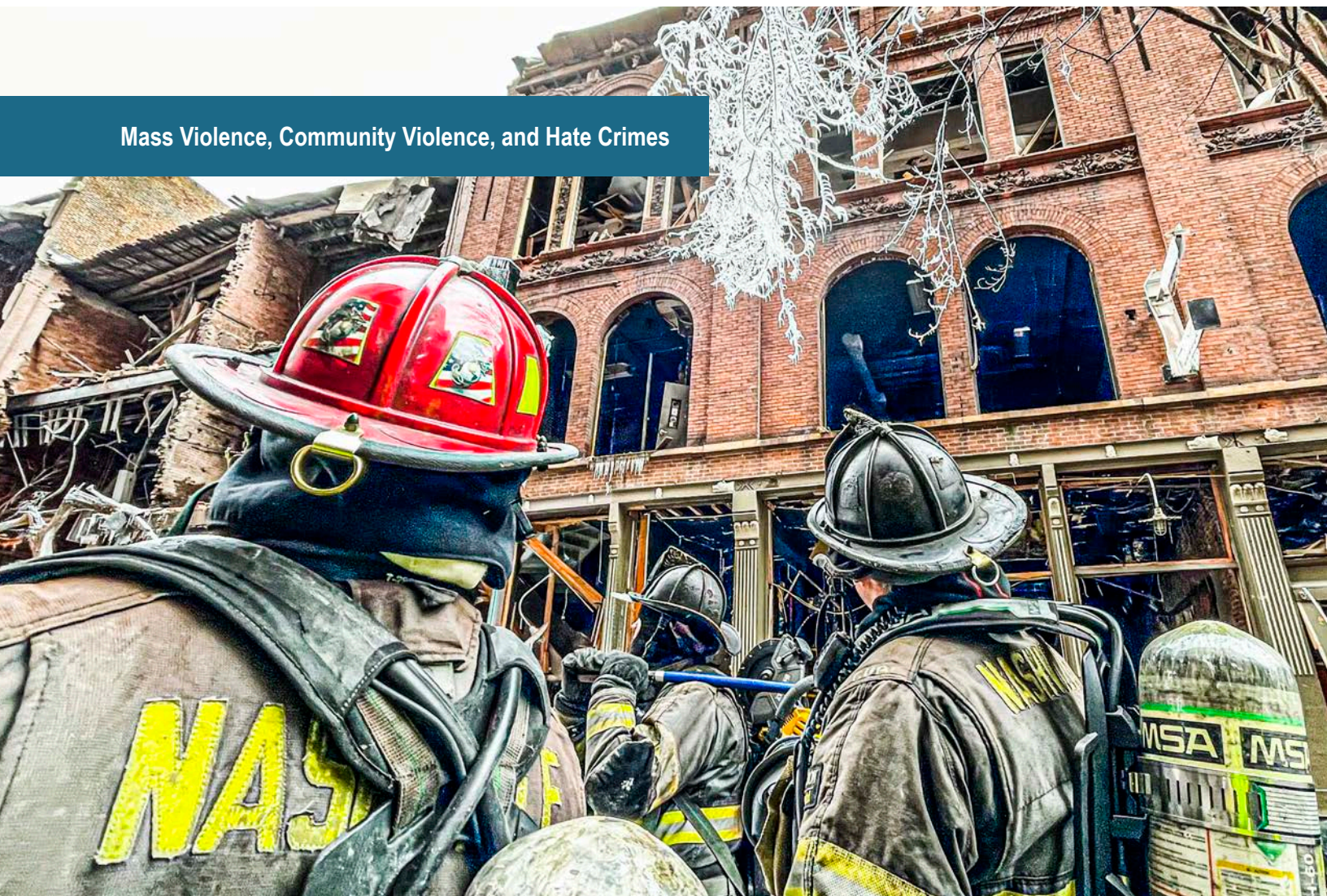


A Quarterly Technical Assistance Journal on Disaster Behavioral Health
Produced by the SAMHSA Disaster Technical Assistance Center

the Dialogue

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Mass Violence, Community Violence, and Hate Crimes



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COVER Photo by Melissa Riley

The Dialogue is a quarterly technical assistance journal on disaster behavioral health which is produced by the Substance Abuse and Mental Health Services Administration (SAMHSA) Disaster Technical Assistance Center (DTAC). Through the pages of *The Dialogue*, disaster behavioral health professionals share information and resources while examining the disaster behavioral health preparedness and response issues that are important to the field. *The Dialogue* also provides a comprehensive look at the disaster training and technical assistance services SAMHSA DTAC provides to prepare states, territories, tribes, and local entities so they can deliver an effective disaster behavioral health response.

SAMHSA DTAC provides disaster technical assistance, training, consultation, resources, information exchange, and knowledge brokering to help disaster behavioral health professionals plan for and respond effectively to mental health and substance misuse needs following a disaster.

To learn more or receive *The Dialogue*, please call 1-800-308-3515, email dtac@samhsa.hhs.gov, or visit the SAMHSA DTAC website at <https://www.samhsa.gov/dtac>.

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In This Issue

Community and mass violence and hate crimes not only take lives but leave a lasting trauma legacy. Exposure to mass violence, such as mass shootings in public places, affects a relatively small number of individuals directly, but the whole community and, in some ways, the whole country may experience behavioral health impacts. Community violence, such as ongoing violence in areas experiencing high rates of poverty, also has undeniable behavioral health impacts, along with other stressors associated with living in poverty and experiencing structural disadvantage. Youth and young adults are especially vulnerable to these incidents of violence, and communities experiencing high rates of poverty and racial segregation may also be disproportionately affected. The subset of community and mass violence incidents that are hate crimes have their own potent effects, as people both near and far to the incident who share an aspect of identity targeted in the hate crime may feel more vulnerable. As the frequency of violent incidents increases in the United States, these mental health impacts affect larger swaths of the population. Community and mass violence have become behavioral health crises.

Violence in our neighborhoods, schools, and places of business is not something that only affects populations

Memorials to victims outside the Tree of Life synagogue. Official White House photo by Andrea Hanks.



A gathering after a violent incident can help restore a sense of community. Adobe Stock photo.

in the short term. The trauma of community or mass violence can create ongoing negative effects for the victims, their families, and entire communities. While intervention strategies are essential in the effort to reduce future occurrences, resilience is the tool needed to counteract the negative impacts of violence, both on the individual and community levels. Building resilience is critical, and something communities and individuals can pursue as they plan and prepare, not only in response to an event. Understanding and preparing for threats is one of the ways to ensure more resilience, thus preventing persistent trauma that can affect a population for years, or even generations.

In this issue of *The Dialogue*, we gather a variety of experts to bring their unique perspectives on these complex topics. In the first article, a first responder recounts the aftermath of a mass violence event and its impact on those responding. Next, an expert discusses the effects of community violence, as well as prevention and intervention strategies. The third feature is an interview with two staff members of the Improving Community Preparedness to Assist Victims of Mass Violence and Domestic Terrorism: Training and Technical Assistance (ICP TTA) Program, which is focused on partnership and planning steps communities can take before violence occurs. In the fourth article, a leader in the response to the October 27,

2018, synagogue shooting in Pittsburgh, Pennsylvania, describes how her community has coped with a hate crime and grown stronger through collective processes of healing. In the following article an expert weighs in on the impacts of natural or human-caused disasters in communities that experience high rates of community and structural violence. The final article explores the topic beyond the United States and examines the effects of community violence on children. The issue also features a poster readers can print and post that provides an overview of the topic of hate crimes and steps communities can take to cope, enhance resilience, and recover.

Have you been part of preparedness, response, or recovery efforts focused on community or mass violence or hate crimes? Other planners and responders can learn

from your efforts and experience. Please contact us to share your stories and lessons learned. ■

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reducing lethal violence among youth and young adults in the United States and other countries. She serves as a core member of the global Armed Conflict and Violence Prevention Research Advisory Group for the United States Agency for International Development's Center for Conflict and Violence Prevention and has coauthored studies on gang desistance in the Northern Triangle, youth violence in Colombia, and a global evidence review of what works to prevent lethal community-based violence. In the United States, Campie has been evaluating, since 2013, Massachusetts' Safe and Successful Youth Initiative, a statewide violence prevention initiative that targets high-impact gun- and

gang-involved males and females (17–24 years) at risk for violence in 14 cities, an intervention that has produced sustained reductions in gun violence over more than 9 years, even when other cities have seen violence spike in post-pandemic times. Campie also leads a longitudinal study on the root causes of school and community violence in California and is evaluating the Community Crisis Intervention Program in Philadelphia, patterned after the Cure Violence model.



Amanda Eagan, M.A.Ed., serves as Senior Training and Technical Assistance Specialist with the ICP TTA at ICF, Inc. She comes to the ICP TTA team after 7 years of working in the higher

education sector at Virginia Tech. During this time, Eagan supported the learning and development of

students, faculty, and staff through the creation and delivery of learning opportunities of various formats, including a continuous learning series, written materials, multiday leadership trainings, seminar courses, and a peer education program. At the start of the COVID-19 pandemic, Eagan was appointed to coordinate Virginia Tech's response for the 10,000-student residential population. In this role, she worked with campus and community partners to develop and execute new policies and procedures to promote the health and safety of the university community at large. In addition to organizing the depopulation and repopulation of campus, Eagan created and directed the university's isolation and quarantine procedures in coordination with university and district health officials. Additionally, Eagan oversaw the evaluation and adjustment of departmental standard operating procedures in alignment with health guidelines. She also developed both internal and external communication streams to keep residential staff, students, and families informed of university decisions related to COVID-19. Eagan received her B.S. in emergency management from Saint Louis University and her M.A.Ed. in higher education and student affairs from Virginia Tech.



Maggie Feinstein, M.A., LPC, is the Founding and Executive Director of the 10.27 Healing Partnership. She is a master's level professional counselor who has distinguished herself in the field of integrated mental

health. She received her undergraduate degree at the University of Wisconsin-Madison in international relations and received her master's degree from the University of San Francisco in counseling psychology. She worked in San Francisco and Anchorage before returning to Pittsburgh. She currently resides in Squirrel Hill with her husband and two children.



Tara S. Hughes, LCSW-R, is the Project Director for ICP TTA at ICF, Inc. The ICP TTA Program delivers training and technical assistance to local, state, regional, and tribal jurisdictions across the country, including

U.S. territories, to augment existing emergency response plans to ensure effective protocols and strategies to address the immediate and long-term needs of victims, families, and first responders after incidents of criminal mass violence and domestic terrorism. Hughes is a subject matter expert in mass violence response, working directly with victims and families to ensure comprehensive care. She oversees work with communities to plan for mass violence response. She has extensive experience working in mass violence/casualty incidents, with a focus on violence that impacts large numbers of people and whole communities. Hughes uses her experience in trauma counseling and crisis response to ensure compassionate and effective care of people impacted by incidents. Her immediate response history encompasses a wide variety of incidents, including the crash of Colgan Air Flight 3407; the 2010 Haitian earthquake; the Newtown, Connecticut, Sandy Hook Elementary School shooting; Boston Marathon bombing; Orlando Pulse nightclub shooting; and October 1, 2017, Route 91 Harvest Festival shooting in Las Vegas. Her long-term recovery work includes the Pittsburgh synagogue shooting; Virginia Beach municipal workplace shooting; and Gilroy, California, Garlic Festival shooting. Hughes received her B.A. in psychology from Boston College and master of social work (M.S.W.) and family therapy certification from Boston University. Her clinical practice has focused on treatment of survivors of trauma, with a concentration on crisis/trauma response and family interventions. She has extensive experience working in communities where violence is the norm and has responded to a variety of communitywide traumatic events.



Robert D. Macy, Ph.D., DMT, is trained as a theatre artist, Taoist martial artist, dance movement therapist, developmental traumatologist, and disaster behavioral health manager.

He has developed body-based

psychological trauma interventions and has launched the design, development, dissemination, and implementation of trauma-informed care assessment and intervention service delivery systems in the United States and overseas focusing on schools, residential treatment centers, inpatient units, communities of color with high-priority populations, emergency services, and large-scale community engagement. Macy is the Founder and President of the International Trauma Center-Boston, and Co-Founder and Executive Director of The Boston Children's Foundation. Macy is a founding member of the National Child Traumatic Stress Network (NCTSN), where he is a primary content provider and National Master Trainer for the development of Psychological First Aid, and primary content provider and National Master Trainer for Skills for Psychological Recovery. He has co-chaired the NCTSN Terrorism and Disaster Network Committee and continues as a senior consultant to the NCTSN Terrorism and Disaster Center and has led numerous response and behavioral health recovery teams during national and international disasters. A senior response member for SAMHSA DTAC, Macy is activated by DTAC for major terrorist attacks and natural disasters in the United States providing Crisis Counseling Assistance and Training Programs (CCPs) and continuum of care trauma-focused interventions for youth, family, and community. Macy was 1 of only 12 experts in the nation to be selected to membership for the Barack Obama-commissioned Attorney General's Federal Advisory Commission on Children Exposed to Violence as part of Attorney General Eric Holder's Defending Childhood Initiative. Macy designs, implements, and evaluates trauma-focused psychosocial resiliency initiatives, violence prevention programs, and trauma-informed care initiatives in the United States, Europe, the Middle East, Eurasia, and Africa.



Melissa Riley, Ph.D., AEMT, CFI, is currently an Assistant Professor in the Department of Applied and Industrial Technologies in the College of Engineering at Tennessee State University. She is from

Nashville, Tennessee, and has worked in emergency services for 30 years. She is a certified firefighter, advanced emergency medical technician (EMT), wilderness EMT, police officer, hostage negotiator, handgun and rifle instructor, search and rescue K9 handler, and public safety rescue/recovery diver. She currently teaches aerospace at Tennessee State University and has over 2,200 flight hours with over 1,500 as a flight instructor. Riley is a national trainer for SAMHSA for the disaster behavioral health grants where she has 12 years' experience working in the disaster behavioral health field. Prior to that she also worked as a crisis counselor for behavioral health in Middle Tennessee. She has worked for SAMHSA DTAC to help create courses for first responders related to depression, posttraumatic stress disorder, and suicide.



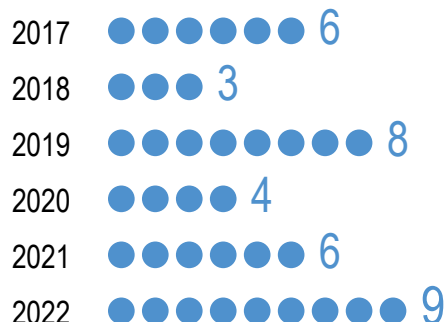
Ciara Suros, LCAS, LCSWA, CSI, is a licensed addiction and mental health clinician in North Carolina. She is a Regional Director for Covenants Sandhills Region. She is a veteran of the U.S. Army

and, shortly after medical retirement, she pursued her education in social work. She currently holds a master of social work degree from Fordham University. She obtained her clinical license in addiction and social work to aid the populations she serves. Suros has a growing family with a husband and children that she loves dearly. Suros remains engaged and active in the community, where she volunteers and advocates for at-risk populations.

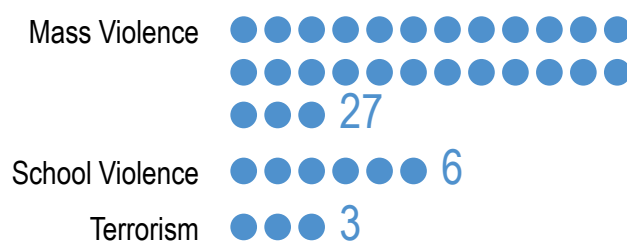
TECHNICAL ASSISTANCE SNAPSHOT

Requests Received by SAMHSA DTAC for TA Related to Violence, 2017–2022

Number of Requests by Year



Number of Requests by Type



Most requests to SAMHSA DTAC for technical assistance (TA) during this period were for incident types other than mass violence, school violence, or terrorism. From 2017 through 2022, there were 2,026 requests to SAMHSA DTAC for TA, and only 36, or about 1.8 percent, were related to violence.

Are you looking for disaster behavioral health resources?

Check out the new and updated
SAMHSA DTAC Disaster Behavioral Health Information Series (DBHIS) installments.



<https://www.samhsa.gov/resource-search/dbhis>

A First Responder's Perspective on Mass Violence Response

By **Melissa Riley, Ph.D., AEMT, CFI**, Tennessee State University



Responders survey an area of Nashville bombed in December 2020. Photo by Melissa Riley.

On Christmas morning, December 25, 2020, there was a report of shots fired in the historic district in downtown Nashville. Then an RV was discovered parked in the district, and it began playing music over a loudspeaker—"Downtown," by Petula Clark—with breaks in the music to announce that a bomb was going to explode. Six on-duty metro police officers responded and risked their lives going door to door and evacuating residents, not knowing when or if a bomb would explode. Eventually the RV's driver detonated the explosives that filled the vehicle outside of the AT&T building on

2nd Avenue, across from multiple businesses and apartments, including Wildhorse Saloon, BBK Blues Club, Coyote Ugly, Rodizio Grill, Old Spaghetti Factory, and 34 other bars and restaurants. The explosion killed the bomber and injured three civilians. Multiple videos of the responding metro police officers' body-worn cameras released to the public after the incident revealed that, as the bomb detonated, each thought that they had lost a fellow officer in the explosion and that they might be killed as well. Many in the area were knocked down by the force of the explosion. Some

debris from the bombing was found embedded into the outside of the Tennessee Titans Football Stadium. The explosion was felt by people over 30 miles away. And all of this occurred on what is supposed to be one of the holiest and most joyful days of the year.

The city of Nashville responded with police officers, firefighters, medics, and search and rescue K9s. Personnel from the Federal Bureau of Investigation (FBI), Tennessee Bureau of Investigation (TBI), U.S. Marshals, and the state medical examiner also responded. Search

“In the midst of mass violence, there is often also bravery, service and compassion. Emergency responders rush to the scene. Strangers come together to apply first aid and transport victims to hospitals. Doctors and nurses work long hours to save lives and give comfort. After the immediate crisis has passed, communities may hold vigils or events to remember their neighbors and friends”
(National Center for PTSD, n.d.).



and rescue operations began around 7:30 a.m. and lasted until 2 p.m. Every apartment, bar, restaurant, and hotel had to be searched to make sure no one else was injured or killed. This meant that hundreds of apartment and business doors had to be breached by firefighters, which was exhausting work done with the ongoing threat that another explosion could occur, and that the damaged buildings could collapse. Gas leaks and small fires were present, and debris was continuing to fall off of buildings and into the street. After the explosion and for the duration of search and rescue operations, fire alarms in the buildings sounded, making verbal communication difficult for all responders.

Every training scenario related to mass violence since 9/11 teaches first responders that the first incident is often used to draw them in, and

then a bigger incident will occur to inflict maximum chaos and confusion. So every first responder working that day knew there was a high likelihood that there could be another explosion while they were conducting search and rescue operations. In addition, the temperature outside was 7 degrees Fahrenheit, so in addition to mental stress and physical exhaustion, there was the environmental exposure of working for long periods outside in abnormally cold conditions for that part of the United States.

The community faced long-term impacts of the bombing—over 1,000 employees of area businesses were left without jobs, and hundreds were homeless. For first responders, as with any incident of mass violence, the incident was not over in a moment or two; rather, it would go on for over a week, and the written reports and follow-up would last for

months. For the officers present at the incident that morning, that meant the added stress of being pulled off of their regular duties for an endless array of TV and radio appearances to talk about their experience. For those helping to collect evidence, it meant a week of sifting through Christmas decorations, children's toys, parts of vehicles, parts of bars and restaurants, broken glass, exploded brick and metal, and fragmented body parts. Each piece had to be photographed and collected from roadsides, staircases, rooftops, etc.

Experience and Impacts of Mass Violence on First Responders

Incidents of mass violence are unique in that all first responders train for them, but there is a big

difference between training for them and actually having to respond. The level of intensity for the responders likely is greater than any call they have responded to before, due to the scale and nature of incidents of mass violence. Responders are also taught that there is a high risk of injury or death due to the large-scale nature of the event and that the event is often designed to inflict maximum damage and to injure or kill the first responders. These events also draw intense media attention to the situation. With cameras, news helicopters flying overhead, and social media exploding, there is

no way to get relief from being reminded of the incident without completing isolating oneself from TV, social media, radio, and even other people.

Because the response is often lengthy to collect the evidence and account for all human remains, exposure to some of the worst sights and smells a first responder can experience can be drawn out over multiple days and be very intense. Long after the initial adrenaline has worn off, they are still seeing, smelling, and touching items that most humans in their

entire lifetime will never encounter. These events can take a very big emotional toll on first responders for the myriad reasons spoken about here. No matter what type of badge first responders wear, they are all human beings. In a profession where over 30 percent will develop a diagnosable mental illness or substance use disorder from the everyday nature of the job, adding in an incident of mass violence can be the deciding reason for responders to leave the profession.

According to Amy Morgan, M.S.C., Executive Training Director at Academy Hour and International Public Safety Association Mental Health Committee Member, trauma from mass violence can create cyclical patterns of negative thinking as well as new trauma (Morgan, 2018). Additionally, it can cause a responder to question the safety of all situations going forward, increasing stress and anxiety, and significantly increasing the chances of developing depression, posttraumatic stress disorder (PTSD), or anxiety disorders. According to Arash Javanbakht, Associate Professor of Psychiatry at Wayne State University, humans become stressed or terrified when exposed to a dangerous event, and when the event is caused by people, the impact can be profound. Javanbakht reports that humans can learn fear and experience terror through exposure to the trauma and fear of others, and this can make a significant impact on the brains of survivors (Javanbakht, 2021).



In a review of studies on the mental health effects of mass shootings, researchers found increases in post-traumatic stress symptoms, depression, and other psychological symptoms among survivors and members of communities where the incidents occurred. Risk factors for challenging psychological reactions included pre-incident trauma and psychological symptoms, higher levels of exposure to the incident, difficulties in emotion regulation, and low social support (Lowe & Galea, 2017).



Images: Mental Health by Victorlur from [Noun Project](https://www.nounproject.com/).

In a profession that has a significantly higher rate than the general population of developing depression, PTSD, and suicidal ideation, responding to an act of mass violence increases the likelihood of developing these illnesses, as it is a “flashbulb” memory event. It will remain with first responders for the rest of their lives, similar to other large events such as 9/11, the space shuttle tragedies, etc. For some first responders, especially if they have been in the field for several years or more, a mass violence event can be a “capstone call” for them. It can be so large and so defining that they do not feel it will be topped and that they can retire or change careers now, feeling like they have given all of themselves that they can to that profession. It is difficult to tell how many first responders leave the profession after mass violence incidents as it is a profession where weakness is frowned upon, so



Responders search a building after the bombing. Photo by Melissa Riley.

stating that a particular incident was too much to handle is rarely done. Instead, in the coming weeks to months, incidences of retirement or resignation of positions may occur without a direct correlation to the event itself.

emotionally process. Added to the ongoing stressors and trauma exposures of their profession, the mass violence incident may be a capstone event that results in resignation or retirement to prevent exposure to such trauma ever again.

Helping First Responders Cope With Mass Violence Events

They key takeaway from these events is that it will impact the responders’ trust in the general goodness of others. It will be an event that imprints on their mind and that by any measure is difficult to understand and

When agencies in a jurisdiction respond to such an event, following up with responders days, weeks, months, and years later is critical. While the media and the community move on, that event will remain with them. It is important to reach out and work with them on tips for developing resiliency, help them understand that this is a significant event and how to do more proactive self-care, potentially develop first responder-specific support groups, and touch base with them around anniversary events or if the

If you’re experiencing distress or other mental health concerns related to disaster, you’re not alone.

Call or text the national Disaster Distress Helpline at 1-800-985-5990 (for Spanish, press “2”)

Disaster Distress Helpline

Call or Text 1-800-985-5990 | disasterdistress.samhsa.gov

perpetrator of the mass violence goes to trial, as all of these can be triggers for what they have experienced, especially if they must testify in court and relive in public what they experienced.

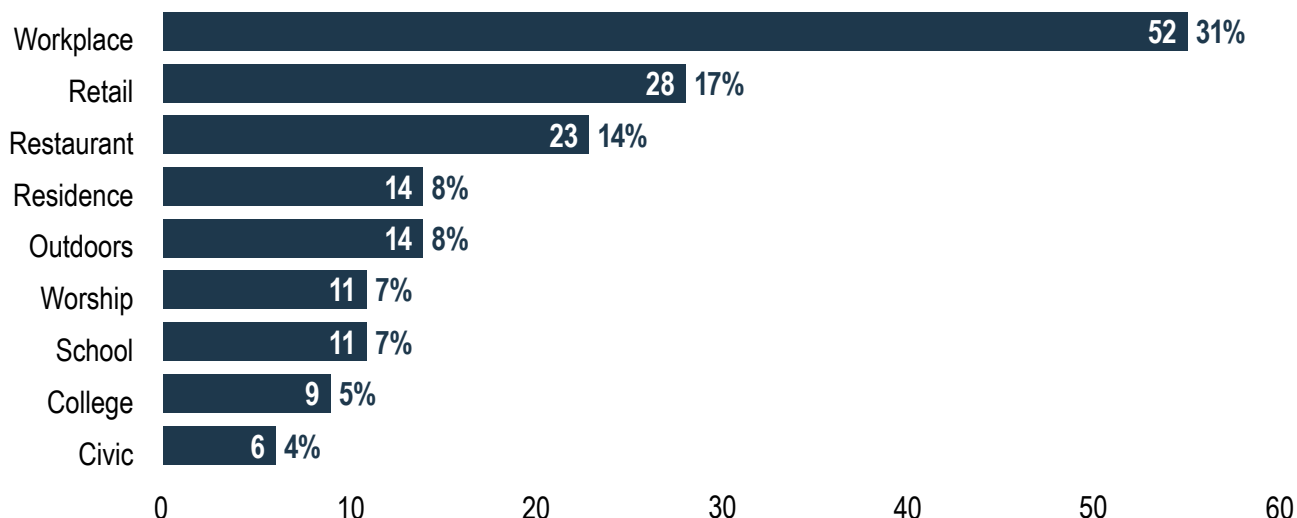
While every first responder trains to respond to an incident of mass violence, it is rare that they have to put this training to use. Creating a proactive network set up for a long, supportive response is key to

keeping first responders healthy and helping them to continue using their skills and talents in the profession and protecting the areas that they serve. ■



Responders in Tennessee. Photo by Melissa Riley.

Number of Mass Shootings by Location



Note: The data in this table come from a Voice of America special report (Shahid & Duzor, 2021) on research done by The Violence Project, which uses a narrower definition of mass shootings than some other data sources and has identified 168 incidents from 1966 to 2020.

Community Violence and Healing: Overcoming Trauma and Instilling Hope

By **Ciara Suros, M.S.W., LCAS, LCSWA**, Covenants Sandhills Region

The communities people live in across the country foster some of the most important experiences in people's lives, including friendships, educational experiences, recreation, and family traditions. However, in communities where violence happens often, the picture is much more complicated. According to the Centers for Disease Control and Prevention (CDC), community violence is a form of violence that happens between unrelated individuals, who may or may not know each other, generally outside the home. Examples include assaults

or gun violence in public places, such as schools and residential areas (CDC, 2022). In 2020, over 1.4 million people were treated for an assault in emergency departments, and nearly 25,000 lost their lives to homicide (CDC, 2022). Fatalities are often the most visible impact of community violence, the one the public and affected communities are aware of, but other impacts of community violence can affect people over the long term and may be unrecognized and left untreated. Many children and adults do not understand or recognize that they are

suffering from long-term reactions to trauma. Others may find themselves receiving treatment or services in areas where their trauma response is most visible, such as services for children in schools to help them cope with attentional differences that owe to stress and trauma, or services for people with substance use disorders and addictions developed out of an attempt to cope with the difficult symptoms of trauma.

Risk Factors

According to the CDC, several factors place people at greater risk



of poor health outcomes, including being exposed to violence. These factors include experiencing systemic racism, and the bias and discrimination associated with it; living in a household where incomes are low and access to wealth and resources is limited; and living

The Centers for Disease Control and Prevention (CDC) defines community violence as violence that **“happens between unrelated individuals, who may or may not know each other, generally outside the home.** Examples include assaults or fights among groups and shootings in public places, such as schools and on the streets” (CDC, n.d.).

in a neighborhood where many people live below the poverty line. “Communities of color often disproportionately experience these negative conditions, placing residents at greater risk for poor health outcomes,” the CDC writes. “For example, Black or African American, American Indian and Alaskan Native, and Hispanic or Latino persons have higher homicide rates than other racial and ethnic demographic groups” (CDC, 2022).

As the United States makes efforts to socially evolve and take more intentional strides to break down biases, discrimination, systemic racism, and other types of inequality and inequity, there is still more work to do and more research to conduct to get a clear understanding of how to support members of communities affected by violence in coping with trauma and reactions to other adverse experiences, so they can heal and reach their potential.

If someone is impacted by the trauma and other adverse experiences that may be part of living in a community affected by violence, that individual typically suffers in silence. However, that same individual’s trauma may be reflected in many areas of their life. Neighborhoods impacted by community violence may also have developed and be served by programs in areas such as healthcare services, scholarships, community services, housing, policing, and financial needs. The community

services and resources have been a major help. Nonetheless, they do not heal the suffering of residents of these communities who have been exposed to violence (Teach Trauma, 2022).

Prevention and Intervention

Change agents throughout the country have a responsibility to produce and provide effective services that aid people in overcoming their barriers. This may seem like a major responsibility; however, in ethical guidelines for many professions, “service” in some capacity is an obligation (e.g., social workers, healthcare professionals, and law enforcement). A large portion of ethical practice in these professions is understanding how social and environmental factors affect members of the community. These factors may act as barriers, keeping community members from accessing services the professionals are trying to provide people. For many community service providers, there is educational material that can be shared with their clients or patients to assist in the prevention of and intervention in community violence, and in community violence reduction or elimination (CDC, 2022). Great examples of the resources are programs such as free mental health and standard care through local departments of social services, Crime Stoppers hotlines, the Big Brothers Big Sisters program, community centers, youth athletic programs, resource

officers, and the 988 Suicide and Crisis Lifeline and other suicide hotlines. Some organizations are researching the accessibility of resources in communities, as well as communities' knowledge of resources, in hopes of better execution and results.

There is no such thing as a one-program-fits-all cure to community violence, as communities encompass so many different cultural, religious, social, and local practices and values. This can cause difficulty in conducting research, trying to help communities reduce and cope with violence, and achieving community cooperation. If possible, it may be helpful to work closely with communities and, specifically, residents who have experienced violence, in planning and implementing programs to help prevent violence. Furthermore, the amount of trauma and adversity that many residents from high-violence communities have suffered can create substantial barriers.

Trauma-informed care is an approach that aids in considering



the trauma of an individual through a social and environmental lens. Trauma-informed care can be used as prevention or intervention in large settings, such as social services agencies, schools, workplace environments, healthcare facilities, and governing bodies. Community service providers should require staff to attend a minimum of one trauma-informed care training a year when serving at-risk populations to aid in providing safe prevention or intervention efforts. Service professionals must understand the impacts of community violence and how it contributes to future involvement in some individuals in

violence, as a perpetrator, victim, or witness.

Conclusion

Community violence impacts people of all races, genders, and ages. These same people are still functioning on a daily basis, going to school and work, while living in fear for their safety. Violence in communities not only robs residents of peace of mind but in some unfortunate circumstances may also steal their hope. The work that is being done to combat community violence is commendable and will give so many people their lives back. ■



“Community violence can cause significant physical injuries and mental health conditions such as depression, anxiety, and post-traumatic stress disorder (PTSD)” (CDC, n.d.).

Bringing More Voices to the Table(top): Planning for Effective Response to Incidents of Violence

By **Tara Hughes, LCSW-R**, and **Amanda Eagan, M.A.Ed.**, Improving Community Preparedness to Assist Victims of Mass Violence and Domestic Terrorism: Training and Technical Assistance (ICP TTA) Program

The management of an emergency involves many professional communities, including first responders, public health and behavioral health professionals, spiritual leaders, and volunteers—as well as (of course) emergency managers themselves. Because of this diversity, different groups may engage in what Tara Hughes and Amanda Eagan of the ICP TTA Program have called “parallel planning,” which can lead to response efforts hampered by inefficiencies, lack of coordination, and conflict.

Hughes and Eagan were recruited to lead the ICP TTA Program because of their rich backgrounds in emergency management and incident response—and in connecting professional communities. A trauma therapist and licensed clinical social worker since 1992, Hughes has served as part of responses to 9/11; plane and bus crashes; the 2010 Haitian earthquake; the Boston Marathon bombing (2013); mudslides in Oso, Washington (2014); and shootings at Sandy Hook Elementary (2012), in Orlando (2016), and Las Vegas (2017). She has served as a National



Tara Hughes (left) and Amanda Eagan (right) bring rich backgrounds and expertise in emergency management and incident response.

Transportation Safety Board liaison for the American Red Cross to plane crashes and as a leader and expert in responses to mass violence. Eagan, for her part, has a background in emergency management as well as training and communications. Employed by a university when COVID-19 hit, she led the school’s pandemic response for its housing and residence life division, which serves about 10,000 students. Hughes and Eagan have worked with other experts to identify 16 best practices in planning that help bring together those who will be involved in response to mass violence incidents, including emergency

management, law enforcement and other first responders, behavioral health care, spiritual care, and victim services.

The Dialogue recently met with Hughes and Eagan to discuss funding and services in response to mass violence, as well as lessons learned from decades responding to mass casualty incidents.

How would you define victim services?

TH: The term “victim services” is very broad, and what it includes depends on who you talk to. But in terms of legislation, funding,

and services, a lot begins with the Victims of Crime Act of 1984, or VOCA. Out of VOCA came what's called the Crime Victims Fund, which is a fund that restitution payments and other non-direct payments from federal crime go into, and which channels funding to the states. The Crime Victims Fund is administered by the U.S. Department of Justice's Office for Victims of Crime, or OVC.

The Crime Victims Fund goes into a number of different pots, the biggest of which are for funding to states for two purposes. One is victim compensation, which is a direct fund that victims of crime get access to that pays for health services, surgeries, rehab, mental health, or other services directly related to the crime. Each state has a statute that dictates what it does with the Crime Victims Fund.

The second pot is crime victim assistance, and assistance involves a connection with a victim advocate. Crime victim assistance also includes some emergency crisis funding that can pay for things that are very directly connected to a crisis that you might be having. That could include, in a domestic violence situation, getting your locks changed or groceries because you can't go to the grocery store. Assistance is the more flexible part of the crime victim funding.

“As we address the trauma of mass violence, it is also important to highlight the fact that **the vast majority of people with mental health problems are no more likely to be violent than anyone else**; studies indicate that only 3–5 percent of violent acts can be attributed to individuals living with a serious mental illness. In fact, **people with severe mental illness are 10 times more likely to be victims of violent crime** than the general population.”

— Miriam E. Delphin-Rittmon, Ph.D., Assistant Secretary for Mental Health and Substance Use, SAMHSA, in a [post to the SAMHSA Blog](#) on June 16, 2022

Another pot of money that comes out of the Crime Victims Fund is a mass violence response fund, and that fund is translated for the most part into the Antiterrorism and Emergency Assistance Program grants.

An important distinction to understand is direct versus indirect victims of crime. According to OVC, direct victims are those who are exposed to the sights, smells, sounds, and tastes of an incident. Indirect victims are people who care for or about direct victims and will help to care for them after the incident.

OVC considers first responders to a mass violence event to be indirect victims. What we know, starting with 9/11, is that mass violence decimates first responder departments. Between 40 and 60 percent of first responders who support the response to an incident of mass violence will either change departments or leave the profession



altogether. Part of OVC's response is trying to help responders so that doesn't happen, because it hurts departments when they lose that many employees and their institutional memory.

AE: A big part of victim services is having an individual that can help walk you through services you qualify for that might be helpful for you—an advocate to walk with you as you access behavioral health, victim compensation, or a variety of other things. It's a pretty large bucket. Victim services encompasses services to meet those needs you have following a crime.

Have you noticed changes in preparedness and response over time?

TH: What I've seen over time is an understanding that we need mental health and spiritual care as part of response, as well as an understanding of the importance of

victim advocacy in response to mass violence. 9/11 was a pivotal moment where life changed quite a bit in so many ways, and specifically in terms of response. People lived through terrible things and would need to manage that going forward, and to help them do that, response had to include a mental health/spiritual care component.

It was during the response to the shooting in Las Vegas that large-scale victim advocacy became known as best practice and something people felt was necessary to include in response. I think part of that was the fact that you had 22,000 potential victims, and with that many victims identified by police, help was needed in managing that aspect of response.

In terms of planning, what we've seen in most places is parallel planning, where you have emergency management and

law enforcement planning for a disaster. At the same time, you have victim advocates, some of them getting trained in crisis response and understanding the potential is there to respond to a mass violence incident. But the integration of those parallel planning streams has been really challenging, and not done in most places. And so that's what the ICP TTA Program does: For the first time, it really says, "We will help you plan, but you need to have all sides of the house in the room so that the planning is integrated and people know each other beforehand."

After responding to multiple incidents, are there things you know now that you wish you'd known when you started?

TH: There are a few things I wish I knew at the beginning. One is the importance of integrating into the larger system, the Incident Command System. Behavioral



The Century 16 movie theater in Aurora. The theater was the site of a mass shooting in 2012.

“Current or former workplaces of perpetrators were the most common sites for mass shootings. Most of the shooters had been fired. . . . Almost all of mass shooters at restaurants, and retail establishments were strangers to those businesses, while perpetrators in workplaces, houses of worship, and schools and colleges tended to be current or former students and insiders known to the victims” (Shahid & Duzor, 2021).

health is integral to response, but it's one piece of many, so just understanding where you fit in that bigger system is really important.

The other thing that I wish I knew starting out was just how flexible I needed to be. We always talk about that with behavioral health. In mass violence response, it is absolutely huge. You need to be able to say you'll do whatever is needed.

Any kind of mass casualty incident, but in particular, an incident of mass violence, brings people out because they want to help. They want to do something. You get the best of the best intentions walking in the door, and people come with their own idea of what they can do and what they have to offer. And a lot of times, if you say to them, that's really great and here's what we need you to do, people really fight against that, and that fight is actually not helpful at all.

AE: I think it's important for people to think about what they would want if they were victims of the incident. It's helping flip that switch of "this is what I want to offer" versus "this is what I would need if I were in their shoes."

TH: When I train behavioral health people to respond to a mass casualty incident, I always tell them that if I were seeing someone with trauma in my office for mental health treatment, I would have to repeat myself four or five times before they really grasp what I am telling them or asking them to do. In the first couple of weeks after mass

violence, that goes up to 10 times. We're really looking at repetitive care where you are saying the same things repeatedly until the victim's brain can process the information. It's all Psychological First Aid, and repeating your message enough times to get people to where they understand their reactions are common and to be expected.

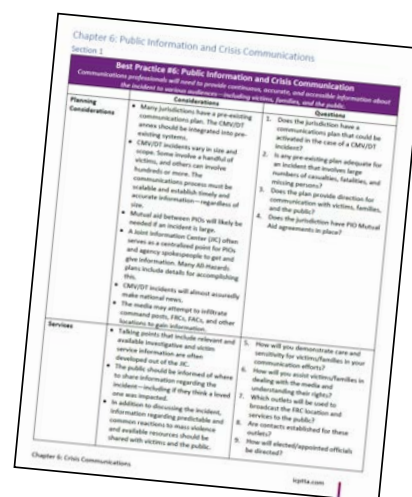
It's also important to understand that people don't always have their crisis immediately after the mass violence incident. Delayed reactions don't necessarily mean that people have PTSD. They may just take some time to process what happened. Their reactions will diminish over time or spike at different times.

How can communities be better prepared for an incident of mass violence?

AE: I think that comes back to what Tara was talking about with the parallel planning that happens, and finding ways to make that coordinated and not parallel. When an incident happens, emergency management is kind of in charge. Their job is to coordinate the response. They have Emergency Support Functions they use to coordinate the response, which are their go-to, and that makes a lot of sense because they're structured really well, and they hit a lot of different needs that people are going to have, regardless of the disaster. But mass violence requires you to think outside of that box, or widen your box. I think for communities to be better prepared, they need to

think about widening that box so that they know what they have, and they can come up with a plan to help dispatch all of those resources in a cohesive and timely way that meets the needs they have at the time.

TH: I just think that all the people who will be involved in response need to be talking to each other, as Amanda just said. One tool we've created to help is our mass violence annex template. It is designed to



A part of the mass violence annex template.

help communities develop an annex to their emergency operations plan specific to incidents of criminal mass violence and domestic terrorism. The template has chapters corresponding to the 16 best practice areas, and then each chapter includes considerations, questions to answer, and a template to use to create a part of the annex. A community just has to sit down in a room together and ask and answer the questions, and they've got themselves well on the way to being really well-prepared for a mass violence incident. ■

COMMUNITIES COPING WITH HATE CRIMES

Hate crimes are at their highest level in 12 years, with over 8,000 reported in 2020.¹

Motivated by hatred toward others based on their race, color, national origin, religion, gender, sexual orientation, gender identity, familial status, or disability, hate crimes vary from attacks on property to attacks on whole communities. Eleven percent are mass casualty attacks.

Below are recommendations to prepare for, respond to, and recover from a hate crime.



PREPARE

Build trust. Hate crimes and acts that lead to hate crimes go underreported. To better prepare communities to report and respond to hate crimes, police need to work on establishing trust with all members of communities they serve.

Increase understanding of hate crimes and signs that lead to them to help encourage reporting and decrease attacks.

Form partnerships. Having partnerships in place can help mobilize resources faster to assist victims and survivors in their recovery.



RESPOND

Center community voices.

The media should center voices of community members impacted by the violence. Responders should develop materials that are culturally sensitive.

Gather resources. Funds for victims and survivors may be needed. Communities should use established partnerships to obtain funds for repairs, funeral costs, and restorative activities.

Show solidarity through a gathering, memorial, or vigil.



RECOVER

Remember. Establish an annual remembrance to allow the community to come together to remember and reflect on the event and continue discussions about reducing hate and building connections in the community.

Educate. Engage with community members who had strong voices in the wake of the event to help spearhead education on hate crimes. Encourage cross-cultural discussion to increase understanding.

Engage. Stay active in the community to help heal bonds that may have been broken in the wake of the attack. Volunteering and fundraising for victims are good ways to stay engaged after a hate crime.

¹ Miller-Idriss & Braniff, 2022

FOR MORE INFORMATION OR RESOURCES
contact SAMHSA DTAC at 1-800-308-3515 or
email dtac@samhsa.hhs.gov.

Telling Every Story: Building Narratives as a Community After Hate-based Mass Violence

By **Maggie Feinstein, M.A., LPC**, 10.27 Healing Partnership

As a resiliency center, we are tasked with supporting our community through deep and unjust tragedy toward greater resilience. The 10.27 Healing Partnership was formed in response to the antisemitic and anti-immigrant mass shooting in Pittsburgh on October 27, 2018, when a perpetrator murdered 11 people from the Dor Hadash, New Light, and Tree of Life congregations gathered in their weekly prayer. We work with individuals, organizations, and the larger community to promote mental health, increase community

resiliency initiatives, and coordinate activities related to Oct. 27th, such as media, commemoration, and memorialization efforts.

Community resiliency work following mass violence offers a challenge that sets it apart from other mental health services. Most professionals would anticipate deep emotions, pain, and sadness. However, those who are new to the work of resiliency centers may not anticipate the depth to which good people, under the circumstances of such a devastating collective trauma,

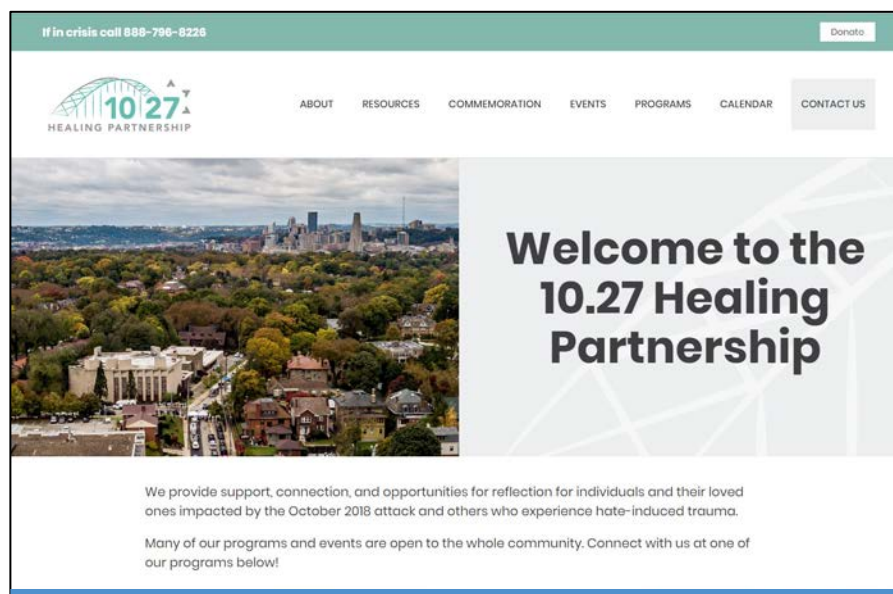
may cause further harm to one another in the aftermath and amplify the pain of the initial event. We work to understand how this happens, and what our role as a resiliency center should be in this conflict.

One focal point of this intra-community conflict after the shooting is the control of the incident's dominant narrative. Every mass violence attack and recovery has a dominant narrative which is formed both internally and externally and is significantly reinforced by national and

A resiliency center is a site established by a community after a hate crime, incident of mass violence, or terrorist attack (Office for Victims of Crime, 2015a). The resiliency center is set up and run to meet the needs of victims, family members, first responders, and community members and others affected by a violent incident; services may include counseling and therapeutic services, psycho-education, group education,



and connection of individuals to resources in the community (Office for Victims of Crime, 2015b). As explained by the ICP TTA Program at their website, “a resiliency center or program will focus on the longer-term needs of victims and/or the local community, depending on the funding secured. Services are free for identified and funded populations. The center provides a safe and supportive healing environment for individuals and groups seeking improved emotional and physical health related to the . . . incident) (ICP TTA, n.d.).



international attention and media. External sources often look for clear-cut answers, opinions, or stories that will feel relatable and easily sympathetic to the public. Stories that emerge after the mass shooting can often be individually positive; we can learn more about the strength and people within the community. However, these stories can be damaging when they coalesce into a single dominant narrative instead of acknowledging the true diversity of perspectives.

This dominant narrative includes, but is not limited to, what the political or societal ramifications of the attack should be, why the attack happened, and who should be centered in the aftermath. Living in Mr. Rogers' neighborhood we have so often heard his quote about when there is tragedy we need to "look for the helpers." There are so many incredible helpers, but not all receive the same attention. Both in our own

experience, and in our dialogue with colleagues, we have learned that the essential efforts within communities after mass violence have not always been the focal point of media. Resiliency centers should strive to make space in the narrative for the significance and stories of both those who are in pain and those who are helping.

The Effects of the Dominant Narrative

The 10.27 Healing Partnership exists within the intimate and historically Jewish neighborhood of Squirrel Hill in Pittsburgh, and while the population we serve shares many similar demographics, the small but significant differences and intersections within the community hold weight. Invariably in tight-knit communities we place a lot of value on other peoples' decisions and experiences, especially when they deviate from our own. When there is a rigid and strict dominant narrative

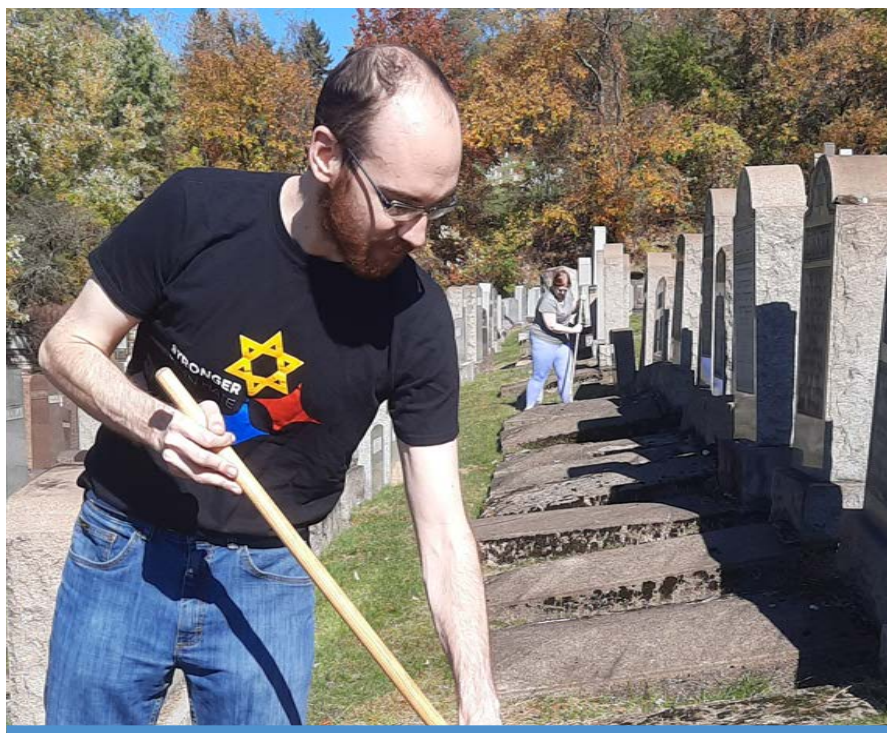
in place, deviations or rejections of that narrative can feel even more personal. It is always problematic to speak on behalf of the whole community or assume that your own perspective on the mass shooting is the only valid one. This is intensified in a community seen by the external world as a monolith.

In the case of a hate-motivated mass violence attack, secondary and vicarious trauma can be incredibly widespread and damaging. A mass violence attack is a communal trauma, and violence that is hate-motivated shatters the sense of safety and increases vicarious trauma for anyone who identifies with the group attacked. In our case, the attack was on Jewish people who were participating in the weekly ritual of communal prayer. Jewish people both within Pittsburgh and around the world share this practice, and all Jewish people can experience increased fear and anxiety about being in a similar position as those who were killed simply for being Jewish. Yet this vicarious trauma is highly stigmatized—many feel that if they were not explicitly and directed impacted, they do not have a "right" to consider their own lives and trauma a part of the communal story around the event. To heal, they may need to acknowledge the legitimacy of their own trauma.

After a mass shooting there are ripple effects that destabilize communities trying to find their balance again. A common ripple effect is inter-community

disagreement, frequently based upon or intensified by the dominant narratives being told. Without resolution, these disagreements can become endemic conflicts. When the community perceives there is one dominant narrative, it can negatively affect healing, community-building, and resiliency-building. “Sides” may be formed, and it can feel as though there is a perpetual conflict over whose narrative is legitimate.

One of the primary causes of this conflict is the assumption that there is a scarcity of who can have a voice. This assumption stems from the belief that if an individual or a group does not supersede another’s voice with their own, they will be forgotten and invisible. This belief is not baseless, and it is the resiliency center’s role to combat factors that lead to this scarcity. We should not underestimate the power of narrative and voice. If people feel that they, or the loved one that was taken from them, will become invisible or misremembered if they do not fight to gain ground on others’ narratives, it can motivate significant conflict. A resiliency center should seek to promote and celebrate a variety of narratives that hold meaning for the affected individuals and encourage opportunities for uplifting new stories. People in pain are not villains; conflict over this dominant narrative is predictable and natural, and not a result of maliciousness or failure. Community organizations must take on some responsibility for productive resolution.



A volunteer for The Jewish Cemetery and Burial Association of Greater Pittsburgh at the 10.27 Days of Service, a collaboration between Repair the World and the 10.27 Healing Partnership. Photo courtesy of the 10.27 Healing Partnership.

Diverse Narratives and Communal Narrative-building

We believe that to combat a harmful dominant narrative, resiliency centers should strive to uplift diverse narratives that hold space for multiple narratives, ideals, priorities, and voices. They can hold both the narratives of those who were directly affected by this shooting, and the broader narratives of the community who have experienced secondary and vicarious trauma.

One strategy toward doing this is to provide direct, actionable opportunities for victims to share their own perspectives. Make space for them to express who they are and their own narrative, and to show the true version of the person that they loved, free from the “flattening”

and “hero-ifying” nature of the media and broader public. These outlets include both communicating media opportunities to those directly affected and finding more creative options. Our partner, Repair the World Pittsburgh, has been invaluable in supporting this work. Every year for Commemoration we coordinate with them and the family members of those who were killed to identify volunteer activities that speak to the core values of those who were killed. This allows for genuine connection and allows for more complexity to fill the narrative.

Identify early on areas that will be emotionally intense to navigate, such as the annual date of the mass shooting, when conflicts over the story and narrative of the event

could be retraumatizing. Give the most directly affected victims the power to identify those places and delineate those times clearly. When a venue requires an apolitical or more concise approach, define other opportunities where there is more space for healthy dialogue or promotion of different narratives. A resiliency center's role here is to facilitate dialogue safely and hold curiosity, not to create solutions for the emotions, feelings, and thoughts brought up during dialogue.

Because it is not always possible in every space to hold many different perspectives at the same time, activities that encourage communal narrative-building in a healthy way are incredibly important. In our American and Jewish culture, it is common to create a public memorial that gives a voice to the tragedy and the people impacted after a communal trauma. We centered the advice of Cliff Chanin, Executive Vice President and Director of the 9/11 Memorial and Museum: "In a memorial, the product will always reflect the process." If you seek to center the victims in a memorial, the process must center their voices. Facilitated by a trained mediator, the memorialization group is currently working to unlearn harmful perspectives that had been built in the two years since the attack. They are working to remove the baggage of judgment and long-held assumptions, helping to break down these endemic narratives and laying groundwork to create healthier communal narratives in



Participants in 10.27 Healing Partnership's drum circle program led by Stephanie and Bob Miller. This program highlights community building and the release of emotion through rhythm and communal music. Photo courtesy of the 10.27 Healing Partnership.

the future. Over time, we seek to help community members find common ground when possible, and respect overall. As Lauren Mallinger, daughter-in-law of Rose Mallinger, who was killed in the synagogue shooting, put it in the wake of former President Donald Trump's visit to Pittsburgh after Oct. 27, "I understand he had to come because this was a crisis and it was his job to show up with his family. So when he did come, we joined the rally and sang peaceful Jewish songs." Healthier dialogue and healthier narratives lead to greater empathy, respect, and peace among community members with differing perspectives.

Refocusing on Connections and Community

A clear understanding of secondary and tertiary trauma is essential for a resiliency center and community members. The goal is not to "rank"

who is the most victimized. The goal is for people to hold the empathy and nuance to understand where they fall in the concentric rings of trauma, and therefore to hold the agency to both speak from their own perspective and seek their own healing while not overshadowing those who are directly impacted in ways they were not. Education and empathy-building can reduce the risk of conflict between secondary and primary victims over who is allowed to have a voice. Mediation is far more successful when all victims feel acknowledged and heard and have engaged in introspection related to their own positioning within the event. Secondary and vicarious trauma is real and deeply painful, and a resiliency center should strive to forge more diversity in the story and the ecosystem of resources after the event that allows for survivors in all spheres of victimization.

Rosh Chodesh is a Jewish ritual to mark the beginning of the Hebrew months. Rosh Chodesh Elul marks the start of the month of Elul in the Jewish calendar (Jewish Federation of Greater Indianapolis, n.d.). Elul precedes Tishrei, the month in which the Jewish High Holidays are celebrated, considered by many Jews to be the holiest time of the year, and immediately followed by the date of the shooting. Elul is a time to prepare for the High Holidays, and then also anticipating and preparing for the commemoration of the shooting (Hammer, n.d.). Observances emphasize restoration and renewal (Splansky, 2012).



Anyone who was a witness or whose loved one was killed is clearly impacted and identifiable, but there are many who experienced trauma who go unidentified. As time passes we begin to hear from individuals who feel marginalized or invisible after the shooting, either because they were unidentified or because they held different perspectives about the shooting or its ramifications. Acknowledging the response and reactions of people who are not as directly impacted can benefit the community as a whole. As we include diverse voices we can allow the narrative to deepen and allow those who were directly impacted to hold evolving and varying viewpoints.

When a communal trauma impacts the group norms of a community there is an opportunity to rebuild some new norms based on old values. It is possible to use the foundation of any shared cultural values, celebrations, and meeting places for our own collective joy. For example, in 2019 we organized a Rosh Chodesh Elul event for the community. As we were

still reeling from the synagogue shooting, the anticipation of the first commemoration was heavy and frightening. Our incorporation of Jewish ritual around Rosh Chodesh Elul and the Jewish values of learning and education into an event about mindfulness and mental health helped to prepare our community in a culturally informed way. Reviving rituals that receive little attention, such as Rosh Chodesh Elul, in a way that can celebrate our identity and resilience, is a technique we carry forward with us. In our ongoing work we lean into Jewish ritual and values, such as grieving rituals and work toward repairing the world, to further our community's healing.

Work to refocus on the shared foundation of values and emphasize your understanding that the community is not a monolith and that people are not expected to “fall into line,” and that diversity of opinions is invited. We all agree that we never want anyone to experience such a traumatic loss as our community did on October 27, 2018, and it is important to remember these similarities in times when the

community may be struggling over who gets to “own” the narrative and story.

Over time, the dominant narrative will always change. Those who felt like their stories were originally centered may feel cast off, and those who felt neglected may find the space to share. Instead of adding to this chaotic cycle, everyone in the community has a part to play in creating diverse narratives. A beautiful start to healing is to become curious about whose story has and has not been heard and the emotions you are feeling about the place you hold in the narrative. Resiliency centers and community organizations should consider the ways they may be unwittingly collaborating toward a single dominant narrative and the role they can instead play in uplifting diverse voices while maintaining a victim-centered approach. It will not be a linear process, but celebrating and respecting one another's stories is key to long-term collective healing: staying invested in continuing this journey together. ■

Disaster Preparedness and Recovery in the Context of Community Violence: Recognizing and Repairing Fragile Relationships To Minimize Harm

By **Patricia Campie, Ph.D.**, American Institutes for Research

Community-based violence impacts the physical, social, emotional, and mental well-being of those directly victimized, while traumatizing bystanders and instilling fear throughout a community. The financial consequences of community-based violence are wide-reaching, totaling close to \$3 trillion annually (Miller et. al, 2021).

The causes of community-based violence are complex, but in places that experience persistent violence, social structures and institutions through absence or oppression often limit individuals from accessing basic protections, placing them at greater risk for injury, disease, and premature death (Dong, White, & Weisburd, 2020). For example, when schools are not well maintained, still contain dangerous building materials (e.g., asbestos, lead), or are located in areas that do not have sufficient health and safety protections, such as crosswalks, street lights, or bus stops, children attending these schools are at greater risk for health-related problems, as well as exposure to victimization and violence in these environments that are unmonitored and abandoned. This type of structural violence has

its heaviest impacts on individuals in lower socioeconomic classes, leading to the highest rates of disease and death, unemployment, homelessness, lack of education, and civic powerlessness in a community.

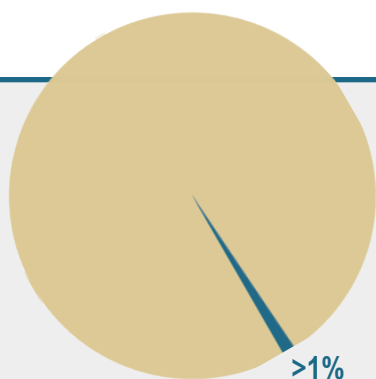
Structural violence is closely linked to social injustice and different types of interpersonal and state-involved forms of violence (Van Soest &

Bryant, 1995). Communities and people who are marginalized geographically, economically, linguistically, or culturally are more vulnerable to persistent violence that can become generational over time.

Those hardest hit by the tragedy of Hurricane Katrina, and hurricanes since, were also communities plagued by high levels of

Contractor installs the Blue Roof on Biloxi, Mississippi homes damaged by Hurricane Katrina. Photo by The U.S. National Archives





“Mass shootings are statistically rare, accounting for **fewer than 1 percent of all firearm homicides in the United States”**
(Shahid & Duzor, 2021).

community violence driven by decades of structural disinvestment. In these low-income communities, housing structures were often substandard and located in areas close to other hazards (e.g., chemical factories impacted by the storm) and isolated from rescue services.

Families in need of home repairs after the storm had a hard time accessing funds due to low credit scores, loss of employment, insufficient savings, and other personal barriers (e.g., disability, language barriers). Relocation for these families was not an option, as those costs are high, and they would be leaving their entire informal

support system of family and friends (Krause & Reeves, 2017).

These structural deficits led many of these same communities to have historically persistent levels of community-based violence (Sharkey & Marsteller, 2022). Abandoned housing becomes a haven for drug dealing that can often lead to violence as conflicts erupt between rival dealers. Residents are either afraid to call the police due to fear of retaliation from those committing the violence or they have experienced a lack of police response when they do call 911, a problem that plagues Black and Brown communities (Weisburd, 2021). Financial constraints make it nearly impossible to relocate to a safer community, as does lack of affordable housing. As a result, the violence continues, community trauma deepens, institutional distrust builds, and vulnerability to crisis increases.

Resilience in the face of violence and victimization requires a mix of supports that promote healthy youth development and family functioning, while strengthening institutions to offer meaningful education, employment, and health resources to reduce risk for violence and recover from its effects after it occurs.

If there is not a trusting relationship between government institutions and the community, the community is not likely to respond to government-initiated prevention strategies or

have the resilience to bounce back after tragedy occurs (Bolger & Walters, 2019). To ensure that these fragile communities are able to benefit from disaster preparedness and recovery resources, system-level reforms must address community trust. There must be investment in building the capacity of neighborhood-level resources that can bridge the gap between wary residents and government agencies that have let them down for generations.

The effectiveness and legitimacy of human-serving systems in the United States has never been more in question following a global pandemic and the historic and persistent police killings of Black men and women, as well as rising rates of community-based violence. For almost 2 years, schools were unable to teach, hospitals were under-equipped to treat, businesses were shuttered, homelessness increased, and there were urgent calls to defund the police and remove political leaders at all levels of government. Although this has been a time of unprecedented institutional breakdowns occurring at the same time, it provides an equally unprecedented opportunity for change.

Reducing the structural drivers of community violence can save lives from human conflict, and also help the most vulnerable communities prepare for and recover from the natural disasters that all communities inevitably will face. ■

Supporting Resiliency in Communities Affected by Violence: Responding to Incidents in the United States and Around the World

By **Robert D. Macy, Ph.D., DMT**, International Trauma Center

The violence inherent in many human-caused disasters, such as mass shootings and acts of terrorism, requires that the purpose and focus of psychosocial intervention and behavioral health disaster management is no longer only about meeting physical and material needs. Psychosocial intervention must also respond to a wider range of factors causing physical and nonphysical human suffering. Stabilizing the physical condition of human beings does not necessarily ameliorate their overall degraded circumstances nor does it eliminate the potential for greater pain and increased suffering. Separation from family, the destruction of community solidarity, the interruption or cessation of basic education, an inability to create an adequate livelihood, continual fear of abuse and concomitant retaliatory violence, deep betrayal and resentment, and personal remorse and guilt are defining characteristics of violence exposures.

Understanding and Assessing Communities Affected by Violence

When managing behavioral health responses in international and U.S. communities exposed to violence, it is important to



Participants in a project with children in western Nepal orphaned by execution during the Maoist revolt or civil war. Photo by Robert D. Macy.

conduct an assessment to gain extensive awareness of current local conditions. When conducting an assessment, managers should work to understand the following:

- Cultural, social, and economic patterns.
 - National or international and humanitarian law.
 - The context of the violence in light of its political, human rights, social, development, and military implications.
 - The trauma or violence exposure variables and dynamics of conflicts and overwhelming events.
- Local capabilities, including the innate capacities of the community. In short, which survivors are already emerging as leaders?
 - Local idioms of distress and eustress—the Traumascape.
 - Local resource capacities to specifically address both the fundamental acute and longer-term psychosocial disruptions occurring during and after violence exposure (ecology of recovery and community tolerance).

Disaster behavioral health management of violence must then address the underlying intense psychological dysregulation at the individual and group levels that often occurs as a result of exposure to violence.

Because memories of violence and bloodshed tend to remain fresh in the minds of impacted populations, they can not only hurt individuals but undermine intergroup harmony and cooperation. Highly traumatized individuals unfortunately often engage in coping strategies, such as substance use and violence directed at themselves and others, that also undermine their ability to become securely engaged in education, employment, or successful parenting. The struggles of these individuals and their coping behaviors serve as a community

reminder of past offenses. Culturally sensitive, highly structured, evidence-based programs addressing the fundamental components of psychosocial disruptions and the underlying psychological trauma that can sustain destructive coping strategies can, therefore, benefit the individuals as well as the community as a whole. In fact, the support and development of such psychosocial intervention structures may significantly reduce the mid-to long-term costs of recovery and reunification post-conflict. These psychosocial intervention structures have a fundamental focus: how to engage survivors in transformational experiences that access the human resiliency response.

Programmatically, helping to stabilize and eventually heal those psychologically impacted by

exposure to extreme violence is critical. As new datasets are being analyzed, we may see perhaps that the most cost-effective interventions, after violence, will be required to include a structured, evidence-based, community-managed psychosocial component targeting activation of resiliency responses. Current research is indicating that the costliest and longest-term negative impacts of trauma exposure, violence, and identity conflicts, and unfortunately the most difficult to address, are the longitudinal psychosocial disruption and attendant psychological impairment, both of which can significantly undermine the rebuilding and stabilization of social capital and the reintegration of the community.

Community Violence and Children

Proliferation of targeted aggression has become the norm in many communities across the United States (U.S. Attorney General's National Task Force on Children Exposed to Violence, 2012). The intensive longitudinal impact of trauma and resulting violence on students, classroom wellness, and student's learning styles is still under-researched and misunderstood, but teachers, support staff, and administrators working in the 97,500 public schools across America see the impact every day. School staffs deal with the consequences of trauma, animosity, targeted aggression, racism, and impoverishment every day. The

The Classroom-based Intervention program (CBI) is a systematic expressive-behavioral program, involving a series of activities which aim to reduce the post-traumatic stress reactions, through the help of what children do the best: playing and learning (Munir et al., 2004). It is a recovery-focused and resiliency-based program. The design is based upon the proven assumption that an immediate, trauma-specific, short-term response for children who have been exposed to life-threatening disasters may significantly decrease the overall negative effects of the disaster experience. The ultimate goal is to bring about immediate short-term benefits as well as long-term preventive effects. The expected (immediate) positive results may include a significant reduction in somatic symptoms such as sleep and appetite problems, an increase in constructive peer relations, an improvement in attention and learning, and an increase in self-esteem and in the sense of safety and control.

socioemotional and resiliency curriculum must be developed to support and enhance the academic curriculum to minimize the negative effects of trauma and violence and maximize individual learning styles.

Macy and colleagues, working with national and international donors over the last 25 years, have launched school-focused, evidence-based, highly structured psychosocial intervention programs, such as the CBI® services continuum, for children and youth exposed to armed conflict and mass casualty natural disasters (Sahin, Batigün, & Yilmaz, 2007). It is important to note that our efforts and our resources are aimed at what appear to be the most at-risk populations impacted by community violence: children and youth. In an epidemiological study by Macy (Unpublished, 2000) Medicaid youth living at the poverty level in U.S. Department of Housing and Urban Development housing exhibited some of the highest rates of severe mental health disturbances yet reported: 609.5 per 1,000 (CI: 601.0–618.0) for the 5- to 12-year-old age group. These youth were not exposed to a discrete threat event but rather have suffered continuous chronic exposure to community violence, an environment not dissimilar to communities impacted by armed identity conflict or community violence and repeated mass casualty events.

We are concerned that when high rates of psychosocial disturbances and resultant mental health disorders

There is no single, official, agreed-upon definition of an incident of mass violence or a mass shooting (Soni & Tekin, 2022).

arise among youth in violence-exposed conflict areas, which tragically now includes urban and suburban school districts in the United States, and these rates go unchecked, the economic and societal consequences for that community may be overwhelming and too costly to rectify in a timely manner. Our method has been and will continue to be the application of state-of-the-art school-based psychosocial assessment and intervention programs targeting the impacted youth in regions requesting psychosocial stabilization and traumatic stress reduction programs. These CBI® service continuum programs have been implemented in the United States and other countries under extraordinarily difficult circumstances. Research results indicate that younger children (5–12 years old) respond much better than older children who have been exposed to combat and war. PTSD symptoms were significantly

reduced, and hope was instilled and rebuilt. Depressive symptoms and functioning did not significantly change.

More research and intervention development is needed to address the current impact of violence exposure among our developing youth. The powerful positive impact of organizing local leadership and impacted citizens to access resources and learn how to implement the CBI® with their own children and loved ones cannot be underestimated and is currently being studied. The ecology of successful long-term recovery responses after violence exposure appear to be hinged most significantly on empowering impacted communities to embrace vulnerability dynamics and access group resiliency response.

We acknowledge that there are no blanket prescriptions for healing wounds and rebuilding communities and that reestablishing community cohesion is an internal process, not one that can be imposed from the outside. Each step must be taken when the time is right and the participants ready. Nonetheless, we have learned that outsiders can play an important role in preparing, supporting, and otherwise encouraging community healing, primarily by working carefully with local partners to build knowledge infrastructure that affords those most impacted by the violence the opportunity to play a central role in the stabilization and recovery of their own community. ■

RECOMMENDED RESOURCES

Tips for Survivors: Coping With Grief After Community Violence

This tip sheet from SAMHSA contains information about some of the signs of grief and anger after an incident of community violence and how to cope. It lists reactions that children may experience—including depression, posttraumatic stress, and risky behavior—and how to help them.

This resource is available through the SAMHSA Store at <https://bit.ly/3xOv0d8>.

Resources for Survivors and the Public Following Disaster and Mass Violence

The National Center for PTSD has a web page of resources available with information and tools to help you deal with the stress you may feel after a disaster or mass violence event. Resources cover how to cope in the short- and long-term, self-care, triggers, and printable handouts. Many of the resources are also available in Spanish.

Find the resources at <https://bit.ly/3r43hkS>.

Community Violence

The National Child Traumatic Stress Network (NCTSN) has a page on community violence and the common types that affect youth, including bullying and shootings in public areas. Living with chronic community violence can cause youth to lose their sense of safety. This page leads to a list of NCTSN resources on how to help youth, create supportive environments, and more.

Find the resources at <https://bit.ly/2OVKtjT>.

Mass Disasters, Trauma, and Loss

The International Society for Traumatic Stress Studies developed this six-page pamphlet to help you better

understand what to expect after experiencing a disaster, whether natural or human-caused. It covers reactions in a variety of categories, including emotional, cognitive, physical, interpersonal, and spiritual. It provides steps to help reduce stress and when it may be time to seek professional help. This resource is also available in [Arabic](#), [Chinese](#), and [Spanish](#).

Find the pamphlet at <https://bit.ly/3DORvm4>.

Violence Prevention

This page from the Centers for Disease Control and Prevention explains what community violence is and how some populations are disproportionately impacted by it. Community violence can not only lead to physical injuries but can leave individuals with mental health conditions such as anxiety and PTSD.

This page is available at <https://bit.ly/3S5fB02>.

Tips for Young Adults: Coping With Mass Violence

This tip sheet describes how incidents of mass violence can affect young adults ages 18 to 26. It identifies common reactions young people may have to mass violence and offers suggestions for coping and enhancing resilience.

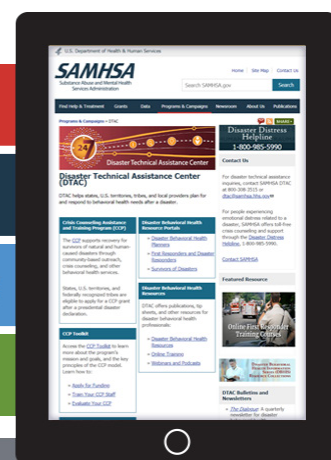
Access the tip sheet at <http://bit.ly/3m0vFVR>.

E-Learning

Webinars

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Trainings



<https://www.samhsa.gov/dtac>

Recent Technical Assistance Requests

In this section, read about responses SAMHSA DTAC staff have provided to recent technical assistance (TA) requests. Send your questions and comments to dtac@samhsa.hhs.gov.

Request: A representative from the Disaster Behavioral Health Services Texas Health and Human Services Commission requested trainings and resources on mass violence for disaster behavioral health professionals.

Response: SAMHSA DTAC provided a list of trainings and resources on mass violence. The resources below are a sample of those sent. For additional information, please contact SAMHSA DTAC at 1–800–308–3515.

■ **Crisis Services: Meeting Needs, Saving Lives**—The book is composed of SAMHSA’s “National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit” and related papers on crisis services. The toolkit reflects relevant clinical and health services research and offers a review of top national program practices, as well as replicable approaches that support best practice implementation. <https://store.samhsa.gov/product/crisis-services-meeting-needs-saving-lives/PEP20-08-01-001>

■ **Resilience and Coping Intervention (RCI)**—This intervention can be used to help children and adolescents cope with disasters and other forms of community trauma. RCI is designed for groups of 5 to 10 people and can be delivered in one or several sessions. RCI groups can be implemented in programs based in schools and other settings and led by teachers, counselors, or other professionals who have been trained in the intervention. <https://dcc.missouri.edu/rci.html>

■ **Helping Victims of Mass Violence & Terrorism Toolkit**—Available through the website of the Office for Victims of Crime Training and Technical Assistance Center, this toolkit includes information and resources to help communities prepare for and

respond to incidents of mass violence and terrorism. While some parts of the toolkit focus on steps to take before an incident, other sections are designed to support responders in participating in and managing effective response and recovery processes. <https://www.ovcttac.gov/massviolence/?nm=sfa&ns=mvt&nt=hvmv>

■ **Unexpected Challenges for Communities in the Aftermath of a Mass Violence Incident**—This tip sheet from the National Mass Violence Victimization Resource Center lists some unexpected issues a community may encounter after experiencing a mass violence incident. The document also provides suggested solutions for managing these challenges and prioritizing a community’s safety and recovery. <https://nmvvr.org/media/301cm3if/tipsheet2.pdf>

■ **Recovery From Large-Scale Crises: Guidelines for Crisis Teams and Administrators**—In this tip sheet, the National Association of School Psychologists (NASP) describes what to expect in schools after disasters and other crises and how school crisis teams and administrators can support the school community in coping and recovery. NASP identifies steps administrators and crisis teams can take at different points after the crisis, from immediately after the crisis to more than a year later. <https://www.nasponline.org/resources-and-publications/resources-and-podcasts/school-climate-safety-and-crisis/school-violence-resources/recovery-from-large-scale-crises-guidelines-for-crisis-teams-and-administrators>

Request: A representative from the U.S. Public Health Service requested resources in response to the Ukrainian refugee crisis.

Response: The resources below are a sample of those sent. For the complete resource list, please contact SAMHSA DTAC at 1–800–308–3515.

■ ***Tips for Survivors of a Disaster or Other Traumatic Event: Managing Stress***—This SAMHSA tip sheet gives stress prevention and management tips for dealing with the effects of a disaster or trauma. It identifies common reactions to disasters and other traumatic events, lists tips to manage and lower stress, and highlights signs of the need for professional support. <https://store.samhsa.gov/product/Tips-for-Survivors-of-a-Disaster-or-Other-Traumatic-Event-Managing-Stress/SMA13-4776>

■ ***Mental Health Considerations After a Traumatic Event***—A product of Voices Center for Resilience, a nonprofit formed after the attacks of September 11, 2001, this tip sheet highlights common reactions to acts of violence, including war, as well as civil unrest and terrorism. It identifies signs of the need for professional mental health support, coping tips during short- and long-term recovery, and signs of mental illnesses that may arise in the aftermath of exposure to violence. https://media.voicesofseptember11.org/projects/tipsheets/trauma_tips_mentalhealth_001.pdf

■ ***Coping With Distress After International Disasters: Tips & Resources for Individuals, Families & Communities***—This guide from Vibrant Emotional Health is a collection of resources and information for those experiencing anxiety, fear, confusion, or loneliness during and after an international incident. It includes links to Person Locator resources, tips for self-care, and links for more help. <https://www.vibrant.org/coping-with-distress-after-international-disasters-tips-resources-for-individuals-families-communities/>

■ ***Understanding Child Trauma***—This web page from SAMHSA presents statistics on child trauma, which may be experienced as part of a natural or human-caused disaster, and lists signs of traumatic stress in children and youth. It also offers tips for parents and other caregivers for helping children and youth cope with trauma. Links are also provided to downloadable infographics in English and Spanish provided by the SAMHSA National Child Traumatic Stress Initiative.

<https://www.samhsa.gov/child-trauma/understanding-child-trauma>

Request: SAMHSA requested a resource letter in response to threats against historically Black colleges and universities.

Response: The resources below are a sample of those sent. For the complete resource list, please contact SAMHSA DTAC at 1–800–308–3515.

■ ***Tips for College Students: After a Disaster or Other Trauma***—This fact sheet from SAMHSA describes common reactions to trauma and provides coping strategies and stress management tips for college students. This fact sheet is also available in Spanish at <https://store.samhsa.gov/product/Tips-for-College-Students-After-a-Disaster-or-Other-Trauma-Spanish-Version-SMA13-4777SPANISH>. <https://store.samhsa.gov/product/Tips-for-College-Students-After-a-Disaster-or-Other-Trauma/SMA13-4777>

■ ***Tips for Survivors: Coping With Grief After Community Violence***—This SAMHSA tip sheet identifies signs of grief and anger after an incident of community violence, provides useful information about how to cope with grief, and offers tips for helping children with coping. <https://store.samhsa.gov/product/Coping-With-Grief-After-Community-Violence/SMA14-4888>

■ ***Mass Violence and Behavioral Health***—This edition of the SAMHSA Disaster Technical Assistance Center *Supplemental Research Bulletin* provides information about the effects of mass violence and explores interventions to support coping and stress management. <https://www.samhsa.gov/sites/default/files/dtac/srb-mass-violence-behavioral-health.pdf>

■ ***College Students: Coping After the Recent Shooting***—Written for students at a college or university where there has been a campus shooting, this NCTSN tip sheet identifies common reactions to an incident of mass violence and effective ways

of coping. The tip sheet concludes by encouraging readers to tap into their networks of support. <https://www.nctsn.org/resources/college-students-coping-after-the-recent-shooting>

- **Helping Youth After Community Trauma: Tips for Educators**—In this one-page tip sheet, NCTSN identifies 10 ways youth may react to community traumas and suggests ways for educators to respond to these reactions and support youth in coping. The tip sheet also advises educators to find professional mental health support for youth—and for themselves—as needed. <https://www.nctsn.org/resources/helping-youth-after-community-trauma-tips-educators>

Request: SAMHSA requested resource letters in response to the shooting at the Brooklyn Subway Station in New York.

Response: The resources below are a sample of those sent. For the complete resource list, please contact SAMHSA DTAC at 1–800–308–3515.

- **Mass Disasters, Trauma, and Loss**—This booklet from the International Society for Traumatic Stress Studies discusses common reactions to disasters, factors that make people more likely to experience reactions for longer periods, and steps survivors can take to cope effectively after a disaster. Signs of the need for professional mental health assistance are also provided. https://istss.org/ISTSS_Main/media/Documents/ISTSS_MassDisaterTraumaandLoss_English_FNL.pdf
- **Mass Violence/Community Violence**—This part of the SAMHSA Disaster Behavioral Health Information Series resource collection focuses on incidents of mass violence, community violence, and terrorism and their effects. Resources discuss common reactions to incidents of mass violence, tips for coping, and ways to support children and youth in coping. https://www.samhsa.gov/resource-search/dbhis?rc%5B0%5D=type_of_disaster%3A20549

■ **Improving Community Preparedness to Assist Victims of Mass Violence and Domestic Terrorism: Training and Technical Assistance (ICP TTA)**

Program—Funded by the Office for Victims of Crime within the U.S. Department of Justice, the ICP TTA Program works to equip U.S. communities to respond effectively to incidents of criminal mass violence and domestic terrorism. The program’s website features a resources page (<https://icptta.com/resources>), which offers vetted resources to help emergency managers, victim service professionals, and others make victim services part of emergency operations plans, as well as a trainings page (<https://icptta.com/trainings>), which includes freely available trainings to help build local capacity. <https://icptta.com>

- **Remembering**—National Mass Violence Victimization Resource Center (NMVVR) This web page describes how communities typically respond in grief after an incident of mass violence and offers guidance for community leaders in supporting communities through this process. Information and downloadable resources focus on communities remembering tragic events, incident anniversaries, and memorials. <https://www.nmvvrc.org/community-leaders/rebuild-your-community/remembering>
- **Talking to Children About the Shooting**—In this tip sheet, the NCTSN provides suggestions to parents and other caregivers for talking with their children in ways that help them to make sense of and cope with their reactions to a shooting. The tip sheet also identifies reactions common in children and teens to shooting incidents. <https://www.nctsn.org/resources/talking-children-about-shooting>

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