVQ; Reynolds & Mazza, 1995) is a 14-item self-report questionnaire that uses yes/no questions to assess how many times a respondent has been exposed to violence in the past year. The questionnaire focuses primarily on witnessing, experiencing, and learning of community violence inn Mazza and Reynold's 1999 study on Exposure to Violence in Young Inner-City Adolescents, though in other iterations has included exposure through media and other secondary sources.

Mental and Behavioral Health Assessments:

Brief Symptoms Inventory (BSI; Derogatis, 1993). The Brief Symptom Inventory (BSI) is a widely used psychological assessment tool designed to measure psychological distress and psychiatric symptoms in individuals aged 13 years and older. Developed by Derogatis (1993), the BSI is derived from the longer Symptom Checklist-90-Revised (SCL-90-R) and offers a more concise evaluation of an individual's mental health status. The BSI consists of 53 items that cover nine primary symptom dimensions: somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Respondents rate the severity of their symptoms over the past week on a 5-point Likert scale, ranging from 0 (not at all) to 4 (extremely). This assessment tool is utilized in various settings, including clinical practice, research studies, and mental health screenings. It provides valuable information about an individual's overall level of distress and specific areas of concern, aiding clinicians in diagnosis, treatment planning, and monitoring therapeutic progress. The BSI yields scores for each symptom dimension, as well as three global indices: the Global Severity Index (GSI), the Positive Symptom Distress Index (PSDI), and the Positive Symptom Total (PST). These indices offer a comprehensive overview of an individual's psychological functioning, with higher scores indicating greater distress and symptom severity. Moreover, the BSI includes additional scales such as the Positive Symptom Total (PST), which provides a count of the number of symptoms endorsed by the respondent, and the Overall Distress Index (ODI), which measures the overall level of psychological distress.

Child Behavior Checklist (CBCL; Achenbach, 1991). The Child Behavior Checklist (CBCL; Achenbach,1991) serves as a comprehensive measure for evaluating emotional and behavioral problems in children and adolescents aged 6 to 18 years. Structured in a questionnaire format, the CBCL is typically administered to parents or guardians who have a thorough understanding of the child's behavior. Additionally, there are versions tailored for teachers (Teacher's Report Form, TRF) and adolescents themselves (Youth Self-Report, YSR). The CBCL covers a broad spectrum of behavioral and emotional domains, encompassing both internalizing problems (such as anxiety, depression, and withdrawal) and externalizing problems (such as aggression and rule-breaking behavior). Respondents rate the extent to which each item applies to the child, with items grouped into scales that assess different aspects of behavior.

The CBCL generates scores for various syndrome scales, which represent clusters of related behaviors. Examples include the Withdrawn, Anxious/Depressed, and Aggressive Behavior scales. Additionally, it produces scores for broadband scales, which capture broader dimensions of behavior such as Internalizing Problems, Externalizing Problems, and Total Problems.

Standardized on large, diverse samples of children, the CBCL provides scores that can be compared to those of a normative group. This comparison helps determine whether a child's behavior falls within a clinically significant range. As a result, the CBCL is widely used in clinical settings to aid in diagnosis, treatment planning, and progress monitoring. It also serves as a valuable tool in research for studying the prevalence and correlates of various behavioral and emotional problems.

Revised Children's Manifest Anxiety Scale: Second Edition (RCMAS-2; Reynolds & Richmond 1985). The Revised Children's Manifest Anxiety Scale: Second Edition (RCMAS-2; Reynolds & Richmond 1985) is a widely used assessment tool developed to measure the level and nature of anxiety in children and adolescents aged 6 to 19 years. The RCMAS-2 consists of a self-report questionnaire completed by the child or adolescent, as well as a parallel form completed by a parent or guardian.

The RCMAS-2 assesses anxiety across various dimensions, including physiological symptoms (e.g., heart pounding, sweating), worry and oversensitivity (e.g., fear of making mistakes, worrying about what others think), and social concerns and concentration difficulties. Respondents rate the frequency with which they experience each item, allowing for a comprehensive evaluation of anxiety symptoms.

The RCMAS-2 provides scores for multiple scales, including Total Anxiety, Physiological Anxiety, Worry-Oversensitivity, Social Concerns-Concentration, and Lie Scale (to detect response bias or denial of anxiety symptoms). These scales help clinicians and researchers understand the specific aspects of anxiety that may be present in a child or adolescent.

Standardized on large, diverse samples of children and adolescents, the RCMAS-2 offers normative data that allow for comparison of an individual's scores to those of a reference group. This comparison aids in identifying the presence and severity of anxiety symptoms and determining whether they fall within a clinically significant range.

Clinically, the RCMAS-2 is used to assist in the diagnosis of anxiety disorders, treatment planning, and monitoring of treatment progress. In research, it serves as a valuable tool for studying the prevalence, correlates, and outcomes of anxiety in children and adolescents.

Center for Epidemiologic Studies Depression Scale (CES-D; Radloff 1977). The Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) is a widely used self-report questionnaire designed to measure depressive symptoms in the general population which was first introduced in 1977 as a tool to identify individuals at risk for depression within community samples.

The CES-D consists of 20 items covering various aspects of depressive symptomatology, including feelings of sadness, loss of appetite, sleep disturbances, and overall well-being. Respondents rate the frequency of experiencing each symptom over the past week on a scale ranging from 0 (rarely or none of the time) to 3 (most or all of the time) and was originally developed to address the need for a reliable and easily administered instrument for assessing depression in large-scale epidemiological studies.

The CES-D has been translated into numerous languages and adapted for different cultural contexts, making it a valuable tool for researchers and clinicians worldwide. Its widespread use in both research and clinical settings attests to its validity and reliability in assessing depressive symptoms across diverse populations.

PTSD Checklist – 5 (PCL-5; Weathers et al.,2013). The Post-traumatic Stress Disorder Checklist-5 (PCL-5; Weathers et. al, 2013) is a 20-item questionnaire that aligns with the DSM-5 criteria for a diagnosis of PTSD. The checklist uses a 5-point Likert scale for respondents to indicate the degree to which they experience the symptoms associated with PTSD as outline in the DSM-5. The scale consists of 20 items that correspond to the four symptom clusters of PTSD: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity.

The PCL-5 is suggested for use in monitoring symptoms during the course of treatment, screening individuals for PTSD, and providing a provisional diagnosis of PTSD before clinical assessment can occur. Unlike previous iterations of the checklist, the PCL-5 makes no differentiation between military personnel and civilians.

Criterion A of the PCL-5 provides an assessment of exposure to traumatic events. This element can be omitted if exposure is measured in another way. Additionally, there are versions of this scale to assess varying time frames including the past month and the past week. Finally, the scale can be administered with the revised Life Events Checklist for the DSM-5 (LEC-5) and an extended Criterion A.

Youth Symptom Survey Checklist (YSSC). The YSSC is a 17-item self-report measure of PTSD symptoms such as hyperarousal (e.g., had strange feelings in your body such as breaking out into a sweat or your heart beating fast), avoidance/numb (e.g., felt that you were not interested in things you used to enjoy doing), and re-experiencing (e.g., had bad dreams or nightmares). The total score (39 items; α=.88) can range from 17 to 68. Margolin, Vickerman, Oliver, and Gordis (2010) report that an arousal subscale of the YSSC had an internal consistency reliability of .85 in a community sample. Higher scores on this subscale were associated with youth experiencing community violence.

The YSSC is based on the symptom clusters of PTSD as presented in the DSM-IV. A search for an updated version yielded *The Child PTSD Symptom Scale for DSM-V (CPSS-V SR).*

The Child PTSD Symptom Scale for DSM-V (CPSS-V SR). The CPSS-SR-5 is a modified version of Child PTSD Symptom Scale self-report (CPSS-SR) for DSM-5. The 20 PTSD symptom items are rated on a 5-point scale of frequency and severity from 0 (not at all) to 4 (6 or more times a week /severe). The 7 functioning items are rated on yes/no. Clinicians may use the 20 symptom items to calculate a total symptom severity score. The CPSS-SR-5 has excellent internal consistency for total symptom severity (Cronbach's alpha = .924) and good test-retest reliability (r = .800). The CPSS-SR-5 also demonstrates convergent validity with CPSS-I-5 (r = .904), and discriminant validity with the Multidimensional Anxiety Scale (MASC) for Children and Child Depression Inventory (CDI). A cut off score of 31 can be used for identifying a probable PTSD diagnosis in children. In sum, the CPSSSR-5 is a valid and reliable self-report instrument for assessing DSM-5 PTSD diagnosis and severity for children and adolescents.

Kiddie Schedule for Affective Disorders and Schizophrenia - Present and Lifetime Version (K-SADS-PL). The Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS) is a semi-structured interview designed to facilitate early diagnosis of affective disorders such as depression, bipolar disorder, and anxiety disorder. Various versions of this test utilize different diagnostic criteria, encompass somewhat varied diagnoses, and employ distinct rating scales for assessment. Regardless of version, all iterations of the K-SADS involve interviews with both the child and their parents or guardians. They employ a mix of screening questions and comprehensive modules to ensure a balance between interview length and thoroughness.

Targeting school-aged children between 6 and 18 years old, the K-SADS, in its different adaptations, serves as a diagnostic tool for a wide array of affective and psychotic disorders. Administered by healthcare professionals or extensively trained clinical researchers, the semi-structured nature of the K-SADS offers

interviewers flexibility in phrasing questions and probing for symptoms while maintaining consistency across assessed disorders. Completion time for the K-SADS can vary depending on the individual being interviewed.

Most versions of the K-SADS incorporate "probes" that prompt further exploration of specific symptoms or diagnostic categories based on the respondent's answers. This approach ensures thoroughness in assessment, as additional symptoms are queried only if relevant probes are endorsed.

Through extensive research and implementation in various treatment settings, the K-SADS has demonstrated reliability and validity, and is a valuable tool in diagnosing childhood mental disorders.

The K-SADS-PL is used to screen for affective and psychotic disorders as well as other disorders, including, but not limited to Major Depressive Disorder, Mania, Bipolar Disorders, Schizophrenia, Schizoaffective Disorder, Generalized Anxiety, Obsessive Compulsive Disorder, Attention Deficit Hyperactivity Disorder, Conduct Disorder, Anorexia Nervosa, Bulimia, and Post-Traumatic Stress Disorder. The majority of items in the K-SADS-PL are scored using a 0–3 point rating scale. Scores of 0 indicate no information is available; scores of 1 suggest the symptom is not present; scores of 2 indicate sub-threshold presentation and scores of 3 indicate threshold presentation of symptoms.

Rosenberg Self-Esteem Scale (Rosenberg, 1965). The Rosenberg Self-Esteem Scale is a widely used psychological instrument designed to measure self-esteem, which is the overall subjective evaluation of one's own worth or value.

The scale consists of ten statements that participants are asked to rate on a four-point scale ranging from strongly agree to strongly disagree. The statements cover both positive and negative feelings about oneself, assessing aspects such as self-worth, self-acceptance, and self-respect. Some examples of statements from the scale include "I feel that I am a person of worth, at least on an equal plane with others" and "I feel that I have a number of good qualities."

Scores on the Rosenberg Self-Esteem Scale can range from 10 to 40, with higher scores indicating higher levels of self-esteem. While the scale provides a quantitative measure of self-esteem, it's essential to interpret scores within the context of the individual's circumstances and cultural background.

The scale has been translated into numerous languages and has been used in various settings, including research studies, clinical assessments, and educational settings. Its brevity, simplicity, and reliability make it a valuable tool for assessing self-esteem across different populations and age groups.

Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988). The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988) is a 12-item measure of perceived adequacy of social support from three sources: family, friends, & significant other; using a 5-point Likert scale (0 = strongly disagree, 5 = strongly agree).

Participants are asked to indicate the extent to which they agree with each statement Sample statements include "My family really tries to help me" (family subscale), "I can talk about my problems with my friends" (friends' subscale), and "There is a special person who is around when I am in need" (significant other subscale).

Scores on the MSPSS can be calculated separately for each dimension of social support or combined to provide an overall measure of perceived social support. Higher scores indicate greater perceived support from the respective source (family, friends, or significant others).

The MSPSS has been translated into multiple languages and has been used extensively in research and clinical settings to assess the perceived availability of social support and its association with various psychological and health outcomes. Its brevity, ease of administration, and strong psychometric properties make it a valuable tool for understanding the role of social support in individuals' lives.

Culturally Specific Wellbeing/ Coping:

Spiritual Well-being Scale (SWBS; Ellison & Paloutzian, 1992). The Spiritual Well-Being Scale (SWBS) can be used to assess an individual's sense of spiritual well-being. It is a comprehensive measure that encompasses both religious and existential dimensions of spirituality. The scale consists of 20 items divided into two subscales: Religious Well-Being (RWB) and Existential Well-Being (EWB). Each subscale contains ten items that assess different aspects of spiritual well-being.

The Religious Well-Being (RWB) subscale focuses on an individual's sense of connection with their religious beliefs, community, and practices. It includes items that assess the perceived closeness to a higher power, the sense of meaning derived from religious beliefs, and the level of satisfaction with one's religious life.

The Existential Well-Being (EWB) subscale, on the other hand, addresses broader existential questions related to purpose, meaning, and fulfillment in life. It includes items that explore an individual's sense of purpose, coherence, and satisfaction with life as a whole, independent of religious beliefs.

Participants rate each item on a Likert-type scale, indicating the extent to which they agree or disagree with statements about their spiritual well-being. Scores on each subscale can be calculated separately, providing insights into the religious and existential dimensions of an individual's spiritual experience. Additionally, a total score can be computed by summing the scores of both subscales, offering a comprehensive measure of overall spiritual well-being.

The SWBS has been widely used in research and clinical practice to assess spiritual well-being across different populations and cultural contexts. Its multidimensional approach and robust psychometric properties make it a valuable tool for understanding the role of spirituality in promoting psychological health and well-being.

John Henryism Scale for Active Coping (James, 1996). The John Henryism Scale is a psychological assessment tool that measures a person's level of John Henryism, a concept derived from the folklore tale of John Henry, an African American folk hero known for his strength and determination. The scale is designed to assess individuals' beliefs in their mental and physical vigor, their commitment to hard work, and their single-minded determination to succeed, particularly in the face of adversity.

The scale consists of a set of questions, often around 12 items, that are designed to capture different aspects of John Henryism. These questions may inquire about beliefs related to personal agency, persistence, resilience, and standing up for one's beliefs despite challenges. For example, questions include statements like, "I've always felt that I could make of my life pretty much what I wanted to make of it," or "Once I make up my mind to do something, I stay with it until the job is completely done."

Respondents rate their agreement with each statement on a Likert-type scale, ranging from "completely true" to "completely false." Each response is assigned a numerical value, and the total score on the scale is calculated by summing these values. Higher scores indicate a greater alignment with the traits associated with John Henryism, such as perseverance, self-reliance, and a strong work ethic.

The John Henryism Scale has been used in research to study its relationship with various outcomes, such as physical health, mental health, academic achievement, and socioeconomic status. It has been particularly validated in studies involving African American participants, given the historical and cultural significance of the John Henry legend within African American folklore.

CONCLUSIONS AND RECOMMENDATIONS

Based on the themes and findings of the scoping review, a comprehensive program addressing the mental health impact of gun violence in Multnomah County should incorporate several key elements. Firstly, it's vital to recognize the significance of family structure and stability in mitigating the risk of secondary exposure to violence, especially in high-crime neighborhoods. Interventions should focus on providing support to single-parent families and addressing factors such as parental instability. Given the anticipated increase in hospitalizations for anxiety and stress-based disorders during spikes in community violence, interventions should prioritize trauma-informed therapy services and community support groups. These programs can capitalize on existing protective factors such as school climate and parental bonding, while also addressing delinquency and risky behavior through tailored interventions. Long-term mental health services should be provided to families affected by gun violence, with a particular emphasis on linguistic continuity and cultural sensitivity. Furthermore, involving participants in program design and implementation can enhance engagement and effectiveness. Evidence-based treatments like Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) should be incorporated, along with elements of model injury and violence prevention programs, focusing on early educational achievement and strengthening community partnerships. The program should aim to bolster collective efficacy within communities, offering conflict resolution and aggression reduction skills to minimize violence exposure and improve mental health outcomes among youth. Overall, a multifaceted approach that integrates diverse therapeutic modalities, cultural adaptations, and community engagement strategies is essential for addressing the complex mental health needs of individuals and families impacted by gun violence in Multnomah County.

The themes of the process analysis reveal that the most valuable aspects of the GVIF program from the perspectives of parents, youth, and stakeholders are the emphasis on relationships and rapport, cultural adaptivity, community efficacy, and family care and integration. The themes also yield a call for prevention efforts to be emphasized within communities. While stakeholders acknowledged and noted prevention-oriented programs throughout the county, the testimonies from the youth and parents indicate a lack of connection in the way that GVIF has been connected.

Community interventions are marked by partnerships across disciplines and sectors, an emphasis on community involvement in the intervention, and the delivery of services in the community (Castillo et al., 2019). A major discussion among stakeholders was the need to partner and collaborate with religious institutions in order to reach deeper into marginalized communities. Specifically, discussions about the engagement of the Somalian community in Multnomah County turned to the discussion of getting community leaders involved.

Broadly, racial, and ethnic demographics are poorly accounted for in census, due to the aggregation of races and ethnicities. For instance, the characterization of “African Immigrant/Refugee” encompasses persons from Africa. Who have immigrated with those who sought asylum and this designation fails to recognize differentiation between countries and cultures of origin. This aggregation across culturally specific groups may leave GVIF ill equipped to engage communities that are impacted by gun violence.

The equity estimate indicates that the program has the potential to serve nearly 50% of all families impacted by gun violence across the county. This estimate suggests the need for GVIF expansion. Given the intentionality, specificity, and adaptivity of the program this expansion should be methodical and strategic. Recommendations for the incorporation of the findings of this evaluation into the expansion of GVIF are detailed in the next and final section.

Program Operations

The results of this evaluation provide a strong argument for the expansion of the program to include more culturally specific and diverse clinicians and personnel. In light of the growing demand for culturally specific mental health services across the county and the imperative to ensure equitable access to care, it is recommended that GVIF undertake a strategic expansion of its workforce. This proposal advocates for the

employment of 10 additional clinicians within the next year, with a deliberate focus on demographic representation to ensure culturally tailored service the diverse population of persons impacted by gun violence in Multnomah County.

Rationale for Workforce Expansion

The decision to increase GVIF's clinician workforce stems from the recognition of several critical factors. First and foremost is the pressing need to address the mental health disparities prevalent among marginalized communities, particularly African American, Latinx, and East African populations. Studies consistently underscore the importance of cultural competence and representation in mental health care delivery, emphasizing the need for services that are sensitive to diverse cultural backgrounds and experiences (Berdychevsky et al., 2022; Duale, n.d.; Gudiño, 2013; Kataoka et al., 2010; McCrea et al., 2019).

Optimal Distribution of Clinicians

To ensure effective and culturally adaptive care, it is recommended that the new hires reflect the demographic composition of the county and the program acceptances. An ideal distribution would entail recruiting 4-5 African American clinicians, 3-4 Spanish-speaking clinicians who identify as Latinx, at least one clinician from the Somali or East African community, and 1-2 clinicians who are not culturally specific.

Equity Analysis and Service Capacity

The equity analysis conducted to estimate service capacity indicates that with ten additional providers, GVIF would be equipped to handle approximately 100 cases per year, with each clinician carrying a caseload of ten. However, it is imperative to recognize that the effectiveness and impact of service provision can be influenced by factors such as the duration of case activity and the level of family and youth involvement. Consequently, there may be a need for smaller caseloads to ensure meaningful intervention and support.

Long-term Strategy for Workforce Development

Looking ahead, GVIF should not view workforce expansion as a one-time endeavor but rather as an ongoing commitment to meeting the evolving needs of the community. Over the course of the next five years, the organization should aim to sustain the same proportional representation in its clinician recruitment efforts. This would entail hiring five culturally specific clinicians annually, resulting in a total of thirty clinicians after five years, with a demographic breakdown of 40-50% African American, 30-40% Latinx and Spanish-speaking, 10% representing disaggregated African immigrants or refugees, and 10-20% non-culturally specific.

The proposed expansion of GVIF's clinician workforce aligns with the organization's mission to provide equitable and culturally competent mental health services. By prioritizing diversity and representation in hiring practices, GVIF can enhance its capacity to address the unique needs of the community while advancing health equity and social justice goals. This strategic investment in workforce development holds the potential to yield significant benefits for individuals and families seeking support and healing.

Clinical Trainings/Skills

Clinician Education

It is recommended that the program seeks to employ mental health providers at both the master’s and bachelor’s levels to diversify its workforce and enhance service delivery. Each level of training brings unique strengths and capabilities that can complement one another within a comprehensive care framework. Masters-level providers typically possess advanced clinical training, including specialized knowledge in assessment, diagnosis, and evidence-based interventions. Their expertise enables them to work with complex cases, provide psychotherapy, and offer in-depth therapeutic interventions. On the other hand, Bachelors-level providers bring valuable skills in case management, psychoeducation, and community outreach. While they may not engage in psychotherapy to the same extent as Masters-level clinicians, their focus on practical support, advocacy, and resource navigation is invaluable in promoting holistic wellness and addressing social determinants of health. Moreover, acknowledging the centrality of rapport and relationships in the GVIF model, it's crucial to highlight that too much educational separation between service users and providers can potentially lead to division within

the therapeutic dynamic. Significant disparities in educational background between providers and the recipients of services, can inadvertently create barriers to understanding, communication, and trust. Service users may perceive their providers as distant or disconnected, making it challenging to establish a genuine therapeutic alliance built on mutual respect and empathy. Furthermore, the power dynamics inherent in the provider-client relationship can be exacerbated by educational discrepancies, potentially fostering feelings of inferiority or skepticism among service users. Therefore, it's essential to strike a balance in the educational composition of the workforce, ensuring that it reflects the diversity of educational backgrounds present within the community served. This approach fosters a more inclusive and equitable environment where service users feel validated, empowered, and genuinely understood, ultimately promoting positive therapeutic outcomes, and enhancing overall service effectiveness.

It is also recommended that GVIF diversify their workforce regrading education as much as possible. There are many educational programs that prepare people to work with youth and families impacted by gun and community violence and each provides the clinician with unique and varied perspectives and approaches to supporting individuals, families, and communities. Social work education emphasizes a holistic understanding of human behavior within the context of social systems and structures. Social workers are trained to address systemic inequalities and advocate for social justice while providing counseling, case management, and community resources. Counseling programs focus on developing clinical skills for individual and group therapy, with an emphasis on psychological assessment, diagnosis, and treatment planning. Counselors work across diverse settings, offering psychotherapy and counseling services to address a wide range of mental health concerns. Human services education encompasses a broad interdisciplinary approach, integrating elements of psychology, sociology, and social work to address the needs of vulnerable populations. Human services professionals often work in roles that involve advocacy, service coordination, and program development within community-based organizations. Marriage and family therapy training emphasizes systemic approaches to therapy, focusing on relational dynamics and family systems theory. Marriage and family therapists are trained to work with couples and families, addressing relational conflicts, communication patterns, and family functioning to promote healing and resilience. While each educational track has its distinct focus and skill set, collaboration among professionals from these disciplines is essential for providing comprehensive and integrated care that meets the needs of diverse clients and communities.

Evidence Based Treatments

Based on the findings of this evaluation it is recommended that clinicians and service providers with GVIF receive training in evidence-based treatments and practices. Evidence-based treatment modalities are proven effective in reducing undesirable symptoms and outcomes through research and assessment. Evidence-based practices contour the ways in which treatments are delivered, and for GVIF this includes delivery in culturally adaptive and informed ways. In order to address the documented outcomes of exposure to gun violence throughout this report, it is recommended that providers through GVIF be trained in the following evidence-based treatments and to employ evidence-based practices that serve to adapt these treatments in culturally relevant ways.

Cognitive Behavior Therapy (CBT) is a widely practiced therapeutic approach grounded in the principles of cognitive and behavioral psychology. It focuses on identifying and changing maladaptive thought patterns and behaviors that contribute to emotional distress and psychological difficulties. In CBT, therapists work collaboratively with clients to examine the connections between their thoughts, feelings, and behaviors, aiming to challenge and reframe negative or unhelpful beliefs and develop healthier coping strategies. The cognitive component of CBT involves helping clients recognize and challenge cognitive distortions, such as catastrophizing or black-and-white thinking, while the behavioral component focuses on implementing practical strategies to modify behaviors and improve mood regulation. CBT techniques may include cognitive restructuring, behavioral experiments, exposure therapy, and skills training. CBT is highly structured, goal-oriented, and typically delivered over a finite number of sessions. This modality also has a strong track record of success in reducing depressive symptoms, anxiety, specific and generalized phobias, and PTSD.

Additionally, adaptations of CBT, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) which has demonstrated the most consistent effect in reducing and managing symptoms of PTSD in youth and adolescents of all racial and ethnic backgrounds, provide opportunities to tailor treatments to the particular needs of individual clients, families, and communities(DePrince & Shirk, 2013; Dumornay et al., 2022; Gillies D et al., 2016; Hanson et al., 2016; Last BS et al., 2020; Pfeiffer et al., 2020; Pigeon et al., 2015).

Interpersonal Therapy (IPT) is a time-limited psychotherapy approach that focuses on improving interpersonal relationships and addressing interpersonal issues that contribute to psychological distress. Originally developed to treat depression, IPT has since been adapted to address a range of mental health concerns, including anxiety disorders, eating disorders, and relationship issues. IPT is based on the premise that difficulties in relationships and social interactions can play a significant role in the onset and maintenance of psychological symptoms. The therapy aims to identify and address specific interpersonal problems, such as grief, role transitions, interpersonal disputes, and interpersonal deficits. Through a structured and goal-oriented approach, IPT helps clients develop greater awareness of their interpersonal patterns, improve communication skills, and make meaningful changes in their relationships. Unlike some other forms of therapy, IPT typically does not focus on exploring unconscious processes or childhood experiences but instead emphasizes present-focused problem-solving and skill-building. By enhancing interpersonal functioning and social support networks, IPT seeks to alleviate symptoms, improve overall well-being, and foster more satisfying and fulfilling relationships for clients. Its structured nature, evidence-based effectiveness, and focus on practical solutions make IPT a valuable therapeutic approach for addressing interpersonal difficulties and promoting emotional wellness. This treatment modality has demonstrated high fidelity with Latine and African American Populations in reducing depressive symptoms, improving social and general functioning, improving self-concept, and social adaptation (Kataoka et al., 2010; Kingston B et al., 2016).

Multi-Systemic Therapy (MST) is an evidence-based therapeutic approach that targets the systemic factors contributing to youth behavior problems and delinquency. To address the multiple systems influencing a young person's life, MST operates on the premise that behavior is best understood and changed within the context of family, peer, school, and community dynamics. This intensive, family-focused intervention is typically delivered in the home or community setting and involves collaboration among various stakeholders, including parents, caregivers, schools, probation officers, and other service providers. MST therapists utilize a range of techniques, including cognitive-behavioral strategies, structural family therapy principles, and behavior management techniques, tailored to the specific needs of each family. By addressing the underlying systemic issues contributing to youth problem behaviors and strengthening family functioning and support networks, MST aims to reduce antisocial behavior, improve family relationships, and prevent out-of-home placements. Its emphasis on ecological systems theory and comprehensive, individualized intervention makes MST a valuable tool in promoting positive outcomes for at-risk youth and their families. MST has been studied in several randomized controlled trials and has demonstrated in primarily African American populations experiencing delinquency, reduction in time-served, self-reported offenses, and arrest rates (Kataoka et al., 2010; Zajac K et al., 2015).

Multidimensional Family Therapy (MDFT) is a comprehensive and integrative approach to treating adolescents with substance abuse and behavioral problems, as well as their families. Grounded in the principles of family systems theory and developmental psychology, MDFT recognizes the interconnectedness of individual, family, peer, and community factors in shaping adolescent behavior. The therapy focuses on understanding the unique dynamics within each family system and tailoring interventions to address the multiple dimensions influencing adolescent functioning. MDFT therapists work collaboratively with adolescents and their families to identify and address underlying issues contributing to substance use and other problem behaviors. This may involve improving communication patterns, strengthening family relationships, and addressing conflict resolution skills. Additionally, MDFT emphasizes the importance of addressing external systems such as schools, juvenile justice, and social services to create a supportive environment for sustained change. By targeting multiple systems simultaneously and promoting adaptive functioning across domains, MDFT aims to reduce substance use, improve family functioning, and enhance overall well-being for

adolescents and their families. Its evidence-based approach and focus on holistic intervention make MDFT a valuable resource in addressing the complex needs of adolescents struggling with substance abuse and related issues (Aytur SA et al., 2022; Eisman et al., 2018; Kataoka et al., 2010).

Evidence-Based Practices

With African Americans. Evidence-based practices that have demonstrated effective implementation of treatment with African-American youth in economically under resourced communities include shortening the number of sessions to easily accommodate school-based administration, modifying examples provided during the course of treatment so that they are both culturally and experientially relevant and enhance the understanding of the treatment model, and excluding the parental support elements in order to accommodate participation without working around work schedules and parent availability(Kataoka et al., 2010). Collaborations and service provision through churches and schools as opposed to clinics and offices have been indicated as significantly impacting the engagement of clients with evidence-based treatments as well.

With Latine/SS. Among Latine and Spanish speaking youth and families, the incorporation of cultural concepts such as familismo, personalismo, sympatico, and respeto have demonstrated increased effectiveness and applicability. These concepts have been evaluated for efficacy in the practice of IPT and CBT specifically, though research does support the integration of culturally specific and relevant concepts as an evidence-based practice. The importance of and integration of religion and spirituality is another practice that has been demonstrated as an effective practice with this population. In addition to necessary linguistic competency and literacy, clinicians working with this population would do well to practice from and evidence-based and culturally adaptive lens.

With African-Immigrants/Refugees. Working with immigrant and refugee populations requires a specific and tailored approach. The practices and considerations that a clinician might employ when working with someone from Eritrea differ from the practices that they might employ when working with someone from Somalia, Senegal, Uganda, or Ghana. While the differences in cultural meaning and understanding among individuals from the continent of Africa make generalizing implausible, there are considerations for practice that can be applied to working with refugees and immigrants on the whole. Establishing a shared definition of mental illness through a culturally informed perspective is imperative. For instance, Duale (2011), notes that among Somalian persons, diagnoses according to the DSM-V are not commonly understood or accepted. Instead, they suggest, that linguistically, Somalian's will describe various mental health conditions as "crazy, insane, and not stable". Another consideration is the impact of migration on the family and individual. Salami et al. (2021) completed a scoping review of the health of African immigrant and refugee children in which they found that mental health outcomes were exacerbated in the context of having witnessed or experienced war, forced migration, familial separation, and community violence (K. Fox & Johnson-Agbakwu, 2020; Ubink & Rea, 2017). The varied experiences of this population and their gross underrepresentation in Multnomah County emphasize a need for culturally specific hiring and training withing GVIF.

Assessments

This report includes a compilation of assessments. It is recommended that GVIF employ assessments as a means of outcome and process monitoring for each individual and family served in the program. Clinicians should receive training in assessment administration, and assessments should be administered in regular intervals throughout the course of treatment.

Recommended assessments include the PCL-5 and the CPSS-V SR for monitoring symptoms of PTSD among youth and young adults, the CEQ for assessing exposure to violence and community experiences among youth and families entering the program, The MSPSS for assessing the perceived social supports of youth and families entering and progressing through the GVIF program, and the SWBS to assess the appropriateness of spiritual or religious collaboration and integration into treatment modalities.

Each of these assessments is discussed in the section on assessments.

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APPENDICES

APPENDIX A. Introduction & Interview Protocol -Adults 18+ (Family Members)(EN)

Thank you for agreeing to participate in an interview. My name is <Interviewer Name> I am conducting this interview on behalf of The Multnomah County Behavioral Health Response Team to evaluate the effect of the program. The purpose of this interview is to help us better understand the effect that the program has had on participants, their families, and the community in general.

You may respond to all of the interview questions based on your experience and perspective as a family member to a participant in the Program. You may also choose to skip a question and return later during the interview. You should have received an email that contained an overview of the types of questions that I would like to ask you today. Did you receive that? Do you have any questions before we begin?

1. From your perspective, what is the main purpose of the BHRT?
2. How did you learn about and come to be a part of the BHRT program??
   Prompt, as necessary:
   a. What did you hope for your family member to achieve by participating in this program?
   b. What benefits did you expect a result of participating in the program?
3. How has your family member's participation in the program affected you?
4. In what way(s) has the BHRT Program met your expectations and/or needs?
5. In what way(s) has the BHRT Program failed to meet your expectations and/or needs?

Participation in a BHRT program can result in outcomes at many levels, including the individual level which you might notice in your family member, the family level, and the community level which includes community health outcomes. We are interested in your perceptions regarding the extent to which the BHRT Program yielded benefits at each of these three levels.

6. Have you noticed your family member using new tools and skills taught through the BHRT?
   a. Describe and talk about examples of tools and skills learned through the program.
7. In what way(s) do you think the skills and tools from this program have impacted:
   a. You individually?
   b. Your family member individually?
   c. Your family as a whole?
   d. Your community?
8. Describe how the program has functioned in terms of increasing your connections and social supports?
   a. Has participation helped you make connections with people in other organizations and/or agencies? If so, please describe.
   b. Has participation helped you make connections with other families who share similar experiences? If so, please describe.
9. How have these new connections been beneficial to
   c. You?
      a. *Prompt as needed for increased knowledge and expertise, enhanced interpersonal relationships, and improved self-confidence/ self-efficacy*
   d. Your family member?
      a. *Prompt as needed for increased knowledge and expertise, enhanced interpersonal relationships, and improved self-confidence/ self-efficacy*

e. Your Family?
    a. *Prompt as needed for increased individual knowledge that has been shared with others in their family, individual knowledge gained in the program that was applied in their home, school, and community.*

f. Your community?
    a. *Prompt as needed for changes in community behaviors, safety, functioning.*

10. In your opinion, what are the most important outcomes or benefits that have resulted from the Program
11. On a scale of one to ten, how successful would you rate the program? One would be a complete failure, and ten would be a total success.
    a. Explain your rating.
12. How effective do you think the program has been at:
    a. Creating a safe environment for learning?
    b. Building trust among program clients?
    c. Encouraging community and social supports among program participants?
13. Are there other factors that you think helped the program succeed or contributed to its failure?
14. Have you experienced any barriers to full participation in the program?
15. How do you think the program can help overcome those barriers in the future?
16. Those are all the questions I have for you; are there any other comments you would like to provide?

Thank you again for your time!
<End Interview>

APPENDIX B. Introduction & Interview Protocol-Children <18y (Clients)(EN)

Thank you for agreeing to talk to me. My name is **<insert name>**. I'm going to ask you some questions about you work with the *BHRT*. You can say anything you want, there are no right or wrong answers. You can also ask me any questions you have during this process. You can also pick the name we use so that no one will know that your answers came from you. Would you like to choose your name? I want to record our conversation to go back and listen later to make sure I get everything right, is it okay if I record? Do you have any questions before we begin?

1. From your perspective, what is the main purpose of the BHRT?
2. How did you learn about and come to be a part of the BHRT program??
   Prompt, as necessary:
   a. What did you think the program was going to be like?
   b. How did you think it would help you?
   c. What was your biggest concern?
3. How has being in the program affected you?
4. In what way(s) has the BHRT Program met your expectations and/or needs?
5. In what way(s) has the BHRT Program failed to meet your expectations and/or needs?

Participation in a BHRT program can result in outcomes at many levels, including the individual level which you might notice in your family member, the family level, and the community level which includes community health outcomes. We are interested in your perceptions regarding the extent to which the BHRT Program yielded benefits at each of these three levels.

6. Have you learned new skills or tools since being in the program?
   a. What new skills and tools have you learned since being in the program?
7. In what way(s) do you think the skills and tools from this program have impacted:
   a. You individually?
   b. Your family members?
   c. Your community?
8. Describe how the program has helped in terms of increasing your connections and social supports?
   a. Has participation helped you make new friends with people in the program? If so, how did it help?
9. How have these new connections been beneficial to
   a. You?
      b. Prompt as needed for increased knowledge and expertise, enhanced interpersonal relationships, and improved self-confidence/ self-efficacy
   b. Your Family?
      c. Prompt as needed for increased individual knowledge that has been shared with others in their family, individual knowledge gained in the program that was applied in their home, school, and community.
   c. Your community?
      d. Prompt as needed for changes in community behaviors, safety, functioning.
10. In your opinion, what are the most important outcomes or benefits that have resulted from the Program
11. On a scale of one to ten, how successful would you rate the program? One would be a complete failure, and ten would be a total success.
    a. Explain your rating.

12. How effective do you think the program has been at:
    a. Creating a safe environment for learning?
    b. Building trust among program clients?
    c. Encouraging community and social supports among program participants?
13. What else helped the program be successful?
14. What would you change about it?
15. Have you experienced any barriers to full participation in the program?
16. How should the program get other people involved?
17. Those are all the questions I have for you; are there any other comments you would like to provide?

Thank you again for your time!

APPENDIX C. Introduction and Focus Group Protocol (EN)

Participants will be greeted upon arrival and given time to mingle and enjoy light refreshments. Pre-Printed Name Tents will be placed around the table to ensure strategic placement of individuals. Once all participants have arrived, no later than 20 minutes after the designated start time, the following script will be used.

Hi everyone, thanks for being here today! If everyone could head toward the seat where their name tents have been placed, we will begin the discussion shortly! (Allow everyone to take a seat and get situated).
I want to start with some introductions! My name is Taylor Geyton and I am a professor in the school of social work at Portland state university. I'll be facilitating our discussion today, and <Student Name> will take notes and manage our audio recording. Each of you have been informed individually that this discussion will be audio recorded, if at any time during the discussion you are uncomfortable and no longer wish to participate you can let us know and we will stop the recording until you've exited the space in order to respect your wishes. You all have been identified as a group of stakeholders with the Gun Violence Impacted Families Initiative through the Multnomah County Behavioral Health Response Team. In order to get acquainted could everyone please:

1. Tell us your name, your pronouns, and how you are involved with the program.

Okay, so now that we are all acquainted let's talk. It's important that we hear from you all as much as possible as you hold unique perspectives that deserve to be heard. One of the major goals of this discussion is to understand the needs of the program. For the following questions we will focus on this goal.

2. From your own perspective what is the intended primary purpose of the program?
    a. Are there secondary or tertiary purposes filled by this program?
3. In its current state, is the program fulfilling its purpose? Explain your response.
4. In your position and relation to the program what is needed to advance the program's success?

Another goal is to understand the role of the program in meeting community needs. To that end

5. What needs in the community do you think this program is best equipped to satisfy?
6. What is the community perception of this program from your understanding?
7. In what way is the community different because of this program?
8. What is your understanding of the community's needs?
    a. Where did you learn of these needs?
9. How is the community involved with the program? What opportunities exist for community involvement?

The final goal is to identify outcome evaluation factors. These are the markers for measuring the impact and efficacy of the program over time.

10. When you think about Multnomah County in five years, what do you hope to be different as a result of this program?
11. What are your current markers of success for the program?
12. In what way is the community different already as a result of this program?
13. What program element is the most valuable in your opinion?
    a. Least valuable?
14. What does success look like from your specific position?

Thank you again for participating!

15. Do you have any thoughts or comments to add that weren't touched on during the discussion?

<End>

APPENDIX D. Script for GVIF Family Recruitment (EN)

E-mail:
Hello Ms./Mr. (Name),

My name is (Name) and I am part of the research team working with the Multnomah County Health Department to evaluate the Gun Violence Impacted Families Program (GVIF).

You previously indicated that you and your family would be willing to participate in a feedback session on the GVIF program.

Below you will find key information about your participation and link to schedule your interview!

Key Information for You to Consider
• **Voluntary Consent**. You are being asked to volunteer for a research study. It is up to you whether you choose to take part or not. There is no penalty if you choose not to join in or decide to stop your involvement. • **Why is the study being done?** The reason for this research is to evaluate the impact of the Gun Violence Impacted Families Behavioral Health Team in Multnomah County. • **How long will it take?** Your participation should last 60-90 minutes, plus the time it takes to schedule and convene for an interview. • **What will I be expected to do?** You will be asked to complete a short demographic survey and then to speak one on one with a researcher in an audio-recorded interview, and answer questions about your experiences and opinions regarding the Gun Violence Impact Families Behavioral Health Team in Multnomah County. • **Risks.** Some of the possible risks or discomforts of taking part in this study are discomfort with sharing details about how you and your family found services with the Gun Violence impacted Families Behavioral Health Team, sharing your thoughts and insights on the community and personal impact of this program, and talking for 60-90 minutes with a researcher via a modality of your choosing. • **Benefits**. Some of the benefits that may be expected include improving services and treatments for your and future families serviced by the Gun Violence Impacted Families Behavioral Health Team and developing new treatments and processes that can help your children and community. • **Options.** Participation in this research is voluntary. There is no penalty for choosing not to participate.

You can schedule your interview using HERE or by pasting the URL into your browser.

Phone:
If no one answers the phone, leave a message:

Hi, my name is (name) and I'm looking for (participant name) to talk with them about an opportunity the expressed interest in regarding the Gun Violence Impact Families Program. I can be reached at 503-568-1270 or via email at . Thank you have a great day.

If someone answers:

<Ask to speak to the person named in our contact information>
Hi, my name is (name) and I'm looking for (participant name) to talk with them about an opportunity the expressed interest in regarding the Gun Violence Impact Families Program.

<When you're sure you have the right person on the phone>

"You previously indicated that you and your family would be willing to participate in a feedback session on the GVIF program and I'd like to give you some key information about your participation. Is now a good time?"

-If no: "Is there a better time to reach you about this or would you prefer that I email you?"
- If they want you to email them, get the email address and use the template.
- If they give you another time to call, make a note and coordinate schedules to make sure they are called at that time.

-If yes:

- Your participation is completely voluntary and based on your terms. There is no penalty if you choose not to join in or decide to stop in the future.
- This research aims to evaluate the impact of GVIF in Multnomah County.
- The feedback session is expected to be about 60-90 minutes long.
- There will be a short demographic survey for you to complete, and you will speak one-on-one with a researcher in an audio-recorded interview we are going to ask about your experiences and opinions regarding GVIF
- You might experience discomfort sharing personal details and insights about Gun Violence Impacted Families Behavioral Health Team has impacted you and your family. It completely depends on how much or how little you want to share, and you can stop the interview at any point.
- We will use this interview to improve services and treatments for yours and future families serviced by GVIF and develop new treatments and processes to help your children and community.
- And again, this research is voluntary. There is no penalty for choosing not to participate. And if you and one other family member do choose to participate, you will receive $150/family of your time

I'd love to answer any questions you have now, and I can also send this in an email for you to reference.

[pause for their questions and answer them].

Can I get you scheduled now for a feedback session?
-If yes: *schedule them*
-If not right now: *offer to follow up in a few days*.
-If no: Thank you for taking the time to listen and have a great rest of your day.

APPENDIX E. Parental Consent Form (EN)

Parent/Guardian Permission to Allow Participation in Research

Project Title: Gun Violence Impacted Families Behavioral Health Team Program Evaluation

Population: Program Clients, Interview

Sponsor/Funder: Multnomah County

Researcher: Taylor Geyton, PhD, Social Work

Portland State University

Researcher Contact: tgeyton@pdx.edu

Your child is being asked to take part in a research study. The box below highlights the main information about this research for you to consider when making a decision whether or not to allow your child to join in the study. Please carefully look over the information given to you on this form. Please ask questions about any of the information you do not understand before you decide to agree to let your child take part.

Key Information for You to Consider
• **Voluntary Consent**. Your child is being asked to volunteer for a research study. It is up to you whether you want to let your child choose to take part or not. There is no penalty if your child chooses not to join in or decides to stop their involvement. • **Why is the study being done?** The reason for this research is to evaluate the impact of the Gun Violence Impacted Families Behavioral Health Team in Multnomah County. • **How long will it take?** Your child's participation should last 60-90 minutes, plus the time it takes to schedule and convene for an interview. • **What will I be expected to do?** Your child will be asked to speak one on one with a researcher, and answer questions about your experiences and opinions regarding the Gun Violence Impact Families Behavioral Health Team in Multnomah County. • **Risks.** Some of the possible risks or discomforts of taking part in this study are discomfort with sharing details about how you and your family found services with the Gun Violence impacted Families Behavioral Health Team, sharing your thoughts and insights on community and personal impact of this program, and talking for 60-90 minutes with a researcher via a modality of your choosing. • **Benefits**. Some of the benefits that may be expected include improving services and treatments for yours and future families serviced by the Gun Violence Impacted Families Behavioral Health Team, developing new treatments and processes that can help your children and community, and an incentive of $150 per family. • **Options.** Participation in this research is voluntary. There is no penalty for choosing not to participate.

Who is doing this research?

The researcher Dr. Taylor Geyton from Portland State University is asking for your consent to this research. Dr. Geyton has been sought out by the Multnomah County Health Department to conduct a formal evaluation of the Gun Violence Impacted Families Behavioral Health Team.

Why is this research being done?
The purpose of the research is to identify the impact of the Gun Violence Impacted Families Behavioral Health Team in Multnomah County. You are being asked to participate because you have a family member who has been identified as a client of these services and your experiences are important in understanding the overall impact of this team's efforts. An estimated 10-30 people will take part in this research study.

How long will my child be in this research?
We expect that your child's part in the study will last will be no more than two hours. Interviews are expected to take about 60 minutes and will be scheduled in 90-minute time slots to allow enough time for thoughtful responses and to answer any and all questions that you may have. Additional time spent involves making contact with the researcher for scheduling and filling out a brief survey about yourself. Time spent on the survey and scheduling are estimated to be less than 20 minutes combined however may vary in extenuating circumstances.

What will I do if I decide to let my child take part?
If you agree to allow your child to be in this research, your child will first complete a brief online survey about themselves. Following the survey, you will receive an email with a link to schedule an interview with the researcher. Your child will engage in an interview that is entirely voluntary with the option to stop and withdraw your responses at any time. We will tell you about any new information that may affect whether or not you want to continue in this research.

What happens to the information collected?
Information collected for this research will be used to develop a narrative about the experience of families engaged with the Gun Violence Impacted Families Behavioral Health Team. Your responses will be confidential. The research will be presented to the Multnomah County Health Department in a report that will help determine future directions for the Gun Violence Impacted Families Behavioral Health Team. This information will also be used for publication in academic journals in order to provide information for other counties and states with similar programs.

How will my child's privacy and data be protected?
We will take measures to protect your child's privacy including using a pseudonym (fake name) to identify their responses, interviewing in a private room, using headphones on zoom and phone calls, and using audio only recordings. Additionally, we maintain all records in password protected and encrypted electronic files that will only be accessible to the researcher and her team. Despite taking steps to protect your privacy, we can never fully guarantee that your privacy will be protected.

Individuals and organizations that conduct or monitor this research may be permitted access to inspect research records. This may include private information. These individuals and organizations include [the Institutional Review Board that reviewed this research and the Multnomah County Health Department.

What if I or my child want to stop taking part in this research?
Your permission to allow your child to take part, and your child's part in this study is voluntary. You do not have to allow your child to take part in the study, nor does your child have to take part in this study. If you do allow your child to take part, your child may stop at any time. You have the right to choose not to allow your child to take part in any study activity or completely stop at any point without penalty or loss of benefits to which your child is otherwise entitled. Your and your child's decision whether or not to join in will not affect your child's relationship with the researchers or Portland State University.

Will I or my child be paid for being in this research?

Participation in this study will be paid at $150 per family as long as participation includes the youth receiving services and at least one family member.

Who can answer my questions about this research?
If you or your child have questions, concerns, or have experienced a research related injury, contact the research team at:

Dr. Taylor Geyton, LCSW
503-725-9914
tgeyton@pdx.edu

Who can I speak to about my child's rights as a part of research?
The Portland State University Institutional Review Board ("IRB") is overseeing this research. The IRB is a group of people who independently review research studies to ensure the rights and welfare of participants are protected. The Office of Research Integrity is the office at Portland State University that supports the IRB. If you have questions about your child's rights, or wish to speak with someone other than the research team, you may contact:

Office of Research Integrity
PO Box 751
Portland, OR 97207-0751
Phone: (503) 725-5484
Toll Free: 1 (877) 480-4400
Email: psuirb@pdx.edu

Consent Statement
I have had the opportunity to read and consider the information in this form. I have asked any questions necessary to make a decision about my child's taking part in the study. I understand that I can ask more questions at any time.

By signing below, I understand that I am agreeing to allow my child to volunteer to take part in this research. I understand that neither I nor my child are giving up any legal rights. I have been provided with a copy of this consent form.

I consent to allow my child to decide whether or not to join in this study.

____
Child's Name

______________________________ ______________________________ ______________
Name of Parent/Guardian **Signature of Parent/Guardian** **Date**

Researcher Signature (to be completed at time of informed consent)
I have explained the research to the parent/guardian and answered all of his/her questions. I believe that he/she understands the information described in this consent form and freely consents to allow his/her child to participate.

______________________________ ______________________________ ______________
Name of Research Team Member **Signature of Research Team Member** **Date**

APPENDIX F. Youth Assent Form (EN)

Assent to Participate in Research

Project Title:	Gun Violence Impacted Families Behavioral Health Team Program Evaluation
Population:	Youth age 9-17, interview
Sponsor/Funder:	Multnomah County
Researcher:	Taylor Geyton, PhD, Social Work Portland State University
Researcher Contact:	tgeyton@pdx.edu

You are being asked to take part in a research study. The box below shows the main facts you need to know about this research for you to think about when making a decision about if you want to join in. Carefully look over the information in this form and ask questions about anything you do not understand before you make your decision.

Key Information for You to Consider

- **Voluntary Assent**. You are being asked to volunteer for a research study. It is up to you whether you choose to involve yourself or not. Even if your parent/guardian says you may take part, you don't have to if you don't want to. There is no penalty if you choose not to join in or decide to stop.
- **Purpose**. The reasons for doing this research are to learn about how the Gun Violence Impacted Families Behavioral Health team in Multnomah County is helping you, your family, and your community.
- **How long?** It is expected that your part should last 60-90 minutes.
- **What will I be doing?** You will be asked to fill out a short survey online about yourself and then to answer questions about your experiences with the Gun Violence Impacted Families Behavioral Health team in Multnomah County in an audio recorded interview.
- **Risks.** Some of the possible risks or worries of your being in this research include talking about the events that led up to you participating in the program.
- **Benefits**. Some of the benefits that you may expect include helping the program help other people with new treatments.
- **Other options.** Participation in this research is voluntary. There is no penalty for choosing not to participate.

What happens to the information collected?

The information collected will be used to help make the Gun Violence Impacted Families Behavioral Health Team better. No one will know what you said in your interview. The research will be presented to the Multnomah County Health Department in a report that will help determine future directions for the Gun Violence Impacted Families Behavioral Health Team. This information will also be used for publication in academic journals in order to provide information for other counties and states with similar programs. Your personal information will not be kept or shared in the future by the research team.

How will me and my information be protected?

We won't tell anyone if you take part in this study or not. When we talk to you, it will be in a private place. This means no one will be able to overhear what you tell us. We will keep your name and what you tell us as safe as possible; however, if, during the course of the study, you tell us that you are, or are intending to hurt yourself or anyone else, or if you or someone else is being abused, we will have to notify the proper authorities and tell them you are in the research study.

What if I want to stop being in this research?
You do not have to take part in this study, but if you do, you may stop at any time. You have the right to choose not to join in any study activity or completely stop your participation at any point without penalty or loss of benefits you would otherwise get. Your decision whether or not to take part in research will not affect your relationship with the researchers or Portland State University.

What will I get in return for doing this?
Each family will get $150 for participating in this research.

Who can answer my questions about this research?
If you have questions, concerns, or just want to talk about the research, call or email the research team at:

Dr. Taylor Geyton, LCSW
503-725-9914
tgeyton@pdx.edu

Who can I speak to about my rights as a research participant?
The Portland State University Institutional Review Board ("IRB") is overseeing this research. The IRB is a group of people who review research studies to make sure the rights and welfare of the people who take part in research are protected. The Office of Research Integrity is the office at Portland State University that supports the IRB. If you have questions about your rights, or wish to speak with someone other than the research team, you may contact:

Office of Research Integrity
PO Box 751
Portland, OR 97207-0751
Phone: (503) 725-5484
Toll Free: 1 (877) 480-4400
Email: psuirb@pdx.edu

Assent Statement
I have had the chance to read and think about the information in this form. I have asked any questions I have, and I can make a decision about my participation. I understand that I can ask additional questions anytime while I take part in the research.

By signing on the line below, I understand that I am volunteering to join in this research. I understand that I am not giving up any legal rights. I have been given a copy of this assent form.

I assent to take part in this study.

____________________	____________________	__________
Name of Youth	**Signature of Youth**	**Date**

Researcher Signature (to be completed at time of informed assent)
I have explained the research to the participant and answered all of his/her questions. I believe that he/she understands the information described in this assent form and freely assents to participate.

____________________	____________________	__________
Name of Research Team Member	**Signature of Research Team Member**	**Date**

APPENDIX G. Adult Consent Form (EN)

Consent to Participate in Research

Project Title: Gun Violence Impacted Families Behavioral Health Team Program Evaluation

Population: Family Member, Interview

Sponsor/Funder: Multnomah County

Researcher: Taylor Geyton, PhD, Social Work
Portland State University

Researcher Contact: tgeyton@pdx.edu

You are being asked to take part in a research study. The box below highlights the main information about this research for you to consider when making a decision whether or not to join in the study. Please carefully look over the information given to you on this form. Please ask questions about any of the information you do not understand before you decide to agree to take part.

Key Information for You to Consider
● **Voluntary Consent**. You are being asked to volunteer for a research study. It is up to you whether you choose to take part or not. There is no penalty if you choose not to join in or decide to stop your involvement. ● **Why is the study being done?** The reason for this research is to evaluate the impact of the Gun Violence Impacted Families Behavioral Health Team in Multnomah County. ● **How long will it take?** Your participation should last 60-90 minutes, plus the time it takes to schedule and convene for an interview. ● **What will I be expected to do?** You will be asked to speak one on one with a researcher, and answer questions about your experiences and opinions regarding the Gun Violence Impact Families Behavioral Health Team in Multnomah County. ● **Risks.** Some of the possible risks or discomforts of taking part in this study are discomfort with sharing details about how you and your family found services with the Gun Violence impacted Families Behavioral Health Team, sharing your thoughts and insights on community and personal impact of this program, and talking for 60-90 minutes with a researcher via a modality of your choosing. ● **Benefits**. Some of the benefits that may be expected include improving services and treatments for yours and future families serviced by the Gun Violence Impacted Families Behavioral Health Team, developing new treatments and processes that can help your children and community, and an incentive of $150 per family. ● **Options.** Participation in this research is voluntary. There is no penalty for choosing not to participate.

Who is doing this research?

The researcher Dr. Taylor Geyton from Portland State University is asking for your consent to this research. Dr. Geyton has been sought out by the Multnomah County Health Department to conduct a formal evaluation of the Gun Violence Impacted Families Behavioral Health Team.

Why is this research being done?

The purpose of the research is to identify the impact of the Gun Violence Impacted Families Behavioral Health Team in Multnomah County. You are being asked to participate because you have a family member who has

been identified as a client of these services and your experiences are important in understanding the overall impact of this team's efforts. An estimated 10-30 people will take part in this research study.

How long will I be in this research?
We expect that your part in the study will be no more than two hours. Interviews are expected to take about 60 minutes and will be scheduled in 90-minute time slots to allow enough time for thoughtful responses and to answer any and all questions that you may have. Additional time spent involves making contact with the researcher for scheduling and filling out a brief survey about yourself. Time spent on the survey and scheduling are estimated to be less than 20 minutes combined however may vary in extenuating circumstances.

What will I do if I decide to take part?
If you agree to be in this research, you will first complete a brief online survey about yourself. Following the survey, you will receive an email with a link to schedule an interview with the researcher. You will engage in an interview that is entirely voluntary with the option to stop and withdraw your responses at any time. We will tell you about any new information that may affect whether or not you want to continue in this research.

What happens to the information collected?
Information collected for this research will be used to develop a narrative about the experience of families engaged with the Gun Violence Impacted Families Behavioral Health Team. Your responses will be confidential. The research will be presented to the Multnomah County Health Department in a report that will help determine future directions for the Gun Violence Impacted Families Behavioral Health Team. This information will also be used for publication in academic journals in order to provide information for other counties and states with similar programs.

How will my privacy and data be protected?
We will take measures to protect your privacy including using a pseudonym (fake name) to identify your responses, interviewing in a private room, using headphones on zoom and phone calls, and using audio only recordings. Additionally, we maintain all records in password protected and encrypted electronic files that will only be accessible to the researcher and her team. Despite taking steps to protect your privacy, we can never fully guarantee that your privacy will be protected.

Individuals and organizations that conduct or monitor this research may be permitted access to inspect research records. This may include private information. These individuals and organizations include the Institutional Review Board that reviewed this research and the Multnomah County Health Department.

What if I want to stop my part in this research?
Your part in this study is voluntary. You do not have to take part in this study, but if you do, you may stop at any time. You have the right to choose not to take part in any study activity or completely stop at any point without penalty or loss of benefits to which you are otherwise entitled. Your decision whether or not to join in will not affect your relationship with the researchers or Portland State University.

Will I be paid for being in this research?
Participation in this study will be paid at $150 per family as long as participation includes the youth receiving services and at least one family member.

Who can answer my questions about this research?
If you have questions, concerns, or have experienced a research related injury, contact the research team at:

Dr. Taylor Geyton, LCSW
503-725-9914
tgeyton@pdx.edu

Who can I speak to about my rights as a part of research?
The Portland State University Institutional Review Board ("IRB") is overseeing this research. The IRB is a group of people who independently review research studies to ensure the rights and welfare of participants are protected. The Office of Research Integrity is the office at Portland State University that supports the IRB. If you have questions about your rights, or wish to speak with someone other than the research team, you may contact:

Office of Research Integrity
PO Box 751
Portland, OR 97207-0751
Phone: (503) 725-5484
Toll Free: 1 (877) 480-4400
Email: psuirb@pdx.edu

Consent Statement
I have had the opportunity to read and consider the information in this form. I have asked any questions necessary to make a decision about my taking part in the study. I understand that I can ask more questions at any time.

By signing below, I understand that I am volunteering to take part in this research. I understand that I am not waiving any legal rights. I have been provided with a copy of this consent form. I understand that if my ability to consent for myself changes, either I or my legal representative may be asked to provide consent before I continue in the study.

I consent to join in this study.

____________________________ ______________________________ _____________
Name of Adult Participant **Signature of Adult Participant** **Date**

Researcher Signature (to be completed at time of informed consent)
I have explained the research to the participant and answered all of his/her questions. I believe that he/she understands the information described in this consent form and freely consents to participate.

____________________________ ______________________________ _____________
Name of Research Team Member **Signature of Research Team Member** **Date**

APPENDIX H. Script for GVIF Family Recruitment (SP):

E-mail:
Hola Señora/Señor (Name),

Me llamo (Name) y soy de parte del equipo de investigación trabajando con el departamento de salud del condado de Multnomah para evaluar el programa de familias impactadas por la violencia armada (GVIF).

Indicó anteriormente que usted y su familia estarían dispuestos participar en la sesión de comentarios por el programa GVIF.

¡Abajo encontrará información importante sobre su participación y enlace para programar su entrevista!

Información Importante Para Considerar
• **Consentimiento Voluntario**. Se le ha pedido participar en un estudio de investigación. Es su decisión si usted elegirá participar o no. No hay penalización si elije no tomar parte o si decide dejar de participar. • **¿Por qué la investigación se hará?** La razón por este estudio es para evaluar el impacto del equipo de salud conductual de familias impactadas por la violencia armada en el condado de Multnomah. • **¿Cuánto durará?** Su participación debería durar 60-90 minutos, además del tiempo que tomará para programar y reunirse por la entrevista. • **¿Qué estaré esperado hacer?** Se le habrá pedido completar una encuesta demográfica breve y luego hablar individualmente con un investigador en una entrevista grabada con audio, y contestar preguntas sobre sus experiencias y opiniones con respeto al equipo de salud conductual para familias impactadas por la violencia armada del condado de Multnomah. • **Riesgos.** Algunos de los riesgos posibles o incomodidades de participar en este estudio es la incomodidad con compartir detalles acerca de cómo usted y su familia encontraron servicios con equipo conductual para familias impactadas de violencia armada, compartiendo sus pensamientos y conocimientos en el impacto de este programa a la comunidad y personalmente, y hablando por 60-90 minutes con un investigador por el modo de su preferencia. • **Beneficios**. Algunos de los beneficios que se puede esperar incluye el mejoramiento de servicios y tratamientos para su familia y familias en el futuro que recibirán servicio del equipo conductual para familias impactadas de violencia armada y el desarrollo de nuevos tratamientos y procesos que les puede ayudar a sus hijos y comunidad. • **Opciones.** Participación en esta investigación es voluntario. No hay penalización por escoger no participar.

Usted su puede programar su entrevista AQUÍ o pegarle al URL en su navegador.

Phone:
If no one answers the phone, leave a message:

Hola, me llamo (name) y estoy buscando por (participant name) para hablar acerca de la oportunidad que expresó interés con respeto al programa de familias impactadas por la violencia armada. Me puede contactar a ###-###-#### o por correo electrónico a spehereresearch@pdx.edu. Gracias, que tenga bonito día.

If someone answers:

<Ask to speak to the person named in our contact information>
Hola, me llamo (name) y estoy buscando por (participant name) para hablar acerca de la oportunidad que expresó interés con respeto al programa de familias impactadas por la violencia armada.

<When you're sure you have the right person on the phone>

Anteriormente indicó que usted y su familia estaría dispuesto para participar en una sesión de comentarios sobre el programa GVIF y me gustaría darle algo de información importante sobre su participación. ¿Es un buen tiempo ahorita para usted?

-If no: "Hay un mejor tiempo para contactarle sobre esto o usted prefería que le mande un correo electrónico?"
- If they want you to email them, get the email address and use the template. - If they give you another time to call, make a note and coordinate schedules to make sure they are called at that time.

-If yes:

• Su participación es completamente voluntaria, y basado en sus propios términos. No hay penalización si usted escoge no participar o si decide dejar de participar en el futuro. • Esta investigación pretende evaluar el impacto de GVIF en el condado de Multnomah. • La sesión de comentarios es esperada durar aproximadamente 60-90 minutos. • Habrá una encuesta demográfica breve para completar usted, hablará individualmente con un investigador en una entrevista grabada con audio, vamos a preguntarle sobre sus experiencias y opiniones con respeto a GVIF.

• Usted se puede sentir incomodidad compartiendo sus detalles personales y conocimientos sobre el equipo de salud conductual para familias impactadas por la violencia armada, como le han impactado a usted y a su familia. Depende completamente a usted, que tanto o que poco quiere compartir, y se puede detener la entrevista en cualquier momento.

• Usaremos esta entrevista para mejorar los servicios y tratamientos para su familia y familias en el futuro que recibirán servicios por el GVIF y desarrollar nuevos tratamientos y procesos para ayudar a sus hijos y comunidad.

• Y otra vez, esta investigación es voluntaria. No hay penalización por decidir no participar. Y si usted y otro pariente decide participar, recibirá $150/familia por su tiempo.

Me encantaría contestar cualquiera de sus preguntas que tiene ahorita, y también puedo mandar esto en un correo electrónico para su referencia.

[pause for their questions and answer them].

¿Puedo programarle para una sesión de comentarios ahora?
-If yes: *schedule them*
-If not right now: *offer to follow up in a few days*.
-If no: Gracias por su tiempo de escuchar y que tenga bonito día.

APPENDIX I. Parental Consent Form (SP)

Padre/Tutor Permiso de Participación en la Investigación

Título del Proyecto: Evaluación del Programa del Equipo Conductual para Familias Impactadas por la Violencia Armada

Población: Clientes del programa, Entrevista

Patrocinador: El Condado del Multnomah

Investigadora: Taylor Geyton, PhD, Trabajo Social

Portland State University

Contacto de la investigadora: tgeyton@pdx.edu

A su hijo le están pidiendo participar en un estudio de investigación. La caja abajo destaca la información principal sobre este estudio, para considerar usted cuando hace la decisión sí o no permitir a su hijo participar en el estudio. Por favor repasa la información en este formulario atentamente. Por favor haga sus preguntas sobre cualquier información aquí que no entiende, antes de decidir si permitirá su hijo participar.

Información Importante para Considerar
• **Consentimiento Voluntario**. Le están pidiendo a su hijo participar en un estudio de investigación. Depende de usted si elegirá permitir a su hijo decidir a participar o no. No hay penalización si su hijo elije no tomar parte o decide dejar de participar. • **¿Por qué están realizando la investigación?** La razón por este estudio es para evaluar el impacto del equipo de salud conductual de familias impactadas por la violencia armada en el Condado de Multnomah. • **¿Cuánto durará?** La participación de su hijo debería durar 60-90 minutos, además del tiempo que tomará para programar y reunirse por la entrevista. • **¿Qué estará esperado hacer mi hijo?** Las actividades que se le pedirá a completar su hijo son una encuesta breve sobre sí mismo y una entrevista individualmente con un investigador grabada en audio y/o video, y contestar preguntas sobre sus experiencias y opiniones con respeto al Equipo de Salud Conductual para Familias Impactadas por la Violencia Armada del Condado de Multnomah. • **Riesgos.** Algunos de los riesgos posibles o incomodidades de participar en este estudio es la incomodidad con compartir detalles acerca de cómo su hijo y su familia encontraron servicios con el Equipo de Salud Conductual para Familias Impactadas por la Violencia Armada, su hijo compartiendo sus pensamientos y conocimientos en el impacto de este programa a la comunidad y personalmente, y hablando por 60-90 minutes con un investigador por el modo de la preferencia de su hijo. • **Beneficios**. Algunos de los beneficios que se puede esperar incluye el mejoramiento de servicios y tratamientos para su familia y familias en el futuro que recibirán servicio del equipo conductual para familias impactadas de violencia armada y el desarrollo de nuevos tratamientos y procesos que les puede ayudar a sus hijos y la comunidad. • **Opciones.** Participación en esta investigación es voluntario. No hay penalización por decidir no permitir a su hijo participar.

¿Quién está realizando esta investigación?

La investigadora Dr. Taylor Geyton de Portland State University está pidiendo por su consentimiento de permitir a su hijo participar en esta investigación. El Departamento de Salud del Condado de

Multnomah se le ha pedido a Dr. Geyton a realizar una evaluación formal del Equipo de Salud Conductual para Familias Impactadas por la Violencia Armada.

¿Por qué se está realizando esta investigación?

El propósito de esta investigación es identificar el impacto del equipo de salud conductual para las familias impactadas por la violencia armada en el Condado de Multnomah. Se le pide a su hijo participar porque le han identificado como un cliente de estos servicios y sus experiencias son importantes para entender el impacto total de los esfuerzos de este equipo. Un estimado 10-30 personas se tomará parte de este estudio de investigación.

¿Cuánto tiempo estará mi hijo en este estudio?

Esperamos que el parte de su hijo se durará no más que 2 horas. Entrevistas son esperadas de tomar aproximadamente 60 minutos y se programarán para 90 minutos para permitir suficiente tiempo para respuestas pensativas y responder a todas las preguntas que usted podría tener. Tiempo adicional usado incluye hacer contacto con la investigadora para programación y llenar una encuesta breve sobre sí mismo. Tiempo usado en la encuesta y programación es estimado tomar menos de 20 minutos combinados, aunque puede variar en circunstancias atenuantes.

¿Qué haré yo si decido permitir a mi hijo participar?

Si usted está de acuerdo con permitir a su hijo tomar parte de este estudio, su hijo primeramente completará una encuesta breve en línea sobre sí mismo. Después de la encuesta, recibirá usted un correo electrónico con un enlace para programar una entrevista con la investigadora. Su hijo participará en una entrevista que es completamente voluntario con la opción de detener y retirar sus respuestas en cualquier momento. Nosotros le diremos sobre cualquier información nueva que pueda afectar si quiere o no continuar con este estudio.

¿Qué pasará con la información recopilada?

Información recopilada para este estudio estará usado en desarrollar una narrativa sobre las experiencias de familias involucradas con el Equipo de Salud Conductual para Familias Impactadas por la Violencia Armada. Sus respuestas serán confidenciales. El estudio será presentado al Departamento de Salud del Condado de Multnomah en un reporte que ayudará determinar direcciones futuras para el Equipo de Salud Conductual para Familias Impactadas por la Violencia Armada. Esta información será usada también para publicación en revistas académicas para proveer información para otros Condados y estados con programas similares.

¿Cómo serán protegidos la privacidad y los datos de mi hijo?

Tomaremos medidos para proteger la privacidad de su hijo incluyendo un seudónimo (nombre falso) a identificar sus respuestas, entrevistando en un salón privado, usando audífonos en zoom y en llamadas telefónicas, y usando solo grabaciones de audio. Adicionalmente, mantendremos todos los archivos en archivos electrónicos protegidos por contraseña y encriptados, que solo serán accesibles a la investigadora y su equipo. A pesar de tomar pasos en proteger su privacidad, nunca podemos garantizar completamente que su privacidad será protegida.

Individuos y organizaciones que realizan o supervisan esta investigación pueden ser permitidos acceso a inspeccionar archivos de la investigación. Este puede incluir información privada. Estos individuos y organizaciones incluyen al Comité de Revisión Instituciónal que revisó esta investigación, y el Departamento de Salud del Condado de Multnomah.

¿Y si yo o mi hijo quiere dejar de participar en esta investigación?

Su permiso de dejar a su hijo participar y el parte de su hijo en el estudio es voluntario. No tiene que permitir que su hijo tome parte en el estudio, ni su hijo tiene que tomar parte en este estudio. Si permite que su hijo toma parte, su hijo puede parar en cualquier momento. Usted tiene el derecho de decidir no permitir a su hijo participar en cualquier actividad del estudio o completamente detener en cualquier momento sin cualquier penalización o perdida de beneficios a los que su hijo tiene derecho. Su decisión y la decisión de su hijo de participar o no, no afectará a la relación entre su hijo y los investigadores o Portland State University.

¿Será yo o mi hijo pagado por ser parte de esta investigación?
Participación en este estudio será pagado al $150 por familia mientras participación incluye el joven recibiendo servicios y al menos un pariente.

¿Quién puede contestar mis preguntas sobre esta investigación?
Si usted o su hijo tiene preguntas, dudas, o ha experimentado una herida relacionada con la investigación, contacte al equipo de investigación:

Dr. Taylor Geyton, LCSW
503-725-9914
tgeyton@pdx.edu

¿A quién puedo hablar sobre los derechos de mi hijo como parte de la investigación? El Comité de Revisión Institucional del Portland State University está supervisando a esta investigación. El comité es un grupo de personas quien revisa independientemente a los estudios de investigación para asegurar los derechos y bienestar de los participantes son protegidos. La Oficina de Integridad de Investigación es la oficina de Portland State University que apoya el comité. Si usted tiene preguntas sobe los derechos de su hijo, o desea hablar con alguien afuera del equipo de investigación, usted se puede contactar:

Oficina de Integridad de Investigación
PO Box 751
Portland, OR 97207-0751
Teléfono:(503) 725-5484
Llamada Gratuita: 1 (877) 480-4400
Correo: psuirb@pdx.edu

Declaración de Consentimiento
Yo he tenido la oportunidad de leer y considerar la información en este formulario. He preguntado cualquier pregunta necesaria para hacer una decisión sobre mi hijo tomando parte en este estudio. Yo entiendo que puedo hacer más preguntas en cualquier momento.

Al firmar abajo, Yo entiendo que estoy confirmando de permitir a mi hijo participar en este estudio. Yo entiendo que no estoy cediendo mis derechos legales, ni los de mi hijo. Me han proporcionado una copia de este formulario de consentimiento.

Consiento en permitir a mi hijo decidir participar o no en este estudio.

____

Nombre del hijo

____

Nombre del padre/tutor Firma del padre/tutor Fecha

Firma de la Investigadora (para ser completado al tiempo del consentimiento informado). Yo he explicado la investigación al padre/tutor y he contestado a todas sus preguntas. Yo creo que el/ella entiende la información en este formulario de consentimiento y consiente libremente a permitir su hijo participar.

____

Nombre del miembro del equipo de investigación Firma del miembro del equipo de investigación Fecha

APPENDIX J. Introduction & Interview Protocol -Adults 18+ (Family Members) (SP)

Gracias por estar de acuerdo de participar en una entrevista. Me llamo <Interviewer Name> Yo estoy realizando esta entrevista por parte del equipo de respuesta de salud conductual del condado de Multnomah para evaluar el efecto del programa de familias impactadas por la violencia armada (GVIF). El propósito de esta entrevista es para ayudarnos a entender mejor el efecto que el programa ha tenido a participantes, sus familias, y la comunidad en general.

Usted puede responder a todas las preguntas de la entrevista por su propia experiencia y perspectiva como un pariente al participante en el programa. También usted se puede saltar una pregunta y volver a la pregunta luego en la entrevista. Debería haber recibido un correo electrónico que contiene un resumen de los tipos de preguntas que me gustaría preguntarle hoy. ¿Recibió ese correo electrónico? ¿Tiene alguna pregunta antes de que empecemos?

1. De su propia perspectiva, ¿qué es el propósito principal del GVIF?
2. ¿Cómo aprendió acerca de, y hacerse parte del programa GVIF?
   Prompt, as necessary:
   a. ¿Qué esperaba usted que logre su pariente en participar a este programa?
   b. ¿Qué beneficios esperaba usted como resultado de participar en este programa? 3. ¿Como le ha afectado a usted la participación de su pariente en este programa? 4. ¿En qué manera o cuales maneras el programa GVIF le ha cumplido sus expectativas y/o sus necesidades?
5. ¿En qué manera o cuales maneras el programa GVIF ha fallado de cumplirle sus expectativas y/o necesidades?

Participación en el programa GVIF puede concluir en resultados en muchos niveles, incluyendo el nivel individual que puede que usted ha notado en su pariente, el nivel familiar, y el nivel comunitario que incluye resultados de salud comunitaria. Nosotros estamos interesados en sus percepciones con respeto al alcance de que el programa GVIF ha dado beneficios a cada uno de estos tres niveles.

6. ¿Usted le ha notado a su familiar usar las técnicas y habilidades enseñadas por el GVIF? a. Describe y habla sobre ejemplos de las técnicas y habilidades aprendidos por el programa.
7. En qué o cuales maneras piensas que las habilidades y técnicas del programa le ha impactado: a. ¿A usted individualmente?
   b. ¿A su pariente individualmente?
   c. ¿A su familia en conjunto?
   d. ¿A su comunidad?
8. Describe como el programa le ha funcionado en términos de aumentar sus conexiones y apoyo social.

   a. ¿Participación le ha ayudado hacer conexiones con gente en otras organizaciones y/o agencias? Sí es así, por favor describe.
   b. ¿Participación le ha ayudado hacer conexiones con otras familias que comparten experiencias similares? Sí es así, por favor describe.
9. ¿En cómo estas nuevas conexiones han sido beneficioso para
   c. ¿Usted?
      a. Prompt as needed for increased knowledge and expertise, enhanced

interpersonal relationships, and improved self-confidence/ self-efficacy

d. ¿Su pariente?

a. Prompt as needed for increased knowledge and expertise, enhanced interpersonal relationships, and improved self-confidence/ self-efficacy

e. ¿Su familia?

a. Prompt as needed for increased individual knowledge that has been shared with others in their family, individual knowledge gained in the program that was applied in their home, school, and community.

f. ¿Su comunidad?

a. Prompt as needed for changes in community behaviors, safety, functioning. 10. En su opinión, ¿qué son los resultados o beneficios más importantes que les han resultado de este programa?

11. En una escala de uno a diez, ¿qué exitoso le considera este programa? Uno sería una falla completa, y diez sería un éxito total.

a. Explica su clasificación.

12. Que tan efectivo piensa que el programa ha sido en:

a. ¿Crear un ambiente seguro para aprendizaje?

b. ¿Construir confianza entre clientes del programa?

c. ¿Animar apoyo comunitario y apoyo social entre participantes del programa? 13. ¿Hay otros factores, piensa usted, que ayudaba al éxito del programa o contribuyía a su falla? 14. ¿Has experimentado algún obstáculo a participación completo en este programa? 15. ¿Cómo piensa usted que el programa puede ayudar en superar esas barreras en el futuro? 16. Estas son todas las preguntas que tengo para usted; ¿hay cualquier otro comentario o comentarios que quisiera proveer?

¡Muchas gracias de nuevo por su tiempo!

<End Interview>

APPENDIX K. Introduction & Interview Protocol-Children <18y (Clients) (SP)

Gracias por estar de acuerdo con hablar conmigo. Me llamo **<insert name>**. Voy a hacerle algunas preguntas sobre su trabajo en el GVIF. Puedes decir cualquier cosa que quieres y no hay respuestas correctas ni incorrectas. Me puedes hacer preguntas que tienes durante el proceso. También puedes escoger el nombre que usaremos para que nadie sabe que las respuestas vienen de ti. ¿Quisieras escoger
tu nombre? Quiero grabar nuestra conversación para volver a escucharlo luego y asegurar que entiendo todo correcto, ¿está bien si grabe? ¿Tienes alguna pregunta antes de que empecemos?

1. Desde tu perspectiva, ¿qué es el propósito principal del GVIF?
2. ¿Cómo aprendiste y te hiciste parte del programa GVIF?

    Prompt, as necessary:

    a. ¿Qué pensabas iba a ser el programa?
    b. ¿Cómo pensabas que te lo ayudaría?
    c. ¿Cuál era su mayor preocupación?
3. ¿Cómo te ha afectado estar en el programa?
4. ¿En qué o cuales maneras el programa GVIF te ha cumplido tus expectativas y/o necesidades?
5. ¿En qué o cuales maneras el programa GVIF te ha fallado las expectativas y/o necesidades?

Participación en el programa GVIF puede concluir en resultados en muchos niveles, incluyendo el nivel individual que puede que usted ha notado en su pariente, el nivel familiar, y el nivel comunitario que incluye resultados de salud comunitaria. Nosotros estamos interesados en sus percepciones con respeto al alcance de que el programa GVIF ha dado beneficios a cada uno de estos tres niveles.

6. ¿Has aprendido habilidades nuevas o técnicas desde entrar al programa?

    a. ¿Cuáles habilidades y técnicas has aprendido desde entrar al programa?
7. En qué o cuales maneras piensas que las habilidades y técnicas del programa le ha impactado: a. ¿A ti individualmente?

    b. ¿A tus parientes?
    c. ¿A tu comunidad?
8. Describe cómo el programa le ha ayudado en términos de aumentar tus conexiones y apoyo social.

    a. ¿Participación le ha ayudado en hacer nuevos amigos con personas en el programa? Si es así, ¿cómo te ayudó?
9. Cómo estas nuevas conexiones han benficiado:

    a. ¿A ti?

        b. Prompt as needed for increased knowledge and expertise, enhanced interpersonal relationships, and improved self-confidence/ self-efficacy

    b. ¿A tu familia?

        c. Prompt as needed for increased individual knowledge that has been shared with others in their family, individual knowledge gained in the program that was applied in their home, school, and community.

    c. ¿A tu comunidad?

        d. Prompt as needed for changes in community behaviors, safety, functioning.
10. En tu opinión, ¿qué son los resultados o beneficios que ha resultado del programa?

11. En una escala uno a diez, ¿qué tan exitoso le considerías el programa? Uno sería una falla completa, y diez sería un éxito total.
    a. Explica su clasificación.
12. Qué tan efectivo ha sido el programa en:
    a. ¿Crear un ambiente seguro para aprendizaje?
    b. ¿Construir confianza entre los clientes del programa?
    c. ¿Animar apoyo comunitario y social entre participantes del programa?
13. ¿Cuál otra cosa ayudó al programa salir exitoso?
14. ¿Qué cambiarías del programa?
15. ¿Has experimentado algunas barreras de participar completamente en el programa?
16. ¿Cómo debería el programa hacer para involucrar más la gente?
17. Esas son todas las preguntas que tengo para ti; ¿hay otros comentarios que te gustaría proveer? ¡Muchas gracias de nuevo por su tiempo!

<End Interview>

APPENDIX L. Introduction and Focus Group Protocol (SP)

Participants will be greeted upon arrival and given time to mingle and enjoy light refreshments. Pre Printed Name Tents will be placed around the table to ensure strategic placement of individuals. Once all participants have arrived, no later than 20 minutes after the designated start time, the following script will be used.

¡Hola a todos, gracias por estar aquí! Si todos se pueden dirigirse para una silla donde su nombre este colocado, empezamos la conversación en breve. (Allow everyone to take a seat and get situated). ¡Quiero empezar con presentarnos! Me llamo Taylor Geyton y soy profesora en la escuela de trabajo social en la universidad Portland State. Yo estaré facilitando nuestra conversación hoy, y <Student Name> tomará notas y manejará nuestra grabación de audio. Cada uno de ustedes han sido informado individualmente que esta conversación estará grabada con audio, si en cualquier momento durante la conversación usted siente incómodo y ya no quiere participar, nos puede dejar saber y detendremos la grabación hasta que sale del espacio para respetar su pedido. Todos ustedes se han identificado como un grupo de accionistas con la iniciativa de familias impactadas por la violencia armada por el equipo respuesta de salud conductual del condado de Multnomah. Para que todos nos conocemos mejor por favor:

1. Comparten su nombre, sus pronombres, y como usted está involucrado en el programa.

Ahora que nos conocemos un poco mejor, hablemos. Es importante que escuchemos lo más posible de ustedes que cada uno lleva una perspectiva única que merece estar escuchado. Una de nuestras metas mayores de esta conversación es entender las necesidades del programa. Para las preguntas siguientes, enfocaremos en esta meta.

2. Desde su propia perspectiva, ¿qué es el propósito principal de este programa? a. ¿Hay propósitos secundario o terciario cumplidos por este programa?
3. ¿En su estado actual, el programa está cumple su propósito? Explica su respuesta.
4. En su posición y relación al programa, ¿qué es necesitado para avanzar el éxito del programa?

Otra meta es entender el rol del programa en satisfacer las necesidades comunitarias. A ese fin,

5. ¿Cuáles necesidades en la comunidad piensan que este programa es mejor equipado satisfacer?

6. ¿Qué es la percepción comunitaria de este programa desde su entendimiento?

7. ¿En qué manera es la comunidad diferente debido a este programa?
8. ¿Qué es su entendimiento de las necesidades comunitarias?
   a. ¿Dónde aprendió de estas necesidades?
9. ¿Cómo es la comunidad involucrada en este programa? ¿Qué oportunidades existen para participación comunitaria?

La meta final es para identificar los factores de evaluación de resultados. Estos son las señales que miden el impacto y eficacia del programa con el tiempo.

10. Cuándo piensa del condado de Multnomah en cinco años, ¿qué espera que sea diferente a resultado de este programa?
11. ¿Cuáles son las señales de éxito para este programa?
12. ¿En qué manera es la comunidad ya es diferente debido a este programa?

13. ¿Cuál elemento del programa es lo más valioso en su opinión?
    a. ¿Menos valioso?
14. ¿Como se ve el éxito desde su posición específico?

¡Muchas gracias de nuevo por participar!

15. ¿Tienen cualquier otro pensamiento o comentario para agregar que no tocamos durante la conversación?

<End>