LOCAL EVALUTION REPORT

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UCDMC Wraparound Hospital-Based Violence Intervention Program

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Executive Summary

Hospital trauma centers are a primary destination for individuals who have experienced violent injury. Healthcare must providers prioritize the treatment of physical wounds but often have limited resources to respond to the enduring psychological and behavioral sequelae associated with violence-related trauma nor the underlying contributors to violence risk. This creates a critical gap in care for violently injured patients, as the social determinants and consequences of violent injury, if left unaddressed, can lead to coping behaviors and survival strategies associated with elevated risk for future violence involvement and injury recurrence, with lasting impacts on health and life chances, particularly for youth and young adults.

To address this gap in care and reduce barriers to recovery, UC Davis Health—the only Level 1 trauma center in Sacramento County—launched the Wraparound Violence Intervention Program ("Wraparound") in 2018, a hospital-based violence intervention program (HVIP) for Sacramento County youth and young adult patients 13-26 years of age who have been injured by community violence (shot, stabbed, or physically assaulted). The program employs nationally certified Violence Prevention Professionals (VPPs) who provide high-quality, trauma-informed, person- and healing-centered outpatient services to violently injured young people through engagement with community partners and community-based resources with the goal of supporting long-term healing, health, and safety.

This Local Evaluation Report (LER)—the result of a multi-year learning and evaluation effort led by researchers at the UC Davis Violence Prevention Research Program in partnership with the Wraparound team—summarizes Wraparound activities from October 1, 2020 through June 30, 2023, and examines effectiveness in meeting the needs of violently injured youth and young adult patients (referred to as "clients" after hospital discharge and program enrollment), affecting change in risk and resilience factors associated with violence, and preventing re-injury. The evaluation focused on the following process and intermediate outcome indicators, which include:

(1) Activities and services provided by three VPPs;
(2) Patient and client eligibility and enrollment data, including:
    a. The number of patients eligible for the program;
    b. The number of completed bedside visits with eligible patients;
    c. The number (and characteristics) of eligible patients that did and did not enroll in the program;
    d. The number (and characteristics) of clients that did and did not complete the program;
(3) The impact (if any) on addressing client needs, including:
    a. The type and frequency of client needs; and
    b. The type and frequency of services received;
(4) The impact (if any) on risk and resilience factors, including:
    a. The type and frequency of client risk factors; and
    b. The type and frequency of client resilience factors;
(5) The impact (if any) on intermediate indicators of client healing and safety, including:
    a. Mental health (PTSD symptoms and depression);
    b. Perceived social support; and
    c. Attitudes towards guns and violence;
(6) The prevention (if any) of violence-related reinjury within 1 year.

The data and methods used to inform the learnings and evaluation findings in this LER include:

- Weekly observations and conversations with VPPs and Wraparound management and leadership staff;
- Descriptive analysis of UC Davis Health trauma registry data;
- Program data and descriptive analysis of client engagements as documented in Wraparound records and activity reporting documents;
- Descriptive analysis of quantitative self-report survey data for Wraparound clients; and
- Qualitative thematic analysis of in-depth, semi-structured, one-on-one interviews with Wraparound clients.

Key learnings and evaluation findings reflect the above mixed methods approach, with particular emphasis on the process evaluation, which was designed to understand and inform procedures for promoting program partnerships, innovation, and improvement. Ultimately, Wraparound successfully provided intensive case management, relationship-based mentoring, financial and resource assistance, and emotional and social support to more than 50 clients during the three-year project period, and achieved recognition within and beyond the UC Davis Health system for helping to reframe community violence as a preventable public health issue that can be transformed through trauma-informed and patient- and healing-centered care in partnership with local communities.

> *"The program helped me a lot, after my incident, it helped me in my trauma, how to heal, how to cope with it, how to not feel anxious. There's nothing that they couldn't help me with. When I had something, like, a need or a help with something, there was always something that they were able to do. Even if it was just a little bit, there was always something that they were able to help me with."*
>
> *-Wraparound Client (Z102)*

> *"When she [Wraparound VPP] came into the hospital and I was sitting there in the hospital bed and there were – she was telling me what the program was. And like I said, with me going through the incident that I went through, I'm, like, 'Well, this sounds like it will be a good program for me to join, with me going through the incident that I'm going through.' And I knew I wasn't gonna be able to deal with all this on my own, so, it gravitated me towards her, and just her energy and personality, how she was in the hospital, talking to me, it gravitated me wanting to give it a try."*
>
> *-Wraparound Client (X666)*

Project Background

Community violence—defined as intentional acts of interpersonal violence that occur between unrelated individuals, usually outside the home and in response to routine disputes—is a significant public health problem that disproportionately impacts youth and young adults in marginalized, minoritized, and low-wealth communities. In California, in 2020, homicide was the most common cause of death among Black young people and the second leading cause among Latinx young people 13-26 years of age; the homicide rate per 100,000 among Black (59.8) and Latinx (10.6) young people was 16X and 3X higher, respectively, than that of white peers (3.7).[1] This uneven burden was exacerbated amid the COVID-19 pandemic, which intensified inequitable conditions at the root of community violence, including poverty, unemployment, and concentrated disinvestment in basic necessities such as food, housing, and schools. With a 2020 homicide rate (7.9/100,000) that was 30% higher than the state overall (6.0/100,000), Sacramento County, and particularly 13-26-year-olds, shouldered an uneven share of this burden: the homicide rate among young people in Sacramento County (13.4/100,000) was nearly 50% higher than the State rate (9.0/100,000).[2] Yet death captures only a fraction of the impact of community violence. For every 2,000 homicides in California, there were approximately 11,650 hospitalizations and 89,570 emergency department (ED) visits for nonfatal assault injuries.[2]

Research has found substantial overlap exists between violence-related victimization and offending,[3] and violent injury is a significant risk factor for subsequent violence involvement and re-injury,[4,5] with injury recurrence rates as high as 62% in communities highly impacted by the structural and social determinants of violence.[6] Trauma centers are a primary destination for individuals who are injured due to community violence. Healthcare providers must prioritize recovery from physical wounds but often have limited resources to address the enduring psychological and behavioral sequelae associated with violent injury (e.g., aggression, posttraumatic stress symptoms, and other mental health problems such as depression and anxiety) nor the underlying contributors to violence risk, such as disconnection from the interpersonal and community-based supports (e.g., in housing, education, occupation, and criminal-legal sectors) that are critical for preventing violence and structuring safety and health.[7-97-9] This creates a critical gap in care and a missed opportunity for violence prevention, as the broader psychosocial determinants and consequences of violent injury, if left unaddressed, can lead to coping behaviors and survival strategies associated with elevated risk for future violence involvement and injury recurrence, with lasting impacts on health and life chances, particularly for youth and young adults.[9,10]

To address these gaps in care and reduce barriers to recovery, UC Davis Health—the only verified Level 1 adult and pediatric trauma center in Sacramento County and the surrounding inland Northern California region—launched the Wraparound Violence Intervention Program ("Wraparound") in 2018. This hospital-based violence intervention program (HVIP) serves youth and young adult victims of community violence-related injury who are: 1) 13-26 years of age; 2) admitted to the hospital trauma service as patients at UC Davis Health; and 3) residents of Sacramento County, with particular emphasis on patients who reside in any of the 15 zip codes (comprising seven "neighborhoods") that have been identified by the Black Child Legacy Campaign (BCLC), a local community-driven public health initiative, as having among the highest number of African American child deaths in the region, including from third-party homicide.[11] Youth and young adult patients who satisfy the above criteria but who are in law enforcement or

corrections custody, are victims of domestic violence or child abuse, or have self-inflicted injuries are ineligible for the program.

Although specifics vary across programs, the general HVIP model is based on four "best practice" steps: (1) an initial assessment of a patient's basic and psychosocial needs and safety, (2) planning to address those needs, (3) identification of allied agencies responsible for post-discharge services, and (4) coordination to ensure service delivery and to mitigate gaps in care.[12,13] HVIPs have a strong basis in evidence, with demonstrated effects across a range of individual-level outcomes, including reducing injury recidivism, preventing entry or re-entry into the criminal legal system,[14-16] identifying and meeting client needs,[17-19] and improving attitudes about violence and aggression.[17,20] Wraparound additionally applies a trauma-informed treatment framework, recognizing the ways in which past trauma may continue to affect violently injured patients and their recovery. The program thus incorporates core principles of safety, trustworthiness, choice, collaboration, and empowerment when supporting individuals in meeting their goals for healing and safety through an aligned para-professional approach, defined as "a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources."[21]

At the heart of this work are Wraparound's nationally certified Violence Prevention Professionals (VPPs) who deliver trauma-informed, person- and healing-centered outpatient services to violently injured young people in Sacramento County through engagement with community partners and community-based resources. The overarching goal of these services is to support long-term healing, health, and safety. The more specific objectives of Wraparound's services are to connect and transition patients (identified as "clients" after hospital discharge and program enrollment) to local resources and natural community-based supports. To these ends, each client is matched with one of the program's three VPPs who completes the program enrollment process by meeting with the client in-person within approximately one week of hospital discharge. The aims during this initial post-discharge meeting are to establish a safety

Violence Prevention Professionals (VPPs)

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plan, identify immediate and ongoing basic needs, and initiate appropriate referrals to mental health resources and other acute social supports. The initial intake assessment also includes preliminary identification of clients' short- and medium-term goals related to education, employment, training, and overall well-being.

Wraparound serves clients for up to approximately 12 months after hospital discharge. The case management process and services offered are unique, based on client needs and priorities identified on intake and reevaluated at 3, 6, 9 and 12 months of program enrollment, but generally encompass relationship-based mentoring and advocacy, assistance with applications for Crime Victim Compensation, referrals to culturally affirming mental health care and substance abuse resources, and connection to and help navigating supportive services for housing, education, employment, and other resources necessary for recovery and safe re-integration into the community. For clients who are under 18 years of age or who have children under 18, Wraparound case management is often collaborative, facilitated by formal partnerships with BCLC-affiliated community-based organizations, called Community Incubator Leads (CILs), that coordinate and implement neighborhood services, and further supported through weekly Multi-Disciplinary Team (MDT) meetings involving Wraproud VPPs and staff from different youth and family serving agencies such as Probation, Job Corps, and the Department of Human Assistance.

To expand understanding of and systematically monitor areas important to making Wraparound a success, a mixed methods process and intermediate outcome evaluation of the program was initiated in 2020 as part of an existing partnership with researchers from the UC Davis Violence Prevention Research Program (VPRP), a multidisciplinary program of research and policy development focused on the causes, consequences, and prevention of violence. The purpose of the evaluation has been four-fold. It (1) documents Wraparound activities from October 1, 2020 through June 30, 2023, and examines effectiveness in (2) meeting the needs of violently injured youth and young adult clients, (3) affecting change in risk and resilience factors associated with violence, and (4) preventing additional harm, including re-injury. The evaluation was designed not as an external instrument of compliance and discipline, but rather to understand and inform internal procedures for promoting program partnerships, innovation, and improvement.[22]

Process Evaluation Method and Design

The process evaluation was guided by the following overarching question, which correlates with Wraparound Workplan Goal #1:

> *Is Wraparound being implemented as intended, including whether the program is reaching its target population and providing the expected range and amount of support and services to clients?*

More specific process evaluation questions included: Who participates in Wraparound? Is there variation by sociodemographic characteristics? Why do clients enter and leave the program? What is the range and amount of client support and service needs?

The metrics used to inform these questions included:

- Number of eligible patients
- Number of referrals
- Number of completed bedside visits
- Number of enrolled clients

- Basic sociodemographic data
- Program completion rate
- Early attrition rate
- Reasons for entering and leaving the program
- Facilitators and barriers to enrollment and engagement
- Frequency of risk factors by type
- Frequency of service needs by type
- Frequency of resilience factors by type
- Time expenditure per client
- Facilitators and barriers to supporting and serving client needs

Data for the process evaluation came from two primary sources:

1) Wraparound records and activity reporting documents. These quantitative data are recorded—usually by the VPPs—during the normal course of Wraparound operations and include: identification (by VPPs via the electronic medical record [EMR] system) and referral (by other hospital staff) of patients who meet Wraparound eligibility requirements; date, time, and location of all contacts between the VPPs and eligible patients/clients, from the initial bedside visit to final closeout; client intake questionnaires assessing basic sociodemographic information, as well as risk, needs, and strengths; individual client case management plans; ongoing case management notes; and client closeout forms.

Additionally, because numbers alone do not capture the full spectrum of Wraparound activities, data also came from:

2) Semi-structured interviews with Wraparound clients. These qualitative data are based on interviews conducted with 13 consented clients who had been enrolled in Wraparound for a minimum of one month and lasted between 60-90 minutes. Interviews were conducted by a VPRP researcher who has extensive qualitative training and experience. A VPP was also present during the interviews to maximize client comfort while accelerating the rapport building process with the interviewer.

The process analysis employed a concurrent nested mixed methods evaluation design. This approach allowed the quantitative data to guide evaluation objectives while embedding (or "nesting") the qualitative data to provide a more in-depth exploration of clients' perceptions of and experience in Wraparound. Analyses proceeded as follows:

1) Wraparound records and activity reporting documents. Data abstraction forms were created to compile quantitative data from program records and activity reporting documents. The data from these forms was analyzed in Excel and Stata software using standard descriptive techniques to document baseline conditions (e.g., client-identified needs), track implementation processes, and capture change measures (e.g., program enrollment, retention/early attrition, and completion). Data abstraction and review of these program performance measures was ongoing with review of summary assessments at regular intervals to inform and adjust program activities where needed.

2) Semi-structured interviews with Wraparound clients. Interviews were audio recorded, transcribed verbatim, and reviewed for accuracy. Transcripts were coded and analyzed using thematic analysis. Researcher triangulation was used to ensure rigor. A codebook was

developed based on both deduction (a priori themes) and induction (emergent concepts found in the data) using an iterative process consisting of independent coding and weekly research meetings to validate initial codes. Dedoose qualitative software was used to code, categorize, and manage data. Approximately 30 codes and 10 subcodes were applied, including clients' decisions to participate, perceptions of success, social justice, fears, life [before/after] injury, life stressors, trauma, safety, and program recommendations.[i]

Outcome Evaluation Method and Design

The intermediate outcome evaluation was guided by the following overarching questions, which correlate with Wraparound Workplan Goals #2 and #3:

To what extent is Wraparound meeting the needs of victims of violence and affecting change in the presence or absence of risk and resilience factors associated with violence?

What are the impacts of participating in Wraparound on subsequent risk for violent re-injury within 1 year of program enrollment?

More specific outcome evaluation questions included: Do clients report progress towards meeting their basic needs and service benchmarks and goals? Do clients report any changes in their mental health, perceived social support, or attitudes towards guns and violence? Do clients report changes in risk and protective factors for violence? How do clients define program success? Are they satisfied with the program? Are rates of re-injury or death, among clients relatively high, low, or about average?

The metrics used to inform these questions included:

- Number of clients who receive injury follow-up medical care
- Number of clients who obtain Victims of Crime financial support
- Number of clients who secure safe housing
- Number of clients who return to school (younger clients) or employment
- Changes in mental health (PTSD, depression)
- Changes in social support
- Changes in attitudes toward guns and violence
- Perceptions of satisfaction with the program
- Perceptions of progress/success
- Re-injury counts

Data for the outcome evaluation came from three primary sources:

1) Client surveys. The VPPs administered a series of validated surveys to clients at intake and approximately 3, 6, 9 and 12 months of program enrollment, including: (1) the Post-Traumatic Stress Disorder (PTSD) Checklist-Civilian Version (PCL-C), (2) the Patient Health Questionnaire 9 (PHQ-9) for measuring depression, (3) the Multidimensional Scale of Perceived Social Support (MSPSS), and (4) the Attitudes Toward Guns and Violence Questionnaire (AGVQ). Surveys were administered in the field through the Research Electronic Data Capture (REDCap) software application using individual electronic devices.

[i] Consistent with past research,[23] quotations used in this report have been adapted to remove *ums* and *ahs* and other speech patterns that might distract from, but whose removal does not alter, the underlying meaning of the material.

2) Wraparound records and activity reporting documents. These quantitative data are recorded—usually by the VPPs—during the normal course of Wraparound operations and include: identification (by VPPs via the electronic medical record [EMR] system) and referral (by other hospital staff) of patients who meet Wraparound eligibility requirements; date, time, and location of all contacts between the VPPs and eligible patients/clients, from the initial bedside visit to final closeout; client intake questionnaires assessing basic sociodemographic information, as well as risk, needs, and strengths; individual client case management plans; ongoing case management notes; and client closeout forms.

Similar to the process evaluation, because numbers alone do not capture the full spectrum of Wraparound outcomes, additional data included:

3) Semi-structured interviews with Wraparound clients. These qualitative data are based on interviews conducted with 13 consented clients who had been enrolled in Wraparound for a minimum of one month and lasted between 60-90 minutes. Interviews were conducted by a VPRP researcher who has extensive qualitative training and experience. A VPP was also present during the interview to maximize client comfort while accelerating the rapport building process with the interviewer.

The outcome analysis employed a concurrent nested mixed-methods evaluation design, similar to the process analysis. Analyses proceeded as follows:

1) Client surveys. Survey scores and sub-scores were abstracted from REDCap and tabulated for each client at every wave (intake, 3, 6, 9 and 12 months) based on standard guidance for each validated instrument. Analyses relied on standard descriptive techniques to examine the frequency of specific symptoms (e.g., PTSD, depression) and violence-related risk and resilience factors (e.g., attitudes toward guns and violence, perceived social support) within individual participants at single points-in-time and over the course of program participation.

2) Wraparound records and activity reporting documents. The research team created data abstraction forms to systematically compile quantitative data from program records and activity reporting documents. The data from these forms was analyzed in Excel and Stata software using standard descriptive techniques to document injury recurrence.

3) Semi-structured interviews with Wraparound clients. Interviews were audio recorded, transcribed verbatim, and reviewed for accuracy. Transcripts were coded and analyzed using thematic analysis. Researcher triangulation was used to ensure rigor. A codebook was developed based on both deduction (a priori themes) and induction (emergent concepts found in the data) using an iterative process consisting of independent coding and weekly team meetings to validate initial codes. Dedoose qualitative software was used to code, categorize, and manage data. Approximately 30 codes and 10 subcodes were applied, including clients' decisions to participate, perceptions of success, social justice, fears, life [before/after] injury, life stressors, trauma, safety, and program recommendations.

For both the process and outcome evaluation data and analysis, clients were assigned unique identifiers to label all data collection instruments/interviews. An electronic, password protected master key with the coded study identifiers was created to protect clients' identifiable information.

Evaluation Results

Between October 1, 2020 and June 30, 2023 (hereafter, "the project period"), UC Davis Health treated 572 violently injured patients who were between 13-26 years of age. Of those, 138 (24%) patients met additional inclusion criteria for Wraparound eligibility. Data on demographic characteristics (age, sex, race and ethnicity) and type of violence-related injury for patients who were eligible and not eligible for Wraparound are presented in Table 1.

Table 1. Violently Injured Patients Ages 13-26, UC Davis Medical Center, UC Davis Health, 10/1/20-6/30/23

	Total (N=572)	Eligible (n=138)	Not Eligible (n=434)
Age (years; mean, SD)	20.7 (±3.7)	20.7 (±3.8)	20.7 (±3.6)
Sex (N, %)			
Male	453 (80%)	119 (86%)	334 (77%)
Female	119 (20%)	19 (14%)	100 (23%)
Race and Ethnicity (N, %)			
American Indian or Alaska Native	6 (1%)	1 (1%)	5 (1%)
Asian			
Japanese	1 (0.5%)	0	1 (1%)
Other	3 (0.5%)	1 (1%)	2 (1%)
Black or African American	207 (36%)	67 (49%)	140 (32%)
Hispanic, Latino, or Spanish	161 (28%)	33 (24%)	128 (30%)
Middle Eastern or North African	14 (3%)	6 (4%)	8 (2%)
Native Hawaiian or Other Pacific Islander	11 (2%)	1 (1%)	10 (2%)
White	111 (19%)	19 (14%)	92 (21%)
Other or Multiracial	58 (10%	10 (7%)	48 (11%)
Violent Injury Type (N, %)			
Assault (non-penetrating)	207 (36%)	22 (16%)	185 (43%)
Stab	75 (13%)	20 (14%)	56 (13%)
Gunshot	261 (46%)	96 (69%)	165 (38%)
Abuse	28 (5%)	0	28 (6%)

Of 13-26-year-old violently injured patients treated at UC Davis Medical Center during the project period, the average age was 20.7 years. There was no difference in the average age of patients based on eligibility for Wraparound. Over 85% of all program-eligible violently injured patients were BIPOC/people of color, with Black and Hispanic, Latino, or Spanish individuals accounting for 49% and 24% of the total eligible patients, respectively. Of patients eligible for Wraparound, 86% (119) were male and 14% (19) were female. Of those who were not eligible, 77% (334) were male and 23% (100) were female. Individuals with gunshot wounds represented 46% of total violently injured patients but nearly 70% of all patients eligible for Wraparound. The reasons why patients were not eligible for Wraparound are shown in Table 2.

Table 2. Exclusion Criteria of Ineligible Patients, 10/1/20-6/30/23 (N=434)

Emergency Department (ED) patient	190 (44%)
Resides outside Sacramento County	152 (35%)
Deceased before contact	26 (6%)
Law enforcement/corrections custody	17 (4%)
Domestic violence/Child abuse	41 (9%)
Other	8 (2%)

Of patients who were not eligible due to program exclusion criteria, 44% (190) were treated and discharged from the emergency department (ED) and therefore not admitted to the trauma service. Another 35% (152) of patients lived outside of Sacramento County, and 9% (41) involved

cases of domestic violence or child abuse. Enrollment status of the eligible patients is presented in Table 3.

Table 3. Enrollment Status of Eligible Patients, 10/1/20-6/30/23 (N=138)	
Enrolled	42 (31%)
Refused (in person contact, refused services)	14 (10%)
Missed and no referral (no in person or phone contact)	35 (25%)
Weekend admission/discharge, no VPP coverage	*19 (54%)*
No VPP available prior to discharge (patient typically discharged within 24 hours of admission)	*13 (37%)*
Other (e.g., patient information incorrect and identified as eligible only after discharge)	*3 (9%)*
Lost contact (no contact after initial inpatient bedside visit)	46 (34%)
Contacted after end of project period	1 (<1%)

Of patients who were eligible for Wraparound, 31% enrolled; 25% were missed with no referral by medical center staff to the program; 34% had no contact following the initial bedside engagement (meaning they were discharged before enrollment was offered); and 10% refused participation. Of the 25% of patients who were eligible but missed with no contact made, over 90% were the result of no Wraparound staff coverage or VPP availability during the patients' admission to the hospital. More specifically, 54% of eligible patients were missed due to no weekend staff coverage; this gap has since been addressed with subsequent funding support from the California Board of State and Community Corrections, California Violence Intervention and Prevention (CalVIP) Grant Program.

The qualitative interviews illuminated the critical importance of the VPPs' ability to build genuine rapport and relationship with clients at the bedside. Clients highlighted the importance of the connection they felt with the VPP as a motivating factor in their decision to enroll. For example, one client commented:

> *"When she [Wraparound VPP] came into the hospital and I was sitting there in the hospital bed and there were – she was telling me what the program was. And like I said, with me going through the incident that I went through, I'm, like, 'Well, this sounds like it will be a good program for me to join, with me going through the incident that I'm going through.' And I knew I wasn't gonna be able to deal with all this on my own, so it gravitated me towards her, and just her energy and personality, how she was in the hospital, talking to me, it gravitated me wanting to give it a try." (X666)*

That same client, when asked why they opted to enroll, noted that the VPP's energy was positive and helpful, in contrast with their experience with police who visited them in the hospital:

> *"I decided to participate because I felt like they were helpful – or her [Wraparound VPP] presence was very, like, it felt positive and it didn't feel like, like how the police felt, like, really negative. So I felt like she was there to help, so that's why I felt, like, 'Yeah, I should, you know.'" (X666)*

Another client intimated that not only did they feel a connection with the VPP who visited their hospital bedside, but also that the VPP's bilingual skills were beneficial for communicating with the client's mother, who was the client's main caregiver during their recovery:

> *"As soon as like she [Wraparound VPP] came and talked to me, I like felt a connection and I was like, okay, this is someone I can like trust and talk to. And at the time, you know, I had my daughter who was still like in like diapers and stuff, and I can't really remember*

too good, but I knew like she was staying connected with my mom because my mom don't really speak English, so she helped a lot with that, too, yeah." (A777).

The demographic and injury characteristics of eligible patients who did and did not enroll in Wraparound during the project period are shown in Table 4.

Table 4. Demographic Characteristics of Eligible Patients by Enrollment Status, 10/1/20-6/30/23

	Enrolled (N=42)	Not Enrolled (N=96)	Total (N=138)
Age (years; mean, SD)	20.1 (± 3.8)	20 (±3.9)	20.6 (± 3.8)
Sex (N, %)			
Male	34 (81%)	85 (88%)	119 (86%)
Female	8 (19%)	11 (12%)	19 (14%)
Race and Ethnicity (N, %)			
American Indian or Alaska Native	1 (2%)	0	1 (1%)
Asian			
Other	0	2 (2%)	2 (2%)
Black or African American	25 (60%)	42 (44%)	67 (49%)
White	4 (10%)	15 (16%)	19 (14%)
Hispanic, Latino, or Spanish	8 (19%)	24 (26%)	33 (24%)
Middle Eastern or North African	1 (2%)	4 (4%)	5 (4%)
Other or Multiracial	3 (7%)	7 (7%)	10 (7%)
Injury Type (N, %)			
Assault (non-penetrating)	6 (14%)	16 (16%)	22 (16%)
Stab	2 (5%)	18 (19%)	20 (15%)
Gunshot	34 (81%)	62 (65%)	96 (69%)

The demographic and injury characteristics of all clients served, including those who were enrolled prior to the start of the project period, are shown in Table 5, stratified by year of enrollment.

Table 5. Demographic Characteristics of Enrolled Clients by Year, 10/1/20-6/30/23

	Year 0 (N=15)	Year 1 (N=11) (10/1/20-6/30/21)	Year 2 (N=16) (7/1/21-6/30/22)	Year 3 (N=15) (7/1/22-6/30/23)	Total (N=57)
Age (years; mean, SD)	21.4 (±3.1)	21.1 (±3.6)	19.4 (±3.7)	20.2 (±3.9)	20.5 (±3.6)
Sex (N, %)					
Male	10 (67%)	10 (91%)	12 (75%)	13 (87%)	45(79%)
Female	5 (33%)	1 (9%)	4 (25%)	2 (13%)	12 (21%)
Race and Ethnicity (N, %)					
Asian					
Other	2 (13%)	0	0	0	2 (3%)
Black or African American	8 (53%)	8 (73%)	8 (50%)	9 (60%)	33 (58%)
Hispanic, Latino, or Spanish	3 (20%)	2 (18%)	5 (31%)	4 (27%)	14 (25%)
Middle Eastern or North African	0	0	1 (6%)	0	1 (2%)
White	1 (7%)	1 (9%)	1 (6%)	2 (13%)	5 (9%)
Other or Multiracial	1 (7%)	0	1 (6%)	0	2 (3%)
Injury Type (N, %)					
Assault (non-penetrating)	2 (13%)	0	3 (19%)	1 (7%)	6 (11%)
Stab	2 (13%)	0	0	4 (27%)	6 (11%)
Gunshot	11 (73%)	11 (100%)	13 (81%)	10 (66%)	45 (78%)

Note: Year 0 includes clients who were already enrolled in Wraparound on 10/1/20 but who continued to receive services during the initial project period.

Wraparound served 57 clients during the project period, including 15 clients who were already enrolled in the program when the project period began. 79% (45) of clients were male; 21% (12) were female. 78% of all clients had been injured by firearms.

Not shown in the above table are selected socioeconomic indicators that were also documented at program enrollment:

- 70% of enrollees (40) were unemployed and 18% (10) were employed; the remaining 7 had unknown employment status.
- 33% (19) had graduated from high school (HS) or completed their GED; 30% (17) had not completed HS/GED; and 9% (5) had completed some college but were not presently enrolled.
- 46% (26/57) reported living with at least one parent at the time of injury; 19% (11) reported living independently; and 7% (4) reported being unstably housed.
- 21% (12) were on Medi-Cal, and 5% (3) were uninsured.

Over the project period, Wraparound served an average of 14 clients per year. The average age of Wraparound clients across the project period was 20.5 years. There were 17 clients who were 18 years old or younger at the time of their focal injury: 3 were under 18 years old at the start of the project period: 2 in Year 1; 7 in Year 2; and 5 in Year 3 (not shown). The number of clients with stab wounds increased noticeably in Year 3 of the project period, from 0 in Years 1 and 2 to 27% (4) of clients served in Year 3.

Detailed characteristics of clients by program completion status are shown in Table 6.

Table 6. Demographic Characteristics of Clients by Program Completion Status, 6/30/23

	Active (n=6)	Completed (n=23)	Dropped (n=5)	Incarcerated (n=2)	Lost (n=12)	Withdrew (n=8)	Other (n=1)	Total (n=57)
Age (years; mean, SD)	17.0 (±3.0)	20.5 (±3.7)	19.8 (±3.6)	22.0 (±2.8)	22.5 (±3.0)	20.0 (±3.8)	20.0 (n/a)	20.5 (±3.6)
Sex (N, %)								
Male	4 (67%)	17 (74%)	4 (80%)	2 (100%)	11 (92%)	6 (75%)	1 (100%)	45 (79%)
Female	2 (33%)	6 (26%)	1 (20%)	0	1 (8%)	2 (25%)	0	12 (21%)
Race and Ethnicity (N, %)								
Asian								
Other	0	2 (9%)	0	0	0	0	0	2 (4%)
Black or African American	3 (50%)	13 (57%)	3 (60%)	2 (100%)	8 (67%)	4 (50%)	0	33 (58%)
Hispanic, Latino, or Spanish	2 (33%)	4 (18%)	0	0	3 (25%)	4 (50%)	1 (100%)	14 (25%)
Middle Eastern or North African	0	1 (4%)	0	0	0	0	0	1 (2%)
White	1 (17%)	2 (9%)	2 (40%)	0	0	0	0	5 (9%)
Other or Multiracial	0	1 (4%)	0	0	1 (8%)	0	0	2 (4%)
Injury Type (N, %)								
Assault (non-penetrating)	1 (17%)	4 (17%)	0	0	1 (8%)	0	0	6 (11%)
Stab	1 (17%)	2 (9%)	0	0	2 (17%)	1 (13%)	0	6 (11%)
Gunshot	4 (67%)	17 (74%)	5 (100%)	2 (100%)	9 (75%)	7 (88%)	1 (100%)	45 (79%)
Primary Contact (N, %)								
Spouse/Partner	0	4 (17%)	0	1 (50%)	1 (8%)	0	0	6 (10%)
Mother	4 (67%)	11 (48%)	3 (60%)	1 (50%)	7 (58%)	6 (75%)	1 (100%)	33 (58%)
Father	0	2 (9%)	1 (20%)	0	0	0	0	3 (5%)
Grandparent	0	2 (9%)	0	0	1 (8%)	0	0	3 (5%)
Legal Guardian	0	0	1 (20%)	0	0	0	0	1 (2%)
Other	2 (33%)	4 (18%)	0	0	3 (25%)	2 (25%)	0	11 (19%)

Relationship Status (N, %)								
Married/Partnered	0	9(39%)	1 (20%)	2 (100%)	4 (33%)	3 (38%)	0	19 (33%)
Single	6 (100%)	14 (61%)	4 (80%)	0	7 (58%)	5 (62%)	1 (100%)	37 (65%)
Unknown	0	0	0	0	1 (8%)	0	0	1 (2%)
Past Violent Injury (N, %)								
No	3 (50%)	21 (92%)	4 (80%)	1 (50%)	7 (58%)	4 (50%)	1 (100%)	41 (72%)
Yes	3 (50%)	2 (8%)	1 (20%)	1 (50%)	5 (42%)	4 (50%)	0	16 (28%)
Children (N, %)								
0	6 (100%)	15 (65%)	5 (100%)	1 (50%)	8 (67%)	6 (75%)	1 (100%)	42 (74%)
≥1	0	8 (35%)	0	1 (50%)	4 (33%)	2 (25%)	0	15 (26%)

By the end of the project period, 23 clients had completed Wraparound programing, and 6 clients were still active. Two clients were incarcerated during program enrollment. Most clients (58%) listed their mother as their primary contact. Most clients were single (65%) and did not have children (74%). Males were overrepresented in the number of clients who were lost to follow-up. Notably, clients who advanced to program completion were substantially more likely to have never been violently injured prior to enrollment than clients who did not complete.

Interviews with clients highlighted the disruptive and traumatizing impact of violent injury on their emotional health and the significance of mental health support, in addition to aid in physical recovery:

> *"But now it's like, now I can't do nothing. Like I can't go to work and live like what I used to because my leg. But I hate sitting at home now. I want to go to work but I can't." (G318)*

> *"I was just worried, like, 'Oh, my god, am I gonna, gonna be able to work?' or, 'What, what is, what is the, the next few months gonna look like for me? Am I gonna be struggling or am I gonna be okay?'" (Z102)*

Of the 8 clients who voluntarily withdrew from the program, according to VPP case notes, many determined that they no longer needed program services or did not have the capacity to participate due to factors such as moving or obtaining employment; one client stated that they *"did not want to relive the traumatic incident any longer."* The 5 clients who were dropped from the program had their cases closed by the VPPs due to a lack of client engagement following initial intake and before the clients had set or completed goals. There were 12 clients lost to follow-up, meaning that the VPP closed their cases due to inability to contact the client post-enrollment and goal setting and after multiple attempts to reach them. Per case notes, a number of these clients completed at least some of their self-identified goals, suggesting that the client may have determined that the program was no longer necessary.

Overall, case notes indicated that of the 51 clients who received services during the project period (excluding the 6 still active clients):

- Nearly half (47%) had achieved at least 80% and the plurality (25%) had achieved 100% of their self-identified goals.

Among the 23 clients who completed the program:

- 78% had achieved at least 80% and more than 1 in 3 (35%) had achieved 100% of their self-identified goals.

The total amount of client engagements during the project period is shown in Table 7.

Table 7. Client Engagement by Program Completion Status, 6/30/23								
	Active (n=6)	Completed (n=23)	Dropped (n=5)	Incarcerated (n=2)	Lost (n=12)	Withdrew (n=8)	Other (n=1)	Total (n=51)
Total Weeks Enrolled (mean, SD)	n/a	56.3 (14.0)	29.4 (16.7)	27.5 (27.6)	35.3 (14.1)	21.9 (13.8)	18.0 (n/a)	41.5 (13.8)
Face-to-Face Case Management (hours; mean, SD)	n/a	182.4 (512.6)	10.0 (7.9)	539.5 (758.7)	186.5 (281.3)	5.0 (3.9)	9.8 (n/a)	149.3 (396.4)
Phone or Text Case Management (hours; mean, SD)	n/a	69.2 (199.7)	6.0 (5.4)	268.5 (376.9)	65.1 (112.9)	2.6 (1.7)	1.0 (n/a)	58.0 (160.8)

On average, clients who completed the program received 56 weeks of VPP services, including 182 hours of face-to-face and 69 hours of phone/text message case management. Notably, whereas clients who became incarcerated during program enrollment received services for roughly half as long (only 28 weeks, on average), their engagement while enrolled was particularly intensive, involving, on average, 540 hours of face-to-face and 269 hours of phone/text message case management.

The qualitative interviews revealed that client engagement and participation were heavily dependent upon the genuine relationship and rapport built with the VPP, as well as the consistency of VPP contact:

> *"It felt like it was more like a – I had mentors guiding me all the time. You know, at the time, I was very young and immature, and still, you know, figuring life out. So I feel like they [Wraparound VPPs] helped me a lot in maturing and my resources, how there is resources, and like that." (Z102)*

> *"And he [Wraparound VPP], he's a down, down to earth person. I enjoy my interactions with him, so I just, you know – he obviously cares about his job, more than just a paycheck. He's always been checking up on me and stuff, every few days or whatever, few weeks… [if] we haven't interacted in a while, he wanna see how I'm doing… he's a people person, really. [Laughs] The caring about my situation, and just be, you know, being real about, genuine about caring about my situation – every time, every time I ask him for help with something, he always says, 'How?' and you know, he tries to help me the best way he can." (A982)*

> *"They [Wraparound VPPs] always had everything, like, if I had a question or I needed help with something, they would – she would help me and figure out how she could help me." (Z102)*

The services regularly offered or provided by VPPs to clients are shown in Table 8, categorized by program completion status.

Table 8. Services Offered and/or Provided to Clients by Program Completion Status, 6/30/23								
	Active (n=6)	Completed (n=23)	Dropped (n=5)	Incarcerated (n=2)	Lost (n=12)	Withdrew (n=8)	Other (n=1)	Total (n=57)
Mental Health (N, %)								
No	1 (17%)	5 (22%)	2 (40%)	1 (50%)	1 (8%)	2 (25%)	0	12 (21%)
Yes	5 (83%)	17 (74%)	3 (60%)	1 (50%)	10 (83%)	6 (75%)	1 (100%)	43 (75%)
Conflict Resolution (N, %)								
No	0	2 (9%)	3 (60%)	1 (50%)	1 (8%)	2 (25%)	0	9 (16%)
Yes	6 (100%)	20 (87%)	2 (40%)	1 (50%)	10 (83%)	6 (75%)	1 (100%)	46 (81%)
Life Skills (N, %)								
No	0	0	1 (20%)	1 (50%)	0	2 (25%)	0	4 (7%)

Yes	6 (100%)	22 (96%)	4 (80%)	1 (50%)	1 (92%)	6 (75%)	1 (100%)	51 (89%)
Mentoring (N, %)								
No	0	0	1 (20%)	1 (50%)	0	1	0	3 (5%)
Yes	6 (100%)	22 (96%)	4 (80%)	1 (50%)	11 (92%)	7 (87%)	1 (100%)	52 (91%)
Housing Resources (N, %)								
No	5 (83%)	10 (43%)	3 (60%)	0	5 (42%)	6 (75%)	0	29 (51%)
Yes	1 (17%)	6 (26%)	1 (20%)	1 (50%)	3 (25%)	1 (12%)	0	13 (23%)
Legal Assistance (N, %)								
No	4 (67%)	10 (43%)	4 (80%)	1 (50%)	4 (33%)	7 (87%)	0	30 (53%)
Yes	2 (33%)	4 (17%)	0	0	4 (33%)	0	0	10 (17%)
Note: Percentages may not sum to 100% due to missingness.								

The services most frequently offered or provided to clients were mentoring (91%), life skills (89%), conflict resolution (81%), and mental health services (75%).

In the qualitative interviews, some clients noted that they benefited from the VPP's expert knowledge of navigating the health system and facilitating the clients' physical recovery needs:

> *"It's been, having an individual [Wraparound VPP] to talk to rather than you know, calling it, calling the hospital. Half the time you get an automated, you get an automated line or you get a receptionist who doesn't know exactly who you are. Doesn't know what you're trying to get to. Having an individual that I can talk to who is an insider on the healthcare side can really help. It's like having, when you're in school, like a counselor or somebody who can help you with scheduling and help you organize, keep yourself on track academically. It's like that. And I really appreciate that." (R772)*

> *"She [Wraparound VPP] actually helped me get a lot of stuff that I needed, which was like my medical records and stuff like that. And she also helped me connect with the doctors. I was able to meet the doctors who saved my life." (W636)*

Others commented on how the program assisted with various needs (transportation, financial, emotional support, etc.) during their recovery, which helped to alleviate additional stress and worry related to not having basic needs met while also managing the physical and emotional consequences of violent injury:

> *"So, pertaining my situation, with me being stabbed in my arm, I couldn't drive, and I had to go to the doctor's a lot, I had to do physical therapy. So the doctor – I couldn't drive, so you guys [Wraparound] ordered me Lyfts, you know, got me there and got me back, got me early, never was late. And that really helped me a lot where I didn't have to look for rides, because I was already dealing and having a lot of emotions with dealing with my incident. So, I didn't wanna have to deal with extra stress, so that helped me out a lot with being able to get to my doctor's appointments, cause those were very needed, you know? So, that was a good place in the program." (X666)*

> *"Well, helping me find at the situation – well, at the moment, I was having this situation where, with my finances and stuff, and me not being able to move on my leg and working and stuff like that. I didn't know if I was gonna be able to work, at the time. So the victim of crime [compensation] and that situation, like, even though I could've done it by myself, and probably found a way to get it done, it was very helpful, in a way, cause I didn't know nothing about it. And my family didn't really have time to help me with it, so that was another thing, too, that caught my attention." (W636)*

> *"The needs that I would come – well, the ones that I would kind of remember were – sometimes I was doing bad, like, really bad, and she [Wraparound VPP] would help me out with, like, a coupon or certificate for, like, a hotel." (Z102*)

> *"I say, for somebody who's, like, you know, mental health, I say, who's going through stuff or need people to talk to or need someone to help them advocate and stuff like that, I feel like this program is really helpful with that. And then, with people that came, like, I say if you can't afford anything materialistic, like with your important needs like hygiene and stuff like that, they're very helpful with that." (W636)*

> *"For one she's [Wraparound VPP] like, she's very helpful. We were talking about schools and things like that. And she sent me different schools. I can call, get enrolled and stuff like that. You usually don't have people like that. I usually got to go find out on my own before she got here. But I really don't got nobody besides my family. I only got a couple people in my family. So." (G318)*

A number of clients received assistance obtaining or completing legal documents, and particularly with applying for victims of crime compensation:

> *"I feel like honestly this program it actually opened up a lot of doors for me, because I didn't have my birth certificate or ID, thanks to her [Wraparound VPP] I got this. I feel like this program opened a lot of doors." (X77)*

> *"Especially, the biggest help that I've gotten from the program has been dealing with the legal aspect of things. Victims compensation especially. I wasn't, I did not realize that I would have to be dealing with that." (R772)*

Markedly, however, while 39 clients (68%) were supported in applying for financial or relocation assistance via the California Victim Compensation Board (CalVCB), only 1 application was approved during the project period; 2 more clients had been approved prior to the start of the project period. In conversations with VPPs, various challenges with CalVCB application approvals were identified, including denials due to perceived lack of client cooperation with law enforcement and eligibility limitations related to incident location.

Several clients who accepted referrals for mental health services commented during the qualitative interviews on the utility of that resource:

> *"I didn't think that it would be as helpful as it was. Initially I didn't think I was going to talk to anybody, like a therapist. But it worked out. And, yeah. It's nice to talk to people." (R655)*

> *"It was more like the counseling and the situation like that, and, you know, just communicating with somebody…So I just, I felt like it would be good hearing the counseling and stuff like that…'Cause at the time, I still was, I felt like I was dealing with stuff, like, looking over my shoulder or feeling, I don't know, there's somebody watching me or something. Like, I still deal with it now, but it's not as bad no more." (W636)*

Another source of emotional support for clients, albeit less formal than referred mental health services, was the Wraparound Peer Support Group. Started in 2021, the Peer Support Group brings current and past Wraparound clients together to offer each other an opportunity to share their experiences and form authentic connections with other violence survivors. During qualitative interviews, one client shared their thoughts about the importance and value of the Group:

> *"I always had a good experience with them [peer support group]. We would always, like they [Wraparound VPPs] would always have dinner for us or they would take us places and stuff like that. So we actually wouldn't just sit there and talk about what we've been through, you know. Just like hanging around people, knowing that they've been through the same situation, you know, and they understand. Honestly, I never thought I would meet anyone who's been through what I've been through and it was crazy when I saw a room full of people." (A777)*

In addition to the many clients who were described by the VPPs as having achieved most of their self-identified goals, as detailed previously in this report, the results of Wraparound services were assessed using client self-report surveys of mental health, perceived social support, and attitudes toward guns and violence. While these survey tools have been validated in other populations, concerns about the relevance and utility of these instruments for marginalized and minoritized youth and young adults injured by community violence were noted internally among Wraparound staff during the project period. Small sample numbers and missingness further limit generalizable conclusions based on these data. Descriptively:

- Posttraumatic stress disorder (PTSD) was assessed using an overall severity score based on 17 items corresponding to key symptoms of PTSD. On average, among those who completed the program, clients' PTSD symptom severity scores were classified as indicative of PTSD at both intake (score: 45.0; n=16) and 12 months of program enrollment (score: 55.6; n=9), based on a PTSD cut point of 44 or greater in the general population (50 or greater in military populations).

- Among clients who completed the program, scores on measures of depression remained in the "moderate" range (scores, 10-14), on average, at both intake (score: 11.3; n=10) and 12 months of program enrollment (score: 11.1; n=8); it is recommended that individuals with scores in the moderate range be assessed for treatment based on symptom duration and functional impairment.

- Perceived social support was classified as in the "moderate" range at intake (mean score: 4.9; n=16) and in the "high" range (mean score: 5.2; n=9) at 12 months of program enrollment, on average, for clients who completed the program; though, in both cases, mean scores were tightly clustered near the cut point between the "moderate" (2.9-5.0) and "high" (5.1-7.0) support categories. Notably, perceived social support scores at intake were lower, on average, among clients who were subsequently lost to follow up (score: 4.5; n=6) and lowest among those who were dropped from the program by the VPPs for non-responsiveness (score: 4.2; n=3).

In qualitative interviews exploring the role of social support, several clients mentioned how the VPPs had become part of their social circle. When asked whether they considered the VPP to be part of their circle, many clients emphatically agreed:

> *"Yeah, he's [Wraparound VPP] good – he's on my – I got his phone number. Hell, yeah, [laughs]. He got my phone number, but he got to be part of my social circle. Because I don't give a lot of people my phone number." (K304)*

When asked to elaborate on why, another client replied simply:

"Because he's [Wraparound VPP] been there for me, too, actually, since I got shot, like, the second, third day after I got shot..." (A982)

- Among clients who completed the program, attitudes concerning guns, physical aggression, and interpersonal conflict were similar, on average, at intake (score: 53.7; n=16) and 12 months of program enrollment (52.0; n=9), with higher scores (max score, 69) indicating greater perceived need for (or environmentally responsive utility of) violence-related behaviors or responses.

In qualitative interviews expanding on violence-related attitudes, behaviors, and influences, clients noted that violence was often a pervasive experience and source of stress in their lives and communities, underscoring the idiom that for many young people in neighborhoods experiencing persistently elevated levels of violence, there is no "post" in posttraumatic stress. As one client reflected in response to a question about how big of a problem is gun violence in their neighborhood:

> *"That – it's pretty bad. Like maybe once every two weeks at least there's popping off somewhere, you know. Pretty close. But. Which sucks because we're out in the front of the apartment, our window is right to the street. The only thing blocking it is the cars that people park there. So. Sometimes I lay down a bit and am like oh damn, I hope nobody shoots this way." (R655)*

Another client further emphasized the prevalence of firearms:

> *"Well, mostly, with our generation that we're living in now, it seems like everybody just wants to carry a gun to just carry a gun. Everybody is just killing each other to just kill each other. And it's just a lot to deal with and it's scary. My grandma used to tell me, back in the day when I was younger, and now that I'm older, I understand that, what she was saying: we're living in our last days…it's just gonna keep being what it is, because these young people wanna keep carrying guns and just killing each other for nothing…It's sad, you know. And then you have kids, and we have kids growing up in this generation, and it's just terrible." (X666)*

However, this same client added that their experience in the program transformed how they would respond in situations that might otherwise lead to violence:

> *"I think I changed a lot. It [Wraparound program] opened my eyes to a lot of things, you know? You have to, um, as bad as I, of the altercation that I went through, and me experiencing the things that I experienced, I think that I learned that, um, sometimes you just have to be the bigger person, you know? And you gotta walk away. As bad as you wanna say things to people and you wanna fight, sometimes it's not that of a idea. You should just be the bigger person and walk away. As you may think that make you a punk or scary or something, sometimes you just have too much to lose to put yourself in that situation." (X666)*

HVIP effectiveness is often evaluated additionally (and at times, solely or primarily) in terms of whether clients are reinjured. A review of medical records for clients who completed the program suggests that no clients were reinjured severely enough to have been readmitted to the UC Davis Medical Center within 1 year of their focal injury, and conversations with the VPPs further confirmed no reinjuries (or deaths) among this group. The same was true of enrolled clients who

did not complete the program (e.g., dropped, withdrew, lost to follow up, etc.); though, one client who was lost to follow up did suffer a reinjury slightly more than 1 year after their focal injury.

Qualitative interviews offered the critical opportunity to explore additional dimensions of program success, beyond violence and injury, as defined by clients themselves. Specifically, clients were asked how they perceive success in Wraparound. In general, clients' responses suggested that they did not view Wraparound as a rigidly structured program, but rather as a key source of support and guidance, with tangible and intangible benefits. Clients who successfully completed ("advanced") noted their improved sense of self, and, rather than framing program success in the narrowly constructed ways that researchers often think about outcomes in violence intervention and prevention (e.g., injury recurrence, arrest, incarceration, subsequent violence involvement, etc.), they deemed success as personal betterment and growth, stronger relationships with family and other sources of social support, and financial and emotional stability. When asked what success looks like to them, clients emphasized:

> *"I wanna buy a house, you know, to leave for my daughter. I just wanna be successful. I wanna be a better role model for her, and for her to look up to. I don't want her to look up to nobody else. You know, I want her to look up to me and say, 'My mom was the best mom,' a mom she can brag about." (X666)*

> *"Like, not, life doesn't end after the accident. We can either just go the same way we were, or we just get more better. And feel like the program has made me a better person." (J175)*

> *"Well, honestly, it benefitted me a lot, because, I went in there, like, trying to fix my trauma, and it helped me a lot, and with the trauma and with – at the time, I was 19, so I feel like it helped me a lot to mature and understand the world more. So yeah, that's the way it helped me." (Z102)*

> *"Well, it [injury incident] was negative, cause I got shot, but at the same time, it was positive, in a way, because they [Wraparound VPPs], well, I ran into people like yourselves in the program and stuff like that. And then it got me and my mom, like, a better, closer relationship – a better mom, basically." (W636)*

> *"I'm here and I'm alive, after my experience, so I'm already winning. And I have a son to be happy about." (A982)*

Currently enrolled or recently advanced clients expressed deep gratitude and appreciation for the bonds they had formed with their respective VPPs, along with the myriad ways that the program facilitated their physical, emotional, and psychological recovery from the violence that introduced them to the program. In fact, a few of them shared in the qualitative interviews that they wanted to offer their positive experiences and perspectives to program and hospital leadership with the intention of ensuring program sustainability:

> *"I enjoy the program, and it's a big help. [Wraparound VPP] has been there for me since I got shot. That's been – that means a lot. That's all I gotta say, really." (A982)*

> *"I mean, the reason why I'm doing this interview, it's, I want to support the program. I think I made it out of this compared to most victims of such things, I made it out really well. And I think this program has a lot of opportunity to offer support, and I was told that it, so far it's not necessarily a permanent program and it runs off of grant funding. And this would help make it a permanent program at UC Davis, and I really want to see that happen. I*

think that this is something very important to have, just available to, to anybody who's in a similar situation to me. So I want to see that go. That's my goal. Expanding, not expand the program. But I mean, legitimize the program, financially." (R772)

"And then, more importantly than all of that, giving back to the program. I feel like I've already benefitted so much, and I want to contribute, in whatever means I can, to help invigorate the program, yeah." (R772)

Discussion of Results

This Local Evaluation Report—the result of a multi-year learning and evaluation effort supported by UC Davis researchers—illuminates successes, challenges, and opportunities related to the UC Davis Health Wraparound Violence Intervention Program's ability to effectively engage and serve violently injured youth and young adult patients ages 13-26 in Sacramento County, California. Wraparound's nationally certified Violence Prevention Professionals (VPPs) provided intensive, individualized case management, relationship-based mentoring, financial and resource assistance, and emotional and social support to more than 50 clients during the three-year project period spanning October 1, 2020 to June 30, 2023. Using standard and validated techniques for tracking patient health and well-being, they also facilitated documentation of clients' physical and mental health progress, as well as their basic, financial, legal, educational, housing, and transportation needs and related activities.

The vast majority of clients who successfully advanced to program completion were reported to have met most of their self-determined program goals. Clients reported high levels of satisfaction with Wraparound's flexibility to meet their individual needs; though, internal capacity to support clients' complex needs was often bounded by the availability, responsiveness, and restrictions of external resources and systems of support, and particularly by limited housing and relocation services and sources of compensation. As a result, as documented in both VPP case management notes and qualitative interviews, clients typically placed greater emphasis on the invaluable role of the genuine connection formed with their VPP early in the engagement, and the stability of the relationship that was consistently maintained and fostered over the duration of the program. Accordingly, Wraparound's VPPs emerged as the backbone of the program, providing an important bridge between violence-impacted young people and both hospital and community systems. The passion, commitment, and significantly, the credibility and rapport they each bring to the work cannot be overstated. Their success and legitimacy stems from the respect they have earned in the Sacramento community, the connections they have cultivated and continually foster with community partners, and their ability to leverage the knowledge of and lived experiences they share with the young people and communities they serve.

Additional key learnings emerged. Over the project period, Wraparound's program coordinator, VPPs, and the evaluation team discussed client data collection and entry, particularly as challenges and opportunities for improvement were identified. For various reasons, frontline violence intervention and prevention professionals are often reluctant or skeptical about data and evaluation. An emphasis on externally imposed data collection and entry may feel unethical or unnatural when, as described above, a central aspect of the work is relationships; further, it may be perceived as a breach of client trust or of social codes, and frontline professionals may be skeptical of who will have access to the information. This learning and evaluation effort provided an opportunity for the Wraparound team to have open conversations about the ways in which data collection can benefit program clients—e.g., through self-reported, survey-identified mental

health needs that were not otherwise verbalized by clients—as well as the program, including identifying opportunities to adjust VPP staffing to progressively reduce missed bedside contacts, especially on weekends. It also offered program leadership clarity about the need to discuss strategies for protecting client identities and sensitive information while normalizing a necessity for thoroughly documenting VPP-client interactions, referrals, and contexts relevant to clients' successful physical and emotional recovery and ongoing safety and health. Innovating on best practices for documentation, including ideas such as incorporating regularly recorded VPP voice memos, is an area for future growth.

This learning and evaluation effort also underscored the limits of conventional metrics for assessing and operationalizing program success and for holistically capturing and contextualizing program impacts on clients, their families, program leadership, and UC Davis Health more broadly. Prior evaluations have typically focused solely or primarily on violence and crime-related outcomes. These remain important dimensions along which the effectiveness and impacts of violence intervention and healing work can be measured—and, indeed, no clients who completed Wraparound were reinjured during their enrollment—but these indicators alone are unlikely to capture the full spectrum of personal transformations and theoretically relevant social-emotional outcomes that can change through program participation. Reevaluating data collection instruments that are meaningful and relevant for assessing these change measures in diverse and structurally vulnerable youth and young adult populations with complex trauma histories is a key area for ongoing program development.

Mental health-related metrics additionally emerged as particularly important for documenting and understanding barriers and facilitators to service utilization and trauma healing. Due to various institutional challenges with creating a Wraparound-specific mental health position, and finding appropriate clinical supervision for such a position, the program continued to rely on referrals to external mental health support. This inhibited systematic tracking of uptake, completion, or outcomes for clients engaging in mental health services, and has been identified as an area for future programmatic growth, particularly in relation to opportunities to leverage support from established and experienced departments/centers within UC Davis Health, including existing trauma recovery services through the Children's Hospital CAARE (Child and Adolescent Abuse Resource and Evaluation) Diagnostic and Treatment Center. Further, and significantly, while quantitative metrics are often necessary for assessing program effectiveness, the mixed methods approach employed in this learning and evaluation effort underscored the value of, and ongoing need for, more explicitly capturing narratives and qualitative data to detail the experiences, perspectives, and priorities of both clients and VPPs themselves.

In addition to these individual and program-specific learnings and successes, the power and potential of Wraparound to positively affect organizational culture and standards of care, within and beyond hospital walls, for violently injured young people served by UC Davis Health has been evidenced in the following ways, among others:

- Wraparound received the 2021 UC Davis School of Medicine Dean's Team Award for Excellence in Community Engagement, in recognition of the program's work to enhance the quality of life of local and regional communities most impacted by violence.
- Wraparound was featured in a 2022 KCRA 3 Project CommUNITY special video report, "Saving Our Cities: Sacramento program designed to help crime victims recover". The report

spotlighted the role of the VPPs and the program's holistic support for youth and young adults recovering from violence-related injuries in the Sacramento region.

- Also in 2022, Wraparound VPPs and leadership staff successfully developed and launched a first of its kind violence intervention services patient care documentation note ("episode type") in UC Davis Health's EPIC electronic medical record system, institutionalizing the vital role of VPPs and their services as part of the patient care team.

The learnings and evaluation findings in this report nonetheless call further attention to various challenges associated with providing adequate and sustained support to, and systematically assessing corresponding impacts on, violently injured young people in the Sacramento region, including:

- Funding: hospital and community-based violence intervention strategies have historically been severely underfunded, and resources for meaningful and thoughtful program evaluation have been even more limited.
- Timing: on top of thin operating budgets, these programs are typically grant-funded with an expectation of achieving substantial change within short time frames, which is incredibly difficult given decades-long headwinds of community disinvestment and trauma.
- Process: many evaluations to date, while rightly examining whether interventions achieved reductions in violence/injury, do not account for programs' theories of change and the ways in which participants and program staff experience or visualize progress or success.
- Context: the potential impacts that a standalone program can have on community-wide violence/injury reduction are constrained without deliberate action to redress the structural and environmental conditions that contribute to violence and safety in the first place.

Despite these challenges, Wraparound stands as a pillar of regional efforts to reframe community violence as a preventable public health issue that can be transformed through trauma-informed, person- and healing-centered care in partnership with local communities. Ultimately, the critical import of the work is best summarized by Wraparound clients themselves:

> *"The program helped me a lot, after my incident, it helped me in my trauma, how to heal, how to cope with it, how to not feel anxious. There's nothing that they couldn't help me with. When I had something, like, a need or a help with something, there was always something that they were able to do. Even if it was just a little bit, there was always something that they were able to help me with." (Z102)*
>
> *"I wish I was still in the program, though. [Laughs] I would even be more happier, but it's okay." (X666)*
>
> *"It [Wraparound] helps, like you know it really, really helps. I mean I don't know, I mean at first, I was like, 'Oh they're trying to help me. I don't want that.' But since I accepted it, it's like it hasn't done me no wrong at all. It hasn't done me no wrong at all. So if somebody was to ask me about this place I'd tell them, 'It helps a lot, true.'"(X77)*

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Appendix

Appendix Table 1. Summary of Key Learning and Evaluation Questions

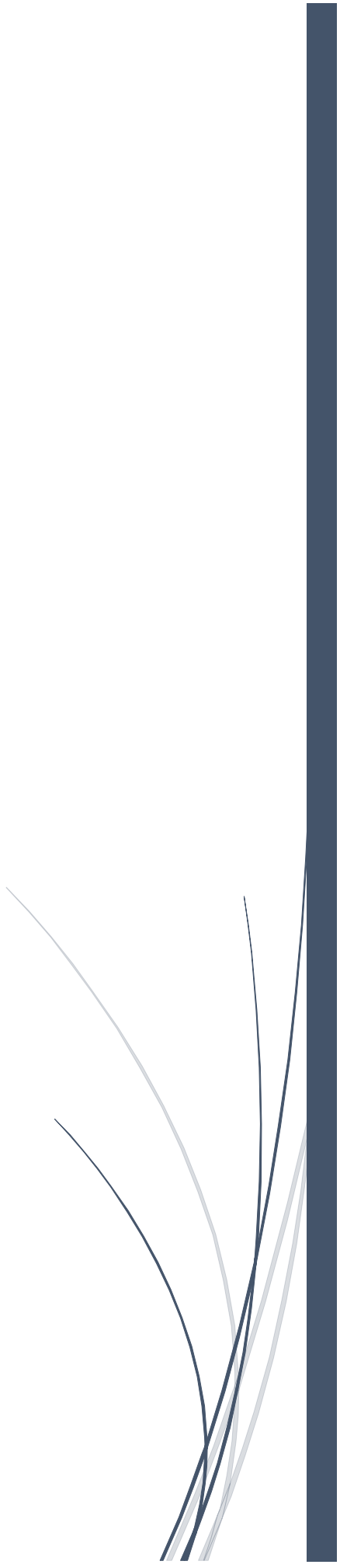
Questions	Measures	Data[1]	Analysis[2]
Research Question #1	**Descriptive and Process Measures**		
Who participates? Is there variation by sociodemographic characteristics?	• # eligible patients • # referrals • # completed bedside visits • # enrolled clients (services only and services + evaluation) • Basic sociodemographic data	D3	A1
Why do clients enter and leave the program?	• Program completion rate • Early attrition rate • Reasons for entering and leaving the program • Facilitators and barriers to enrollment and engagement	D1 D3	A1 A3
What is the range and amount of client support and service needs?	• Frequency of risk factors by type • Frequency of service needs by type • Frequency of resilience factors by type • Time expenditure per client • Facilitators and barriers to supporting and serving client needs	D1 D2 D3	A1 A2 A3
Research Question #2	**Intermediate Outcome Measures**		
How many clients are surveyed and interviewed?	• # completed client surveys • # completed semi-structured interviews	D3	A2
Do clients report progress towards meeting their basic needs and service benchmarks and goals?	• # receive injury follow-up medical care • # obtain Victims of Crime financial support • # secure safe housing • # return to school (younger clients) or employment	D1 D3	A1 A2 A3
Do clients report any changes in their mental health, perceived social support, or attitudes towards guns and violence?	• Changes in mental health (PTSD, depression) • Changes in social support • Changes in attitudes toward guns and violence	D1 D2	A1 A3
Do clients report changes in risk and protective factors for violence?	• Changes in risk and protective factors for violence (e.g. substance misuse)	D1	A1 A3
How do clients, hospital staff members, and community partners perceive the HVIP and define program success? Are they satisfied with the program?	• Satisfaction ratings • Unanticipated positive and negative outcomes • Perceptions of progress/success	D1 D2	A1 A2
Research Question #3	**Short-term Outcome Measures**		
Are rates of re-victimization, as measured by re-injury or death, among HVIP clients relatively high, low, or about average?	• Re-injury counts	D3 D4	A2

[1]Type of Data Collection: D1=Semi-structured Interviews; D2=Survey/Scale; D3=Program Records/Reporting Documents; D4=Injury Surveillance Data

[2]Analysis Plan: A1=Thematic Analysis; A2=Descriptive

Appendix Table 2. Wraparound Workplan Goals

(1) Goal:	To facilitate holistic recovery for youth and young adults injured by violence			
Objectives	A. Within 3 months of program enrollment, youth and young adults (i.e., clients) will have a documented individual plan for holistic recovery comprised of person-centered goals B. At 3, 6, 9 and 12 months after hospital discharge, clients will have reviewed and adapted their plan goals with a Violence Prevention Professional (VPP) C. Within 12 months of program enrollment, clients will have a documented summary of progress toward goals with advancement plan			
Project activities that support the identified goal and objectives		Responsible staff/ partners	Timeline	
			Start Date	End Date
1. Enroll eligible patients in Wraparound program		VPP	10/1/2020	6/31/2023
2. Establish plan for immediate and ongoing safety and basic needs		VPP		
3. Guide clients in creating holistic recovery goals		VPP		
4. Connect clients with mental health and community services		VPP		
5. Assist clients with CalVCB applications		VPP		
(2) Goal:	To transition clients from hospital care to long-term mental health, community-based and natural supports			
Objectives	A. Within 1 month of program enrollment, client will have been referred to a CBT trained and licensed mental health professional B. Within 1 month of program enrollment, eligible clients residing in Black Child Legacy Campaign (BCLC) communities will have a completed referral to the appropriate BCLC Community Incubator Lead (CIL) and multidisciplinary team (MDT) C. Within 1 month of program enrollment, eligible clients will have submitted a California Victim Compensation Board (CalVCB) application D. Within 3 months of enrollment, client and VIS will identify resources needed for long term support based on recovery goals E. Within 12 months of enrollment, clients will have established relationships or contact with identified resources			
Project activities that support the identified goal and objectives		Responsible staff/ partners	Timeline	
			Start Date	End Date
1. Establish and maintain MOUs with community partners		Administrator	10/1/2020	6/31/2023
2. Refer youth to appropriate BCLC CIL and resources		VPP		
3. Attend weekly CIL MDT meetings as appropriate		VPP		
4. Introduce and facilitate warm hand-off of clients to long-term mental health, community-based and natural supports		VPP		
(3) Goal:	To reduce risk factors and promote protective factors associated with violence in order to prevent reinjury and future violence involvement			
Objectives	A. Within 3 months of program enrollment, clients will identify individual, environmental, and psychosocial risk factors for reinjury from violence B. Within 6 months, client will be introduced to evidence-based strategies to mitigate the risk of exposure to violence and to increase resilience C. At 12 months, program clients will be independently competent in evidence-based strategies to mitigate the risk of exposure to violence and to increase resilience			
Project activities that support the identified goal and objectives		Responsible staff/ partners	Timeline	
			Start Date	End Date
1. Engage and maintain relationship-based mentoring		VPP	10/1/2020	6/31/2023
2. Assist client in completing validated self-assessment for Post- Traumatic Stress Disorder (PTSD), Depressions, Social Support and Attitudes Towards Guns and Violence		VPP		
3. Facilitate client exposure and empowerment in new domains to strengthen resilience		VPP		



UCDMC Wraparound Local Evaluation Report

December 2023

Wraparound Logic Model 2023

Inputs

Core Staff

Program Leads
- 1 Trauma Prevention Program Coordinator/administrator
- 1 Trauma Surgeon/Co-Administrator

Front Line Staff
- 3 Violence Prevention Professionals (VPP)
- 1 Mental Health Professional (vacant)

Multidisciplinary Research Team
- 2 Faculty Research Evaluators within VPRP

Key Internal Partners
- Hospital Social Workers

Community Partnerships

Black Child Legacy Campaign
- Community Incubator Leads in 7 high risk neighborhoods
- Multidisciplinary teams
  - Department of Human Assistance
  - Probation
  - CPS
  - Health community clinics

WHY SAC – youth service provider network

California Victim Compensation Board (CalVCB)

Program Materials

Informational flyer

Program informational video

Webpage, Facebook, Instagram

Funding

BSCC CalVIP Grant (June 2025)

Qualitative Research Grant (through June, 2021)

Hospital

School of Medicine

Firearm Violence Research Center at UC Davis (state funded)

UC Davis Violence Prevention Research Program

Documentation and Data Collection

Electronic Medical Records (EMR)
- Wraparound Consult Order
- VPP case management notes in patient EMR records (VIS specific workflow documentation)

Trauma Registry Database

REDCap secure electronic database
- Program Intake Form
- Case Management Plan/Goals
- Patient surveys
- Program Advancement Form

Mixed Methods Data Collection

Activities

Identify and Enroll Patients
- UCDMC patients ages 13-26yr with violence-related injuries, identified in EMR or EPIC Referral
- Initial meeting with VPP staff
- Use trauma registry to retrospectively identify patients not contacted by VPPs
- Enroll and complete intake forms

Inpatient Services: Initial Needs Assessment/Personal Treatment Plan
- Rapport building by Violence Prevention Professionals
- Identify needs
- Safety planning

Outpatient Services: Case Management
- Submit Crime Victim Compensation application
- Client Advocacy, support, and mentoring
- Connection to mental health services
- Identify client individual needs for holistic recovery
- Individualized goal setting activities
- Transportation and daily living expenses direct assistance
- Referral to community services
- Comprehensive follow-up and case management
- Linking to community programs
- Peer Support Groups

Community Support
- BCLC Multidisciplinary team
- WHY SAC –youth service provider network

Internal team support
- Weekly team case management debriefings
- Weekly research and program evaluation meetings
- Violence Prevention Professionals debriefs on ad hoc basis (more than weekly)

Trainings
- Violence Prevention Professional Certification
- CITI training, hospital required trainings
- Institutional culture and practice norms change
  - Symposium with hospital staff

Hospital staff training/
- ICU staff meeting (bi-annually)
- Monthly lunch trainings
- Annual refresher trainings

Outputs

Process Evaluation
- Monthly report from trauma registry database for all youth (13-26yrs)
  - # of patients eligible to be enrolled
  - # of patients enrolled
  - # of patients potentially missed and reason
  - Zip codes of youth residence and location of injury
  - Demographics
  - Mechanism of injury

Client Outputs
- Attainment of recovery goals
- Connecting with community services
- Uptake of mental health services

Program Evaluation outputs
- Amount of time spent with intervention specialists
- Counts of violent injury recidivism among program participants
- Type of needs, risk factors and barriers identified in personal treatment plans
- Type of personal goals identified in personal treatment plans
- # interactions between violence intervention specialists and participants
- Type and # of services referred to
- Type and # of services utilized
- Progress towards goal attainment
- Average length of time in program
- Qualitative data (Patient Experience)
- Quantitative Data
  - 4 validated survey indicators: PTSD; Social Support; Depression; Attitudes towards guns and violence
- Post Discharge Case Management- VIS specific workflow documentation in EMR.

Outcomes

Short Term Outcomes (1-2 years)

Client outcomes
- Stabilization of patients (e.g., physical/mental recovery; relocation to ensure safety)
- Clients achieve personal goals
- Reduce re-injury
- Transition to natural resources in the community to address social determinants of health

Program outcomes
- Increased community network to provide linkages to accessible services for program participants
- Program recognition
- Affecting clinical practice change
  - Create culture change from top down

Longer Term Outcomes (2-5 years)
- Reduce future violence exposure
- Reduced mortality rate for at risk youth
- Community perception of program and hospital
- Change in bias and perceptions around hospital staff
- Program sustainability: program becomes standard of care and institutional within hospital system

Impact
- Reducing Implicit bias and improving relationships between hospital and community
- Organizational culture change
- Facilitate emotional recovery and reintegration into society for victims of violence
- Reduced rates of hospital re-admission and related cost
- Reduce violence related outcomes in community
- Sustained and embedded standard of care

Grantee Highlight

B. Sanchez, 18 years of age, was admitted to UC Davis Medical Center in April 2022 with a gunshot wound. Mr. Sanchez's injuries were severe enough that he required weeks of in-hospital treatment. When his physical health stabilized, Mr. Sanchez was visited in the hospital by one of the Wraparound VPPs, Mr. Chevist Johnson, and accepted enrollment into the program. Mr. Sanchez and Mr. Johnson formed an early connection and developed a strong and genuine bond. When Mr. Sanchez was discharged from the hospital, his engagement in Wraparound continued, and he was able to not only continue to physically heal from his injury, but he also reported improved mental health. Mr. Johnson assisted Mr. Sanchez in securing stable housing, applying for financial assistance with CalVCB (though the application was denied), enrolling in school, and planning to obtain employment once cleared by his physician to work. Mr. Johnson is also aiding Mr. Sanchez in his application to the Social Security Administration for long-term disability assistance. Through the Wraparound program, Mr. Sanchez has been empowered to publicly share his experience as a violence survivor and Wraparound program success story. With the support and collaboration of the Wraparound team, Mr. Sanchez currently facilitates trainings on trauma-informed care within the UC Davis Health system, completing workshops delivered to health care providers in trauma, emergency medicine, and nursing. He has also taken on a leadership role in the Wraparound Peer Support Group, encouraging other violently injured patients along their own healing journeys.

When asked to reflect on the Wraparound program, Mr. Sanchez offered these remarks:

> *"I'm so thankful for Wraparound for helping me go through my situations. They helped me go through every step of my journey. I believe that if everyone has a chance to experience this program, that cares about your wellbeing, both physically and mentally, this program would help them. This program also helped me ease back my way into society, and I feel that this program could do the same for everyone else that's in this program."*

The Wraparound team is profoundly proud of Mr. Sanchez's courage, drive, and success, and the team passionately looks forward to continuing to support Mr. Sanchez and other clients on their own journeys of healing and thriving.