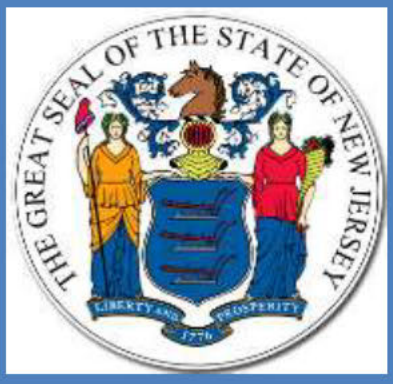
REPORT OF THE STUDY COMMISSION ON VIOLENCE



Study Commission on Violence

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EXECUTIVE SUMMARY

The Study Commission on Violence discharged its duty to examine trends and sources of violence, the impact of violence on the community, identified funding opportunities that address violence, and the mental health system through the receipt of subject matter expert briefings, public hearings, and its own independent research. This report summarizes the Study Commission's findings and its recommendations to the Legislature and the Governor.

Violence in our communities is a concern we heard expressed time and again in our public hearings and in examining data related to the frequency of violence in New Jersey. There is no one source of violence or a single impact on the communities where it occurs. Rather, violence is brought on by a host of socio-economic factors and individual decisions made by people who choose to perpetrate violent acts against others or themselves. While "violence" is an all-encompassing term, it can also be imprecise. Deaths due to violence are at a generational low; yet, violence remains stubbornly high in certain areas - in New Jersey, roughly 80 percent of all violent crime occurs in just 21 cities. It is not coincidental that these cities also have lower rates of high school graduation, higher rates of unemployment, lower rates of household income, and higher rates of school truancy. Violence does not occur in a vacuum; rather, it thrives in poor and disadvantaged communities where educational and economic opportunities are limited and residents have become accustomed to a certain level of lawlessness. In recent years, the challenges facing these communities have been compounded by economic turmoil that has resulted in reductions in law enforcement. Violence, however, is not confined to urban settings and occurs in suburban and rural communities as well. The issue of violence should be a concern to all New Jersey residents, to one degree or another.

And while violent "street" crime is found disproportionately in a small number of places in New Jersey, certain crimes like domestic violence are more widespread. Still others, like elder abuse, are emerging as concerns in the community. At the same time, a consensus has begun to form around the manner in which those who are drug addicted, particularly those suffering from heroin addiction, are treated when they are arrested. Whereas public policy once focused exclusively on incarcerating individuals, even for low-level offenses, for significant periods of time, current policy has shifted toward diverting non-violent offenders away from incarceration and into treatment. Moreover, this trend has extended into how law enforcement treats juvenile delinquents. Through diversion programs that offer community-based oversight, some county youth detention facilities have closed because too few juveniles are being remanded to custody and the number of juveniles in Juvenile Justice Commission facilities has dropped by roughly half.

Of course, violence is not limited to acts by one person against another. Self-directed violence in the form of suicide and attempted suicide is also prevalent in our country. Indeed, the number of suicides that occur nationally each year is more than twice the number of homicides that occur in our nation. The Study Commission took seriously its

charge to examine the trends, sources, and impact of violence in the community, the availability of grant funding to combat violence, the implementation of expanded involuntary outpatient commitments, and whether and how defendants with identified mental health disabilities but who are charged with crimes, can be offered an alternative to incarceration in the form of a structured, case managed program of treatment and counseling.

The Commission learned that there are a wide range of programs and services available to those with a diagnosed mental health disability or illness. Indeed, coverage for mental health treatment is now available to more individuals through the expansion of Medicaid under the Affordable Care Act. That said, issues still remain regarding access to that treatment due to limited resources and reimbursement for practitioners who treat these patients. With respect to at least one specific charge of the Commission – examining the involuntary outpatient commitment program and whether it should be extended statewide – the Commission determined that this has been mooted by legislation passed by the Legislature and signed by the Governor.

It is the Commission's hope that the submission of this report is the beginning of a robust conversation among policy makers in our state regarding the ways in which violence can and should be addressed and how people with mental illness, and particularly those who come into contact with the criminal justice system, are treated. The Commission met many people of good faith who are working each day to make their communities safer. We also learned about a number of programs being led in cities throughout our state that are attempting to address some of the root causes of violence and address it at both ends of the spectrum – through crime prevention initiatives that try to reduce the incidences of violence occurring in the first place and through reentry initiatives that work with ex-offenders to decrease the likelihood that they will commit crimes in the future. We also found a heightened awareness of, and interest in, programs that offer diversion out of the criminal justice system for clinically appropriate defendants whose conduct is driven by their mental illness or drug addiction and, through treatment, have a lesser chance of recidivism.

At bottom, there is no single program or initiative that will address all of the issues the Study Commission was charged with examining. Rather, our investigation confirmed that a multi-disciplinary approach that incorporates as many stakeholders addressing the suite of challenges offers the greatest likelihood of success.

INTRODUCTION

A. The Creation of the Study Commission on Violence

1. Legislation in Response to Violence

On August 8, 2013, and in response to recent incidents of mass violence in America, Governor Christie signed a bill passed by the New Jersey Legislature establishing the Study Commission on Violence.[1] Statistics from the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention ("CDC"), give one indication of how heavy the burden of violence is on society - there were over 16,600 homicides and 41,000 suicides in the United States in 2013 alone.[2] Nationally, homicide is in the top five leading causes of death for everyone up to age 45, and suicide is in the top five leading causes of death from ages 15 through 54.[3] In New Jersey, homicide is the second leading cause of death among 15 to 24-year-olds and 25 to 34-year-olds, and suicide is in the top five for every age group from ages 15 through 54.[4] Beyond fatalities, there are economic and societal costs. In 2013, data from the New Jersey Department of Health, Center for Health Statistics and Informatics ("CHSI") show that the cost of treatment for the 27,000 hospitalizations and emergency department visits for non-fatal assaults and 4,800 non-fatal self-inflicted injuries in New Jersey hospitals was more than $530 million, with substantial impacts to healthcare resource use, families, and communities.[5]

2. About the Commission

The New Jersey Legislature found that it is "in the public interest for the State to establish a commission to study violence in order to raise awareness about one of this country's most significant public health crises."[6] The Study Commission on Violence ("The Commission") is comprised of nine members: one member representing the Attorney General, the Department of Health, the Administrative Office of the Courts, and the Department of Human Services, the President of the County Prosecutor's Association, and four public members, two of whom were selected by the Governor and one each by the President of the State Senate and Speaker of the State Assembly. Support staff is provided by the Department of Law and Public Safety.

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[1] N.J.S.A. 52:17B-239 et seq.
[2] CDC, Centers for Injury Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). Available at: http://www.cdc.gov/injury/wisqars/
[3] Ibid.
[4] Ibid.
[5] Center for Health Statistics and Informatics, The New Jersey Violent Death Reporting System: Surveillance Updates and Trends, 2003-2013 (Trenton: New Jersey Department of Health, 2015 (in publication)
[6] N.J.S.A. 52:17B-239(1)(q).

As outlined in the legislation, the Commission enlisted field experts from academia, various violence prevention agencies, organizations, and community groups to assist with the Commission's directives, and held public hearings where testimony from interested groups, local officials, and the general public was heard and recorded.

3. The Commission's Mandate

Under the enacting Legislation, the Commission has the following duties:[7]

a) To study the trends of violence, the source of violence, and the impact of violence on the community, to develop a method to address the epidemic of violence at the federal and State levels, and to make recommendations for State and Congressional action;

b) To seek out funding and grants for the implementation of programs to reduce violence from sources including, but not limited to, the Centers for Disease Control and Prevention and any other funding sources;

c) To study the issue of insufficient access to mental health treatment and violence;

d) To study and make recommendations regarding whether the Special Offenders Unit created by the Union County Prosecutor's office to address the increase in criminal prosecutions against individuals with mental illness should be expanded to other counties; and

e) To study and recommend whether the community-based mental health treatment system, through which there are involuntary outpatient commitments under a court order supervised by a case manager, should be expanded to all counties in this State and how to adequately fund the program in all counties.

4. Commission Activities

The Commission was briefed by various experts on those factors they believe contribute to violence in New Jersey, as well as their thoughts on solutions. With their assistance, the Commission studied the impact of various factors such as family structure, poverty/economic class, education, behavioral and mental health, substance abuse, recreational activities, gender, social and community norms, prison culture and recidivism.

The Commission held eight public hearings across the state where members of the public provided oral testimony. The Commission also received written statements and email from the public expressing their views on the topics we were charged with examining. This information was reviewed and considered in conjunction with the expert briefings, independent research, and statistical analysis conducted by the Commission.

[7] N.J.S.A. 52:17B-241.

B. The Public Health Approach To Violence Prevention

As directed by the State Legislature, the Commission used the public health approach to guide its examination of violence in New Jersey. As initially described by the World Health Organization ("WHO") and implemented at the federal level in the United States primarily by the CDC, the public health approach for violence prevention starts with the underlying assumption that violence is preventable, like infectious diseases, and with multiple possible points of intervention. It is an interdisciplinary approach that emphasizes "collective action from members of diverse fields such as health, education, social services, criminal justice, and policy, and encourages the development of additional public/private partnerships with the ultimate aim of providing the maximum benefit for the largest number of people."[8]

An evolution in thinking about the very nature of the intersection of violence and health started in the United States in the late 1970s. According to the CDC's historical timeline,[9] in 1979 the U.S. Surgeon General's Report, *Healthy People*, first identified stress and violent behavior as a key priority area for public health. During the 1980's, the CDC began collaborating with local agencies and law enforcement to investigate incidents such as the Atlanta child murders and a disturbing pattern of suicides in Texas; this work demonstrated the effectiveness of using field epidemiology methods to investigate violent deaths. In 1993, the CDC established the Division of Violence Prevention, thereby solidifying violence as a public health issue of importance with possible prevention strategies. The following year, the World Health Organization declared that "violence is a leading worldwide public health problem." In 2002, WHO published its *World Report on Violence and Health*, the first worldwide comprehensive summary of violence, with an emphasis on challenging long-held assumptions on what violence actually *is*, who it affects, and who can prevent it.[10]

The complex nature of violence, which involves individuals, relationships, environments, and cultural factors, makes trying to identify a single strategy to understand and prevent violence impossible. The "public health approach" is rooted in the scientific method, and involves a four-step process that can be applied to violence as well as many other health problems that affect populations. The approach, as outlined by WHO, involves:

1) Uncovering as much basic knowledge as possible about all the aspects of violence – through systematically collecting data on the magnitude, scope, characteristics and consequences of violence at various levels;

[8] Krug, E., et al., eds. *World Report on Violence and Health* at 3-4 (Geneva, World Health Organization, 2002). http://apps.who.int/iris/bitstream/10665/42495/1/9241545615_eng.pdf
[9] CDC, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. "A Timeline of Violence as a Public Health Issue" (2014) http://www.cdc.gov/violenceprevention/overview/timeline.html.
[10] Krug, *supra* fn. 8 at 5.

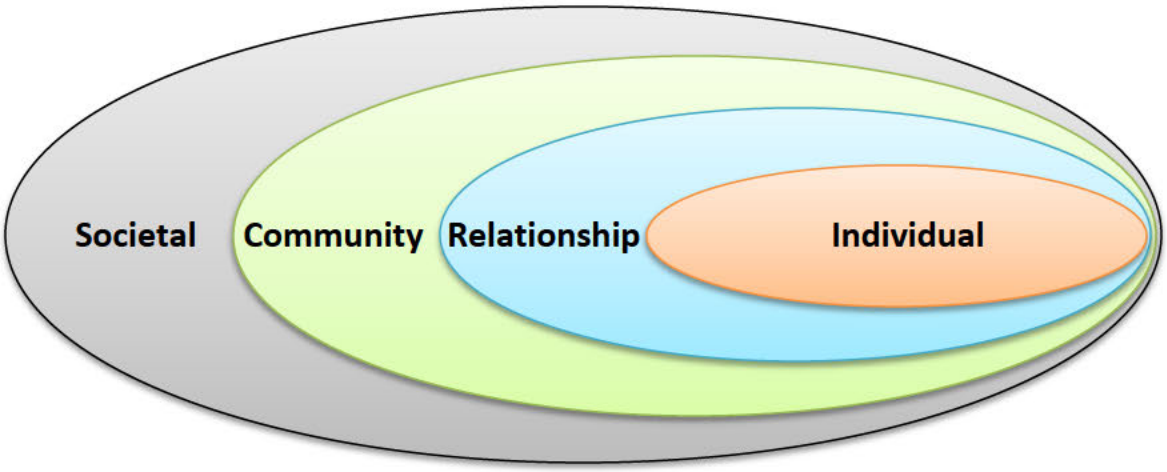
2) Researching why violence occurs, including the causes and correlates of violence, the factors that increase or decrease the risk for violence, and the factors that might be modifiable through interventions;

3) Exploring ways to prevent violence, using the information from the above, by designing, implementing, monitoring and evaluating interventions; and

4) Implementing, in a range of settings, interventions that appear promising, widely disseminating information and determining the cost-effectiveness of programs.[11]

To begin to understand the many aspects of violence, WHO applied an ecological model ("socio-ecological model") which was first introduced in the late 1970's to study child abuse and has subsequently been used in other fields of violence research.[12] The model consists of four levels of relationships and contexts that ultimately influence behavior. The first level identifies biological and personal factors that influence how *individuals* behave and increase their likelihood of becoming a victim or perpetrator of violence. The second level looks at close *relationships* such as those with family, intimate partners, friends, and peers, and explores how these relationships may increase the risk of being a victim or perpetrator of violence. The third level explores the *community* in which social relationships occur, such as schools, workplaces and neighborhoods, and seeks to identify the characteristics of these settings that increase the risk for violence. The fourth level encompasses the broad *societal* factors such as poverty, cultural norms, tensions between communities, and the level of acceptability of violence that create a climate in which violence is encouraged or inhibited (Figure 1).[13]

Figure 1. Ecological model for understanding violence (WHO, 2002.)



The ecological model helps to illustrate the associations between an individual and their complex interpersonal relationships, how risk factors can be augmented in different

[11] Id. at 4.
[12] Id. at 12.
[13] Id. at 12-13.

contexts or interactions, and suggests that to prevent violence it is necessary to act across different levels at the same time and throughout the lifespan.[14]

While the first two steps of the public health approach are focused on describing the problem with appropriate definitions, data, and research on the risk and protective factors for populations at risk, the practical application of the public health approach is in developing targeted programs, putting prevention into action, and evaluating results.

There are three distinct phases of injury and violence that prevention can address. *Primary prevention* is aimed at preventing violence before it occurs; *secondary prevention* seeks to lessen the immediate damage of violence through strategies that may employ limitations on the availability of deadlier weapons, adequate emergency response, and health care treatment; and *tertiary prevention*, which focuses on long-term needs after violence occurs, including rehabilitation and disability care.[15]

The strategic development of most public health injury and violence prevention programs starts with diagramming the problem using the Haddon Matrix. William Haddon, Jr., was the Director of the National Highway Traffic Safety Administration and the Insurance Institute for Highway Safety in the 1960s and 1970s. Dr. Haddon is considered a visionary in the field of injury epidemiology. His work posited that motor vehicle crash injuries were foreseeable events, and could be described in a similar epidemiologic framework as a disease, with a host, vector/agent, and environment that could be analyzed for risk factors and intervention and prevention opportunities.

The Haddon Matrix can also be applied to violence prevention. Table 1 shows an example of using the Haddon Matrix to describe the various event phases of domestic violence; a prevention program may focus on identifying and altering pre-event or event phase factor(s) that may make a victim more susceptible to domestic violence. The victim (host) could have strengths such as good existing health or limitations such as smaller size or co-dependence. The perpetrator (agent) could have larger size to deliver more energy to the victim, thereby doing more damage, or fear of losing control over their partner. They both may have common pre-existing risk factors such as being witness to violence in the past, and both may be intoxicated or have issues with substance abuse. The environment could be a slippery surface or an isolated area which may increase injury severity, and the criminal justice system could be the social environment within which the incident takes place.[16]

[14] Id. at 15.
[15] Ibid.
[16] Hamberger, L.K. & Phelan, M.B., *Domestic Violence Screening and Intervention in Medical and Mental Healthcare Settings,* 272-275 (New York: Springer Publishing Company, Inc., 2004).

Table 1. The Haddon Matrix: Domestic Violence (Hamberger and Phelan, 2004.)

	HOST (aka VICTIM)	AGENT (aka PERPETRATOR)	ENVIRONMENT	
			SCENE	CULTURAL, SOCIOECONOMIC
Pre-event	• Witness to or victim of physical or sexual abuse as a child. • Dependent on perpetrator financially, emotionally, co-parenting. • Young age (18-24). • Experience of prior verbal abuse within relationship. • Isolation from family and friends. • Intoxication.	• Witness to violence in family setting as a child. • May have been a victim of physical or sexual abuse as a child. • Perpetrator uses power and control within the context of an adult relationship. • May include verbal, emotional, sexual abuse. • May do so incrementally. • Intoxication.	• Car, home, workplace, public areas. • Lack of pre-existing security (i.e., workplace plan). • Lack of safety plan.	• Legislation (i.e., mandatory arrest). • Victim's access to alternate housing. • Occurs in all cultures, and across socioeconomic classes. • Immigrant status may further increase isolation.
Event	• Pushing, punching, kicking, grabbing, striking with blunt object. • Use of weapon (gun, knife). • Sexual assault.	• Perpetrates the violence described on the host during the event phase.	• Home without a phone or perpetrator blocks access to phone or escape. • Workplace not secure.	• Cultural, religious, or familial expectations. • Economic dependence.
Post-event	• Tissue damage secondary to crush injury, laceration. • Fractures, head injury, intra-abdominal injuries. • Sexually transmitted disease exposure, including HIV. • If medical attention sought for injuries, may be entry point for legal aid, education, counseling services.	• May be victim of retaliatory violence with injuries similar to above. • Negative behavior reinforced if no consistent negative consequences, or if achieves desired effects (i.e., control over partner). • If medical attention sought for injuries, may be entry point for legal aid, education, counseling services.	• Methods of response: 911, security guards. • Scene secure for EMS/police access.	• Reporting may be minimized because of language barriers, or concerns of deportation. • Culturally sensitive outreach and resource availability in appropriate language may improve access.

Each of these elements and phases presents opportunities for prevention or mitigation, and completing the matrix guides prevention specialists toward systematically examining a problem to determine pursuit of the best strategy.

CHAPTER 1: THE SOURCES, TRENDS AND IMPACT OF VIOLENCE

A. Introduction – What Is Violence?

The first duty assigned to the Commission was:

> "To study the trends of violence, the source of violence, and the impact of violence on the community, to develop a method to address the epidemic of violence at the federal and State levels, and to make recommendations for State and Congressional action."[17]

To do so, the Commission first had to determine how broadly to define the word "violence." The WHO defines "violence" as:

> The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.[18]

The intention to use force or power is the key aspect in defining "violence" irrespective of the outcome; the use of violence can be reactive, proactive, or criminal in nature, done in the public versus private spheres and simply be contemplated, not actualized. As the WHO's World Report notes:

> This definition covers a broad range of outcomes - including psychological harm, deprivation, and maldevelopment. This reflects a growing recognition among researchers and practitioners of the need to include violence that does not necessarily result in injury or death, but that nonetheless poses a substantial burden on individuals, families, communities, and health care systems worldwide. Many forms of violence against women, children, and the elderly, for instance, can result in physical, psychological, and social problems that do not necessarily lead to injury, disability, or death. These consequences can be immediate, as well as latent, and can last for years after the initial abuse. Defining outcomes solely in terms of injury or death thus limits the understanding of the full impact of violence in individuals, communities, and society at large.[19]

The CDC follows this definition. Since 2006, the CDC's Division of Violence Prevention has developed strategic plans around certain topics in violence reflective of the WHO's typology. The plans are organized around the many areas of public health research and practice in the United States that also link back to the overall field of violence prevention

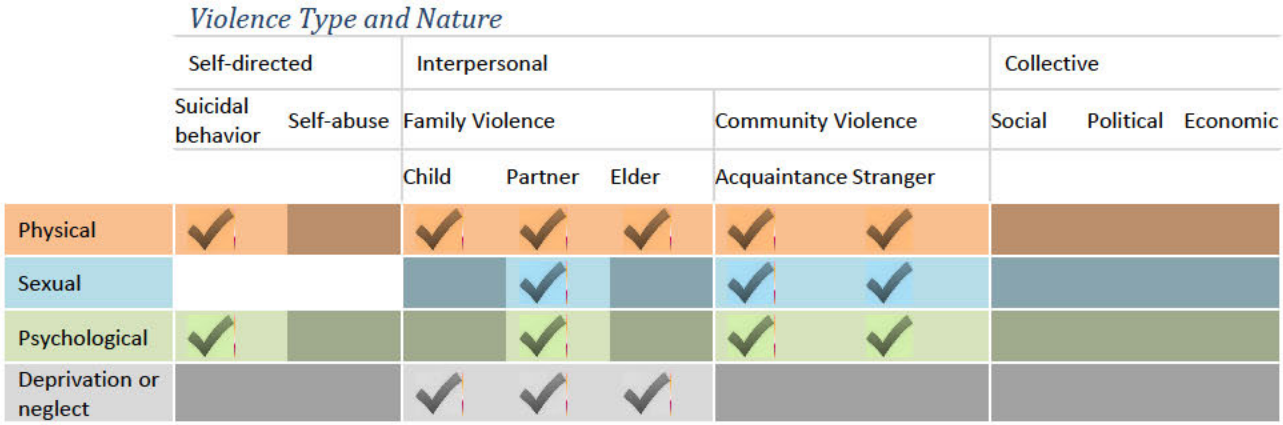
[17] N.J.S.A. 52:17B-241.
[18] Krug, *supra* fn. 8 at 5.
[19] Ibid.

and the broader agency goals of assisting states in using evidence-based practices and standards in carrying out violence prevention activities[20]

WHO proposed a broad categorization of violence that takes into account both the type of victim and the nature of the violent acts.[21] In the World Report, the WHO devotes separate chapters to the types of violence that affect the majority of people in everyday life: **youth violence, child abuse and neglect by parents and other caregivers, violence by intimate partners, abuse of the elderly, sexual violence, self-directed violence (suicide), and collective violence.**[22]

Based on alignment with its mandate and the availability of data and expertise, the Commission focused on a portion of these for study inclusion (as indicated by the checkmarks in Figure 2).

Figure 2. Typology of violence and the Commission's topics of inclusion (adapted from WHO, 2002).



B. Data And Resources

Review and analysis of different types of violence are often limited by available data. Because most data on violence is collected for practical and/or agency-driven purposes, definitions and quality issues among different data sources may also need to be settled in order to ensure better accuracy. A law enforcement summary report such as the Uniform Crime Report ("UCR") will capture data on events that occur in jurisdictions throughout the country, whereas death certificate data are generally reported by residence municipality, county, and/or state.

Another reason to understand the strengths and limitations of data are when merging data with definitional differences or inclusion criteria. For instance, consider a situation where a police officer shoots and kills a suspect in the line of duty:

- The death certificate, using the International Classification of Diseases (ICD-10) coding system for statistical analysis, will code this as a "legal intervention" death

[20] http://www.cdc.gov/violenceprevention/overview/strategicdirections.html.
[21] Krug, *supra* fn. 8 at 7.
[22] Krug, *supra* fn. 8 at Introduction.

provided the information about police involvement is noted on the certificate.[23,24] Otherwise, it would be coded as "homicide."

- Medical examiners do not use the ICD-10 when coding death cases. Guidance from the National Association of Medical Examiners ("NAME") defines homicide as when death results from "an injury or poisoning or from a volitional act committed by another person to cause fear, harm, or death." The intent to cause death is a common element but not required for classification as homicide. [25] This same death will be reported simply as a "homicide" in their data set as there is no separate category for legal intervention deaths.
- This death would not be included at all in the UCR because officer-involved shootings are excluded from that report.

Data for non-fatal injuries resulting from violence are primarily obtained from hospital discharge data from health departments. In New Jersey, these data are maintained by the Office of Health Care Quality Assessment within the state Department of Health. However, because of limitations in coding and lack of mandatory reporting systems for conducting surveillance for most injuries, non-fatal violent injuries are believed to be substantially under-reported. Table 2 outlines the minimum recommended data sets that should be available to a state health department for conducting violence surveillance.[26]

Table 2. Core injuries, injury risk factors, and data sets for state injury surveillance (adapted)

	Vital Records	**Hospital Discharge Data**	**BRFSS YRBSS**	**ED data**	**Medical Examiner data**	**Child Death Review**	**Other***
Firearm injuries	X	X		(X)	(X)	(X)	(UCR) (EMS) (NVDRS)
Homicides	X	X		(X)	(X)	(X)	(UCR) (NVDRS)
Suicides	X	X		(X)	(X)	(X)	(NVDRS)
Suicide Attempts		X	Both	(X)			(EMS)

BRFSS = Behavioral Risk Factor Surveillance System; YRBSS = Youth Risk Behavior Surveillance System; ED = Emergency Department; UCR = Uniform Crime Reporting System; EMS = Emergency Medical Services; NVDRS = National Violent Death Reporting System. () Parentheses indicate data sets that are considered supplementary, all others are considered essential. *NVDRS does not appear in the original listing but is available in New Jersey.

[23] WHO, *International Statistical Classification of Diseases and Related Health Problems 10th Revision* (ICD-10)(2015) available at http://apps.who.int/classifications/icd10/browse/2015/en#/y35-y36.
[24] Ibid.
[25] Centers for Disease Control and Prevention, National Center for Health Statistics, *Medical Examiners' and Coroners' Handbook on Death Registration and Fetal Death Reporting, 2003 Revision* (Hyattsville: Department of Health and Human Services Publication Number 2003-1110)(April 2013) available at www.cdc.gov/nchs/data/misc/hb_me.pdf.
[26] State and Territorial Injury Prevention Directors Association, Injury Surveillance Workgroup 5, *Consensus Recommendations for Injury Surveillance in State Health Departments* (Atlanta: State and Territorial Injury Prevention Directors Association, 2007).

C. General Risk and Protective Factors

As part of its charge, the Commission studied the various root causes and contributing factors of violence, as well as the various protective factors that mitigate the effects of violence and lessen their impact on people and communities. In addition to hearing expert testimony on various types of violence, which in many cases discussed root causes and contributing factors, the Commission reviewed existing research and reports compiled by WHO, CDC, state agencies, and academic peer-reviewed journals.

A joint publication by the CDC and Prevention Institute, Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence (2014), quotes Deborah Prothrow-Stith, M.D., an adjunct professor at Harvard School of Public Health, as saying, "Gang violence is connected to bullying is connected to school violence is connected to intimate partner violence is connected to child abuse is connected to elder abuse is connected. It's all connected."[27] This comprehensive publication is intended to assist practitioners in developing strategically designed prevention programs and employing coordinated, integrated responses to violence.

In Connecting the Dots, risk factors for violence were broken down into societal risk factors, community risk factors, and relationship risk factors. Under this approach, societal risk factors include:

- cultural norms that support aggression toward others;
- media violence;
- societal income inequity;
- weak health, educational, economic, and social policies and laws; and
- harmful norms around the concepts of masculinity and femininity.

Community risk factors include:

- neighborhood poverty;
- high alcohol outlet density;
- community violence;
- diminished economic opportunities/ high unemployment rates, and
- poor neighborhood support and cohesion.

Relationship risk factors include:

- social isolation and lack of social support;
- poor parent-child relationships;
- family conflict;

[27] Wilkins, N., et al., (quoting Deborah Prothrow -Stith, M.D.), National Center for Injury Prevention and Control, Centers for Disease Control and Prevention and Prevention Institute, *Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence*, (Atlanta: Centers for Disease Control and Prevention and Oakland: Prevention Institute, 2014).

- economic stress;
- associating with delinquent peers;
- gang involvement;
- low educational achievement;
- lack of non-violent problem-solving skills;
- poor behavioral control and impulsiveness;
- history of violent victimization;
- witnessing violence;
- psychological and mental health problems; and
- substance abuse.[28]

CDC also considered and evaluated the protective factors that make it less likely that people will experience violence and/or increase their resilience against risk factors for violence. Protective factors can include community protective factors, relationship protective factors, and individual protective factors. Community protective factors can include:

- coordination of resources and services among community agencies;
- access to mental health and substance abuse services; and
- community support and connectedness.

Relationship protective factors include:

- family support and connectedness;
- connection to a caring adult;
- association with pro-social peers; and
- connection and commitment to school.

A protective factor for individuals is having non-violent problem-solving skills.[29]

The authors then compared studies from peer-reviewed journals and considered surveys and statistics that show the association between the above-referenced risk and protective factors and eight different types of violence perpetration: child maltreatment; teen dating violence; intimate partner violence; sexual violence; youth violence; bullying; suicide; and elder maltreatment. The results are staggering. Substance abuse is a risk factor for every category of violence, as are a history of violent victimization and a lack of non-violent social problem-solving skills. Similarly, witnessing violence is a risk factor for all but one type of violence perpetration, and family conflict and harmful norms around masculinity and femininity were contributing factors to all but two types of violence perpetration. The two protective factors with the most far reaching implications across the most types of violence are community support and connectedness, as well as connection and commitment to school.[30]

[28] Ibid.
[29] Ibid.
[30] Id. at 8-9.

Research specifically focused on recurring themes of violence in New Jersey yielded similar findings. Prior exposure to violence, particularly domestic violence, was found to be a significant factor in becoming a victim of future violence. The New Jersey Child Fatality and Near Fatality Review Board reported that of the 158 deaths from 2011 that were reviewed, 50 percent of child suicide victims had been involved in or exposed to domestic violence, and 38 percent of the child homicides involved perpetrators who also had domestic violence in their history.[31] Substance abuse was found to be a powerful predictor of violence.[32] Work by authors at The Violence Institute of New Jersey (formerly UMDNJ, now Rutgers University), found that violence is more likely to occur in areas that are socially disorganized and suffer from economic deprivation,[33] and research from the Michigan State University School of Criminal Justice comparing intimate partner homicide in Newark, New Jersey with Indianapolis, Indiana, found that gender roles and cultural norms were found to be significant risk factors for intimate partner violence and that particular risk factors may vary widely by location.[34]

D. Specific Risk and Protective Factors

The 2002 WHO World Report makes the case that violence is preventable and that public health has a crucial role to play in addressing its causes and consequences. In doing so, the WHO report compiled extensive research and identified and described several key risk factors for different types of violence and further categorized each risk factor as an individual, relationship, community, or societal factor.

1. Youth Violence

WHO's World Report chapter on youth violence reported that at the individual level there are a number of major personality and behavioral factors that may predict violence: hyperactivity, impulsiveness, poor behavioral control, and attention problems.[35] Low intelligence levels and low levels of achievement in school have also been consistently found to be associated with youth violence.[36] Relationship factors for youth violence include family and peer influences, with peer influences gaining increased significance in adolescence.[37]

Regarding family influences, "[p]arental behavior and the family environment are central factors in the development of violent behavior in young people."[38] Specifically, "[p]oor

[31] New Jersey Child Fatality and Near Fatality Review Board, *2013 Child Fatality & Near Fatality Review Board Annual Report,* (Trenton: Department of Children and Families, 2014).
[32] Zarza, M. & Adler, R., *Latina Immigrant Victims of Interpersonal Violence in NJ: A Needs Assessment Study,* J. Of Aggression, Maltreatment and Trauma, Vol. 16 (2008).
[33] Boyle, D. & Hassett-Walker, C., *Individual-Level and Socio-Structural Characteristics of Violence: An Emergency Department Study*, J. Interpersonal Violence, Vol. 23, No. 8, 1011-1026 (2008).
[34] Dejong, C., et al., *Can Situational and Structural Factors Differentiate Between Intimate Partner and "Other" Homicide*, J. Fam. Violence (2011).
[35] Krug, *supra* fn. 8 at 32.
[36] Krug, *supra* fn. 8 at 33.
[37] Krug, *supra* fn. 8 at 33.
[38] Ibid.

monitoring and supervision of children by parents and the use of harsh, physical punishment to discipline children are strong predictors of violence during adolescence and adulthood."[39] Moreover, "[v]iolence in adolescence and adulthood has been strongly linked to parental conflict in early childhood . . . and poor attachment between parents and children."[40] With respect to peer influence, having delinquent friends is associated with violence in young people, but it is not clear whether having delinquent friends came before or after a young person violently offends.[41]

The communities in which young people live are powerful influences. Studies have shown that boys in urban areas, and particularly in high-crime areas, are more likely to be involved in violence. The "presence of gangs, guns and drugs in a locality is a potent mixture, increasing the likelihood of violence."[42] The degree of cohesion or solidarity within a community — or "social capital" — of young people in those communities is also correlated with violence. Violence increases when young people feel less connected, and develop an increased mistrust of other community members due to destruction of infrastructure, amenities, and opportunities.[43] Societal factors such as income inequality, political structures, and cultural influences projecting a norm around violence are also associated with increased violence in young people.[44]

The CDC has made similar findings in its work. In 2011, more than 700,000 young people ages 10 to 24 were treated in emergency rooms nationwide for non-fatal injuries sustained from assaults.[45] On average, 16 people between the ages of 10 and 24 die by homicide each day in the United States.[46] Youth violence jeopardizes the future strength and growth of all communities and it harms the physical, mental, and economic health of all residents.[47] Youth violence has been described as "harmful behaviors that can start early and continue into young adulthood. The young person can be a victim, an offender, or a witness to violence."[48] Youth violence includes acts such as bullying, slapping, hitting which can cause more emotional harm than physical harm, and other acts such as robbery and assault which can lead to serious injury or even death.[49] There are a number of risk factors that can contribute to a youth becoming violent, including individual, family, peer/social and community risk factors. However, there are a number of protective factors that can "buffer" young people from the risks of becoming

[39] Ibid.
[40] Ibid.
[41] Id. at 34.
[42] Id. at 34-35.
[43] Id. at 36.
[44] Id. at 36-37.
[45] CDC, *Youth Violence National and State Statistics at a Glance*, p. 1 (2013) available at www.cdc.gov/violenceprevention//pub/yv_datasheet.html.
[46] CDC, *Youth Violence: Consequences*, p. 1 (2013) available at www.cdc.gov/violenceprevention/youthviolence/consequences.html.
[47] CDC, *Taking Action to Prevent Youth Violence,* p. 2-4, available at ww.cdc.gov/violenceprevention/youthviolence/pdf/opportunities-for-action-companion-guide.pdf.(June 2014).
[48] CDC Injury Prevention & Control: Division of Violence Prevention, *Youth Violence*, 1 (March 8, 2015). available at www.cdc.gov/violenceprevention/youthviolence/index.html.
[49] Ibid.

violent.[50] The goal is to stop youth violence and find prevention efforts that are aimed at reducing factors that place youth at risk for perpetrating violence and promote factors that protect youth at risk for violence.[51]

There are many ways to prevent youth violence but concerted individual efforts are essential. Young people can be taught the skills to help cope with violent situations and develop the self-esteem needed to solve differences without violence. They can be taught about the situations or actions that are likely to result in violence such as associating with violent peers, alcohol and drug use, possessing firearms and weapons. They can be provided with mentors and role models, and provided training, support and recreation.[52] Many resources are needed to have a successful community violence prevention program, but the greatest resource of all is the collaborative effort of the community.[53]

During our public hearings, we heard from many organizations across the state, some at a "micro-local" level, who expressed interest in developing the types of programs that incorporate CDC principles. The overwhelming concern expressed was a lack of available funding for such programs and the limitation on the number and type of participants who can be served. Consistency and follow-up with program participants is essential, as it may be the only stable thing in a child or adolescent's life at that time. Community members have ideas that they are excited about, but identified certain obstacles, including:

- A lack of appropriate spaces to meet (recreation centers, after school spaces, community centers, churches);
- A lack of minimal funds for resources such as extra hours of security staff or utilities, food for the children who were in attendance, or gas money to help with pick-up and drop-off;
- Youth with minor records that would benefit from a program are often excluded from larger funded programs because of restrictions on participant eligibility;
- Adults with records who wish to re-join the community through mentoring are often excluded from larger funded programs because of restrictions on mentor eligibility;
- Loss of program identity - a potentially good community idea gets absorbed by a larger program, and leaves the originators behind;
- While overall strategies may be employed across county and municipal lines, the details of programs and efforts are local and need to cross jurisdictions when appropriate; and

[50] CDC, *Youth Violence: Risk and Protective Factors*, p. 1-4, available at: www.cdc.gov/violence prevention/youthviolence/riskprotectivefactors.html
[51] CDC, *Youth Violence, Prevention Strategies,* p. 1, available at: www.cdc.gov/violencepreventiion/youthviolence/prevention.html
[52] CDC, *The Prevention of Youth Violence: A Framework for Community Action*, p. 3, available at: http://wonder.cdc.gov/wonder/prevguid/p0000026/p0000026.asp
[53] Id. at 10.

- A lack of resources for developing a program, no central directory of programs, and that organizers do not know where to go to get started.

The overwhelming message from the public hearings and expert briefings was that communities want to do this for themselves, to be in control of their neighborhoods, but they need assistance, recommendations on best practices, and resources to help them evaluate, improve, and potentially expand their programs.

2. Child Abuse and Neglect by Parents and Other Caregivers

Based on limited international research in this area, the WHO reported there are a number of factors believed to increase a child's vulnerability or risk of abuse, including those that relate to both the child and caregiver.[54] Age is one such factor, and the risk of the *type* of abuse changes as children get older. While young children are at increased risk for becoming victims of physical abuse, children are more likely to become victims of sexual abuse after the onset of puberty and with the approach of adolescence. Physically abusive parents and caregivers "are more likely to be young, single, poor and unemployed and to have less education than their non-abusing counterparts."[55] Abusers are more likely to have been similarly maltreated by their own parents and/or to be in a violent relationship with an intimate partner, thereby continuing the cycle of abuse.[56] Stress and social isolation of the parent or caregiver is also associated with child abuse and neglect, as is substance abuse.[57]

On a community level, there is a strong association between child abuse and neglect and poverty. Children living in areas with less "social capital" appear to be at greater risk of abuse and have more psychological and behavioral problems.[58] Societal factors such as cultural norms surrounding gender roles, child and family policies, and the strength of the social welfare system are believed to be associated with violence but studies of the impact of these factors are lacking.[59]

In New Jersey, the Child Fatality and Near Fatality Review Board ("NJCFNFRB") was established by passage of the New Jersey Comprehensive Child Abuse Prevention and Treatment Act.[60] The principal objective of the Board is to "provide an impartial review of individual case circumstances and to develop recommendations for broad-based systemic, policy, and legislative revisions for the purpose of preventing future tragedies".[61] Their selective reviews are not limited to homicides or undetermined causes of death - the Board review includes suicides among children and young adults up to age 21, deaths where substance abuse may have been a contributing factor, and

[54] Krug, *supra* fn. 8 at 59-81.
[55] Krug, *supra* fn. 8 at 67.
[56] Id. at 67-68.
[57] Id. at 68.
[58] Id. at 68.
[59] Id. at 68-69.
[60] N.J.S.A. 9:6-8.88.
[61] NJCFNFRB, *2013 Annual Report* (issued 2014) available at www.state.nj.us/dcf/documents/abouut/commissions/fatality/CFNFRB.report2013.pdf.

unintentional injury deaths such as drowning and certain motor vehicle crash situations. The Board's activities include:

- Reviewing child fatalities and near fatalities in New Jersey in order to identify the cause of the incident, the relationship of the incident to governmental support systems, as determined relevant by the Board, and methods of prevention;
- Describing trends and patterns of child fatalities and near fatalities in New Jersey based upon its case reviews and findings;
- Evaluating the response of government support systems to the children and families who are reviewed and to offer recommendations for systemic improvements, especially those that are related to future prevention strategies;
- Identifying groups at high risk for child abuse and neglect or child fatality, in terms that support the development of responsive public policy; and
- Improving data collection sources by developing protocols for autopsies, death investigations, and the complete recording of the cause of death on the death certificate, and make recommendations for system-wide improvements in data collection for the purpose of improved evaluation, potential research, and general accuracy of the archive. [62]

3. Intimate Partner Violence

Through the Commission's work, it has found violence and abuse in the family is connected to all other manifestations of violence, including intimate partner violence ("IPV"), child abuse, sexual violence, youth violence and bullying.

IPV (also referred to as domestic abuse or domestic violence) is prevalent in our communities. 1 in 3 women and 1 in 4 men have experienced some form of physical violence by an intimate partner within their lifetime. 1 in 5 women and 1 in 7 men have experienced severe physical violence by an intimate partner.[63]

For the purposes of this document, IPV is defined as: the willful intimidation, physical assault, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another. It includes physical violence, sexual violence, threats, and emotional abuse. The frequency and severity of domestic violence can vary dramatically.[64]

The risk for women in a relationship with an abusive partner is significant. According to a 2012 report by the Violence Policy Center, 72 percent of all murder/suicides involved an intimate partner and 94 percent of those victims were female.[65] Intimate partner

[62] Ibid.
[63] Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M., *The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (2011) available at http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf.
[64] http://www.ncadv.org/images/National_Domestic_Violence_Statistics.pdf.
[65] Violence Policy Center, *American Roulette: Murder-Suicide in the United States (2012)* available at www.vpc.org/studies/amroul2012.pdf.

homicides also affect the community at large. A study of intimate partner homicides found that 20 percent of victims were not the intimate partners themselves, but family members, friends, neighbors, persons who intervened, law enforcement responders, or bystanders.[66] It is also worth noting that there appears to be a connection between mass shooting incidents and domestic violence. Of 43 instances of "mass shootings" (defined as incidents where at least 4 people are shot) between 2009 and 2013, in at least 17 cases (40%), the shooter killed a current or former spouse or intimate partner, and at least 6 of those shooters (20%) had a prior domestic violence charge.[67]

The CDC recognizes that IPV is "a serious, preventable public health problem that affects millions of Americans," and in 2002 published a set of uniform data elements and definitions for states to use in developing their own surveillance systems for IPV.[68] While women are the most frequent victims of IPV, men can be victims of intimate partner violence and more are starting to come forward; CDC does not exclude men as victims from its prevention efforts.

There are four main types of IPV according to the surveillance definitions: (1) physical violence, such as "hitting, choking, shoving, pushing, or punching with the potential for causing death disability, injury or harm;" (2) sexual violence, including the use of force to compel someone to engage in a sexual act against their will, attempting or completing a sexual act against someone unable to consent due to illness, incapacitation, disability, intimidation or pressure, and abusive sexual contact; (3) threats of physical or sexual violence through words, gestures, or the brandishing of weapons to communicate the intent to cause death, disability, injury or harm; and (4) psychological/emotional violence where IPV victims experience trauma due to acts, threats of acts, or coercive conduct meant to minimize, humiliate, embarrass or diminish them.

In addition, stalking is often included among the types of IPV. Stalking generally refers to "harassing or threatening behavior that an individual engages in repeatedly, such as following a person, appearing at a person's home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing a person's property."

According to the WHO report, among the individual demographic factors associated with intimate partner violence are young age and low income. Both "were consistently

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[66] Smith, S., Fowler, K., & Niolon, P., *Intimate Partner Homicide and Corollary Victims in 16 States: National Violent Death Reporting System, 2003-2009*. American Journal of Public Health, 104(3), 461-466 (March 2014).

[67] Mayor's Against Illegal Guns, *Mass Shootings since January 20, 2009*, available at http://www.washingtonpost.com/blogs/wonkblog/files/2013/02/mass_shootings_2009-13_-_jan_29_12pm1.pdf.

[68] Saltzman LE, Fanslow JL, McMahon PM, Shelley GA, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, *Intimate partner violence surveillance: uniform definitions and recommended data elements, version 1.0*. (Atlanta: Centers for Disease Control and Prevention, 2002) available at www.cdc.gov/violenceprevention/pdf/ipv/intimatepartnerviolence.pdf.

found to be factors linked to the likelihood of a man committing violence against a partner."[69] A history of violence in the family — both being abused as a child and witnessing parental abuse by a father — has been found to be a "powerful risk factor for partner aggression by men."[70]

Studies have also shown that men who assault their partner are more likely to be emotionally dependent, to be insecure and have low self-esteem, to have difficulty controlling impulses, and exhibit greater anger and hostility than non-violent peers.[71]

Some common traits of men who perpetrate domestic violence include: (1) holding traditional beliefs about gender roles (men are "breadwinners," women should stay home); (2) a personal history of, or exposure to, abuse, particularly as a child; (3) previous history of violence against a woman (those who have a history of physical violence against their partners are 13 times more likely to commit future acts of physical aggression compared to persons who have never committed this form of physical abuse.[72]); (4) childhood bullying (men who reported bullying their childhood peers in school were found to be significantly more likely to physically or sexually abuse their female partners as adults); and (5) substance abuse, particularly alcohol, correlates to IPV; however, while drugs and alcohol impair judgment, IPV is a matter of choice often conducted in a "safe" setting for the batterer that minimizes their risk of detection, occurs at a time of their choosing and against a predetermined victim.

According to the Prevention Institute, there are social norms that promote violence against women (such as IPV, sexual assault and stalking):[73]

- Traditional gender roles of men in society, including those that promote domination, control and dangerous risk-taking behavior;
- Traditional gender roles of women in society, including those that promote objectification and oppression of women and girls;
- Power, where value is placed on claiming and maintaining control over others;
- Violence, where aggression is tolerated and blame is attributed to victims; and
- Privacy, individual and family privacy are considered sacrosanct - secrecy and silence is fostered and those who witness violence are discouraged from intervening.

[69] Id. at 97.
[70] Id. at 98.
[71] Id. at 99.
[72] Lisak, D., Hopper, J., & Sung, P., *Factors in the cycle of violence: Gender rigidity and emotional construction*, Journal of Traumatic Stress, 9(4), 721-743 (1996).
[73] Cohen, L. et al., *Poised for Prevention: Advancing Promising Approaches to Primary Prevention of Intimate Partner Violence, Prevention Institute* (2007) available at http://www.preventioninstitute.org/component/jlibrary/article/id-32/127.html.

Similar to the New Jersey Child Fatality and Near Fatality Review Board, the New Jersey Domestic Violence Fatality and Near Fatality Review Board ("Domestic Violence Review Board") was created in 2000 by Executive Order No. 110 and codified by legislation in 2004.[74] The Domestic Violence Review Board's most recent report to the Legislature examined intimate partner violence among women in New Jersey's African American community and found it to be triple that of white women.[75,76]

Children are also affected by IPV – 15.5 million children in the United States live in families where intimate partner violence occurs at least once a year and seven million children live in families where severe partner abuse has occurred.[77] Thirty-one percent of children who witnessed intimate partner violence reported being physically abused themselves.[78] Of those children who did not witness intimate partner violence, only 4.8 percent reported physical abuse. The findings for psychological abuse were similar.[79]

While IPV can be perpetrated by men and women, research shows that 78% of incidents involve male perpetrators, most commonly fathers, and that most children who report seeing IPV have only witnessed male-perpetrated violence.[80] Overall, studies indicate that children who witness domestic violence can have increased experiences of negative emotions, such as anxiety and depression, and can suffer from post-traumatic stress disorder (PTSD).[81]

The longer-term impact on children who are exposed to IPV is also troubling. A study of young adolescents in the Cleveland area found that "recent exposure to violence at home…was one of the most significant predictors of a teen's use of subsequent

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[74] N.J.S.A. 52:27D-43.17b.

[75] New Jersey Domestic Violence Fatality and Near Fatality Review Board, *Findings and Recommendations of the 2013 Domestic Violence Fatality & Near Fatality Review Board: Intimate partner violence in New Jersey's African American Community: Findings and recommendations of the 2013 Domestic Violence fatality & Near Fatality Review Board,* p. 1 (Trenton: Department of Children and Families, 2013) available at http://www.nj.gov/dcf/news/reportsnewsletters/taskforce/DVFNFRB%20Report.pdf.

[76] Center for Health Statistics, New Jersey Department of Health, *Deaths Associated with Intimate Partner Violence (New Jersey Violent Death Reporting System),* (Trenton: New Jersey Department of Health and Senior Services, 2009).

[77] Whitfield, C., Anda, R., Dube, S., Felittle, V., *Violent Childhood Experiences and the Risk of Intimate Partner Violence in Adults: Assessment in a Large Health Maintenance Organization*. Journal of Interpersonal Violence. 18(2): p. 166-185.(2003).

[78] Rosewater, A., *Promoting Prevention, Targeting Teens: An Emerging Agenda to Prevent Domestic Violence,* Family Violence Prevention Fund, 11 (2003).

[79] Hamby, S, Finkelhor, D., Turner, H., & Ormrod, R. *The Overlap of Witnessing Partner Violence with Child Maltreatment and Other Victimizations in a Nationally Representative Survey of Youth*, 34 *Child Abuse and Neglect,* p. 734, 737 (2010).

[80] Ibid.

[81] Summers, A., *Children's Exposure to Intimate Partner Violence and Other Family Violence, Juvenile Justice Bulletin (Office of Juvenile Justice and Delinquency Prevention),* October 2011 at p. 7 available at https://www.ncjrs.gov/pdffiles1/ojjdp/232272.pdf.

violence at school or in the community."[82] Of the roughly 457,000 14 to 24 year-olds that leave the juvenile justice system, federal and state prisons or local jails annually, a "high percentage" have experienced or witnessed violence at home.[83]

Intimate partner violence also affects adolescents. One in three adolescent girls in the United States is a victim of physical, emotional or verbal abuse from a dating partner, a figure that far exceeds victimization rates for other types of violence affecting youth.[84] Boys are more likely to inflict injuries as a result of perpetrating dating violence than girls. This trend – where girls slap and push and boys hit and punch – continues into adulthood.[85] Teen victims of physical dating violence are also more likely than their non-abused peers to smoke, use drugs, engage in unhealthy diet behaviors (taking diet pills or laxatives and vomiting to lose weight), engage in risky sexual behaviors, and attempt or consider suicide.[86]

4. Women's Use of Force

Following changes in law enforcement policies that encourage or mandate the arrest of domestic violence offenders, a concomitant increase in women arrested and mandated to batterer treatment programs has occurred. Most research shows that heterosexual intimate partner violence is gendered – that is, men engage in IPV as a means to wield power and control, whereas women engage in IPV for self-defense or for non-aggressive reasons.[87]

That said, there are instances when women use force to gain power and control over their partner; however, research suggests this more commonly occurs as a means of retaliation or resistance against abuse and is done to stop or escape from violence.[88] While women can be the instigators of IPV, it is far less common and rarely is the use of violence the first or only tactic to stop their partner's ongoing abuse. Often, violence occurs after other tactics such as negotiation, appeasement, seeking help from others

[82] Singer, M.I., Miller, D.B., Guo, S. et. al., *Children's Exposure to Domestic Violence: A Guide to Research and resources,* 21-23(National Council of Juvenile and family Court Judges et. Al., 2006) available at http://www.ncjfcj.org/sites/default/files/Childrenss%20Exposure%20to%20Violence.pdf (last accessed August 10, 2015).
[83] Rosewater, A., *Promoting Prevention, Targeting Teens: An Emerging Agenda to Prevent Domestic Violence*, Family Violence Prevention Fund, p. 11 (2003).
[84] Id. at 11.
[85] The National Council on Crime and Delinquency, *Interpersonal and Physical Dating Violence Among Teens,* 1 (Sept. 2008) available at http://www.nccdglobal.org/sites/default/files/publication_pdf/focus-dating-violence.pdf.
[86] Silverman, J, Raj A, et al. 2001. Dating Violence Against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behavior, Pregnancy, and Suicidality. *JAMA*. 286:572-579. Available at http://jama.ama-assn.org/cgi/reprint/286/5/572.
[87] Silverman, J, Raj A, et al., *Dating Violence Against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behavior, Pregnancy, and Suicidality*, 286(5) Journal of American Medical Association, p. 572-578 (2001).
[88] Susan L. Miller, S.L. & Michelle L. Meloy, *Women's Use of Force: Voices of Women Arrested for Domestic Violence*, 12(1) Violence Against Women 89-115 (2006).

(e.g., family, friends, law enforcement), and/or threatening to leave or withdraw from the relationship have failed.[89]

5. Elder Abuse

The WHO defines elder abuse as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person." It can include "physical, psychological or emotional, sexual and financial abuse." It includes intentional and unintentional neglect.[90]

Research on individual risk factors of elder abuse reported by the WHO indicates that abusers who are physically aggressive are more likely to have substance abuse problems and mental health issues than non-violent family members and caregivers.[91] Financial difficulties on the part of abusers also appear to be an individual risk factor.[92] Relationship risk factors include the level of stress of the caregiver as a contributing factor in cases of abuse, but a dependent victim and overstressed caregiver does not in itself predict elder abuse.[93] Older people are more at risk of abuse when living with the caregiver. In terms of community and societal risk factors, "social isolation emerges as a significant one in elder mistreatment."[94] "Cultural norms and traditions — such as ageism, sexism and a culture of violence — are also now recognized as playing an important underlying role" in elder abuse.[95]

6. Sexual Violence

The WHO defines sexual violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work."[96] Coercion can include physical force, psychological intimidation, blackmail, or threats, and encompasses situations where the victim is unable to give consent.[97] It includes rape, attempted rape and gang rape:

- Rape – physically forced or otherwise coerced penetration of the vulva or anus, using a penis, other body parts or an object.

[89] Larance, L., *Serving Women Who Use Force In Their Intimate Heterosexual Relationships: An Extended View*. Violence Against Women, 12(7) p. 622-640 (2006).
[90] Ibid.
[91] World Health Organization, *Elder Abuse*, available at: http://www.who.int/ageing/projects/elder_abuse/en/
[92] Ibid.
[93] Ibid.
[94] Krug, *supra* fn. 8 at 130.
[95] Id. at 131.
[96] Ibid.
[97] Ibid.

- Gang rape – the rape of a person by two or more perpetrators.[98]

Forms and contexts of sexual violence include:

- rape within marriage or dating relationships;
- rape by strangers;
- systematic rape during armed conflict;
- unwanted sexual advances or sexual harassment, including demanding sex in return for favors;
- sexual abuse of mentally or physically disabled people;
- sexual abuse of children;
- forced marriage or cohabitation, including the marriage of children;
- denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases;
- forced abortion;
- violent acts against the sexual integrity of women, including female genital mutilation and obligatory inspections for virginity; and
- forced prostitution and trafficking of people for the purpose of sexual exploitation.[99]

Although there is not a single definition, trafficking for the purpose of sexual exploitation includes "the organized movement of people, usually women, between countries and within countries for sex work" and "coercing a migrant into a sexual act as a condition of allowing or arranging the migration."[100]

According to the WHO report, factors increasing a woman's vulnerability to sexual violence include being young, consuming alcohol or drugs, having been previously raped or sexually abused, having many sexual partners, being involved in sex work, poverty, and, in situations where sexual violence is perpetrated by an intimate partner, becoming more educated or economically empowered.[101] Factors increasing a man's risk of committing rape include, alcohol and drug consumption (particularly cocaine) and various psychological factors. Men who commit rape are more likely to consider the victims responsible for the rape, are less knowledgeable about the impact of rape on the victims, misread cues by women in social situations, have problems with aggression and impulse control, have coercive sexual fantasies and are generally encouraged by access to pornography.[102]

Among the reported peer and family risk factors for sexual violence are childhood environments that are physically violent, emotionally unsupportive, and patriarchal (as opposed to egalitarian) family structures.[103] There is also evidence to suggest that

[98] Ibid.
[99] Id. at 149.
[100] Ibid.
[101] Ibid.
[102] Krug *supra* fn. 8 at 149-150.
[103] Id. at 160.

sexual violence is learned behavior in some men, particularly with child sexual abuse.[104] Poverty is a community risk factor for sexual violence and it is linked both to the perpetration of sexual violence and the risk of becoming a victim.[105] Another community risk factor is the tolerance of a community and the strength of sanctions for the sexually violent conduct.[106] Societal factors include laws and policies about sexual violence, global trends and economic factors (that may increase the likelihood of sex trafficking), and societal norms such as ideologies of male sexual entitlement and the use of violence as a means to achieve objectives.[107]

As with tracking the problem of intimate partner violence in the United States, the CDC has developed a set of uniform definitions and data elements for states to use in their sexual violence surveillance efforts.[108] Passage of the Violence Against Women Act in 1994 established the Rape Prevention and Education program at CDC ("RPE"), with the goal of strengthening sexual violence prevention efforts at the state, local, and national level. All 50 states, the District of Columbia, Puerto Rico, and four United States territories participate in the program. An inter-departmental collaboration occurs in New Jersey, as the Department of Health is the grantee for funds and the Department of Children and Families implements the programs.

7. Suicide or Self-Directed Violence

In the course of defining its scope of work, the Commission felt it was important to gain an in-depth understanding of suicide and self-directed injury in addition to interpersonal violence. While suicide and self-directed injury have traditionally not been regarded as "violence" the way child abuse or homicide have been (unless it is a murder-suicide), suicide and attempted suicide are unquestionably violent acts that result in harm and death, with many of the same characteristics as homicide. Again, from the World Health Organization:

> Suicide (self-directed violence) is a focus because suicidal behavior is often the end result of many of the same underlying social, psychological, and environmental factors as other types of violence.[109]

From the hearings and briefings, it became apparent that prevention programs for suicide face many of the same hurdles that homicide prevention programs face: lack of funding for programs and limitations on the number and type of participants able to be served. This can include inconsistent mental and behavioral healthcare follow-up with those at risk for suicide and suicidal behavior, regardless of a patient's insurance status;

[104] Id. at 161.
[105] Ibid.
[106] Ibid.
[107] Id. at 162.
[108] Basile K., Smith S., Breiding M., Black M., Mahendra R., Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, *Sexual Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 2.0.* (Atlanta: Centers for Disease Control and Prevention, 2014).
[109] Krug, *supra* fn. 8 at p. 5.

being known to law enforcement for disruptive or unusual behavior without the recognition of suicidality; and stigma attached to seeking help, particularly among the groups most at risk for completing suicide (middle-aged men, veterans, police and correctional officers). In addition to deaths and injuries, the Commission also recognizes the important but difficult-to-measure experience of suicidal ideation, which is defined as thinking about, considering, or planning for suicide.[110]

According to the CDC, suicide was the 11th leading cause of death overall in the United States every year from 1999 through 2007; from 2008 through 2013 (when the most recent data are available), suicide became the 10th leading cause of death in our country. In 2013, more than 41,000 people died by suicide nationally, two and half times the number that died from homicide and legal intervention combined.[111]

In alignment with the WHO definition of "violence,"[112] the CDC further describes suicidal violence as, "behavior that is self-directed and deliberately results in injury or the potential for injury to oneself." The CDC gives further clarification of what the behavior is *not*: "this does not include behaviors such as parachuting, gambling, substance abuse, tobacco use or other risk taking activities, such as excessive speeding in motor vehicles."[113] The distinction being that, while the behaviors may be life-threatening, there is no intent on the part of the risk-taker to injure themselves or die.

According to the WHO report, self-directed violence, or suicidal behavior "ranges in degree from merely thinking about ending one's life, through developing a plan to commit suicide and obtaining the means to do so, attempting to kill oneself, to finally carrying out the act."[114] As with other types of violence, research indicates that suicidal behavior has a large number of complex factors that interact with one another, and many of them are repeated across violence types. The risk factors include demographic factors, as well as psychiatric, biological, social, environmental factors, and factor related to an individual's life history, including:

- family history of suicide;
- family history of child maltreatment;
- previous suicide attempt(s);
- history of mental disorders, particularly clinical depression;
- history of alcohol and substance abuse;
- feelings of hopelessness;
- impulsive or aggressive tendencies;
- cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma);
- local epidemics of suicide;
- isolation, a feeling of being cut off from other people;

[110] http://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf (2012).
[111] CDC, WISQARS, *supra* fn. 2.
[112] Krug, *supra* fn. 8 at 5.
[113] CDC, *supra* fn. 2.
[114] Krug, *supra* fn. 8 at 185.

- barriers to accessing mental health treatment;
- loss (relational, social, work, or financial);
- physical illness;
- easy access to lethal methods; and
- unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts[115]

Some of the principal psychiatric and psychological factors associated with suicide are:

- major depression;
- other mood affective disorders;
- schizophrenia;
- anxiety, personality, and conduct disorders;
- impulsivity; and
- a sense of hopelessness.[116]

There are also biological and medical markers for suicide, such as:

- having a family history of suicide; and
- altered levels of serotonin metabolites in the cerebrospinal fluids.[117]

Physical illness is also an important contributory factor to suicidal ideation and completion, particularly when accompanied with psychiatric symptoms.[118] Life events that may serve as precipitating factors for suicide include:

- personal loss;
- interpersonal conflict;
- a broken or disturbed relationship; and
- legal or work-related problems.

These difficult life events can lead to feelings of hopelessness and depression.[119] Other types of life events, such as being a victim of physical or sexual abuse in childhood, are also risk factors for suicide, as they may result in feelings of humiliation and shame and negatively impact the victim's ability to maintain positive interpersonal relationships.[120] In adolescents and young adults, sexual orientation may be related to an increased risk of suicide due to discrimination, stress in interpersonal relationship, and limited sources of support, among other reasons.[121]

Social and environmental risk factors for suicide include:

[115] Krug, *supra* fn. 8 at 191-192.
[116] Id. at 192.
[117] Id. at 194.
[118] Id. at 194.
[119] Krug, *supra* fn. 8 at 193.
[120] Id. at 193-94.
[121] Id. at 195.

- the availability of the means of suicide;
- a person's place of residence, employment, or immigration status;
- religious affiliation; and
- economic conditions such as periods of recession and high unemployment.[122]

There is a great deal of national attention paid to the availability of firearms and the risk of suicide. The Firearm Injury Center at the University of Pennsylvania published a data report that looked at firearm use in suicide, and found that firearms were the most commonly used weapon to complete suicide nationally, a result confirmed by CDC.[123] In New Jersey, the most utilized method of suicide is hanging/strangulation/suffocation, with firearms ranked second and drug overdoses ranked third.[124]

More recently, New Jersey has seen a trend toward more extreme methods of suicide, including suicides involving pedestrians jumping in front of moving trains or motor vehicles on highways.[125] With the online publication of an update to the suicide how-to book "Final Exit" in 2009, New Jersey experienced an increase in suicide methods directly referenced in the book, indicating an increasing use of the internet for researching suicide methods among people with the intent to complete suicide.[126,127]

Although they have not been studied as extensively as risk factors, understanding protective factors for suicide is equally as important as understanding risk factors, and they are consistent with protective factors for other types of violence. According to the U.S. Public Health Service,[128] these protective factors may include:

- effective clinical care for mental, physical, and substance abuse disorders;
- easy access to a variety of clinical interventions and support for help seeking;
- family and community support (connectedness);
- support from ongoing medical and mental health care relationships;
- skills in problem solving, conflict resolution, and nonviolent ways of handling disputes; and
- cultural and religious beliefs that discourage suicide and support instincts for self-preservation.

[122] Id. at 196-98.
[123] Firearm and Inquiry Center at Penn (FICAP), *Firearm Injury in the United States (*2011), available at: http://citeseerx.ist.psu.edu/viewdoc/download;jsessionid=7E26A51558378A7472DDD0CF83D7AADB?doi=10.1.1.394.3321&rep=rep1&type=pdf
[124] Center for Health Statistics, NJVDRS Update (2015). http://www.nj.gov/health/chs/oisp/njvdrs.shtml
[125] Ibid.
[126] Jacquemin, B., *Increased Use of Helium and Plastic Bag Suicide Technique in New Jersey, 2003-2009,* Portland, OR, 2010 CSTE Annual Conference (2010).
[127] CHSI, *NJVDRS Update,* 2015 supra fn. 124.
[128] CDC, Injury Prevention and Control: Division of Violence Prevention, *Suicide: Risk and Protective Factors*, available at http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html.

8. Collective Violence

The final category of violence and its risk factors as addressed by the WHO is collective violence, which includes, among other things, war, terrorism and other violent political conflict, as well as organized violent crime such as banditry and gang warfare.[129] Risk factors for collective violence include political factors, such as unequal access to power; economic factors, such as unequal access to or unequal distribution of resources and control over drug production and trading; societal and community factors, such as the fueling of group fanaticism along ethnic, national or religious lines, and the ready availability of small arms and other weapons, and rapid demographic change.[130]

As discussed later in this report, a gang presence can be found throughout the state of New Jersey. While the World Report does not go into detail on gang violence in the United States or in New Jersey, this is a significant segment of interpersonal violence, especially in urban areas. Many times this is the primary manifestation that comes to mind when the word "violence" is heard. This discussion is included in the "Collective Violence" category because while the suspect-victim interaction is primarily a subset of interpersonal violence, whole neighborhoods and communities are traumatized by gang violence. Additionally, significant resources are diverted to this problem to the detriment of other community priorities.

E. Statistics On Violence

1. National Statistics

Violence continues to be a significant problem in the United States and affects people in all stages of life. In 2013, more than 41,000 people died by suicide, and homicide claimed nearly 17,000 lives.[131] Since 1965, homicide and suicide have consistently been among the top 15 leading causes of death in the United States.[132]

The Federal Bureau of Investigation ("FBI") reports on violent crime in the United States each year through the publication of its annual Uniform Crime Report ("UCR"). The UCR defines "violent crime" as: murder and non-negligent manslaughter, rape, robbery, and aggravated assault, and involve force or the threat of force (similar to the WHO's definition).[133] In 2013, an estimated 1,163,146 violent crimes occurred in the United States, a decrease of 4.4 percent from the 2012 estimate. Aggravated assaults accounted for 62.3 percent of violent crimes reported, robbery offenses 29.7 percent;

[129] Krug, *supra* fn. 8 at 215.
[130] Krug, *supra* fn. 8 at 220-22.
[131] CDC, WISQARS, *supra* fn. 2.
[132] National Center for Health Statistics, National Vital Statistics System. *Leading Causes of Death 1900-1998*, available at: http://www.cdc.gov/nchs/data/dvs/lead1900_98.pdf.
[133] Uniform Crime Reporting Program, U.S. Department of Justice, Federal Bureau of Investigation, *Crime in the United States 2013* available at: http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2013/crime-in-the-u.s.-2013/violent-crime/violent-crime-topic-page/violentcrimemain_final.

rape 6.9 percent, and murder 1.2 percent. Firearms were used in 69 percent of the nation's murders, 40 percent of robberies and 21.6 percent of aggravated assaults.[134]

A second report, the National Crime Victimization Survey ("NCVS"), that surveys victims of crime, also found there to be a decrease in violent crime in 2013; however, it found no statistically significant change in the rate of "serious violence," which NCVS defines as rape or sexual assault, robbery or aggravated assault.[135] Additionally, the NCVS found there was no significant change from 2012 to 2013 in the rates of firearm violence, violence resulting in injury to a victim, domestic violence or intimate partner violence.[136]

While national violent crime statistics, which enumerate interpersonal violence, show a small decrease from 2012 to 2013, national suicide statistics show that a rise in suicide rates that began in 2004 has continued through 2013.[137] Citing a 2013 SAMHSA study, the latest report from the American Association for Suicidology indicates there is a 25:1 ratio, meaning that for the 41,000 Americans who died by suicide in 2013, there were nearly 1,030,000 suicide attempts.[138] However, the ratio of attempts to suicides varies greatly depending on age range. For example, the ratio is 100-200:1 for young people but 4:1 for the elderly. It is estimated that each suicide intimately affects 6 other people, which makes 1 out of every 64 Americans a "suicide survivor" - a close family friend or loved one left behind when someone takes their own life.[139]

2. New Jersey Statistics

New Jersey is home to a broad multi-cultural population living in small towns and villages older than the nation itself, sprawling suburban developments, and city centers within commuting distance to our nearest major metropolitan influences, New York City and Philadelphia. The state is organized into 21 counties, 566 municipalities, and with a population of nearly 9 million people, New Jersey is the most densely populated state in the nation.[140] The locally-oriented nature of the state can present certain challenges when attempting to define a problem statewide and implement generalized solutions.

a. Homicide and Interpersonal Violence

Interpersonal crime in New Jersey is reported at the state, county, and municipal level, and is included in the state's contribution to the FBI's UCR. The six largest communities have been identified as "Major Urban" in the UCR - these are Camden, Jersey City, Paterson, Elizabeth, Newark and Trenton. The 15 urban communities with populations

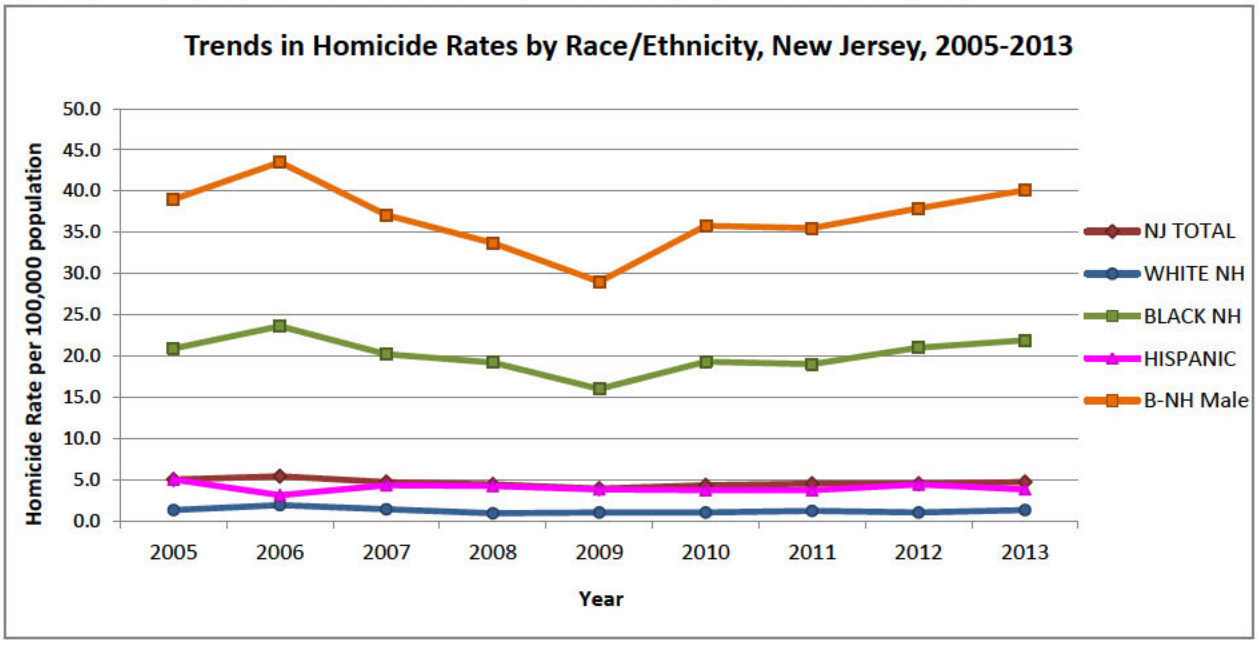
[134] Ibid.
[135] *National Crime Victimization Survey 2013* available at: http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5111
[136] Ibid.
[137] Drapeau, C., & McIntosh, J., *U.S.A. Suicide 2013: Official Final Data,* American Association of Suicidology, available at http://www.suicidology.org.
[138] Ibid.
[139] Ibid.
[140] https://www.census.gov/compendia/statab/2012/tables/12s0014.pdf.

of 50,000 or more are classified as the "Urban 15": Bayonne, Camden, Clifton, Toms River, East Orange, Elizabeth City, Irvington, Jersey City, Newark, Passaic, Paterson, Trenton, Union, Vineland and Woodbridge.[141] These large urban cities represent about 19 percent of New Jersey's population but account for a significant percentage of the violent crime in our state. For example, more than half of all murders in New Jersey occur in the six "major urban" areas and roughly three-quarters of all violent crime occurs in the Urban 15 cities.[142]

Overall, crime is trending down in New Jersey. Preliminary data shows that violent crime was down 9.9 percent in 2013 versus 2012 and that crime overall was down more than 7 percent;[143] however, the reductions in crime the state has experienced have not been evenly distributed. For example, in the past ten years, violent crimes (murder, rape, robbery and aggravated assault) have decreased by 18 percent statewide; however, in the six major urban cities they have experienced only a 1 percent decrease.

Another source of data regarding violent crime is the New Jersey Department of Health's New Jersey Violent Death Reporting System ("NJVDRS"). Although the NJVDRS is limited to deaths due to violence, the program follows the CDC and WHO definition of "homicide" and is therefore more inclusive than the UCR. Deaths are reported both at the level of occurrence of the injury and the victim's municipality of residence. The NJVDRS incorporates the UCR as one of its data sources, along with data from death certificates and the Office of the State Medical Examiner.

Figure 3. Trends in homicide rates in New Jersey, 2005-2013 (CHSI, NJVDRS 2015 Update)



[141] Uniform Crime Report, *supra* fn. 133 at 106.
[142] Id. at 104.
[143] http://www.nj.gov/oag/newsreleases15/2013_Uniform-Crime-Report.pdf

As Figure 3 indicates, although homicide rates overall and among non-Hispanic whites and the Hispanic population have remained relatively stable over the past 10 years, homicide rates among the black, non-Hispanic population and among the black male, non-Hispanic population began trending upward around 2009. This initial uptick occurred in places like Newark, Camden, and Trenton that experienced reductions in law enforcement. In response, federal, state, and local law enforcement agencies throughout the state have emphasized the need for greater collaboration and cooperation to address violent crime. In places like Camden and Trenton, more recent reductions in murders have been attributed to integrated, multi-agency law enforcement collaboratives that utilize concepts like intelligence-led policing, community outreach, and improved technological capability.[144] Statewide, homicides were down 5% in 2014 as compared to 2010 and the total number of violent crimes was down 15% compared to 2010.[145]

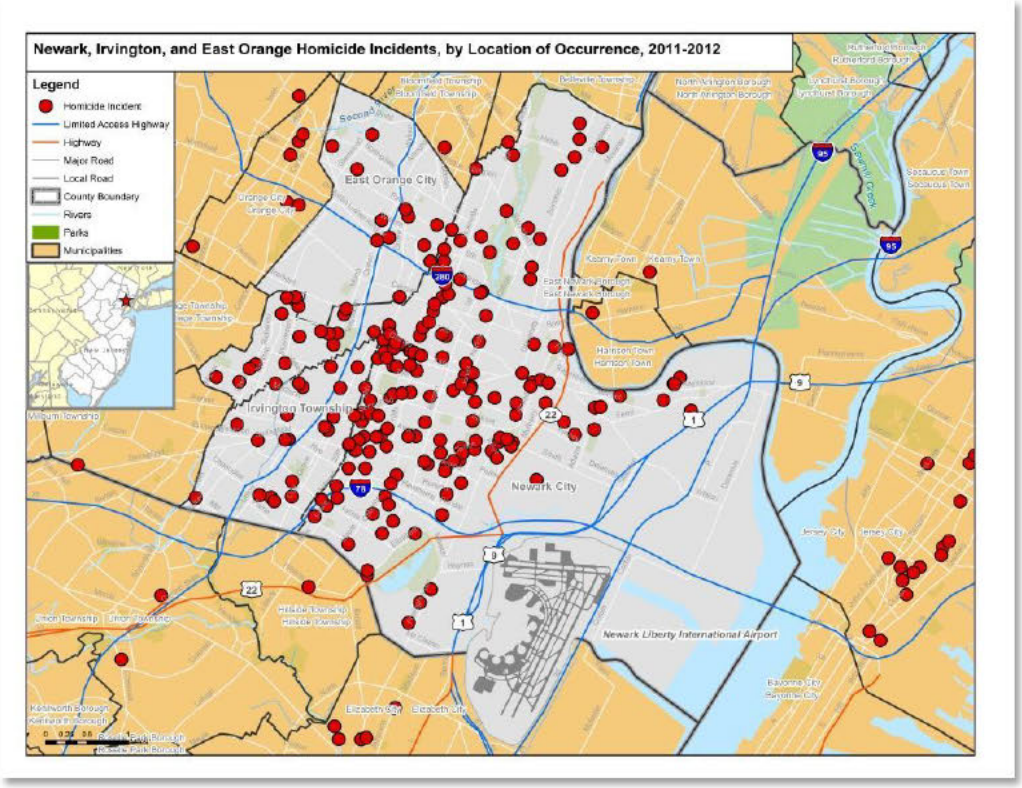
The need for collaborative law enforcement is best illustrated in Northern New Jersey, with its densely populated cities and proximity to mass transportation. As Figure 4 indicates, homicides occur in concentrations that cross municipal boundaries, as highlighted in the example of the neighboring municipalities of Newark, East Orange, and Irvington. The Commission notes that a cross-jurisdictional effort, Corridor-Status ("Corr-Stat"), launched nearly three years ago among agencies in North Jersey, now includes more than 30 local law enforcement agencies, five county prosecutor's offices, and federal and state partners who meet regularly to discuss crime trends and patterns and share information on the criminal environment in their cities. Corr-Stat is now supported by the Real Time Crime Center, which opened in Newark in December 2014. The RTCC pushes out intelligence as it is generated and will help investigators in the field by getting them information more quickly.

144

http://www.nj.com/news/index.ssf/2015/01/declines_in_newark_camden_drive_nj_homicides_down_15_percent_in_2014.html,
http://www.nj.com/opinion/index.ssf/2015/02/editorial_trenton_police_meeting_with_community_fo.html,
http://nj.gov/oag/newsreleases14/pr20140514c.html

145 http://www.njsp.org/info/ucr2010/pdf/2010_uniform_crime_report.pdf (2010 statistics),
http://www.njsp.org/info/pdf/ucr/current/20150904_ucr_2014stats.pdf (2014 statistics).

Figure 4. Violence does not respect municipal borders (CHSI, NJVDRS 2015 Update)



Firearms play a large role in the lethality level of interpersonal violence. Firearms are responsible for between 65 percent and 70 percent of all homicides occurring in New Jersey annually, followed by sharp instruments accounting for nearly 15 percent of homicides and blunt instruments accounting for 7-10 percent of homicides each year. This relative proportion in weapon of choice has been fairly stable for at least the last decade.[146]

b. New Jersey Gang and Gun Statistics

According to the 2010 New Jersey State Police Gang Survey,[147] all 21 counties have a gang presence and of the 565 municipalities that responded to the survey, 45 percent reported a gang presence, and 30 municipalities reported a gang presence for the first time. Nine municipalities that had previously reported a gang presence reported that they were gang free. In all, 1,575 sets of 244 gangs were reported to be present in New Jersey, including:

- Latin Kings – reported presence in 106 towns;
- Sex Money Murder Bloods – reported presence in 95 towns;
- Nine Trey Bloods – reported presence in 86 towns;
- Pagans Motorcycle Club – reported presence in 79 towns;
- G-Shine/G.K.B. Bloods – reported presence in 73 towns;
- MS-13 – reported presence in 67 towns; and

[146] CHSI, NJVDRS Update, *supra* fn. 124.
[147] New Jersey State Police Gang Survey available at http://www.njsp.org/info/pdf/gangs_in_nj_2010.pdf.

- Grape Street Crips – reported presence in 51 towns.[148]

Nine out of 21 counties reported a presence of 90 or more gangs:

- Essex – 106 gangs
- Monmouth – 132 gangs
- Middlesex – 126 gangs
- Ocean – 114 gangs
- Bergen – 108 gangs
- Camden – 107 gangs
- Burlington – 101 gangs
- Atlantic – 97 gangs
- Union – 95 gangs[149]

c. 2014 Statistics

The following is a comparison of the 10 cities with the highest reported gang population and the 10 cities with the highest number of shooting hits (data as of 11/12/14 provided by the New Jersey State Police). As Table 5 shows, six of the cities with the highest reported gang population are also in the top 10 of reported shooting hits.

Table 5: Cities with the highest number of shooting hits cross-referenced with cities with the highest number of known gang members

Municipality	**Number of Gang Members**	**Number of Shooting Hits**
Newark	2,664	296
Paterson	1,940	112
Camden	Not in top 10	117
Trenton	1,330	140
Jersey City	Not in top 10	77
Elizabeth	Not in top 10	51
Plainfield	1,030	24
Irvington	885	37
Orange	685	Not in top 10
Bridgeton	600	Not in top 10
East Orange	584	15
Union City	522	Not in top 10
Atlantic City	488	52
New Brunswick	Not in top 10	18

While New Jersey has some of the strictest gun control and safety laws in the country,[150] many of the guns used in crimes here are trafficked into New Jersey from

[148] Id. at 1.
[149] Ibid.

other states. As Table 6 notes, out of 3,834 guns recovered in New Jersey in 2013, approximately 87 percent were purchased in another state and transported into New Jersey. The cities where the most guns were recovered are also the cities with the highest number of shooting murders, including Newark, Camden, Trenton, Paterson, Atlantic City, East Orange, and Irvington. In sum, while guns play a significant role in incidents of violent crime in New Jersey, most of the guns used in the commission of crime appear to be purchased from out-of-state and brought into New Jersey.

Table 6: More crime guns originate from out-of-state than New Jersey (USDOJ, ATF, 2013 Report #143900)

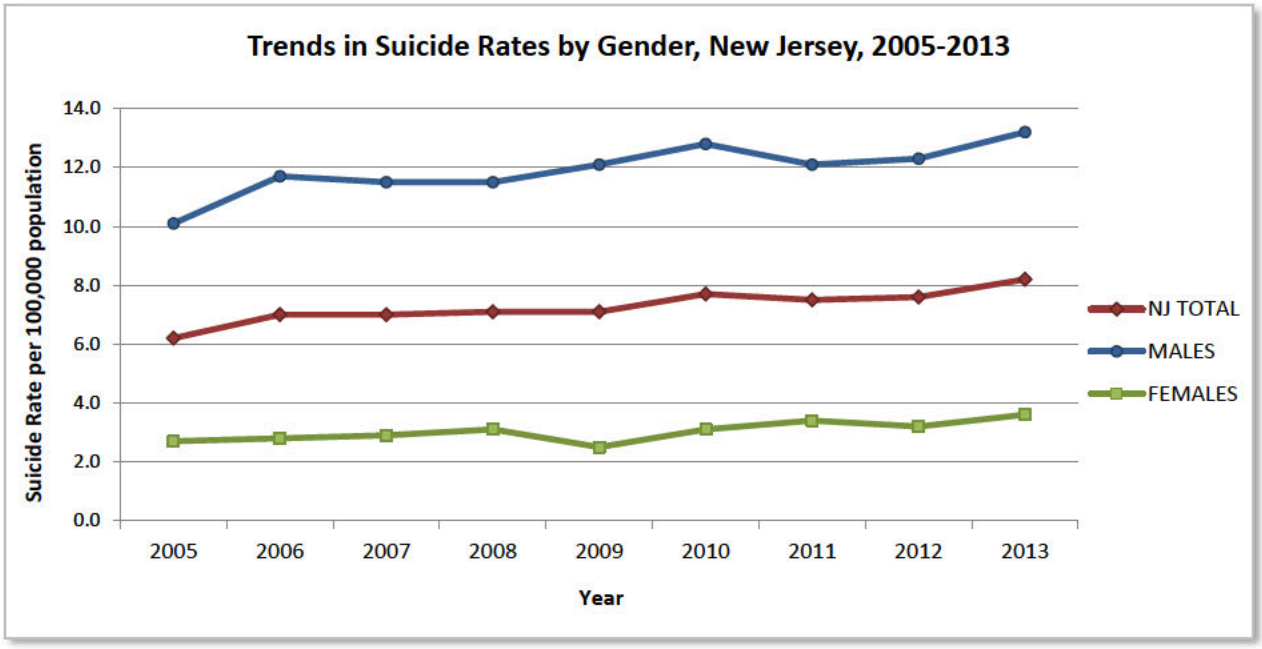
State of Origin	**Number of Guns Recovered**
New Jersey	496
Pennsylvania	363
Virginia	189
North Carolina	176
Georgia	158
South Carolina	137
Florida	135
Ohio	78
New York	66
Texas	48
Alabama	45
West Virginia	31
Tennessee	20
California	17
Louisiana	17
Indiana	17

d. Suicide and Self-Directed Violence

While homicide is what traditionally comes to mind when discussing "violence", it is only part of the picture - one of several possible outcomes for people who face, in many ways, similar challenges in their lives and communities. For every homicide in New Jersey since 2005, there have been on average 1.7 suicides, and recent trends indicate that suicide is increasing in New Jersey (Figure 5).[151]

[150] The Law Center to Prevent Gun Violence and the Brady Campaign to Prevent Gun Violence, *2013 State Scorecard: Why Gun Laws Matter*, 4 (2013) available at: www.bradycampaign.org/sites/default/files/2013-scorecard.pdf.
[151] CHSI, NJVDRS Update, 2015, *supra* fn. 124.

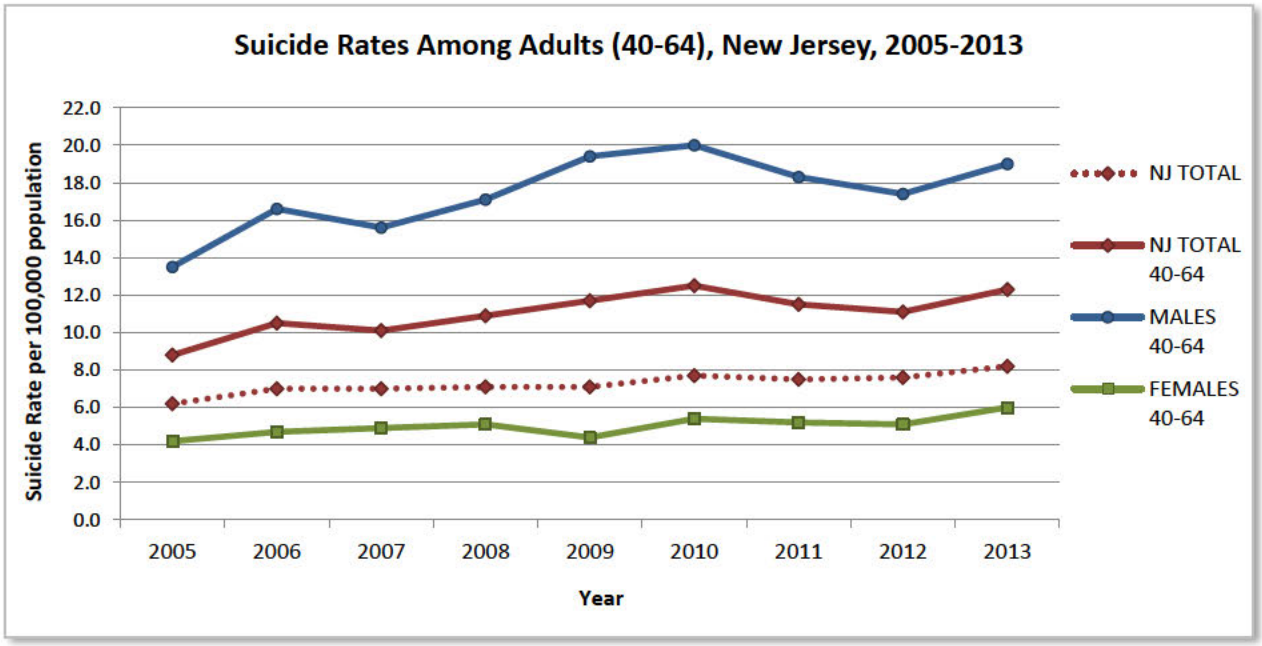
Figure 5. Suicide is increasing nationally and in New Jersey (CHSI, NJVDRS 2015 Update)



Simply being "male" is a risk factor for injuries and violence. While the overall suicide, overall female suicide, and middle-aged female suicide rates have slowly but steadily increased in the past decade, the overall male suicide rate and the middle-age male suicide rates have risen dramatically (Figure 6).[152] Suicide is predominant among white non-Hispanics than other race and ethnic groups (Figure 7).[153]

[152] Ibid.
[153] Ibid.

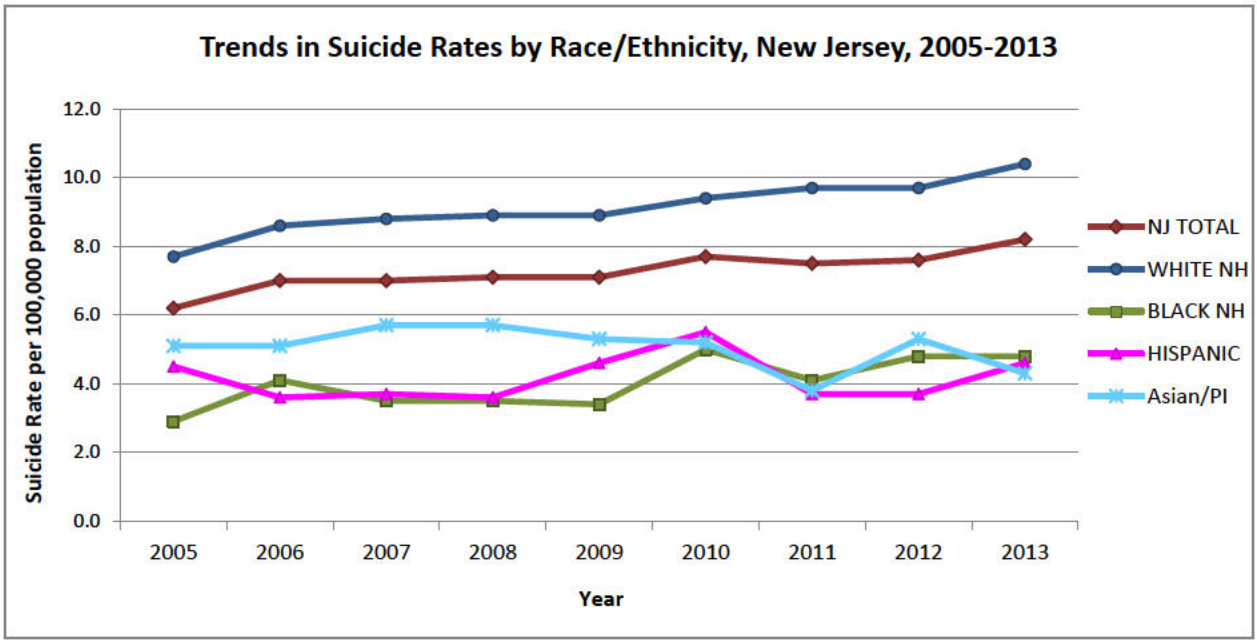
Figure 6. Middle-aged men have largest increase in suicide rate (CHSI, NJVDRS 2015 Update)



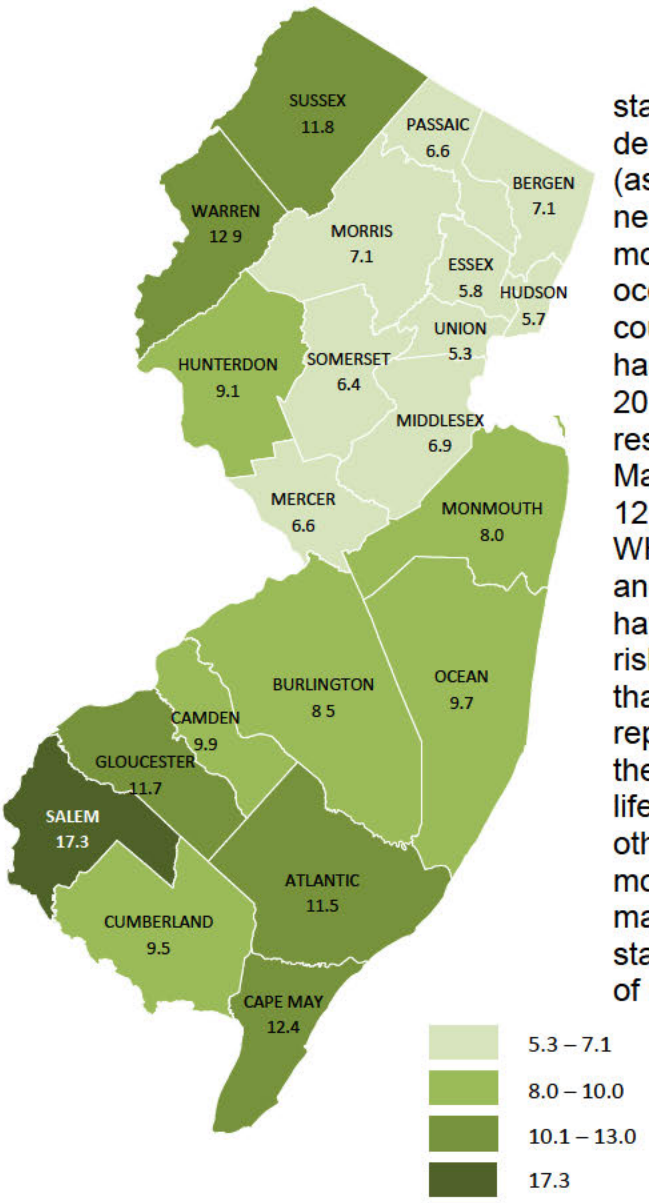
The number of young people who die by suicide in New Jersey is relatively low, both statewide and compared to other age groups,[154] but the effects of youth suicide are particularly devastating to families and communities. The New Jersey Department of Children and Families 2013 Youth Suicide Report indicated that in 2010 alone there were 92 New Jersey residents ages 10 to 23 years-old who died by suicide, with a rate of 5.3 per 100,000 age-specific population.[155] The CDC ranks suicide as the third leading cause of death nationally for youth ages 10 to 24 years-old.[156] From 2010-2012, 233 young people died by suicide in New Jersey, with people ages 19 to 24 accounting for 72 percent of the suicides. Many more are treated in hospitals and emergency departments for non-fatal suicide attempts. From 2010 to 2012, 2,248 children and young adults in New Jersey were hospitalized for attempted suicide and/or self-inflicted injuries. Females attempt suicide at a rate 50 percent higher than males, but males complete suicide nearly four times more often (7.1 per 100,000) than females (1.8 per 100,000).[157]

[154] Ibid.
[155] New Jersey Department of Children and Families, *2013 Youth Suicide Report,* (2013) available at http://www.state.nj.us/dcf/news/reportsnewsletters/dcfreportsnewsletters/Adolescent%20Suicide%20Report%202013.pdf.
[156] The Center for Disease Control and Prevention, *Youth Risk Behavior Surveillance System* (2011).
[157] DCF, Youth Suicide Report, *supra* fn. 155 at p. 2.

Figure 7. Suicide is most common among White non-Hispanics, but affects everyone (CHSI, NJVDRS 2015 Update)



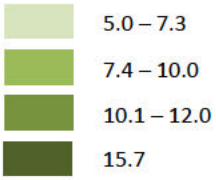
Map 2. Suicide rates in New Jersey by county of residence, 2011-2013 (CHSI, NJVDRS 2015 Update)



Rates are calculated per 100,000 NJ County residents, age-adjusted using the 2000 US Standard population.

Suicide affects New Jersey residents statewide, and while living in a high population density area is a known risk factor for homicide (as it relates to unemployment, crime, and neighborhood disorganization), suicide is much more widespread across New Jersey, and occurs at higher rates in less populated counties. Union, Hudson, and Essex counties had the lowest suicide rate in the state from 2011-2013 (5.3, 5.7, and 5.8 per 100,000, respectively), and Salem, Warren, and Cape May counties had the highest (17.3, 12.9, and 12.4 per 100,000, respectively)."[158] supporting WHO and CDC's assertion that social isolation and living in rural areas (and thereby not having easy access to mental health care) are risk factors for suicide. These are also counties that have a higher percentage of residents who report having a gun in or around the home than the more urban counties (consistent with "rural" life)[159] and higher rates of firearm suicide than other counties, indicating that having access to more lethal means for self-directed violence may result in higher fatal outcomes.[160] In fact, statewide, firearms are not the leading weapon of choice for suicide for either gender; rather, more suicide deaths are by hanging, strangling, or suffocation than any other method.[161]

[158] CHSI, NJVDRS Update 2015, *supra* fn. 124.
[159] Center for Health Statistics, *Suicide and Firearm Ownership, New Jersey, 2004-2006 UPDATE* (Trenton: New Jersey Department of Health and Senior Services, 2008). http://www.state.nj.us/health/chs/monthlyfactsheets/firearm_suicide_brief_908.pdf
[160] Id. at p. 2.
[161] CHSI, NJVDRS Update 2015, *supra* fn. 124.



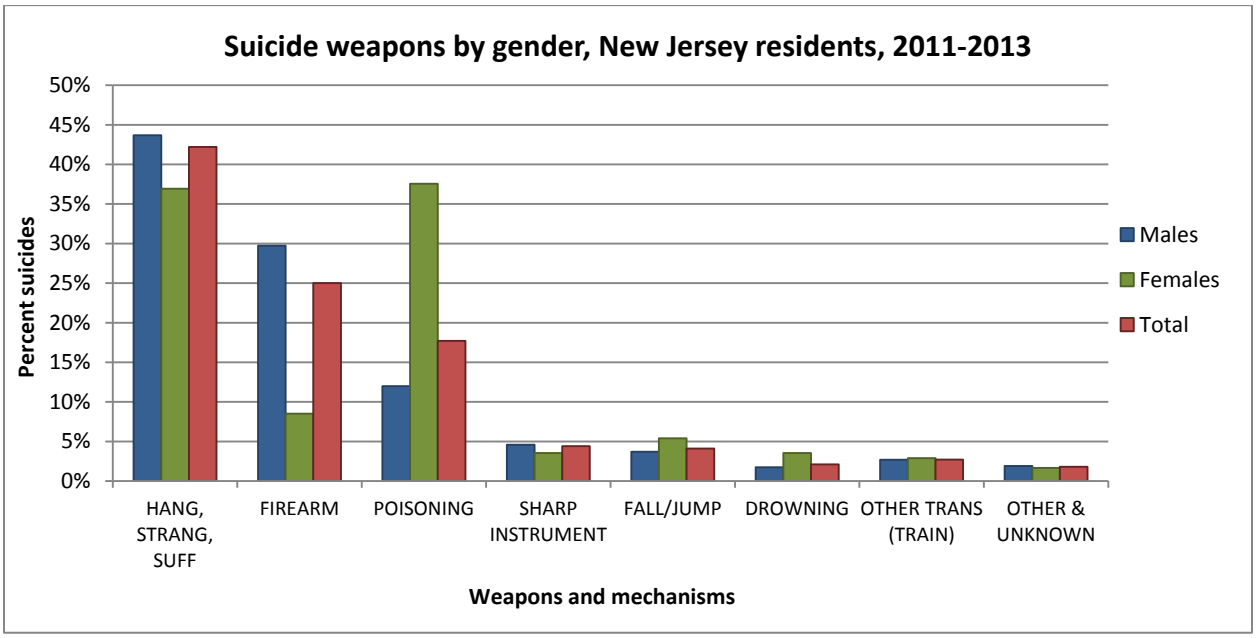
Rates are calculated per 100,000 NJ County residents, age-adjusted using the 2000 US Standard population.

Despite the fact that suicide is the tenth leading cause of death in this country, there has been a meager investment of both public and private funds dedicated to suicide research in the United States, and while the overall trend in suicide mortality is increasing, the overall funding trend is decreasing.[162] There has been very little funded research focusing on early intervention efforts, promotion of protective factors, or interventions such as means restrictions, which is even more striking given that a recent WHO report on suicide prevention showed that many nations have successfully reduced their suicide rates by reducing access to lethal means such as pesticides, firearms, and bridges (by building barriers).[163]

Of course, limiting access to means for suicide is just a portion of an overall suicide prevention strategy. A recent publication by The Robert Wood Johnson Foundation and the Institute for Health, Health Care Policy and Aging Research at Rutgers University reports that from 2005-2010 there has been not only an increase in suicide associated with the economic crisis and financial hardships among those in middle age, but that the increased use of suffocation as the method of choice makes designing prevention efforts difficult because of the widespread availability and inherent lethality of the method.[164] More research needs to be done in order to answer outstanding key questions about suicide, such as why do people become suicidal, how can we better predict suicidal behavior and identify risk factors, what are effective personal and environmental interventions, and what is the best treatment for suicidal people.[165]

[162] National Action Alliance for Suicide Prevention: Research Prioritization Task Force, *U.S. National Suicide Prevention Research Efforts: 2008-2013 Portfolio Analyses*, 21 (National Institute of Mental Health and the Research Prioritization Task Force, 2015) available at http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/portfolioanalyses.pdf.
[163] World Health Organization, *Preventing Suicide: A Global Imperative* (Geneva: World Health Organization, 2014).
[164] Hempstead, K. & Phillips, J., *Rising Suicide Among Adults Aged 40-64 Years- The Role of Job and Financial Circumstances*, Am J Prev Med (2015) (in press)
[165] National Action Alliance for Suicide Prevention, *supra* fn. 162 at p. 23-24.

Figure 8. Method of Suicide Based on Gender



Source: Center for Health Statistics and Informatics, Suicide Weapons By Gender (CHSI, NJVDRS Update 2015)

F. Recommendations

- Individual Interventions: An individual approach to violence prevention and reduction focuses on healthy attitudes and behaviors in children and young people and addresses negative attitudes and behaviors among those who may be at-risk of, or have already shown a propensity towards violence. Such interventions should include:
    - Educational programs that provide incentives for students to complete secondary schooling, vocational training for economically disadvantaged youths and young adults, and programs focused on drug abuse prevention;
    - Social development programs designed to help children and adolescents develop social skills, manage anger, resolve conflicts, and develop an appropriate moral perspective to reduce the chances they will engage in bullying;
    - Therapeutic programs to provide counseling for victims of violence and those exposed to violence and support services for those with depression or other disorders associated with an increased risk of suicide; and
    - Treatment programs in a group format that address gender issues and teach skills such as anger management, personal

responsibility, and medical treatment for people at risk of harming themselves or suffering from psychiatric disorders.[166]

- Relationship Interventions: A relationship approach focuses mainly on influencing the types of relationships that victims and perpetrators have with people they interact with on a regular basis. Such interventions should include:
    - Training for parents/caregivers that focuses on improving the emotional bonds between parents/caregivers and children and encourages consistent child-rearing methods;
    - Mentoring programs that pair youth at-risk of developing anti-social behavior with a caring adult from outside the family to provide a positive role model;
    - Family therapy programs that improve communication between parents and children and teaches problem-solving skills to assist them;
    - Home visitation programs that include regular visits from a nurse, mental health or other health care professional to the residences of families in need of special support or are at risk of child maltreatment; and
    - Groups that learn skills to develop healthier relationships with their partners (with intimate partner violence assessed prior to the group's formation.)[167]

- Community-Based Interventions: A community-based approach is geared toward raising public awareness about violence, stimulating community action, and providing for the care and support of victims. Such interventions should include:
    - Public education campaigns using the media to address community violence;
    - A focus on environmental improvements such as repairing and bolstering street lighting, creating safe routes for children and youth to school, addressing public works concerns in a timely fashion such as abandoned buildings, vacant lots, pothole repair, and nuisance complaints;
    - Extracurricular activities for young people such as sports, drama, art, and music;
    - Training for police, health and education professionals, and employers to help them identify and respond to different types of violence;
    - Community policing that places a greater emphasis on "walking the beat" and having officers interact with and get to know the residents they serve; and
    - Coordinating community interventions by having local agencies partner in service and program delivery.[168]

[166] Krug, *supra* fn. 8 at 25.
[167] Id. at 26.
[168] Id. at 27.

- Societal Interventions: Societal approaches focus on the cultural, social, and economic factors related to violence and emphasize changes in legislation and public policy.

Collaboration and Coordination of Services: During our public hearings, the Study Commission heard from many organizations and individuals who have attempted to curtail violence in their communities by utilizing one or more of the intervention strategies discussed above. The Study Commission also determined that resources are sometimes not well-coordinated or are scattered among agencies that do not work together. Accordingly, the Study Commission recommends that:

- Each county should establish a "Division on Violence Prevention and Intervention" that brings together all county and local resources to share experiences and strategies for addressing violence prevention and reduction. It is further recommended that cities and those municipalities interested in sharing services also be encouraged to form a Division on Violence Prevention and Intervention if they deem it appropriate. The Division on Violence Prevention and Intervention should:
    - Create a directory of existing violence prevention services and activities in the County;
    - Develop or recommend services to be funded by local governing bodies encompassing both interpersonal violence and suicide prevention programs;
    - Identify vacant properties or existing community spaces that could be transformed for use by local organizations that lead violence prevention activities or provide supportive services to at-risk youth and their families;
    - Develop a network of volunteers and mentors within the community who can address issues such as youth violence, suicide prevention, and go into schools to speak with young people about engaging in prosocial behavior;
    - Emphasize collaboration among all agencies that work with at-risk populations, identify cross-cutting risk factors and prevention strategies and establish working groups to address core issues such as homicide and suicide prevention, youth violence, and drug abuse;
    - Encourage locally-led groups to seek out grant funding to scale their initiatives and reach a critical mass of individuals. Provide technical assistance and support so that applications have the greatest likelihood of success;
    - Partner with a local university to develop an evaluation tool for violence prevention and reduction strategies and partner on grant applications to implement prevention and reduction plans; and
    - Focus on providing assistance to ex-offenders with an expressed interest in transitioning back into the community through employment assistance, treatment and counseling, and housing. Utilize ex-offenders who have rehabilitated themselves as mentors or role models for at-risk youth who

have engaged in criminal activity or are at-risk of engaging in criminal behavior.[169]

- The Commission recognizes that there are a number of ways to address intimate partner violence. A best practice in this field is the Family Justice Center (FJC) model. FJC co-locates a multi-disciplinary team of police officers, prosecutors, civil legal service providers, and community-based advocates in one location to provide coordinated services to victims of family violence. Accordingly, the Study Commission recommends:

    - Each county establish a Family Justice Center and provide adequate funding and space for its implementation;
    - That the Legislature consider legislation that would authorize any city, county, of community-based non-profit organization to establish a multi-agency, multi-disciplinary family justice center to assist victims of domestic violence, sexual assault, elder or dependent abuse, and/or human trafficking; and
    - That county-level liaisons communicate with the Center for Hope International (formerly the National Family Justice Center Alliance) for input and recommendations on obtaining FJC funding and sustainability strategies.

Intimate Partner Violence: Currently, if perpetrators of intimate partner violence are required to receive treatment and counseling, many are referred to services that do not fully address the perpetrator's violence, such as anger management. However, anger management is often not an appropriate form of counseling for someone who perpetrates IPV. An alternative to anger management is a Batterer's Intervention Program (BIP), that focuses more on the root causes of IPV, batterer accountability, and coordinated community response.[170] Accordingly, the Study Commission recommends the following:

- That the Legislature and Governor consider the implementation of BIPs that include the following components: psycho-education groups for men who perpetrate abuse, assistance to victims for safety, and ongoing communication collaboration, and training with judicial and child welfare systems to hold perpetrators accountable and keep victims safe. Among the topics that should be included are: IPV as abusive behavior tied to power and control, focus on accountability for one's behavior, examining and changing thoughts and beliefs that contribute to abusive behavior, impact on gender norms, respectful co-parenting with partners, and the impact IPV has on children;
- That the Legislature and Governor consider additional funding for current and future research into the effectiveness of BIP program outcomes that includes an

[169] Id. at 28.

[170] A best practice in this area is the "Duluth Model" developed by the Domestic Abuse Intervention Programs in Minnesota available at http://www.theduluthmodel.org.

examination of re-offense and recidivism rates, but also measures whether the safety of victims and their children increased;[171]

- If charged, women who use force should attend a program that addresses their violent behavior and teaches alternatives to force and the impact using force has on their victims, themselves, and other family members;
- Training should be provided to judicial staff about the differences that commonly occur when IPV is perpetrated by women against men as opposed to the other way around;
- Women who use force should not be ordered to a BIP for males; and
- Professionals who respond to incidents of IPV should be trained to assess and differentiate between using violent behavior for retaliation/resistance/self-defense versus coercive control;

Primary Violence Prevention: The Commission agrees with the CDC that primary prevention should start at an early age. Accordingly, the Study Commission recommends the following:

- As mandated by law, ensure that all school districts have implemented dating abuse education into their health curriculum[172] and have either adopted the state Department of Education policy regarding dating abuse or adopted one of their own.[173] Encourage schools to collaborate with local domestic violence agencies for information and assistance in fulfilling this mandate;
- Develop a statewide primary violence prevention awareness campaign in consultation with violence prevention experts that addresses a range of strategies to address violence, including, gun violence and intimate partner violence;
- Consider appropriating additional funds for primary prevention programs; and
- Encourage the Department of Children and Families and the Department of Education to consult with national and state domestic violence/dating abuse experts to identify curricula, programs, and training that can be shared with interested community organizations, youth sports teams, and other groups to educate parents and children about intimate partner violence and dating abuse.

Sexual Violence: The Study Commission believes there are several ways the state and universities and colleges can be responsive to the issue of sexual violence and therefore recommend the following:

- Creation of a Coordinated Community Response Team comprised of representatives from the college or university (e.g., student affairs, faculty, residence life, athletics, campus security/police, survivors of abuse), local law enforcement, the county prosecutor's office, and victim's advocates to discuss

[171] Kelly, L. and Westmarland, N., *Domestic Violence Perpetrator Programs: Steps Toward Change. Project Mirabel final report.* (London and Durham: London Metropolitan University and Durham University, 2015).
[172] N.J.S.A. 18A:35-4.23a.
[173] N.J.S.A. 18A:37-35(3)b.

and develop policies and programs to address sexual violence, dating violence, domestic violence and stalking on campus;

- That County Prosecutors should develop protocols, consistent with Attorney General guidelines, for investigating campus sexual assaults. The Study Commission recommends that the County Prosecutors work with campus police/security, local law enforcement, victim's advocates, campus judicial affairs, and campus Title IX coordinators in developing these protocols;
- That New Jersey become a "Start by Believing" state and encourage towns, municipalities, and cities to build "Start by Believing" public awareness campaigns that focus on changing the way we respond to rape and sexual assault in our communities;[174] and
- That appropriate law enforcement, health, and victim's advocates be made aware of the availability of End Violence Against Women International's free online training curriculum and encourage those who investigate sexual assault cases or interact with sexual assault victims, access training as needed.

Expand Mentoring Programs: The Study Commission supports the concept of mentoring for people of all age groups, and in particular, for young people in economically distressed and/or high crime areas. Accordingly, the Study Commission recommends:

- Creating a website that identifies all existing mentoring programs in New Jersey;
- That the Legislature and Governor consider making funding available on a competitive basis for non-profit and other community groups who lead mentoring programs that will allow for greater participation by at-risk youth and adults; and
- Convening a forum that highlights successful mentoring programs in communities throughout the state.

Establish an Injury Surveillance and Statistics Program: The Study Commission recommends the creation of an Injury Surveillance and Statistics program within the state Department of Health to serve as a resource for injury and violence epidemiology and statistics and serve as a clearinghouse for resources on injury and violence prevention.

Review Quality and Timeliness of Administrative Data Reported to the State Department of Health: The Study Commission recommends that the state Department of Health should engage injury and violence prevention stakeholders to conduct an evaluation of hospital encounter data (e.g., emergency department and inpatient data) for timeliness and case identification suitability.

Appoint an Additional Study Commission Member: As the legislation forming the Study Commission requires it to report on a yearly basis, we recommend appointing an additional member drawn from a university or college with a background in violence prevention using a public health model.

[174] http://www.startbybelieving.org/BuildYourCampaign.aspx.

Study Group on Police/Community Relations: The Study Commission recommends the formation of a working group comprised of members of law enforcement, community and faith leaders, and academic experts in the field of community policing to survey current efforts in New Jersey focused on building trust between police and the communities they serve, consider the feasibility of creating citizens police review boards, to review the President's Task Force on 21st Century Policing, and issue a report containing recommendations regarding ways to strengthen the relationship between police departments and the people they serve.

CHAPTER 2 – FUNDING AND GRANTS

A. Overview

As part of its charge, the Study Commission was directed to "seek out funding and grants for the implementation of programs to reduce violence from sources including, but not limited to, the Centers for Disease Control and Prevention and any other funding sources."[175]

In 1992, the CDC established the National Center for Injury Prevention and Control ("NCIPC") to focus on the question of violence prevention. Within NCIPC, the Division of Violence Prevention ("DVP") has as its mission the prevention of injuries and deaths caused by violence.[176] The DVP focuses on monitoring violence-related injuries, conducting research into the risk and protective factors attendant to being a perpetrator or victim of violence, creating and evaluating violence prevention programs, and providing technical assistance to other levels of government in implementing violence prevention programs.[177] Through this effort, the DVP works to reduce many things including intimate partner violence, sexual violence, youth violence, and suicidal behavior.

The DVP also collects information and reports on studies being conducted throughout the country regarding violence prevention. A recent DVP report highlighted a wide range of topics, including, protecting against teen dating and intimate partner sexual violence, recent findings on risks and protective influences on violence, the economic impact of violence, preventing suicide through "connectedness," and other topics.[178] Part of the strategy at the DVP is fostering collaborative efforts between academia, government, and local organizations. One such initiative is the National Centers of Excellence in Youth Violence Prevention. These centers are currently funded with the expectation that they engage in collaborations among researchers, local organizations, and a high-risk community with a common goal of reducing youth violence.[179]

In addition to the CDC, there are a variety of other federal agencies that have committed resources to a panoply of violence and violence-reduction strategies that the Commission studied. While it is impractical to provide a complete accounting of every program at the federal level that addresses in some way the issues the Study Commission is charged with examining, a few bear noting:

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[175] N.J.S.A. 52:17B-241(b).
[176] Center for Injury Prevention & Control: Division of Violence Prevention available at http://www.cdc.gov/violenceprevention/overview/index.html.
[177] Ibid.
[178] National Center for Injury Prevention and Control, Division of Violence Prevention, *Understanding and Preventing Violence: Summary of Research Activities: Summer 2013,* available at http://www.cdc.gov/violenceprevention/pdf/dvp-research-summary-a.pdf.
[179] Center for Injury Prevention & Control: Division of Violence Prevention, *National Centers of Excellence in Youth Violence Prevention* available at: http://www.cdc.gov/violenceprevention/ace/index.html.

- The White House: My Brother's Keeper mentoring program that works specifically with African-American youth, of which, Newark, New Jersey is a member;
- The White House: The National Forum on Youth Violence, of which, Camden, New Jersey is a member;
- The U.S. Department of Justice: Second Chance Act grant funding for programs targeted at supporting ex-offenders;
- The U.S. Department of Justice: Project Safe Neighborhoods grant funding that seeks to reduce gang and street violence, of which, Jersey City, New Jersey is a grant recipient;
- The U.S. Department of Education: Promise Neighborhood programs have launched throughout the country that are focused on ensuring children have access to good schools and strong support networks with the ultimate goal of having those children matriculate to college; and
- Substance Abuse and Mental Health Services Administration (SAMHSA): Provides grant funding for a number of different projects in New Jersey, including suicide prevention, youth substance abuse prevention, and trauma care for youth who have been exposed to violence.[180]

Similarly, state and local governments are the recipients of, and provide for, programs that address violence reduction and violence prevention. An extensive list of those programs is appended to this report as Appendix A, however, the Study Commission takes note of several promising initiatives:

- Jersey City Employment and Training Program: Hailed as a national model for prisoner re-entry, the Jersey City Employment and Training Program focuses on providing sober living, employment, and housing for ex-offenders while integrating social services to improve their likelihood of a successful transition back into the community. The Jersey City model is being rolled out in five other cities statewide – Atlantic City, Newark, Paterson, Toms River, and Trenton;

- Trenton Violence Reduction Strategy: TVRS works with ex-offenders and at-risk adults by providing wrap-around services to program participants and their family members to include employment, treatment and counseling, and life skills training. Modeled as a hybrid of the Boston and Chicago CeaseFire programs, TVRS also includes a law enforcement component that communicates to those who opt against participating in the program that future criminal activity will be dealt with swiftly and seriously;

- Justice-Involved Services: Through funding provided by the Department of Human Services, JIS is operational in 15 county jails and assists in transitioning individuals with mental illness from county jails back to the community as well as working with probation and the courts;

[180] http://www.samhsa.gov/grants-awards-by-state/details/New%20Jersey.

- Probation Mental Health Supervision: The Division of Probation within the Administrative Office of the Courts designates caseloads to officers with specific training in working with individuals with mental illness. Probation officers are able to provide a greater level of management and supervision while assisting probationers in overcoming barriers that might otherwise hinder their chances of successfully completing their term of supervision;[181] and

- Crisis Intervention Team Training: CIT is an innovative national model that provides an intensive, 40-hour training curriculum to police officers, mental health professionals, and advocates on how to appropriately respond to people experiencing a behavioral crisis who pose a risk to themselves or others. Because law enforcement officials are often the first on the scene when a person experiences a mental health crisis, this specialized training gives the officers the capabilities to respond to these unique and sensitive situations in a professional and humane manner. In New Jersey, more than 2,000 police officers from more than 70 police departments have completed CIT.

B. Recommendations

Although the Commission was directed to "seek out funding and grants for the implementation of programs to reduce violence," as a practical matter, the Study Commission is not the appropriate vehicle through which grant applications should be submitted. Typically, funding is limited to government agencies or non-profit organizations and also requires dedicated resources to manage, supervise, and lead any effort. Moreover, the Study Commission determined that there are numerous programs funded through either the federal or state government that, in one way or another, address violence prevention and reduction.

That said, public information and awareness of the vast array of initiatives aimed at reducing violence could be strengthened and many municipalities that may be interested in applying for grant funding but are not well-versed in the mechanics of doing so, could benefit from receiving technical assistance. Finally, certain promising programs merit consideration by the Legislature and the Governor for replication and expansion. Accordingly, the Study Commission recommends:

- Creation of a Grants Website: Public awareness would be increased if there was a single website that listed all violence prevention and reduction grant programs in New Jersey. Such a website should not only include the name and description of all such programs, but the source of funds, the amount of funds received, the duration of the program, and a point of contact for those interested in receiving additional information. The website should also provide links to grant opportunities that may be of interest to governmental and non-profit agencies.

[181] http://www.judiciary.state.nj.us/atlantic/mentalhealth.htm.

- Statewide Forum: The Study Commission recommends that a statewide forum be held for the purposes of information sharing among grant officers regarding funding opportunities. The forum would provide individuals who apply for, manage, and/or implement grant programs the chance to learn more about other initiatives that may be of interest to them and to discuss grant application strategies.

- Technical Assistance: The Study Commission recommends that technical assistance be offered by state agencies with expertise in applying for grants to local and municipal governmental agencies interested in applying for grant funding but in need of assistance in the application process.

- Replication Project – Trenton Violence Reduction Strategy: The Study Commission recommends that the Legislature and Governor consider appropriating funding that would allow for the replication of the Trenton Violence Reduction Strategy in at least one other city in New Jersey and that hews to best practices for violence reduction and prevention based on programs such as CeaseFire (now known as Cure Violence) and Project Safe Neighborhoods.

- Replication Project – Promise Neighborhoods: The Study Commission recommends that the Legislature and Governor consider appropriating funding for at least three local programs modeled on the Promise Neighborhood initiative led by the U.S. Department of Education or the Harlem Children's Zone model upon which Promise Neighborhoods is itself modeled.

- Justice-Involved Services Expansion: The Study Commission concurs with the New Jersey SAFE Task Force that the Legislature and Governor consider making funds available to expand JIS into the six counties without such a program. Additionally, the Study Commission recommends that the Legislature and Governor consider making funds available to counties interested in expanding existing JIS programs.

CHAPTER 3 – MENTAL HEALTH AND ACCESS TO TREATMENT IN NEW JERSEY

A. Introduction - Defining Mental Illness

The CDC defines mental illness as "disorders generally characterized by dysregulation of mood, thought, and/or behavior, as recognized by the Diagnostic and Statistical Manual, 5th edition, of the American Psychiatric Association (DSM-V)."[182] The National Institute of Mental Health ("NIMH") defines serious mental illness as a mental, behavioral or emotional disorder which is diagnosable currently or within the past year, of sufficient duration to meet diagnostic criteria in the DSM-V, and results in serious functional impairment which substantially interferes with or limits one or more major life activities.[183]

Mental illness is much more prevalent than many believe. SAMHSA and the NIMH recently released a report providing detailed information on the prevalence of many specific types of mental disorders among adults (age 18 and older). The report, "Center for Behavioral Health Statistics and Quality (CBHSQ) Data Review: Past Year Mental Disorders Among Adults in the United States," includes information on the prevalence of mood disorders, anxiety disorders, eating disorders, substance use disorders, adjustment disorders, and psychotic symptoms, shows that an estimated 22.5 percent of American adults (51.2 million people) had at least one mental disorder in the past year. Seventeen million adults (7.4 percent of the adult population) suffered mood disorders, including major depressive disorders and bipolar disorders.[184]

The data shows that 5.7 percent of adults (12.9 million people) suffered some form of anxiety disorder in the past year such as social phobia, panic disorder and agoraphobia. The report also indicates that 7.8 percent of adults (17.9 million people) experienced some form of substance use disorder in the past year.[185]

An estimated 6.9 percent of adults (16 million people) experienced a past year adjustments disorder -- a variety of functionally impairing emotional or behavioral symptoms that result from an identifiable stressor. The study shows that 0.6 percent of adults (1.3 million people) had psychotic symptoms in the past year.[186]

B. Mental Illness and Violence

Mental illness is often associated with violence in the public's mind. The Institute of Medicine concluded that "although findings of many studies suggest a link between mental illnesses and violence, the contribution of people with mental illnesses to overall

[182] http://www.cdc.gov/mentalhealth/basics/mental-illness.htm.
[183] http://www.nimh.nih.gov/about/director/2013/getting-serious-about-mental-illnesses.shtml.
[184] http://www.samhsa.gov/data/sites/default/files/NSDUH-DR-N2MentalDis-2014-1/Web/NSDUH-DR-N2MentalDis-2014.htm.
[185] Ibid.
[186] Ibid.

rates of violence is small." Further, "the magnitude of the relationship is greatly exaggerated in the minds of the general population."[187] For people with mental illnesses, violent behavior appears to be more common when there is also the presence of other risk factors. These include substance abuse or dependence; a history of violence, juvenile detention, or physical abuse; and recent stressors such as being a crime victim, getting divorced, or losing a job.[188] That said, those individuals who have a mental illness and seek treatment should get access to it, and in particular, right after or as soon after a traumatic event as possible.

The enacting legislation creating the Study Commission on Violence directed us to "study the issue of insufficient access to mental health treatment and violence."[189] The question of whether and to what degree a nexus between mental illness and violence exists was examined at some length by the New Jersey SAFE Task Force.[190] Like the Institute of Medicine, the SAFE Task Force's findings tended to confirm that individuals with a mental health disability are more likely to be victims of violent crime as opposed to perpetrators of violent crime. Indeed, the SAFE Task Force noted that one study found that criteria such as unemployment, divorce within the past 12 months, and a history of physical abuse were greater indicators of a person's propensity for violence in the next three years than whether that person suffered from mental illness.[191]

On the other hand, violence is correlated with substance abuse. One survey of individuals receiving addiction treatment indicated that 75 percent had a past incident of violent behavior. In fact, it is when substance abuse co-occurs with mental illness that we see a connection to criminal activity. For example, a SAMSHA study found that among prisoners with a mental health disorder, 72 percent also had a substance abuse problem.[192] The same study found that two-thirds of all juveniles who are exposed to the criminal justice system have co-occurring mental health and substance use disorders.[193]

C. Recommendations

The Study Commission takes notice of the recommendations of the New Jersey SAFE Task Force and concurs with the following recommendations provided by that group:

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[187] Institute of Medicine, *Improving the Quality of Health Care for Mental and Substance-Use Conditions* (2006) available at http://www.ncbi.nlm.govbooks/nbk19831/#a2000e8elddd00058.

[188] Elbogen and Johnson, *The Intricate Link Between Violence and Mental Disorder*, Archives of General Psychiatry, 66(2):152-161(February 2009) available at http://archpsyc.jamanetwork.com/article.aspx?articleid=210191.

[189] N.J.S.A. 52:17B-241.

[190] http://nj.gov/oag/newsreleases13/NJSAFE-REPORT-04.10.13-WEB.pdf. *See generally*, p. 39-44.

[191] Elbogen and Johnson, *supra* fn. 188.

[192] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders* (2002) at p. 13 available at http://www.nasmhpd.org/docs/Policy/Behavioral%20Health%20Primary_CoOccurringRTC.pdf.

[193] Ibid.

- Mental Health Parity: Establishing mental health parity for State health insurance plans provided such action would not have a meaningful, negative impact on access to care or insurance rates.

- Early Intervention & Crisis Screening: The Study Commission recommends that the Legislature and Governor consider providing appropriations to adequately fund early response and intervention support services as well as mobile crisis screening to a significantly broader group of individuals whose emotional difficulties have not risen to the level of emergency room care or law enforcement intervention and for those who have suffered a trauma because of one or more forms of violence.

- Access to Outpatient Treatment: The Study Commission recommends that the Legislature and Governor consider providing appropriations to adequately fund and expand access to outpatient licensed clinical treatment services for children and adults so that emergency services are better utilized for those in crisis and those who need more routine counseling and treatment are not taxing those scarce resources. Such an expansion would directly address those who have suffered trauma as a result of violence, a concern raised on numerous occasions during the Commission's hearings. These services and any trauma outreach should be coordinated with the Prosecutor Victim Assistance Program as a trauma response.

- Screening Centers: The Study Commission recommends that the Legislature and Governor consider additional appropriations to (1) create a pilot to expand the capacity of screening centers and other community-based points of entry for those with substance abuse or substance abuse and co-occurring mental illness so that triaging and treatment options can be provided and (2) for the substance abuse treatment system generally so that patients can access services recommended at the screening centers or community-based points of entry.

- Public Awareness: Launching a media and public awareness campaign that destigmatizes mental illness and encourages those suffering from mental illness to seek treatment.

CHAPTER 4 – MENTAL HEALTH DIVERSION WITHIN THE CRIMINAL JUSTICE SYSTEM

A. Overview

As state prison populations increased in the late 1990s and early 2000s, greater attention was paid to utilizing alternatives to incarceration, and in particular, for those charged with low-level or non-violent criminal offenses and who have a substance abuse problem, mental health disability, or co-occurring substance use and mental health disorder.

In New Jersey, Drug Courts have been utilized for more than a decade to offer defendants the opportunity to avoid incarceration in exchange for rigorous, monitored supervision of a drug treatment program. Since 2002, when the Drug Court program was expanded statewide, more than 17,500 participants have enrolled and there are more than 5,800 active participants.[194] For those defendants who graduate from Drug Court, their outcomes are very promising – less than 19 percent are re-arrested for a new, indictable crime within three years of graduation, only 7 percent are re-convicted of a new indictable crime, and under 3 percent serve a new sentence in state prison.[195] Indeed, the Drug Court model has proven so successful that its reach was recently expanded so that judges now have the authority to mandate that a defendant participate in the program.[196]

Like Drug Court, providing alternatives to incarceration for defendants with mental health disabilities is borne out of the idea that offering treatment is both a more fiscally responsible option and one that will decrease the chances that a defendant will recidivate.[197] The enacting legislation creating the Study Commission on Violence directed it to examine the mental health diversion program in Union County and to provide a recommendation as to whether that model should be expanded to other counties.[198]

B. Current Mental Health Diversion Programs

The Union County Prosecutor's Office established its Special Offenders Unit ("SOU") in 2004 to deal exclusively with mentally ill criminal defendants. The goal of the SOU was to incorporate a treatment plan into the disposition of these cases so that mentally ill

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[194] New Jersey Adult Drug Court Program, *New Jersey Statistical Highlights* (May 4, 2015) available at https://www.judiciary.state.nj.us/drugcourt/njstats.pdf.

[195] Ibid.

[196] Prior to the passage of N.J.S.A. 2C:35-14.1 participation in Drug Court was voluntary.

[197] McNeil, D., and Binder, R., *Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence*, American Journal of Psychiatry (September 2007).(A study of the Mental Health Court program in San Francisco estimated a more than $22,000 per defendant cost savings over three years for individuals in their Mental Health Court program) available at http://www.sfsuperiorcourt.org/sites/default/files/pdfs/2417%20Examine%20Program%20Costs%20and%20Outcomes.pdf.

[198] N.J.S.A. 52:17B-241(d).

defendants could receive immediate medical treatment. In 2006, and with funding provided through the Department of Human Services, the Union County Prosecutor's Office launched a formal partnership with Bridgeway Rehabilitation Services and Trinitas Hospital that diverts and case manages criminal defendants – primarily those charged with third and fourth degree offenses, but with some second degree charges considered on a case-by-case basis – out of prison and into supervised counseling and treatment.

In 2011, Dr. Kenneth Gill of the University of Medicine and Dentistry of New Jersey conducted an evaluation of the Union County program. Among Dr. Gill's findings were the fact that the program resulted in "decreased jail and prison time, fewer and later arrests, and increased global level functioning" among the program participants. Like Drug Court, Dr. Gill found the benefits of the program most pronounced among individuals who completed the program. For those individuals, in the 12 months after enrollment compared to the 12 months before enrollment, the number of days they spent in jail dropped by nearly 80 percent (25 days vs. 4 days). Only 14 percent were re-incarcerated at all in the first year of the program and after five years, only 33 percent had been re-incarcerated.[199]

In 2014, the New Jersey Department of Law & Public Safety made funding available on a competitive basis for County Prosecutors interested in implementing a mental health diversion program. Awards were issued to Ocean County and Essex County, with the former standing up a new program and the latter utilizing funding to expand an existing program.[200] Although both programs will be evaluated, neither has been operational for a sufficiently long period of time to engage in a meaningful academic study.

Lastly, the Warren County Prosecutor's Office has created a Mental Health Unit to work with defendants with serious mental health illnesses. The Prosecutor's Office works with defense attorneys and mental health providers to develop a plan of treatment, with the intent of a rehabilitative sentence focused on avoiding further or future court involvement. This program provides opportunities for diversion to probation with treatment oriented conditions for legally involved individuals with serious mental illness while ensuring the safety of the community and the individual. Currently, the program relies entirely on collaborative relationships and flexibility in the utilization of existing resources.

C. Recommendations

Studies have shown that a well-tailored mental health diversion program can decrease recidivism among defendants who complete the program, reduce costs by lowering the number of days spent in prison and the attendant treatment expenses, and provide more robust treatment and counseling for those who commit low-level and non-violent offenses. The current range of prosecutor-led programs shows that the diversion

[199] Gill, K. and Murphy A., *Report on Union County Jail Diversion Program 2006-11* (May 24, 2011).

[200] The Department of Law and Public Safety has issued a Notice of Available Funding for the expansion of this program into up-to two additional counties. *See*, 47 N.J.R. 2008(a)(August 3, 2015).

process can be accomplished with or without dedicated funding, however, the comprehensiveness of the program and the options available are necessarily limited when dedicated funding is not provided and/or adequate mental health services are unavailable.

- Create a Toolkit for County Prosecutors: The Study Commission recommends that those prosecutors with mental health diversion programs work with mental health providers on a toolkit from which other prosecutors could understand how a diversion program would be implemented. Among the information that the toolkit should include would be an identification of the agencies and organizations necessary for the partnership, how (and by who) defendants are screened for clinical appropriateness, options for which criminal charges are or are not permitted for consideration into the program, and what training assistant prosecutors and investigators should receive to be assigned to the program.

- Expand the Availability of Crisis Intervention Training: The Study Commission recommends that the Department of Law and Public Safety consider providing funds that would expand the availability of CIT training, and in particular, for the expansion of the CIT Center for Excellence so that CIT training can be made available throughout the state. The Study Commission further recommends that the Department of Law and Public Safety and the Department of Human Services consider forming a task force that would work with County Prosecutors and municipal police departments interested in formalizing CIT and other police/community-based diversion interventions as part of their law enforcement strategy.

- Develop a Plan for Law Enforcement and Mental Health Cross Training: The Study Commission recommends that the Department of Law and Public Safety, Department of Human Services, State Parole Board, and Administrative Office of the Courts consider developing a plan for coordinated cross-training of law enforcement officers, first responders, mental health providers, and families and consumers of mental health services. Such a plan would identify education and training from awareness of mental illness and the criminal justice process through advanced techniques for CIT-certified officers.

- Expand Mental Health Diversion: The Study Commission recommends that the Legislature and Governor consider funding be appropriated to the Department of Law and Public Safety for the development, in conjunction with the Department of Human Services, of a Request for Proposals (RFP) that would be submitted by County Prosecutors interested in developing a new, or expanding an existing, mental health diversion program. Such appropriations should include funding to support both prosecutorial and concomitant case management and mental health services.

CHAPTER 5 – OUTPATIENT COMMITMENT

A. Introduction and Background on Outpatient Commitment

The Commission has been tasked with studying involuntary outpatient commitment in the State and recommending whether it should be expanded to all counties and how to adequately fund the program.[201] In carrying out this task, members of the Commission reviewed the outpatient commitment law, met with staff from DMHAS, reviewed funding for the program, attended a meeting of an outpatient commitment workgroup created by DMHAS, reviewed data regarding implementation of the program, and interviewed representatives from outpatient commitment programs in Essex and Warren Counties.

Outpatient commitment refers to the process by which a court orders an individual with mental illness to comply with a community treatment plan.[202] Failure to abide by a treatment plan may but does not always result in hospitalization. The vast majority of states utilize some form of involuntary outpatient commitment as part of an existing framework for providing mental health services in the community. Patients utilize services that are offered to all public mental health care recipients, and no additional funding is provided for services for individuals on outpatient commitment status. In a minority of states, such as New York, outpatient commitment programs involve a separately funded and distinct infrastructure of services.[203] As more fully explained below, New Jersey funds its outpatient commitment program at a level which allows community agencies to provide primarily case management services and to link consumers with existing services funded separately.

Researchers have classified three types of outpatient commitment: first, conditional release from a hospital where a patient is discharged on the condition that he or she continues to receive treatment in the community; second, an alternative to inpatient hospitalization for individuals who otherwise meet the criteria for hospitalization but are instead ordered to receive outpatient treatment when such treatment is deemed sufficient to render them non-dangerous; and third, mandatory treatment for individuals who do not currently meet the legal criteria for inpatient hospitalization, but who are at risk of decompensation to the point that they may qualify for hospitalization if left untreated.[204] However, it appears that, regardless of whether outpatient commitment applies to individuals who are currently dangerous or at risk of decompensation, states often use it as a discharge planning tool for patients who are hospitalized. For example, in New York, where outpatient commitment is allowed to prevent deterioration before

[201] N.J.S.A. 52:17B-241(e).
[202] Monahan et al., *Mandated Community Treatment: Beyond Outpatient Commitment*, 2 (2014) available at: http://www.macarthur.virginia.edu/article.pdf.
[203] Esposito, et al., A *Guide for Implementing Assisted Outpatient Treatment,* 7 (2012) available at: www.treatmentadvocacycenter.org/storage/documents/aot-implementation-guide.pdf.
[204] Monahan, *supra* fn. 202.

hospitalization is necessary, nearly three-quarters of individuals were committed upon discharge from a hospital.[205]

A growing body of research has found that outpatient commitment, when paired with sufficient community services, is effective in treating serious mental illness, preventing and shortening lengths of hospitalization, and reducing arrests and violence. The most extensive study to date concerned New York's outpatient commitment law, called "Kendra's Law."[206] According to the researchers, New York's program "features more comprehensive implementation, infrastructure and oversight" than any other comparable program in the country, largely because the enactment of Kendra's Law was accompanied by a substantial amount of funding for new services.[207] The Kendra's Law study revealed that individuals on outpatient commitment status were hospitalized at less than half the rate than prior to commitment.[208] Moreover, individuals who received intensive case management services on a voluntary basis were more likely to be hospitalized (58%) than individuals who received these same services involuntarily on an outpatient commitment order (36%). The researchers also found evidence that individuals on outpatient commitment status were less likely to be arrested than other individuals with serious mental illness, as the monthly rate of arrest for individuals dropped from 3.7 percent to 1.9 percent.

Outcomes for individuals after they were discharged from outpatient commitment varied depending on their length of commitment status. For individuals who were committed for fewer than six months their chances of hospitalization decreased post-discharge only if they continued to receive intensive case management services. However, the rate of hospitalization of individuals who were committed longer than six months decreased regardless of whether they continued to receive case management.

Similarly, a 1999 study of North Carolina's outpatient commitment program found that outpatient services when paired with outpatient commitment of greater than six months reduced hospitalization 57 percent when compared to individuals receiving the services alone.[209]

Several other studies have concluded that outpatient commitment reduces arrests and incidents of violence among individuals with serious mental illness. A 2010 study of Kendra's Law found that the odds of arrest for individuals receiving outpatient commitment services were nearly two-thirds lower than for individuals who had not yet

[205] Swartz and Swanson, *New York State Assisted Outpatient Treatment Program Evaluation (*2009) available at https://www.omh.ny.gov/omhweb/resources/publications/aot_program_evaluation/

[206] Ibid.

[207] New York allocated an annual total of $32 million for direct support of outpatient commitment programs. Additionally, the state allocated $125 million yearly for enhanced community supports, which benefitted all recipients of community services, not only individuals on outpatient commitment.

[208] Ibid.

[209] Swartz & Swanson, et al, *Can Involuntary Outpatient Commitment Reduce Hospital Recidivism?* 156(12) American Journal of Psychiatry 1968-75 (1999).

initiated involuntary commitment or only signed a voluntary service agreement.[210] Likewise, a 2008 study of Florida's outpatient commitment program found that outpatient commitment reduced days spent in jail among participants from 16.1 to 4.5, a 72 percent reduction.[211] The 1999 study of North Carolina's program found that, for individuals who had a history of multiple hospital admissions combined with arrest or incidents of violence in the prior year, long-term outpatient commitment reduced the risk of arrest by nearly 75%.[212] Similarly, another study of Kendra's Law revealed that outpatient commitment recipients were four times less likely to commit acts of serious violence after undergoing treatment, despite having histories of violence.[213]

B. Outpatient Commitment in New Jersey

New Jersey's outpatient commitment law, which was enacted in 2009, utilizes outpatient commitment as an alternative to inpatient hospitalization, rather than expanding commitment criteria to individuals who may deteriorate if untreated.[214] It allows outpatient commitment for individuals who are already dangerous and otherwise would have been hospitalized, but whose dangerousness is not imminent and can be alleviated with outpatient treatment.

Specifically, an individual with mental illness is in need of involuntary commitment to treatment (inpatient or outpatient) when his mental illness causes him to be dangerous to self, others or property and he is unwilling to accept appropriate treatment voluntarily.[215] An individual may be committed to outpatient treatment, rather than inpatient hospitalization, when such treatment "is deemed sufficient to render the person unlikely to be dangerous to self, others or property in the reasonably foreseeable future."[216] Conversely, an individual should be committed to inpatient treatment when "he is immediately or imminently dangerous or if outpatient treatment is deemed inadequate to render the person unlikely to be dangerous to self, others or property within the reasonably foreseeable future."[217] A screening service shall consider an individual's prior history of hospitalization and treatment and the person's current mental health condition in rendering this determination.[218]

When committed to outpatient treatment, an individual is required to comply with a plan of outpatient treatment, which is "a plan for recovery from mental illness approved by the court … that is to be carried out in an outpatient setting and is prepared by an outpatient treatment provider for a patient who has a history of responding to

[210] Gilbert & Moser, et al., *Reductions in Arrest Under Assisted Outpatient Treatment in New York,* 619(10) Psychiatric Serv., 996-999 (October 2010).
[211] New Jersey Adult Drug Court Program, *supra* fn. 194 at 14.
[212] Ibid.
[213] Phelan, et al., *Effectiveness of Outcomes of Assisted Outpatient Treatment in New York State Psychiatric Services,* Columbia University, Vol. 61 No. 2 (2010).
[214] N.J.S.A. 30:4-27.1 et seq.
[215] N.J.S.A. 30:4-27.2.
[216] N.J.S.A. 30:4-27.5.
[217] Ibid.
[218] Ibid.

treatment."[219] If a patient fails to materially comply with the outpatient treatment plan, or if the outpatient treatment provider determines that the plan is inadequate to meet the patient's mental health needs, then the provider shall notify the court and the screening service and the patient shall be considered for inpatient hospitalization.[220]

Initially, the outpatient commitment law required the Commissioner of DHS to phase in implementation of the program over a three-year period, implementing outpatient commitment in seven counties in the first year, seven more counties in the second year, and the remaining seven counties in the third year.[221] Ultimately, DHS was appropriated approximately $2 million for outpatient commitment in 2012, which allowed the agency to implement the program in six counties – Burlington, Essex, Hudson, Ocean, Warren and Union. In 2014, DHS was appropriated an additional $4.5 million to expand the program statewide. DMHAS issued a Request for Proposals for outpatient treatment providers in the remaining fifteen counties on March 17, 2014. As a result of this RFP, DMHAS awarded contracts to outpatient providers in eleven additional counties – Atlantic, Bergen, Camden, Cape May, Cumberland, Gloucester, Hunterdon, Mercer, Passaic, Salem and Somerset. DHS did not receive satisfactory bids for Middlesex, Monmouth, Morris and Sussex Counties. Outpatient commitment is now operational in fourteen counties.[222] DMHAS will continue to seek providers in the outstanding four counties.

Each county outpatient treatment provider receives approximately $300,000 per year in State funding. Providers may also seek reimbursement for certain services through Medicaid and insurance to the extent individuals served are eligible for these programs. This funding gives providers the capacity to serve approximately 30 to 40 individuals at any one time. Outpatient treatment providers generally consist of a full-time program director, two full-time case managers, and a psychiatrist who is available approximately 15 hours a week to provide evaluations, clinical certificates and court testimony. Providers mainly offer intensive case management support, linking patients with already-existing community services, resolving legal issues and ensuring that patients attend court hearings and other appointments. Providers also monitor treatment compliance and report to the commitment court. Outpatient commitment programs do not provide residential services, so individuals must already have housing to be eligible to participate in the program. The programs sometimes provide therapy session on-site or at patients, but generally cannot provide more robust services due to limited funding. Instead, they primarily link patients with community services already funded by DMHAS through other programs.

The outpatient commitment law requires DHS to monitor and evaluate the program and to report to the Governor and Legislature on its implementation.[223] Factors to be

[219] Ibid.
[220] N.J.S.A. 30:4-27.8a.
[221] P.L. 2009, Ch. 112.
[222] While DMHAS has awarded a contract to a community agency to operate outpatient commitment programs in Cumberland, Gloucester and Salem Counties, that agency was still searching for psychiatrist services and the programs had not begun at the time this report was written.
[223] *See*, fn. 221, *supra*.

evaluated include the effect of outpatient commitment on individuals, the extent to which outpatient commitment affects the rate of institutionalization and incarceration, whether sufficient services are available to individuals who have been committed to outpatient treatment, and the effect of outpatient commitment on the availability of services to voluntary consumers with mental illness. As authorized by statute, DHS contracted with the Rutgers University School of Social Work to assist the agency with conducting this evaluation. The first Rutgers' report is expected in June 2015.

DMHAS provided data from fiscal year 2014 for the six outpatient programs that were operational at that time. These programs served 374 individuals during the fiscal year. 103 of these individuals were hospitalized while on outpatient commitment status, although DMHAS noted that some of these individuals may have been hospitalized for non-psychiatric, medical reasons. Even disregarding this qualification, the hospitalization numbers appear favorable when considering that absent outpatient commitment, these individuals may have all been hospitalized. DMAHS does not yet have data regarding arrests of individuals on outpatient commitment, but it is anticipated that the Rutgers' report will include this data.

The Commission interviewed representatives from the outpatient commitment programs in Essex and Warren Counties in an effort to learn more about how outpatient commitment works in practice. The Essex County program receives $294,000 per year from the State. Additionally, it is able to bill Medicaid for approximately $150,000 per year for case management services. The Essex County provider agency initially anticipated that it could serve up to 65 individuals in its outpatient commitment program with this funding. But it has since realized that it may effectively serve up to 45 individuals, which still appears to more than other counties with outpatient commitment programs. The Essex County program typically serves individuals who have been hospitalized on multiple occasions over the past year. Indeed, the vast majority of individuals served in Essex County have been converted to outpatient commitment from inpatient hospitalization at a county hospital or short term care facility.

The Essex County program consists of a Director, three to four case managers, a part time secretary, and a part-time psychiatrist who is available about 20 hours per week. During the first two to four weeks of an individual's outpatient commitment, the outpatient team provides intensive case management services, seeing the client up to seven days per week at his home or at on-site at the program. They continue to provide case management throughout the duration of the commitment. The team links patients with various other mental health services, in addition to providing therapy. The team is in court approximately once every two weeks for outpatient commitment purposes. If successfully discharged, a patient remains linked to other programs and may continue to receive case management through other programs.

Outcomes for individuals who have been involuntarily committed to Essex County's outpatient commitment program have been generally positive. On average, 6 percent of patients are involuntarily hospitalized per month and 7 percent are voluntarily hospitalized. Arrests of individuals on outpatient commitment have been rare. The

Essex County representative advised that voluntary hospitalization is preferable because the patient does not lose his outpatient commitment status and can return to the program upon discharge. In contrast, involuntarily hospitalized patients lose their outpatient commitment status and must be re-committed or converted to outpatient commitment upon discharge from a hospital, assuming the outpatient program is aware of the discharge.

The Warren County program also receives $294,000 per year in State funding, although it is not able to bill Medicaid for its case management services to the degree that Essex County can. The Warren County program originally intended to serve 30 people at a time, but has since learned that 20 individuals is a more reasonable amount. When fully-staffed, the program consists of a supervisor/director who also serves in a clinical role, two case managers, and a part-time psychiatrist who is available 12 hours per week. However, at the time of the interview the director had resigned and they were struggling to find a replacement due to the salary limitations. Unlike Essex County's Program, where patients usually are converted to outpatient commitment from inpatient hospitalization, Warren County's patients are typically committed to outpatient commitment directly from a screening center.

The Warren County program provides intensive case management services and links patient with other services. Like the Essex County program, the Warren County program also attends court approximately once every two weeks. Court appearances for patients as well as travel to service providers are often difficult due to a lack of transportation options. The program's representative estimated that about 30 percent of its patients have been discharged successfully to date. Others have been involuntarily hospitalized or are still under outpatient commitment.

The Warren County representative felt that the outpatient program helps individuals to live in the community more safely and to access need services. She advised that the program could serve more individuals with more funding and staffing.

C. Recommendations

The issue of whether outpatient commitment should be expanded to all counties in the State is largely moot. DHS has already begun efforts to expand the program statewide and has been appropriated funding to do so. The Commission agrees with this decision. Outpatient commitment has proven to be a valuable tool in treating mental illness in the community and reducing inpatient hospitalization. Individuals who can benefit from this program should have access to it regardless of their county of residence. That said, the Study Commission recommends:

- Outpatient Commitment Analysis: The Commission also recommends that a county-by-county analysis be made to determine the average wait times for those with serious mental illness that are coming out of state and county psychiatric hospitals and those at risk of hospitalization. Based on the findings of this survey, the Commission recommends appropriations be provided where necessary to reduce wait times and ensure speedy access to treatment.

GLOSSARY OF TERMS

BIP – Batterer's Intervention Program
CDC – U.S. Department of Health and Human Services, Centers for Disease Control & Prevention
CHSI – New Jersey Department of Health, Center for Health Statistics and Informatics
CIT – Crisis Intervention Training
Corr-Stat – Corridor-Status
DHS – New Jersey Department of Human Services
DMHAS – New Jersey Department of Human Services, Division of Mental Health and Addiction Services
DSM-V – Diagnostic and Statistical Manual, 5th Edition
DVP – Division of Violence Prevention
EVAWI – End Violence Against Women International
FJC – Family Justice Center
IPV – Intimate Partner Violence
JIS – Justice-Involved Services
NAME – National Association of Medical Examiners
NIMH – National Institute of Mental Health
NCIPC – National Center for Injury Prevention and Control
NJCFNFRB – New Jersey Child Fatality and Near Fatality Review Board
NJDVFNFRB – New Jersey Domestic Violence Fatality and Near Fatality Review Board
National Crime Victimization Survey
NJVDRS – New Jersey Violent Death Reporting System
NVDRS – National Violent Death Reporting System
SAMHSA – Substance Abuse and Mental Health Services Administration
SOU – Special Offenders Unit
TVRS – Trenton Violence Reduction Strategy
UCR – Uniform Crime Report
WHO – World Health Organization

ACKNOWLEDGEMENTS

The Study Commission gratefully acknowledges the following individuals, organizations, and institutions for their assistance:

Acting Union County Prosecutor Grace Park
Assistant Union County Prosecutor Doreen Yanik
Dr. Doug Boyle, Rutgers University – Violence Institute of New Jersey
Nicole Morello, New Jersey Battered Women's Shelter
Anthony Ambrose, Chief of Detectives, Essex County Prosecutor's Office
The Newark Anti-Violence Coalition
Captain Thomas Ulrich, Vineland Police Department
Rev. Gary Holden, Police Chaplain Program
Ocean County Prosecutor Joseph D. Coronato
Cumberland County Prosecutor Jennifer Webb-McRae
Warren County Prosecutor Richard T. Burke
Atlantic County Prosecutor James P. McClain
Tracy Swan, Rutgers University – Walter Rand Institute for Public Affairs
Mayor Dana L. Redd, City of Camden
Dr. Louis Tuthill – Rutgers University
Bernadette Shanahan, Camden County Boys and Girls Club
Richard Stagliano, Center for Family Services
Dr. Bernadette Hohl, Rutgers University – School of Public Health
Elizabeth Manley, New Jersey Department of Children and Families
Roger Canaff, End Violence Against Women International
Lieutenant Greg Demeter, New Jersey State Police
Kurt Baker, Attitudes in Reverse
Trish Baker, Attitudes in Reverse
Shavar Jeffries, Esq., Lowenstein Sandler, LLC
Governor James E. McGreevey, Jersey City Employment and Training
John Koufos, Jersey City Employment and Training
Lisa Ciaston, New Jersey Department of Human Services
Jane Shivey, New Jersey Coalition for Battered Women
Dr. Roger Mitchell, Medical Examiner, District of Columbia
Detective Alexis Durlacher, Trenton Police Department
Abdul Muhammad, Co-Ordinator, Trenton Violence Reduction Strategy
Dr. Sandy Gibson, The College of New Jersey
The U.S. Attorney's Office for the District of New Jersey
William Paterson University
Rutgers University – Camden Campus
Shiloh Baptist Church (Trenton)
St. James AME Church (Newark)
Cumberland County Community College
Barnabas Health
Newark Beth Israel Hospital

Greater Newark Healthcare Coalition
Paterson CeaseFire
Mary Houtsma, CSW, DVS, Essex County Family Justice Center
NJ CIT Center of Excellence
Dr. Maria Kirchner, New Jersey Department of Human Services

APPENDIX A – VIOLENCE REDUCTION AND PREVENTION PROGRAMS AND MENTAL HEALTH SERVICES

The Study Commission on Violence provides this summary of programs our respective agencies are involved with and programs that were brought to our attention during the course of our survey of anti-violence, crime prevention, and mental health initiatives in New Jersey.

Department of Human Services

- NJ HOPELINE (1-855-654-6735): NJ HOPELINE is a 24-hour-a-day, 7-day-a-week peer support and suicide prevention hotline operated by Rutgers University's Behavioral Health Care unit through a contract with the New Jersey Department of Human Services Division of Mental Health and Addiction Services (DHS-DMHAS). Calls are handled by trained volunteers and paid staff. A clinical supervisor is assigned to each shift and works with the volunteers and staff to transfer calls to emergency service providers as needed.
- NJ HOPELINE Advertising: New Jersey Transit ("NJT"), in conjunction with DHS-DMHAS, has placed NJ HOPELINE posters at every NJT station in New Jersey.
- Adult Suicide Prevention Plan. DHS-DMHAS developed an adult suicide prevention plan.[224] The plan is designed to address the rate of suicide in New Jersey and contains strategies and an action plan for crisis response and practical application in the field. While New Jersey does not lead the nation in suicide numbers, 60% of all violent deaths are suicides and suicides outnumber homicides nearly two to one in New Jersey.[225]
- Mental Health First Aid: Mental Health is an 8-hour adult public education program that introduces participants to risk factors, warning signs, and symptoms for a range of mental health problems, including comorbidity with substance use disorders; builds participants' understanding of the impact and prevalence of mental health problems; and provides an overview of common support and treatment resources for those with a mental health problem. In New Jersey, Mental Health First Aid training is already being utilized by Administrative Office of the Courts - Probation Services and the New Jersey State Human Services Police, among others. In December 2013, 30 individuals from the Department of Human Services attended the five-day train-the-trainer program and are now certified to train others throughout the State in Mental Health First Aid.
- Peer Respite Centers: [226] The DHS-DMHAS funds a Peer Respite Center in each region of New Jersey. These facilities provide beds, temporary lodging, and treatment alternatives for individuals who may be experiencing a psychiatric

[224] New Jersey Department of Human Services, Division of Mental Health and Addiction Services, *Adult Suicide Prevention Plan (2014-2017)* available at www.sprc.org/sites/sprc.org/files/adult%20suicide%20pevent%20plan%20final%202014-17.pdf.
[225] Center for Health Statistics, New Jersey Department of Health, *New Jersey Violent Death Reporting System (*2013).
[226] NJDHS-DMHAAS, *supra* fn. 217 at 7.

crisis situation but do not warrant an inpatient level of care. Patients stay on average between 7 and 16 days and are then linked to community self-help centers and other supportive services in the community.[227]

- Peer Recovery WarmLine: Operated by the Mental Health Association of New Jersey, the Peer Recovery WarmLine is a statewide toll-free line operating year round to assist individuals with mental health concerns or in times of need.[228]
- Short Term Care Facility: These facilities are locked units to which individuals are involuntarily committed for a limited duration. The facilities are operated by 24 different agencies in all 21 counties.
- Designated Screening Service Programs: These programs provide screening, assessment, crisis intervention, referral, linkage to other programs, and crisis stabilization in every part of the State 24-hours-a-day, 365-days-a-year. Screening Service programs manage individuals who are in acute psychiatric crisis, and determine whether involuntary commitment is necessary.
- Early Intervention Support Service: These programs provide rapid access to short term, non-hospital based crisis intervention and stabilization services. They are designed to divert the undue use of emergency rooms and inpatient programs.
- Intensive Outpatient Treatment Support Services: These programs operate in 19 counties to alleviate strain on the acute mental health system.
- Involuntary Outpatient Commitment: Individuals are committed to outpatient treatment when they are dangerous because of mental illness, but whose dangerousness is not imminent and can be alleviated on an outpatient basis without the need for hospitalization. Such individuals are court ordered to comply with an outpatient treatment plan which is created and overseen by outpatient treatment providers.
- Outpatient services are provided in a community setting to individuals with a psychiatric diagnosis including clients who are seriously and persistently mentally ill, but excluding substance abuse and developmental disability unless accompanied by treatable symptoms of mental illness. Periodic therapy, counseling, and supportive services are generally provided for relatively brief individual, group or family sessions. Services may also include medication monitoring under the supervision of a licensed physician, certified nurse practitioner or clinical nurse specialist.
- Partial Care & Partial Hospitalization are comprehensive, structured, non-residential health services provided to seriously mentally ill adult clients in a day program setting to maximize client's independence and community living skills. Partial Care programs provide or arrange services necessary to meet the comprehensive needs of the individual clients.
- Programs in Assertive Community Treatment: A multi-disciplinary mobile treatment team provides a comprehensive array of mental health services to individuals with serious mental illness. The program is designed to meet the needs of individuals, who are at high risk for hospitalization, are high service

[227] Ibid.
[228] http://www.mhanj.org/peer-recovery-warmline-prw/

users and who have not benefitted from other mental health services. Although an EBP, PACT is considered to be part of the acute care system.

- Integrated Treatment for Co-occurring Disorders: This program provides combined mental health and substance abuse disorder treatment for adults. It aims to reduce hospitalization and homelessness, and to increase independent living and employment. The program is incorporated in existing services including Integrated Case Management Services, Partial Care and Supported Housing, and is not a stand-alone service.
- Supported Employment: The SE program provides employment assessment, job placement and ongoing support for individuals with mental illness. Supported employment assists mental health consumers in forming an attachment to the workforce through employment and education and is critical to their community integration and economic independence.
- Supported Education: Supported education programs serve individuals with severe mental illness and/or co-occurring disorders who participate or desire to participate in post-secondary education. Services include accommodation education, managing disclosure issues, and exploring/securing funding options.
- Illness Management Recovery: Illness Management Recovery is a psychiatric rehabilitation practice which seeks to empower consumers with severe mental illness to manage their illness and develop their own goals for recovery. Components include psychoeducational, behavioral tailoring for medication relapse prevention training, and coping skills training.
- Veterans' Services: DMAHS provides mental health and related support services to members of the armed forces and veterans as part of its regular behavioral health service delivery system.
- Projects for Assistance in Transition from Homelessness: These programs conduct outreach to locations known to be frequented by homeless individuals in an effort to assess and identify individuals with serious mental illness who may benefit from linkage to mental health and housing programs.
- Supportive Housing: DMHAS contracts with supportive housing providers and supervised residential providers in all 21 countries. Services range from consumer-leased housing to supervised settings with 24/7 staffing. Supportive housing promotes community inclusion, housing stability, wellness, recovery and resiliency.
- Intensive Family Support Programs: These programs provide families with greater knowledge about mental illness, treatment options, the mental health system, and skills useful in managing and reducing symptomatic behaviors of the member with a serious mental illness. Services include psycho-education groups, family support groups, single family consultation, respite activities and referral/linkage.
- Consumer Operated Services: At the state level, the DMAHS involves individuals with mental illness in upper level management decision-making, program development, proposal reviews, community site reviews, state hospital monitoring, and participation in key committees and workgroups. DMHAS provides funding and support for peer providers working in the system. There are also peers working in designated screening centers/psychiatric emergency

rooms, and plans are underway to develop peer-operated alternatives to crisis and screening. DMHAS currently funds and supports 33 consumer operated self-help centers statewide, including a self-help center on the grounds of three State hospitals.

- Managed Behavioral Health Organization: In January 2015, the Governor announced that the Division is developing an interim managing entity (IME) for addiction services as the first phase in the overall reform of behavioral health services for adults in NJ. University Behavioral Health Care (UBHC) will be the IME with an implementation date of July 1, 2015. The IME will serve as a single point of entry for those seeking treatment for substance use disorders. The IME will ensure that individuals are receiving the right level of care for the right duration at the right intensity. This will allow the state to manage its resources across payors and across the continuum of care.
- Justice Involved Services: JIS identifies and intervenes with individuals in the criminal justice system whose mental illness and behavior directly results in violence or increases the risk of violence through criminal actions. DMHAS funds 15 JIS programs which serve about 1,500 consumers each year. The services are as follows:
    - Re-entry services: JIS provides referrals for inmates being released from county correctional facilities; programs have between 1 to 2 case managers who interview and enroll potential candidate while in jail, provide pre-release planning and then successful linkage and coordination to mental health and other social/community services. No psychiatric or treatment services are directly provided by the program; rather, they link existing mental health services. Counties include: Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Gloucester, Hudson, Monmouth, Morris, Middlesex, Mercer, Passaic, Ocean, and Union.
    - Pre-booking Jail diversion: This option typically involves a police-based intervention to avoid arrest for non-criminal, non- violent offenses. Police are trained to identify and de-escalate situations involving individuals with mental health disabilities and to divert them to mental health crisis or pre-crisis services.
    - Post-booking diversion: This option typically involves intervening so that consumers are released from detention earlier than they otherwise would be. Individuals are released on their own recognizance or released from jail with mental health intervention and treatment conditions.

- Veterans Mental Health Diversion Program: The Atlantic County Prosecutor's Office leads a diversion program that offers military veterans and active duty personnel accused of committing certain crimes the opportunity to avoid incarceration if they are deemed clinically appropriate for treatment and with the approval of the prosecutor's office. Program participants are case managed by a non-profit service provider and receive counseling and treatment consistent with their needs.
- Hudson County Municipal Court Program: DMHAS funding has been used in Jersey City to assign a case manager/municipal court liaison directly in the

Jersey City Municipal Courts. The liaison provides individual consultations to the judges and attorneys, upon request regarding defendants with mental illness and recommended options for care and treatment in lieu of incarceration.

- PROMISE Parole program: A joint effort among DMHAS, the State Parole Board and & Parole Collaboration is a collaborative program of the State Parole Board, DMHAS and the Housing and Mortgage Finance Agency to assist parolees with serious mental illness to transition and integrate into their community and provide mental health and other wrap around services including employment and housing to reduce the number of violations of probation. DMHAS funds a case manager who provides linkages and coordination of services.
- Inmate Screening: DMHAS meets regularly with representatives from the Department of Corrections, Ann Klein Forensic Center to review prisoners with serious mental illness who are nearing their "max out" release date to determine whether the prisoners may need continued commitment at AKFC or at a community mental health service facility.
- Veterans Assistance Initiative (VAI): This program provides services to veterans/service members who get arrested and need linkage and coordination with services through the local Veterans Service Offices of the Department of Military and Veterans Affairs. DMHAS-licensed providers provide case management & treatment services as needed in an effort to avoid or reduce the incidence and length of incarceration.

<u>Department of Children and Families</u>

- 2NDFLOOR: Youth Helpline of New Jersey is a DCF funded confidential and anonymous statewide helpline for New Jersey's youth and young adults. Youth can call 2NDFLOOR at (888) 222-2228 and receive support to find solutions to any problems they are having with school, family, peers, etc. The helpline is available 24 hours per day every day of the year.[229]
- New Jersey Youth Suicide Prevention Project: Through funding from the U.S. Department of Health and Human Services, Substance Abuse Mental Health Services Administration (SAMHSA), 860 mental health professionals have been trained in evidence-based and best practice suicide prevention strategies. Trainings have been conducted in Passaic, Camden, Monmouth, and Bergen Counties.
- New Jersey's Children's System of Care (CSOC): A Division of the Department of Children and Families (DCF), the Children's System of Care provides behavioral health treatment services, developmental and intellectual disability services, and substance use treatment services to the children and youth of New Jersey. Services may be accessed by calling Performcare at 1-877-652-7624.[230]
- Family Support Organizations (FSOs): FSOs provide direct peer support and assistance to children and families by family members of children currently involved in the Children's System of Care. Among the services offered by FSOs

[229] http:www.2ndfloor.org.

[230] http://www.performcarenj.org/index.aspx.

are peer mentorship, education and advocacy, information, referral, and the hosting of parent and peer support groups. FSOs are operational in all 21 counties within New Jersey.

- Transitions for Youth (TFY): TFY is a multi-faceted statewide initiative that utilizes a positive youth development framework to address the complex needs of youth transitioning to adulthood, particularly those who are aging out of foster care or who were involved with the juvenile justice or behavioral health systems. TFY's goal is to ensure that youth develop essential skills and competencies in education, employment, daily living, decision-making, and interpersonal communications.[231]
- Mobile Response and Stabilization Services (MRSS): MRSS provides face-to-face intervention for children who are experiencing escalating emotional and/or behavioral issues. MRSS initially focuses on de-escalation, assessment and crisis management and can, as needed, provide longer-term care and stabilization services. MRSS is available 24 hours a day, 7 days a week and attempts to deploy staff within one hour of receiving a request for assistance. MRSS can be accessed 24 hours per day every day of the year by calling 1-877-652-7624.
- Outreach to At-Risk Youth (OTARY): OTARY is a DCF initiative designed to prevent crime and deter gang involvement by providing enhanced recreational, vocational, educational, outreach and supportive services to youth aged 13 to 18. OTARY programs are primarily located in communities with high crime rates and high levels of gang violence.[232]
- School-Based Youth Services Program (SBYSP): SBYSP is a program led by DCF's Office of School-Linked Services and is operated by non-profit organizations or the school district itself in communities throughout New Jersey. SBYSP programs offer services before, during, and after school and throughout the summer to youth aged 10 to 19 in areas including, mental health and family services, health services, substance abuse counseling, employment services, pregnancy prevention programs, learning support services, and referrals to community-based services.[233]
- DCF Inventory of Statewide Resources: The Department of Children and Families provides an online resource guide for programs and services available by county for youth in need of support services.[234]

<u>Department of Law & Public Safety (Office of the Attorney General)</u>

- Trenton Violence Reduction Strategy: A three year, $1.1 million initiative in Trenton geared toward providing ex-offenders and those at-risk of engaging in criminal activity the opportunity to receive supportive assistance and wrap around services if they are willing to take responsibility for their past mistakes and ownership of their future. The program is led by the Trenton Police Department,

231 http://www.socialwork.rutgers.edu/instituteforfamilies/officeofchildwelfareinititives/TFY.aspx.
232 http://www.nj.gov/dcf/adolescent/oasresourceguide.pdf.
233 http://www.state.nj.us/dcf/families/school.
234 http://www.state.nj.us/dcf/families/dfcp/DFCPDirectory.pdf.

The College of New Jersey, and Isles, a non-profit in Trenton, who are now working with more than 40 individuals and assisting them in securing employment, receiving counseling and treatment, providing educational opportunities, and other needed support.

- Positive Youth Development Grants: In 2014, the OAG awarded grants to six non-profits throughout the state to provide supportive services to vulnerable youth under the age of 21 who are experiencing adverse circumstances because they live in economically disadvantaged or high crime areas. The key objective is deterring delinquency and criminal conduct while encouraging prosocial behavior.
- Municipal Planning Boards: The OAG convenes a diverse group of stakeholders from government, community and faith-based organizations and law enforcement who focus on a core mission of juvenile crime prevention and coordination of services for at-risk youth. There are six MPBs operational in nine cities (Atlantic City/Pleasantville, Asbury Park, Camden, Cumberland County (Bridgeton, Millville, Vineland), Newark, and Trenton). OAG is in discussion with leaders from three other areas – Paterson, Jersey City, and Burlington County to create MPBs in those areas as well.
- Faith-Based Outreach: The Attorney General convenes two separate working groups of faith leaders – the Muslim Outreach Committee and the Interfaith Advisory Council to discuss issues of importance to these religious leaders and their congregants.
- Corridor-Status Initiative ("Corr-Stat"): Launched nearly three years ago among agencies in North Jersey, Corr-Stat now includes more than 30 local law enforcement agencies, five county prosecutor's offices, and federal and state partners who meet regularly to discuss crime trends and patterns and share information on the criminal environment in their cities. Corr-Stat is now supported by the Real Time Crime Center, which opened in Newark in December 2014. The RTCC pushes out intelligence as it is generated and will help investigators in the field by getting them information more quickly.
- SJ Stat: Building off the success of Corr-Stat, the Attorney General's Office stood up a similar regional collaborative in South Jersey to cover Cumberland, Salem, and Atlantic Counties and bring together law enforcement agencies from those areas to address the criminal element in their communities.
- Prosecutor-Led Mental Health Diversion Programs: OAG funds prosecutor-led mental health diversion programs in Ocean and Essex Counties. These programs offer diversion from incarceration for clinically appropriate defendants who are approved for the program by the County Prosecutor.

<u>Other Governmental Programs</u>

- Crisis Intervention Team Training (CIT): CIT is an an innovative national model that provides an intensive, 40-hour training curriculum to police officers, mental health professionals, and advocates on how to appropriately respond to people experiencing a behavioral crisis who pose a risk to themselves or others. The curriculum focuses on educating law enforcement officers about mental illnesses

such as schizophrenia, bi-polar disorder, post-traumatic stress and others and strategies to de-escalate situations when a person with a mental illness is in severe crisis. When utilized effectively, individuals who might have otherwise been incarcerated receive treatment, the safety of officers and the general public is heightened during these encounters, and police/community relations are strengthened because family members see that their loved ones are not treated as criminals, but rather, as sick people in need of help. In New Jersey, more than 2,100 officers and State Troopers across 9 counties and more than 70 jurisdictions have completed the 40-hour curriculum.

- National Forum on Youth Violence Prevention:[235] The National Forum on Youth Violence Prevention is focused on building federal-local collaboration to increase awareness, drive action, and build local capacity to more effectively address youth violence. Camden, New Jersey is one of ten cities that participate in this effort.[236]
- Juvenile Detention Alternatives Initiative (JDAI): In 2004, New Jersey was selected by the Annie E. Casey Foundation to participate in the national JDAI initiative. The primary goal of JDAI is to offer alternatives to detention for youth engaged in low-level delinquent activity. Eighteen counties in New Jersey participate in JDAI, which has resulted in a roughly 60% reduction in the number of juveniles in detention on any given day. JDAI has been so successful that the Casey Foundation designated New Jersey as a model site and representatives from fifteen other states have traveled to New Jersey to learn more about our program.
- Project Safe Neighborhoods (Jersey City):[237] In September 2014, Jersey City was awarded $500,000 from the U.S. Department of Justice to implement a Project Safe Neighborhood program. Funding will support ongoing efforts to reduce gun and gang violence through collaborative law enforcement strategies.
- Promise Neighborhoods (Camden): The Center for Family Services received a grant from the U.S. Department of Education to implement a Promise Neighborhood program in the Cooper Lanning neighborhood of Camden. The primary objective of the grant is to develop and implement a “cradle-to-career” service plan designed to improve academic achievement (including college matriculation) and healthy development of children in the Cooper Plaza and Lanning Square area.
- Jersey City Employment Training: Hailed as a national model for prisoner re-entry, the Jersey City Employment and Training Program focuses on providing sober living, employment, and housing for ex-offenders while integrating social services to improve their likelihood of a successful transition back into the community. The Jersey City model is being rolled out in five other cities statewide – Atlantic City, Newark, Paterson, Toms River, and Trenton

[235] http://youth.gov/youth-topics/preventing-youth-violence.

[236] http://www.ci.camden.nj.us/wp-content/flyers/camdencityforumplan2013.pdf.

[237] http://www.justice.gov/usao-nj/pr/us-department-justice-awards-500000-crime-fighting-grant-new-jersey.

Non-Governmental Programs

Boys and Girls Club of New Jersey: The Boys and Girls Clubs effectively serve youth nationwide and in New Jersey. In 2013, Boys and Girls Clubs nationwide worked with nearly 3.8 million youth ages 6-18. In New Jersey, there are 23 active Boys and Girls Clubs who work with young people throughout the state to help them achieve academic success, good character and citizenship, and maintain healthy lifestyles.

Mentoring Moms:[238] Mentoring Moms is a program led by the Volunteer Center of Bergen County. Since 1995, Mentoring Moms has provided education and support services to parents and care-givers to address the issue of child maltreatment and prevent future interaction with violence either as victim or perpetrator. Mentoring Moms has trained approximately 500 mentors and provided mentoring services to over 500 mothers/guardians. Mentoring Moms recruit, train and supervise adult volunteer mentors who serve as a caring, supportive network to overwhelmed mothers or guardians in need of parenting and life skills. Mentors commit to spending a minimum of 2-3 hours per week in shared activities, for one year, in a peer-to-peer relationship with a mother.

[238] http://www.bergenvolunteers.org/info.aspx?c=4bd3e1131e1985a8&n=502&p=Mentoring%20Mom.