Process Evaluation of the Crisis Assistance Response and Engagement for Survivors (C.A.R.E.S.) Program

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EXECUTIVE SUMMARY

PURPOSE OF RESEARCH: PROCESS EVALUATION OF CARES

This report summarizes the results of a process evaluation of the Philadelphia District Attorney's Office Crisis Assistance Response & Engagement for Survivors (CARES) program. CARES is a victim service program designed to provide culturally competent crisis intervention and referral to long-term services in the 45 days after a homicide. First conceptualized in 2017 with funding from the Commonwealth of Pennsylvania beginning in 2018, the program is now housed in the Philadelphia District Attorney's Office (DAO). CARES reports to the First Assistant to the District Attorney and is staffed by a Program Director, a Program Manager, and a Program Administrator, who support and supervise a team of Peer Crisis Responders (PCRs). The PCRs have lived experience as survivors of homicide and are selected for their demonstrable compassion and empathy. Lived experience is increasingly seen as a unique, valuable qualification for social service workers, and many on the CARES team reported this as a strength of the program. By summer of 2021, the program employed 14 part-time PCRs who typically hold other jobs, some full time. All staff undergo a formal training program developed by CARES administrators, which includes a series of trainings required by Pennsylvania Council on Crime and Delinquency's (PCCD) Office of Victims' Services for direct providers of victim services. Immediately after a homicide, PCRs are deployed to hospitals, crime scenes, and homes of next of kin to offer support and referral to counseling. CARES services are voluntary but rarely declined, staff members report.

CARES, which began providing services in 2019, was specifically designed to fill the gaps in services that existed for next-of-kin and loved ones of the deceased in the immediate days after a homicide. These family members, relatives, kin and close friends of the deceased are known as "co-victims." Many have complex needs. The unique trauma brought on by the nature of the violent and sudden death may be further exacerbated because it co-occurs with experiences and consequences of social disadvantage or with social harms from public scrutiny and stigma associated with murder. These social harms can complicate the grieving process as the co-victim's grief may not be openly acknowledged, socially validated, or publicly supported. The short- and long-term harms of co-victimization include anxiety and depression, post-traumatic stress disorder, rage, difficulty for children in school and social settings, physical symptoms, drug or alcohol abuse, dependence, or addiction, family disruption, and severe economic hardship. In addition, co-victims may have emotionally challenging relationships with criminal justice system actors, as they search for answers about the homicide perpetrators or attempt to navigate various aspects of the criminal legal system. Some co-victims have prolonged grief—grief that extends for years and impedes healthy functioning, essentially incapacitating them.

Funded by the PCCD, the process evaluation was conducted between 2019 and 2021 by researchers from the Temple University Department of Criminal Justice, with assistance from faculty at Drexel University. Process evaluations help document program operations and describe outcomes are achieved. The research team designed the evaluation to focus on obtaining a clear understanding of program components with a particular emphasis on the timing, frequency, and type of contact staff had with co-victims. The research team knew going into the project that they would not have contact with the co-victims themselves, so the research tasks were prioritized

around documenting the services provided by the PCRs and identifying measurable outputs and outcomes, and collecting data to measure some outcomes. The overarching objectives were to:

1. Document the logic and operations of the program;
2. Identify any significant changes made to the program model during the study period;
3. Examine factors that impeded or facilitated the intended delivery of services to co-victims; and
4. Determine, to the extent possible, whether key program outcomes (those that were measurable) were achieved.

MEETING THE NEEDS OF THE TARGET POPULATION & PARTNERSHIPS

CARES aims to reach every person affected by homicide in Philadelphia and connect them with the relevant and necessary services to heal in the aftermath of a traumatic loss. In 2020, CARES staff also began to respond to vehicular manslaughter (sometimes referred to as vehicular homicide). Co-victims served include not only family members but also friends and neighbors who have been touched by the death and may need services. CARES staff carefully assess the needs of the co-victims and attempt to match families with a PCR that possesses the cultural and language background to meet their needs. For example, CARES has at least one PCR who is Muslim. Throughout the program, CARES leaders attempted to hire PCRs who speak Mandarin, Vietnamese, French, French Creole, and other languages, but to date, they have not been able to. CARES does, however, employ PCRs who speak Spanish.

To meet the unique and comprehensive needs of its target service population, CARES coordinates externally with a variety of programs and agencies. These partnerships are managed at the CARES administrative level and maintained with frequent community-based contacts by PCRs. Philadelphia's Anti-Violence Partnership (AVP) is a central partner to CARES and has an established set of roles (and corresponding budget lines) as part of CARES (e.g., staffing a part-time LCSW to assist with supporting many aspects CARES services). AVP's core mission is to reduce the cycle of violence by providing a wide range of services from support and counseling for victims and their families to rebuild their lives in the aftermath of violence.

CARES also works closely with criminal justice partners to meet co-victims' varied needs. There are three agencies within the criminal justice system that CARES interacts with regularly: the Philadelphia Police Department (PPD), the Medical Examiner's Office (MEO), and the Victim Services Unit within the District Attorney's Office (DAO). As a now established routine, police provides push notifications to the CARES Program Director with real-time information about homicides as it comes in to PPD, allowing for timely deployment of respondents. Additionally, CARES leaders have established solid relationships with police detectives to facilitate communication with families, when needed. CARES also coordinates closely with the Medical Examiner's Office. The collaboration helps ensure that there are few gaps in services for co-victims as they identify their loved ones remains. Similarly, CARES coordinates often with the DAO's Victim/Witness Services Unit.

Because CARES was designed to fill the gap in the immediate need for crisis services, a key component of the CARES model is coordination with and referral of co-victims to the appropriate community-based victim services provider. These include the police division-based victim service agencies operating in Philadelphia and funded by the PCCD, as well as other

community-based victim services that are not directly part of state and city-funded victim services.

As their main service provisions, CARES staff provide peer support and advocacy directed towards the specific needs of each family member. In the initial 24-hour period, PCRs may accompany co-victims to the hospital or Medical Examiner's Office, help co-victims understand police protocol, navigate communication with the media, assist in contacting family and friends, provide peer counseling, arrange childcare, and secure appropriate medical or psychiatric services. After the initial crisis period, PCRs work with families to develop support and recovery plans to ensure that a reliable support system is in place, that they are knowledgeable about their rights to apply for victim compensation, are connected to an array of appropriate services, are receiving clear, helpful communication from the police and wider justice system, and that they are taking steps to take care of their own health and wellness. Ultimately, and usually within a 60-day period, families are referred to a community-based victim service provider for long-term services and application support for the Victims Compensation Assistance Program (VCAP).

OUTCOMES

In 2020 there were 499 homicide incidents in Philadelphia, plus 18 incidents of vehicular manslaughter. CARES PCRs attended to all incidents where a next-of-kin name and contact information was determined. Responders were deployed to 465 families, making successful contact and providing at least one service across 431 incidents. This translates into an engagement rate of 93% in 2020. Because CARES services are designed to reach the whole family with tailored services, more than one co-victim can be served. In 2020, CARES staff recorded service provision to 621 individuals.

In any given program quarter, the most frequently provided services by CARES staff are: (1) individual advocacy, (2) victim rights information provision, (3) hotline/crisis line counseling, (4) crisis intervention and (5) referral to other victim service or community-based service provider. These services are most often delivered in combination during a service visit or phone call. During the Covid-19 pandemic, most services were delivered on the front porch/front yard or over the phone. On any particular co-victim engagement, the combination of services can vary widely.

In less than two years of operation, CARES has had a number of successes, serving the majority of homicide and vehicular manslaughter co-victims in Philadelphia. Across adult co-victims served, 77% were women; 89% were people of color and the average age of adult victims was 41 years of age. Responders also served dozens of children, but it wasn't until 2021 when staff became able to document in the case management performance database detailed information about the services provided to family members beyond the next-of-kin. Co-victims have received anywhere from 1 to 36 services, with an average of 6.5 services being delivered within the short three-month window of service provision.

PROGRAM STRENGTHS & SUCCESSES

The process evaluation identified several clear strengths of the CARES program. These include:

- **Flexible case management/comprehensive support**: CARES provides wrap-around services for a typically underserved population. Depending on unique needs and circumstances, PCRs can customize their approach to cases.
- **Peer support**: With lived experience, CARES staff bring their understanding of complex grief, as well as numerous other strengths and skills.
- **Rapid crisis response**: Response is immediate and tailored to the needs of individuals and family members. This includes fulfilling basic needs such as the provision of meals and water.
- **Low refusal rate**: CARES has documented few service refusals. Of co-victims who say they are not ready for help immediately after the death, most engage in services weeks or months later.
- **Self-care is a priority**: Training, resources, and support for self-care undergird the program.
- **Diversity of staff**: CARES Staff represent diverse racial and ethnic backgrounds and come from a wide range of neighborhoods across Philadelphia.
- **Teamwork**: Aside from hands-on training that brings staff together, CARES respondents are almost always deployed in pairs. Recent hires also shadow a more senior responder and observe the process before taking the lead when they are ready.
- **Strong leadership**: Program leaders have decades of experience in victim services, extensive connections and are themselves survivors of homicide.
- **Trauma-informed**: CARES utilizes evidence-based practices and principles of trauma-informed care. It provides continued training for staff and benefits from support from AVP's on-staff clinical social worker.
- **Sustainable partnerships**: Strong partnerships with AVP, the police department, the Medical Examiner's Office, and community-based victim services leverage resources to improve outcomes.
- **Insider access**: As a program housed in the District Attorney's Office, CARES has greater access to resources and information that help them better serve co-victims. It can more easily coordinate with attorneys and the Victims/Witness Services Unit to get updates on legal cases.
- **Data driven**: CARES' case management software enable staff to track services as they are delivered, assess any gaps, and document performance.

PROGRAM CHALLENGES

Unsurprisingly, the process evaluation also identified several challenges, most of which emerged as themes in the qualitative data we collected (i.e., the interviews). These challenges relate to the following:

- **Social context, compounded trauma, and limited services**: CARES staff members frequently brought up the larger context of poverty, violence, and disadvantage faced by Philadelphia communities. Furthermore, some families and communities have experienced repeated tragedies due to homicide by the time they come into contact with the CARES program. Many PCRs also reported that the limitations in services in general (all types) is a serious barrier to the recovery of the homicide survivors.

- **Political climate and community relations in Philadelphia**: DA Krasner's progressive agenda has been interpreted by some as being favorable to perpetrators of crime, antagonistic to police, and unsupportive of victims.
- **Program agency setting**: CARES responds on-site to homicides on a 24-7 basis, while the hosting agency, the DAO, follows a 9am to 5pm, Monday through Friday schedule. For PCRs without office employment experience, navigating the bureaucratic procedures of the DAO may have been a challenge.
- **Initial organizational development**: In the early days of the program, staff were not only doing the work of serving families, they were also navigating ongoing program development. At the inception of the program, there were few formalized protocols, with no implementation manuals, clear script or template for staff on how to handle cases, and no formalized hiring and training process.
- **Constraints of part-time role of the CARES staff**: Currently both the PCRs and the program counselor work for CARES on a part-time basis, although their job resembles more a "24/7" continuous effort. This creates certain challenges and constraints for the program related to scheduling and capacity. (CARES administrators are working to hire at least a few full-time PCRs.)
- **Coordination with partners:** Despite developing strong partnerships with criminal justice agencies and community-based services, occasionally (and especially in the program's early days) friction, inconsistencies, or lapses in communication can exist.
- **Vicarious trauma and burnout:** Despite PCRs' lived experience being a major strength of the program, the responders' own co-victim status leaves them vulnerable to re-experiencing trauma and personal loss. Furthermore, the concentration of violence in certain Philadelphia neighborhoods enhances the likelihood that PCRs will be personally familiar with the co-victims assigned to CARES.
- **Concern for staff safety:** An important factor in strategizing staff deployment is ensuring their physical safety. Given the PCR's role of being available for a co-victim and family members when requested, and sometimes being present at the scene of a homicide and in the days following, there may be a real threat of violence from simply being in close geographic proximity to the co-victims.
- **Meeting the diversity of the target population:** Despite program strengths deriving from current staff diversity and reliance on the peer model, both administrative and line staff indicated that there is a need for greater diversity among the staff to better match the demographics/cultural diversity of the survivors.
- **Impacts of COVID-19 pandemic:** Like providers around the world, the CARES staff had to adapt to social distancing, reliance on digital communication, and new health protocols in all aspects of life and work. According to PCRs, social distancing especially impacted co-victims' grieving process and ability to connect with services. The inability to hold funerals, to go in person to the MEO to identify their loved one, and the risk in seeing and receive support from friends and families in-person, may have created more suffering and alienation for co-victims.

RECOMMENDATIONS

The structured interviews with CARES staff, leadership, and key stake holders revealed multiple opportunities for program growth and improvement. We identified four key areas where

CARES can build on its strengths and enhance its services. These related to: (a) program capacity; (b) partnerships; (c) target population; and (d) data and evaluation.

Program Capacity

Recommendation 1: Create full-time PCR roles. A major program challenge identified above was the constraints of part-time roles. CARES administrative leaders have been attempting to obtain funds that would convert some of the PCRs to full-time, and by now it has obtained two full time PCR positions. Continuing to expand the budget to include additional full-time PCRs could improve overall staff retention and facilitate responsive service delivery practices. The need for full-time PCRs should be carefully balanced so CARES could still have a diverse staff who reflect the demographics and needs of the co-victims and their geographic locations throughout the city.

Recommendation 2: Formalize hiring criteria. Prior to establishing full-time PCR roles, it would be beneficial to formalize and systematize the hiring criteria. For example, decisions should be made about how soon after a loss someone can be hired to the role. Consideration should also be given to whether to expand the "peer" element to include anyone who had experienced a serious loss, as opposed to the loss of a loved one to *homicide* specifically. Another key consideration in hiring should also be expanding cultural competency and the ability to reach diverse segments of the target population beyond the current staff competencies. Deciding these issues will likely require deep conversation among CARES staff, stakeholders, and community members, but will assist with hiring in the future.

Recommendation 3: Hire two full-time LCSWs. Nearly all staff members interviewed mentioned the need for increased clinical capacity and counseling services. The first and current LCSW works full-time with the Anti-Violence Partnership and part-time with CARES. Within that part-time role, the LCSW provides case consultation, emotional support and counseling to PCRs themselves, and sometimes provides crisis counseling to co-victims who are in urgent need. Additional staff in this area would better support PCRs and the people CARES serves.

Recommendation 4: Allocate funds to meet more co-victim needs. Multiple staff members mentioned the pain of not being able to immediately provide something a family in grief needed, such as food or a safe place to stay. By allocating more financial resources to be used for material support for co-victims, PCRs can serve families more quickly and efficiently than via the later referral process. Examples of material needs mentioned in interviews include: temporary housing relocation; grief-related medical emergencies; groceries and prepared food; and transportation to the MEO or DAO.

Partnerships

Recommendation 5: Take a network approach. Forming partnerships is a strength of the CARES program. With increased staff capacity, the program could extend this collaborative approach to form a small network of agencies that respond to homicide co-victims. Despite previous efforts, at present, there is no Philadelphia-wide body that supports a network approach to victim services, with the exception of the PCCD. Such a network would reduce duplication of services and ensure families are not overwhelmed with calls or letters from multiple agencies. The city recently established an Office of the

Victim Advocate, planning to appoint the victim advocate sometime in late. With careful oversight, this office might be able to achieve the goals of a network approach: fill gaps in need, reduce duplication, and support capacity-building efforts for victim serving organizations and programs. CARES administrative staff could seek the assistance of the new Office to build networked resources to serve co-victims of homicide.

Recommendation 6: Continue to build organic partnerships. Developing more extensive partnerships would also allow CARES to serve more specific needs. In particular, we recommend creating stronger partnerships with agencies that have extensive lists of services and referrals for children and those that specialize in conflict mediation in instances of street violence. One way to foster collaboration with other agencies is to continue what CARES leadership have been doing—inviting other agencies to present about their services at CARES staff meetings—but to increase the frequency and sharpen the focus of these partnership-building efforts.

Recommendation 7: Continue building out the partnership with AVP. In mid-2021, CARES was given satellite space at one of AVP's offices in West Philadelphia. This space will provide the opportunity for co-learning between CARES and AVP staff and for sharing ideas about how their partnership can continue to grow to meet additional needs of Philadelphia victims and co-victims. An expanded partnership with AVP will also allow CARES staff to write grants where the fiscal agent is a non-profit (i.e., AVP) and not a government entity (DAO), as many and some grant portfolios exclude government entities from applying and private funders are often only interested in supporting work of non-profit, community-based agencies. An expanded partnership would also provide means for CARES to hire additional LCSWs and streamline the hiring process that takes place within a large bureaucratic government agency.

Recommendation 8: Test the possibility of having round-the-clock PCR staff who are able to partner with the police to deliver the death notification. Research shows that one of the most defining moments for the co-victim is that moment when police come to the door or call to notify next-of-kin of that their loved one has died. A trained PCR could be available for support as the information is being conveyed. The police may not be viewed positively in many communities and there may be added tension and emotion when police deliver the information.

Reaching the Target Population

Recommendation 9: Continue to expand reach to all affected co-victims across each homicide incident. In efforts to offer services to anyone affected by a homicide, not just immediate family, CARES should leverage its position for larger and more meaningful community engagement, such as partnerships with schools. The CARES administrative team should ensure that the extensive needs of all those affected by the homicide are captured and documented through specific notes or data forms. If the service/performance data do not demonstrate that this need is there, funds for additional staff or services is unlikely to follow.

Recommendation 10: Establish additional satellite offices throughout the city's neighborhoods most affected by homicide (in addition to the AVP space in West

Philadelphia). Such satellite offices would enable the PCRs to reach the co-victims more easily. Co-victims would also have access to victim services nearby their homes, if needed. Working from satellite offices would also increase PCRs' efficiency, for eliminating, for example, the sometime cumbersome trips to the agency's office in the downtown area of the city Having additional offices could also help overcome issues related to lack of office space for discussing private information and mechanisms for hiring part-time workers with limited building access or employee payment options.

Recommendation 11: Partner with organizations that specialize in preventing retaliation. One of the original aims of the CARES program was to prevent retaliatory violence after a homicide. Staff members interviewed expressed concerns about the possibility of a co-victim being interested in retaliation. However, some PCRs stated that they did not quite feel prepared to bring up the likelihood of retaliation or intervene in any way to prevent retaliation. We recommend that CARES partner with programs such as Cure Violence or the Community Crisis Intervention Program (CCIP), which have staff with specialized experience in conflict mediation and may be able to provide training or serve as a referral for CARES staff.

Recommendation 12: Continue to prioritize the hiring of PCRs that represent the diversity of co-victims. CARES staff are sensitive to the need for cultural competency and have tried to match families to PCRs in a way that will best serve the co-victims. Multiple people interviewed mentioned the need for PCRs that are competent with unique populations, including: people of various faith backgrounds; non-English speaking families; people of diverse gender identity; and young people and their networks.

Data and Evaluation

Recommendation 13: Improve processes to streamline data collection and fill gaps in performance measures. The research team was impressed with the PCCD/OVS' requirement that grantees use the ETO software for data collection and reporting. This requirement provides the PCCD with a method to summarize service provision for state-funded victim services across the Commonwealth. The PCCD provides grantees a very detailed manual for ETO and well as training. However, some improvements could be made in ETO that allow grantees to easily add forms and create customized reports that facilitate reporting on a wider range of program outputs and outcomes. For instance a "back-end" improvement to ETO could improve front-end experience. A highly-streamlined, organized, and easy-to-use data management interface in ETO would help CARES staff spend less time on data entry and more time on participants. Many staff members interviewed found data input overly time-consuming, while others found it manageable. CARES should continue to improve its data collection by solidifying procedures, formalizing categories for services and referrals, and training PCRs on data input in ways that improve validity and consistency. To put these recommendations into practice, we recommend hiring a PCR who also possesses data reporting skills and could establish beneficial practices such as quarterly and yearly reports that are more detailed than the stock reports sent to the PCCD. Deciding on a few key program metrics and establishing reliable ways to measure, collect, and communicate the data are essential to a

program's long-term success.

Relatedly, CARES could hire a program intern from a local college or university whose role is to develop procedures that allow direct data capture on all aspects of CARES referrals with regard to which service agencies were receiving referrals and enrolling co-victims in services, including completing applications for victim compensation. Follow-ups could be done directly with partner victim services agency to ascertain successes and challenges with regard to co-victim access to and engagement with referral agencies. The intern or someone from CARES staff would first have to make sure that information sharing protocols include using identifying information when talking with/accessing information and data directly from referral agencies.

Recommendation 14: Increase response rate of co-victim exit/satisfaction survey. The research team developed and implemented exit/satisfaction surveys for co-victims to fill-out voluntarily at the conclusion of CARES services. The survey, based on the Empowerment and Satisfaction Questionnaire (ESQ), was designed to obtain more targeted information about the services that CARES provided. Questions on the specific types of services received, including items on details related to applying for victim compensation were added. Hence, the Temple exit survey was a few pages longer than the ESQ-LF (Long Form). The process was developed so that CARES staff (as opposed to the researcher) would provide the co-victim the survey to complete at the end of the services. This was the same process that would have been used with the original ESQ—client self-administration at the conclusion of services. The downside with self-administration of surveys when clients are exiting services is that there is little opportunity for follow-up, unless the survey is administered with an Internet option. The research team did develop an online option. The survey had a very low response rate, with only roughly two dozen surveys being completed in 2020. We recommend that, in the coming years, CARES determine which "new" survey items would be most important to retain as outcome measures in addition to the main ESQ items, and that a streamlined version of the exit survey be administered with regular follow-up. For more information on the ESQ, see Collins et al., 2008.

Recommendation 15: Use the data and ESQ-LF exit survey results to celebrate programmatic successes. CARES staff should develop new data-related procedures and reporting that routinely highlight the aspects of CARES that are working well and particularly when exit survey results have been strong. This practice will help develop and solidify best practices, build optimism, and help to sustain engagement and morale across staff.

CONCLUSION

One of the main goals of the process evaluation was to determine how faithfully the strategy was implemented according to the logic model designed in partnership with the original proponent/developer of CARES. The logic model is displayed in Figure 2, in Chapter 2. For the most part, the model was implemented as planned with the resources sought being put into place to serve co-victims in the immediate crisis period following the homicide. This in and of itself, can be deemed a success, particularly given the turnover in the leadership of CARES at its

inception and the move from its intended implementation within a community-based agency versus now at the DAO. A new CARES Program Director stepped in to implement a vision drawn up by someone else, within a government agency that had an amorphous organizational structure in 2018. The new CARES leadership worked diligently to hire staff and draft protocols and procedures, as well as trouble shoot whenever challenges arose. Any changes that were made, were put in place to keep the implementation of CARES moving forward or to overcome unexpected challenges. All changes generally aligned with key outcomes sought.

The two main differences between the logic model and the program as it was implemented on the ground are:

(1) CARES staff are not the ones to notify the next-of-kin that they lost their loved one. Notification is still conducted by police personnel, but as suggested in our recommendations, perhaps a partnership could be developed and new staff positions hired, so a social worker or a counselor could conduct the notification of death, as opposed to law enforcement or accompanied by law enforcement.

(2) CARES PCRs are not trained to reduce the likelihood that families would retaliate against presumed perpetrators. CARES leaders determined that although this would be a valuable outcome of the work of CARES, the training needed to do this in an appropriate and safe manner is not within the resources that CARES leadership currently has. Leadership staff thought it would be more appropriate to partner with agencies already on the ground who work in the area of conflict mediation. CARES leaders also indicated that if conflict mediation were to be a part of CARES, they would need to change their priorities with regard to hiring and the qualities and traits sought when hiring PCRs. Finding staff who are credible as conflict mediators is not an easy task, and perceptions of credibility and trust would vary greatly across incidents depending on the specifics of the events that led to the homicide.

These “changes” from the original CARES blueprint do not minimize the huge accomplishments and successes of CARES implementation. CARES filled a large hole in the victim services landscape in Philadelphia. Prior to the formation of CARES, outreach to co-victims was inconsistent and the process of accessing services and applying for VCAP was daunting. National and local studies show that the majority of violent crime victims, including co-victims, simply don't know that services are available to them at no cost (Roman et al., 2020). But even those victims who know that services exist may not access them due to a wide range of challenges and barriers. For residents living in neighborhoods characterized by disadvantage and poverty, health inequities have been well-documented. CARES not only opens the door to a host of services, but also provides flexible and reliable support and encouragement when needed—from staff who draw from their personal experiences. This can lead to greater engagement and satisfaction with services, as well as overall improvements in quality of life. With regard to peer support, although there is little evaluation research on the topic, the research literature suggests that trauma-informed peer support, alone, is a key component that can reduce the use of other formal services—medical, mental health and other social services, ultimately reducing the long-term costs of the harm experienced by survivors of homicide.

CHAPTER 1: INTRODUCTION & BACKGROUND

Losing a loved one can lead to feelings of grief, financial instability, and uncertainty in the future. When a loss is violent and sudden, such as in cases of murder, accident, or suicide, the impacts of trauma and shock are magnified. Victim service providers often refer to people who have lost someone to homicide—including family members, friends, or neighbors—as "co-victims" or "survivors" of homicide (OVC, 2021). Researchers have estimated that each homicide leaves behind seven to ten close friends and family members (Redmond, 1989), but we know that the harms from homicide and grief can extend much further into communities. Studies show that homicide co-victimization is associated with short- and long-term harms that are psychological, physical, social, and economic (OVC, 2021).

The Philadelphia District Attorney's Office Crisis Assistance Response & Engagement for Survivors (CARES) program is a victim service designed to provide culturally competent crisis intervention and referral to long-term services in the 45 days after a homicide. First conceptualized in 2017 with funding from the Commonwealth of Pennsylvania beginning in 2018, the program is now housed in the Philadelphia District Attorney's Office (DAO). CARES reports to the First Assistant to the District Attorney and is staffed by a Program Director, a Program Manager, and a Program Administrator, who support and supervise a team of Peer Crisis Responders (PCRs). The PCRs have lived experience as homicide co-victims and are selected for their demonstrable compassion, empathy, and respect. Lived experience is increasingly seen as a unique, valuable qualification for social service workers, and many on the CARES team reported this as a strength of the program. Immediately after a homicide, PCRs are deployed to hospitals, crime scenes, and homes of next of kin to offer support and referral to counseling. CARES services are voluntary but rarely declined, staff members report.

This report summarizes the results of a process evaluation of CARES. Process evaluations help document program operations and how outcomes were achieved. The Pennsylvania Commission on Crime and Delinquency (PCCD), which funds victim services in Pennsylvania, seeks to understand how best practices are developed and how they can be used to inform future program strategies. The PCCD funded the Philadelphia DAO and their partner, Temple University, to engage in research and data collection towards this process evaluation. Evaluations can assist organizations in showing that they are engaged in carefully implemented services and that residents are receiving tangible benefits. The results from an evaluation can also help program staff identify challenges and strategize about potential changes to operations.

For this evaluation, the research team utilized a logic model approach to examine the resources devoted to the program, the program activities, and the outputs from those activities, and the targeted outcomes articulated by program developers. Measuring the outputs across the various CARES services and activities helped assess how the final outcomes were achieved. These outputs also serve as performance measures for monthly, quarterly, and annual performance reporting.

PROCESS EVALUATION OBJECTIVES & METHODS

The research team designed the process evaluation to focus on obtaining a clear understanding of program components with a particular emphasis on the timing, frequency, and type of contact staff had with co-victims. The research team knew going into the project that they would not have contact with the co-victims themselves, so the research tasks were prioritized

around assessing the services provided by the PCRs. In general, the overarching objectives were to:

1. Document the logic and operations of the program;
2. Identify any significant changes made to the program model during the study period;
3. Examine factors that impeded or facilitated the intended delivery of services to co-victims; and
4. Determine, to the extent possible, whether key program outcomes (those that were measurable) were achieved.

The research team developed research questions to align with these objectives:

- How faithfully was the strategy implemented according to the logic model and expectations of key staff? Did any changes made align with achieving key outcomes?
- What were the types and quantities of services delivered, who were the beneficiaries of those services, and what resources were used to deliver the services?
- Which program components, services, or attributes (or combinations of these) were most critical to effective implementation?
- How does the program draw on the attributes and the strengths of the PCRs to achieve its goal?
- What implementation challenges were encountered by the staff and other stakeholders?
    - Were there any specific needs of co-victims that staff identified as not being met? Or that staff had difficulty meeting?
- How did contextual factors influence the implementation and operation of the model?
    - How do the organizational attributes of the DAO and key referral agencies (e.g., victim services agencies, other social services, etc.) influence the design and delivery of the program?
    - What aspects of the political and economic climate, both state and local, appeared to impact program operations?
    - How did the global Covid-19 pandemic impact operations and how did staff adjust programming and practices to account for challenges brought on by the pandemic?
- What recommendations does the research team have for program leaders for maintenance or expansion and for other jurisdictions that may be considering a similar program?

To answer these questions, the research team employed a range of methods that included: embedding a researcher at the DAO offices, a review of agency documents, examining and extracting electronic data from the case management system, conducting semi-structured interviews with staff and stakeholders, holding bi-monthly meetings with the Program Director, participating in victim services trainings, and analyzing exit surveys with co-victims (proctored by program staff). Throughout this report, we embed quotes from the semi-structured interviews that serve to highlight key points that were made by respondents (staff and partners), most often when the majority of respondents had the same perception or sentiment. Sometimes, we use a quoted passage to highlight a point or success or particular challenge that was not articulated by the majority of respondents. In these instances, we indicate that. To preserve anonymity, we do not attribute any quoted passages.

LITERATURE REVIEW: CO-VICTIMS OF HOMICIDE & VICTIM SERVICES

SCOPE OF THE PROBLEM

In 2019, there were roughly 14,000 homicides in the United States,[1] with urban areas experiencing the highest rates. Systematic data are not routinely collected on co-victims, making it difficult to accurately describe the population of survivors, the challenges they face, the scope of the trauma, and other potential harms. Only a handful of studies have examined the overall prevalence of homicide co-victims in the United States. In a study that utilized random digit dialing, Amick-McMullan and colleagues (1991) identified a sample of 12,500 adults, of which 9% reported to be co-victims of homicide. A later study employed structured telephone interviews with a national sample of 1,753 young adults and revealed a higher co-victim prevalence of 15% (Zinzow et al., 2009). Although urban communities have higher rates of homicide than suburban and rural communities (Glaeser & Sacerdote, 1999), all communities experience homicide. The intersection of race and age is a key factor for homicide co-victimization, with a growing body of research focusing on the overrepresentation of people of color among co-victims (Amick-McMullan et al., 1991; Zinzow et al., 2009).

THE AFTERMATH OF HOMICIDE

In the aftermath of a homicide, grief, shock, and other factors often drive the suffering of co-victims. 'Grief' is the process of experiencing the psychological, behavioral, social, and physical reactions to the loss (Rando, 1993, p. 23). In addition to losing the relationship with the deceased, those left behind also face the loss of many things including their future plans, trust in others, feelings of control, sense of fairness, and elements of their perceived legacy.

According to crisis theory (Horne, 2003), the initial 4- to 8-week period following the traumatic bereavement event is critical because a homicide precipitates an emotional state of disequilibrium during which surviving family members' usual repertoire of coping mechanisms may be insufficient to handle and process the homicide event. Numerous studies have identified consequences of homicide co-victimization ranging from post-traumatic stress disorder (PTSD) (Amick-McMullan et al., 1991), in addition to anxiety, depression, (Amick-McMullan et al., 1989; McCreery & Rynearson, 1993; Norris et al., 1998; Zinzow et al., 2009; 2011), rage (Friedman et al., 1988; Gross, 2007; van Wijk et al., 2017), a difficulty for children in school and social settings (Burgess & Clements, 2002; Vigil & Clements, 2003), physical symptoms (Mastrocinque et al., 2015; van Wijk et al., 2017), drug or alcohol abuse, dependence, or addiction (Zinzow et al., 2009), family disruption (Casey, 2011), and severe economic hardship (van Wijk et al., 2017). During semi-structured interviews in one qualitative study, some co-victims even reported that they felt they had been given a "life sentence" (van Wijk et al., 2017). Studies also show that grief, especially prolonged grief, can increase the risk of suicidality in homicide co-victims (Latham & Prigerson, 2004; Prigerson et al., 1997).

The unique events leading to the death by homicide may also change or magnify aspects of co-victims' grief. In some instances, there is a perception that the deceased person played a role in their own death. This perception contributes to "disenfranchised grief" that results from social stigma and prevents grief from being openly acknowledged, socially validated, or publicly

[1] https://ucr.fbi.gov/crime-in-the-u.s/2019/crime-in-the-u.s.-2019/tables/expanded-homicide-data-table-1.xls

supported (Doka, 2002). Examples of situations that contribute to disenfranchised grief include drug overdoses and violence among gang members. The effects of social stigma complicate and lengthen the grieving process, which presents with wide variation in intensity, duration, and expression (Goldman, 2014).

VICTIM SERVICES AND INTERVENTIONS

Throughout the country, there are hundreds of programs that provide services or support for the victims of crime. Though relatively established today, these programs did not become common aspects of the human services landscape in the United States until the late 1970s and early 1980s when the interest in victimization and victims of crime was spurred by the increase in crime in the 1960s (Young & Stein, 2004). The majority of existing programs at the time had focused on meeting the needs of rape victims and domestic violence victims. But as practitioners began to translate their knowledge and practices into reports and training materials that were increasingly disseminated throughout the country, programs for all crime victims were soon developed. The first extensive publication describing how to meet the needs of victims of crime (*Crime Victim's Book*) was published in 1979 (Bard & Sangrey, 1979). A few years later, President Ronald Reagan proclaimed the first national-level Crime Victims Week in April of 1981 (OVC, 2021).

Today, every single state has programs that provide no-cost services for victims, including money for direct compensation. These resources are often made available through the Crime Victims Fund (CVF), a fund that is authorized through the federal Victims of Crime Act (VOCA), passed in 1984. The funds are generated almost entirely from the revenue by criminal justice policies and practices applied to individuals who commit crimes (e.g., criminal fines, forfeited bail bonds, penalties, and special assessments), and more recently by private donations. The Office for Victims of Crime (OVC) manages the VOCA funds, which then provides awards to state victim compensation programs. The state programs can then make direct payments to victims or beneficiaries, or funds can go directly to state VOCA assistance administrators to direct to service providers (Newmark et al., 2003). The Victims Compensation Assistance Program (VCAP), is designed to cover a range of costs, including a loss of earnings and out-of-pocket expenses for medical care for physical injuries or psychological trauma. The program may also help with costs associated with counseling and home healthcare services, and crime-scene clean-up. Victims cannot be reimbursed for pain and suffering or stolen or damaged property. However, costs for some medical items such as canes or wheelchairs are allowed. For co-victims of homicide, the program can also be used to support funeral and burial expenses. VCAP is known as the payer of last resort because the program only pays where and when insurance does not (if victim has medical insurance).

Although there are hundreds of services and programs for the direct victims of crime throughout the United States, in many jurisdictions co-victims of homicide are overlooked. Programs specific to co-victims, or those designed to serve all co-victims in a jurisdiction, are rare. A few cities provide services for co-victims of homicide through branches of the justice system, but most existing programs are community-based and survivor-driven, meaning that they were founded by and are operated by past co-victims of homicide. Some of these programs are volunteer-based, and others may have a formal structure with paid staff members. Over the years there have been several organizations that have grown in size to develop a cross-country network of chapters, such as Homicide Survivors Inc., headquartered in Tucson, Arizona, or Mothers in Charge which began, and is headquartered, in Philadelphia, Pennsylvania. The breadth of

programming also varies greatly. For instance, Homicide Survivors Inc. is a relatively large organization that has developed a full range of services and supports for co-victims. The organization offers monthly support groups, walk-and-talk support groups, trauma-informed yoga, hope and healing workshops, youth mentoring, and classes on parenting through grief for both parents and children. Services may also include assistance with securing necessary resources including, by not limited to, applying for victim compensation, accessing death certificates, medical examiner and police reports, support for organizing funerals, memorials or funding drives, and funds for rent and utilities, or travel expenses for court. The support provided often includes direct financial assistance beyond what victim compensation would cover. The program also has staff who are trained to assist co-victims with press conferences for cold or unsolved cases. Other organizations or programs might only offer victim advocacy and referral to services or be focused on advocacy around victim rights and legal support, such as Justice for Homicide Victims (JFHV), located in Los Angeles, California. JFHV conducts periodic seminars explaining victims' rights and outlining expectations through the legal process. An entirely volunteer-based organization, JFHV collaborates with law enforcement, district attorney's office staff, and other victim advocates to provide advice and insight into arraignment, preliminary hearings, and trial. Volunteers will also assist in gathering data for parole hearings.

In recent years some programs have emerged to explicitly serve a subset of co-victims of homicides. Victim service advocates recognized the need for specialized services geared toward co-victims of homicide where the homicide has especially challenging or traumatizing circumstances—often because the victim or witness was a young child or the threat of harm to the co-victim is high. These include gang-related homicides, intrafamilial homicides, homicides involving child witnesses, and deaths caused by someone driving under the influence of alcohol or drugs.

With regard to research on the effectiveness of co-victim-focused victim service programs, there exists relatively little evaluation work specific to crime victimization compared to evaluations of social work and public health practices that seek to reduce short and long-term health harms, such as effective coping practices and post-traumatic stress disorder. The study of victims of crimes and services and supports for victims is a relatively new field. In fact, it wasn't until 1990 that bills of rights for victims were adopted by every state, leading to increased funding and resources for victim services and compensation programs. As resources and programming for victims expanded, so too did interest in research. Although early evaluations of outcomes related to victim services programs were focused on victims of interpersonal violence and sexual assault, the last decade has seen an expansion in research relating to all types of victim services and across a wide range of crime types (e.g., fraud, human trafficking, etc.) and populations (e.g., elderly victims, LGBTQ, etc.). However, it is important to note that given the sensitive nature of victimization, particularly violent victimization, there are not many studies that include primary data collection with crime victims—where researchers interact with crime victims to study a range of outcomes; the majority of studies focus mostly on program satisfaction (OVC, 2013).

The few studies that evaluate homicide survivor programs tend to be either those that focus specifically on psychological interventions or skills-building interventions (e.g., managing physical and emotional reactions to upsetting situations) or those that focus on immediate outcomes (as opposed to final outcomes). These immediate outcomes include service engagement or satisfaction with the program (see Alves-Costa et al., 2019). A 2015 systematic

review of the literature on homicide co-victims published between 1985 and 2012 found 40 articles that met the inclusion criteria but only eight of those described interventions. The vast majority were simply describing the extent of grief, processes of grieving, and the psychological and occupational effects of being a co-victim of a homicide (Connolly & Gordon, 2015). The studies that described interventions were primarily focused on the effectiveness of family therapy or psychoeducation support groups that taught survivors the importance of self-care. Interestingly, of the 40 articles, five articles discussed the relationship between co-victims and the criminal justice system. The authors of the systematic review found that these studies had common findings that indicated families had negative experiences with the criminal justice that impeded their grieving process. One study reported that many victims had difficulty accessing information about the case as it worked its way through the system, that there was little follow-up when perpetrators were paroled or released from incarceration, and that there were difficulties with interfacing with the medical examiner's office in the immediate aftermath of the homicide (Beard & Kashka, 1999). Other studies detail co-victim perceptions of insensitive and unfair treatment (Norris, Ruback, & Thompson, 1996), and the impact of negative media reporting on the homicide case (Adkins, 2003; Riches & Dawson, 1998).

PHILADELPHIA IN CONTEXT

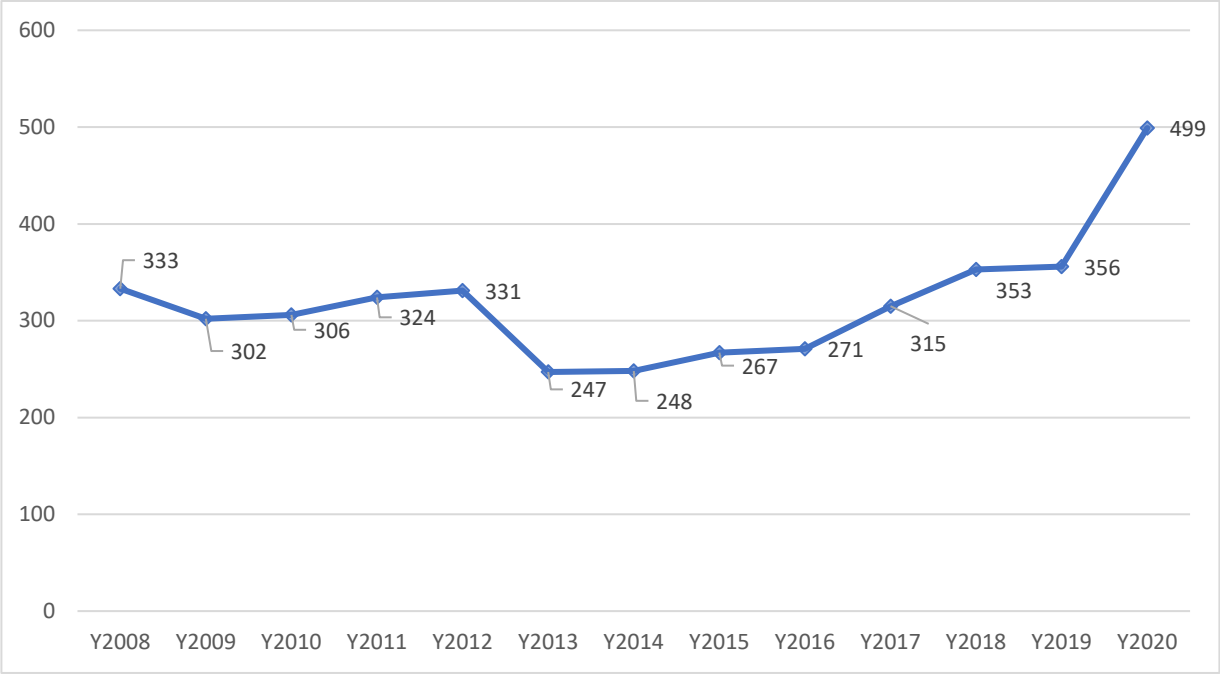
When the CARES strategy was being conceived in 2017, Philadelphia was ranked among the top five large cities by homicide rate: 20.1 homicides per 100,000 (Grawert & Kimble, 2019). This translated into 315 criminal homicides in 2017. Over the last decade, Philadelphia has, almost every year, remained in the top five in this ranking. In addition, since 2017, the number of homicides has increased each year, with 2020 witnessing the largest number of homicides since the 1990s. Figure 1, below, shows the number of homicides in Philadelphia from 2008 through 2020.

Philadelphia not only has a high burden of homicide as a whole, but also particular neighborhoods witness extreme levels of violence, which further exacerbates the need for supportive victim services. Research shows that homicides are not randomly distributed within a jurisdiction; they are most often clustered in low-income neighborhoods. A snapshot of homicide data from the Philadelphia Department of Public Health from 2016 shows that 50% of homicide victims lived in census tracts with the lowest median annual household incomes (less than $25,800 per year), while only 2% lived in census tracts with the highest incomes (median household incomes greater than $52,200 per year).[2] Comparing Census tracts by the number of victims of firearm homicides within them shows that the rate ranges from 31.9 to 1.5 per 100,000 residents for those living in the lowest to highest income areas — a 21-fold difference. These differences matter for numerous reasons, but with regard to human services, this disparity likely translates to a critical need for access to timely trauma-informed support services for co-victims of homicide for many neighborhoods within Philadelphia. For instance, new research from Philadelphia that examined pediatric emergency department admissions shows that children living within a quarter mile from shootings had more acute mental health symptoms than children living further way from gun violence (Vasan et al., 2021). Another study (which included respondents from Philadelphia) found that those exposed to firearm homicides—either directly or vicariously—had significantly higher levels of psychological distress, depression,

[2] https://www.phila.gov/media/20181106124821/chart-v2e10.pdf

suicidal ideation and/or psychotic experiences compared to those not exposed. (Smith et al., 2020). The implications of these studies for victim services, coupled with other studies that indicate there are negative consequences for the health and wellbeing of residents who experience homicide of a loved one, is that areas of high violence have particular and acute needs that are likely not being met. Research on access to medical, mental health, and general public health support services indicate that inner city areas suffer disproportionately from insufficient access to support services (Alvidrez et al., 2008). In turn, when these resources are inaccessible or inadequate care is provided, health outcomes tend to be very poor (Noonan et al., 2016; Williams & Rucker, 2000).

Figure 1. Philadelphia Criminal Homicides, 2008-2020



Data Source: Philadelphia Police Department; Criminal homicides exclude officer-involved shootings.

THE VICTIM SERVICES SYSTEM IN PENNSYLVANIA AND PHILADELPHIA

In Pennsylvania, victim service agencies typically are funded through the PCCD Office of Victims' Services (OVS). OVS funds community-based agencies and government agencies to deliver a range of services and programs supported through federal VOCA dollars. This includes VCAP), with funding based on a formula that accounts for both population size (75%) and crime counts (25%). To dispense VCAP funding in Philadelphia, the city is divided into six regions that align with the Philadelphia Police Department's (PPD) crime patrol boundaries. This creates a direct relationship between the area served by both PPD and the victim services agencies. In turn, agencies are familiar with local law enforcement personnel and practices so they can, in theory, follow up with every crime victim in a particular geographic area. In other words, there are neighborhood-based victim service agencies that have a core mission to administer VCAP funds distributed across the city. These victim services agencies receive the Part I crime incident

data (homicide, sexual assault, robbery, aggravated assault, burglary, motor vehicle theft, larceny, and arson) from the PPD for their respective Police Districts, and then the victim service agency staff send letters to the crime victims to inform them of the relevant victim services. To receive victim compensation, there must be a police report. Victims are excluded from the free services if they did not cooperate with police (i.e., when police came to the scene) and if the police listed the victim on the report as having precipitated the criminal incident (Roman et al., 2020).

CHAPTER 2: PROGRAM OVERVIEW & BACKGROUND

HISTORY & BACKGROUND OF CARES

The need for a dedicated homicide crisis response program has long been the subject of conversation among victim services and advocates in Philadelphia. In 2017, the Anti-Violence Partnership of Philadelphia (AVP), along with the CHARLES Foundation, surveyed the victim service agencies and support groups to determine what services existed and whether the capacity existed to develop a comprehensive crisis response initiative. It was determined that there was no coordinated system in place to provide immediate crisis support to co-victims in the aftermath of a homicide. This led to the application for funds to initiate a survivor-driven, community-based, peer-led crisis support program geared to serve families and individuals in a time of great need.

Acronym Glossary

- **CARES** – Crisis Assistance Response & Engagement for Survivors
- **PCRs** – Peer Crisis Responders
- **DAO** – District Attorney's Office
- **MEO** – Medical Examiner's Office
- **PPD** – Philadelphia Police Department
- **AVP** – Anti-Violence Partnership
- **VCAP** – Victims Compensation Assistance Program
- **VOCA** – Victims of Crime Act

Originally, CARES was a partnership between CHARLES Foundation and AVP, developed under the leadership of the Executive Director/Founder of the CHARLES Foundation and funded by a two-year grant from the PCCD. After the director of the CHARLES Foundation was appointed interim Victim Services Supervisor at the DAO, DAO leaders worked with the PCCD to bring the grant funding (the original fiscal agent was AVP) to the DAO. On August 1, 2018, CARES was officially launched under the DAO and run by the Founder of the CHARLES Foundation. By October 2018, the first hires were made for a Program Coordinator and Program Manager, and the first wave of PCRs was interviewed the following month. On January 1st, 2019, the CARES team began responding to homicides in Philadelphia.

TARGET POPULATION

CARES aims to reach every person affected by homicide in Philadelphia and connect them with the relevant and necessary services to heal in the aftermath of a traumatic loss. In 2020, CARES staff also began to respond to vehicular manslaughter (sometimes referred to as vehicular homicide[3]). Co-victims served include not only family members but friends and neighbors who have been touched by the death and may need services. CARES staff carefully assess the needs of the co-victims and attempt to match families with a PCR that possesses the cultural and language background to meet their needs. For example, CARES has at least one PCR who is Muslim. Throughout the program, CARES leaders attempted to hire PCRs who

[3] PA statute defines the offense of homicide by vehicle as any person who recklessly or with gross negligence causes the death of another person while engaged in the violation of any law of this Commonwealth or municipal ordinance applying to the operation or use of a vehicle or to the regulation of traffic except section 3802 (relating to driving under influence of alcohol or controlled substance) is guilty of homicide by vehicle, a felony of the third degree, when the violation is the cause of death.

speak Mandarin, Vietnamese, French, French Creole, and other languages, but to date, they have not been able to. CARES does, however, employ PCRs who speak Spanish.

PROGRAM SETTING

CARES is housed in the DAO under the direct supervision of the First Assistant District Attorney. The program was staffed by people with personal experience of homicide and strong ties to community organizations and victim service providers. All staff, including leadership and PCRs have lost a loved one to homicide.

There is some debate among program staff and other stakeholders as to whether the DAO is an appropriate setting for the CARES program. However, many acknowledge that the program's association with the DAO conveys access and resources it would not possess in a community setting. These considerations will be discussed in more detail in later sections of the report.

ORGANIZATIONAL DEVELOPMENT

When the grant was moved from AVP/CHARLES Foundation to the DAO, CARES operated under the DAO Victim/Witness Services Unit and was coordinated externally with the PPD Homicide Unit and the Medical Examiner's Office (MEO), as well as community-based service providers. The PCCD supports CARES staff and some services provided by staff at AVP (e.g. supports dedicated time for the program's Licensed Clinical Social Worker (LCSW) to provide services). PPD is a core partner because the PPD Homicide Unit notifies the Program Director when homicides occur. At the grant's inception, there was a lag in CARES receiving the homicide notification. The lag was often between 24 to 48 hours long. After holding a number of discussions with PPD the program began to receive more timely notifications. By October 2019, CARES began receiving immediate homicide notifications from the PPD, allowing CARES staff to more immediately respond to crime scenes and hospitals. For safety reasons, CARES staff do not respond to homicides after midnight but instead wait until early morning to respond.

CARES staff have also expanded their partnership with the MEO through their relationship with AVP. In recent years AVP has received VOCA support to partially support a grief counselor at the MEO. CARES works directly with the grief counselor to provide extra support when needed. Family members come to the MEO to identify their loved ones' remains. CARES staff often accompanies the family members. When CARES staff applied to the PCCD for continuation funding in 2020, the CARES budget included funds to support an expansion of crisis counseling so that a grief counselor would be available on weekends and holidays. The grief counselor may take down information about the family members and pass it along to AVP for further outreach and services within CARES.

In January 2020, CARES shifted from under the DAO Victim/Witness Services Unit to the direct supervision of the First Assistant District Attorney. Having a direct line to the DAO leadership helped prioritize the program's requests for essential items (e.g., official DAO identification badges, uniforms, water bottles to provide to co-victims in meetings, etc.) and additional resources. During this time, PCRs were also shifted from contracted workers to part-time seasonal employees, which granted them recognition as City employees and allowed them to join the City's payroll system. This allowed for more consistent and predictable pay periods for the PCRs. Around this time, the Program Coordinator resigned and the Program Manager was promoted to Program Director. Additionally, four more PCRs were hired at this time.

In mid-February 2020, a PCR was promoted to the role of Administrative Manager to assist with data entry, PCR deployment, and tracking case statuses. Shortly after, another PCR was promoted to fill the Program Manager role. These two staff positions created additional structure, oversight, and supervision, which allowed the PCRs to be divided into two groups: Immediate Responders and Case Managers. The program director was also given a direct say in the hiring process of new PCRs and began participating in hiring interviews. As the program continued to evolve, leadership reevaluated the initial budget and sought to bring some PCRs on as full-time employees.

PROGRAM OBJECTIVES

CARES' original project proposal outlined the following nine objectives that aimed to close the service gaps for co-victims of homicide:

1. Collaborate with the Philadelphia Police Department to assist in compassionate, trauma-informed death notification and establish communication links with the family members to enable crisis response.
2. Sustain a coalition of victim service agencies and community-based homicide victim survivors' organizations to implement a coordinated, cooperative crisis response system in Philadelphia.
3. Recruit, train, and deploy twelve homicide survivors that live in different sections of Philadelphia to serve as contracted, part-time Peer Crisis Responders to provide trauma-informed peer support and advocacy services to friends and families of homicide victims.
4. Operate a 24/7 telephone service that can immediately deploy a PCR to assist a co-victim when a homicide occurs after the victim is identified.
5. Stay with the co-victims for up to 24 hours after notification of the death based on the wishes of the family and provide peer support and advocacy as needed by the family. For example, helping the family understand police protocol, interact with police investigators, securing translation/interpretation services for non-English speaking survivors, navigating communication with the media, helping to contact family and friends, providing peer counseling, arranging childcare, and securing appropriate medical or psychiatric services.
6. After the initial 24-hour crisis period, schedule a needs assessment and develop a Support and Recovery Plan that ensures that a reliable support system is in place, that the co-victims are connected to a wide array of appropriate services, the co-victims are receiving clear, helpful communication from the police and wider justice system, and that the co-victims are taking steps to take care of their own health and wellness.
7. Provide intensive support and services to the family based on the Support and Recovery Plan for up to 45 days after the homicide. Services may include, for example, provide information for crime victims' compensation, facilitate ongoing communication with the police and DAO, accompany survivors to court and advocating on their behalf, providing referrals to medical, psychiatric, therapeutic, and other needed services.
8. Refer the co-victims to ongoing support services and peer support groups.
9. Fund an additional part-time social worker housed at the MEO to provide crisis counseling services outside of traditional hours.

LOGIC MODEL

Figure 2 highlights the logic model of the program, developed in the early stages of the initiative in collaboration with the research team conducting the process evaluation. The logic model translates the program objectives into a theory of change that helps highlight short- and long-term goals. The model starts with the identification of the problem (high rates of homicide and co-victimization, a culture of retaliation, unaddressed needs, and low utilization of services). It then moves to the description of resources that CARES would capitalize on (e.g., collaboration with MEO and grief counseling support). This is followed by the project activities meant to bring about intended outcomes (e.g., immediate notification to survivors/co-victims, development of funeral plans). Finally, the last two columns/boxes describe potentially measurable program outputs (e.g., number of trauma-informed notifications, number of referrals to other services) and outcomes (short term, intermediate, and long-term – e.g., reduced trauma from notification; high level of needs met, increased trust in the criminal justice system).

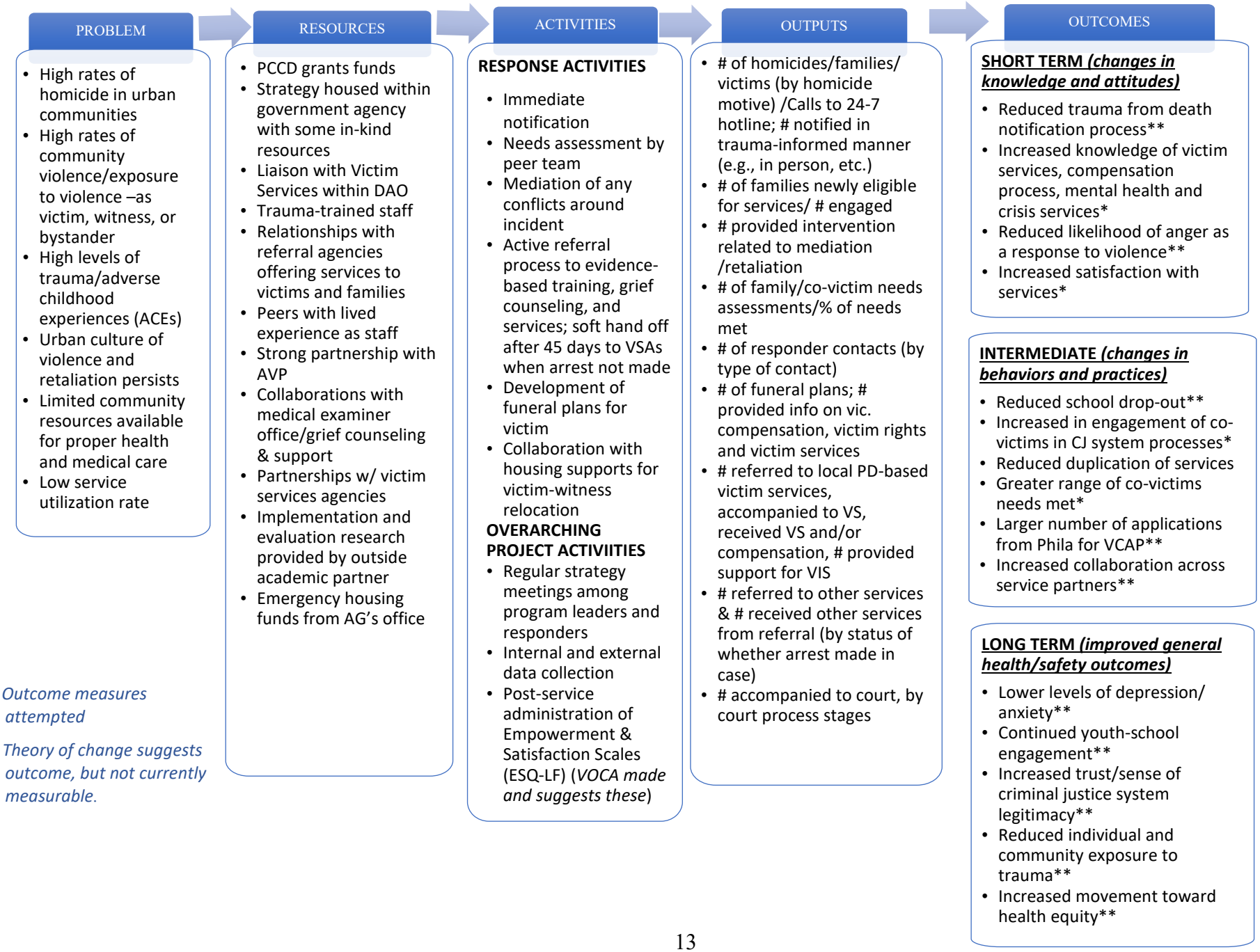
PARTNERSHIPS & COLLABORATION

CARES coordinates externally with a variety of programs and agencies to receive an immediate notification of homicides, connect co-victims to services, and obtain information about legal proceedings. Partnerships with criminal justice agencies and community-based victim services are managed at the CARES administrative level and maintained with frequent community-based contacts by PCRs.

ANTI-VIOLENCE PARTNERSHIP (AVP)

Philadelphia's AVP is a central partner to CARES and has an established set of roles (and corresponding budget lines) as part of CARES. AVP's core mission is to reduce the cycle of violence by providing a wide range of services from support and counseling for victims and their families to rebuild their lives in the aftermath of violence. They provide comprehensive and collaborative programs throughout Philadelphia in schools, social service agencies, the courts, and community sites. They are also the city/state-funded community-based victim services agency for West Philadelphia, supporting crime victims from the 12th, 16th, 18th, 19th Police Districts. But it is important to note that, given the extent and breadth of their services, they serve crime victims from all over Philadelphia. In August 2021, AVP began to provide a large portion of their West Philadelphia Community Center office to CARES staff. This site is well-located near public transportation, has street parking, and is comprised of several rooms that can be used as office space for staff, quiet space for co-victims, and space for counseling and group sessions.

Figure 2. CARES Program Logic Model



** Outcome measures attempted*

*** Theory of change suggests outcome, but not currently measurable.*

CRIMINAL JUSTICE AGENCIES

There are three agencies within the criminal justice system that CARES interacts with regularly. These include the Medical Examiner's Office (MEO), the PPD, and the Victim Services Unit within the DAO. Table 1 below describes CARES' main criminal justice partners and their services.

Table 1. Criminal Justice Agency Partners

Medical Examiner's Office	The MEO offers bereavement support to everyone in need including those who experienced the loss of an infant or child or lost a loved one to drug overdose, suicide, or homicide. Bereavement support specialists provide grief support, information about next steps, short-term grief counseling, and referrals for long-term counseling or other needs.
Phila. Police Department	The PPD employs Victim's Assistance Officers (VAO) that liaise with the PPD's Crime Prevention Officer, victims' advocacy groups, and other officers and detectives. The VAO's primary responsibilities are to notify crime victims of their rights, provide them with information about available services, and partner with the representative victim service agencies to refer victims to those agencies for services (PPD Directive 4-14, 2014).
DAO Victim/Witness Services Unit	This DAO unit advocates on behalf of crime victims and witnesses in the city. If an investigation leads to an arrest and charges are filed by DAO, a Victim/Witness Coordinator is assigned to the case. Coordinators notify victims/witnesses about case updates, court proceedings, accompaniment to court, help with Victim Impact Statements, and assistance accessing other services.

COMMUNITY PARTNERS

Philadelphia has specific victim services agencies assigned to police districts that work closely with law enforcement to collaborate on providing information on victim rights and services. These police division-based agencies provide crisis support, referrals to other community agencies, court accompaniment, and assistance with victim's compensation claims. Each agency receives the list of criminal victimizations occurring in that catchment area from the PPD and conducts outreach to make victims aware of their legal rights and available services. These district-based agencies provide a variety of services but at minimum offer assistance with victim compensation claims and referrals to counseling and related services.

In addition to these agencies that are specifically tasked with serving Philadelphia crime victims by PPD division, there are other community-based victim services that are not directly part of city-funded victim services. Some of these other organizations serve co-victims, including three of the more established organizations—The CHARLES Foundation, Mothers in Charge, and Every Murder Is Real. Table 2, below, provides a snapshot of some of the victim service agencies operating in Philadelphia.

Table 2. Community Partners	
Central Division Victim Services	Central Division Victim Services serves the 6th, 9th and 22nd Police Districts which cover many North and Central Philadelphia neighborhoods. https://www.cdvservices.org/
East Division Victim Services	East Division Victim Services serves those residents living in the 24th, 25th and 26th police districts. Funding for these services are provided through two organizations: Congreso and Concilio. https://www.congreso.net/services/health-promotion-and-wellness/crime-victim-advocacy-services-of-the-east-division/ https://www.elconcilio.net/portfolio-items/victim-witness-services/
Northeast Victim Services	Northeast Victim Services serves the 2nd, 7th, 8th, and 15th Police Districts which include the neighborhoods of Bridesburg, Burholme, Bustleton, Castor, Fox Chase, Frankford, Holmesburg, Lawncrest, Mayfair, Far Northeast, Oxford Circle, Rhawnhurst, Somerton, Tacony, Torresdale, and Wissinoming. https://www.nevs.org/
Victim/Witness Services of South Philadelphia	Victim/Witness Services of South Philadelphia (VWSSP) offers direct assistance and support to crime victims, witnesses and their families in the three Police Districts of South Philadelphia (1st, 3rd, and 17th Districts). http://www.vwssp.org/index.html
Northwest Victim Services	NVS was one of the earliest community-based victim service providers in Philadelphia. The agency provides a wide range of services and serves the 5th, 14th, 35th, and 39th Police Districts. http://www.northwestvictimservices.org/about_nvs
Anti-Violence Partnership (and West/Southwest Victim Services)	AVP is a core partner in CARES operations, receiving funds from the PCCD grant to support a part-time LCSW. AVP also serves as the neighborhood-based victim service provider for West Philadelphia serving the 12th, 16th, 18th, 19th Police Districts. AVP began in the early 1980s as a chapter of Parents of Murdered Children

	(POMC). This led to the creation of the non-profit organization Families of Murder Victims (FMV). Shortly after, FMV opened in the Philadelphia DAO Homicide Unit and received VOCA funding in 1984. FMV grew into what is now known as AVP, which continues to provide programs and services supporting victims of violence. AVP offers court accompaniment, as well as help with protection orders, registering for victim notification, and writing victim impact statements. They also provide emotional and crisis support, service referrals, and help with filing for victims compensation. https://avpphila.org/
The CHARLES Foundation	In 2011, Charles Andre' Johnson was shot and killed in a case of mistaken identity. His family created a foundation dedicated to advocacy and capacity-building, with the intent of reducing violence and homicide in Philadelphia. The CHARLES Foundation (Creating Healthy Alternatives Results in Less Emotional Suffering) is a community-based resource center that hosts a conflict resolution and mentorship program, support groups, educational forums, and offers a community food pantry. The founder of the CHARLES Foundation, Movita Johnson-Harrell, was the original developer of the Philadelphia CARES' homicide crisis response model.
Every Murder is Real	Every Murder is Real (EMIR) works to treat the trauma resulting from homicide and promote healing through education and emotional support. Based around the concepts of mobilization, engagement, and healing, EMIR organizes with partners and stakeholders to begin "rethreading" the community after a homicide occurs on the block. EMIR partners with the PPD on interactive workshops about safety precautions for students in city schools. When a student is the victim of a homicide, EMIR provides school-based crisis response for students and teachers. EMIR also has school advocates that help families navigate their child's "acting out" in response to the trauma. EMIR also provides specialized services to victims of domestic homicide.
Mothers in Charge	Mothers in Charge (MIC) is a grassroots survivor-based organization founded by grieving mothers who lost children to homicide. Now recognized as a national endeavor (through "chapters"), MIC originated in Philadelphia. The mission of MIC is violence prevention through education which is achieved through engagement in proactive intervention with children,

	teenagers, young adults, and families affected by violence. Mothers in Charge is comprised of mothers, grandmothers, aunts, and sisters working together to prevent another mother from experiencing the tragedy of losing a child to violence.
Uplift Center for Grieving Children	The Uplift Center for Grieving Children has multiple locations around Philadelphia and offers peer support groups to youth from Kindergarten to 12th Grade who have experienced the death of a significant person in their lives. Groups are divided by age and are tailored to meet the participants' unique needs. Uplift also offers support groups to parents and caregivers and provides crisis services to support the larger school community, including students and staff in the aftermath of a death.
Network of Neighbors Responding to Violence	Network of Neighbors Responding to Violence (NNRV) is considered a community-based endeavor but is coordinated by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIdS). NNRV is comprised of volunteers trained to support and respond to stress, trauma, loss, and violence in their neighborhoods. NNRV focuses solely on addressing the impact of trauma and violence, leaving prevention work to other partners. Many Network Trauma Responders are known in their communities and have been exposed to the same trauma and violence to which they are responding. Services are community-initiated and rely on the support of devoted volunteers willing to expend the time and energy.
Operation Save Our City	Based in the Fairhill neighborhood, Operation Save Our City was founded by Rosalind Pichardo to support the families of victims of violent crime. The organization holds public demonstrations and vigils to generate attention for cold cases.

CHAPTER 3: PROGRAM OPERATION & SERVICE DELIVERY

This chapter describes the CARES program operations and service provision in detail, drawing on interviews with program staff and leadership, supplemented by a review of agency documents and data. This section includes information on staff structure and responsibilities, program services, outputs, administration, and documentation.

STAFF STRUCTURE & DUTIES

Currently CARES operates as an independent program within the DAO and is overseen by a First Assistant District Attorney. As indicated above, the program is staffed by a Program Director, Administrative Manager, and Program Manager, all full-time employees of the DAO. The program's current Licensed Clinical Social Worker (LCSW) is a full-time employee at the Anti-Violence Partnership (AVP) and works with CARES on a part-time basis. By summer of 2021, the program employed 14 PCRs, who either work as Case Managers or Immediate Responders. In addition to their part-time work for CARES, some PCRs are employed in other jobs; many hold full-time jobs. Table 3 lists the main responsibilities of each staff role in the program.

Table 3. CARES Administrative Structure

PROGRAM ADMINISTRATION	
Program Director	• Responsible for the administrative, fiscal, technical, and operational oversight of the CARES program • Supervises Program and Administrative Managers • Coordinates with AVP, community agencies, the PPD, and the DAO's Victim/Witness Services Unit • Participates in hiring process led by city's Central Human Resource Department
Administrative Manager	• Deploys PCRs for crisis response and follow-up • Oversees cases for the first seven days after assignment • Provides support to PCRs in the field and on service visits • Oversees the completion of required documentation including input into Efforts-to-Outcomes (ETO) database intake forms, and follow-up forms
Program Manager	• Oversees cases from day 7 to day 45 (or closure) • Confirms closure and hand-off to long-term services • Meets with individual PCRs twice monthly to provide direct supervision and development and to review cases
Lead Crisis Responder	• New fulltime position as of summer 2021; manages response practices, assists with visits and provision of services, as needed

	• Assists with training new PCRs
CLINICAL SERVICES & TRAINING	
Licensed Clinical Social Worker (Part-Time)	• Coordinates with the administrative team • Attends staff meetings and trainings • Provides debriefings for PCRs after a homicide response • Available for individual PCR counseling by request (is confidential) • Leads PCR trainings on managing vicarious trauma and developing appropriate self-care routines, etc.
CRISIS RESPONSE & CASE MANAGEMENT	
Peer Crisis Responders (Part-Time)	• All current PCRs have lived experience of loss due to homicide • Required to have access to a car and valid driver's license • Deployed on-site immediately after a homicide • Accompany co-victims to MEO for body identification • Provide emotional support, wellness checks, home visits • Refer families to immediate and long-term services • Coordinate with Administrative Manager to complete documentation, including intake forms and ETO

WHAT CARES DOES

The CARES program was developed to serve co-victims in the initial 24-hour crisis period following a homicide, as well as to provide ongoing support and connection to long-term services during the following 45 days. If during this period, CARES staff have not made a successful referral (known as a "soft hand-off") to the respective neighborhood-based victim services agency, CARES staff often continue to support the co-victim(s) until a good rapport with the new agency can be established. The sections below describe the delivery of services to co-victims across this timeframe and detail the activities of PCRs.

PEER SUPPORT MODEL

Peer support models rely on staff who bring knowledge from their own experiences to support others who are in a similar situation or are experiencing a similar condition. Staff are trained to provide practical, social and emotional support to those served. Peer support models are increasingly common in mental health services and the substance abuse field, with recent expansions to emergency departments, state psychiatric hospitals, and even wellness coaching (see Myrick & Del Vecchio, 2016). According to the initial CARES job posting, the primary qualification for the PCR position is identifying as a co-victim of homicide. Although experience as a peer support specialist or work within social services was included as a 'strong plus,' the required skills and knowledge for the position included lived experiences coping with the trauma of losing a loved one to homicide, strong interpersonal communication skills, the ability to

interact with people from diverse backgrounds, and the ability to work both independently and as a part of a team.

Crisis Response

After receiving confirmation of the homicide from the PPD, the CARES Program Director deploys two Immediate Responders to the crime scene or hospital, depending on whether or not the victim's body has already been transported from the location of the incident. After the emergence of COVID-19, deployed responders began making their first contact with co-victims over the phone (see Challenges section below). When deployed for an in-person response, PCRs are selected based on their availability, geographic location, and current caseload. Prior to the pandemic, the two Immediate Responders would meet near the location and arrive together on the scene. Paired deployment eases safety concerns and allows PCRs to lend support to each other in difficult, uncertain, and often chaotic scenarios (see Strengths section below). As stated earlier, CARES staff do not immediately respond to homicides that take place between the hours of midnight and 6 a.m.

Once on-scene, PCRs promptly identify the people most affected by the homicide, usually the victim's family and loved ones. PCRs carefully approach the family and introduce themselves, making it clear that their primary goal is to offer compassion, lend a listening ear, and ensure that the family's basic needs are being met. While speaking to those gathered at the scene, hospital, or home of the family, PCRs share the CARES informational brochure, describe the next steps in the process, and collect names and contact information for as many co-victims as possible. When CARES staff meet co-victims at the hospital, they often meet with the family member(s) in a family consultation room if one is available. Not all hospitals in Philadelphia have an available physical meeting space, but staff noted that there is one hospital that routinely provides CARES with a family consultation room. After leaving the response scene, PCRs are expected to debrief with their partner, the Program Director, or the LCSW.

Often, PCRs will arrange to accompany a family to the MEO, which usually takes place the following business day. CARES staff call the co-victim and arrange a joint time to go to the MEO. During the pandemic, however, MEO was not open to families. With this closure, CARES staff are not able to accompany the family member when they identify the deceased. The identification process is done over the telephone or by video.

Accompaniment to the Medical Examiner's Office

When deployed to a homicide, PCRs explain the procedures of the body identification process and ensure that co-victims have transportation and directions to the MEO. Sometimes PCRs are not able to make contact with co-victims at the scene of the homicide. In those cases, they may contact the MEO and arrange to meet the family to introduce themselves and offer services.

The process to identify the deceased can be traumatic for distraught co-victims. In a normal identification, co-victims receive a photo of the body after it has been prepared by the Medical Examiner. PCRs report that the reaction is usually very emotionally charged, and PCRs are present to console the family and offer whatever words of support or physical comfort the family needs. Sometimes families request to view the body itself, in which case the PCR will accompany them downstairs to the viewing room and console them after the viewing. In

interviews, CARES staff members stated that MEO accompaniment in particular can create a strong bond between PCRs and co-victims.

Although CARES staff members indicated that MEO accompaniment can be a bonding experience between staff and co-victim, they also expressed how hard this process is. “It’s difficult to stay strong for them.” This quote is illustrative of the sentiment held by multiple PCRs. They regard this task as one of the most difficult aspects of their work because of the likelihood of being retraumatized themselves. “They [the Program Director & Manager] tell us, ‘Don't look at the body, stand behind the wall, you're there for the family.’ I had to get strong and not be so emotional.” Another PCR recalled their own lived experience: “When my [family member] was murdered, my mother didn’t want to go identify the body, so I had to go and do it. The Medical Examiner’s Office was very cold.” Despite the discomfort, multiple PCRs mentioned the importance of offering MEO accompaniment, stating that “[n]o one else does that.”

At the time of this writing (October 2021), the office remains closed to families. In other words, families are unable to view the deceased in person. Procedures were developed for families to identify their loved ones through photographs and sometimes video. Many staff noted that the public is likely unaware of this negative consequence of the pandemic, which may exacerbate a co-victim’s trauma and grief.

Information About Victims’ Rights & Compensation

Depending on the circumstances of the homicide, some co-victims qualify for financial compensation from the Pennsylvania Victims Compensation Assistance Program (VCAP) to cover funeral costs and related expenses. PCRs encourage each co-victim to file for VCAP funds, and they connect them with a victim service agency that can assist with filling out the forms and submitting them to the state agency. These referral agencies have a direct line to the Pennsylvania Office of Victim Services and are equipped with the institutional knowledge to navigate the application process. The PCRs do not file the VCAP applications because the entire process takes longer than CARES’ 45-day service period. However, PCRs can provide co-victims with the forms, answer questions about the process, and encourage them to apply for VCAP. One PCR reported that while it seems like more people are somewhat aware of victim’s compensation, most co-victims require support in completing the application and accessing the needed funds. Additionally, staff members noted that referral for VCAP assistance can serve as a bridge for connection to other services. For example, a co-victim may not initially want supportive counseling but once they are engaged with a service agency for the VCAP application, they can be encouraged to connect to other programs and provided with information about these options.

Individual Advocacy & Emotional Support

A significant aspect of the PCR role is to provide co-victims with ongoing emotional support and wellness checks in the form of phone calls and home visits. Multiple staff members mentioned offering co-victims tissues, hugs, and bottles of water as signs of emotional and physical care, emphasizing how much “the little things” matter. Hydration is an important aspect of staying healthy through grief and tears, and it is sometimes overlooked. PCRs report that they frequently remind co-victims to continuously drink water, explaining that they need to replace the liquid leaving their body while mourning. Multiple PCRs mentioned keeping cases of water

bottles in their car and offering them to co-victims on the scene of a homicide, at hospitals, or during home visits.

Due to their lived experience as co-victims, PCRs know the unique difficulty of practicing self-care while grieving. “The first thing to go is food. My mom didn’t cook after my brother was killed. I don’t know what we ate. Cereal.” Multiple PCRs mentioned that co-victims without large family support systems struggle to buy food and feed themselves, either because they are not able to afford it or due to debilitating grief. “Families will ask you, ‘Do y’all have any food? Because I can’t get out of bed.’” As part of their role, PCRs sometimes refer families to food banks or help them obtain food vouchers, in addition to reminding them to eat regularly. Similarly, some PCRs reported how they have to remind the survivors to take their prescribed medications (e.g., for blood pressure or diabetes), stressing the importance of taking care of their health issues at a time of great distress.

Although the original CARES grant did not include a budget for emergency food assistance and water, CARES staff came up with creative methods to support families in their need for food supplies, temporary meals, and water. By the time CARES staff applied for continuation funding for CARES in partnership with AVP, they had incorporated, as AVP’s portion of the budget, gift cards, and supplies for food and basic emergency provisions (these budget items could not easily be part of a city government agency’s budget).

The PCRs and program leaders universally reported that the COVID-19 restrictions (i.e., inability to meet in person) limited their ability to connect with the survivors in a personal and fully supportive way. Multiple respondents lamented, “we can’t give them a hug,” and, “they can’t put a face to the voice over the phone.” Most PCRs reported that only a few co-victims took FaceTime or Zoom video calls, preferring regular phone calls instead. One PCR noted that this also limits the time that the PCRs have available to make a first impression and build a connection, as most people tend to put a limit on a phone conversation that they would not on an in-person visit. In those cases in which the survivors agreed to Zoom meetings, the logistics of bringing the whole family together and technological difficulties also posed serious challenges. Several of the PCRs shared the view that COVID-19 restrictions only compounded the grief of the co-victims, forcing them into isolation at a time when emotional support was needed even more.

Referrals to Other Services

“No two families are the same.” The view that each family and its needs are different is universally shared among the CARES staff. PCRs use a flexible case management approach to meet co-victims diverse needs (see “Strengths” section below). After deploying immediate homicide response, the Administrative Manager sends an email to a Case Manager PCR with the homicide victim’s name, dates of birth and death, the name of the detective investigating the homicide, and the name, address, and phone number of their next of kin. Case managers work with the homicide co-victims following the intervention of the Immediate Response Team, assuming responsibility for the case after the Immediate Responders (IRs) have responded to the scene, contacted the next of kin, and provided support immediately after the homicide. Case Managers work with co-victims to develop a Support and Recovery Plan that identifies a reliable support system, ensures that the co-victims are taking care of dependents and engaging in self-care, and assesses for connection to appropriate services. Case Managers also help facilitate clear, helpful information from the police and criminal justice system. Information for referral to

other victim service providers and agencies is also included in the deployment email. Upon receipt of that assignment, Case Managers are instructed to make outreach to that family as soon as possible, and no later than by the end of that day.

Case Managers are expected to give a case status update to the Program Administrator within seven days of assignment via phone or email. Case statuses are brief updates regarding the level of contact the Case Manager has maintained with the co-victim on the case. For example, Case Managers may have been unable to make contact with the co-victim or may be waiting for a call to be returned. In other situations, the case status updates inform the Program Administrator that contact has been made, the content of that contact, and the steps the PCR plans to take next. Case status updates allow the Program Administrator to track the progress of each case and determine whether paperwork is missing because it has been lost or is overdue, or if paperwork does not yet exist because contact with the family has been delayed.

Case Managers work to address a variety of co-victim needs, and predominantly make referrals to grief counseling and therapy. As stated earlier, they frequently refer to providers that can file victim compensation claims paperwork. Sometimes co-victims express the need for relocation due to safety issues or profound grief associated with the homicide location; PCRs work with the Victim Services Unit in the DAO to assess this need and options for relocation. Case Managers also provide information to co-victims regarding food pantries or drives, assistance with bills, or community events and activities like a neighborhood movie night or face painting for children.

When referring to an external service or agency, Case Managers make a courtesy call to that service provider to ensure that the co-victim gets connected with the appropriate services and to make sure that they do not have to wait long to enroll in services. Many PCRs report that there is a 'pretty good' turnaround rate for the responsiveness of victim services and that they have general success referring to the community resources. But some staff indicated that depending on an agency's calendar and the timeline for different services (e.g., group counseling, peer counseling, etc.), co-victims might have to wait weeks or even months for a "new" session or cohort to begin. In other words, many support groups and group counseling programs are broken up into cohorts with each cohort lasting for several weeks or more. If a group is already several weeks into meetings, a new homicide co-victim must wait until the next cohort starts. PCRs will check back in with the victim service agency to determine the next start date for a new cohort so that they can keep the family informed about when they can start receiving those services. Sometimes the wait is too long and co-victims seek services through other care providers that rarely specialize in the care of homicide co-victims. Generally, some staff reported that the wait time (even what could be considered relatively short, such as a couple of weeks) can be a barrier when survivors have an immediate need for services. Staff indicated that meeting the immediate support and service needs of co-victims is critical, with an emphasis on the day-to-day assessment of basic needs during the time of grief. Staff indicated that within 45 days many co-victims are not ready for therapeutic services or counseling and are simply dealing with their immediate grief and needs related to funeral services, burial, etc. Although many staff indicated that the more clinical services (i.e., individual and group counseling and therapy) are more appropriate for service providers that receive the referrals (after 45 days) from CARES, some staff did indicate that having multiple options for more immediate short and long-term grief therapy and possibly provided as part of CARES could be beneficial. CARES' partnership with AVP provides for multiple options for counseling and therapy and staff have

expanded these options with the PCCD continuation funding. By August 2021, AVP's West Philadelphia Community Center site, which is shared with CARES staff, had rooms for group and individualized counseling and therapy.

Notification of Criminal Justice Events

As part of their duties, PCRs sometimes assist co-victims with obtaining updates on investigations and legal proceedings. Occasionally, families will ask PCRs to accompany them to court. One PCR stated: "We sit with them, hold their hand, explain the process. Sometimes they sit on the wrong side of the court next to the defendant's family and don't realize it." Though court accompaniment is not a regular part of every case—the 45-day service period is often shorter than the time it takes for the case to be processed in the courts—PCRs occasionally appear in court for various reasons. Sometimes a family will "slip through the cracks," and may be difficult to get in contact with to provide services. In these cases, communicating about upcoming court dates can be an opportunity for PCRs to connect with those co-victims, offer support, and connect them to victim services. Other times, PCRs will go to court at a co-victim's request. "There is tension and there is sorrow, and we need to be there to offer them support."

It took some time for the CARES program and the DA's Victim/Witness Services Unit to work out whether court accompaniment should only be a service provided by the DA's Victim/Witness Services Unit. Before CARES was able to engage with co-victims, the Victim/Witness Services Unit would provide general court support for those victims who had cases being processed through the court system. Additionally, the AVP also provides support in the courts for families of murder victims. Furthermore, as indicated, court proceedings often take place beyond CARES' 45-day service window, raising issues around continuity of care through the legal process. However, co-victims and families will occasionally bond with their responder and may request that the PCR attend court.

Relatedly, many PCRs reported that they routinely interact with the police and homicide detectives on behalf of their co-victims (and all provide the survivors with contact information for the police officers working their cases). Such services include phone calls for updates regarding case status (e.g., asking about whether a suspect was identified or arrested, and other investigation-related matters). Some staff we interviewed identified this task as one of the more challenging ones, describing that it can be difficult "to avoid giving false expectations" to the co-victims, on one hand, and not give the appearance [to the detectives] that they want to interfere with the investigation ("let them do their work"), on the other hand.

Administrative Activities

In addition to external activities in service to co-victims, CARES performs numerous internal tasks and processes. This section provides an overview of the program's administrative activities, operational protocols, and staff training procedures.

Trainings

After being hired, PCRs undergo various mandatory trainings before deployment in the field. Training content includes topics such as the impacts of grief on families, navigating domestic violence situations, how to deliver a death notification, and how to make effective referrals. Programs funded by grants from the PCCD using VOCA dollars require those providing direct services to have participated in OVS' "Foundational Academy." The Foundational Academy is a multi-day training curriculum that includes training on advocacy

skills, counseling skills through a trauma informed lens, crisis intervention/safety planning, mandated reporter, working with persons with disabilities, diversity and cultural competency, ethics, values, overview of the criminal justice and juvenile justice systems, communication skills, victims' compensation, victims' rights, and the importance of self-care. The PCCD usually asks that new staff attend the training within six months of their hiring date. For PCRs who hold full-time jobs in addition to their role as a PCR, these multi-day trainings have been difficult to schedule and complete, largely due to the fact that the training is only offered a few times each year and there are limited seats.

The CARES part-time LCSW also conducts trainings. Trainings topics include, but are not limited to, managing vicarious trauma and PCR self-care. New staff also attend trainings on the use of Efforts to Outcomes (ETO), the CARES intake forms, and the City's timesheets. Other mandatory trainings are provided intermittently through partner organizations. Partner agencies or colleagues from other victim service agencies often present on a particular topic during the CARES team monthly meetings. Multiple PCRs spoke positively of the CARES program's comprehensive training process, stating they were "happy to have access to trainings" through the DAO and other partner agencies. After completing mandatory trainings, new PCRs receive hands-on field experience by shadowing senior PCRs as they connect with co-victims. This being said, some PCRs also expressed the view that no amount of training can fully prepare them for the first actual field experience and the possible reactions from survivors (the most common examples given were the visit to crime scene and accompaniment to MEO for identification of loved ones)—and that their growing experience in the field itself has helped them become better responders.

Not surprisingly, the pandemic also had effects on training schedules and method of delivery. A number of staff stated that in-person trainings are particularly important because new staff can learn informally from others in a group setting by asking questions to their co-workers sitting next to them and those in the room who already have experience serving co-victims. "If we were in person, we could be right there with the trainers, asking questions right as they came up, or asking our co-workers the next time we see them." Essentially, the pandemic restrictions of not having in-person trainings and regular in-person meetings made it harder for new staff to get quick answers to any questions.

SUPERVISION & CASE REVIEW

Supervision check-ins and case review meetings are two opportunities for interaction and professional development between the administrative team and PCRs. In November 2019, the Program Manager and Licensed Clinical Social Worker (LCSW) at AVP instituted the first monthly case review, during which PCRs had the opportunity to discuss difficult experiences with their cases. This process of reviewing and discussing challenging and successful cases has been institutionalized. Administrative staff schedule monthly all-staff check-ins and case reviews so that PCRs have the opportunity to share updates, concerns, or obstacles with individual cases. The LCSW participates in these meetings. Additionally, all PCRs are scheduled for individual supervision meetings with the Program Manager twice a month to provide an opportunity to review case notes, discuss difficult cases, and receive additional direction or support.

INTAKE FORM COLLECTION

CARES program staff complete and collect intake forms from co-victims, providing an important source of records and data regarding potential service recipients. Initially, the intake

forms were paper forms that were signed by co-victims after they were told about CARES services and agreed to participate. The intake forms include only the most basic information needed to set up a new client record in the program's case management software—Efforts-to-Outcomes (ETO). The use of ETO is mandated by the PCCD for data collection for all their victim services grantees.

Over time, the intake form was expanded to prompt PCRs to inquire about additional information that could help the program improve its service delivery to those affected by homicide in Philadelphia. For example, the form was expanded to include non-nuclear family members who may not live in the same household but may also need services. Additionally, CARES started utilizing intake forms to collect more information about youth and juvenile co-victims in order to better coordinate school-based counseling resources. CARES intake forms also include a section requesting consent from the co-victim to participate in the program, and consent for PCRs to share information with other stakeholders throughout the referral process.

During the first year of the program, the hardcopy intake forms were brought to the DAO by each PCR and then CARES leaders entered the data into a DAO-designed spreadsheet and then staff created the ETO record. Since the pandemic began, the PCRs call the Program Administrative Manager with the information that they then enter into ETO. This process is organized by the Administrative Manager so leadership staff can obtain a sense of the needs of each CARES participant. PCRs then use ETO on their own to input their case contacts and services (see below).

It is also important to note that the ETO system did not have the ability to include multiple family members as part of a homicide response. If staff wanted to list multiple family members, each family member had to be added as a "new participant." To limit the confusion and streamline the data entry, staff, in the early days of CARES, only filled out the information for the next-of-kin. Because of this limitation, for the first two years of the program, CARES maintained a separate spreadsheet where they recorded all the information for homicide responses that involved multiple family members. This became a serious issue that CARES leaders would bring up repeatedly to the PCCD because staff would be spending significant amounts of time providing services to children or other family members who were not listed as next-of-kin. Therefore, the data documentation process was not capturing the extent of critical crisis services that were being appropriately provided by the program. Not having all these touchpoint services documented within ETO might make it appear that staff were not providing services at a rate that was reflective of the amount of staff on the payroll and the CARES budget. Furthermore, and more importantly, if someone were to assess the data documentation within ETO as it stood at the beginning of CARES, the limitation would make it impossible to understand the extent of services and supports needed by families, and how the need might vary by and within families. After many requests by CARES staff, by spring 2021, the PCCD modified ETO to include the ability for PCRs to input information about multiple co-victims per homicide and provided the capability to show how the family members were linked to one homicide response.

CASE NOTES

PCRs are expected to provide detailed notes about each contact (or attempted contact) with co-victims and other entities related to the case. PCRs are trained to format their case notes using the "Data, Assessment, Plan" (DAP) Method of documentation. Notes begin with a Data

section detailing the demographics of the co-victims or factors that influence service delivery. Next, the Assessment section describes the services, interventions, or referrals that were provided on the visit. The nature of CARES program operations as specified to the PCCD with the initial grant application dictates the scope of services that CARES can deliver. For CARES, these services are:

- Victims Compensation Claim Assistance
- Crisis Counseling/ Intervention/ Safety Planning
- Information about the Criminal Justice Process
- Information about Victim Rights
- Referral to Other Victim Service Programs
- Referral to Other Services
- Advocacy/Accompaniment to Medical Forensic Exam or Law Enforcement Interview Advocacy/Accompaniment
- Individual Advocacy
- Immigration Assistance
- Intervention: Employer, Creditor, Landlord, etc.
- Transportation Assistance
- Interpreter Services
- Emergency Financial Assistance
- Emergency Shelter or Safe House
- Relocation Assistance
- Notification of Criminal Justice Events
- Victim Impact Statement Assistance
- Assistance with Restitution
- Prosecution Interview Advocacy/Accompaniment

Finally, the "Plan" section contains next steps, including the intended follow-up date and method. PCRs are required to enter these notes into the ETO database within 72 hours of a visit or case contact, as well as submit a hard copy to the Administrative Manager.

Efforts to Outcome Data Entry and Performance Measurement

For the first six months of the CARES program, data was entered into ETO by the Program Director and Program Manager after the PCRs submitted hardcopy intake forms. In July 2019, PCRs underwent training on the ETO system and assumed responsibility for entering their own data. However, there remained a number of program forms that were to be filled out in hardcopy, including the main intake form. The pandemic, which shut down offices, created issues with the timeline of getting hardcopy forms from PCRs to administrative staff.

Before the pandemic, the research team had a graduate student assisting at the DAO one-to-two days each week with data collection and development and organization of performance measures, but when pandemic restrictions were put in place in March 2020, the graduate student no longer had access to hardcopy forms (because no one was allowed in the offices). The graduate student turned her attention to matching case records in ETO with homicide records from the PPD. This process would allow performance measures to be developed that highlighted the percentage of homicide incidents that were part of the CARES caseload. This procedure is done outside of ETO, in Excel. ETO is not designed to record every homicide incident,

regardless of whether or not successful CARES outreach to a co-victim occurred. The graduate student also assisted with matching family members to the same homicide incident, as initially, there was no method to link family members in ETO.

Because most PCRs find the ETO system to be not very intuitive or user-friendly, and there are many screens and fields, the Program Director and Manager regularly review data entered in ETO by PCRs in an attempt to catch any errors. In the first 16 months of the program, the administrative team had to invest numerous hours in technical support, troubleshooting, re-training staff on the ETO system. A few staff indicated that the system is very clunky and it is difficult to navigate screens or that the system does not make it easy to call up the necessary form. For instance, one staff member indicated: "When we want to input information on follow-up, the intake screen pops up. This isn't right." Staff indicated that having fillable PDF forms would facilitate some of the data processes or even better, a system where any paper forms directly matched the ETO input structure when a staff member logs on and chooses the task.

The PCCD (the funder of CARES) requires that grantees submit quarterly reports and annual reports from ETO using the reporting framework that PCCD creates for each grantee. The CARES Program Director is responsible for reviewing and submitting the reports to the DAO's financial reporting manager who oversees the administrative and financial reporting on CARES. When the research proposal was submitted during the first year of CARES, the plan was for the graduate student to have developed a regular system of reporting on program outputs that would allow for monthly reporting to staff and additional outcome measures to be submitted to the PCCD. But the pandemic curtailed this plan, and internal reporting from the research team to CARES administrators was limited.

CHAPTER 4: PERFORMANCE MEASURES & DATA

As stated in the preceding chapter, CARES staff is required by the PCCD to enter specific information in ETO about the services delivered. Additionally, the program collects other pertinent data and notes to inform their practices and provide context to cases. Much of this information was originally collected by the PCRs on hard-copy forms which were then submitted to program administration for review. Over time, the intake form data was directly entered into ETO by the PCR. Essentially, the data collected by the program has evolved through several iterations of intake and follow-up forms designed to maximize the case management impact of CARES.

This chapter summarizes our response to three research questions set forth in the introduction. In the sections below, we provide some selected performance measures that summarize aspects of CARES programming designed to answer:

What were the types and quantities of services delivered?
Who were the beneficiaries of those services?
What resources were used to deliver the services?

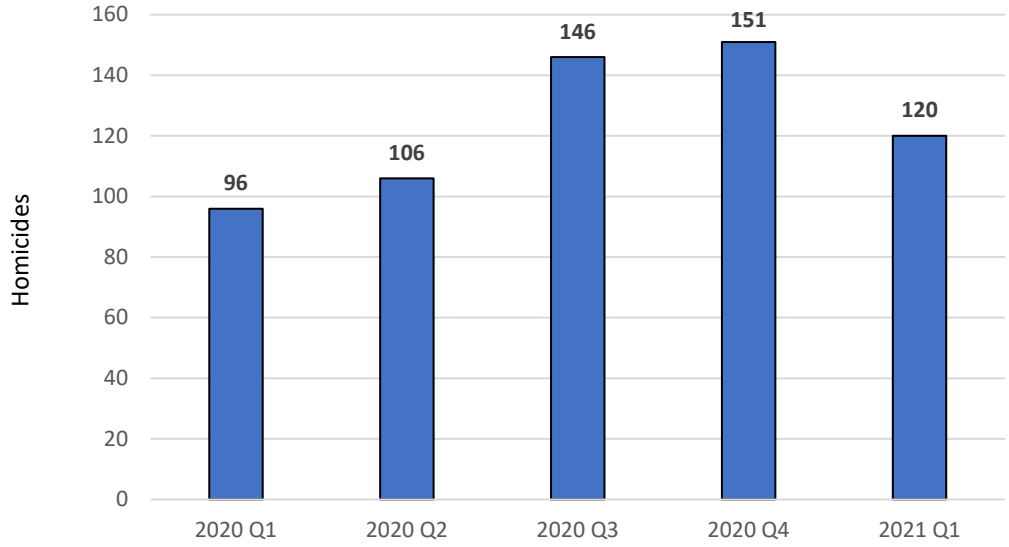
Although CARES has been operating since 2019, the methods and mechanisms to report on CARES services have changed over the last 30 months, necessitating that we focus this data section mainly on the period from Quarter 1 of 2020 (January 1, 2020) through Quarter 1 of 2021 (March 31, 2021). Depending on the measure, data are not always available for all quarters.

SELECTED PERFORMANCE MEASURES

During the five quarters that span Jan 2020 through March 2021, 619 homicides took place in Philadelphia to which the CARES teams could have responded (499 in 2020, alone). As shown in Figure 3 below, the number of these incidents increased across each of the four quarters in 2020. Although a slight decrease was observed in the beginning of 2021, the incident numbers at that time were still greater than the quarterly numbers in the first half of the previous year.

Each homicide incident during this period had, on average, 1.07 co-victims with whom the PCRs interacted. The range of co-victims supported for each homicide goes from one to a maximum of 10 family members in some instances (std. dev.= .824). The majority of responses involved only one family member, though it should be noted that earlier versions of the ETO database did not allow for reporting on more than one family member per homicide (the record would have had to been entered as a separate event with little ability to link across records in the system except manually through the identification of similar homicide identifying numbers provided by the PPD).

Figure 3. CARES-assigned Homicides by Quarter, January 1, 2020, March 31, 2021



Notes. The quarterly numbers reported in this figure exclude vehicular manslaughter.

The CARES team reached out to the next-of-kin for every homicide during this 15-month period (and also to family members for incidents of vehicular manslaughter—which are not included in Figure 3). In 93% of all cases (n= 619) a CARES PCR was deployed to respond to a given homicide incident. The 7% of events that did not have a deployment involved cases where the contact information for the next-of-kin was not valid or there was simply no return call from the next-of-kin. For those incidents where there was a deployment, approximately 71% of the responses took place immediately after the incident, while the balance occurred in the weeks following. When considering the incidents where the necessary data was available, PCRs were able to make contact with a co-victim in 87% of all cases (n= 597) in which there was a deployment. The majority of these efforts were successful; co-victims declined the services of the PCRs in only 2% of all cases (n= 599) in which contact was made. It is important to note, however, that sometimes co-victims declined services at the initial contact, but asked staff to follow-up at a later time. Reviewing the separate Excel spreadsheet on initial deployment and contacts shows that the rate of co-victims declining services is higher than the rate showing in the ETO database.

As shown in Table 4, below, the rates of response were high and fairly consistent throughout the performance period. For example, a consideration of how these rates changed between quarters shows that the rate at which a PCR was deployed (between 84% and 92%), the rate of those deployments that resulted in successful contacts (between 96% and 90%), and the rate at which services were accepted when PCRs interacted with the co-victims (between 100% and 91%) were relatively high throughout the period. Overall, these measures strongly suggest

that when PCRs were able to make contact with a co-victim, they were able to provide at least some services throughout 2020 and early 2021.

A more detailed consideration of the CARES workload in calendar year 2020 provides data on additional performance and workload-related measures. As a given homicide may result in CARES seeking to contact multiple co-victims, the 499 homicide events in calendar year 2020 resulted in PCRs making or seeking contact with 621 distinct individuals. During this period, there were, on average, 1.24 co-victims engaged per homicide.

A consideration of the cases where a deployment date and an incident date were both available (n=452) indicates that the response to each co-victim was generally rapid. Among all of those cases, the average length of time to deployment was 3.34 days. The range, however, was quite wide, varying from 0 to 117 days (std. dev = 10.06). In fact, 44.9% of all deployments occurred within one day of the homicide event. Figure 4, below, illustrates the strong rightward skew of this distribution and underscores the fact that most deployments were made relatively quickly, though a small number did not take place for several weeks or even months.

Table 4. Acceptance of CARES Services, Conditional on Deployment and Contact, January, 1, 2020 to March 31, 2021

		Response to Homicide Incidents		When Deployed, Contact Made		When Contact Made, Services Accepted	
		pct.	n	pct.	n	pct.	n
2020							
	Q1	84%	81	90%	73	99%	72
	Q2	99%	105	96%	101	99%	100
	Q3	96%	140	94%	132	99%	130
	Q4	92%	139	93%	129	100%	129
2021							
	Q1	93%	101	90%	91	91%	83

As shown in Table 5, with regard to basic demographics that are available through ETO, 77% of adult co-victims were women and the average age of adult co-victims was 41 years of age. The overwhelming majority of those served were people of color (89%).

Figure 4. Days between Homicide Event and CARES Deployment, 2020

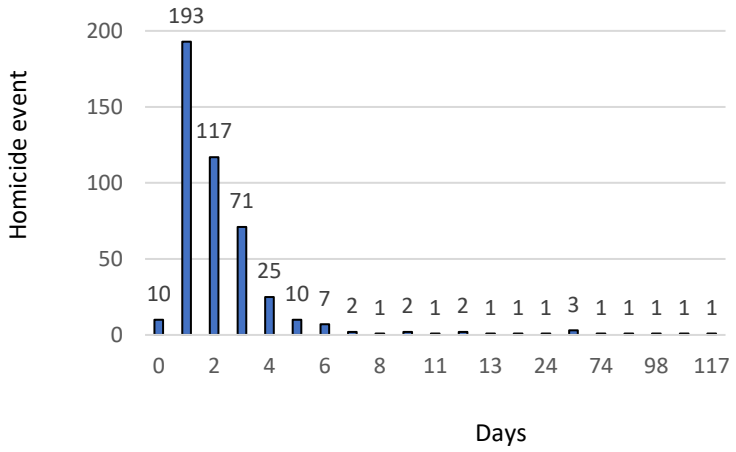


Table 5. Basic Demographics of Adults Served, Selected Variables

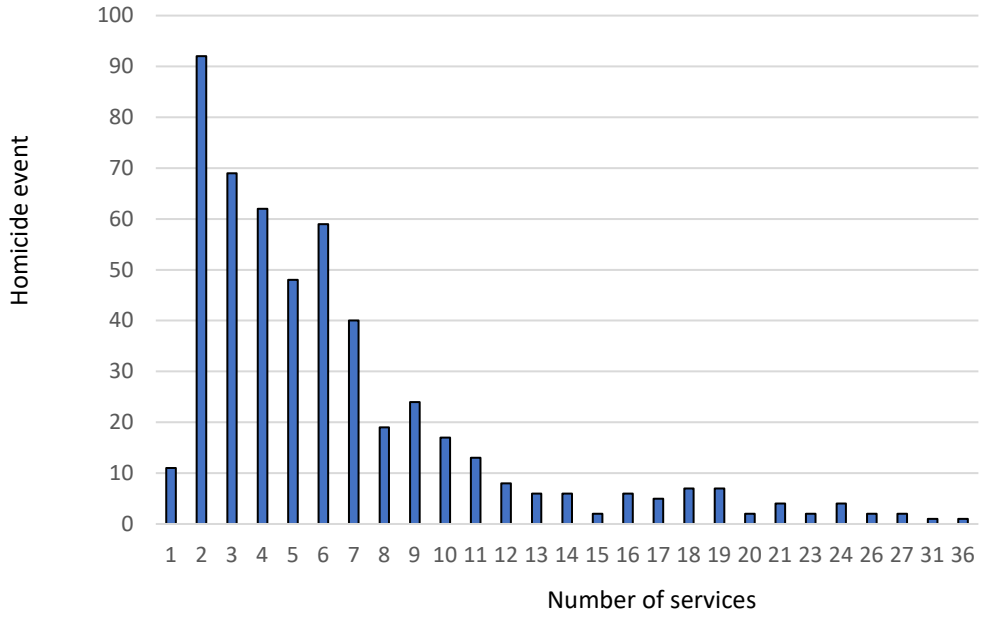
Average age	41 years
Sex	
Female	77%
Male	23%
Race/ethnicity	
People of color	89%
White	11%

Finally, a consideration of the cases where data on the number of distinct services that were provided to co-victims by PCRs illustrates the impact of the program (n= 519). On average, 6.50 services per co-victim were provided by CARES (min= 1, max= 36, std. dev.= 5.25). Co-victims required or requested varying numbers of services. On any particular staff visit, the range of services provided usually was centered on services that fall under the umbrella of "victim advocacy."

As shown in Figure 5, below, the majority (54.3%) of individuals used five or fewer distinct services over the few months that co-victims were involved in CARES services in 2020.

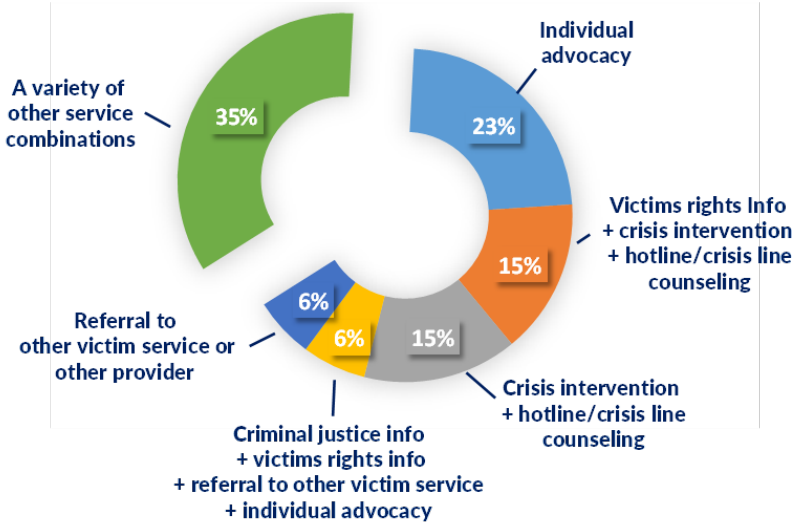
However, most co-victims required multiple services; just 2.1% of all co-victims required the provision of only a single service during their tenure with CARES.

Figure 5. Number of Distinct Services Provided by PCRs (2020)



In any given program quarter, the most frequently provided services by CARES staff were: (1) individual victim advocacy, (2) victim rights information provision, (3) hotline/crisis line counseling, (4) crisis intervention and (5) referral to other victim service or community-based service provider. These services are most often delivered in combination during a service visit or phone call. During the Covid-19 pandemic, most services were delivered on the front porch/front yard or over the phone. On any particular co-victim engagement, the combination of services can vary widely; the donut graph in Figure 6 highlights the most delivered suite of services per engagement ("service visit") in the five quarters that span 2020 and early 2021.

Figure 6. Suite of Services Provided per CARES Visit



THE CARES EXIT SURVEY

In Pennsylvania, all the PCCD grantees are encouraged to ask individuals being served by VOCA-funded programs to complete an exit survey. The exit survey is the Empowerment and Satisfaction Questionnaire-Long Form (ESQ-LF) and is designed to be self-administered at the end of program participation. Because this survey was designed for programs other than a multi-component one like CARES, the research team modified a number of the ESQ-LF items and added a few questions that were relevant for CARES. For instance, questions on the specific types of services received, including items on details related to applying for victim compensation were added.

The surveys were distributed both via hardcopy and with a Web option (using Qualtrics software) in the spring of 2020, and administration continued through to spring of 2021. The PCRs were responsible for providing the surveys to the co-victims at the end of program participation, and self-addressed, stamped envelopes were provided so the surveys would be returned directly to the research team. In some cases, the PCRs would conduct follow-up calls to remind families to complete the survey. This process yielded few fully completed surveys. The response rate hovered around 6%. Because the response rate for the surveys was so low, no survey data are reported here. Furthermore, in mid-2021, the PCCD asked that CARES staff administer the ESQ-LF and not continue (or separately continue) the Temple-designed exit survey. We recommend that, in the coming years, CARES determine which "new" survey items would be most important to retain as outcome measures in addition to the main ESQ items, and that a streamlined version of the exit survey be administered with regular follow-up. For more information on the ESQ, see Collins et al., 2008.

CHAPTER 5: STRENGTHS AND CHALLENGES

PROGRAM STRENGTHS

The process evaluation identified a number of clear strengths of the CARES program as discussed in detail below.

PEER SUPPORT MODEL

As discussed earlier in this report, the core idea behind the peer support approach is that individuals who share similar experiences can better understand each other and, consequently, may offer more authentic validation and empathy to another person facing that situation (Myrick & Del Vecchio, 2016). Despite acknowledging the risk for one's own re-traumatization and related vulnerabilities, nearly all staff members mentioned CARES PCRs' lived experience as co-victims as a strength of the program model, with many affirming that the shared experience allowed them to work more effectively with families experiencing loss. Indeed, the research team repeatedly heard from staff and partners that peer expertise in CARES helped to improve connections, trust, and service delivery for the families served.

When the research team inquired about whether or not PCRs disclose to the co-victims the fact that they themselves have been through similar experiences, some PCRs said that disclosing themselves as co-victims is essential for opening up the trust of the survivors. One PCR stated: "I don't tell them I know what they're going through—because everybody's experience is different—but I tell them that I too lost someone like this [homicide]." Another PCR, whose son was murdered almost two decades ago stated:

> *Because I had lost a son to murder, I understand the trauma, sadness, shock and loneliness--the heartbreak of it all to losing a loved one. This would give me an opportunity to put a real face to other people who are going through this to let them know there is a light at the end of the tunnel. And so I wanted people not to be at a loss and wanted to let them know they can [have help] to get through this. But everyone has different personalities. Seeing someone else who had gone through it can help. Co-victims often ask: 'How did you get through this?' I say: 'We all go through this differently but I will share with you what I went through if you want me to, and perhaps it may help you.'*
>
> *I cannot ensure that they are going to get it through it but it helps to see others. I don't share my story with everyone, only when I see it is needed to be shared. I let them ask me questions –for instance: 'How long did it take for you to feel okay?' I am an open book, I share. I let them know how I did it, what I did. I will share if they ask. What has helped me was being consumed and busy. Being busy, the days go faster and time seems shorter. My son has been dead 18 years. But you have to go day by day, week by week, year by year to get through those years.*

Other PCRs indicated that just having had the experience themselves helps them be more effective with their assistance. One stated: "Many families don't know that the services exist. Murder is an interruption, so unless you've been through it before, you don't know about it."

LEADERSHIP, TEAMWORK, PARTNERSHIP & TRAINING

CARES leadership staff have a long history of working in victim services in Philadelphia and know how to navigate the complexities of city and state funding. This experience is a benefit when creating networks and partnerships with other agencies. Because a number of CARES staff have worked together before, or know each other from previous victim services work, there appears to be a lot of trust across administrative staff and with many of the partnership agencies. For instance, the Program Director had previously worked with the Medical Examiner's Office and AVP prior to leading CARES. Multiple PCRs expressed respect and appreciation for their Program Director and administrative staff, indicating that they go "above and beyond" when PCRs reach out to them for help. This unprompted praise for program leadership serves as an indication of strong cohesion around the operations and running of the program model.

In addition, strong leadership was evidenced through the confidence administrative leaders had in talking with project monitors at the PCCD and submitting budget modifications, when needed, to provide more flexibility for program growth and implementation. CARES leaders were always on the lookout for outside funding or support for small budget items such as food, water or staff uniforms. The administrative staff was constantly strategizing to expand the program and create a flexible service model that would best support families in their time of need. When the first funding cycle was nearing its end, the Program Director was very prepared to submit a proposal for continuation funding that contained a budget for the type of funding needed to aid staff and full implementation of CARES. For instance, procuring the two vans with the continuation funding provided staff the ability to focus more on service delivery than problem-solving around transportation for staff for certain events or service visits.

Other successes related to leadership and teamwork include the hands-on, continued training process. Multiple interviewees mentioned the benefits of CARES' hands-on training and paired deployment. Recent hires shadow a more senior responder and observe the process before taking the lead when they are ready. Similarly, when PCRs make home visits or are deployed to crime scenes, it is most often in pairs. Home environments can be chaotic, and PCRs do not always know what to expect. Working in pairs mitigates safety concerns and allows responders to offer support to more co-victims who may be present. Multiple staff members also mentioned the benefit of this teamwork, saying it allows them to take breaks, "swap out" if things get too emotional, "split up" and connect with more co-victims, etc.

DIVERSITY OF STAFF

Staff represent diverse cultural, racial and ethnic backgrounds and come from a wide range of neighborhoods across Philadelphia. Having diverse staff is a core principle in CARES operations. At the beginning of CARES implementation, the Program Director and Manager sought to fill PCR positions with staff who represent differences across race/ethnicity, culture, gender, religious beliefs, languages spoken and neighborhood of residence. Staff generally have been successful in this regard, but with turnover of staff (given the large number of PCRs, turnover is likely), it is not always possible to fill the role by someone who fills a specific diversity gap. This priority must compete with the priority to hire swiftly, given the large increase in the number of homicides that have occurred over the course of the program's implementation and development. For the most part, however, if there is turnover in PCRs, lead staff specifically seek to fill the position with an individual who fills a particular need across the

team of PCRs. For instance, by the end of summer of 2021, there was turnover in the male PCRs, so staff have been searching to fill this gap, as well expand the number of languages spoken by staff.

TRAUMA-INFORMED MODEL

Staff utilize evidence-based practices and principles of trauma-informed care. Essentially, trauma-informed practices guide the entire CARES logic model and system of care. AVP's on-staff clinical social worker provides regular trainings framed around promoting recovery and healing, developing connections, building trust and resiliency, and making time for self-care. Taking time for self-care is a practice for the staff, and those practices are discussed with and stressed as important to convey to co-victims.

The staff clinical social worker is available for regular "check-ins" with all staff, as needed, and leads the monthly training sessions, which are mandatory for all staff. In addition, the lead CARES staff also are trained to recognize vicarious trauma, which is defined as the physical, emotional, cognitive, and behavioral reactions resulting from witnessing or hearing about other people's pain and suffering (McCann & Pearlman, 1990). Vicarious trauma often results in the same symptoms as direct trauma and can be treated similarly. Self-care principles are infused throughout all programmatic operations as part of techniques to prevent and/or minimize vicarious trauma. One staff leader commented during her semi-structured interview: "Vicarious trauma as a provider is a workplace hazard. We factor that in."

RAPID CRISIS RESPONSE

According to interviews with staff and stakeholders, one gap the CARES program fills is that it provides immediate crisis support to co-victims where no coordinated response effort for survivors of homicide previously existed. Prior to the formation of CARES, outreach to co-victims was inconsistent and multiple staff members reported that the process was daunting when they lost loved ones. Staff members emphasized the benefit of on-the-scene responding: "You're able to create a bond with the family almost immediately because you're meeting them on the worst day of their life." Another stated: "In those immediate moments when you need someone, we are there. We talk to families in their moment of need."

Because of the lived experience of CARES staff, they recognize how traumatizing the moment of death notification can be; staff work hard to make contact immediately with co-victims, and to be there to provide support as close to the time that police notification to the next-of-kin takes place. Qualitative studies of co-victims indicate that the notification itself is a defining moment in the memory of a loss of a loved one. CARES staff have developed a strong relationship with the PPD so that the information on each homicide is automatically pushed out to CARES leaders as soon as the homicide incident is recorded. CARES staff respond immediately whenever possible—either by going to the homicide scene, to the hospital or the home of the next-of-kin.

FLEXIBLE CASE MANAGEMENT MODEL

By using a flexible case management model, CARES is better able to meet the diverse needs of co-victims and fill more service gaps. One administrative leader indicated: "CARES is a catch-all. Even though more services are contacting families now, people can fall through the cracks. We get the victims everyone misses." Depending on unique needs and circumstances,

PCRs can customize their approach to cases. Some families make extensive use of CARES services, while some request minimal information and check-ins. Their lived experience also helps PCRs see details and needs that other victim services might miss. One staff member noted that, sometimes, "it's not a time for therapy, but it's a time for psychological triage and assessing day-to-day needs." Another staff member stated: "We show them how to do self-care."

This flexible approach works to the program's advantage. Of those staff members who were asked if the 45-day service period was long enough, most responded that it was generally sufficient. However, multiple respondents noted that 45 days "isn't always 45 days." Families may get busy with funeral arrangements, are initially surrounded by friends and loved ones, then find that a month after the homicide they need more formalized services. PCRs stated that while 45 days is a good guideline, they appreciate that they can work with co-victims for as long as is needed. Citing concerns regarding continuity of care, some PCRs suggested that it would be beneficial if the 45 day program period would be formally expanded. However, program leaders have suggested that most referrals should be completed and verified within 60 days.

Low Rates of Service Refusal

All staff members reported that most co-victims contacted by CARES have expressed appreciation for the program and its services. Some comments from staff include: "People are happy to see the DAO supporting not just the police, but families. They appreciate that someone is there to offer assistance." And "They're always grateful." Consistent with the data reported in ETO as reported in an earlier chapter, the PCRs reported that very few families had refused services or refused to have any contact. This may be partially attributable to the program's flexible nature, which allows PCRs to customize their support to each family and co-victim, meeting them where they are and on their own timeline. Even if a family is concurrently being provided victim services through another agency, there may be a particular service that the co-victim is happy to have CARES provide, as it may be more convenient or more readily available through CARES.

Insider Access

As a program housed in the District Attorney's Office, CARES has good access to resources and information that help them better serve co-victims. Multiple staff members mentioned that their status as DAO employees fortified their legitimacy with co-victims, law enforcement officers, medical personnel, and other stakeholders. As a DAO program, CARES can coordinate with attorneys and the Victims/Witness Services Unit to get updates on legal cases. It is important to also note, however, that several staff members noted the challenges of running a community-oriented program within a law enforcement agency. Ironically, legitimacy issues may work in the other direction, where co-victims are hesitant to engage in criminal justice-related services from a government agency. Regardless of the negatives here, most interviewees acknowledged some advantages to the program's current host organization.

Program Challenges

In addition to the strengths identified above, the research team set out to examine program challenges, as delineated in some of our guiding research questions reported in the report's introduction:

- *What implementation challenges were encountered by the staff and other stakeholders?*

    - *Were there any specific needs of co-victims that staff identified as not being met? Or that staff had difficulty meeting?*
- *How did contextual factors influence the implementation and operation of the model?*
    - *How do the organizational attributes of the DAO and key referral agencies (e.g., victim services agencies, other social services, etc.) influence the design and delivery of the program?*
    - *What aspects of the political and economic climate, both state and local, appeared to impact program operations?*
    - *How did the global Covid-19 pandemic impact operations and how did staff adjust programming and practices to account for challenges brought on by the pandemic?*

Unsurprisingly, our process evaluation identified several challenges, most of which emerged as themes in the qualitative data we collected (i.e., the interviews). These challenges relate to a range of factors, but many were related to the general organizational and broader Philadelphia-context in which CARES is operating. And the global pandemic exacerbated the challenges caused by many of these "contextual" factors—in particular the social and economic problems facing the city of Philadelphia, which are, for the most part, the same factors directly impacting the lives of those individuals and families served by CARES.

Key challenges experienced by CARES during implementation included: (1) the social context, compounded trauma, and limited services for co-victims of homicide; (2) the political climate and community relations in Philadelphia; (3) the agency setting (within DAO); (4) the initial organizational development; (5) the constraints of part-time role of the CARES staff; (6) coordination with partners; (7) the role of vicarious trauma and burnout for program staff; (8) the concern for staff safety; (9) the need to meet the diversity of the program's target population; and (10) the impacts of the COVID-19 pandemic.

SOCIAL CONTEXT, COMPOUNDED TRAUMA & LIMITED SERVICES

When asked about the challenges they face in the work, staff members frequently brought up the larger context of poverty, violence, and disadvantage faced by Philadelphia communities. According to one PCR: "Lack of resources and opportunities is the number one issue in the community. If people don't have anything to live for, they don't care." Relatedly, during the implementation of CARES, the number of homicides was creeping upward, with the Covid-19 pandemic, the police killings of George Floyd (Minneapolis on May 25, 2020) and Walter Wallace (Philadelphia, October 26, 2020) likely impacting violence and police tensions in the city. During 2020, Philadelphia had 499 homicides, which averages out to 1.4 each day. As of September 30, 2021, city homicides stood at approximately 415, up roughly 18% from 2020. During semi-structured interviews, staff continually stated that as soon as they made contact with and started serving one family for a new homicide, they were likely to be given another case. Most PCRs who had started in early 2020 indicated that at the beginning of their tenure, they often only had one new case a week or less, but the case referral rate to PCRs increased greatly as homicides mounted.

Furthermore, some families and communities have experienced repeated tragedies, and have lost multiple loved ones due to homicide by the time they come into contact with the CARES program. Essentially, families who are not just grieving the loss of one, but multiple

family members over span of time. One interviewee described visiting a neighborhood block where five mothers in five households had lost children to homicide. “The trauma faced by the people in these communities is enough to overwhelm a society.” Some staff feel that this recurrent trauma in communities may be further worsened by a cultural hesitancy to engage in therapy or counseling. “There is a lot of trauma in the culture.”

As alluded to earlier, although praising the responsivity and cooperation of local victim service agencies, many PCRs also considered the limited service availability (services outside of CARES) as a serious barrier to the recovery of the homicide survivors—as exemplified by the time co-victims would have to wait to get into a program (either because the referral agencies are full or the programs operate on a cohort approach with specific start and end times).

POLITICAL CLIMATE & COMMUNITY RELATIONS

“He’s on the reform side.” District Attorney Larry Krasner was elected in 2018 on a platform of progressive prosecution and widespread criminal justice reform. A vocal opponent of mass incarceration, cash bail, and lengthy probation sentences, DA Krasner’s agenda has been interpreted by some as unsupportive of victims, antagonistic to police, and favorable to those who perpetrate violence. These political considerations can have a significant impact on program implementation. For example, staff reported a lack of recognition and courteous reception by police officers on the scene of a homicide, connecting it to police perceptions of the current DAO leadership. One PCR described being yelled at by a crime scene officer before a homicide detective intervened, saying, “I know him, I know why he’s here, let me handle this.” Multiple staff have reported a positive relationship with homicide detectives, specifically, and how, over time, the detectives came to really appreciate the PCRs’ presence at the crime scene and their trauma-informed interaction with the co-victims.

The political climate may also influence the receptiveness and satisfaction of the families that CARES serves. Staff reported that some individuals share the view that the DAO is more sympathetic to perpetrators of violence rather than victims, which may affect their impression of the CARES program. Additionally, some staff reported that some co-victims experience a deep distrust of law enforcement and the criminal justice system, leading them to be suspicious of a DAO-run program. For these reasons, some PCRs and stakeholders expressed the view that the setting of the program within the District Attorney’s office can be a double-edged sword. While DAO may offer access to information and resources otherwise not easily available to a community-based victims program, CARES also has to overcome the mistrust that the community has in any law enforcement agency. Many stakeholders with whom we spoke discussed their belief that there is inherent conflict between the goals of a prosecutor or law enforcement agency and the interests of victims. However, as mentioned above in the “successes” section, some CARES staff did express a belief that the placement of the program within DAO may in fact lead to an *increase* in trust and better relationships with the community, as some of its most vulnerable members come to realize—via their positive experience with CARES—that the leadership of law enforcement in the city truly cares about their needs. As one PCR put it, “CARES brings credibility to the [DAO] office.” Another PCR indicated that they always thank the survivors they meet for their time “on behalf of DA Larry Krasner,” emphasizing that it is important to mention the DA by his name and for the co-victims to feel more personally attended to by the DAO leadership.

It is also worth noting that during the first year of CARES operations, DA Krasner rarely mentioned CARES in meetings, City Council testimony about gun violence or other events where he had the potential opportunity to discuss CARES. Many community agencies working in the gun violence reduction arena did not know much about the CARES model, or that it was run out of the DAO. But by early 2021, DA Krasner more regularly publicized and touted the CARES model as a central piece of the DAO's priorities to decrease violence and the trauma caused by violence. In 2021 CARES staff were regularly highlighted in DAO newsletters, data briefs, and press conferences.

AGENCY SETTING

Moving beyond criminal justice legitimacy issues, several staff described the difficulty of implementing a community-oriented program in a government-run justice agency setting. CARES responds on-site to homicides on a 24-7 basis, while the DAO follows a 9am to 5pm, Monday through Friday schedule. Multiple PCRs described the difficulty of coming to the DAO and parking in downtown Philadelphia in order to pick up a check, use the computer or printer, or to reserve a meeting space (the PCRs do not have dedicated office space within DAO). A related issue is that the DAO is located in Center City, Philadelphia, which is an area with a low homicide rate. PCRs spend their time traveling to visit co-victims who tend to live far from Center City. To mitigate some of these access issues, multiple PCRs suggested the use of CARES satellite offices situated in the community (see "Recommendations" section below).

For PCRs without office employment experience, navigating the bureaucratic procedures of the DAO may have been a challenge. The program staff also experienced difficulties in securing basic professional necessities, included dedicated work cell phones (issued after six months of program operation), tablets (of which they only received half of number requested), and ID badges. Only the administrative staff has office space in the agency, which they did not secure until many months into the program. Timesheets and payroll were done by hand, and initially PCRs were not issued city-affiliated email addresses. Some of these difficulties may have eased when PCRs were reclassified from "contracted workers" to "part-time seasonal employees" within the DAO, and were incorporated into the main payroll system. Recently, the program also procured two vehicles (vans) that the PCRs can use for their field visits through a reservation system.

ORGANIZATIONAL DEVELOPMENT

One of the greatest challenges mentioned by staff who were hired early on in the program's timeline was that there were few formalized program protocols. Staff reported that in the early phase there were no implementation manuals, no clear script or template for how to handle cases, and no formalized hiring and training process. Some staff were able to rely on their work and personal experience in order to "build the template as they went." This initial lack of organizational structure may have created extra work for PCRs: "People don't expect to have to help the job to do the job, they expect to come in and do it." In the early days of the program, staff were not only doing the work of serving families, they were also navigating ongoing program development. Early turnover in program leadership likely contributed to this initial lack of formalized structure.

The CARES program also struggled to find its place within the organizational structure of the DAO. Carving out the role of CARES in relation to the DA's existing Victims/Witness Services Unit required extensive conversation. After some restructuring, CARES now falls under

the purview of the First Assistant District Attorney and works collaboratively with the Victims/Witness Services Unit.

These organizational challenges should be seen in the context of broader organizational changes within the DAO. DA Krasner had only taken office in January 2018, and CARES was trying to get off the ground later that year. When the DA took office, he appointed a new person to run the Victim/Witness Services Unit (the person who brought the CARES model to the DAO), but she left within a year to become a candidate for the PA State House of Representatives. This abrupt change left CARES staff to develop many of the implementation procedures and protocols on-the-fly while implementing the service model. Even where implementation protocols were in place, the new administrative leader essentially had to problem-solve in a vacuum as issues arose, as the DA had not yet formally adopted an organizational structure and set of procedures for clear lines of communication and reporting for the office as a whole.

CONSTRAINTS OF PART-TIME ROLES

Currently, the PCRs and the program counselor work for CARES on a part-time basis, although they commonly described their jobs as a "24/7" continuous effort. This creates certain challenges and constraints for the program related to scheduling and capacity. For example, both Immediate Responder and Case Manager PCRs support families on nights and weekends, while the DAO operates on a Monday-Friday, 9am-5pm schedule. Furthermore, many PCRs also hold a full-time or another part-time job in addition to their work with CARES. Trainings, debriefings, and case reviews sometimes conflict with the team's diverse schedules and external priorities. Multiple interviewees suggested it would be beneficial to add full-time PCR roles to the program structure. By spring 2021, CARES leadership formalized a new budget plan to add at least two full-time PCRs.

The current counselor attached to the CARES program is an LCSW who is employed by AVP and dedicates part or her time to CARES. Although multiple interviewees mentioned the counselor's availability and beneficial support, the program's clinical capacity is clearly strained. Given the wait times for grief counseling cohorts at the City's victim service organizations, the CARES counselor sometimes provides emergency counseling to families and co-victims as well. It is challenging for one person, especially a part-time employee, to provide external crisis counseling and internal counseling and clinical supervision for staff. Both program administration and PCR staff mentioned the need for multiple full-time roles in this capacity.

COORDINATION WITH PARTNERS

In order to provide immediate crisis response and case management for co-victims, CARES relies on a diverse network of partner agencies and organizations. Occasionally these partnerships exhibit friction, inconsistencies, or lapses in communication. New PCR hires have to quickly learn about the referral network and key staff at each agency and become familiar with the somewhat piecemeal landscape of victim services in Philadelphia.

With regard to CARES' partnership with the PPD, for the first 10 months of operation, CARES struggled to build a relationship that would facilitate receiving real-time homicide information. Staff members reported relying on news reports and the Citizen crime notification app to identify co-victims in the aftermath of a homicide or shooting. Some of the challenge here was likely related to the fact that in late 2019, the PPD Commissioner had resigned, and was

replaced by an interim Commissioner until the current Commissioner was appointed in late December 2019 (but did not begin until February 2020). Over time, as CARES built relationships and bridged gaps, information sharing improved and CARES now receives prompt notifications from the PPD.

Other coordination challenges with partners remain. One staff member mentioned that an area hospital does not allow CARES responders to accompany families into the building, possibly due to lack of administrative relationship to the program. Similarly, PCRs mentioned getting their wires crossed with other victim service providers. Families may be contacted by multiple service providers, or provided duplicated information. "Everyone is throwing VCAP [victims' compensation] forms at them and other resources. They get overwhelmed." Some staff mentioned that not all community agencies trust each other, because historically there has been little sharing of resources and agencies might feel competitive with regard to making inroads with a family. This issue may be exacerbated by the way the PCCD reimburses for services provided by service item. In the views of one stakeholder interviewed, this kind of "territoriality is misguided" as CARES is an addition to other local victim services and is not taking away resources from other programs. Some staff, too, expressed the view that, if anything, more victim service programs are needed, as the current needs of the victims are certainly not met by the existing resources within the community.

Some of these partnership-related challenges may be due to limited city-level coordination of victim services programming. At present, there is no Philadelphia-wide body that supports a network approach to victim services, with the exception of the PCCD. But the PCCD is a state agency, and is only coordinating grantees (i.e., those that are funded by them), and is not responsible for coordinating and understanding the array of victim services and potential gaps or duplication in services (although to the PCCD's credit, they actively seek to understand the gaps and fill them with their funding efforts). In the past, Philadelphia had at least two city-wide victim services-related collaborations where victim service agencies met to discuss how to create and maintain partnerships to best serve Philadelphia residents, but these collaborative are no longer operational: the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIdS) monthly Victim Community Support Collaborative (VCSC), and the Philadelphia Coalition for Victim Advocacy (PCVA). The Covid-19 pandemic may have been partially responsible for their departure or hiatus (although it is not clear if these collaboratives will return). When these collaboratives were meeting regularly, interviewees reported that they helped highlight where the gaps were in services and the issues related to racial and ethnic disparities. The meetings were a great way for providers to learn about best practices, innovations, and new programs.[4] The collaboratives also increased the likelihood that new partnerships would emerge across attending agencies. The formal and informal discussions that took place at these meetings and around them helped make agencies aware of where duplication in services might be happening.

VICARIOUS TRAUMA & BURNOUT

Nearly all of the interviewees mentioned the PCRs' lived experience as a major strength of the program. However, responders' own co-victim status leaves them vulnerable to re-

[4] A member of the research team had regularly attended the VCSC meetings.

experiencing trauma and personal loss. Furthermore, the concentration of violence in certain Philadelphia neighborhoods enhances the likelihood that PCRs will be personally familiar with the co-victims. Multiple PCRs mentioned this proximity to communities affected by homicide, recounting times they were deployed to homes and realized they knew the family. Occasionally, cases will exhibit similarities to their own loss, and crisis responders may become overly affected or involved. "The peer element can be a weakness if you don't have the skill of boundary setting." Many staff also mentioned that the most emotionally taxing cases involve children, either as the victims of homicides, or survivors and/or witnesses to the crime—and that sometimes they decline to take on cases such as these.

The program navigates this challenge by offering debriefings and clinical counseling to PCRs on a group and individual basis. Multiple staff members mentioned that if they are having a hard time with the work and it's "getting to them" mentally and emotionally, they can reach out to the LCSW. Multiple employees also mentioned the sensitivity and availability of the program administration staff, who offer emotional support and self-care suggestions. For example, when accompanying a family to the Medical Examiner's Office, PCRs are instructed not to look at the family, nor at the body photo, to avoid unnecessarily retraumatizing themselves. The program's trainings emphasize self-care and encourage that PCRs take breaks and time off for themselves. One staff member emphasized the importance of knowing one's own weaknesses, and to "know what will affect you and what should be avoided."

Concern for Staff Safety

Related to the concern above regarding staff wellness, an important factor in strategizing staff deployment is ensuring their physical safety. As indicated already, most of their deployments happen in high-crime neighborhoods. This is a main reason the deployment operates in pairs and the staff are trained about safety precautions, such as active shooter training. This being said, several PCRs discussed how they always have to be mindful of the danger they may walk into, that they have to "read" the room or crime scene about the potential for co-victims to attempt retaliation, and to think about how to de-escalate potential danger.

The vast majority of the PCRs are middle-age women of color, and some recognized that their demographics makes them less susceptible to possible threats of violence in the neighborhoods in which they have to operate. It is important to note that given the PCR's role of being available for a co-victim and family members when requested, and sometimes being present at the scene of a homicide and in the days following, there may be a real threat of violence from simply being in close geographic proximity to the co-victims. However, one Black male PCR specifically said he has to be conscious of the potential of being seen as a threat, especially by other young black males residing in the neighborhood. It is one of the aspects considered when deployments are being discussed to determine which PCRs will respond.

A number of staff also brought up, during interviews, their agreement with CARES policy that PCRs will not respond to homicides between midnight and 6:00 in the morning. This policy is specifically in place to minimize the possibility that staff might be harmed.

Meeting the Diversity of the Target Population

The peer component of the CARES program—the requirement that all PCRs have lived experiences similar to those of the target population—ensures that the cultural diversity of the co-victims is generally well matched by staff that is attuned to the needs of their clients. For

every case deployment, the program director, after getting the information on the co-victims, attempts to assign the most culturally competent PCR to that family. Some PCRs themselves also indicated that before deployments, they look up information about the neighborhood and do their best to appear in a non-obtrusive way, so they blend in when deployed. "You don't show up in your Sunday best" is how one PCR put it.

This being acknowledged, both administrative and line staff indicated that there is a need for greater diversity among the staff to better match the demographics/cultural diversity of the survivors. Two areas emerged in particular: the need for more Spanish-speaking PCRs, and the need for more men. The former would respond to the increasing number of LatinX minorities among survivors of homicides. As for the latter, the views expressed underscored several benefits: the likelihood that male co-victims would open up more to a male PCR during their grieving process; that male PCRs would serve as role models to other minority men in the community; and that the PCR staff process of debriefing cases would benefit from the dynamics of gender diversity when discussing challenges and issues in various cases.

Another potential benefit of having (additional) male PCRs is the role they could potentially play in mediating potential anger at or conflict with the perpetrator(s) of the homicide. There may be homicides where family members might have some idea who the perpetrator is, or where police are still searching for an identified perpetrator, and there is some indication that family members want retribution or revenge. A few PCRs indicated that having men trained in conflict mediation or as potential de-escalators could be a benefit, or partnering CARES with organizations such as Cure Violence Philadelphia (i.e., an organization trained in street outreach and violence interruption) for assistance, if needed, could be a benefit to CARES. (The research protocol for the semi-structured interview specifically asked staff about whether there was a need for staff skilled in conflict mediation, as the original developer of CARES included this role as a potential role for PCRs.)

IMPACTS OF COVID-19

There are number of places throughout this report where we discuss particular impacts that the global coronavirus pandemic had on CARES operations. In these paragraphs below, we summarize how the COVID-19 pandemic severely altered the implementation of the CARES program. Fortunately or not, given the ever-increasing need for co-victim services as homicides in Philadelphia continued to mount since CARES inception, the pandemic did not fully impede service delivery. Like providers around the world, the CARES staff adapted to social distancing, reliance on digital communication, and new health protocols in all aspects of life and work.

According to PCRs, social distancing especially impacted co-victims' grieving process and ability to connect with services. The inability to hold funerals, to go in person to the MEO to identify their loved one, and the risk in seeing and receive support from friends and families in-person, may have created more suffering and alienation for co-victims. Social distancing measures also made it more difficult for PCRs to introduce themselves to and connect with new co-victims. "There's a barrier between your phone and theirs." Under COVID-19 precautions, PCRs said it was harder to do basic wellness checks, even as families needed more emotional support than ever. Multiple PCRs described dropping off materials to a family then speaking to them from the sidewalk in order to safely connect in-person.

In mid-March 2020, the city of Philadelphia issued a stay-at-home order in response to COVID-19 which closed the DAO to non-essential employees and prevented PCRs from

responding to hospitals and conducting home visits with families. By March 23rd, even the MEO was closed to the public and the Bereavement Care Coordinators at the MEO were doing the identification process over the phone. One CARES PCR was designated as the immediate responder, reaching out to the next of kin of all homicide victims early in the morning following receipt of the information from the PPD homicide unit. Every other PCR was assigned to manage and follow-up with these cases, operating solely by phone.

Trainings and meetings were restructured to accommodate the restrictions posed by the pandemic and were held mostly over teleconference call and sometimes Zoom. In the early days of the shutdowns, these meetings and trainings were held weekly, but as time progressed and the number of homicides skyrocketed, the all-staff meetings were reduced to occur once a month. However, PCRs began to be scheduled for direct supervision meetings with the Program Manager starting in July 2020. A few months later in October 2020, the Program Manager together with the Program Director began conducting monthly case audits to check on random cases for each PCR to ensure that data entry and paperwork were properly completed and submitted.

CHAPTER 6: RECOMMENDATIONS

RECOMMENDATIONS

The data collected for the process evaluation and particularly the semi-structured interviews with CARES staff, leadership, and key stakeholders revealed opportunities for program growth and improvement. Thus, this concluding chapter outlines the research team's recommendations. We identified four key areas where CARES can build on its strengths and enhance its services: (a) program capacity; (b) partnerships; (c) target population; and (d) data and evaluation. Discussions about these insights and recommendations were ongoing with the CARES Program Director throughout the implementation of CARES, and hence many of the recommendations below have been or are currently being put into practice. The CARES leadership team continues to embrace expansion and opportunities to overcome challenges and fill any relevant gaps that are not outside their purview or control.

PROGRAM CAPACITY

Recommendation 1: Create full-time PCR roles. A major program challenge has been the constraints of part-time roles. PCRs who had a second job or a full-time job in addition to being employed as a PCR often were not available to do immediate responses to homicides. Even if available for the immediate response, scheduling conflicts for follow-up engagements and/or transportation issues made it difficult to be responsive to the needs of co-victims. CARES administrative leaders have been attempting to obtain funds that would covert from of the PCRs to full-time, and by mid-2021, CARES was able to obtain at least two full-time PCR positions. Continuing to expand the budget to include additional full-time PCRs could improve overall staff retention and facilitate responsive service delivery practices. But the need for full-time PCRs should be carefully balanced so CARES could still have a diverse staff who reflect the demographics and needs of the co-victims and their geographic locations throughout the city.

Recommendation 2: Formalize hiring criteria. Prior to establishing full-time PCR roles, it would be beneficial to formalize and systematize the hiring criteria. For example, decisions should be made about how soon after a loss someone can be hired to the role. Working as a PCR too soon after loss of loved one may be re-traumatizing. Additionally, responses were mixed when staff members were asked how necessary the experience of homicidal loss was to the work. Multiple respondents were in favor of expanding "peer" to include anyone who had experienced a serious loss, while others said PCRs should have experienced the loss of a loved one to *homicide* specifically. Another key consideration in hiring should also be expanding cultural competency and the ability to reach diverse segments of the target population beyond the current staff competencies. While the current staff are very diverse, there are few male PCRs (and at the time of writing this report, there were none), and only English and Spanish were among the languages spoken by the staff. Last, a few staff members suggested that it might be beneficial to require PCRs to have strong organizational skills and knowledge or experience in data entry and documentation. Having these skills would facilitate the administrative side of program functioning. Deciding these issues will likely require deep conversation among CARES staff, stakeholders, and community members, but will assist with hiring in the future.

Recommendation 3: Hire two full-time LCSWs. Nearly all staff members interviewed mentioned the need for increased clinical capacity and counseling services. The first and current LCSW works full-time with the Anti-Violence Partnership and part-time with CARES. Within

that part-time role, the LCSW provides case consultation, emotional support and counseling to PCRs themselves, and sometimes provides crisis counseling to co-victims who are in urgent need. Multiple interviewees mentioned the need for at least two full-time licensed social workers in the program. Additional staff in this area would better support PCRs and the people CARES serves.

Recommendation 4: Allocate funds to meet more co-victim needs in the immediate period of need. This includes dedicated funds for housing re-location. Multiple staff members mentioned the pain of not being able to immediately provide something a family in grief needed, such as food or a safe place to stay. CARES staff members stated that PCRs "move mountains" to meet a family's needs but often have to rely on referrals. By allocating more financial resources to be used for material support for co-victims, PCRs can serve families more quickly and efficiently. Examples of material needs mentioned in interviews include: temporary housing relocation; grief-related medical emergencies; groceries and prepared food; and transportation to the MEO or DAO. The expanded partnership with AVP—including budget line items for AVP to support basic food and emergency needs (implemented in the second half of 2021) will help to meet some of these needs.

With regard to housing relocation, CARES leadership articulated a dire need for more resources for emergency or temporary housing; over the course of the evaluation, leaders indicated that there was a dramatic uptick in need for housing relocation resources. This need often derives from the problem of witness intimidation, as survivors of homicide may have been witnesses to the death of their family member. In September 2021, the Philadelphia Inquirer reported (Orso, 2021) that the DAO (as a whole) is allocated roughly $260,000 (much of this comes from the State Attorney General's Office) and a single relocation can cost $30,000. CARES leadership has expressed interest in working with DAO colleagues and other partners to develop a mechanism for dedicated funding that would allow for implementation of a comprehensive "Safety Plan" for co-victims.

PARTNERSHIPS

Recommendation 5: Take a network approach. Forming partnerships is a strength of the CARES program, evidenced by their inclusion on police alerts, their access to the MEO, their partnership with AVP, and their collaboration with other community organizations. With increased staff capacity, the program could extend this collaboration to additional agencies and form a small network of agencies that respond to homicide co-victims. As stated in the challenges section, at present, there is no Philadelphia-wide body that supports a network approach to victim services. CARES leaders could work with the relevant city department leaders to re-establish a collaborative, or facilitate a strong partnership with the new Office of the Victim Advocate that is currently being put in place. It is likely that the mayor will soon (late 2021) appoint a victim advocate (with the consent of the city council) to lead the office. With careful oversight, this office might be able to achieve the goals that had been outlined by DBHIdS VCSC, fill gaps in need, reduce duplication, and support capacity-building efforts for victim serving organizations and programs. CARES administrative staff could seek the assistance of the new city office to build networked resources to serve co-victims of homicide. This recommendation to form or facilitate a collaborative is directed more at the city of Philadelphia than to CARES leadership, and will be more important as the millions of "new" dollars flows through to the city from the Biden-Harris Administration's effort to support

Community Violence Intervention.[5] Many of these efforts include a priority focus on victim services, and as of the writing of this report, Philadelphia had already awarded a number of grants to community agencies to serve victims of violence, including survivors of homicide.

Recommendation 6: Continue to build organic partnerships. Developing more extensive partnerships would also allow CARES to serve more specific needs. Multiple staff members mentioned that co-victims who are children often have unique or acute needs that not all victims service organizations are prepared to meet. We recommend creating stronger partnerships with agencies that have extensive lists of services and referrals for children and those that specialize in conflict mediation in instances of street violence (for more on the latter see Recommendation 11). One way to foster collaboration with other agencies is to continue what CARES leadership have been doing—inviting other agencies to present about their services at CARES staff meetings—but to increase the frequency and sharpen the focus of these partnership-building efforts. As stated in Recommendation 6, the need for solid partnerships and collaborative around victim services becomes more urgent as new victim services-focused grants are being made.

Recommendation 7: Continue building out the partnership with AVP. In mid-2021, CARES was given satellite space at one of AVP's offices in West Philadelphia. This space has at least five different rooms. Use of these rooms provides co-victims a place to meet CARES staff, meet other co-victims both formally via group theory or informally. They will have a quiet space to grieve and have the opportunity to participate in group counseling sessions at that site. This space will provide the opportunity for co-learning—where CARES staff can learn from their AVP staff present in the office and vice versa and share ideas about how their partnership can continue to grow to meet additional needs of Philadelphia victims and co-victims. An expanded partnership with AVP will also allow CARES staff to write grants where the fiscal agent is a non-profit (i.e., AVP) and not a government entity (DAO), as many and some grant portfolios exclude government entities from applying and private funders are often only interested in supporting work of non-profit, community-based agencies. This expanded partnership will widen CARES eligibility to apply for grants, as well and give them the capacity to ask for and receive donations that can be applied for resources (such as food and water) that typically aren't funded under many government grant portfolios). An expanded partnership would also provide means for CARES to hire additional LCSWs and streamline the hiring process that takes place within a large bureaucratic government agency.

Recommendation 8: Test the possibility of having round-the-clock PCR staff who are able to partner with the police to deliver the death notification. Research shows that one of the most defining moments for the co-victim is that moment when police come to the door or call to notify next-of-kin of that their loved one has died (Spungeon, 1998). A trained PCR could be available for support as the information is being conveyed. The police may not be viewed positively in many communities and there may be added tension and emotion when police deliver the information. Having a PCR deliver the news to a family about the loss of loved one was one of the few original goals of CARES that was not implemented.

[5] https://www.whitehouse.gov/briefing-room/statements-releases/2021/06/23/fact-sheet-biden-harris-administration-announces-comprehensive-strategy-to-prevent-and-respond-to-gun-crime-and-ensure-public-safety/

REACHING THE TARGET POPULATION

Recommendation 9: Continue to expand reach to all affected co-victims across each homicide and vehicular manslaughter incident. One strength of CARES is that they have the ability to reach out and offer services to anyone affected by a homicide and vehicular manslaughter, not just immediate family. Friends, neighbors, classmates, and other community members are all affected when a homicide occurs, but not every service reaches them or serves them. CARES may be able to leverage its position to serve as a vehicle for larger and more meaningful community engagement, such as partnerships with schools.

Over the course of the evaluation, some staff stressed the need for PCRs to have experience working with children and adolescents, and the ability and interest to be a liaison to school district personnel. Although the CARES model was not created to work with students, the rising number of homicides in general translates into more homicides of parents with school-age children. Working with students, even within the immediate aftermath of the homicide, often necessitates having open lines of communication with school personnel. In addition, staff noted that some of these children may need a range of services related to crisis and grief counseling and/or services that address anger and motivations around retaliation.

To show the extensive need across families, the CARES administrative team should ensure that paperwork and data reporting clearly document the wide range of needs across co-victims –through specific notes or data forms that have the ability to highlight the need for services and all those affected by the homicide. If the service/performance data do not demonstrate that this need is there, funds for additional staff or services is unlikely to follow.

Recommendation 10: In addition to the AVP office space in West Philadelphia, **establish additional satellite offices throughout the city's neighborhoods most affected by homicide.** Many PCRs suggested that having some satellite offices spread throughout the city, especially in the areas with the highest rates of homicide, would enable them to reach the co-victims more easily. Co-victims would also have access to victim services nearby their homes, if needed. Other PCRs suggested that working from satellite offices would also increase their efficiency, for eliminating, for example, the sometime cumbersome trips to the agency's office in the downtown area of the city (where parking is scarce and expensive). Having additional offices could also help overcome issues related to lack of office space for discussing private information and mechanisms for hiring part-time workers that limited building access or employee payment options, etc.).

Recommendation 11: Partner with organizations that specialize in preventing retaliation. One of the original aims of the CARES program was to prevent retaliatory violence after a homicide. Many of the staff members interviewed were asked about this aspect, and several mentioned experiences where they overheard something or a parent reported to the PCR they were worried that a sibling of the co-victim was angry or interested in retaliation. However, at least a few PCRs stated that they did not quite feel prepared to bring up the likelihood of retaliation or intervene in any way to prevent retaliation. We recommend that CARES partner with organizations like Cure Violence Philadelphia or the Community Crisis Intervention Program (CCIP) which has specialized experience in conflict mediation and may be able to provide training or serve as a referral for CARES staff.

Recommendation 12: Continue to prioritize the hiring of PCRs that represent the diversity of co-victims. CARES staff are sensitive to the need for cultural competency and have

tried to match families to PCRs in a way that will best serve the co-victims. Multiple people interviewed mentioned the need for PCRs that are competent with unique populations, including: people of various faith backgrounds; non-English speaking families; people of diverse gender identity; and young people and their networks.

DATA & EVALUATION

Recommendation 13: Improve processes to streamline data collection and fill gaps in performance measures. The research team was impressed with the PCCD/OVS' requirement that grantees use the ETO software for data collection and reporting. This requirement provides the PCCD with a method to summarize service provision for state-funded victim services across the Commonwealth. The PCCD provides grantees a very detailed manual for ETO and well as training. However, some improvements could be made in ETO that allow grantees to easily add forms and create customized reports that facilitate reporting on a wider range of program outputs and outcomes. For instance a "back-end" improvement to ETO could improve front-end experience. A highly-streamlined, organized, and easy-to-use data management interface in ETO would help CARES staff spend less time on data entry and more time on participants. Many staff members interviewed found data input overly time-consuming, while others found it manageable. CARES should continue to improve its data collection by solidifying procedures, formalizing categories for services and referrals, and training PCRs on data input in ways that improve validity and consistency. To put these recommendations into practice, we recommend hiring a PCR who also possesses data reporting skills and could establish beneficial practices such as quarterly and yearly reports that are more detailed than the stock reports sent to the PCCD. Deciding on a few key program metrics and establishing reliable ways to measure, collect, and communicate the data are essential to a program's long-term success.

Relatedly, CARES could hire a program intern from a local college or university whose role is to develop procedures that allow direct data capture on all aspects of CARES referrals with regard to which service agencies were receiving referrals and enrolling co-victims in services, including completing applications for victim compensation. Follow-ups could be done directly with partner victim services agency to ascertain successes and challenges with regard to co-victim access to and engagement with referral agencies. The intern or someone from CARES staff would first have to make sure that information sharing protocols include using identifying information when talking with/accessing information and data directly from referral agencies.

Recommendation 14: Increase response rate of co-victim exit/satisfaction survey. The research team developed and implemented exit/satisfaction surveys for co-victims to fill-out voluntarily at the conclusion of CARES services. The survey, based on the Empowerment and Satisfaction Questionnaire (ESQ), was designed to obtain more targeted information about the services that CARES provided. Questions on the specific types of services received, including items on details related to applying for victim compensation were added. Hence, the Temple exit survey was a few pages longer than the ESQ-LF (Long Form). The process was developed so that CARES staff (as opposed to the researcher) would provide the co-victim the survey to complete at the end of the services. This was the same process that would have been used with the original ESQ—client self-administration at the conclusion of services. The downside with self-administration of surveys when clients are exiting services is that there is little opportunity for follow-up, unless the survey is administered with an Internet option. The research team did develop an online option. The survey had a very low response rate, with only roughly two dozen

surveys being completed in 2020. We recommend that, in the coming years, CARES determine which "new" survey items would be most important to retain as outcome measures in addition to the main ESQ items, and that a streamlined version of the exit survey be administered with regular follow-up. For more information on the ESQ, see Collins et al., 2008.

Recommendation 15: Use the data and ESQ-LF exit survey results to celebrate programmatic successes. CARES staff should develop new data-related procedures and reporting that routinely highlight the aspects of CARES that are working well and particularly when exit survey results have been strong. This practice will help develop and solidify best practices, build optimism, and help to sustain engagement and morale across staff.

CHAPTER 7: CONCLUSION

One of the main goals of the process evaluation was to determine how faithfully the strategy was implemented according to the logic model designed in partnership with the original proponent/developer of CARES. The logic model is displayed in Figure 2, in Chapter 2. For the most part, the model was implemented as planned with the resources sought being put into place to serve co-victims in the immediate crisis period following the homicide. This in and of itself, can be deemed a success, particularly given the turnover in the leadership of CARES at its inception and the move from its intended implementation within a community-based agency versus now at the DAO. A new CARES Program Director stepped in to implement a vision drawn up by someone else, within a government agency that had amorphous organizational structure in 2018. The new CARES leadership worked diligently to hire staff and draft protocols and procedures, as well as trouble shoot whenever challenges arose. Any changes that were made, were put in place to keep the implementation of CARES moving forward or to overcome unexpected challenges. All changes generally aligned with key outcomes sought.

The two main differences between the logic model and the program as it was implemented on the ground are:

(1) CARES staff are not the ones to notify the next-of-kin that they lost their loved one. Notification is still conducted by police personnel, but as suggested in our recommendations, perhaps a partnership could be developed and new staff positions hired, so a social worker or a counselor could conduct the notification of death, as opposed to law enforcement.

(2) CARES PCRs are not trained to reduce the likelihood that families would retaliate against presumed perpetrators. CARES leaders determined that although this would be a valuable outcome of the work of CARES, the training needed to do this in an appropriate and safe manner is not within the resources that CARES leadership currently has. Leadership staff thought it would be more appropriate to partner with agencies already on the ground who work in the area of conflict mediation. CARES leaders also indicated that if conflict mediation were to be a part of CARES, they would need to change their priorities with regard to hiring and the qualities and traits sought when hiring PCRs. Finding staff who are credible as conflict mediators is not an easy task, and perceptions of credibility and trust would vary greatly across incidents depending on the specifics of the events that led to the homicide.

These “changes” from the original CARES blueprint do not minimize the huge accomplishments and successes of CARES implementation, as documented in an earlier chapter. CARES filled a large hole in the victim services landscape in Philadelphia. Prior to the formation of CARES, outreach to co-victims was inconsistent and the process of accessing services and applying for VCAP was daunting. National and local studies show that the majority of violent crime victims, including co-victims, simply don't know that services are available to them at no cost (Roman et al., 2020). But even those victims who know that services exist may not access them due to a wide range of challenges and barriers. For residents living in neighborhoods characterized by disadvantage and poverty, health inequities have been well-documented. CARES not only opens the door to a host of services, but also provides flexible and reliable

support and encouragement when needed—from staff who draw from their personal experiences. This can lead to greater engagement and satisfaction with services, as well as overall improvements in quality of life. With regard to peer support, although there is little evaluation research on the topic, the research literature suggests that trauma-informed peer support, alone, is a key component that can reduce the use of other formal services—medical, mental health and other social services, ultimately reducing the long-term costs of the harm experienced by survivors of homicide.

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