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An Analysis of the Homicide Response Team in Rochester, New York

by

Nicole Pratt

A Capstone Project Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Science in Criminal Justice

Department of Criminal Justice

College of Liberal Arts

Rochester Institute of
Technology Rochester, NY

May 8th, 2023

RIT

Master of Science in Criminal Justice

Graduate Capstone Approval

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Graduate Capstone Title: An Analysis of the Homicide Response Team in Rochester, New York

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Chapter 1

Literature Review on Community-Based Responses to Violence

Introduction

The focus of this capstone project is on the Homicide Response Team in Rochester, New York, which is a collaborative effort among various government and local agencies to provide outreach services to the family members of homicide victims. This capstone seeks to examine community-based responses to violence, their impact on the community, and related literature, including community organizations and crisis intervention teams. The objective of the literature review is to display the various types of intervention services, whether though hospitals, street outreach, or different kinds of crisis intervention teams.

One way to reduce crime within a community is by implementing community-based violence intervention programs. different types of programs exist that are conducted by different organizations, this paper will specifically focus on programs that are not ran by law enforcement agencies with officer responses. These programs work to reduce homicides and shootings through partnerships with community stakeholders and connect individuals who are at risk of these events with those they can rely on, such as trusted community members (Amaning & Bashir, 2022). There are many different types of programs that exist in the U.S. These include, but are not limited to, hospital-based violence intervention programs, street outreach programs, group violence intervention, and more (Amaning & Bashir, 2022). There are also mental health-based community response teams (See Helfgott, Hickman, and Labossiere, 2016), and drug use-based (See Ray, McCarthy-Nickila, Richardson and Maahs (2023), and Englander et al. (2017)). While these different response teams have differences in factors such as methodology, and population served, they serve a similar goal of serving the community. Many of the members of the various teams are from the community they serve, as will be mentioned later in the paper. Many of them also provide similar services, such as referrals and connections to other

organizations and partners, financial assistance, and counseling services, though some organizations will provide services that others do not (DeLaus, 2020). Part of the goal of a community response team is to divert outreach from being mainly police-based to external organizations, allowing officers to spend more time and resources on responses that would benefit from their presence. These external organizations or individuals can be social workers, mental health specialists, or volunteers with specialized training, and can vastly reduce the number of times that officers respond to certain calls. One study found that in a program where social workers, mental health counselors, and medical staff respond to a call instead of officers, only 0.625% of them requested police backup in 2019 alone (DeLaus, 2020). One example of these types of these responses is CAHOOTS, which will be discussed later in the paper. Community organizations are one way that violence reduction can occur. While there is not much research that exists on the impact of community organizations and crime, there is evidence that there is some positive effect, as will be discussed in the following section.

Community Organizations

One crucial aspect of reducing crime rates in a community is through the involvement of community organizations that focus on addressing underlying issues and contributing factors to criminal behavior, rather than solely focusing on direct violence reduction. While street outreach programs and hospital-based violence intervention programs- which will be discussed further in the paper- are typically run by community organizations or hospitals, their goals tend to be more focused on reducing violence by directly interacting and working with the individuals involved in a crime, while community organizations tend to target the social and economic factors that drive violence. Both work with individuals who have been negatively affected in some way, but community organizations work to aid in issues that may indirectly effect crime, such as drug

usage or homelessness. Community organizations are open to all the residents of a physical community such as a neighborhood, and work to improve the physical, economic, and social environment of its community. This is done by focusing on one or more of issues such as housing, health, education, microfinance, safe water, and sanitation (Aideyan, 2018). Some of these nonprofit organizations dedicate their cause to helping to reduce violence in their neighborhood, and the research on whether these types of organizations have an impact on crime is mixed. This is because the literature on community organizations and their impact on crime is so limited, as mentioned by one paper, “few empirical studies have focused on how organizations and institutions can be vehicles for increasing socialization and achieving positive neighborhood outcomes.” (Roman, Kane, Baer and Turner, 2009). While it is known that crime in America has decreased over the past few decades, the impact that community organizations that focus on violent crime and the community creates is relatively unknown. Some research has predicted a 9% drop in the murder rate, 6% drop in the violent crime rate, and a 4% reduction in the property crime rate for every 10 organizations that focus on crime and community life (Sharkey, Torrats-Espinosa, Takyar, 2017). These changes have shown to be the greatest in the most extreme communities, the ones that are the poorest, most segregated, and most violent, but these findings cannot be generalized outside of the six neighborhoods that were observed in the study.

A review of the literature revealed a lack of groups or programs that specifically and only respond to homicides in other communities. Instead, a limited number of Crisis Intervention Teams that work with local law enforcement and other agencies in different cities were found. This next section will describe hospital-based intervention programs, street outreach programs, and different intervention teams in various cities in the U.S,

Hospital-Based Intervention

Hospital-based violence intervention programs (HVIPs) are a type of community-based intervention where emergency rooms or trauma centers are a valuable resource in violence prevention. Hospital workers identify patients who could be seen as having a high risk for revictimization through screenings that test for previous trauma, and Intervention Specialists work with patients who are willing to change their lifestyle and behavior to prevent future incidents (National Institute for Criminal Justice Reform). Hospital based intervention programs rely on teachable moments, which is when individuals are responsive to interventions, and combine teachable moments with intervention specialists or case managements, links to community-based services, and long-term case management (Purtle et al, 2013) One of the earliest forms of this type of program is Caught in the Crossfire, a youth violence intervention program that started in 1994. When a patient between the ages of 12 to 20 enters the hospital with a violence-based injury, Intervention Specialists arrive to help the victim and consider alternatives to retaliation (Becker, Hall, Ursic et al., 2004). Once the victim is willing, a plan is developed to help the victim stay safe, along with providing emotional support, alternative strategies, and case management and mentoring for six months following discharge from the hospital. Completing the program meant a minimum of three contacts with a Crisis Intervention Specialist within six months of being injured, with at least one being in person (National Gang Center). For youths that participated in the program, there was a 70% reduction in arrests for any offense when compared with the control group and were 60% less likely to have any involvement with the criminal justice system compared to those who were not in the program (Becker, Hall, Ursic et al., 2004).

Street Outreach

There are various forms of implementation for Street Outreach Programs, which are another type of community-based intervention. Street outreach programs target the way that violence spreads from person to person, similar to a disease. The viewpoint of seeing violence as a disease has led to the development of programs such as Cure Violence Global, which views violence as a community health approach. Cure Violence Global (CVG), trains community partners to find and disrupt conflict, while also promoting healthier behaviors amongst high-risk individuals. The program has its roots in Chicago but has since spread to cities in both the U.S and worldwide, like Cape Town, South Africa, Baltimore, Maryland, New York City, and the United Kingdom, to name a few (Cure Violence Global, 2021). Multiple studies have proven the effectiveness of CVG, citing a 40% to 70% decrease in shootings and killings in high crime communities (Cure Violence Global, 2021, pp. 8-14). In Chicago alone, there was a 100% reduction in retaliation killings. Cure Violence focuses on three strategies to meet their goals: Detecting and Interrupting Potentially Violent Conflicts, Identifying and Treating Individuals at the Highest Risk, and Mobilizing the Community to Change Norms (Cure Violence Global, 2021)

Fox Cities, WI

The Victim Crisis Response Team (2022) in Fox Cities, Wisconsin is a team of trained volunteers who assist local law enforcement agencies in responding to calls such as domestic violence, suicide, homicides, robbery, and more (Fox Cities Victim Response Team, 2022). These volunteers provide emotional support, crisis intervention, referrals to community resources, assistance with crime victim compensation and making phone calls, among other services. The VCR Team is a 501c3, non-profit organization funded by the Wisconsin Department of Justice Victims of Crime Act (VOCA grant) in addition to donations from

citizens, groups, and businesses (Fox Cities Victim Response Team, 2022). Fifteen local law enforcement agencies work with the VCR Team and are set to action when officers on scene request their services through the county dispatch. Based on their Facebook group, the VRC has been providing services since at least 2012, but there have been no evaluations done to determine the effectiveness of this program.

Los Angeles, CA

The Los Angeles Police Department has their own team, the Crisis Response Team (CRT), which was formed in 1992 (note that the LAPD website indicates that the team originated in 1998, but the CRT site lists 1992 as the origin year). It is a *volunteer* program offered through the Office of the Mayor, currently with one full-time staff member and over 250 screened and trained volunteers (LA Mayor's Crisis Response Team, n.d). These volunteers are trained in crisis care, intervention, and collaborating with other city departments. The team responds to an average of 400 requests each year from the L.A Police Department and the Fire Departments, which can include major traffic accidents, homicides, death notifications, drive-by shootings, and fires. The volunteers support families and victims by attending to immediate survival needs, being a liaison between victims and emergency personnel, and providing resources and referrals for long-term needs. The CRT is funded annually in part by a grant from the Allstate Insurance Company (LA Mayor's Crisis Response Team, n.d). Statistics from the official website of the CRT show that an average of 20 volunteers are deployed weekly, with volunteers logging over 3,000 hours in 2019 alone (LA Mayor's Crisis Response Team, n.d). Of the 713 calls that the CRT responded to in 2019, 415 (58%) of these were follow-ups, with traffic fatality calls the second most common, comprising 11% of the calls.

Syracuse, NY

One study looked at a response team based in Syracuse, New York. However, contrary to other previously mentioned response teams, the Trauma Response Team focuses solely on gang-related homicides and gun violence (Jennings-Bay et al., 2015). The Team began in 2010 and consisted of mostly volunteer residents who lived in neighborhoods with the highest levels of murder. They partnered with the local police, emergency response teams, healthcare organizations, and faculty from Syracuse University to provide outreach and intervention services. Through their partnerships, the TRT received information on any homicides, and assist with on-scene crowd control, providing comfort to the victim's families, and providing a community assessment after the deceased or injured have been moved from the scene. This process is the same if the victim is located at the hospital as well. Members of the TRT follow-up with families of the victim to assist in providing financial assistance or other forms of assistance.

While this Team is very similar in operation to Rochester's Homicide Response Team, two key differences exist between them. The first being that there are more members in the TRT than in Rochester's HRT. While Rochester's Homicide Team consists of 4-6 members that respond to the scene of a crime, the TRT had almost 40 volunteers at the time of the study, many of whom responded to the scene to help with crowd control. The second, and largest difference between the two organizations, is that the TRT focuses on gang-related violence and conducts prevention activities related to gangs. One example is identifying hotspots where feuds between rival gangs take place and set up a hot dog grill to discuss prevention and make recommendations to the community about deescalating feuds (Jennings-Bay et al., 2015). In contrast, HRT focuses on all homicides, regardless of whether it is gang-related or not, with the only exception being vehicular homicides.

In terms of effectiveness, the TRT has shown positive results in reducing gang-related violence. Authors Jennings-Bey, Lane, Rubinstein, Bergen-Cico, Haygood-El, Hudson, Sanchez, and Fowler (2015) analyzed murders and gun shots fired over the span of five years and found that they decreased by 20%, while non-gang related homicides increased by one-third (Jennings-Bay et al., 2015). Total gunshots fired remained relatively consistent, but after breaking it down by category, the gang-related gunshots decreased by over 20%, while non-gang related shots increased by almost half. While these results seem promising, it is unknown whether these results are directly correlated to the work of the TRT. The authors believe that this possibility is supported by the timeline in which the study was conducted, which was one year before the TRT was implemented, and then the following four years afterwards (Jennings-Bay et al., 2015). Another potential factor is the fact that the Gang Violence Task Force, was also implemented in the city in 2003, which could have its own contributions to reducing gang-related violence.

Cleveland, OH

Another organization with a similar process to Rochester's HRT is the Traumatic Loss Response Team in Cleveland, Ohio. The Team provides case management to family, friends, and coworkers of victims of a homicide. Rather than operating on their own, the Team is funded by the U.S Department of Justice's Office of Victims of Crime, or OVC (Spilsbury et al, 2016), and is housed under Frontline Service. Frontline Service is a non-profit that has had experience in working with families and children who have witnessed violence. The TLRT works closely with the Cleveland Division of Police and the Cuyahoga County Witness/Victim Service Center. While the TRT in Syracuse consisted mostly of volunteers, the TLRT is a small team of licensed, master's degree social workers who are very experienced in dealing with traumatized

individuals. One difference between Rochester's HRT and the TLRT is the fact that the TLRT does not automatically respond to the scene after being informed of a homicide or death. Instead, the "on-call" staff member contacts the family first to determine if they are willing to meet, and the staff and family meet typically within the first 24 hours of the incident (Spilsbury et al, 2016). Occasionally though, staff are requested by the police to respond to the scene of the crime without asking the family members first. Interestingly, while the HRT only responds to homicides, excluding ones caused by a motor vehicle, the TLRT responds to many kinds of homicides and deaths, including suicides, heart attacks, drownings, and a drug overdose. Additionally, three of the cases did not involve a death of any kind, as they were abduction cases.

Challenges with the TLRT mirror Rochester's HRT. One of the major challenges faced by the TLRT is the overwhelming case load and nature of the cases, especially considering the level of trauma associated with many of the cases. To help with this, staff often worked in pairs, having supervisors be available to discuss concerns and take time off if needed, resiliency exercises, and staff education in vicarious trauma (Spilsbury et al, 2016). Another challenge that may have been similar for HRT is the collaboration between the police and other community organizations. Considering that the HRT was the first of its kind in Rochester as a non-police response to homicide was, it may have been difficult to establish a solid purpose to the Rochester Police Department and proving their usefulness at the scene. As the study mentions, "The presence of any organization on scene needs to be carefully considered, and its 'value added' needs to be clearly demonstrated to detectives." (Spilsbury et al, 2016). This initial wariness of the presence of the TLRT and HRT could have easily been present. Table 2 compares the TLRT and the HRT.

Eugene, OR

One program that has garnered some notoriety is the CAHOOTS program, or the Crisis Assistance Helping out on the Streets. The program is based in Eugene, Oregon, and is operated by the White Bird Clinic. The teams are in pairs that consist of crisis workers and medics who respond to 911 and non-emergency calls that involve people in behavioral crises. They are trained to provide services such as "crisis intervention, mediation, information and referral to social services, first aid, and basic level emergency medical care" (Beck, Reuland, Pope, 2020). When a crime is involved, police are sent to the scene to act as primary or co-responders. The intention is to reduce police contact that can be considered unnecessary, allowing the police to respond to more important calls.

CAHOOTS has long worked with the Eugene Police Department, starting in 1989, and shares the budget with the police department and dispatch system. It has since expanded to multiple cities such as Denver, Oakland, Maine, and more. In fact, due to this relationship with the police department, CAHOOTS staff carry around a police radio used by emergency dispatch to request members of the team to respond to those in crisis (Beck, Reuland, Pope, 2020), totaling to around 24,000 calls that CAHOOTS received in 2049. Of these 24,000 calls, only 311 required police, and CAHOTS resolved nearly 20% of calls received. Many of the responses are for situations such as self-harm reports, or welfare checks, and CAHOOTS members are extensively trained for months in preparation for field responses like these. The backgrounds of members range from individuals with an undergraduate degree, to those with experience working in crisis lines or shelters, to others who have behavioral health conditions (Beck, Reuland, Pope, 2020).

The CAHOOTS model has led to departments in different cities adopting a similar method. An example of this is the Support Team Assisted Response (STAR) in Denver, Colorado. The team was directly influenced by the CAHOOTS model, and responds to issues such as mental health, depression, homelessness, and substance abuse problems (Community Resource Hub, 2021).

There are not many community-led homicide response programs in the U.S. The teams that were described in this section were varied, and while some responded to homicides, others covered a range of responses and were not restricted to just homicides as the HRT is. Note that most of these teams are not a part of any police department, rather they are separate organizations that work parallel to law enforcement and emergency response teams to provide services.

Table 4 lists each intervention, program, or team, level of law enforcement involvement, and program focus area. Law enforcement involvement in this case is defined as whether the program members work with the police department, either by assisting them or working together with them.

Table 1: Intervention/Program/Team Characteristics

Intervention/Team	**Type of Intervention**	**Is Law Enforcement Involved?**	**Responds to Homicides?**	**Team Size?**	**Focus Area**
Caught in the Crossfire (Oakland, California)	Hospital Based	No	No	Unknown	Youth violence and retaliation reduction

Cure Violence Global (Chicago, Illinois)	Street Outreach	No	No	Unknown	Violent crime, preventing retaliation
Homicide Response Team (Rochester, New York)	Intervention Team	Yes	Yes	Small (4-6)	Families of homicide victims
Victim Crisis Response Team (Fox Cities, Wisconsin)	Intervention Team	Yes	Yes	Small (2 member teams)	Emotional support, crisis intervention, referrals to community resources, assistance with crime victim compensation and making phone calls, among other services
Crisis Response Team	Intervention Team	Yes	Yes	Very Large (over 250 volunteers)	Families and victims

(Los Angeles, California)					
Trauma Response Team (Syracuse, New York)	Intervention Team	Yes	Yes	Large (40 volunteers)	Gang-related homicides and gun violence
Traumatic Loss Response Team (Cleveland, Ohio)	Intervention Team	Yes	Yes	Unknown	Case management to family, friends, and coworkers of victims of a homicide
CAHOOTS (Eugene, Oregon)	Intervention Team	Yes	Yes	Small (2-3)	911 and non-emergency calls that involve people in behavioral crises

As seen in Table 1, there a many different examples of interventions that exist, whether they are street outreach, hospital-based, or more notably, crisis intervention teams. Majority of the interventions involve law enforcement in some capacity, such as the intervention teams. Intervention teams often work on-scene with law enforcement, and have even been dispatched by

them, such as in the case of CAHOOTS. Many of the intervention teams deal with case management in some form, and cater to friends and family of victims of a homicide. The exception to this is CAHOOTS, as members of the team work with alternative responses to the police, rather than case management for victims, or friends and family of victims.

Team sizes between each intervention greatly varies. Caught in the Crossfire begins its operation within hospitals, where there is no need for large teams, since the intake process for a victim is performed by a hospital staff member. Cure Violence Global is a street outreach program that utilizes any number of volunteers that are willing to come to the scene, and members do not respond in a set number, compared to other teams that respond in teams of two or more. The Traumatic Loss Response Team is a possible exception, as there was no mention of how many members are in a team or how many volunteers are active. The Crisis Response Team and Trauma Response Team consist of a large number of members, but it remains unclear how many individuals are dispatched to the scene simultaneously. It is possible that members are alerted to an urgent situation that requires their assistance, and whoever is available and prepared to respond may do so.

Potential Problems Experienced by Community Intervention Teams

The limitations of community intervention teams were analyzed in a study, highlighting potential challenges that may impede their effectiveness. Mendenhall (2006) identified five limitations such as the scope of practice, turf battles, interpersonal boundaries and dual relationships, compassion fatigue, and cultural competence.

Mendenhall states that while each member of a trauma team has their own background and experiences, they must all be trained in handling situations related to crisis interventions and management. While this is fine, this can potentially lead to professionals struggling with issues

that relate to the scope of their practice. An example given is whether a physician should provide mental health interventions if another member of the team is a professional therapist, or for a high school teacher to run a group intervention for families who have a missing loved one (Mendenhall, 2006). While some roles of a member might require a specific skillset, many do not, and may be considered outside the typical scope of a person's professional work duties, and Mendenhall stresses the importance of maintaining role flexibility as a member to ensure effective fieldwork. Turf battles are another valid concern that could be encountered in crisis intervention teams. However, Mendenhall mentions that in his own experience, turf battles are not as present compared to everyday practice, and there is more concern from the families in whether the members of the team care and how they care.

Interpersonal boundaries and dual relationships, compared to turf battles, are much more present. Considering the blend of different professional and non-professional backgrounds colliding with the unique situations they work on, difficulties maintaining a professional boundary is more common. This can be from situations such as supervisors and supervisees sleeping and using facilities in the same space. One that Mendenhall mentions is the struggle team members who become friends struggling with whether they should prescribe medications to each other for issues like headaches or sleep difficulties, and that the line between being a friend and performing a professional duty (Mendenhall, 2006). Mendenhall's suggestion is to make clear the boundaries between supervisors and supervisees or men and women, which can be done with curtains separating the two, and schedules to prevent potentially uncomfortable interactions.

One issue that Mendenhall expresses as important is compassion fatigue, which is defined as the breakdown of an individual's physical, emotional, and spiritual health, are running

on low. (Mendenhall, 2006). This can show in the form of irritability, headaches, stomachaches, numbness, being overwhelmed, and more. In Mendenhall's own experience, scheduling was the most important factor in alleviating this, ensuring that members were not on-call for long periods of time and no more than two weeks before another team transitioned.

Finally, Mendenhall discussed cultural competence as a potential issue, being that members of a team will frequently interact with others from different backgrounds. While the way that Mendenhall describes it is different from what members of the Homicide Response Team may encounter, there are still similar themes of interacting with a culture that may be foreign to members who have not been raised or lived in the area they are serving. In those instances, it is imperative that members familiarize themselves with different communities and professional groups in an area, such as police departments or community organizations. Overall, many of the potential problems described by Mendenhall are similar to what the HRT has faced, especially burnout when the team consists of few members compared to some of the other groups discussed in the paper.

Chapter 2

Rochester's Homicide Response Team Background and Methodology

Introduction

This is the second paper in the capstone on the Homicide Response Team in Rochester, New York. This paper will focus on the background and creation of the HRT, as well as the methodology in collecting the data and meeting with the HRT Coordinator. The goal of this paper is to explain where the Homicide Response Team originated from, the original goal of the team, as well as explain the methods that were used to answer the research question: "What are the key elements of the Homicide Response Team intervention?". The background of the HRT consists of its origin and the protocol that members follow when working on the scene. Following this section, there is a brief description of the trauma that can be experienced by both the community and individuals, including those within the HRT. The goal of this section is to highlight the often-hidden impact that trauma can have on a community. The methods used to analyze the Homicide Response Team include meetings with the main HRT Coordinator, and collecting data from the HRT checklist and the Family Needs Checklist, both of which are completed by the HRT Coordinator. The two checklists will be described in detail, as well as the regular meetings that were held with Alia Henton-Williams, who is the Crisis Services Manager for the HRT.

Background and Structure

In October 2020, City Council renamed the Department of Recreation and Youth Services to the Department of Recreation and Human Services (DRHS) (City Council 10/13/20 minutes). Per City Council's October minutes:

> "The name change is necessary to represent the department's full scope of services available to the community, including services provided to young adults, adults, and

families. The new name is also responsive to the recent implementation of the Crisis Intervention Services unit within the department." (pg.34).

The Office of Crisis Intervention Services was created in response to the death of Daniel Prude in March of 2020. Daniel Prude's in-custody death created local and national outrage at the handling of the incident, from officer use of force to withholding information from the public.

Currently, the Office of Crisis Intervention Services is managed by Alia Henton-Williams, who joined in September 2020. The Manager of Crisis Services oversees the office and coordinates across all community responses to crises (Hamblin, Spectrum News, 2020). Henton-Williams manages all aspects of the office, which includes case management, victim services, and the community response teams; she reports to the DRHS Deputy Commissioner. Henton-Williams has a unique background similar to other HRT members, in that she has lost two of her siblings to homicides, giving her the ability to empathize with the victims of families and motivating her work in the community.

When the Homicide Response Team was first formed in September 2020, it was tasked with responding to every homicide with a 4–6-member unit to support the families of the victim(s) by connecting them to services that were provided by the Victim Assistance Unit (VAU) and any other community-based providers. However, the first few months involved a transition period, which was completed on July 1st, 2021, leading to the creation of new positions, such as community support counselors, and the hiring of a Deputy Commissioner in June 2021.

The HRT was initially comprised of one paid staff member tasked with immediately responding to all homicides. Once on scene, she would make the determination whether to call in additional team members. Initially, the support team members consisted of the City's Manager of

Violence Prevention Services and a member of the volunteer group, Rise Up Rochester. However, at the end of the summer, a dedicated Persons In Crisis (PIC) Community Support Counselor became an HRT member, while continuing to work on PIC cases as well. This member has a unique skill set and background that makes her especially equipped to respond to homicide scenes. She has experience working with the Person In Crisis Team, and her son was murdered a few years ago.

In January 2022, the Executive Director of Rise Up Rochester became a paid Crisis Intervention Unit consultant tasked with disbursing wraparound funds to victims of violence. The resources provided for this position ensured that the Executive Director of Rise Up Rochester would be able to respond to homicides on a consistent basis while being properly compensated. Wraparound funds are available for tangible support for families after the homicide (e.g., relocation funds).

In January 2022, there was a setback, as the Manager of Violence Prevention resigned and therefore the HRT lost a member. As of January 2022, the HRT Team Members consisted of the Manager of Crisis Services (HRT Lead Responder), Rise Up Rochester Executive Director, and the Community Support Counselor. However, the former Manager of Violence Prevention volunteers his time to respond as needed.

HRT Purpose

The Homicide Response Team is tasked with an on-call response to homicides. The January 2021 City Council minutes are the first mention of the homicide response team, though it had been under development for a number of months. As part of the Roc Against Gun Violence Coalition led by City Council Member Willie Lightfoot, CPSI staff drafted the *Comprehensive Coordinated Community Response Plan* in summer 2020. This plan was based

on knowledge gained at the coalition meetings, review of the literature, and expertise in violence reduction. The Homicide Response Team was part of this plan, and was borne out of discussions centered on addressing individual and community trauma experienced from shootings and homicides (RAGV Notes, 9/30/20). The idea evolved into a mobile trauma unit, that would include a van, purchased with Rochester Police Department (RPD) forfeiture funds, that would respond to homicide scenes independent of RPD protocols and staffed by civilians not affiliated with the RPD (RAGV Notes, 7/22/2020). In these meetings, the operating purpose of the HRT was a trauma-informed response to homicides.

The Comprehensive Coordinated Community Response Plan outlined the suggestions made for the initial formation of the Homicide Response Team. In this plan, it is noted that the goal of the community response is for the victim(s) and their family members to see that the City of Rochester cares about them (Comprehensive Coordinated Community Response Plan, 2020). The plan also listed basic protocols that the team should follow, including having a coordinator oversee the process; having organization members (Rochester Police Department, hospital staff, etc) understand the goal and purpose of the response team; 4-6 staff with availability to access the entire city; team members that consist of outreach workers, health care on-call staff, organization members, and social workers; immediately meeting with the family to determine their needs, including their Homicide Response Needs, and finally, connecting survivors of a homicide to services.

Once implemented, the purpose of the HRT was described as an effort to provide a "non-law enforcement, comprehensive community response to all homicides" (City Budget, 2021). The HRT also provides grief services and intervention services to prevent future retaliation or

continued violence (City of Rochester). The program is funded by the City, part of which came from the savings in reducing the size of the police recruit class (Cleveland, 2021).

HRT On-Scene Protocol

The HRT process, as envisioned, is that RPD sends a message through a secure text messaging service alerting the Mayor and other high level staff, including the HRT Lead Responder (HRT Lead), that a homicide occurred. The HRT Lead then sends a message to the HRT Responders alerting them to stand-by. The HRT Lead gathers more information and arrives at the scene. Once on-scene, she assesses the situation, which includes speaking with the Lieutenant of the Major Crimes Unit, to determine which other responders are needed, if any. This includes whether the Mobile Trauma Unit (operated by RPD) should respond to the scene. Next, she dispatches the appropriate responders. While on scene, she connects with the family. She introduces herself and explains the services offered while passing out a bag with a blanket, tissues, and other items. Note that this is always voluntary, families can refuse services at any time. If the mobile trauma unit responds, then the family and HRT Lead will board the unit in order to have a private, quiet, comfortable space for the family that is now experiencing complicated grief.

Once the family has spoken with the HRT responders the HRT Lead continues to provide support until the family no longer needs the on-scene support or the scene is cleared. Before departing the scene, the HRT Lead informs the family of the next steps in the Medical Examiner and RPD processes, describes the services to be provided by Crisis Services, and lets the family know that they will be contacted the following day once they are assigned to a community support counselor. The following day, the community support counselor completes and submits

the intake information. The HRT Lead also continues communicating with the family over the next few days and she is present when the family comes in to complete the paperwork.

Given the profound impact of chronic trauma on individuals and communities, it is clear that effective responses to trauma are essential for reducing the incidence of violence and supporting those affected by it. In the case of community violence, trauma is not just limited to the victims and their families, but is also experienced by first responders, social workers, and others involved in the homicide response. The following section will go over the various types of trauma that can be experienced by individuals and the community, as well as some brief recommendations for processing vicarious trauma that members of the Homicide Response Team may experience.

Trauma

Trauma exposure occurs every time someone is killed in the community. Living in communities with high rates of violence exposes people to trauma on a regular basis and leads to chronic trauma (Smith et al., 2019). Chronic trauma impacts decision-making, problem-solving, goal setting, and how individuals interact with others (Davis, Pinderhughes and Williams, 2016). Further, trauma gets in the way of violence prevention as it undermines any intervention (Prevention Institute, 2016). For these reasons, it is critical that trauma is responded to with empathy for everyone involved in the homicide response, from the surviving loved ones to HRT staff to the community. One instance of community level reaction to trauma was the death of a community member who was well known in various community support groups. When his death occurred, members of Rise Up Rochester, Should Never Use Guns (SNUG), and Pathways to Peace were present at the scene to provide support.

Individual Trauma. Learning about the loss of a loved one is devastating, and while the HRT is there to support families, individuals will respond in different ways to the trauma. Initial reactions to trauma can include blunted affect, agitation, sadness, confusion, anxiety, and exhaustion (SAMHSA, 2014). For example, one may respond by going numb, while someone else may respond with outbursts of anger.

Because of the nature of the loss (i.e., a homicide), surviving loved ones often experience complicated grief. Complicated grief (also referred to as traumatic loss) is when the surviving family members experience grief *and* trauma responses as a result of the unanticipated, violent nature of their loved one's death (Smith & Patton, 2016). Studies have shown that surviving loved ones are at higher risk of developing longer and more severe psychological distress than those who experience a non-violent loss (Alves-Costa et al, 2019). Greater PTSD symptoms as well as a longer duration of symptoms have important implications for intervention. The surviving loved ones may require longer intervention periods than others who have not experienced this type of grief and practitioners should be specially trained to work with surviving loved ones (Alves-Costa et al., 2019).

Vicarious Trauma. Vicarious trauma is "an occupational challenge for people working and volunteering in the fields of victim services . . . and other allied professions, due to their continuous exposure to victims of trauma and violence" (Department of Justice, Office of Victims of Crime). This negative response to trauma exposure manifests in a variety of ways, including being easily distracted, increased irritability, fatigue and physical symptoms (Office of Victims of Crime; Trippany, Kress, & Wilcoxon, 2004). Recognizing that HRT responders are exposed to this kind of trauma and acting proactively to reduce the negative responses is important. Suggestions include, discussing vicarious trauma with a supervisor; supporting

healthy eating and sleeping habits; allowing flexible work schedules; support connections with family and co-workers; a diverse caseload; a safe, comfortable, and private work environment; and create time and space at work for reflection (Bell, Kulkarni, & Dalton, 2003; Kim, Chesworth, Franchino-Olsen, & Macy,2021; Office of Victims of Crime).

Community Trauma. Trauma is not exclusive to the family; it is distressing for friends, peers, witnesses, co-workers, and even the offender. All of these individuals make up the community. One of the original justifications for the HRT was to address community trauma (RAGV Notes, 9/30/20). Our evaluation has found that it is not well articulated how the HRT, and specifically RPD's Mobile Trauma Unit, will address community trauma.

Methodology

Process Evaluations

Process evaluations are an important aspect of a program, as they are key in identifying the goals and desired outcomes from a process. There are three themes involved in developing a process evaluation for intervention-based programs: implementation, mechanisms, and context (Moore et al., 2015).

Implementation involves how the delivery of the intervention is done, the training involved, the resources allocated, and more (Moore et al., 2015). The goal of the implementation portion is to see whether the intervention was done as it was intended to, and the amount of people the intervention served, and can observe how the intervention was delivered to the population. Mechanisms are the specific processes or causal pathways through which an intervention brings about a particular change or effect. Understanding these mechanisms is essential for evaluating the effectiveness of an intervention and identifying ways in which similar

interventions can be designed or improved in the future. Context is anything external to the intervention that could be seen as an obstacle to it being implemented or for it to have the intended effects. In order to effectively understand the outcomes of an intervention, one must know the context behind it, especially in cases of complex interventions that utilize a variety of mechanisms designed to create a certain outcome.

Any process evaluation should attempt to follow certain key recommendations outlined by the MRC Population Health Science Research Network. These recommendations fall under the categories of Planning, Design and Conduct, Analysis, and Reporting. In Planning, there should be clear parameters of the relationship between the intervention developers, as well as ensuring that the research team has the proper expertise to conduct the research, and determining the degree of separation or integration between the process and outcome evaluation teams (Moore et al., 2015). Design and Conduct involves the design of the intervention itself, such as the causal assumptions that will be made, potential limitations and uncertainties, as well as which methods and questions will be made to address specific outcomes. In Analysis, the research team should collect and analyze any data, and ensure that the data collected can build off one another. If possible, the data should be analyzed before trial outcomes are revealed in order to avoid any potential biases. Reporting should involve a detailed description of the findings, methodology, and logic model, and describe how the logic model was used to guide the process and questions that were used (Moore et al., 2015). This following section details the specific methodology used by the CPSI research team in evaluating the Homicide Response Team

Approach. When working on the project, the research question: “What are the key elements of the Homicide Response Team intervention?” was kept in mind throughout the

process. To answer the research question, a checklist was created for the on-call homicide response. The checklist was a way to track actions as they occurred as well as what happened at the homicide scene. A Family Needs checklist was also developed as a way to document the family's immediate needs (e.g., burial costs, funeral home, transportation, etc.) and is completed in the days after the homicide. Regular process meetings between CPSI Research Staff and the Crisis Services Manager (who is also the main HRT responder) were held in order to understand how well implementation was going, including challenges and successes.

The goal of the preliminary research was to understand the extent that the core components outlined by the planning committee were implemented, not to assess the impact of the HRT on the community. To do this, we conducted a descriptive analysis of the HRT checklist and the Family Needs Checklist. The two checklists will be described in detail, as well as the regular meetings that were held with Alia Henton-Williams, who is the Crisis Services Manager for the HRT. The following section will detail the content of the two checklists, and the results of the data collected from these checklists will be analyzed in the next capstone paper.

Check List Measures

Both checklists were developed in cooperation with the HRT coordinator. The HRT checklist assesses intervention processes and the frequency that certain practices were carried out for each homicide response. Some of the questions in the checklist were related to the Mobile Unit, which, according to the 8/5/2021 meeting with Alia, was described as being used as an enclosed space that allows the family to have distance from the scene of the crime and a quieter place to talk with investigators and/or the HRT (8/5/2021 Meeting Notes). However, the city has

described it as a team that provides psychiatric services to the families of victims and the community.

Rochester Homicide Response Team Checklist

The Homicide Response Team Checklist was filled out following a homicide response. As noted in Appendix A, The single page checklist started with basic information, such as the date the form was filled out, the name of the victim, and where the HRT responded. In some cases, there were multiple locations that the HRT responded to, and this was coded appropriately in the master file that was kept by CPSI staff. The next set of question asked for the date of victimization, death of the victim, and the date that contact was first made with the victim's family. After this, the coordinator was asked if there was an immediate response following the homicide. If they answered "yes", they filled out the rest of the form, and if they answered "no", they would list the reason why there was not an immediate response at the bottom of the page in the comments section. When the coordinator answered "yes", they provided times for when events occurred, such as when they received the initial notification that was sent to city leadership; when they notified the HRT and requested standby; when they notified leadership of the homicide; when they connected with Major Crimes from RPD for information; when they connected with the Mobile Unit to dispatch them to the scene, if applicable; when they arrived on the scene; when they requested additional HRT members to arrive on scene; when the Mobile unit arrived; and when they left the scene. Additional questions were asked, including whether family was present; whether RPD notified the family about the homicide before the HRT coordinator arrived; which members were requested to arrive on the scene; if the HRT and family members waited on the Mobile Unit; if investigators spoke with the family on the Mobile Unit; and if the HRT checked in with the family before they left. One of the final questions that

were asked focused on the date and time the HRT had their debrief on the case, which was often a weekly meeting held between the members of the HRT, and what the mode of communication was, which was usually a video-meeting held through zoom. The last two questions asked when the family was assigned to a Victims' Assistance Counselor, and whether the coordinator contacted the family within 24 hours.

Family Needs Checklist

The Family Needs Checklist was usually filled out by the HRT Coordinator after conducting an informal meeting with a member of the victim's family, such as the mother, father, siblings, or child of the victim. The checklist was only filled out if the family or family member was having their case managed by Crisis Intervention Services and to determine their needs for services or assistance of some kind, such as financial assistance or housing. Almost every question was yes or no response, meaning the data was coded with a simple "0" for a no response, and "1" for a yes response.

The Family Needs Checklist asked ten different categories of questions, as shown in Appendix B: Investigation, Safety, Food, Children, Housing, Financial, Faith-based, Therapy, Decline Assistance, and Additional. Most of the categories had only one question, with the exception of the Food, Children, and Financial categories, but each question gave the opportunity for elaboration. For example, the Safety category asked if the intake felt safe, and if they said "no", there was space on the form to explain why they did not feel safe. After asking for basic information such as the name of the family member, contact information, and date the form was filled out, the intake filled out the rest of the questions. The Investigation category asked for the name of the RPD point of contact the intake has for the family; the Safety Category asked if the intake felt safe; Food asked if the intake had food available, and if HRT can assist with meals or

food; Children asked if the victim had children, if the intake needed emergency daycare, and if the children had any other needs. If the victim did have children, the intake was asked to list the names and ages of the children; Housing asked if intake needed emergency housing; Financial asked if the intake needed financial assistance associated with the death of the victim (burial costs, funeral costs, death certificate, etc.), and if they need additional financial support, which could be due to lost wages if the victim was the main breadwinner; Faith-Based asked if the intake was connected to a church or other faith-based institution; Decline Assistance asked if the intake wanted space and wanted to decline any assistance from HRT; and Additional asked if the intake had any additional needs.

Meetings with the HRT Coordinator

Each month, meetings were held between Alia Henton-Williams, the HRT Coordinator Lead and Manager of Crisis Intervention Services, and research staff from the Center for Public Safety Initiatives. These meetings were intended to get a different perspective and more detailed look at the HRT process. It also gave CPSI staff the chance to clarify any inconsistencies found with the data that was sent to CPSI staff, and see if Alia had any concerns or suggestions for CPSI staff. One example of this is the addition of a new member to the HRT Team. In the HRT Checklist, the name Leslie appeared more consistently as a coordinator that was requested to respond. In the 9/22/2021 meeting, Alia provided background on Leslie, stating that she was a new addition to the team who used to be on the Person in Crisis team (9/22/2021 Meeting Notes). In one of the last few meetings held with Alia, she stated that she does not see a lot of major changes with HRT since it is solid and seems to be working (1/27/2022 Meeting Notes). Despite this hope, Alia did express some complaints related to the HRT processes. One of these

concerns is the communication issues that can be experienced between families of the victims and HRT, including in the way that the HRT operates from the perspective of the family. According to the 9/22/2021 meeting notes:

> "She mentioned that people want HRT to move very quickly with funding, despite the fact that the turnaround for financial support can take days. Funeral homes will go to the victim's families and schedule funerals for a few days after the incident but the funds would not be ready by then. Family members of the victim have also complained about receiving no contact from HRT coordinators, but Alia says that these family members are not answering the phone, and then getting upset that no one is contacting them."

The communication issues were not restricted to family members alone, as Alia had also mentioned communication problems between HRT and other community organizations. One of these organizations is Rise Up Rochester, which does not typically respond to homicide scenes, but at once point began showing up. Alia noted in the 1/27/2022 meeting that it had been disrupting the process at the scene, especially in hospitals, where they may arrive in large groups and cause further disruption (1/27/2022 Meeting Notes).

Chapter 3

Homicide Response Team Results and Recommendations

Introduction

This is the third paper related to the Homicide Response Team in Rochester, New York. The previous paper focused on the methodology of the Preliminary Analysis and explored the topic of trauma experienced by the community, individuals, and workers. The objective of this paper is to present the findings of the analysis based on the previous paper's methodology, and the recommendations that came from it. This paper will build upon the previous one by providing a thorough analysis of the HRT's Preliminary Analysis results. First, it will discuss the overall homicide statistics between May 14th, 2021, and May 31st, 2022, including age, gender, and race demographics. It will then go over the results from the Homicide Response Team Checklist, which includes the elimination process for the total number of cases the analysis is primarily based off. This is followed by the second form, the Family Needs Checklist, and the answers that were given by the family members. Finally, the paper concludes with a list of suggestions for the HRT's future consideration, and a brief discussion on meetings held with Alia Henton-Williams, the Head Coordinator for the Homicide Response Team.

The research question that was kept in mind during this analysis was "*What are the key elements of the Homicide Response Team intervention?*". The question was intended to help the researchers determine how closely the implementation of the HRT follows the original project design and will offer insight concerning how the project evolved over time.

Findings

The Homicide Response Team (HRT) went live in November 2020, and the evaluation began five months later, in May 2021. May was an appropriate starting point because the HRT had been up and running for a few months, allowing time to work out some of the initial

problems expected with any new program rollout, especially a program run out of a brand-new government office (i.e., Office of Crisis Intervention Services).

Homicide Data

From May 14th, 2021, to May 31st, 2022, there were 86 total homicides in Rochester. There were initially 81 at the time of data collection, however, when writing this report, the numbers have since been updated. One case is excluded from this dataset, because it involved RPD, so the data was not in the Rochester Police Department's Open Data Portal. Of the 85 homicides that occurred between May 14th, 2021, to May 31st, 2022, 86% involved male victims. The median age of the victims was 31. The race of the victims was 78% Black, 21% White, and approximately 80% of the victims were non-Hispanic. The most common method of death was by a firearm (74%), followed by stabbing/cutting (11.8%). Other methods included two cases that were caused by "physical" methods, indicating blunt trauma, and three cases with an unknown cause of death. As will be discussed in this paper, the Homicide Response Team conducted an immediate response to 47 out of the 86 homicides. Table 1 shows this in detail.

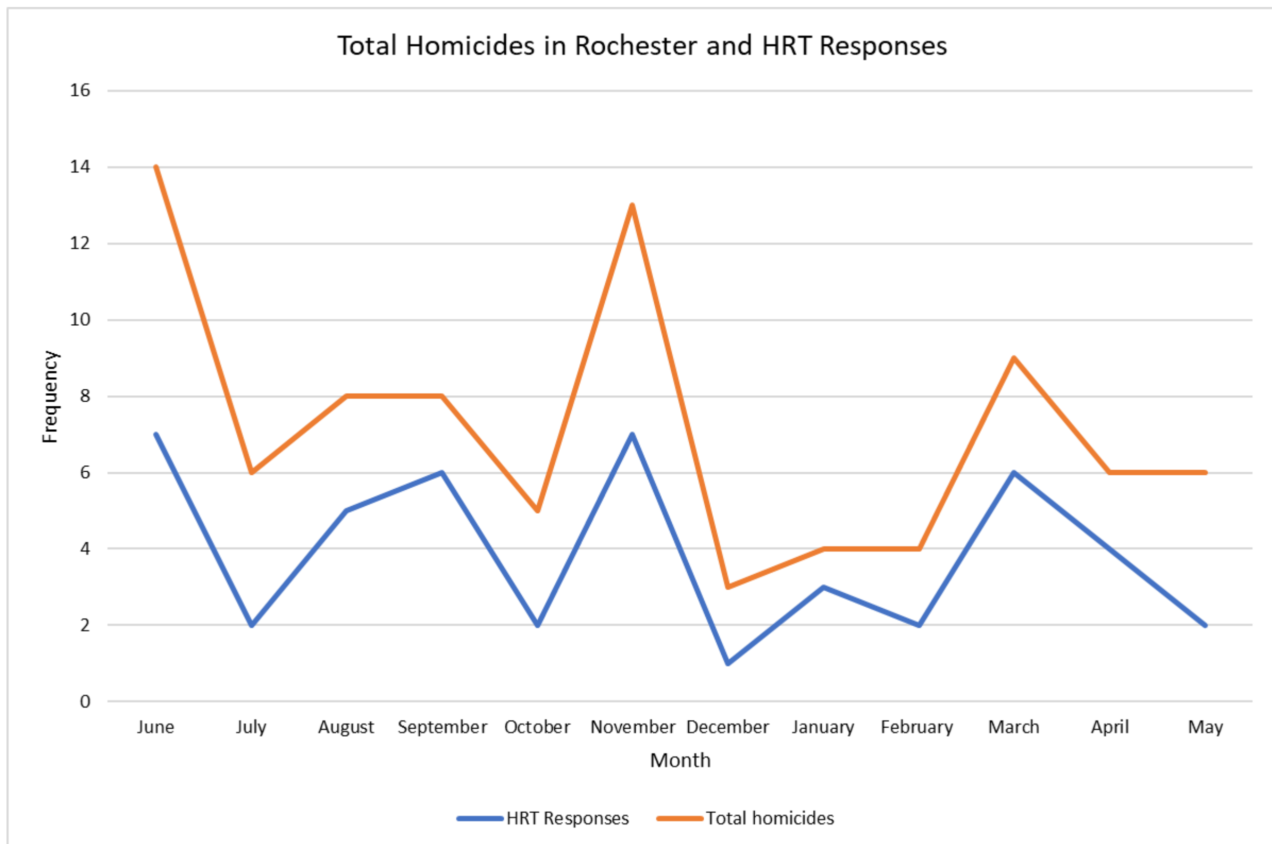
Table 1: Rochester Homicides and HRT Responses

Month of Response	HRT Responses	Total homicides	Percentage
June	7	14	50.0%
July	2	6	33.3%
August	5	8	62.5%
September	6	8	75.0%
October	2	5	40.0%
November	7	13	53.8%

December	1	3	33.3%
January	3	4	75.0%
February	2	4	50.0%
March	6	9	66.7%
April	4	6	66.7%
May	2	6	33.3%
Total	47	86	54.7%

As shown in Table 1, June and November had the highest number of homicides with 7 each month. However, the HRT only responded to a little over half of the cases for those months. The months with the highest percentage of responses were September and January, responding to 75% of the homicides in those months. As mentioned in the previous paper, the reasoning for these cases not having an immediate response could be for a variety of reasons, including motor vehicle death, or lack of family being present. Chart 1 shows the information above in a different format.

Chart 1: Rochester Homicides and HRT Responses



HRT Cases

Figure 1 below shows the homicide data and the number of responses by HRT. Of the 81 homicides, 16 cases were deemed ineligible for the homicide response. Among the ineligible cases, four were motor vehicle homicides, and twelve were incidents with the death occurring more than a day after the fatal/initial injury. For example, in one case, the victim was injured on 4/18/2022, but died on 5/29/2022, giving a 41-day difference between the victimization and the death. In these cases, the victimization is ruled a homicide long after the event occurred, meaning there was no reason for HRT to immediately respond. Among the remaining cases, 65 were

eligible for an immediate response. From these 65 cases, 15 did not receive an immediate response. Three of them did not receive a response because of a process error (n = 3), and in seven cases, RPD requested no HRT response or there was some communication error (n=7). The remaining four cases did not specify the reason why there was no response. Additionally, as shown below, one homicide had a delayed response a few days after the incident. Out of the total number of cases, 50 received a response from the HRT in some form or another. However, there were 3 cases that did not receive an immediate response due to the absence of family members at the location or a hospital. Therefore, there was no need for the HRT to respond to these three cases (n=3). However, the family members from these 3 cases were still contacted to get support from the HRT in the days following the death of the victim.

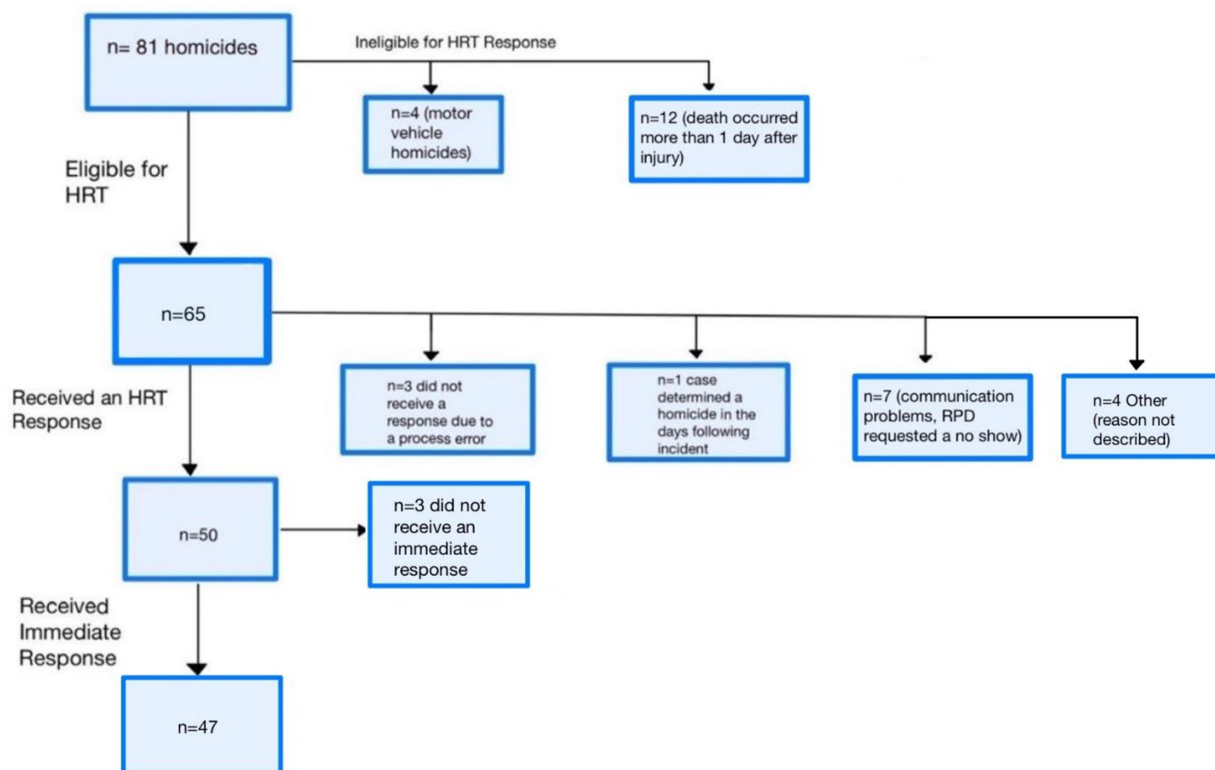


Figure 1. *Homicide Data Received*

As noted in Figure 1, the HRT responded to 47 homicides during the study period. As detailed in Table 1, of these 47 cases, 14% (n = 7) had more than one HRT response location. One-third of the cases (n = 19) were responded to at a local hospital (Rochester General Hospital, University of Rochester Medical Center). Family members were present in 80% of the cases (n = 39). The most common family member present was the victim's mother, who was present in 28 of the cases with family present. The victim's father was present in 10 of the 39

cases and three cases reported victim's children present. Other family members included victims' siblings, cousins, and aunts and uncles.

A variety of resources were used in these homicide responses. At least one support team member was requested to respond in most cases (71%). The mobile unit responded in 14 of the incidents (29%). Once contacted, it took an average of 50 minutes for the Mobile Unit to arrive at the scene. And the family used the mobile unit in nine of those incidents when they arrived on the scene. This is represented in Table 1.

Table 1. Response Data

	Frequency	Percentage
Response Locations		
Multiple Response Locations	7	15%
Responded at the Hospital	19	40%
Family Members Present		
Cases with Family Present	39	68%
Mother Present**	28	71%
Father Present**	10	26%
Victim's Children Present**	3	8%
Support Services		
At Least One HRT Member Present	36	77%
Mobile Unit Responded	14	30%
Family Used Mobile Unit	9	19%

**Percentages in this section are based on total cases with family present (n=39)

The average time spent at the location was almost two hours (115 minutes minutes). In about half of the cases (n = 24), the coordinator stayed on scene for more than an hour. The length of time on the scene ranged from 15 minutes to three hours and 50 minutes.

Of the 47 eligible cases that received a response, the coordinator was notified for most of the cases at night between the hours of 12 a.m. and 3:59 a.m. (n=15), with the second most frequent time being between the hours of 12 p.m. and 3:59 p.m. (n=9). The least common times for homicide alerts were early in the morning between the hours of 8 a.m. and 11:59 a.m., with only four notifications occurring during those times. Of these 47 cases, the most frequent day of death was Sunday with 14 deaths, followed by Saturday, which had nine deaths, and Monday and Friday, which had seven deaths each. The least frequent day of death was Tuesday, counting only one death. Table 2 describes this data in detail.

Table 2: Day of Death

Day of the Week	Frequency	Percentage
Monday	6	12.8%
Tuesday	1	2.1%
Wednesday	7	14.9%
Thursday	3	6.4%
Friday	7	14.9%
Saturday	9	19.1%
Sunday	14	29.8%

A Family Needs List was completed by 29 of the families, and of those cases, 93% (n=27) requested assistance with burial services, and 89% (n=26) requested assistance with

funeral costs and the death certificate. Nearly half of the victims had at least one child (n = 13 victims), with one victim having five children. At least 8 of the children were under the age of 10 years old. Of the 29 cases, 37% (n=11) said they were connected to a church or faith organization, and 17% (n=5) requested food assistance, as seen in Table 2.

Table 2: Family Needs Checklist

Question	Frequency	Percentage
Do you feel safe	27	93%
Do you have food available	27	93%
Can we assist you with meals or food	5	17%
Does the victim have children	13	45%
Do you need emergency daycare	0	0%
Do the children have any other needs	0	0%
Do you need emergency housing	0	0%
Do you need financial support associated with the death	27	93%
Do you need additional support (e.g., lost wages)	0	0%
Are you connected to a church or other faith-based institution	11	38%
Do you want counseling/someone to talk to	2	7%
Do you want space? Decline assistance from HRT at this time	0	0%
Do you have any additional needs	0	0%

While the responses imply that some participants did not feel safe or did not have food available, this is not the case, as not every question was filled out by participants. For example,

over half of the participants did not answer the question "Are you connected to a church or other faith-based institution" and opted to leave it blank (n=16). One form did not answer any of the questions, aside from the basic participant information such as name and the date the form was signed. Slightly less than half of the participants stated that the victim had children. Not every participant specified the age and gender of the victim's children, and others did not give any details. Based on the numbers that were given, each of the children was under the age of 10. Only one participant stated that they felt unsafe. However, this contrasts what was said by the Head Coordinator Alia Henton-Williams, in one of the monthly meetings held between her and CPSI staff. In the September 22nd Meeting, it was mentioned that the overall theme that Alia was observing in HRT was that none of the participants felt safe, and many were requesting to be relocated (9/22/2021 Meeting Notes). It is possible that these concerns were expressed after the form was initially filled out.

The least common answers on the form were needing emergency daycare, emergency housing, any additional support for the children or the participants themselves, and declining assistance from HRT. Only 7% of the participants requested counseling or someone to talk to (n=2). Most of the participants requested financial assistance associated with the death, which included burial costs, funeral costs, and the death certificate. Nearly every participant requested financial assistance with all three expenses mentioned, apart from one, who only requested assistance with burial costs (n=1). Only one participant requested assistance with purchasing a headstone (n=1).

Family Contact Sheet

One of the final forms that was requested to be filled out was the Family Tracking Sheet, which documented the number of times contact was made with each family, as well as the details of the interaction. Due to the fact that there was a backlog of cases being sent to CPSI, as discussed in the 8/5/2021 meeting, "Janelle and Irshad mentioned that we do not need the contact sheet and family needs checklist at this moment in time, but she can continue to use the sheets for her own internal use." (8/5/2021 Meeting Notes). Alia continued to send these forms up until 1/21/2022, sending 30 Tracking Sheets out of 60 total cases received. The table below details the maximum number of times each family had been contacted.

Table 3: Family Tracking Sheet

Number of Times Contact was Made	Frequency
1	4
2	15
3	7
4	3
5	1
6	0
Total	72

While there were only 30 forms, contact was made with families 72 different times. For some cases, Alia only made contact once, but in others, contact was made 3 times for one case. The highest number of times a family was contacted was 5 times. However, it is worth noting that there could have been more contact between the family and Alia, but CPSI was only sent one

version of the Tracking Sheet, and not the updated versions. Therefore, it is entirely possible that families were contacted more than once, but was documented after the form had been sent to CPSI. As noted in the table, 20% of cases were contacted a maximum of 2 times (n=15).

Meetings with Alia

As was mentioned in the previous capstone paper, regular meetings with Alia Henton-Williams were an essential part of the process. According to Alia, homicide numbers have gone down since the implementation of the HRT (8/5/2022 Meeting Notes). There was a gap in meetings between June 2021 and August 2021, but in June, there were 12 total homicides, compared to 6 in the following month. However, 2021 was a record year for homicides in Rochester, with 38.4 homicides per 100,000 people and a record total of 81, which is a dramatic increase from the 52 homicides in 2020 and 32 in 2019 (Altheimer, Rodriguez, and Holland, 2022). It is unknown if the HRT has influenced homicides since then, and what the causes are for this sudden increase in homicides.

One of the recommendations made in this paper was to take burnout into consideration when scheduling coordinator responses. This is especially true for Alia, who was the primary responder to homicide scenes. During the data collection period, Alia had expressed this concern with burnout several times, but appeared to adapt to it. In the 8/5/2021 meeting, Alia mentioned that she was on call 24/7, including holidays (8/5/2021 Meeting Notes). This is primarily because Alia responds to the scene initially to determine if there is a need to request other HRT members. If there are no family members present, or there is no need to request additional team members, Alia does not send for them. However, this seemed to change over time, as in the 10/27/2021 meeting, Alia stated that one team member was assigned to respond in lieu of her, responding on

Wednesdays and Fridays so she does not have to on those days (10/25/2021 Meeting Notes). She also mentioned that a holiday schedule was worked out.

Another recommendation focuses on establishing clear protocols for the mobile unit and support teams, and when they are supposed to respond. This particular recommendation was based on comments made in several meetings with Alia. In the 12/8/21 meeting, Alia mentioned that it was agreed that support team members would show up to scenes as HRT members, not as members of their respective outreach groups (12/8/2021 Meeting Notes). This was because she did not want a lot of people at the scene, and they would already be connected to the victim's families so they can reach out as their team after the response to provide support. However, after a few months, non-HRT support team members began showing up to homicide scenes, including the hospitals, potentially leading to issues with hospital staff and the Rochester Police Department. For the Mobile Unit, it had been noticed that the City of Rochester had been describing the Mobile Unit differently than its intended purpose, stating that it was a team at provides psychiatric services to the families of victims and the community. However, Alia stated in the 8/5/21 meeting that she has never used it for what the City described, as the Mobile Unit was used as an enclosed space that allowed the family to have distance from the scene of the crime and a quieter place to talk with investigators and the HRT (8/5/2021 Meeting Notes).

Recommendations

Ten recommendations were made based on the results of this study. These recommendations are outlined below:

1. More clearly articulate the goal and objectives of the Homicide Response Team and determine indicators of success.

2. Understand and respond to trauma at each level (individual, community, and vicarious); do not treat all these levels as the same.

3. Continue to track and report results to the community, including connecting families to mental health services and the use of wraparound funds if possible.

4. Establish clear protocols for when certain support teams and the mobile unit are to be dispatched. For example, does the Rise Up Rochester Executive Director get dispatched to every scene as long as family is present? Does the Violence Prevention Manager get dispatched only when RPD indicates that there is a known dispute and the potential for retaliation? Does the Mobile Unit respond to scenes when the family's home is very close to the homicide?

5. Consider whether different protocols should be developed depending on the type of scene, e.g., whether it is a hospital or community response. For example, should the mobile trauma unit ever respond at the hospital? If there is a hospital response, then what does the community response look like? Should it be a different response?

6. Be proactive about burnout. Support the mental health of staff by discussing and recognizing the symptoms of burnout. Ensure a safe and healthy work environment that provides staff with the tools and support to prevent burnout. Policies and procedures should be reviewed to make sure they do not contribute to burnout. For example, if the HRT Lead responded to a homicide at 4 a.m., then the expectation that they attend a 9 a.m. meeting may not be appropriate. A flexible work arrangement is one example.

7. Continue to adhere to and document the process. This is a strength of the HRT. While the HRT Lead is a critical component, it is important that there are mechanisms in place for the HRT to continue relatively undeterred, if she were to leave tomorrow.

8. Interventions should work to support healing and connection between individuals, support safe and healthy behaviors, and build on indigenous knowledge, expertise, and leadership (Davis, Pinderhughes and Williams, 2016). Some suggestions include creating space for positive interaction in the aftermath of the homicide such as, opportunities for art, sports, or other activities that build community in addition to the vigil; building on existing community assets (e.g., fully funding support groups for homicide victims' loved ones or leveraging neighborhood block clubs); or partnering with neighborhood cultural institutions like the Black Box theater and Grupo Cultural Latinos.

9. It is important to build up program capacity in a manner that takes burnout into consideration. For example, when the program first began, it could have operated 5 days/week, or some other appropriate times and days. One of the early stressors of homicide responses was the time of day, particularly in the evening. Many homicides happen in the early morning hours, and coordinators are required to go into the office the following morning, creating added stress. The HRT may consider expanding their immediate response to include these homicide types, if possible. However, as this was a pilot, it was reasonable to limit the types of homicides, especially because the two types described here are less frequent than the more typical homicides caused by gunshot, stabbing, or blunt force trauma.

10. Finally, while there is limited information on non-law enforcement driven homicide responses, the Urban Institute has done some work in this area[1]. The findings indicate that building authentic relationships with the community is key to solving these crimes, including collecting information, managing shooting scenes, and conducting successful

investigations (Urban Institute, 2019). Study respondents wanted service providers to demonstrate compassion and empathy in every interaction with the family; this included acknowledging the trauma experienced by family members. Survivors and family members revealed that open and proactive communication, including an explanation when information is not available or cannot be shared, was key. This respectful, clear communication was important while on scene but also in the aftermath. While communication was key, respondents described a variety of needs including financial assistance; assistance addressing PTSD, depression, and trauma; relocation support, therapy/counseling; and peer support. The HRT should consider these needs as it continues to develop.

Conclusion

The Homicide Response Team in Rochester, New York is a team that responds to homicides to provide support to families of a homicide victim. The purpose of the original study this capstone is based on was to understand the extent that the core components outlined by the planning committee were implemented through an analysis of the various forms that were filled out by the Head Coordinator, Alia Henton-Williams. The findings from this study found a strong indication that the HRT was roughly adhering to its original purpose, which was to serve as a trauma-informed response to homicides. The process in this evaluation was based on results from the Homicide Response Team Checklist and Family Needs Checklist, finding that over half of the homicides that occurred during the analysis period had an immediate response (53%). Future research should follow-up with the Homicide Response Team and evaluating their process after the recommendations from this study have potentially been implemented.

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