



College of Liberal Arts

**Center for Public Safety Initiatives**

# Homicide Response Team Preliminary Analysis

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## Introduction

The Rochester Homicide Response Team (HRT) consists of non-law enforcement persons who respond to homicides and support the families and loved ones of homicide victims and community members. The HRT provides a consistent and immediate on-scene response to support family members dealing with complicated grief and connect them with support services in the aftermath. The City's Department of Recreation and Human Services partnered with the Center for Public Safety Initiatives to conduct a process evaluation of this newly established initiative. A process evaluation is used to determine whether program activities and components are implemented as intended and what barriers and facilitators exist. This paper provides an overview of the HRT, then summarizes our findings to date, and concludes with recommendations.

## Rochester's Homicide Response Team

### 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.

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.

## Process Evaluation

### Research Question

This work was guided by the following research question: *What are the key elements of the Homicide Response Team intervention?* Addressing this question will help determine how closely the implementation of the HRT follows the original project design and will offer insight concerning how the project evolved over time.

## **Approach**

To answer the research question, a checklist was created for the on-call homicide response. The checklist is 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 this preliminary research is 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. We also utilized qualitative data from the process meetings to inform the process evaluation. The findings are described below.

## **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. Examples of HRT checklist questions include whether the coordinator was called to the scene of a particular homicide, whether the family of the homicide victim was at the scene of the crime and whether the mobile crisis unit was dispatched in response to the homicide. The HRT checklist is included in Appendix A. The Family Needs Checklist assesses the unique concerns and needs of the homicide victim's

family. It is used to determine if the family feels safe, whether the family has emergent needs (i.e. food, transportation, shelter), and if the family is connected to a church or other community institution that could provide support in response to the trauma caused by the homicide. The Family Needs Checklist is included in Appendix B.

## 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

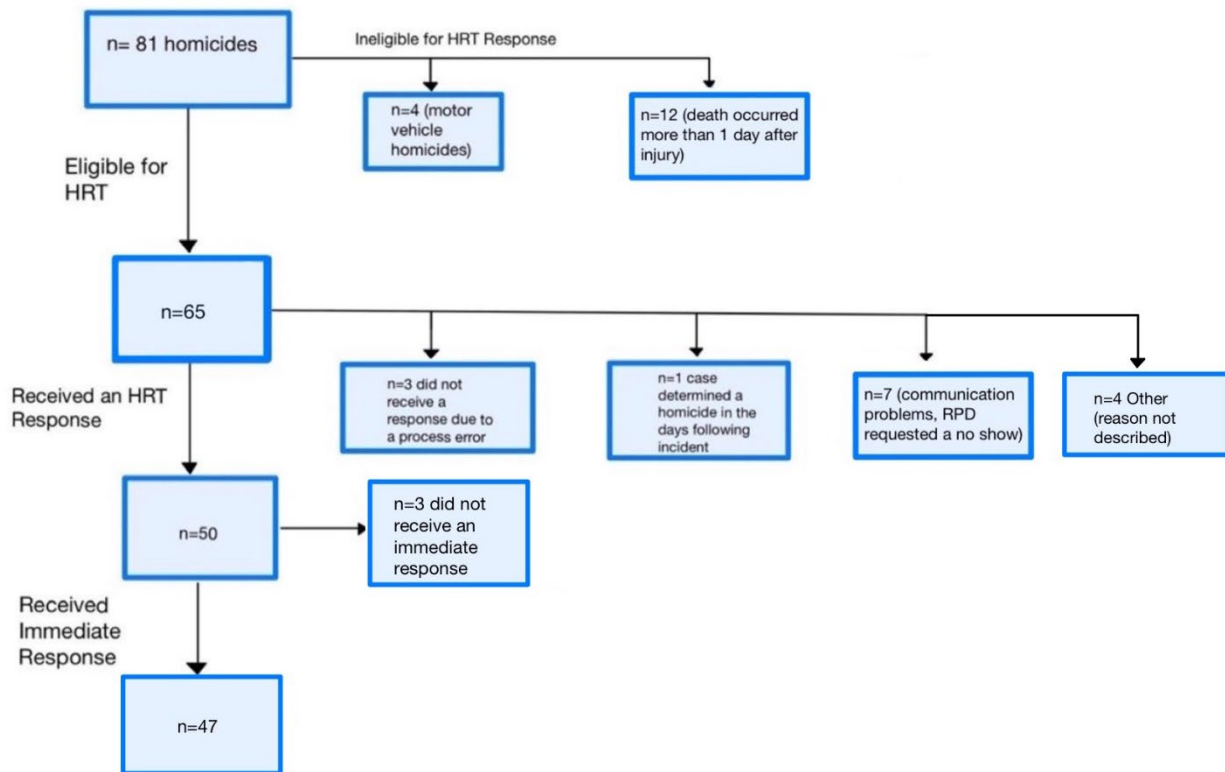
From May 14<sup>th</sup>, 2021 to May 31<sup>st</sup>, 2022, there were 81 total homicides in Rochester. However, one case is excluded because it involved RPD, and the data was not in the Rochester Police Department's Open Data Portal. Of the 80 homicides that occurred between May 14<sup>th</sup>, 2021 to May 31<sup>st</sup>, 2022, 88% involved male victims. The median age of the victims was 31. The race of the victims was 79% Black, 21% White, and approximately 81% of the victims were Non-Hispanic. The most common method of death was by a firearm (78%), followed by stabbing/cutting (13%). Other methods included three cases that were caused by "physical" methods, indicating blunt trauma, and two cases with an unknown cause of death.



## Checklist and Family Needs

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. Among the remaining cases, 65 were eligible for an immediate response and 47 cases received an immediate HRT response. Three of the 56 eligible cases 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. Further, as noted below, one homicide received a response a few days later. Figure 1 below shows the homicide data and the number of responses by HRT.

Figure 1. Homicide Data Received



As noted in Figure 1, the HRT responded to 47 homicides during the study period. 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, Strong or University of Rochester Medical Center). Family members were present in 80% 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 the majority of 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 where they arrived on the scene. This is represented in Table 1.

*Table 1. Response Data*

	Frequency	Percentage
<b>Response Locations</b>		
Multiple Response Locations	7	15%
Responded at the Hospital	19	40%
<b>Family Members Present</b>		
Cases with Family Present	39	68%
Mother Present**	28	71%
Father Present**	10	26%
Victim's Children Present**	3	8%
<b>Support Services</b>		
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). In about half of the cases (n = 24), the coordinator stayed on scene for more than an hour. Length of time on 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 was 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.

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 Overview*

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%

## Implementation Challenges

### Determination of Homicide

One ongoing challenge has been the determination that an event is a homicide, which would then trigger the HRT Response. In New York State, the legal definition of a homicide is “conduct which causes the death of a person under circumstances constituting murder, manslaughter in the first degree, manslaughter in the second degree, or criminally negligent homicide” (NYS Senate, Section 125.00). Although many homicide cases are straightforward, some cases require more investigation to determine the intent of injury, such as whether or not the case was a suicide or accidental death. For example, someone found dead in a car, with no obvious injuries, may take much more time (even days) to determine the cause and intent. Further, deaths as a result of police interaction tend to be treated differently than a

civilian homicide, in spite of the fact that such deaths may generate considerable community trauma. Another challenge is which homicide types are eligible for a homicide response. Rochester's HRT does not immediately respond to vehicular homicides, nor does it respond to homicides that occur more than a day after injury.

### **Location of Death**

Another special case is when victims die in the hospital and not at the scene of the crime. For example, someone may be shot at the scene, transported to the hospital, and then pronounced dead at the hospital. While family members are likely present at the hospital, there may still be loved ones at the crime scene, and there may also be community members who witnessed the homicide, observed the on-scene response, heard gunshots, or any other possible exposure to the crime. This is one aspect of community trauma. So while one issue is how to appropriately and compassionately respond to the family waiting in the hospital, another issue seems to be what *should* the on-scene response look like in these cases. What if no one is at the crime scene? Does that mean that there is no community trauma associated with the homicide? In such cases, what is the role of the HRT? Is an on-scene response more appropriate the next day? And what would that look like?

### **Staff Burden**

The HRT in Rochester is a small team that is on call 24 hours a day, 365 days a year. A small group required to be on-call at all times can create significant strain on staff. Further, the nature of the work (homicide scenes) combined with the 24/7 availability can be problematic for an employee's mental health and wellness. This is particularly problematic when considering that many homicides happen in the late evening or early in the morning

and responses to such events are likely to be very disruptive for HRT members. The risk of burnout runs high when staff are overburdened and on-call (Dettmers, Vahle-Hinz, Bamberg, Friedrich, & Keller, 2016; Ziebertz et al., 2015).

## **Process**

It was clear from our observations and conversations with the HRT Lead that she was deliberate in following a process. Rumors will always be floating around (e.g., “A house just got shot up on X Avenue!”), but until she receives official notification of a homicide, the HRT Lead will wait to respond. The homicide response is time sensitive, so immediate notification of the homicide and meeting with the surviving loved ones is key to the intervention.

However, there were a few instances when there was a significant lag in notification to the HRT. For example, in October there were headlines that a dead body was found in a car and that it was a homicide investigation. While the media was reporting this, the HRT still had not received notification. The HRT Lead did not receive the notification until a few days had gone by, losing precious time to connect with the family. In the days following the homicide, the HRT Lead communicated with RPD to identify the gap to prevent it from happening again.

## **On-Scene Crowd**

As violence increased in 2021, more community members became involved, resulting in additional people showing up to homicide scenes. In some cases, new grassroots groups were formed while in other cases existing groups were strengthened. Using both word of mouth and police scanners, these groups increased their on-scene homicide presence. There is value in community outrage in the immediate aftermath of a homicide. However, concern regarding families should be in the forefront of these responses.

## **Scope Creep**

Rochester went from having minimal services for family members of homicide victims to now having a specific individual and an entire office to call for assistance (community support team). Surviving family members likely have a high level of needs that go beyond obtaining victim's services funds for funerals, connecting the family to RPD investigators, or referrals to mental health services. Family members are dealing with complicated grief, while they may also have issues with housing, or concerns for their safety. For example, nine months into implementation, the HRT Lead was asked by RPD to find a crime scene clean-up crew due to the nature of the particular homicide: Mom's son was killed in front of her by her abusive partner/boyfriend. Law enforcement was under the impression that mom was going to return to the home, and so they were concerned that she would walk into a crime scene with her son's blood on the floor. The HRT Lead took on this task and coordinated with the adult daughter to get a crew in and clean. While this was a courageous, empathic action, it is not the role of the HRT Lead. Further, expanding the scope HRT job tasks can lead to burnout.

## **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.

## **Discussion**

Considering the roll out of the HRT and all the new, moving pieces involved, the HRT has

been responding to homicides in a consistent manner. Over 39 families have been served and received an on-scene response. While we identified some challenges, operationally, the HRT has made tremendous progress in responding to homicides in spite of being housed in a brand new office, a new administration, and ongoing shifting of related services. Below we list recommendations rooted in our findings.

## **Recommendations**

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 of 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<sup>1</sup>. 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

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<sup>1</sup> The Urban Institute partnered with the Urban Peace Institute to assess how well the Oakland Police Department responded to homicides and shootings (2017). Through interviews with community members (including violence victims and family members), law enforcement, and other service providers, the Urban Institute [published three reports](#) highlighting their results.

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.

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# Appendix A: Homicide Response Team Checklist

## Rochester Homicide Response Team Checklist

Activity	Time and Any Additional Info	
1. Coordinator receives initial notification sent to City Leadership	:	
2. Coordinator notifies HRT of details and requests standby	:	
3. Coordinator notifies leadership of homicide	:	
4. Coordinator connects with Major Crimes and Mobile Unit for information and dispatch of Unit	:	
5. Coordinator arrives on scene	:	
6. RPD contact name and role:		
7. Family present	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. RPD notified family of homicide prior to HRT coordinator arrival.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Coordinator introduces self to any present family members.	Family members (e.g., brother, mom):	
10. Coordinator requests teams to dispatch to scene	:	<input type="checkbox"/> N/A
11. Support Teams arrive on scene	:	<input type="checkbox"/> N/A
12. Mobile Unit arrives	:	<input type="checkbox"/> N/A
13. Which support teams showed up? (circle)	PTP, Mobile Unit, FACIT, RUR, Other _____	
14. Did HRT member and family wait on Mobile Unit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
15. Did investigators speak with family on Mobile Unit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
16. Check-in with family before leaving scene	<input type="checkbox"/> Yes <input type="checkbox"/> No	
17. HRT departs the scene	:	
18. HRT Debrief Date: ___/___/___                      Who Present: Time: ___:___ Mode: In-person, phone call, text		
19. Coordinator contacts VAU with family information	:	Date: ___/___/___
20. Did coordinator contact family within 24 hours?	<input type="checkbox"/> Yes, left a message <input type="checkbox"/> No <input type="checkbox"/> Yes, directly connected with a family member	

Date: \_\_\_\_\_

Case Name/Victim Name \_\_\_\_\_ HRT Response Location: \_\_\_\_\_

Special Notes about Homicide (e.g., child death, multiple victims)



## Appendix B: Family Needs Checklist

### HRT Guide for Family's Needs

Family Name: \_\_\_\_\_

Contact Info: \_\_\_\_\_

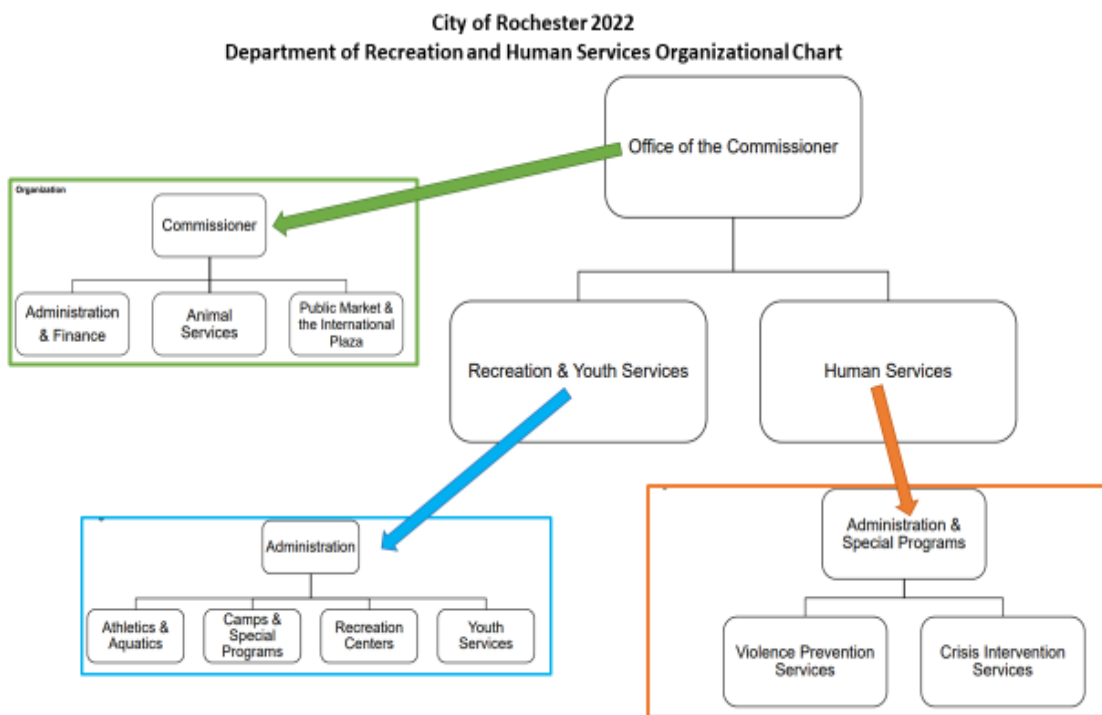
Date: \_\_\_\_\_

Investigation	Who is the RPD Point of Contact for the family?	
Safety	Do you feel safe?	<input type="checkbox"/> Yes <input type="checkbox"/> No, explain:
Food	Do you have food available?	<input type="checkbox"/> Yes <input type="checkbox"/> No, explain:
	Can we assist you with meals or food?	<input type="checkbox"/> No <input type="checkbox"/> Yes, explain:
Children	Does the victim have children?	<input type="checkbox"/> No <input type="checkbox"/> Yes: names, ages,
	Do you need emergency daycare?	<input type="checkbox"/> No <input type="checkbox"/> Yes, explain:
	Do the children have any other needs?	<input type="checkbox"/> No <input type="checkbox"/> Yes, explain:
Housing	Do you need emergency housing?	<input type="checkbox"/> No <input type="checkbox"/> Yes, explain:
Financial	Do you need financial support associated with the death?	<input type="checkbox"/> No <input type="checkbox"/> Other, explain: <input type="checkbox"/> Burial costs <input type="checkbox"/> Funeral costs <input type="checkbox"/> Death certificate
	Do you need additional financial support (e.g., lost wages)?	<input type="checkbox"/> No <input type="checkbox"/> Yes, explain:
Faith-based	Are you connected to a church or other faith-based institution?	<input type="checkbox"/> No <input type="checkbox"/> Yes, explain:
Therapy	Do you want counseling/ someone to talk to?	<input type="checkbox"/> No <input type="checkbox"/> Yes, explain:
Decline Assistance	Do you want space? Decline assistance from HRT at this time?	<input type="checkbox"/> No <input type="checkbox"/> Yes, explain:
Additional	Do you have any additional needs?	<input type="checkbox"/> No <input type="checkbox"/> Yes, explain:

## Appendix C: DRHS Organizational Charts

Figure 1 below shows the new structure of the Department of Recreation and Human Services (DRHS) (created from the approved [2021-2022 Budget](#)). The office of the DRHS Commissioner includes Administration and Finance and two other aspects, while the Bureau of Recreation and Youth Services includes Youth Services, Recreation Centers, Athletics, and Camps. Finally, the Bureau of Human Services is divided into Violence Prevention Services and Crisis Intervention Services.<sup>2</sup> The HRT falls within Crisis Intervention Services.

Figure 1. Rochester DRHS Organizational Chart



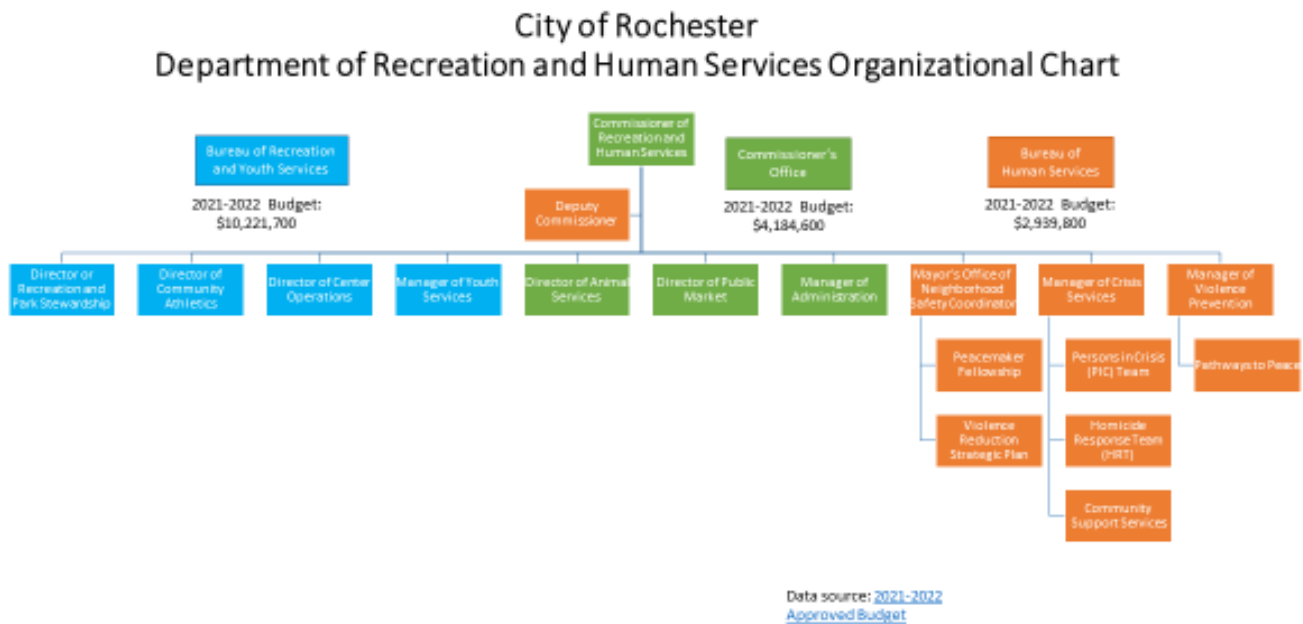
The organizational chart below (Figure 2) shows the organization of the [DRHS Leadership Team](#), with more detail included for the Bureau of Human Services because that is where the HRT falls ([2021-2022 budget](#)). The colors indicate whether the program falls within the office

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<sup>2</sup> Announced by the new Mayor Evans in January, 2022, the Office of Violence Prevention Services will now be under the Mayor's Office.

of the Commissioner (green), Recreation and Youth Services (blue), or Human Services (orange). Note that when this was put together, there were some noticeable gaps on the DRHS Leadership website, including no mention of the Manager of Violence Prevention or the Coordinator of the Office of Neighborhood Safety. However, as noted above, new Mayor Evans shifted the Manager of Violence Prevention and the ONS to the Mayor's Office, so it no longer falls under DRHS.

Figure 2. Rochester DHHS Organizational Chart



## About the Center for Public Safety Initiatives

The Center for Public Safety Initiatives is a unique collaboration between RIT's **Department of Criminal Justice**, the City of Rochester, and the criminal justice agencies of Greater Rochester including the Rochester Police Department and Monroe County Crime Lab. Its purpose is to contribute to criminal justice strategy through research, policy analysis and evaluation. Its educational goals include training graduate and undergraduate students in strategic planning and policy analysis.

The foundation of the Center is the practice of action research in which relevant data and analyses are brought to bear on the day to day decision-making processes of organizations. The Center serves the practice of policy development and implementation in real-time.

To access our full library of white papers, visit our website at [rit.edu/center-public-safety](http://rit.edu/center-public-safety).



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