CRIMINAL MASS VIOLENCE AND DOMESTIC TERRORISM

Emergency Operations Annex Planning Document Focused on Victim Care

Community Name

NMVC Presenter Name / Contact if desired

ICP TTA
Assisting Victims of Mass Violence And Domestic Terrorism

NMVC
National Mass Violence Center
Providing Resources to Victims, Survivors, & Those Who Serve Them

Rev. 12/2024

Table of Contents

This product is supported by Cooperative Agreement #15POVC-23-GK-00555-AERX awarded by the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this product are those of the contributors and do not necessarily represent the official position or policies of the U.S. Department of Justice.

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Introduction

The Need for Coordinated Planning and Response

Criminal Mass Violence and Domestic Terrorism (CMV/DT) incidents are challenging in both planning and response due to their size, scope, and intensity. While many of the needed response components are put into practice every day as first responders answer their typical calls, other tasks, services, and relationships are unique to CMV/DT incidents. CMV/DT incidents involve more destruction, more separations of loved ones, more injuries, and more deaths than other incidents. It is often challenging to understand how and why the incident happened. The criminal nature of the incident is an added element. Additionally, CMV/DT incidents include non-traditional responders, whose day-to-day jobs focus on a single case, person, family, or small group at one time in a controlled setting. They are rarely exposed to the Incident Command System (ICS) first responders use regularly.

In many cases, jurisdictions do not have plans that cover the needed response to victims comprehensively. The unique response to CMV/DT incidents requires expanding plans, relationships, trainings, and exercises to ensure effective action and services. The process of developing and exercising a CMV/DT Annex will allow a community to prepare for and respond from a place of awareness and community cohesion.

Purpose of an Annex

An Emergency Operations Plan (EOP) explains how a jurisdiction will deal with the effects of common hazards that are typical for a jurisdiction. EOPs are often called “All-Hazards Plans” and provide information on general tasks that must be addressed following an incident to ensure life safety, property conservation, and incident stabilization. For example, earthquakes, floods, and hurricanes can destroy property and force people from their homes. The EOP includes a plan to evacuate at-risk populations, establish temporary shelter, and provide food for those displaced from their homes, regardless of disaster type.

Annexes to an EOP, on the other hand, detail responsibilities, tasks, and operational actions that are needed to respond to specific incidents—in this case, a CMV/DT. The contents of incident-specific annexes focus on the unique planning needs generated by the subject hazard. The following are characteristics of annexes:

- Unique and regulatory response details that apply to a single hazard and do not repeat basic information found in the EOP.
- Identifies actions that ensure an effective response and aid in preparing for emergencies.
- Provides detailed descriptions of the methods agencies and departments should follow for critical operational functions.
- Includes supporting documents to clarify the annex or plan's content, e.g., maps marked with evacuation routes and responder checklists.

ICP TTA CMV/DT Victim Services Annex Template

The Improving Community Preparedness to Assist Victims of Mass Violence or Domestic Terrorism: Training and Technical Assistance Program (ICP TTA) CMV/DT Victim Services Annex Template is

designed to assist communities in developing effective operational plans that meet the needs of victims, loved ones, and the impacted community during and after a CMV/DT incident. The template is organized around ICP TTA's 16 Best Practices in Planning (Best Practices, BPs). Program staff and subject matter experts from across the fields of emergency management and victim services developed the Best Practices collaboratively from their lived experiences. Each Best Practice defines a necessary component of an effective response to CMV/DT. The Best Practices apply to any mass casualty scenario and can be followed at the jurisdiction's discretion.

1. Incident Command	2. Committee Identification & Engagement	3. Up-to-Date Contact List	4. Friends & Relatives Center (FRC)
5. Victim Identification & Notification Protocol	6. Public Information & Crisis Communications Protocol	7. Volunteer Management Protocol	8. Family Assistance Center (FAC) Plan
9. Financial Donation Management Protocol	10. Memorial & Special Event Management Protocols	11. Community Behavioral Health Response	12. First Responder Support
13. Planning & Preparedness Grants and Emergency Funding Assistance	14. Community Resilience Planning	15. Criminal Justice System – Victim Support	16. Training and Exercise

Organization and Use

This annex template is organized into 16 Best Practices—one for each Best Practice. Each Best Practice has two sections.

- Section 1 provides planning considerations that reflect standards and lessons learned from past responses. It includes questions the jurisdiction needs to answer during the planning process. Each question is numbered. The questions should guide the planning conversations. Planning considerations should inform the jurisdiction's answers to the questions.
- Section 2 is the written annex for the respective Best Practice Best Practice. The annex incorporates the answers developed in Section 1 into a plan that establishes common language, responsibilities, and action steps for stakeholder agencies during planning and response. Section 2 uses a fill-in-the-blank format; however, jurisdictions are encouraged to edit template language if needed. Each blank is highlighted and marked with a number corresponding to a question number in Section 1.

Once section 2 is complete for each Best Practice, compile all section 2s into a complete CMV/DT Annex to use during an incident response. Section 2 for each Best Practice must be copied and pasted into a new, separate document. Alternatively, incorporate the information into the body of the existing EOP if that is consistent with the overall jurisdictional plans.

In addition to the Best Practice content, multiple appendices include information that jurisdictions may find helpful in the planning and response processes. These include—

- Common roles and responsibilities, and

- Possible floorplans for the Friends and Relatives Center (FRC) and Family Assistance Center (FAC).

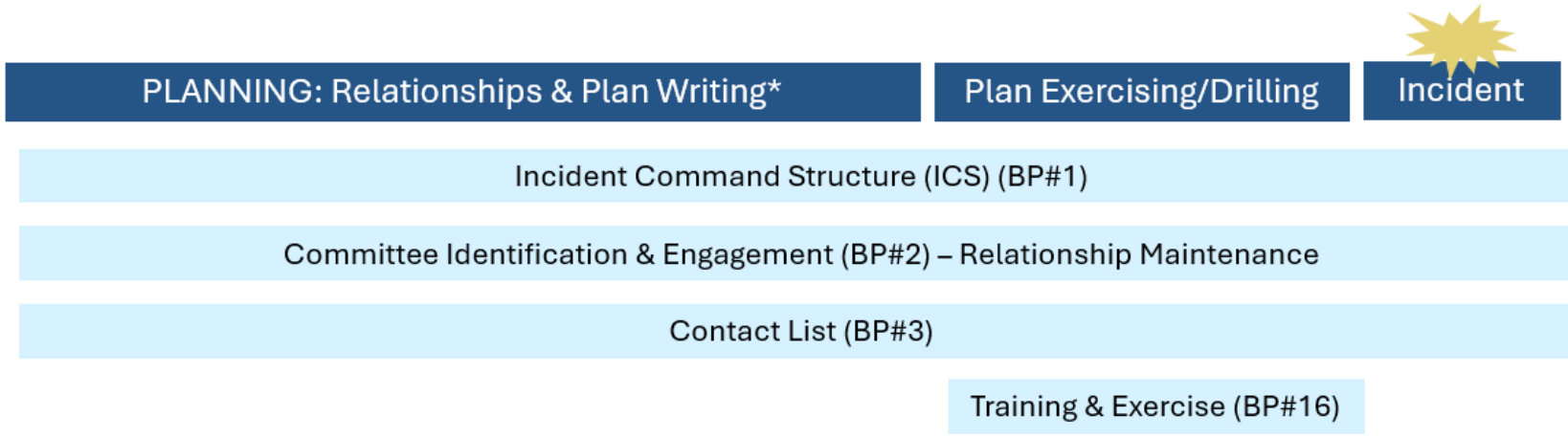
There will be links throughout the main body of the document indicating when relevant appendices are available. The appendices include definitions and acronyms for ease of use.

Additionally, a description of Emergency Support Functions (ESF) is provided. An ESF groups governmental and certain private sector capabilities into an organizational structure to depict those most likely needed to manage domestic incidents—like the earthquakes, floods, and hurricanes described above. As the CMV/DT Annex supplements jurisdictions' existing EOPs, which are typically developed using the ESF structure, each Best Practice will reference the ESFs relevant to the Best Practice under discussion. Please note that not all states use the same ESF numbers and functions, so the reader may need to compare their jurisdiction's ESFs with those listed in the appendix.

Background charts

The Sample Mass Violence Planning chart (page 6) and the Sample Victim Services Response Timeline (page 7) provide overviews of when each of the 16 Best Practices is applicable during incident response and how they are related. As you can see, BPs 1, 2, and 3 appear on both charts and have components both before and during an incident.

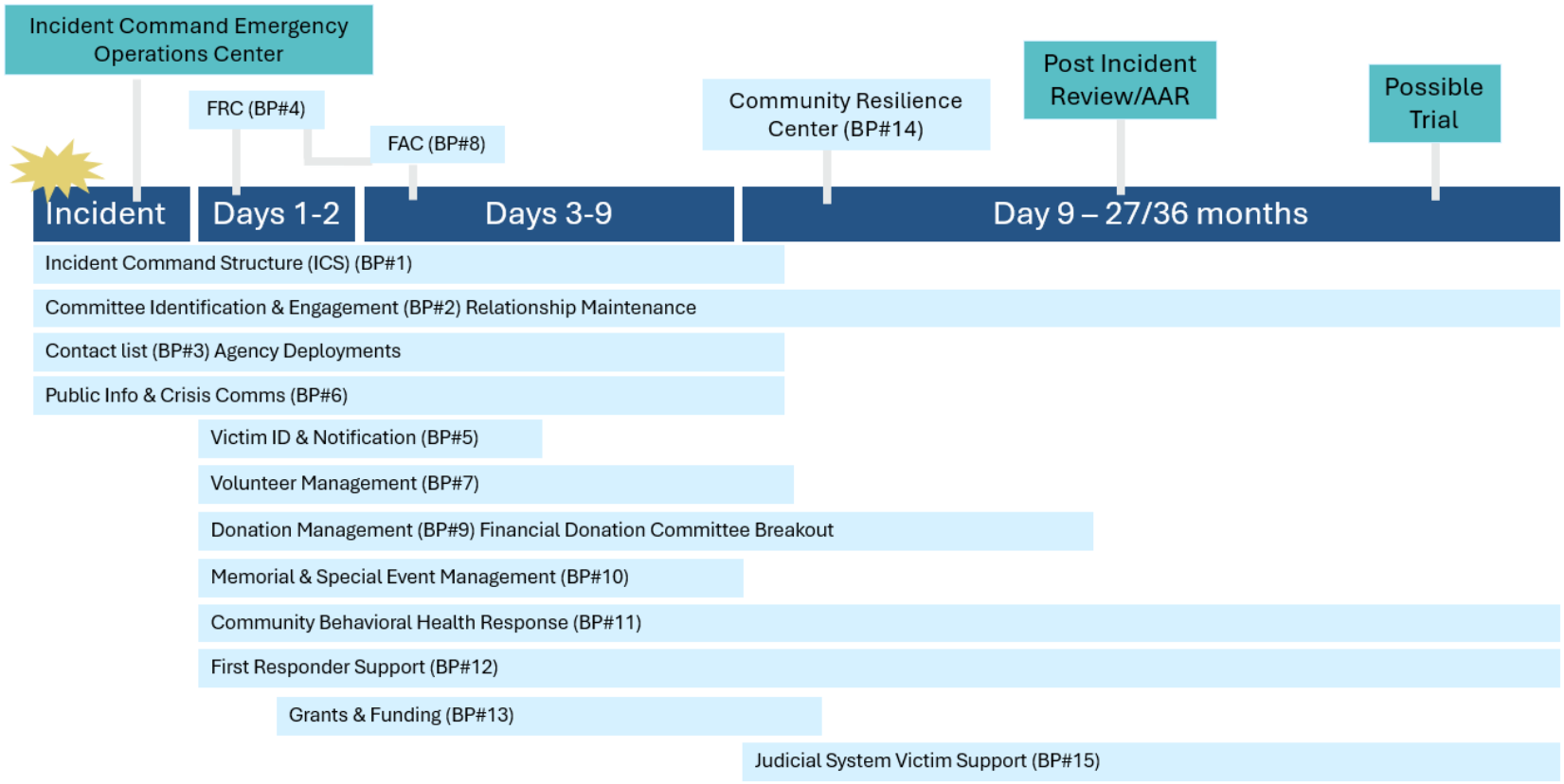
Sample Mass Violence Planning: Incorporation of Victim Care



*PLANNING encompasses developing protocols for all Best Practices (BP).

Response Timeline indicates real-time chronology of incident and implementation of protocols.

Sample Victim Services Response Timeline



Best Practice 1: Incident Command System

Section 1

Best Practice #1 Incident Command System (ICS) *It is important that all responders, including victim services professionals and other nontraditional responders, are trained in ICS or the locally adopted incident management system to reduce chaos by increasing understanding of the framework, lines of reporting, and roles.* *A Joint Family Support Operations Center (JFSOC) is often opened to support victim care.*		
	Considerations	**Questions**
Planning Considerations	• All jurisdictions should have adopted and implemented a local incident management system based on the National Incident Management System (NIMS). • All organizations and personnel involved in response should be familiar with ICS or the locally adopted incident management system. • Not all CMV/DT incidents are equal in size, scope, or loss. Therefore, using ICS is critical as it allows for incidents to grow or shrink resources based on the size and complexity of the incident. • Many victim services (VS) organizations, and some first responders, are not familiar with ICS or the locally adopted incident management system. • Emergency management (EM) and first responders are often unfamiliar with VS, especially the service strategies for a mass violence incident. **<u>JFSOC</u>** • A Joint Family Support Operations Center may open to support victim care with onsite logistics, planning, and coordination functions.	1. Are VS staff familiar with ICS or your local adopted incident management system? 2. What formal training have VS staff already completed? 3. Are EM staff trained in the basics of VS? 4. Do supporting VS agencies/NGOs understand how to coordinate with IC/EOC and the public information officer (PIO)? 5. What mutual aid agreements exist within the state/EM district/county? 6. Are the primary VS roles/responsibilities outlined in the jurisdiction's EM plan? 7. How will VS organizations be linked to the ongoing response so that service roll-out is efficient and timely?

	• The JFSOC is the VS link to the Incident Command (IC) structure/Emergency Operations Center (EOC).	
Services	**JFSOC** • The JFSOC coordinates a Friends & Relatives (FRC), a Family Assistance Center (FAC), and services related to special events/vigils/memorials. Find more information about these in Best Practices 4, 8, and 10.	
Staffing	• Typically, VS is based out of the Operations Section of the ICS structure. See Best Practice 1, section 2 for a recommended structure. • FEMA provides virtual ICS training options on its website. ICP TTA recommends all responders take IS 100.c, IS200.c, IS700.b, IS800.d, and IS242.b, at minimum. • A VS liaison is responsible for monitoring and following up on information that comes to incident command in the EOC from the JFSOC. • The VS liaison should have a solid working knowledge of ICS. VS participation in EM drills and exercises can assist with this. See Best Practice 16 for more information. • It can be helpful for VS agencies to present their capabilities and services to EM and other responders to build a better understanding of VS work. **JFSOC** • JFSOC staffing plan will include FAC leads and an EOC liaison. • EOC liaison in the JFSOC will be the main conduit of information	8. Where will VS be housed within the ICS structure? 9. What ICS training should VS and other nontraditional response organizations complete? 10. How will ICS training be administered? 11. Who is responsible for tracking training compliance? **JFSOC** 12. What is the JFSOC staffing plan? 13. How will the JFSOC fit into the ICS structure?

	between the JFSOC and incident command. They will work with the VS liaison based in the EOC.	
Activation	**Potential ESF Activation: 5, 6, 8**	14. Who is responsible for the establishment of a JFSOC?
Location/Material Resources	**JFSOC** • The JFSOC is typically co-located with the FAC to ensure rapid responsiveness to needs.	15. Where will the JFSOC be physically located?
Communication	• VS is not usually integrated into standard communication streams, so methods of communication with VS staff may fall outside the typical protocols. (e.g., cell phones rather than radios). See Best Practice #6 for more information.	

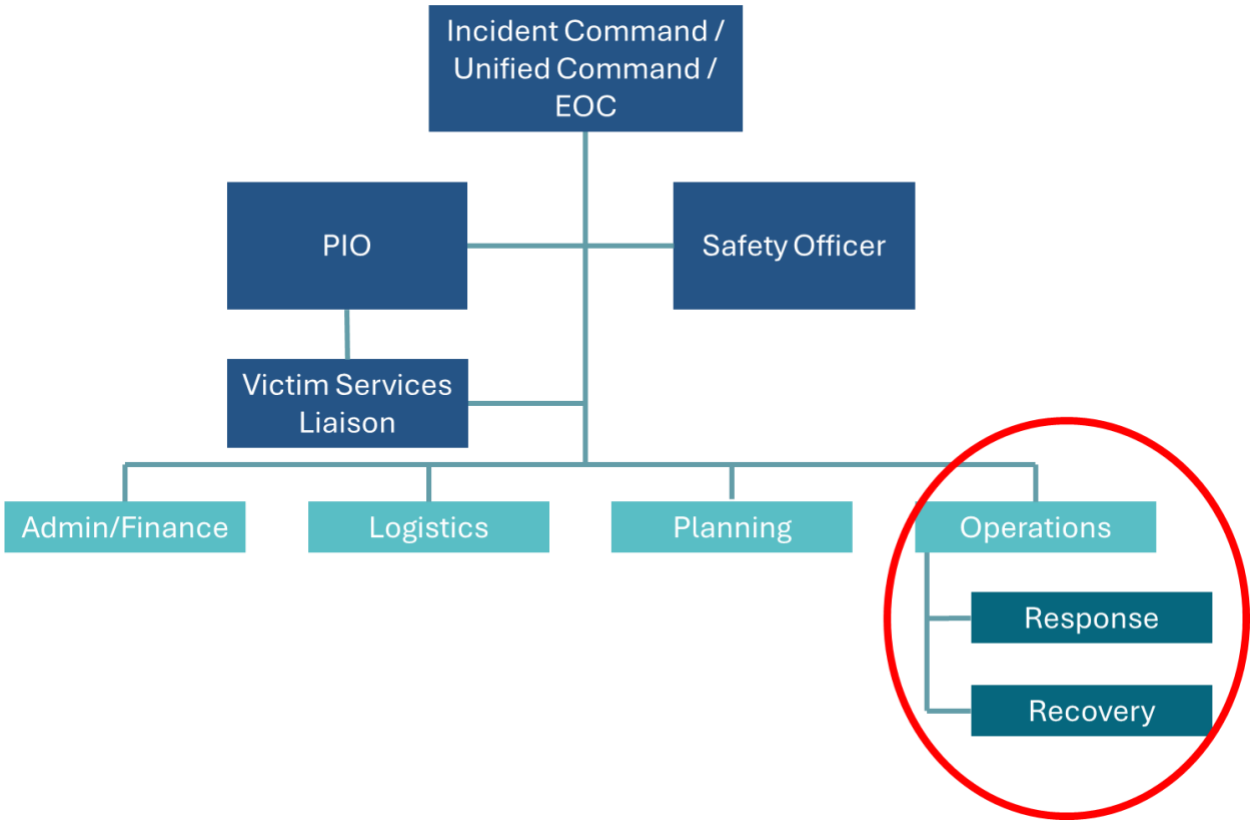
Section 2

BP #1 Incident Command
Potential ESF Activation: 5, 6, 8

1.0 Victim Services Best Practice #1 Incident Command. Victim services shall be linked to the existing emergency management incident command structure to ensure timely and efficient services for victims and loved ones.

1.1 Incident Command System Framework. ICS is used to coordinate the response of multiple agencies, including victim services agencies, to the same emergency. Services to victims of mass casualty emergencies are included in the Incident Command structure under "Victims Services Operations."

1.1.1 Victim services will operate [8] as part of the Incident Command Operations Section; within the Response and Recovery Branches, as shown below.



1.2 Victim Services Operations Overview. Following a CMV/DT incident, victims and their loved ones will have many needs. Victim services are organized into "response services" and "recovery services" to meet these needs in an ongoing, timely fashion.

1.2.1 Response. Response services are deployed as soon as possible following the emergency.

1.2.1.1 [7] The Joint Family Support Operations Center serves as the liaison between victim service operations and Incident Command in the Emergency Operations Center [13] as shown below.

1.2.1.2 The JFSOC provides logistical and planning support to the Information & Notification Center, Family Assistance Center, and events such as vigils and memorials. Each of these items serves different functions.

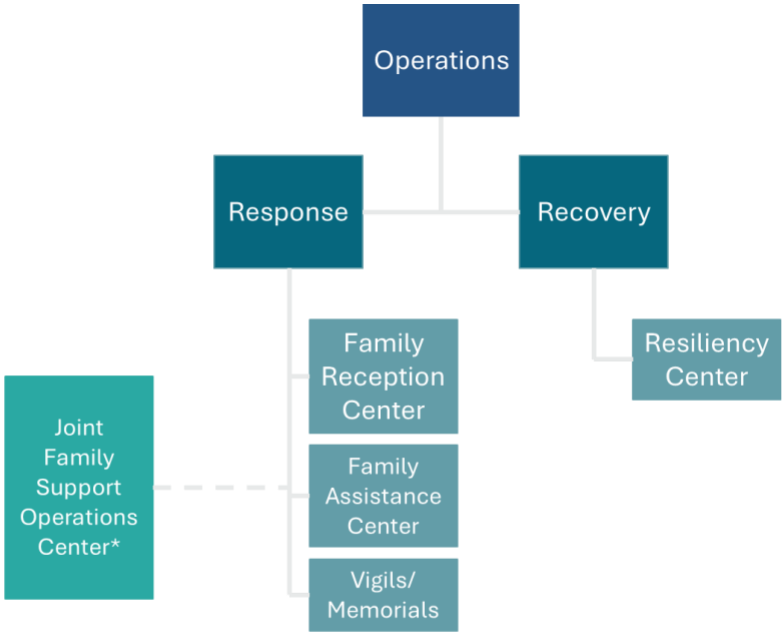
1.2.1.3 The FRC provides a common gathering place, information, and essential support services for survivors and loved ones for the first 24 to 48 hours following an incident. Details on the FRC are in section 4 of this annex.

1.2.1.4 When the FRC is closed, the FAC provides victims with targeted, streamlined access to agencies, resources, and information to meet their immediate needs. Details on the FAC are in section 8 of this annex.

1.2.1.5 Victims, families, responding agencies, community members, and dignitaries may plan vigils, memorials, and other special events. Details on these events are in section 10 of this annex.

1.2.2 Recovery. Recovery services are designed to meet the long-term needs of victims and loved ones.

1.2.2.1 Most long-term services are funneled through a Resiliency Center. Details on the Resiliency Center are in section 14 of this annex.



*Joint Family Support Operations Center (JFSOC) – embedded logistics, planning and coordination support for victim care

1.2.3 CMV/DT incidents can overwhelm available resources quickly. The following mutual aid agreements (formal or informal) exist for (insert jurisdiction name) to ensure successful response and recovery efforts

[5]Agency	[5]Description of Aid/Services	[5]Link to Agreement

1.3 JFSOC Operations.

1.3.1 The JFSOC may be activated as part of the initial IC/EOC notification.

1.3.2 [14] (Insert name/position) is responsible for establishing the JFSOC.

1.3.3 When the JFSOC is established, the baseline staffing structure is as follows:

[12] Agency Name	[12] Responsibility	[12] Agency POC Name, Phone Number, Email	[12] Alternative POC Name, Phone Number, Email

1.3.4 The JFSOC's physical location can be at [15] (insert location options)

1.4 Orientation and Training. All responding staff shall be familiar with the ICS framework and the existence and responsibilities of other responding agencies to ensure effective integration and efficient delivery of services.

1.4.1 FEMA provides virtual ICS training. At a minimum, all VS responders and nontraditional response organizations shall complete [9] (insert required trainings).

1.4.2 [11] (Insert name/organization) shall ensure personnel are aware of ICS training and facilitate the provision of trainings according to [10] (insert how trainings will be administered/incorporated into existing processes)

1.4.3 EM and traditional first responders will become familiar with the work of victim service professionals through [3] (insert means of introduction to VS)

1.5 Communications. Communications are a vital part of ICS.

1.5.1 VS leaders shall participate in the initial incident briefing following an incident, which provides Incident Command with basic situational information and resources.

1.5.2 VS resources should be discussed during incident briefings. This includes information regarding establishing an FRC/FAC, services needed and currently available, and the number of victims and loved ones currently registered.

1.5.3 Ongoing briefings involving VS leaders shall be established as part of the Incident Action Planning process.

1.5.4 Detailed crisis communications and coordination with the PIO, JIC, and Incident Command are addressed in section 6 of this annex.

Best Practice 2: Committee Identification and Engagement

Section 1

Best Practice #2 Committee Identification and Engagement *Key stakeholders, including victim service providers, will meet regularly to conduct planning and coordination efforts. This group will help lead VS efforts during the response to an incident and is a good source for possible key leadership positions in the response Table of Organization.*		
	Considerations	**Questions**
Planning Considerations	• Committees should include representatives from key VS providers, government agencies, nonprofit, faith-based, and other community-based organizations. • Including key state and federal government officials (e.g., U. S. Attorney's Offices, the FBI, consulates) and the state Victims of Crime Act (VOCA) administrators in planning and response will ensure comprehensive response and services if the incident involves victims from multiple jurisdictions, states, or countries. • Consider developing a conflict resolution protocol to address and resolve the conflicts that may arise among agencies and individuals during planning, response, and recovery.	1. What VS stakeholder will coordinate the VS group during the planning process, including gathering input from VS providers and assisting with plan development? 2. What agencies are involved in planning processes currently? Are there agencies/NGOs/stakeholders missing? 3. How will conflicts between stakeholders be managed? 4. Who will be responsible for facilitating conflict resolution between stakeholders using established protocols?
Services	• Committee members should develop a plan for CMV/DT collaboratively; however, lead member(s) should be identified to coordinate efforts. • If the jurisdiction has an active Local Emergency Planning Committee or a standing Unmet Needs Committee, the VS committee meeting could fit in to those regular meetings.	5. Who is responsible for coordinating planning during the steady state? 6. When and how often does the committee meet?

	In the case of an actual event— • Develop a structure for conducting an initial meeting, ongoing meetings, and a debriefing • Participate in the After Action Review process.	
Staffing	• Emergency management, first responders, communications, and victim service professionals should be represented. • Include agencies with identified victim care responsibilities. These include, but are not limited to: victim advocates, district attorney representatives, VOADs, COADs, mental health professionals, spiritual care professionals, social services, and crisis resource centers. • Assigning a VS provider to work as co-chair of the committee alongside the Emergency Manager/Planner can ensure VS concerns are prioritized when needed. • Committee members may act in leadership roles during a response and should have the authority to perform the roles and responsibilities assigned under the local ordinance. • At a minimum, all new committee members should receive a copy of the existing CMV/DT annex and information regarding their role and the development process to date.	7. What agencies will be represented on the planning committee? 8. If the committee chooses to have a VS co-chair work alongside the jurisdiction's Emergency Manager, what agency or person will serve in that role? 9. What onboarding will new committee members receive? 10. Who is responsible for maintaining the committee roster? How often will the roster be updated?

Activation	**Potential ESF Activation: 2, 5, 6, 7, 8, 15**
	In the case of a real event—
	• Committee members help ensure coordinated, effective short- and long-term services for victims, families, and friends. These include:
	  ○ Organizing and coordinating victim services response activities
	  ○ Making or recommending key decisions
	  ○ Providing critical information to incident command staff
	• Example criteria used to activate committee members include size/scope of the incident, number of casualties/fatalities, and number of jurisdictions involved.
	• It is a best practice for committee members to be part of the existing ICS/EM Notification protocol used for call downs and assignments for their jurisdiction.
		11. What criteria will be used to activate the committee during an actual incident?
		12. Who is responsible for activating committee members in an actual incident?
		13. How will committee members be notified to begin work during an actual incident?
		  ○ Does EM/EOC use a notification system?
		  ○ Can VS Steering Committee members be included in EM notification system call downs?
		14. What are the responsibilities of the committee during an actual incident?
		15. How will committee members be brought up to speed on the incident when beginning their work?

Location/Material Resources	N/A	16. How will meetings be conducted during an actual incident? Virtually? In-person? 17. What technology and other materials does the committee need during an actual incident?
Communication		18. What communications will committee members receive during non-activation times? How?

Section 2

BP #2 Committee Identification and Engagement
Potential ESF Activation: 2, 5, 6, 7, 8, 15

2.1 In coordination with the local emergency management planning committee, a victim services committee shall be established to conduct planning efforts and coordinate response efforts in the case of a CMV/DT incident.

2.2 **Steady State Planning.** The VS committee will be led by [1, 5, 8](position(s)/agency(s)) and shall consist of the following member organizations:

[7]Agency Name	[7]Agency POC Name/Title	[7]Agency POC Phone Number and Email	[7]Alternate POC	[7]Alternate POC Phone Number and Email

2.2.1 The VS committee shall meet [6](monthly/quarterly/biannually).

2.2.2 Outside of meeting times, the VS committee shall maintain [18](insert types of communications), including [18](insert information included in communications), to maintain relationships with other committee members and remain up-to-date on CMV/DT annex processes.

2.2.3 The VS committee roster will be maintained by [10](insert position/agency) and updated on [10] (monthly/quarterly/biannually).

2.2.4 New VS committee members shall be provided a copy of the existing CMV/DT annex and complete recommended trainings as outlined in Best Practice 1. Additional onboarding requirements include [9](insert required onboarding activities).

2.2.5 In the case of conflict between committee members, [4] (insert position/agency) shall be responsible for mediating the conflict using these procedures [3](insert conflict mediation protocols).

2.3 **Actual CMV/DT Incident Response.** Committee members could serve in leadership roles during a response and should have the authority to perform the roles and responsibilities assigned under the local ordinance and/or agency directives.

2.3.1 Committee member responsibilities during an actual incident [14]include:

2.3.1.1 Organizing and coordinating victim services response activities

2.3.1.2 Making or recommending key decisions

2.3.1.3 Providing critical information to incident command staff.

2.3.2 The VS planning committee shall be activated during an actual CMV/DT incident when [11](insert criteria used to determine activation).

2.3.2.1 [12](Insert agency/position) is responsible for activating committee members using [13](insert system/protocol for activation) within 2 hours of a CMV/DT incident.

2.3.2.2 When activated, committee members will participate in [15](insert activity to bring the committee up to speed on the incident and their responsibilities) organized and led by [15] (insert position/agency).

2.3.3 Meetings shall be conducted in an [16]in-person/virtual setting.

2.3.3.1 Virtual meetings will be conducted using [16] (insert platform) managed by [16] (insert agency)

2.3.3.2 In-person meetings will be held at [16] (insert location).

2.3.3.3 The following technology and other materials will be procured for committee member meetings during an actual incident. [17] (Insert needed supplies)

Best Practice 3: Contact List

Section 1

Best Practice #3 Contact List *Maintain a contact list of all potential responding agencies and points of contact for each. Update the list regularly and keep it easily accessible should a CMV/DT incident occur. Responding agencies will maintain their own call-down lists and procedures to enact once the agency is deployed.*		
	Considerations	**Questions**
Planning Considerations	**CENTRAL CONTACT LIST** • The contact list will be used to source responders needed to establish and run the JFSOC, FRC, and FAC. • All organizations represented on the VS committee (BP #2) should be included on the contact list, but the contact list may also include agencies not represented on the committee. • The contact list should provide each agency's primary point of contact (POC) and secondary and tertiary POCs. It is not a master list of all staff for each agency. • Note the latest date the contact was revised. **AGENCY CONTACT LISTS** • Each agency is responsible for maintaining its own roster of available staff. • At a minimum, update the contact lists annually.	1. Who is responsible for compiling and maintaining the central contact list? 2. How often is the central contact list updated? 3. Where will the central contact list be stored? 4. Has the VS lead for the jurisdiction identified their VS agencies? 5. Have agencies identified their trained responders?
Services		
Staffing	**CENTRAL CONTACT LIST** • Central contact lists will include agency planning members or identified POCs. • Include agencies providing accessibility services for special populations (e.g., interpreters, signers).	6. What agencies in your jurisdiction or surrounding areas could assist following a CMV/DT incident? 7. What is the approval process for adding new agencies to the central contact list? 8. How will agencies and their staff be credentialed before a CMV/DT incident?

	AGENCY CONTACT LISTS • Agency contact lists should be developed in accordance with the staffing needs under BP Best Practices #4 (FRC) and #8 (FAC).	
Activation	**Potential ESF Activation: 2, 5, 6, 7, 8, 15** **CENTRAL CONTACT LIST** • Typically, members of the planning committee are activated through EM processes. Committee members then use the contact list to activate needed agencies. **AGENCY CONTACT LISTS** • VS and partners are likely to have their own call-down procedures that are most likely separate from the EM process.	9. What notification system(s) will be used for the central contact list activations? (Align with BP #2) 10. What criteria will determine the need to activate agency contact lists? 11. What process will each agency use to activate their personnel? 12. What information will be included in the notifications? 13. What is the timeframe in which VS staff must respond? 14. What happens if the initial notification does not provide enough VS staff resources?
Location/Material Resources		
Communication		15. If a centralized notification software/system is being used, who is responsible for ensuring all necessary personnel have access to and training on said software? ○ How and when is the notification system tested?

Section 2

BP #3 Contact List

Potential ESF Activation: 2, 5, 6, 7, 8, 15

3.1 **Contact List.** Because CMV/DT incidents tend to be "no notice" events, maintaining a contact list is critical to integrating VS successfully into the response.

3.1.1 [1](Insert name/agency) is responsible for maintaining a central contact list of vetted agencies that will fill leadership roles (within the EOC, JFSOC, FRC, and FAC) and provide vital response services. Additional information regarding important roles and responsibilities for the EOC, JFSOC, FRC, and FAC can be found in Best Practices 1, 4, and 8.

3.1.2 The central contact list will be updated on a [2](insert timeframe) basis and stored [3](insert location if stored outside this annex). The latest date of revision shall be listed on the contact list.

3.1.3 The following agencies can assist currently following a CMV/DT incident.

[6]Service/Role	[6]Agency	[6]POC Name, Email, Phone	[6]POC 2 Name, Email, Phone	[6]POC 3 Name, Email, Phone

3.1.4 Each agency's POC(s) is responsible for maintaining contact lists of individuals within their agency who can fill critical positions and provide critical services.

3.1.5 Additional agencies may be added to the central contact list by [7](insert approval process).

3.1.6 All agencies and their staff shall be credentialed before participating in a CMV/DT incident according to the following procedures [8](insert procedures).

3.2 **Activation.**

3.2.1 The central contact list will be activated during an actual CMV/DT incident when [10](insert criteria used to determine activation).

3.2.2 [9](Insert agency/position) is responsible for activating agencies on the central contact list using [9](insert system/protocol for activation).

3.2.2.1 [15](Insert agency/position) shall ensure all necessary personnel have access to and are trained to use the notification system. The notification system shall be tested on a [15] (insert timeframe) basis.

3.2.3 Once an agency is activated, the agency POC(s) shall activate their personnel using [11](insert description of procedures).

3.2.3.1 The following information will be provided to agency personnel as part of the activation notification: [12](insert notification information)

3.2.3.2 Activated personnel are expected to respond to the activation notification within [13](insert timeframe) to report their availability to respond.

3.2.4 If the initial notification does not yield enough staff, [14](insert contingency plan).

Best Practice 4: Friends and Relatives Center (FRC)

Section 1

Best Practice #4 Friends and Relatives Center (FRC) *It is critical to identify a temporary, safe location for families of victims and missing persons to gather to await information immediately after an event occurs.* *(Formerly referred to as Family Reception or Reunification Center FRC, Information Notification Center (INC))*		
	Considerations	**Questions**
Planning Considerations	• The FRC is a "holding environment" where initial information will be collected from and given to victims, impacted populations, loved ones, and families. • FRCs are usually open for 24–48 hours after an incident (24-hours/day) • FRCs often transition to the FAC if continued services to victims are needed. • FRC operations should be incorporated into the jurisdiction's exercise calendar.	1. Which stakeholders need to be involved in planning for and responding to the FRC?
Services	The following services are needed. Many will continue at the FAC once that transition takes place. • Disaster-trained behavioral health • Disaster-trained spiritual care (To include guidance and support for religious and cultural handling of remains and burial. See Best Practice 5 for more information.) • Missing persons (See Best Practice 5 for more information.) • Victim identification (See Best Practice 5 for more information.) • Reunification • Death notification (See Best Practice 5 for more information.) • Communications/IT • Transportation • Limited food/beverage	2. What agencies will provide these essential services? 3. Who is the POC for each agency?

Staffing	• An FAC Table of Organization sample can be found in Appendix B. • Find the typical roles that are needed in Appendix A. • Staffing plans should include provisions to rotate personnel. 12-hour rotations are standard. • Conduct staff briefings at each shift change. Scheduling a 30-minute overlap between shifts allows for this. • Orientation typically includes: 1. Incident overview/update 2. FRC org structure and who to go to for questions 3. FRC layout and current services 4. Do's/Don'ts of working with victims 5. Behavioral expectations (e.g., no cell phones, quiet voices, getting to "yes" with victims/families) • Many volunteers, both those officially linked to stakeholder agencies and those unaffiliated, will self-deploy. All volunteers need to follow established protocols. This includes those who arrive with dogs or other support animals. Refer to Best Practice 7 for more in-depth guidance on volunteer and animal management.	4. What will the org chart look like? 5. Who will fill the roles identified in the Staffing Chart in section 2? 6. How will service providers be scheduled? 7. Who is responsible for developing staffing plans? 8. What will be included in the orientation as staff start their roles? 9. How will you ensure staff are credentialed appropriately?
Activation	**Potential ESF Activation: 2, 5, 6, 7, 8, 13, 15** • Since the FRC will need to open as quickly as possible after an incident, Incident Command will often determine the need for an FRC and the location. • The JFSOC should be initiated as early as possible to coordinate victim care. • Senior representatives from stakeholder agencies (often those involved in the planning process) shall be activated and will need the	10. Who decides that an FRC should open? 11. Who is activated? 12. What notification system is used to activate personnel? 13. Has the notification system been tested? 14. If a centralized notification software is being used, do all necessary personnel have access to and training on the software? 15. What information is included in the activation notification? 16. Who sends the activation notification?

	authorization to allocate agency resources. • Once key stakeholders are activated, they often proceed to do call downs and deployments of their own agency personnel. • Activation notifications should indicate where to report upon arrival and contain concise directions to the FRC.	17. How long will it take to activate and get the FRC up and running?
Location/Material Resources	• The EOC will likely assist with securing and allocating resources. • Potential facilities should be pre-identified throughout all areas of jurisdiction. • Find a sample floorplan for an FRC/FAC in section 2 of this Best Practice. • Consider the demographics of the impacted population when choosing the FRC location. • It should be out of the line of sight, sounds, and smells of the incident. • Follow occupancy limitations. • The size is dependent on the scope and scale of the incident. • Communication capabilities, such as high-speed Internet and phone lines, are necessary at the location. • Should have space for 1:1 meetings with families. • Adequate parking and access to public transportation are necessary. • The ability to record information about those who enter is immediately vital to operations (electronic or paper).	18. What facilities could be used as a potential FRC? 19. Have Memorandums of Understanding/Agreements been developed? If yes, are they current? 20. What criteria will determine an "on-the-fly" location if none of the pre-identified locations are available? 21. Who is responsible for selecting the FRC location? 22. Who is responsible for preparing the facility? 23. What equipment and materials are needed? 24. What potential population characteristics need to be considered in determining the location and services at the FRC? (neighborhoods, known vulnerable populations, etc.)

Communication	• Public information is essential at this stage to keep friends and family aware of where to go for continued information, assistance, and services. • Use the media to broadcast the location of the FRC. See Best Practice 6 for more detailed information on crisis communications. • Information briefings for victims and families should be scheduled periodically, and the highest level of authorities should provide the information.	25. Who will be the primary conduit for information sharing between VS and emergency management? 26. Who will approve the public release of incident-related information? 27. If possible, were template communications created?

Section 2

BP #4 Friends & Relatives Center (FRC)
Potential ESF Activation: 2, 5, 6, 7, 8, 13, 15

4.1 **Services.** An Information & Notification Center shall serve as a "holding environment" where initial information will be collected from and given to victims, impacted populations, loved ones, and families.

4.1.1 The FRC shall provide key short-term mental health support to surviving victims and loved ones.

4.1.2 Victim identification and notification services shall be provided as information becomes available.

4.1.3 During registration/intake at the FRC, staff shall determine if victims or witnesses have contacted law enforcement regarding the incident. Those who have not shall be referred to law enforcement for investigative purposes.

4.1.4 The standard services for an FRC shall include:

Service	[2]Providing Agency	[3]Agency POC	[3]Agency Backup POC
Mental/Behavioral Health			
Spiritual Care			
Victim Identification/Tracking			
Communications/IT			
Transportation			
Limited food/beverage			

4.1.5 Population characteristics of victim groups shall be considered in determining additional needed services. Populations that may be impacted in the jurisdiction include [24](insert prominent populations within the jurisdiction).

4.1.6 Other agencies that may provide essential services to victims and families at the FRC include:

Service	Providing Agency	Agency POC	Backup POC

4.2 Staffing.

4.2.1 The following administrative roles shall be filled for FRC operations.

Role	[5]Filled By	[5]Contact Information
Lead Agency Manager		
Security/Safety		
Logistics/Mass Care		
Planning		
Liaison to Incident Command (IC)		
Registration		
Witness/Victim Interviews		
Health Triage and Support		
Liaison to Centralized Victim/Patient Tracking		
Notification Team		
Staff Management		
Communications Lead (PIO or Liaison)		
Media Management		

4.2.2 Service providers identified in **4.1** shall report to the individual filling the staff management role.

4.2.3 The table of organization below depicts the FRC reporting structure.
[4](insert Table of Organization)

4.2.4 Staffing plans will be developed by [7](insert role/agency(s) responsible).

4.2.5 Service providers will be scheduled using the following parameters.

4.2.5.1 [6](insert staffing requirements)

4.2.6 All staff members shall participate in an orientation to their role before beginning work. Orientation shall discuss [8](insert topics)

4.2.7 [9]All staff members shall be credentialed in accordance with the procedures explained in section 7.

4.3 Activation.

4.3.1 Coordination of victim services shall remain with the IC/EOC until JFSOC is operational.

4.3.2 [10](Insert position/agency) shall determine the need for an FRC.

4.3.3 The FRC site will be operational within [17](insert number) hours of notification.

4.3.4 [11](Insert who) shall be activated by [16](insert position/agency) using [12](insert notification system/process for both administrative and service provider roles).

4.3.4.1 [14](insert position/agency) is responsible for ensuring all necessary staff have access to and training on this system.

4.3.4.2 This system shall be tested on a [13](insert timeframe) basis.

4.3.5 Activation notification shall include [15](insert notification information).

4.3.6 The FRC shall remain open until a seamless transition to the FAC can occur—typically 24–48 hours following the incident.

4.4 Location. The FRC may start operations virtually while standing up a physical facility.

4.4.1 [21](Insert position/agency) is responsible for determining the location of the FRC.

4.4.2 The following is a list (and/or link to a GIS map) of preplanned potential FRC facilities.

[18] Name	[18]Facility Address	[18]Occupancy Limit	[18]Point of Contact (POC) Name, Phone Number, and Email	[19]MOU Dates

4.4.3 In situations that require an alternative site that is not on the list, a site that fulfills the following criteria will be used to select an "on-the-fly" site. [20](select and/or add options from the list below)

4.4.3.1 Out of the line of sight, sounds, and smells of incident

4.4.3.2 Has communications capabilities, including high-speed Internet and phone lines

4.4.3.3 Offers space for 1:1 meetings with families

4.4.3.4 Adequate parking

4.4.3.5 Access to public transportation

4.4.3.6 Occupancy limits are appropriate to the scale of the incident—allowing adequate space for victims, families, and needed responders

4.4.3.7 Appropriate for the population impacted by the incident

4.4.4 Population characteristics of the victims shall be considered in determining FRC location.

4.4.5 [22](Insert role/agency) shall be responsible for preparing the FRC facility for operation. Contact [22] (insert POC) at [22] (insert contact info).

4.4.6 The following equipment and materials shall be procured for FRC operations: [23](insert required equipment/materials)

[23]**Item**	[23]**Quantity**	[23]**Procurement Options**

4.4.7 A sample FRC layout is in Best Practice 8.

4.5 Communications.

4.5.1 [25](Insert role/entity) shall be the primary conduit for information sharing between victim services at the FRC and emergency management/ICS leadership.

4.5.2 The release of incident-related information shall be approved by [26](insert role) in accordance with the practices detailed in section 6.

4.5.3 Information briefings shall be scheduled periodically at the FRC for victims and families.

4.5.4 An FAQ document that lists victim assistance and services available at the FRC and online shall be developed and distributed.

4.5.5 Find FRC-specific communication templates here [27](insert location, if applicable).

Best Practice 5: Victim Identification and Notification

Section 1

Best Practice #5: Victim Identification and Notification *There must be processes to identify and track large numbers of victims—including information on victims' health and location—to facilitate notifications of involvement, injury, missing status, or death. This information will also help to connect survivors to their loved ones.*		
	Considerations	**Questions**
Planning Considerations	• Many jurisdictions address victim identification and fatality notification in public health or existing All-Hazards plans. The CMV/DT annex must be integrated into pre-existing systems. • CMV/DT incidents can involve large numbers of both casualties and fatalities. Therefore, systems must have a large capacity to manage this outcome. • Identification and notification can span multiple phases of the response. • Notifications include involvement in the incident, injury/hospitalization, missing status, and death notifications. • A comprehensive list of victims of the incident will include those recorded in hospitals, morgues, the FRC/FAC, and those who self-identify when seeking services during long-term recovery and fit the legal eligibility.	1. Does the jurisdiction have a plan for victim identification/notification? 2. Are missing persons addressed in the pre-existing plan? 3. Is patient tracking addressed in the pre-existing plan? 4. Is any pre-existing plan adequate to manage large numbers of casualties, fatalities, and missing persons? a. If no, what processes can be modified for CMV/DT situations? 5. Does any pre-existing plan address notification of family/friends adequately regarding the status of their loved ones? 6. What agency will be responsible for the centralized, comprehensive list of victims and their status?

Services	**FATALITY MANAGEMENT SERVICES** • State law governs fatality notifications. Therefore, plans should align with existing state and local protocols. • It may be helpful to approach lawmakers and request provisional language that adjusts fatality notification processes in the case of a CMV/DT incident. For example, if current laws only allow one person/position to make fatality notifications, a CMV/DT incident may require expanding the number of approved personnel. • Medical Examiners' (ME) offices are aware of religious and cultural observances. Spiritual care professionals can assist with this and provide information. **MISSING PERSONS SERVICES** • FRC/FAC staff, hospitals, MEs/coroners, and local law enforcement will need to coordinate to report and locate missing persons. • Assistance will be required for children separated from parents/guardians or orphaned. • Including the National Center for Missing and Exploited Children (NCMEC) in this process can be helpful. They will assist with protecting the rights of unaccompanied children and ensuring all laws/rules are followed when connecting children back to their guardians. • Anticipate large volumes of missing person reports. **PATIENT TRACKING** • Jurisdictions will need to track the movement of injured victims as they are transported from the scene to local health care facilities. • In addition to EMS, victims may be transported by law enforcement,	**FATALITY MANAGEMENT SERVICES** 7. What adjustments need to be made to any pre-existing fatality management plans to support CMV/DT response efforts adequately? 8. What agreement exists for Disaster Mortuary (DMORT) services through the state or FEMA? 9. What agreements exist for accessing mobile morgues if needed? **MISSING PERSONS SERVICES** 10. Where will missing person reports be made/collected? 11. How will ME and others coordinate with EOC and the larger response? 12. What is the local phone number for NCMEC, and how will they be activated? 13. What happens if a minor is separated from their parent/guardian due to the event? **PATIENT TRACKING** 14. What actions will it take to track patients from the scene through the course of their health care? 15. How will victims who do not require medical care be identified? 16. How will the FRC/FAC connect with hospitals, ME/coroner, and law enforcement? 17. How will reunification be managed? **OTHER** 18. How will personal effects be tracked and managed? 19. Who is responsible for coordinating the return of personal effects? 20. If transportation for family/friends is needed, who can provide it?

	personal vehicles, ride-share companies, and by foot in large incidents. • Give special consideration to individuals with disabilities, animals, or medical equipment. • Make plans for both closed and open group tracking. See Definitions for more information. • *Notifications of surviving patients*, hospitalized or not, are not dictated by law in most places; however, HIPAA and hospital protocols dictate the release of information for those who are or have been hospitalized. **<u>OTHER</u>** • Family/friends may require transportation to appropriate locations to be reunited with loved ones or receive death notifications. • Personal effects will be collected at the scene, and a process will be set up for people to claim returnable items. Personal effects will only be released once it is determined that they are not needed as evidence. • The return of personal effects is generally delayed by a few days and extends for many months after the FAC is closed. Items are often cataloged online on a secure website.	
Staffing	• Notification teams often include law enforcement (LE), victim advocates, mental health professionals, and faith leaders. • Ensure proper staffing of the death notification team to comply with local and state laws. • Conducting death notifications is a draining task. Consider multiple teams to limit secondary trauma and ensure	21. What is the governing agency for death notifications in the jurisdiction? 22. Who is responsible for managing and requesting information on missing persons? 23. Who is responsible for patient tracking? 24. Who will provide information on surviving victims, hospitalized or not? 25. Who should be included on a death notification team?

	staff have the emotional capacity to conduct assigned notifications.	26. What training do members of death notification teams need to receive?
Activation	**Potential ESF Activation: 6, 8**	27. How are responsible parties notified of their roles and responsibilities following an incident?
Location/Material Resources	• It is recommended that a centralized system oversee patient and victim tracking services. This will reduce chaos and increase the speed with which connections and notifications can be made. • Victim lists should be shared with all service providers. • The agency responsible for long-term care should maintain the victim list. Victim lists should not be held solely by the FBI, as the FBI's policies hinder the sharing of victim lists with those providing services. • Victim identification and notification may be a function of both the FRC and FAC. • An EOC request may fill resource gaps (personnel, equipment, and material). • Family locator tools such as American Red Cross Safe and Well or Google Person Finder may be helpful.	28. What data collection and management strategies exist in the jurisdiction that can be adjusted to support victim identification and notification? 29. Who will be responsible for adapting the existing data collection tool to perform all needed tracking tasks? 30. Where will notifications be performed? 31. What data management system will be used for patient/victim tracking? 32. Who will have access to this system? 33. What training is required to use this system? How will this be provided?
Communication	• LE missing person reports should be monitored. • HIPPA and FERPA compliance may impact information able to be shared. • The American Red Cross and NTSB have HIPPA exemptions that can assist a community with patient tracking following an incident. • Call centers are often used to collect and relay information—including information regarding missing persons. See Best Practice 6.	34. How will hospital information be shared with families? 35. What MOUs are needed to facilitate information sharing? 36. Where will the public be directed to report missing persons?

Section 2

BP #5 Victim Identification and Notification
Potential ESF Activation: 6, 8

5.1 Data Management. CMV/DT incidents typically result in victims in different locations with a variety of health statuses; therefore, a comprehensive list of victims shall be kept to track victims recorded in hospitals, morgues, the FRC/FAC, and those who self-identify when seeking long-term recovery services.

5.1.1 [6](Insert position/agency) shall oversee all tracking services and manage resources used to identify victims. This includes the management of the centralized victim tracking list.

5.1.1.1 Tracking shall be managed out of the FRC and FAC.

5.1.2 Given the increased scope and scale of a CMV/DT incident, the following adjustments to existing data management systems are required to support victim identification and notification processes.

5.1.2.1 [28](Insert adjustments needed).

5.1.3 [31](Insert data management system) will be used to manage centralized victim tracking functions.

5.1.3.1 Access to the data management system shall be provided to [32] (insert agencies/roles). Identified staff will receive [33](insert training type) by means of [33](insert how and timeframe in which training will be provided).

5.1.4 [29](Insert agency/position) shall be responsible for making needed adjustments to data management processes and systems to manage a CMV/DT incident.

5.1.5 MOUs that are in place/needed to facilitate information sharing include:

[35]Summary of MOU	[35]Agency 1	[35]Agency 2	[35]Agency 3	[35]MOU Storage Location

5.1.6 Personal effects will be tracked and managed by [18](insert entity and process).

5.2 Standard Functions and Staffing for victim identification and notification shall include:

Service	Responsible/Lead Agency	POC	Back-Up POC
Managing and requesting information on missing persons	22	22	22
Patient tracking through health care systems	23	23	23
Fatality management	21	21	21
Fatality notifications	21/25	21/25	21/25
Providing information on surviving victims, hospitalized or not	24	24	24
Personal effects return	19	19	19

5.2.1 Entities responsible for conducting required functions will be notified of their roles and responsibilities following an incident by [27](insert process for activation of personnel).

5.2.2 The responsible party shall develop staffing plans for each service.

5.2.3 Staffing plans shall include provisions to rotate staff every 12 hours, at minimum, and provide overlap between shifts to allow for situational briefings.

5.3 Patient Tracking supports tracking the movement of causalities through the health care system.

5.3.1 CMV/DT incident victim groups are divided into two categories.

5.3.1.1 A closed group is when all potential victims are known. Closed group tracking shall be accomplished using basic accountability processes.

5.3.1.2 An open group is when an incident occurs in public, and all potential victims are unknown. Open group tracking is more complex.

5.3.2 Victims who are transported from the scene will be tracked by [14](Insert steps to track movement)

5.3.3 Victims who do not require medical care will be identified by [15](insert processes).

5.3.4 For tracking and notification purposes, staff in the FRC/FAC shall remain in contact with all entities receiving and working with victims. This will be done by:

Entity	Contact Method
Hospitals	[16]
Medical Examiner/Coroner	[16]
Law Enforcement	[16]

5.3.4.1 When speaking with hospitals, make inquiries regarding official medical transports and personal transports from the scene to hospitals.

5.3.5 In the case of a surviving victim, family notification and reunification will be managed by [17](insert entity and process) at [30](insert location for reunification).

5.3.5.1 Hospital information will be shared with families by [34](insert entity and processes).

5.3.5.2 If transportation is needed for family/friends to receive notification or reunification, this can be provided/coordinated by [20](insert entity/process for coordination).

5.4 Fatality Management.

5.4.1 The following adjustments will be made to the fatality management plan to support the increased scope and scale of a CMV/DT incident adequately.

5.4.1.1 [7](Insert adjustments needed).

5.4.2 As needed, [8](insert agency) shall provide disaster mortuary services in accordance with [8](insert pre-existing agreement).

5.4.3 Mobile morgues shall be accessed by [9](insert protocol and/or providing agency) in accordance with [9](insert pre-existing agreement) as needed.

5.4.4 Fatality notification teams shall consist of representatives from [25](insert fields/agencies). However, in accordance with [25] (insert state law), [25](insert agency) is required to perform the actual notification.

5.4.4.1 Before performing notifications, all team members will receive [26](insert information on training content, modality, and facilitator).

5.4.5 Fatality notifications shall be performed at [30](insert location).

5.4.5.1 If family/friends need transportation, it can be provided/coordinated by [20](insert entity/process for coordination).

5.4.6 Medical Examiner shall coordinate with the EOC and larger response efforts through/by [11](insert means) to assist in patient tracking and reconciling missing person cases.

5.4.7 Should fatalities involve international visitors, the U.S. Department of State and foreign consulates shall be contacted for additional direction and information on repatriating remains to a foreign country.

5.5 Missing Persons.

5.5.1 Large numbers of missing person reports are expected following a CMV/DT incident. Led by the agency identified in section 5.2, FRC/FAC staff, hospitals, medical examiner/coroner, and local law enforcement shall coordinate to report and locate missing persons.

5.5.1.1 If a centralized tracking system is not established, missing person lists shall be reconciled with hospital and ME/coroner unidentified patient lists at least every 24 hours.

5.5.2 Missing person reports will be collected through [10](insert means/locations).

5.5.3 The public will be directed to report missing persons by [36](insert preferred missing persons reporting process).

5.5.4 If a minor is separated from their guardian, [12](insert protocol to manage unaccompanied minors).

5.5.4.1 The National Center for Missing and Exploited Children can be contacted at [13](insert phone number) if services are required.

Best Practice 6: Public Information and Crisis Communications

Section 1

Best Practice #6: Public Information and Crisis Communication *Communications professionals will need to provide continuous, accurate, and accessible information about the incident to various audiences—including victims, families, and the public.*		
	Considerations	**Questions**
Planning Considerations	• Many jurisdictions have a pre-existing communications plan. The CMV/DT annex should be integrated into pre-existing systems. • CMV/DT incidents vary in size and scope. Some involve a handful of victims, and others can involve hundreds or more. The communications process must be scalable and establish timely and accurate information—regardless of size. • Mutual aid between PIOs will likely be needed if an incident is large. • A Joint Information Center (JIC) often serves as a centralized point for PIOs and agency spokespeople to get and give information. Many All-Hazards plans include details for accomplishing this. • CMV/DT incidents will almost assuredly make national news. • The media may attempt to infiltrate command posts, FRCs, FACs, and other locations to gain information.	1. Does the jurisdiction have a communications plan that could be activated in the case of a CMV/DT incident? 2. Is any pre-existing plan adequate for an incident that involves large numbers of casualties, fatalities, and missing persons? 3. Does the plan provide direction for communication with victims, families, and the public? 4. Does the jurisdiction have PIO Mutual Aid agreements in place?
Services	• Talking points that include relevant and available investigative and victim service information are often developed out of the JIC. • The public should be informed of where to share information regarding the incident—including if they think a loved one was impacted. • In addition to discussing the incident, information regarding predictable and common reactions to mass violence and available resources should be shared with victims and the public.	5. How will you demonstrate care and sensitivity for victims/families in your communication efforts? 6. How will you assist victims/families in dealing with the media and understanding their rights? 7. Which outlets will be used to broadcast the FRC location and services to the public? 8. Are contacts established for these outlets? 9. How will elected/appointed officials be directed?

	• Public messaging that contains predictable and common reactions to the incident will reduce the "worried well" from flooding health and behavioral health services mistakenly believing they are demonstrating trauma reactions. • Guidance should be shared with elected/appointed officials. • Victims/families will likely receive outreach from the media. This outreach can be overwhelming for them, particularly during a crisis.	
Staffing	• Public Information Officers (PIO) are responsible for gathering, assessing, prioritizing, and communicating information to victims/families and the public. While others assist them, PIOs set guidelines and hold approval power. • CMV/DT incidents often involve multi-agency and multi-jurisdictional responses. With so many players, JICs are often used to promote consistent, verified information sharing. • VS agency spokespeople should be an integral part of the JIC to ensure open lines of communication; however, these individuals do not have the authority to release information without approval from the incident PIO. • 24/7 coverage may be needed. • It can be helpful to activate a regional PIO group to provide adequate coverage of shifts and needs. • Regions and jurisdictions can sometimes access PIO resources through established centralized multi-agency groups (e.g., MACs or Task Forces). • Jurisdictions can outsource communications to crisis communication firms to assist with developing and distributing crisis messaging (ex. Black Swan).	10. What position/agency will fill the PIO role following a CMV/DT incident? 11. What mechanism will be used to activate PIO networks, if applicable?

	• Jurisdictions can outsource call center communications to crisis communication firms (ex. Black Swan).	
Activation	**Potential ESF Activation: 2, 6, 15** • Spokespeople for responding victim service agencies should be notified and report to IC/EOC/JIC. • Typically, the lead PIO for the incident is activated as part of the initial activation of the IC. • Agency-specific spokespeople are often activated as part of the activation of the FRC/FAC.	12. How will the lead PIO be notified of the need to respond? 13. How will other communications personnel be notified of their need to respond?
Location/Material Resources	• Small jurisdictions sometimes outsource call centers and crisis communications to crisis communications firms. **SOCIAL MEDIA** • Social media can be a good tool to distribute information quickly. The best practice is to select one social media account to post the most up-to-date information. All other accounts should point people to the selected account. • Post the same messages if you choose to share information across multiple platforms (e.g., the lead police department's Facebook and Twitter accounts). • Social media can be an ongoing challenge during a response. Information about the incident or investigation, identities of injured and deceased, motives for the incident, etc., may be released unofficially. This information is often incorrect. Official social media will need to focus on quelling rumors and incorrect information. • Consider using third-party platforms (e.g., Hootsuite or OnSolve) to monitor social media.	14. Which platforms will be used to provide continuous and accessible public information about the disaster? 15. Who is responsible for managing/staffing these platforms? What guidelines will be used for operation? 16. Which platforms will be used to provide information to the victims and families? 17. If using a call center, what happens if the call center capacity is exceeded? 18. How will staff be apprised of necessary login information for those sources? 19. If applicable, what centralized phone number will be used? 20. What method will be used to monitor social media? What agency will take the lead on this effort?

	WEBSITE • A website is another method to distribute accurate and timely information. The website should be administered by a governmental agency or the organization overseeing the response if used. People are referred to that specific website for "official" information. • It can also be helpful to post information on affiliated agencies' websites so people can get the information from an organization they trust. • The website will serve as a resource for call center operators who are answering inquiries, and it can be updated based on requests for information received at the call center **PHONE** • A centralized phone number helps minimize confusion. Chaos often results from multiple agencies putting out multiple numbers. • Google Voice has been beneficial in previous incidents. • Call centers are often used to both collect information and answer questions. • Call center operators will use existing electronic knowledge bases to access needed response information to answer calls and identify missing information from those knowledge bases so they can be updated. **PUSH ALERTS** • They can be beneficial when delivering news or updates to a large group of people. Example systems include Cleo Streem, Amerilert, ADT Select Link. • Your community may already have an Emergency Notification System.	

	• They can also be used to post information regarding status updates, changes in court dates, etc.	

Communication	• Victims and families need information on their loved ones, the status of the case, who to contact with questions or concerns, where to access services, and how to access donations.
	• Tailor information specifically for victims/families. This includes informing them of developments before the public when possible.
	• It is best practice to conduct regular briefings with victims/families and the media. These should be separate events.
	• The communications team will develop and funnel specific information related to other BPs (donations, memorials/vigils).
	• It can be helpful to have pre-developed templates. At a minimum, consider the following:
	  ○ Predictable reactions to a CMV/DT incident
	  ○ FRC info (where, who, when)
	  ○ FAC info (where, who [using defined victim pool], when, what services to expect)
	• The criminal prosecution of a living offender will impact what information can be communicated and how.
	• Consider using various media and multilingual formats when broadcasting the location and services of the FRC and FAC.
		21. What population demographics need to be considered that will impact how information is communicated (language, cultures, use of and trust in the media)?
		22. What processes will be used to brief groups of victims? These include updating them on the status of the case, where to go for resources, who to contact for further information, and how to access funds.
		23. How will you communicate with individuals unable to travel to the FRC/FAC, particularly those in medical facilities?
		24. How will briefings be conducted for the media? How often?
		25. Where will staff find pre-developed templates (e.g., FAQs, fact sheets, talking points)?
		26. Who will develop additional resources for victims and the public that list available victim assistance?
		27. How will these resources be distributed to victims/families?

Section 2

BP #6 PIO/Crisis Communications
Potential ESF Activation: 2, 6, 15

Note: Most jurisdictions have a communications plan as part of its All-Hazards plan. If that plan is sufficient, and the answers to questions 1-3 are "yes," this section may refer to the relevant section in the All-Hazards plan. The CMV/DT annex should be integrated into existing systems.

6.1 **Incident Public Information Officer** shall be responsible for all public-facing communications with approval or authority from the Incident Commander.

- **6.1.1** The PIO position shall be filled by [10](insert position/agency).
- **6.1.2** The PIO will be notified of their need to respond by [12](insert entity and process).
- **6.1.3** The PIO shall gather, assess, prioritize, and communicate information to victims, families, and the public.
- **6.1.4** Others may assist the PIO; however, the PIO shall set guidelines and hold approval power.

6.2 **Partner and support agencies** may also have spokespeople who assist with incident response communications. These individuals do not have authority to release information without approval from the Incident PIO.

6.3 A **Joint Information Center** may be opened to provide a centralized location for the PIO(s) and agency spokespeople to receive and give information. See [1](insert plan name and location) for details on establishing a JIC.

- **6.3.1** Spokespeople from victim service agencies shall be present at the JIC.
- **6.3.2** Individuals working in the JIC will be notified of their need to respond by [13](insert entity and process)
- **6.3.3** The JIC shall develop talking points that include relevant and available investigative and victim services information.

6.4 24/7 coverage may be needed following a CMV/DT incident.

- **6.4.1** If needed, [4](insert PIO mutual aid agreement(s)) are in place.
- **6.4.2** PIO networks will be activated by [11](insert process).

6.5 Information shall be categorized into two categories. The incident PIO must approve the release of both.

- **6.5.1** Public Information is very general information about the incident and response authorized for release to the public.
- **6.5.2** Information for victims and families, on the other hand, will not be released to the public but may be authorized to be shared with those impacted by the incident.

6.6 Prioritize care and sensitivity for victims and families at all times. The following guidelines will be useful in communication efforts.

- **6.6.1** All information provided to the media should be shared with victims/families/friends in advance.
- **6.6.2** [5](insert additional strategies).

6.7 **Public Information** will be shared in a continuous and accessible manner using [14](insert platforms that will be used and reference relevant section below…i.e., social media [6.9], call center [6.11]).

6.7.1 The public shall be informed of where they can share information regarding the incident, including if they think a loved one was impacted.

6.7.1.1 The FRC location and services shall be distributed through various media and in multilingual formats for higher visibility and accessibility.

6.7.1.2 The FRC location and services will be shared via the following outlets:

Outlet	Contact Name	Contact Information
7	8	8
7	8	8

6.7.2 Information regarding predictable and common reactions to mass violence and available resources shall be shared with the public.

6.7.3 Population demographics shall be considered in determining communication strategies. Important considerations include [21](insert prominent populations within jurisdiction and impacts on communication needs).

6.8 **Victims and families** shall be briefed on the case/investigation status, where/how to obtain services and other resources, and who to contact for further information.

6.8.1 Briefings will be conducted by [22](insert role/entity) on a [22](insert timeframe) basis at [22](insert location).

6.8.1.1 Some victims and family members may not be able to travel to a designated briefing location due to hospitalization of victims, for example. Information will be shared with these individuals by [23](insert communication means).

6.8.2 Outside of briefings, information will also be shared with victims and families via [16](insert platforms/strategies that will be used).

6.8.3 Additional resources that describe available assistance and services shall be compiled by [26](insert role/agency). These resources will be distributed to victims and families by [27](insert how resources will be distributed).

6.8.4 Victims and families will need guidance on dealing with the media. Information regarding victims' and family rights and strategies for media management will be provided through [6](insert how you will assist victims/families).

6.9 **Mainstream Media.** [14](Delete if not being used)

6.9.1 [15](Insert role/agency) is responsible for managing mainstream media.

6.9.2 Media briefings will be conducted via [24](insert manner) on a [24](insert timeframe) basis.

6.9.3 [15](Insert additional mainstream media information/guidelines)

6.10 **Social Media.** [14](Delete if not being used)

6.10.1 Social media will be used to both distribute and collect information.

6.10.2 [20](Insert role/agency) is responsible for monitoring social media for information collection purposes.

6.10.2.1 Monitoring will be done by [20](insert strategies for monitoring).

6.10.2.2 Relevant/urgent information gathered will be shared with the JIC and PIO.

6.10.3 [15](Insert role/agency) is responsible for pushing out information on social media.

6.10.3.1 Staff will be apprised of log-in information by [18](insert process).

6.10.4 [15](Insert additional social media information/guidelines)

6.11 Website. [14](Delete if not being used)

6.11.1 [15](Insert role/agency) is responsible for managing website content.

6.11.1.1 Staff will be apprised of log-in information by [18](insert process).

6.11.2 [15](Insert additional website information/guidelines)

6.12 Call Center. [14](Delete if not being used) It may be necessary to establish a centralized mechanism for managing missing person inquiries and collecting information to help identify potential next of kin and gather antemortem information to assist with victim identification. This typically involves establishing a call center to collect information about missing and unaccounted for people and document the names of individuals looking for potential victims.

6.12.1 A centralized phone number will be used to minimize confusion. [19](Insert phone number) has been reserved and configured for crisis situations.

6.12.2 [15](Insert role/agency) is responsible for managing the call center.

6.12.3 [15](Insert additional social media information/guidelines)

6.12.4 If call center capacity is exceeded, [17](insert actions to be taken).

6.13 Push Alerts. [14](Delete if not being used)

6.13.1 [15](Insert role/agency) is responsible for sending push alerts.

6.13.1.1 Staff will be apprised of log-in information by [18](insert process).

6.13.2 [15](Insert additional website information/guidelines)

6.14 Elected/appointed officials will likely wish to be involved in response efforts. The following guidance shall be provided.

6.14.1 [9](insert strategies to balance elected officials' interests with victims' needs).

6.15 Messaging templates have been developed for the following:
They can be found [25](insert location, if applicable).

6.15.1 [25](Insert templates that have been developed)

Best Practice 7: Volunteer Management

Section 1

Best Practice #7: Volunteer Management *Jurisdictions need to identify, train, credential, and collaborate with volunteer agencies, including NGOs, places of worship, and private sector organizations. Spontaneous volunteers need to be managed as well.*		
	Considerations	**Questions**
Planning Considerations	• Many jurisdictions will have volunteer management as part of their All-Hazards plan. This includes identifying, training, credentialing, and coordinating volunteer agencies • Non-typical roles are likely to be needed to meet the needs of victims in a mass violence incident. These include mental health, spiritual care, victim advocates, and navigators. Planning will need to consider these roles and incorporate the volunteer agencies into the planning process. • CMV/DT incidents typically involve more volunteers than other incidents. The number of volunteers, particularly spontaneous volunteers, may exceed existing plans. • It is critical to have a detailed process for dealing with spontaneous volunteers. Otherwise, masses of well-intentioned volunteers may overwhelm responders and detract from victim services. Turn away unneeded or unsuitable volunteers.	1. Does the jurisdiction have a plan for volunteer management? 2. Is the existing plan scalable for large numbers of volunteers? 3. Are spontaneous volunteers addressed in the pre-existing plan? 4. Does the plan include volunteers who fall outside of the typical response needs? 5. Does the jurisdiction have an active CERT program or Goodwill Ambassador program that can be leveraged? 6. What agencies in the community have been vetted and can provide needed volunteer services applicable to victims and families in a CMV/DT response?
Services	• Coordination of voluntary agencies, nongovernmental organizations (NGO), places of worship, and the private sector ensures that capabilities, resources, and services are integrated into local, state, Tribal, territorial, and insular area response. • It is a best practice to create a list of agencies that utilize volunteers and work with those agencies to identify roles/responsibilities that spontaneous volunteers can fill.	7. What responsibilities could be managed by affiliated volunteers? 8. What responsibilities could be managed by spontaneous volunteers?

	• Some jurisdictions will stand up a Volunteer Intake Center to manage volunteers. Other communities may depend on agencies that use volunteers as a clearinghouse for all volunteers.	
Staffing	• The planning committee should determine the eligibility requirements of volunteer and paid staff, including how eligibility is affected if the incident directly impacts staff. • Verify good standing with licensing or credentialing boards at the time of the incident, even for pre-identified staff. • It is a best practice to ensure a background check is completed for all staff working with victims, particularly vulnerable populations (children, older people, people with disabilities). • Pre-identified, affiliated stakeholders and agencies will be aware of the specific roles their volunteers are trained and credentialed to take on. These will vary depending on the type of agency. • Spontaneous volunteers unaffiliated with a known responding agency will need to be vetted to determine the appropriateness of their involvement. • Spontaneous volunteers unaffiliated with a known responding agency should have no unsupervised access to victims until they are vetted and pass an approved background check. • A volunteer management system shall have plans, policies, and procedures for the safe and appropriate use of trained facility dogs following guidance from the FBI Victim Services Division. • Individuals and teams will spontaneously deploy with support animals, especially dogs. **Only use trained facility dogs**. • Clear guidance regarding the training and purpose of different types of	9. What requirements will determine volunteer eligibility? 10. What is the organizational structure for volunteer management? 11. Who is responsible for managing affiliated volunteers? This could be an agency or a position. 12. Who is responsible for managing spontaneous volunteers? This could be an agency or a position. 13. How will licenses, credentials, and background checks be verified for pre-identified staff? 14. Who is responsible for conducting background checks for spontaneous volunteers? 15. How will spontaneous volunteers be vetted for licenses and credentials?

	animals will assist jurisdictions in refusing animal entry to service delivery locations. ○ Facility dogs are bred to remain calm during a mass casualty response, with specific training to manage large numbers of emotionally impacted individuals. ○ Therapy dogs are trained to support one person or a small group of people experiencing emotional stress. They become overwhelmed by the number of emotionally needy people during a CMV/DT response and should not be used. ○ Emotional support animals are not trained to provide support but rather develop a relationship with a single person to provide constant support. Therefore, they are not appropriate supports to deploy during a CMV/DT incident.	
Activation	**Potential ESF Activation: 6** • Volunteers are at risk for vicarious trauma. Establish processes to educate volunteers about and monitor for vicarious trauma.	16. Who will determine how volunteers are used? 17. How will affiliated volunteers be activated to respond? 18. How will spontaneous volunteers be managed? 19. What type of training will spontaneous volunteers receive? 20. How will liability issues for volunteers be managed? 21. How will volunteers be monitored for vicarious trauma?
Location/Material Resources	• Check-in/registration centers will be needed for both affiliated and spontaneous volunteers. • Distance the spontaneous volunteer registration from the FAC and EOC.	22. What is the process for determining and operating volunteer check-in/registration center(s)?
Communication	• Volunteers should be updated regularly on available services, roles, and procedures. Briefings and	23. Who is responsible for devising and maintaining job descriptions? 24. Where will job descriptions be stored?

	debriefings at the beginning and end of each shift are recommended. • It is helpful to have volunteer job descriptions in advance to ensure volunteers are matched with roles appropriately.	25. How will volunteer input and observations be collected?

Section 2

BP #7 Volunteer Management.
Potential ESF Activation: 6

Note: Most jurisdictions have a pre-existing volunteer management plan. Should that plan address the scope and scale of affiliated and spontaneous volunteers expected for a CMV/DT incident sufficiently, this section can simply refer to that pre-existing plan.

7.1 All volunteer management activities will be overseen by [10](insert role/agency). [10] (Insert additional information regarding reporting structure as needed).

7.1.1 [16](insert role/agency) will determine how volunteers are used during incident response.

7.1.2 [23](insert role/agency) is responsible for devising and maintaining volunteer job descriptions.

7.1.2.1 Job descriptions will be stored [24](insert location).

7.1.3 The JFSOC shall coordinate with [10](insert role/agency) and volunteer agencies to ensure accurate accounting of volunteer resources and hours.

7.2 **Volunteer Agency Coordination.** Volunteer agencies shall be identified, trained, credentialed, and coordinated to support services needed by victims and their loved ones. The agencies below have been identified and vetted to support victim services in the following roles:

[6]Agency	[6]Role	[6]Location
Ex. Red Cross	*Behavioral Health*	*FAC*
Ex. All Faiths Center	*Spiritual Care/Vigils*	*FAC/FRC*

7.3 All volunteers must meet the following requirements to be eligible to volunteer.

7.3.1 [9](Insert requirements. These should encompass both affiliated and spontaneous volunteers).

7.4 **Affiliated Volunteers** are individuals who registered with a known volunteer agency assisting with incident response.

7.4.1 Affiliated volunteers will be managed by [11](insert role/agency).

7.4.2 Affiliated volunteers may be appropriate to assist with tasks, including [7](insert tasks).

7.4.3 Affiliated volunteers will be activated to respond by [17](insert entity and process).

7.4.4 All affiliated volunteers shall be checked for good standing with licensing or credentialing boards and have a clear background check before beginning work. [13] (Insert position/agency) is responsible for verifying licenses, credentials, and background checks by [13](insert procedure).

7.5 **Spontaneous Volunteers** are individuals who self-deploy to assist with incident response and are not associated with a responding agency. Spontaneous volunteers can become a significant resource drain if protocols are not developed and enacted to deal with the influx.

7.5.1 Affiliated volunteers will be managed by [12](insert role/agency(s)).

7.5.2 Upon self-deployment, volunteers will be directed to [18](insert process for how spontaneous volunteers will be managed).

7.5.3 Spontaneous volunteers may be appropriate to assist with the following pre-identified tasks. Typically, this list is narrow in scope.[8]

[8]Job/Location	[8]Responsible Agency	[8]Notes
Ex. Feeding Support/FAC	*Salvation Army*	*X hrs/daily*

7.5.4 Spontaneous volunteers unaffiliated with a known responding agency must be vetted to determine the appropriateness of their involvement.

7.5.4.1 [14](Insert position/agency) is responsible for conducting background checks for spontaneous volunteers.

7.5.4.2 [15](Insert position/agency) is responsible for vetting the licenses and credentials of spontaneous volunteers using the following process:

7.5.4.2.1 [15] (Insert additional information on vetting procedures, as needed)

7.5.5 Spontaneous volunteers unaffiliated with a known responding agency shall have no unsupervised access to victims until they are vetted and pass an approved background check.

7.5.6 Before beginning work, selected spontaneous volunteers shall participate in training covering [19](insert type of training received).

7.5.7 All unneeded or unsuitable volunteers shall be dismissed or referred to agencies that may utilize volunteers for other purposes.

7.6 **Support Animals.** Individuals and teams will likely spontaneously deploy with support animals, especially dogs. **Use only trained facility dogs.**

7.6.1 Facility dogs are bred to remain calm during a mass casualty response, with specific training to manage large numbers of emotionally impacted individuals.

7.6.2 Therapy dogs are trained to support one person or a small group of people experiencing emotional stress. They become overwhelmed by the number of emotionally needy people during a CMV/DT response and should not be used.

7.6.3 Emotional support animals are not trained to provide support but rather develop a relationship with a single person to provide constant support. Therefore, emotional support animals should not be used to assist with CMV/DT incidents.

7.7 All affiliated and spontaneous volunteers shall report to a check-in/registration center before each shift.

7.7.1 The location for check-in/registration will be determined by [22](insert entity).

7.7.1.1 The spontaneous volunteer registration station shall be distanced from the FRC, FAC, and EOC.

7.7.2 Processes for opening and operating check-in/registration are as follows:

7.7.2.1 [22](Insert processes)

7.8 Volunteers shall be regularly updated on available services, roles, and procedures.

7.8.1 Volunteer observations and input shall be collected [25](insert how).

7.9 Liability concerns arise when utilizing volunteers. [20](Insert information on how liability issues will be managed)

7.9.1 Limits on liability protection should be shared with volunteer agencies and individual volunteers.

7.10 Volunteers are at risk for vicarious trauma. [21](Insert how vicarious trauma will be monitored/addressed)

Best Practice 8: Family Assistance Center

Section 1

Best Practice #8 Family Assistance Center (FAC) *The FAC is a secure facility that provides services to meet the immediate needs of those identified as victims by lead law enforcement and prosecution entities in coordination with the lead victim service agency.*		
	Considerations	**Questions**
Planning Considerations	• A well organized FAC is critical to supporting victims and their families. • The FAC is established as the FRC closes and remains open for 8–9 days. • FAC hours of operation are dependent on the incident. Typically, they are open 12 hrs/day or 24 hrs/day. • When the FAC closes, it is a best practice to have the Resiliency Center (see Best Practice 14) open on the next business day to avoid a lapse in services. • "Family" is not limited to a legal next-of-kin relationship and may include immediate family, friends, partners, or distant relatives. • The prosecutor and lead law enforcement agency will determine the legal victims of the crime. • Access to the FAC is generally limited to legally identified victims since some key services (Victim Assistance, Victim Compensation, federal victim resources) will only be available to those identified victims. • The media should not be allowed access to the FAC.	1. What affiliated agencies need to be involved in conversations about victim care? 2. How will drills and exercises involving the FAC be included in the jurisdiction's exercise calendar? 3. Who will collect information about victims'/loved ones' needs? How? 4. Who will determine what services will be available at the FAC?

Services	• FACs allow victims streamlined access to multiple partner agencies, resources, and information to meet their immediate needs
	• One person should oversee service coordination to reduce confusion and ensure that all immediate needs are met.
	• The following services are needed:
	  ○ Client registration
	  ○ Navigators (assist with identifying the needs of victims and loved ones and connecting them to resources within the FAC)
	  ○ Disaster-trained behavioral health (may act as Navigators)
	  ○ Disaster-trained spiritual care
	  ○ Missing persons (see Best Practice 5 for more information)
	  ○ Victim identification (see Best Practice 5 for more information)
	  ○ Death notification (see Best Practice 5 for more information)
	  ○ Communications/IT
	  ○ Transportation for families of injured or deceased to and from hospitals and FAC
	  ○ Travel and lodging services for out-of-town loved ones (usually two per victim)
	  ○ Disaster-trained childcare (often activated through Red Cross)
	  ○ Crime victim compensation
	  ○ Guidance for legal matters related to death or injury
	  ○ Referrals to local and regional mental health counseling services
	  ○ Health care support
	  ○ Food/beverage
	• It is helpful to develop a document that lists services and available resources that is updated and distributed daily to navigators and agency personnel.
		5. What agencies will provide FAC/VS essential services?
		6. How will security be managed?

Staffing	• A sample of the FAC Table of Organization can be found in Appendix B. • Typical roles that are needed can be found in Appendix A. • Agency staff are likely to change daily. A daily roster of personnel should be maintained. • Approved staff will need to be identified quickly as they move around the FAC. It is best practice to use color coding on visible ID badges. Dot stickers are often used. • Staffing plans should include provisions to rotate personnel in 12-hour rotations. • Staff briefings and debriefings should be conducted at each shift change. • Many volunteers, both those officially linked to stakeholder agencies and those who are unaffiliated, will self-deploy. All volunteers need to follow established protocols. This includes those who arrive with dogs or other support animals. Refer to BP #7 for more indepth guidance on volunteer and animal management.	7. What roles are needed? 8. What responsibilities need to be covered? 9. Has an organization chart been developed? 10. Who will fill the identified roles? 11. How will credentialing be managed? 12. Who is responsible for developing staffing plans? 13. How will service providers be scheduled? 14. How will approved FAC staff members be identified each day? 15. How will the lead/POC for each agency be recorded each day? 16. How will daily personnel rosters be communicated to FAC operations staff? 17. Who is responsible for developing staff protocols that will govern staff behavior and procedures for operations?
Activation	**Potential ESF Activation: 2, 5, 6, 7, 8, 13, 15** • Incident Command usually oversees initial VS operations at the FRC and will need to coordinate the transition to FAC with the FAC lead with JFSOC support. • Senior representatives from key agencies authorized to allocate agency resources need to be engaged in the FRC to FAC transition planning. • Stakeholder agency POCs will usually do call downs and deploy their own agency personnel to staff FAC.	18. Who decides when to transition from an FRC to FAC? 19. Which agencies are activated? 20. Who is responsible for notifying agencies? 21. Which agency is responsible for opening/setting up the FAC? How will they be contacted? 22. What agency is responsible for operating the FAC? 23. How will response agencies activate personnel? 24. If a centralized notification software is being used, do all necessary personnel have access to and training on said software? 25. How often will notification

	• Activation notifications should indicate who the responder should report to on arrival and contain concise directions to the FRC, at a minimum. **<u>JFSOC</u>** • JFSOC location should be within or close to the FAC. • JFSOC staff should be assigned early to assist in coordinating the transition from FRC to FAC.	system be tested? 26. What information is included in the activation notification?
Location/Material Resources	• FACs should have a physical location and a website for online access. • Potential FAC facilities should be identified throughout all areas of the jurisdiction. • A sample floorplan for an FRC/FAC can be found in section 2. • Hotels and conference centers are proven effective FAC spaces during past incidents because food, lodging, and parking are readily available. • It should be out of the line of sight, sounds, and smells of the incident. • Occupancy limitations must be followed. • Size is dependent on the scope and scale of the incident • Communication capabilities such as high-speed Internet and phone lines are necessary. • Should have space for 1:1 meetings with families.	27. Who is responsible for selecting the FAC location? 28. What facilities could be used as a potential FAC? 29. Have Memorandums of Understanding/Agreements been developed? If yes, are they current? 30. What criteria will determine the FAC location "on-the-fly" if none of the pre-identified locations are available? 31. What equipment and materials are needed for service provision? 32. Where will web-based services be hosted?
Communication	• Public information is essential at this stage to keep friends and family aware of where to go for notifications and services. • It is helpful to distribute information describing resources, assistance, and services available at the FAC and online.	33. Who has primary responsibility for information sharing between FAC/VS and emergency management? 34. Who will approve the release of incident-related information to victims and families? 35. Have communication templates been developed? If yes, where can they be found?

	• It can be helpful to develop templates developed in advance for the following:
	  ○ Communications overview—how will information flow
	  ○ Investigative updates
	  ○ Service updates
	  ○ ME/coroner updates
	• Briefings are often held at the FAC to provide updates to victims and families. See Best Practice 6 for additional information.
		36. Who will coordinate the distribution of information about the FAC?

Section 2

BP #8 Family Assistance Center
Potential ESF Activation: 2, 5, 6, 7, 8, 13, 15

8.1 Services. A well organized Family Assistance Center (FAC) is critical to supporting victims and their families. FACs allow victims streamlined access to multiple partner agencies, resources, and information.

8.1.1 Services offered shall be based on the needs of victims and loved ones. [3](Insert position/agency) shall collect information regarding their needs by [3](insert strategies for collecting information).

8.1.2 Using the needs assessment, [4](Insert position/agency) shall determine what services will be available at the FAC.

8.1.3 The standard services for an FAC shall include:

Service	[5]Providing Agency	[5]Agency POC	[5]Agency Backup POC
Client Registration			
Navigation			
Behavioral Health			
Spiritual Care			
Victim Tracking and Notification			
Communications/IT			
Transportation			
Travel and Lodging			
Crime Victim Compensation			
Guidance for Legal Matters Related to Death or Injury			
Referrals to Local/Regional Mental Health Counseling Services			
Health Care Support			
Childcare			

Food/Beverage			

8.1.4 Additional services may be needed depending on the incident and the populations impacted.

8.2 **Access** to the FAC shall be limited to legally identified victims, their families, and approved FAC staff members.

8.2.1 "Family" shall not be limited to a legal next-of-kin relationship and may include immediate family, friends, and distant relatives.

8.2.2 Media shall not be allowed access to the FAC.

8.2.3 The following security measures shall be enacted:

8.2.3.1 [6](Insert security protocols to be used).

8.2.3.2 FAC staff members will be identified each day by [14](insert identification protocols).

8.3 **Staffing.**

8.3.1 [21](Insert agency) will serve as the lead agency responsible for operating the FAC.

8.3.2 Many roles initiated at the FRC will continue at the FAC. Individuals/agencies filling the continuing roles may remain the same; however, in some cases, roles may be filled by new agencies or individuals within those agencies.

8.3.2.1 The following administrative roles shall be filled for FAC operations.

[7/8]Role	Role from FRC?	[10]Filled By	[10]Contact Information
Services/Community Partners Coordinator	No		
Childcare	No		
Lead Agency Manager	Yes		
Security/Safety	Yes		
Logistics/Mass Care	Yes		
Planning	Yes		
Liaison to Incident Command	Yes		
Registration	Yes		
Witness/Victim Interviews	Yes		
Health Triage and Support	Yes		
Liaison to Centralized Victim/Patient Tracking	Yes		
Notification Team	Yes		
Staff Management	Yes		
Communications Lead (PIO or Liaison)	Yes		
Media Management	Yes		

8.3.3 The Table of Organization below depicts the FAC reporting structure.
[9](insert table of organization)

8.3.4 Staffing plans will be developed by [12](insert role/agency(s) responsible).

8.3.4.1 The staffing plan shall assume the FAC will be operational for 8–14 days.

8.3.4.2 The Lead Agency Manager shall determine hours of operation but are typically between 12hrs/day and 24hrs/day, depending on the scope and scale of the incident.

8.3.4.3 The staffing plan shall account for both a physical and web-based FAC. See section 8.5 for more information.

8.3.5 Service providers will be scheduled using the following parameters:

8.3.5.1 [13](insert staffing requirements)

8.3.5.2 Staff briefings and debriefings shall be conducted at each shift change.

8.3.6 Service agency staff will likely change daily. A daily roster of personnel shall be maintained.

8.3.6.1 The lead POC for each agency will be recorded by [15](insert procedure).

8.3.6.2 The daily personnel rosters shall be communicated to FAC operations staff by [16](insert procedure).

8.3.7 [11]All staff members shall be credentialed in accordance with the procedures explained in section 7.

8.3.8 Protocols shall be developed to govern staff behavior and procedures for operations. [17](insert role/agency) is responsible for developing necessary protocols.

8.4 Activation. Victim services shall remain based at the FRC until a seamless transition to the FAC can occur—typically 24–48 hours following the incident.

8.4.1 [18](Insert position/agency(s)) shall determine when to transition from the FRC to the FAC.

8.4.1.1 Victims and families shall be notified of the transition from the FRC to the FAC, including the location, date, and time of the transition.

8.4.2 [20](insert position/agency) shall activate the service agencies listed in 8.1.3 [19](or, if preferred, list specific agencies) to begin providing services at the FAC by contacting agency POCs.

8.4.2.1 Following agency activation, agency POCs shall activate their agency's personnel by [23](insert process or reference protocols laid out in section 3).

8.4.3 Activation notifications shall include [24](insert information).

8.4.4 If a central notification system is used to activate administrative staff or service agency personnel, the notification system shall be tested on a [23B](insert timeframe) basis to ensure proper functioning.

8.4.4.1 [23A](insert position/agency) is responsible for ensuring all necessary staff have access to and training on this system.

8.4.5 FAC shall remain open for 8–9 days or until services are no longer needed or are being transitioned to a resiliency center the next business day.

8.5 Location. The FAC shall have a physical location and a website for online access.

8.5.1 [25](Insert position/agency) is responsible for determining the location of the FAC.

8.5.2 The following is a [26]list (and/or link to a GIS map) of preplanned potential FAC facilities.

[26] Name	[26]Facility Address	[26]Occupancy Limit	[26]Point of Contact (POC) Name, Phone Number, and Email	[26A]MOU Dates

8.5.3 In situations that require an alternative site that is not on the list, a site that fulfills the following criteria will be used to select an "on-the-fly" site. [27](select and/or add options from list below)

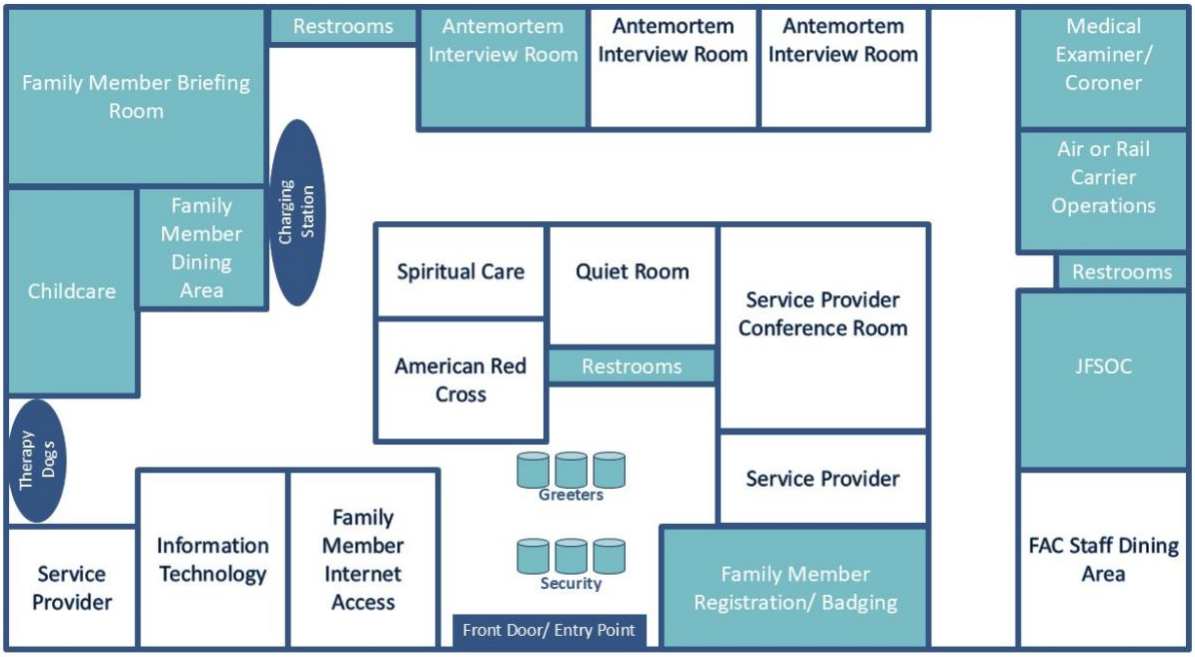
- **8.5.3.1** Out of the line of sight, sounds, and smells of the incident.
- **8.5.3.2** Has communications capabilities, including high-speed Internet and phone lines.
- **8.5.3.3** Offers space for 1:1 meetings with families.
- **8.5.3.4** Adequate parking.
- **8.5.3.5** Access to public transportation.
- **8.5.3.6** Occupancy limits are appropriate to the scale of the incident, allowing adequate space for victims, families, and needed responders.
- **8.5.3.7** Appropriate for the population impacted by the incident.

8.5.4 [21](Insert role/agency) shall be responsible for preparing the FAC facility for operation. Contact [21] (insert POC) at [21] (insert contact info).

8.5.5 The following equipment and materials shall be procured for FAC operations: [28](insert required equipment/materials)

[28]Item	[28]Quantity	[28]Procurement Options

8.5.6 A sample FAC layout is below.



The diagram is a schematic. There are operations/service provider areas not drawn to size or meant to indicate location. Specific FAC layout will be based on the physical facility. Areas indicated in TEAL are critical areas that should be considered when determining the layout of an FAC.

8.5.7 Some victims and family members may not be able to visit the physical FAC location due to hospitalization of victims or inability to travel, for example. A web-based FAC shall be established to provide services in these cases.

8.5.7.1 The web-based FAC will be hosted on [29](insert agency website/domain).

8.6 Communications.

8.6.1 [30](Insert role/entity) shall be the primary conduit for information sharing between victim services at the FAC and emergency management/ICS leadership.

8.6.2 The release of incident-related information shall be approved by [31](insert role) in accordance with the practices detailed in section 6.

8.6.3 Information briefings shall be scheduled for victims and families periodically at the FAC.

8.6.4 Resources that describe assistance and services available at the FAC and online shall be compiled and distributed by [33](insert role/agency).

8.6.4.1 This document shall be updated and distributed daily to navigators and agency personnel.

8.6.5 FAC-specific communications templates can be found [32](insert location, if applicable).

Best Practice 9: Donation Management

Section 1

Best Practice #9: Donation Management *Donation management allows jurisdictions to accept, manage, and distribute solicited and unsolicited resources, including monetary donations, facilities, and goods.*		
	Considerations	**Questions**
Planning Considerations	• Financial and material donations should be considered separate activities. • Develop advisory groups for both material and financial donations. • Be aware of fraud, which is a real circumstance, with people claiming they are victims in order to access financial and material donations. **MATERIAL DONATIONS** • Most jurisdictions have some donations management (typically material items) written into their base plan. In that case, this section may refer to the specific section of the base plan. • The volume and type of material donations will vastly exceed the norm. **FINANCIAL DONATIONS** • There are many nuances to consider regarding financial donations. The National Compassion Fund (NCF) is an excellent resource and has administered more than $95 million in donated funds following CMV/DT incidents since 2014. • Review current statutes, rules, and regulations governing financial support for victims, survivors, family members, and first responders to ensure compliance. • A nongovernmental agency should oversee financial donations to ensure a perception of impartiality. • Crime Victim Compensation is a "payer of last resort," meaning that it will only cover allowable expenses that are not paid through some other source, such as insurance or a civil lawsuit. Other	**MATERIAL DONATIONS** 1. Does your existing Donations Management plan provide the flexibility needed to manage the scope and scale of donations during a CMV/DT incident? If not, what strategies exist to do so? **FINANCIAL DONATIONS** 2. Who will fill the roles on the Financial Advisory Group? 3. Who will convene this group? How often will it meet? 4. What strategies are available to manage the high volume of donations that typically occur following mass violence/domestic terrorism incidents? 5. What strategies will you use to define eligibility and exclusionary criteria for funds immediately following an incident? 6. How can you safeguard the process from fraud? 7. How will you balance the competing interests of public transparency and victim privacy?

	financial issues, such as the effect of monies raised by GoFundMe accounts impacting Crime Victim Compensation payments, should be considered in the overall picture of recovery and donations. For example, if the GoFundMe appeal says, "Help the victim pay funeral expenses or hospital bills," Crime Victim Compensation may consider GoFundMe donations a collateral source benefit, thereby lessening the Crime Victim Compensation payments. • Local law firms and financial managers are useful resources to help the planning group understand current statutes, rules, and regulations governing financial support.	
Services	• Communications regarding funds should include the fact that ongoing needs assessments will be conducted to identify and address emerging and unanticipated needs as they surface. This means that— 1) Distributions will be delayed to accommodate this, and/or 2) A certain percentage of the funds will be withheld until X time to accommodate later assessments. • It is virtually impossible to distribute funds and material goods in a way that makes everyone happy, including disposing of unneeded material goods. **<u>MATERIAL DONATIONS</u>** • The plan shall also include provisions for donated goods. Again, refer to the existing plan to ensure proper integration. • Volunteers are an essential donated service, which comes with various issues. Refer to Best Practice #7 for additional information. • Victim advocates (e.g., liaison, navigator) assigned to victims and family members	8. What timeframe will be set aside to conduct ongoing victim needs assessments? 9. Who will decide if distributions will be delayed to accommodate ongoing assessments or if funds will be held in reserve for unanticipated needs? 10. How will this be communicated to the victims? **<u>MATERIAL DONATIONS</u>** 11. Who are potential corporate donors? 12. How will you manage unsolicited or perishable goods? 13. How will donated goods be distributed to victims and their families? Responders? 14. How will donated goods be transported?

	can help coordinate the disbursement process for goods and services. • Consider leveraging or developing partnerships with local city services to assist in transporting goods and services. • Discussions will need to be ongoing regarding the disposition of unneeded material donations. **FINANCIAL DONATIONS** • In addition to going directly to victims, funds will be needed for recovery initiatives for the overall impacted community and for agency expenses to address these services. • Funds should address unmet needs. • Restricted donations may impact government funding.	**FINANCIAL DONATIONS** 15. How will you include victims in implementing a financial donation management strategy after an incident? 16. How will victim navigation of the donation management process be integrated into or alongside other responding victim services?

Staffing	• Both traditional and nontraditional partners are key to assisting with staffing.
	
	MATERIAL DONATIONS
	• N/A
	
	FINANCIAL DONATIONS
	• Following a CMV/DT incident, a Financial Donation Policymaking Group is needed. The pre-CMV incident group and a post-incident policymaking body may have some of the same members.
	• Include the following specialists in your Financial Donation Policymaking Group:
	  • A mental health professional with a background in psychological trauma
	  • Someone from the medical community
	  • A trusts and estates lawyer
	  • A non-probate lawyer
	  • Development/philanthropy/political fundraising
	  • Large, locally based corporations or industries
		MATERIAL DONATIONS
		17. What existing agency serves as the lead for material donation management?
		18. Who could serve as the donation management coordinator?
		19. Who could be part of a donations management team?
		20. Have you developed a reporting organizational structure that provides clearly defined roles?
		
		FINANCIAL DONATIONS
		21. Who will fill the necessary roles in the post-incident policymaking group?
		22. Who will fill the necessary administrative roles?
		23. What existing 501(c)(3) agency would be willing to collect, track, acknowledge, and disburse monetary donations?
		24. If no existing 501(c)(3) agencies wrote that they could collect, track, acknowledge, and disburse monetary donations in their

	• Media/communications • Victim services representative • Victim of a past mass shooting • In addition to the policymaking group, several administrative roles must be filled to manage donations. These can be found in Appendix A. • Often a nonprofit organization, like the NCF, has the authority to collect, track, acknowledge, and disburse monetary donations. • Government entities should never administer financial donations.	mission statement or board of director's guidance, which agency would be willing to do so, or will you include an outside organization, like NCF? 25. How will you vet organizations operating relief funds?
Activation	Potential ESF Activation: 6 **MATERIAL DONATIONS** • N/A **FINANCIAL DONATIONS** • Victim advocates (system-based, e.g., DA's office, PD), victim compensation, and advocates connected to donated fund administration, etc., will need to coordinate with each other in terms of tasks related to victims, but include all of them in fund distribution. • You will need to identify and describe how policy decisions will be made regarding eligibility and distribution and which body is authorized to make those decisions. Victims and the public will need to know this.	**MATERIAL DONATIONS** 26. Who will coordinate and determine when to activate and implement the plan? 27. How will staff members responsible for the material donations facility be notified of the plan's activation and the reporting date, time, and location? **FINANCIAL DONATIONS** 28. Who will coordinate and determine when to activate and implement the plan? 29. How will participants be notified of the activation of the plan? 30. What actions need to be taken to receive, manage, and distribute cash contributions? 31. Who will cover the administrative costs of managing financial donations?
Location/Material Resources	**MATERIAL DONATIONS** • Consider storage for large quantities of material goods. • Because material donations may arrive in a tractor-trailer, a facility with a loading dock is most appropriate.	**MATERIAL DONATIONS** 32. What facilities/locations may be used as a staging area for material donations and transportation vehicles? 33. How will donations be tracked?

	• Because donations may be palletized, forklifts and pallet jacks are useful equipment at a material donations facility. **FINANCIAL DONATIONS** • N/A	34. What equipment will you need in a material donations facility? **FINANCIAL DONATIONS** 35. Do you have a web-based program for donations from the public?
Communication	• Most jurisdictions likely have a communications plan. • The Communications/Public Information Officer (PIO) Branch should release media information to publicize the established methods for donating materials and monies. See Best Practice #6 for more information. • Specificity about donation needs is incredibly important. **MATERIAL DONATIONS** • Ensure victims and advocates are informed of centralized numbers, email, and text that can be used in communications to let people know how to contact the appropriate groups for donations. • Sometimes material donations are made available directly to the victims (teddy bears, quilts, etc.). This information should be funneled to victims and families through the FAC and Resiliency Center. **FINANCIAL DONATIONS** • It is best practice to make a single statement to the public regarding the use of funds. This statement should explain that funds will be distributed to both victims and victim-serving agencies. • Incorporate fraud alerts and consumer protection announcements into any public communications related to donations.	36. How will the public be informed of the proper donation channels? 37. How will the comprehensive list of victims complied in BP #5 be shared with this committee? 38. Is there a centralized number, email, or text that can be used to let people know how to contact the appropriate groups for donations? Will a call center be used? 39. How will victim input and feedback be incorporated? **MATERIAL DONATIONS** 40. How will information about specific donations intended for victims and families be given to the FAC and Resiliency Center? **FINANCIAL DONATIONS** 41. How will victims be kept informed of available funds, eligibility, and the process for obtaining funds?

Section 2A: Material Donations

BP #9 Donation Management
Potential ESF Activation: 6

Note: Most jurisdictions have a material donation management plan as part of its All-Hazards plan. In that case, this section may simply refer to the relevant section in the All-Hazards plan.

9.1 High volumes of material donations typically occur during and after mass violence/domestic terrorism incidents. Strategies available to manage these donations include:

- **9.1.1** Ongoing needs assessments shall be conducted to determine solicitation of material goods. Needs assessments will be conducted on a [8](insert timeframe) basis.
- **9.1.2** Unsolicited goods will be managed by [12](insert strategies).
- **9.1.3** Perishable goods will be managed by [12](insert strategies).
- **9.1.4** [1](Insert additional donation management strategies)
- **9.1.5** Donated goods will be transported by [14](insert partners and/or strategies).

9.2 **Activation.** The Material Donations Management Plan will be activated by [26](insert agency/title responsible for activating the plan).

- **9.2.1** Staff members will be notified of the plan activation and the reporting date, time, and location by [27](insert method used to notify staffing members).

9.3 **Location and Material Resources.** Material donations require a facility to house them.

- **9.3.1** [33](Insert the web-based donation program used by the jurisdiction) is the web-based program that (jurisdiction) will use to track donations received from the public.
- **9.3.2** The following list (and/or link to a GIS map) of preplanned facilities can serve as staging areas for material donations and transportation vehicles.

[32]Facility/Location Name	[32]Facility/Location Address	[32]Size/Area of Facility	[32]Facility POC Name, Phone Number, and Email	[32]MOU Dates

- **9.3.3** The following baseline equipment and materials will be needed to operate a material donations and transportation vehicle staging area:

[34]Item	[34]Quantity	[34]Procurement Options

9.4 Staffing. The material donation management team will be led by [17](insert role/agency).

9.4.1 The reporting structure for the donation management staff is as follows:
[20](Insert org chart)

9.4.2 Additional roles and responsibilities will be filled by:

Role	Agency Name	Agency POC Name, Phone Number, and Email	Alternate POC
Donation Management Coordinator	18	18	18
Donation Management Team Member	19	19	19
(Other)	Other	Other	Other

9.4.3 The Donation Management Coordinator or designee will develop staffing plans for material donations.

9.5 Allocation.

9.5.1 Goods and services will be distributed according to the following process and parameters:

9.5.1.1 [13](Victims - Insert process and parameters)

9.5.1.2 [13] (Families – Insert processes and parameters)

9.5.1.3 [13] (Responders – Insert processes and parameters)

9.5.2 A comprehensive list of victims shall be shared with those distributing donated material goods by [37](insert process) to ensure goods are distributed appropriately.

9.5.3 Information about specific donations intended for victims and families will be shared with the FAC and Resiliency Center by [40](insert process).

9.5.4 [9](Insert role/agency) shall determine if distributions will be delayed or held in reserve to accommodate ongoing needs assessments and/or unanticipated needs.

9.5.4.1 Should donations be held in reserve, this will be communicated to victims by [10](insert role and/or process)

9.5.5 As victims provide input and feedback on donated goods, services, and collections and distribution procedures, [39](insert who will be responsible for collecting this input) will work with [39] (insert who will work to incorporate changes needed based on feedback) to incorporate appropriate changes to the donations plan.

9.6 Public Communication.

9.6.1 All incident-related information shall be funneled through the incident PIO in accordance with the procedures described in Best Practice 6.

9.6.2 The following outlets may be used to inform the public of current needs and proper donation channels

[36]Outlet Type (e.g., social media, TV, newspaper)	[36]Outlet Name	[36]Outlet POC Name	[36]Outlet Contact Information

9.6.3 Donations may be directly solicited from the following corporate donors:

Corporation Name	Contact Information	Potential Donation Description

9.6.4 Should individuals or corporations have questions regarding donations, they will be directed to contact [38](insert email, phone number, agency, etc.).

Section 2B: Financial Donations

BP #9 Donation Management
Potential ESF Activation: 6

9.1 Donated funds shall be used to address unmet needs and shall not duplicate or supplant established victim funds (state and federal).

9.2 Financial Donation Management shall operate using two distinct leadership bodies: an advisory group and a policymaking group.
- **9.2.1** Advisory Group: This group operates pre-incident.
- **9.2.2** Policymaking Group: This group operates post-incident.
- **9.2.3** The pre-incident advisory group and post-incident policymaking group may have some of the same members.

9.3 **Pre-Incident Advisory Group** exists to get different entities on the same page and clarify roles should a CMV/DT incident occur.
- **9.3.1** Victims Compensation, law enforcement, and [2](insert additional members) should be involved in the advisory group.
- **9.3.2** [3](Insert role/entity) is responsible for convening the group on a [3](insert timeframe) basis.
- **9.3.3** Examples of clarifying processes and procedures include:
  - **9.3.3.1** Victim compensation needs to clarify whether or not victim funds are considered a collateral source benefit so gifts can be structured appropriately to avoid duplication.
  - **9.3.3.2** Law enforcement must consider how they will organize victim statements from a large group of victims. Concerns with the process, scope, and scale can be addressed pre-incident. Existing systems will be used post-incident, as there is no time to create new systems.

9.4 **Post-Incident Policymaking Group** includes members with explicit authority to make decisions and set policies that will be followed when funds are structured, solicited, managed, and distributed. This group will develop a donation management strategy and assist in fund administration.
- **9.4.1** The Policymaking Group shall consist of the following members:

[21]**Financial Donation Policymaking Group Members**	[21]**Point of Contact (POC) Agency, Phone Number, and Email**	[21]**Alternate POC**
Mental health professional with a background in psychological trauma		
Medical professional (HIPAA issues, etc.)		

Trust and estates attorney		
Non-probate attorney		
Individual with development, philanthropy, or political fundraising experience		
Large, locally based corporations or industries		
Communications/media specialist		
Victim services representative		
Victim of a past mass shooting		

9.5 **Fund Administration.** Several administrative roles are needed to administer funds following a CMV/DT incident. These are in addition to the policymaking group.

9.5.1 Roles will be filled by the following:

Role	Filled By	Contact Information
Lead Administrator	22	22
Finance	22	22
Victim Specialist	22	22
Communications	22	22
Technology	22	22

9.5.2 A lead agency is required for financial donations. Monetary donations will be collected, tracked, acknowledged, and dispersed by [23/24](insert willing 501(c)(3) or outside organization(s)).

9.5.2.1 Organizations' operating funds will be vetted by [25](insert protocol).

9.5.2.2 [35](Insert platform) will be used to collect donations from the public.

9.5.3 Administrative costs of managing financial donations will be covered by [31](insert how administrative costs will be covered/reimbursed).

9.5.4 The following strategies can be used to manage the high volumes of donations that arise following a CMV/DT incident.

9.5.4.1 [4](Insert strategy)

9.6 [28](Insert role/agency) shall determine when to activate and implement a financial donation plan and coordinate group members.

9.6.1 Members of the policymaking group and administrative staff will be notified of plan activation and the date, time, and location of meetings by [29](insert method and process used to notify staff members).

9.6.2 Once activated, take the following steps to receive, manage, and distribute cash contributions.

9.6.2.1 Ongoing needs assessments shall be conducted to determine solicitation of financial donations. Needs assessments will be conducted on a [8](insert timeframe) basis.

9.6.4.1 The policymaking group shall determine whether all donated funds will go directly to victims or if some funding will be designated to support community initiatives and service agency expenses not covered by other funding sources.

9.6.2.2 [30](insert additional steps to receive, manage, and distribute cash donations)

9.6.3 Include victims in the implementation of a financial donation management strategy. This can be done by:

9.6.3.1 [15](Insert strategies to incorporate victims)

9.6.3.2 As victims provide input and feedback on financial donation collection and distribution procedures, [41](insert who will be responsible for collecting this input) will work with [41] (insert who will work to incorporate changes based on feedback) to incorporate appropriate changes to the donations plan.

9.7 Distribution.

9.7.1 Share a comprehensive list of victims with those distributing donated material goods by [37](insert process) to ensure goods are distributed appropriately.

9.7.2 The following strategies may be used to define eligibility and exclusionary criteria for funds immediately following an incident.

9.7.2.1 [5](Insert strategy)

9.7.3 Financial donation administration can be safeguarded from fraud by:

9.7.3.1 [6](Insert strategy)

9.7.4 Keep victims informed of available funds, eligibility, and processes for obtaining funds by [41](insert process).

9.7.4.1 Funding opportunities shall be integrated into and alongside other victim services.

9.7.5 [9](Insert role/agency) shall determine if distributions will be delayed or held in reserve to accommodate ongoing needs assessments or unanticipated needs.

9.7.5.1 Should donations be held in reserve, [10](insert role and/or process) will communicate this to victims.

9.7.6 The policymaking group and administrative staff should develop plans to address dissatisfaction with how funds are allocated.

9.7 Public Communication.

9.8.1 The interests of victim privacy and public transparency will often be at odds. This will be balanced by [7](insert how the discrepancy will be handled).

9.8.2 Donated funds shall be characterized accurately at the time of solicitation to ensure compliance with donor intent.

9.8.2.1 This includes specifying whether all donated funds will go directly to victims or if some funding will be designated to support community initiatives and service agency expenses not covered by other funding sources.

9.8.3 All incident-related information shall be funneled through the incident PIO in accordance with the procedures described in Best Practice 6.

9.8.4 The following outlets may be used to inform the public of current needs and proper donation channels.

[36]**Outlet Type (e.g., social media, TV, newspaper, etc.)**	[36]**Outlet Name**	[36]**Outlet POC Name**	[36]**Outlet Contact Information**

9.8.5 Fraud alerts and consumer protection announcements should be included in public communications related to financial donations.

9.8.6 Should individuals or corporations have questions regarding donations, they will be directed to contact [40](insert email, phone number, agency, etc.).

Best Practice 10: Memorials and Special Events

Section 1

Best Practice #10: Memorials and Special Events *This section focuses on spontaneous memorial sites that develop and special events that occur within the first 2–4 weeks after an incident.*		
	Considerations	**Questions**
Planning Considerations	• Memorials, vigils, and other special events may be very spontaneous and require flexibility and rapid response by the community to ensure safety. This is especially true for dignitary visits, which are likely to include state and federal officials. • Jurisdiction should include the proper departments and agencies (e.g., law enforcement, emergency management, victim services, public works, Department of Transportation, public health, public information officers, and elected officials). • The media and the public often inundate funerals and memorials. • Spontaneous memorials near the incident site will result in significant numbers of cards, items, and photos at the location. These need to be protected. • You can't save everything from the memorial sites; organic materials can't be saved, paper items blow away, fragile items are sometimes broken, and larger items may be a public hazard. • Manage items to allow for consideration of possible inclusion in a permanent memorial. • Memorial items that are left to honor a specific victim should be offered to the victim's family. • Law enforcement tributes with lights and sirens, church bells ringing, and 21-gun salutes may re-traumatize victims.	1. Which departments and agencies should be included in the planning process for memorials and special events? 2. Who will serve as the lead for planning memorials and special events? 3. What liability issues arise from conducting memorials and special events, including visiting the incident site? 4. How might the jurisdiction manage items left at spontaneous memorial sites?

Services	• Victim and family participation is always voluntary.
	• Respect for the victims is essential.
	• Victim services may be asked to take a more active role in these activities.
	• Events that can be expected include:
	  ○ Joint vigil/memorial
	  ○ Incident site visit for victims/families
	  ▪ Site visits are secure and private for victims and families, with support services (mental health and spiritual care support) in attendance. The FBI and Red Cross have experience with orchestrating site visits. No media, politicians, or speeches.
	  ○ Dignitary visits
	  ○ Spontaneous memorial sites
	
	<u>PERMANENT MEMORIAL</u>
	• The permanent memorial will likely take years to plan and fall outside this document's parameters.
	• Words matter. The word "remembrance" is preferred over the word "anniversary." Anniversaries are typically happy occasions.
		5. How will victims be kept informed or included in the planning of memorials or special events?
		6. When family/friends plan an event, will the jurisdiction provide support to assist with event coordination if requested?
		7. When family/friends plan an event, will jurisdiction serve as a liaison if requested?
		8. If support is requested, will the jurisdiction provide support to a private organization that planned an event?
		9. Which organizations can assist with or serve as liaisons for these events?
		10. Which organizations can assist with securing transportation to these events for families and victims if needed?
		11. What services will the jurisdiction provide for safety and security (fire, police, EMS)? Who will develop the security staffing plan?

Staffing	• Both traditional and non-traditional partners are key to helping with staffing. • Victim advocates, mental health care, and spiritual care provide support and should stay in the periphery at memorials/vigils with minimal identifiers (lanyards or basic victim advocate jackets). They should keep an eye out for	12. Who in your jurisdiction will lead/coordinate a memorial or special event? 13. Which departments or agencies will be responsible for collecting the items left at spontaneous memorials? 14. What department or agency within the community can be responsible for documenting the memorials

	individuals who might need emotional or other support. • Faith-based leaders will often coordinate a vigil/memorial. • Law enforcement and public works personnel will often provide safety and security for participants.	(spontaneous and planned) and vigils? 15. What agency can be responsible for watching social media for information about memorials and vigils being planned outside the official response? 16. Who in your jurisdiction will decide if support is needed for events that initiate outside of the official response? 17. Who in your jurisdiction will assist with transportation routes and street closures? 18. Are additional roles needed to support a memorial or special event? 19. What additional responsibilities need to be covered?
Activation	**Potential ESF Activation: 5, 6, 7, 8, 15** • Many vigils and gatherings will be planned outside of the official response. These may require official support if they become large.	20. Who will determine when a memorial or special event should be hosted? 21. How will support staff members be notified that an event is being planned? 22. Who will obtain the necessary approvals or paperwork if permits or approvals are needed? 23. Who will be responsible for funding approval if there are costs associated with a memorial or special event?

Location/Material Resources	• Collaborate with the landowner where physical memorials are located to decide when memorials should be relocated. • Written notice should be posted at the site 24–48 hours before moving/removing memorials that indicate where items will be moved. This information should also be given to all navigators working with families, distributed by PIOs, and posted on all social media and websites. • Museums have created an informal support network to share lessons learned about preserving items left at spontaneous memorial sites. • Memorial items that will be placed in a museum need to be curated and archived. • The intake, cataloging, and archiving of memorial site items can take a museum several years to complete. • Museums keep most of their artifacts in temperature-controlled storage, which requires space and funding.	24. What facilities are available to host memorials or special events? 25. What material resources will be needed to host memorials or special events, such as barricades, safety lighting, etc.? 26. What facilities are available to store items collected from memorials until a determination of disposition is made?
Communication	• Inform victims and families of memorials and special events.	27. How will victim input and feedback be incorporated? 28. How will communications about memorials and special events be shared with the public?

Section 2

BP #10: Memorials and Special Events
Potential ESF Activation: 5, 6, 7, 8, 15

10.1 Memorial vigils and special events tend to be very spontaneous—both in timing and location. They require flexibility and rapid response by the community to ensure safety. The jurisdiction shall plan to manage or assist with site visits, memorials, vigils, and other special events that arise. Events will include but are not limited to dignitary visits, politician visits, and candlelight services.

10.2 Memorials and special events may be hosted or coordinated by numerous entities, including, but not limited to, jurisdictions, victims, families, community members, and private organizations.

10.1.1 At the jurisdiction level, the following may determine that they should host, lead, or coordinate an event.

[12] Official/Agency Name	[12] Name, Phone Number, and Email	[12] Alternate POC

10.1.2 When family/friends plan an event, the jurisdiction [6](will/will not) provide support to assist with event coordination if requested.

10.1.3 When family/friends plan an event, the jurisdiction [7](will/will not) serve as a liaison if requested.

10.1.4 When private organizations plan an event, the jurisdiction [8](will/will not) provide support if requested.

10.1.5 For events that initiate outside of the official response, [16](insert role/agency) will decide if support is needed.

10.3 The families' wishes and respect for the victims are essential when determining the details of a memorial or special event.

10.3.1 Victims and families shall be informed of special events by [5](insert primary conduit and general methods)

10.3.2 Victim input and feedback will be incorporated by [27](insert general methods)

10.4 A planning group shall be convened when the jurisdiction agrees to lead or assist with memorials or other special events. This group will be led by [2](insert position/agency).

10.4.1 Other group members include:

[1,9]Planning Group Members	[1,9]Point of Contact (POC) Agency, Phone Number, and Email	[1,9]Alternate POC

10.4.2 This planning group, in coordination with [20](insert role/entity, if needed), will determine when a memorial or special event should be hosted.

10.4.3 A permanent memorial committee will develop later in the process and is outside the scope of this annex.

10.5 **Safety and Security.** The jurisdiction can/will provide the following safety/security services for approved memorials and special events.

10.5.1 [11](Insert safety and security services)

10.5.2 Security plans and staffing for a memorial, vigil, or special event will be developed by [11](insert who is developing) and staffed by [11](insert who will provide security staff).

10.6 **Staffing.** In addition to safety and security (10.5.1), many roles and responsibilities must be covered for memorials or special events.

Responsibility	Agency/Organization Managing	POC Name and Contact Information
Transportation routes and street closures	17	17
Obtaining permits or other approvals	22	22
Tracking costs and obtaining funding approvals	23	23
Securing transportation for victims and families, if needed	10	10
Documentation (photos, articles, etc.)	14	14
Monitoring social media for information about events planned outside of the official response	15	15
18/19	18/19	18/19

10.6.1 The role of a victim advocate at a memorial site is one of support.

10.6.1.1 Victim advocates, mental health providers, and spiritual care providers should stay in the periphery, with minimal identifiers such as lanyards or basic victim advocate jackets.

10.6.1.2 Victim advocates shall keep an eye out for individuals who might need emotional or other support during the memorial or special event.

10.6.2 Staffing members will be notified of the memorial plans and the reporting date, time, and location of memorials, vigils, and special events by [21](insert method used to notify staffing members).

10.7 Location. The following is a list (and/or link to a GIS map) of preplanned facilities for memorials, vigils, and special events—other than site visits—which will occur at the incident scene.

[24] Facility Name	[24] Facility Address	[24] Size/Area of Facility	[24] Facility POC Name, Phone Number, and Email	[24] MOU Dates

10.7.1 The site shall have all utility and communications capabilities required to host memorials, vigils, or other special events or the willingness and ability to install them temporarily.

10.7.2 The following is a list of equipment and materials that will be needed to host memorials, vigils, or special events:

[25] Item	[25] Estimated Quantity	[25] Procurement Options

10.8 Spontaneous Memorials near the incident will result in a significant number of cards, photos, flowers, stuffed animals, and other items.

10.8.1 Items left at spontaneous memorials will be [4](insert general guidance for managing items).

10.8.2 It is important to collaborate with the landowner where memorials are located to decide when memorials should be relocated.

10.8.3 [13](Insert role/agency) shall be responsible for collecting items left at spontaneous memorials.

10.8.4 Items left to honor a specific victim shall be offered to that victim's family. The family shall determine whether to keep, dispose of, or donate the item(s) to a future permanent memorial. They may also decide they are not yet ready to make this decision.

10.8.5 All collected items shall be packaged and cataloged until a final determination of disposition is made.

10.8.6 Some of the memorial items may be placed in a permanent display or archived in the future to preserve the memorials. The following locations will be used to store these items until a plan is finalized. The finalization of a plan may take years.

[26]Facility	[26]Address	[26]POC Name and Contact Info

10.9 [28](Insert communication avenue) will be the primary conduit for informing the public of memorial, vigil, and special event-related information when appropriate. [28] (Insert position/organization) will approve the release of all memorial, vigil, and special event-related information. Reference the [28] (insert existing plan) to review current communications or social media strategies.

10.9.1 The following outlets may be used to broadcast information related to the memorial, vigil, and special event when appropriate/as needed.

[28]Outlet Name	[28]Outlet POC Name	[28]Outlet Contact Information

Best Practice 11: Community Behavioral Health

Section 1

Best Practice #11: Community Behavioral Health *Community Behavioral Health may be called upon to assist with the psychological first aid needs of victims and the community immediately after an incident. They will also assess and build capacity to meet the ongoing and increased needs for services due to a CMV/DT incident.*		
	Considerations	**Questions**
Planning Considerations	• Behavioral health encapsulates mental health, addiction, psychiatry, and overall physical wellness such as sleep, nutrition, exercise, etc. • Mental health is narrower in scope and looks at emotional health and mental health treatment. • Behavioral health leadership should develop immediate, short-term, and long-term response plans. • A subcommittee (see Best Practices 2 and 3) will be activated during an actual incident to deploy immediate responders and explore funding options for behavioral health services. **<u>IMMEDIATE RESPONSE</u>** • Psychological first aid support is the recommended response to mass violence incidents during the immediate and short-term responses. Stabilization and normalization of reactions are the goals. • Extensive coordination with agencies (e.g., state emergency preparedness organizations, state mental health providers, National Organization for Victim Assistance, and local Best Practices of the American Red Cross and the United Way) and federal and state law enforcement and prosecution personnel are necessary components of an effective immediate response to mass violence.	1. What agencies should be represented on the Behavioral Health Subcommittee? 2. How will state and/or county disaster mental health and spiritual care response teams be included in the plan? 3. What VOAD/COADs in the community need to be included in the behavioral health plan? 4. What state statutes and regulations exist regarding contracts with mental health providers? 5. Which existing entities within the jurisdiction provide behavioral health services?

	LONG-TERM • Once victims are ready for more traditional treatment, use evidence-based interventions for long-term treatment. • Additional psychological needs may emerge as time progresses and people find it difficult to go home or function well at work. The Resiliency Center will continue to assess the needs of victims as time progresses. (See Best Practice 14.)	
Services	**IMMEDIATE RESPONSE** • The lead law enforcement agency and prosecution will determine who will be considered a legal victim of the incident. This impacts who is eligible to receive state or federally funded victim services. • An initial and ongoing assessment of victims' needs should be conducted at the FRC and FAC. This will help determine what essential services are needed at the FAC (see Best Practice 8) and later at the Resiliency Center (see Best Practice 14). • Individuals who share the experience of a mass violence incident do not necessarily share the same traumatic reactions. • Trained mental health professionals can identify individuals who may have pre-existing issues or be in extreme distress. • Engage a holistic approach, which includes diverse faith or spiritual healing practices, to support survivors and surviving family members long-term; however, remember that not all victims are religious or spiritual. • Initial efforts by mental health professionals should focus on	6. Once it is determined who will be considered a legal victim, how will that information be communicated to those involved in the response and the public? 7. How will a comprehensive list of those who are eligible for services be compiled and shared among agencies? 8. How will you ensure victims who want to access follow-up services are connected to linkage services and funded resources, such as those found at the Resiliency Center or program? (See Best Practice 14.) 9. How will the behavioral health response ensure that there are multiple methods for accessing needed care (i.e., as many "open doors" as possible) and that alternative interventions are included?

	providing compassionate support and information to help victims cope and bolster resilience. **LONG-TERM** • Service linkage and tracking should shift to the Resiliency Center once it opens. • Many victims benefit from grief counseling, but this type of counseling generally is more appropriate at a later time as individuals adjust to day-to-day life. • Address the potential for increased risk of substance, physical, sexual, and emotional abuse.	
Staffing	**IMMEDIATE RESPONSE** • The Behavioral Health subcommittee should designate a POC to oversee the immediate coordination of providers for the FRC and FAC. • Behavioral health community providers must be represented on the funding team (see Best Practice 13). • Staff impacted by the incident will likely be working through their own trauma and should not be assigned to provide behavioral health care to others. **LONG-TERM** • An appropriate trauma therapist must be knowledgeable and trained about evidence-based trauma treatments and practices, particularly those that are effective in treating victims and survivors of violent crime.	10. Which providers can supply bilingual professionals when needed? 11. How will behavioral health service providers be included in the incident management organizational structure? 12. What roles are needed? 13. What responsibilities need to be covered?

Activation	**Potential ESF Activation: 6, 8** **IMMEDIATE RESPONSE** • Trained mental health and spiritual care teams and victim advocates should be deployed to the FRC (see Best Practice 4) and the FAC (see Best Practice 8) to provide psychological first aid support to victims and loved ones. • These trained teams will provide psychological first aid and support to victims, families, and loved ones. They may also assist victim advocates with navigation to services in the FAC. • Communities can always rely on the Disaster Distress Helpline at 1-800-985-5990 (call or text). **LONG-TERM** • Behavioral health support and referrals to behavioral health care in the community will transition to the Resiliency Center. (See Best Practices 8 and 14 for more information.)	14. How will incident-specific behavioral health services be coordinated? 15. How will you notify/activate credentialed mental health professionals, victim advocates, and crisis counselors? 16. Who is responsible for ensuring volunteers are managed according to the standards set in BP #7? 17. Who is responsible for activating and staffing the hotline, if applicable? 18. Who is responsible for documenting which agencies are providing services? 19. How will the jurisdiction continue to ensure services are available and coordinated after the immediate response to the incident?

Location/Material Resources	**IMMEDIATE RESPONSE** • Behavioral health teams may be available in the jurisdiction through VOADs (e.g., National Organization for Victim Assistance, American Red Cross, or Salvation Army) and through state or county-developed and maintained teams. • Federal grants may be available to fund or reimburse jurisdictions for the provision of behavioral health services. Applying for this funding is time-sensitive after a CMV/DT incident. (See Best Practice 13.) **LONG-TERM** • A list of behavioral health services with the capacity to work with victims for the long term should be developed by the Behavioral Health subcommittee. This list should be available during FAC and Resiliency Center operations for referrals. • Victims will need to bypass standard waitlists. • Funding may be available to supplement the local resources and services to ensure that resources are sufficient and not diverted to CMV/DT victims to the detriment of other crime victims. (See Best Practice 13.) • Referrals should be tracked for reporting, funding, and auditing purposes. This will be completed at the Resiliency Center if one is opened, but tracking is needed regardless of whether there is a Resiliency Center. • Unfortunately, many individuals are interested in providing services right after an incident, but as the months go by and the news cycle changes, people may lose interest.	20. How will you fund immediate behavioral health services at the response locations? 21. Who is responsible for developing a list of behavioral health agencies that are willing and have the capacity (or are willing to bypass existing waitlists) to work with victims? 22. How will referrals to behavioral health professionals be provided to victims? 23. How will referrals be tracked?

Communication	**IMMEDIATE RESPONSE** • All public communication should be approved by the incident PIO. (See Best Practice 6 for more information.) • PIOs should communicate that trained behavioral health and spiritual care support is available for victims at all service locations. • PIOs should communicate to unaffiliated/spontaneous behavioral health volunteers where they should report (e.g., Volunteer Intake Center) so they don't arrive at service sites where victims are gathering. **LONG-TERM** • Ensure victims are informed of the behavioral health services available. • First responders may also need behavioral health services but may be reluctant to seek them. Therefore, additional communication efforts may be necessary to encourage first responders to seek services when needed. (See Best Practice 12.) • Ensure victims and advocates are informed of centralized numbers, email, and text they can use to get information on acquiring behavioral health services.	24. How will behavioral health services information be shared with victims? 25. How will communications about behavioral health services be shared with those involved in the response? 26. How will victims be informed of changes to the call center or centralized phone numbers? 27. How will victim input and feedback about services be collected and analyzed?

Section 2

BP #11: Community Behavioral Health
Potential ESF Activation: 6, 8

11.1. Behavioral health encapsulates mental health, addiction, psychiatry, and overall physical wellness such as sleep, nutrition, exercise, etc.

11.1.1. Mental health is narrower in scope and looks at emotional health and mental health treatment.

11.1.2. To the greatest extent possible, proposed mental health interventions should be evidence-based/empirically supported treatments or evidence-based practices.

11.2. [4] These state statutes and regulations regarding contracts with mental health providers will be followed:

11.3. A Behavioral Health subcommittee shall develop plans for immediate, short-term, and long-term response.

11.3.1. The following entities/organizations should be represented on the Behavioral Health subcommittee:

[1] **Entity/Organization**	[1] **Point of Contact (POC) Agency, Phone Number, and Email**	[1] **Services Provided**

11.4. [2, 3] (Insert method used) will ensure that state and/or county disaster mental health, spiritual care response teams, and VOADs/COADs will be included in the plan.

11.5. The following entities/organizations within the jurisdiction, including faith-based organizations, can provide behavioral health services:

[5] Entity/Organization	[5] Point of Contact (POC) Agency, Phone Number, and Email	[5] Services Provided

11.6. Services. The prosecutor and lead law enforcement agency will determine who will be considered a legal victim.

11.6.1. Once the definition of who will be considered a legal victim is determined, [6](insert method used) will communicate that information to those involved in the response and the public.

11.6.2. Individuals who share the experience of a mass violence incident do not necessarily share the same traumatic reactions.

11.6.3. A thorough assessment is essential to determine the mental health needs of mass violence survivors.

11.6.4. Engage a holistic approach, which includes diverse faith or spiritual healing practices, to support survivors and surviving family members long-term; however, remember that not all victims are religious or spiritual.

11.6.5. Initial efforts of mental health professionals should focus on providing compassionate support and information to help victims cope and bolster resilience.

11.6.6. Many victims may benefit from grief counseling, but this type of counseling is generally more appropriate at a later time as individuals adjust to life.

11.6.6.1. (Insert agency/department responsible) will be responsible for determining who will be eligible for behavioral health services by [7](insert process used to determine eligibility).

11.6.6.2. [7]Once a comprehensive list of those who are eligible for services is compiled, (insert method used) will be used to share this information among agencies.

11.6.6.3. [8](Insert method used) will be used to ensure victims who want to access followup services are connected to linkage services and funded resources, such as those found at the Resiliency Center or other programs. (See Best Practice 14.)

11.6.6.4. [9](Insert method used) will ensure that there are multiple behavioral health response methods for accessing needed care (i.e., as many "open doors" as possible) and that alternative interventions are included.

11.7. Organizational Chart/Staffing. In the aftermath of a mass violence/domestic terrorism incident, communities are often inundated with offers of help and support. An appropriate trauma therapist must be knowledgeable and trained about evidence-based trauma treatments and practices, particularly those that are effective in treating victims and survivors of violent crime.

11.7.1. Provider credentials shall be vetted by (insert vetting process).

11.7.2. Behavioral health service providers may be included in other organizational structures, such as the Family Assistance Center structure. If there is a need for a separate

organizational structure, the following organizational chart will be used. [11](The organizational chart identifying reporting structure for behavioral health services should be inserted here.)

11.7.3. The roles and responsibilities of staffing for a behavioral health team include:

[12, 13] Role	[12, 13] Responsibility(s)	[12, 13] Providing Agency	[12, 13] Agency POC	[12, 13] Backup POC

11.7.4. Bilingual service providers can be overlooked during staff planning. The following providers include bilingual professionals:

[10] Entity/Organization	[10] Point of Contact (POC) Agency, Phone Number, and Email	[10] Services Provided

11.8. Activation. Behavioral health services are needed throughout the response and recovery of an incident. Services may be included from the immediate response through the Family Assistance Center and long-term recovery at the Resiliency Center.

11.8.1. Behavioral health needs may change as time progresses. More psychological needs may emerge later when people find it difficult to go home or function well at work.

11.8.2. (Insert department/agency responsible) will be responsible for coordinating incident-specific behavioral health services.

11.8.3. [14] (Insert method used) will be used to coordinate incident-specific behavioral health services.

11.8.4. [15] Credentialed mental health professionals, victim advocates, and crisis counselors will be notified of the activation of their services and the reporting date, time, and location, if appropriate, by (insert method used to notify staffing members).

11.8.5. [16] (Insert department/agency responsible) will be responsible for ensuring volunteers are managed according to standards set in BP #7.

11.8.6. [18] (Insert department/agency responsible) will be responsible for documenting which entities/organizations are providing/have provided services.

11.8.7. [19] The following actions need to be taken to ensure services are still available after the immediate response to the incident:

11.8.8. [17] When/if it is determined that a hotline should be made available to assist victims or provide them with behavioral health service options/locations, (insert agency/department responsible) shall be responsible for activating and staffing the hotline.

11.9. Location and Material Resources. Low-cost or no-cost behavioral health providers may be available to assist in the immediate aftermath of an incident. Federal grants may also be available to fund or reimburse jurisdictions for the provision of behavioral health services.

11.9.1. [20] Costs associated with providing these services may be covered by (insert exercise funding options).

11.9.2. Behavioral health services will be provided at the following locations:

Facility Name	Facility Address	Facility Hours
EX: Stand Alone Facility Name		
EX: Family Assistance Center		
EX: Resiliency Center		
EX: Private Office by Referral		

11.9.3. [21] (Insert agency/department responsible) will be responsible for developing a list of behavioral health agencies that are willing and have the capacity (or are willing to bypass existing waitlists) to work with victims.

11.9.4. [22] Victim referrals to behavioral health professionals will be provided by (insert method used).

11.9.5. [23] Victim referrals will be tracked by (insert method used).

11.10. Communication. (Insert agency/department responsible) will be responsible for informing the victims of available behavioral health services.

11.10.1. [24] (Insert communication avenue) will be the primary conduit for informing the victims of available behavioral health services.

11.10.2. [25] (Insert communication avenue) will be the primary conduit for sharing behavioral health service information with those involved in the response.

11.10.3. [26] (Insert agency/department responsible) will be responsible for informing the victims of changes to hotlines or call centers for behavioral health services available via (insert communication avenue).

11.10.4. [27] (Insert agency/department responsible) will be responsible for collecting and analyzing victim input and feedback about the behavioral health services provided via (insert method used).

Best Practice 12: First Responder Support

Section 1

Best Practice #12: First Responder Support *CMV/DT incidents can be more challenging for many responders than more common critical incidents. Therefore, jurisdictions must prepare for more complicated and longer-lasting support and behavioral health needs of responders following a CMV/DT incident.*		
	Considerations	**Questions**
Planning Considerations	• This section encompasses traditional first responders like police, fire, EMS, and all others responding to the incident. This includes emergency management, FRC/FAC staff, behavioral health providers, etc. • Mass violence/domestic terrorism incidents place tremendous amounts of pressure on responders. • It is important that jurisdictional plans, policies, procedures, and training materials include language or guidance informing responders that support and counseling will be available following CMV/DT incidents. • Not every off-duty responder who arrives at a mass casualty incident will check in, even if an Incident Command Post is established. • Off-duty responders may need to self-identify the role they play in a response. For example, following the 1 October shooting, all police officers were mandated to author a memo detailing their actions. This assisted with recognition and the provision of mental health services. • Funding through OVC defines first responders as indirect	1. Which jurisdictional plans, policies, procedures, and training materials address the possible need for first responders to access support and services following mass casualty incidents? 2. Other than check-in at the Incident Command Post, what process can be used to track off-duty responders who self-deploy to a mass casualty incident? 3. What process will the jurisdiction use to make support available to first responders—including the command staff—as they demobilize from each shift? 4. What process will be used to offer support and services to the families of first responders? 5. What process will ensure that situational updates are shared with first responders?

	victims of a mass violence incident. This ensures that resources are available for their needs related to the incident. • While all responders are at risk, care for responders who provide direct patient care, triage, and fatality management should be included in short-term and long-term after-incident care plans. • During incidents of mass violence, first responders may transport victims to hospitals in unconventional vehicles such as patrol cars. This may have a psychological impact and pose legal challenges. • Routine exposure to violence can make it difficult for responders to admit that they need to talk about an incident. • Trauma that surfaces for responders during a CMV/DT incident may be from previous trauma that wasn't addressed. • Experience from previous incidents indicates that supportive services for responders should be available at all stages of the response and recovery. • Demobilization at the end of a shift can be more challenging for first responders during a mass violence or domestic terrorism incident. Having support available to assist with transitioning from the incident back to routine life (home, work, parenting, etc.) is important for responders in the immediacy of the moment and long-term recovery.	

	• The families of first responders may need support and access to services. • It is helpful for Command Staff to endorse the use of support and services for rank-and-file staff, including their own steps to access support. • Providing situational awareness updates about an incident for first responders is essential. • Compassion fatigue is a broadly defined concept that can include emotional, physical, and spiritual distress in those providing care to another. It is characterized by emotional exhaustion and the decreasing ability to provide compassionate care. • Vicarious trauma is a potential occupational challenge for people working and volunteering in victim services, law enforcement, emergency medical services, fire services, and other allied professions due to their continuous exposure to victims of trauma and violence. It is characterized by internalizing someone else's trauma as your own with resultant trauma reactions.	

Services	• First responders may need support, resources, and behavioral health service referrals.
	• A respite area provides some relief for responders at an incident scene.
	• First responder support services may include the following:
	  ○ Distribution of self-care information.
	  ○ Complementary wellness services include massage therapists, acupuncturists, mental health professionals, and spiritual care specialists.
	  ○ Available childcare during support meetings and services may include activities to help children with the impact of the incident on them.
	• Families of first responders should receive information about accessing support, resources, and behavioral health services for themselves.
	• At annual observances:
	  ○ A private ceremony or event may be helpful to bring first responders together away from their caretaking roles.
	  ○ Allow time for first responders to reflect as part of their healing.
	  ○ Any first responder ceremony should not be publicized outside the target group, should be in a safe environment, and should be tailored to the current needs of the responders.
		6. Which agency/department is responsible for coordinating organizations that provide complementary wellness services to first responders?
		7. Which agency/department is responsible for coordinating organizations that can provide onsite childcare services during support and services?
		8. Which agency/department is responsible for coordinating annual observance ceremonies or events for first responders?

Staffing	• Easily accessible mental health providers, peer support staff, and spiritual care providers who first responders know are vital. • Peer support teams consisting of first responders trained to provide support to other first responders have been helpful in previous incidents. • Responders are more likely to talk with support service providers if they have been introduced prior to the incident. • A respite area for responders may be staffed with trained clergy, peer support, and mental health providers. • Peer support teams should collaborate with victim advocates to ensure access to information and service navigation. • Spiritual care providers should be integrated into available support systems. • Usual peer support teams or other supports will likely need supplementation as CMV/DT incidents often have more widespread and profound impacts than typical critical incidents. • Reminder: Support and services staff will also need support due to the size and scope of the assistance they provide.	9. How can the jurisdiction coordinate and collaborate with mental health providers, peer support staff, and spiritual care providers to ensure first responders recognize these individuals? 10. Who is responsible for maintaining a list of peer support individuals and agencies? 11. Who is responsible for assessing responder needs during an incident to request assistance? 12. How does First Responder Support fit into the established Table of Organization for the incident? 13. How will organizations providing support services to first responders be vetted before an incident occurs? 14. How will new support and mental health agencies be vetted after an incident has occurred if additional support is needed? 15. What actions will supplement the usual Peer Team or other support? 16. How will peer support staff receive their own support? 17. What additional roles and responsibilities are needed?
Activation	**Potential ESF Activation: 6, 8** • First responders may need multiple opportunities to speak with support and service providers about an incident. • As tactical operations wind down, Peer Teams and other supports should be available to	18. Who will coordinate the activation of first responder support structures? 19. Who will coordinate the activation if the Incident Commander opens a respite area at the incident site? 20. How will respite area staff be notified of the activation?

	provide responders with focused support, services, and resources.	21. How will Peer Teams be notified of the activation?
Location/Material resources	• First responder support should be located at a separate location from victim service centers such as a Family Assistance Center. • Support and services must be available so responders can access them easily and without anxiety. • More responders may seek support and services if established outside the responder's agency or department.	22. Where could first responder support services be housed?
Communication	• Available support and services should be promoted daily through agency roll calls, the Incident Commander, and all first responder organizations. • Responder resource packets with information about web-based resources, trauma reactions, how to help people cope with trauma, tips for special population groups, information about locations to receive help, etc., should be available for first responders. • Put responder resource packets in places where people can find them.	23. Who is responsible for informing first responders of available support and services and how to access them? 24. How will information related to support and services, and how to access them, be shared with first responders? 25. Which agency/department can create responder resource packets to distribute at first responder facilities? 26. How will these resource packets be distributed?

Section 2

BP #12: First Responder Support

Potential ESF Activation: 6, 8

12.1 CMV/DT incidents place tremendous pressure on responders. It is important that jurisdictional plans, policies, procedures, and training materials include language or guidance informing responders to plan to receive behavioral health care following mass casualty incidents.

12.1.1 While all responders are at risk, responders who provide direct patient care, triage, and fatality management should be included in short-term and long-term after-incident care plans.

12.1.2 [1](Insert plans, policies, procedures, and training materials) address the need for first responders to plan to receive behavioral health care following mass casualty incidents.

12.1.2.1 Since some off-duty responders who arrive at a mass casualty incident will not check in, even if an Incident Command Post is established, [2](insert secondary process for tracking responders who do not check in) will serve as a backup tracking system for first responders.

12.1.2.2 Sending responders home right after an incident may be a mistake because they may not be ready to face their families. [3](Insert process used) will ensure behavioral health services are available to first responders, including command staff, before they are released to go home.

12.1.3 Trauma that comes out during an incident may be from previous trauma that wasn't addressed.

12.1.3.1 Some first responders are so accustomed to dealing with violence as part of their daily lives that it is often difficult to admit that they need to talk about an incident.

12.1.4 Families of first responders may also need behavioral health care.

12.1.4.1 [4](Insert process used) will ensure behavioral health services are available for the families of first responders.

12.1.5 First responders are invested in the response. Therefore, it is important to provide situational awareness updates and lessons learned about an incident.

12.1.5.1 [5](Insert process used) will ensure first responders receive situational awareness updates and information associated with lessons learned.

12.2 **Services.** First responder support should be all-encompassing.

12.2.1 Services at First Responder Care/Resource Center(s) should include:

12.2.1.1 Distribution of self-care information.

12.2.1.2 Complementary wellness services could include massage therapists, acupuncturists, behavioral health professionals, and spiritual care specialists.

12.2.1.2.1 [6](Insert agency/department responsible) will be responsible for coordinating organizations that provide complementary wellness services to first responders.

12.2.1.3 Onsite daycare with child activities.

12.2.1.3.1 [7](Insert agency/department responsible) will be responsible for coordinating organizations that can provide onsite daycare services.

12.2.2 Annual observances should also provide services specific to first responders.

12.2.2.1 A private ceremony or event may be helpful to bring first responders together away from their caretaking roles.

12.2.2.2 Remember to allow time and space for first responders to reflect and heal.

12.2.2.3 Any first responders' ceremony should not be publicized outside the target group, should be in a safe environment, and should be tailored to the current needs of the responders.

12.2.2.4 [8](Insert agency/department responsible) will be responsible for coordinating annual observance ceremonies or events for first responders.

12.3 **Staffing.** If mental health providers, peer support staff, and spiritual care providers show up often enough that responders recognize them, then the responders are more likely to talk to them.

12.3.1 [11](Insert department/agency responsible) will be responsible for conducting a responder needs assessment during an incident to request assistance.

12.3.2 A respite area and First Responder Care/Resource Centers may be staffed with trained clergy, peer support, and mental health providers.

12.3.3 [9](Insert process used) will be used to coordinate and collaborate with mental health providers, peer support staff, and spiritual care providers to ensure they are invited to show up at incidents frequently enough to ensure first responders recognize these individuals.

12.3.4 [10](Insert department/agency responsible) will be responsible for developing and maintaining a list of the cadre of individuals and agencies trained and willing to serve in a peer support role.

12.3.5 Peer support teams are often overwhelmed or unable to provide sufficient services following a CMV/DT incident.

12.3.5.1 Working with victim service advocates frees up some burdens on peer support staff.

12.3.5.2 Peer support staff may also need their own support after being exposed to the trauma of their peers. [16](Insert process used) will be used to coordinate opportunities for peer support staff to speak with each other or another behavioral health provider.

12.3.6 Usual peer support teams will be supplemented by [15](insert supplementary options).

12.3.6.1 Prior to an incident, behavioral health organizations providing support services to first responders will be vetted by [13](insert process used to evaluate organizations).

12.3.6.2 If additional assistance is needed, and organizations that have not been vetted need to be used, they will be vetted by [14](insert process used to evaluate organizations).

12.3.7 Behavioral health service providers for first responders may be included in other organizational structures, but the following organizational chart will be used if a separate organizational structure is needed. [12](The organizational chart identifying reporting structure for behavioral health services should be inserted here.)

12.3.8 Additional roles and responsibilities of staffing for a behavioral health team for first responders include (remove if not needed):

[17] Role	[17] Responsibility(s)	[17] Providing Agency	[17] Agency POC	[17] Backup POC

12.4 Activation. First responders will need multiple opportunities to speak with behavioral health providers about an incident.

12.4.1 The Incident Commander may determine that a respite area should be opened at the incident site to provide some relief for responders.

12.4.1.1 [19](Insert department/agency responsible) will be responsible for coordinating the activation of the respite area.

12.4.1.2 [20]Mental health professionals, victim advocates, and crisis counselors will be notified of the activation of their services at the respite area and the reporting date, time, and location, if appropriate, by (insert method used to notify staffing members).

12.4.2 A First Responder Care/Resource Center(s) can also be established to provide responder-focused behavioral health services and resources. First Responder Care/Resource Center(s) will be located at a separate location from victim services centers such as a Family Assistance Center.

12.4.2.1 [18](Insert department/agency responsible) will be responsible for coordinating the activation of the First Responder Care/Resource Center(s).

12.4.2.2 Peer support teams will be notified of the activation of their services and the reporting date, time, and location, if appropriate, by [21](insert method used to notify staffing members).

12.4.2.3 Mental health professionals, victim advocates, and crisis counselors will be notified of the activation of their services at the First Responder Care/Resource Center and the reporting date, time, and location, if appropriate, by (insert method used to notify staffing members).

12.5 Location/Material Resources. Several support sources/locations may be necessary following an incident of mass violence.

12.5.1 More responders may seek services if behavioral health services are established outside an agency or department.

12.5.2 The following is a list (and/or link to a GIS map) of preplanned facilities for First Responder Care/Resource Center(s).

[22] Facility Name	[22] Facility Address	[22] Size/Area of Facility	[22] Facility POC Name, Phone Number, and Email	[22] MOU Dates

12.6 Communication. Respite areas and First Responder Care/Resource Center(s) services should be promoted daily through agency roll calls, the Incident Commander, and the first responder organizations.

12.6.1 [23](Insert agency/department responsible) will be responsible for informing first responders of behavioral health services available to them and the locations for these services.

12.6.2 [24](Insert communication avenue) will be the primary conduit for informing the first responders of the locations and behavioral health services available.

12.6.3 Responder resource packets with information about web-based resources, trauma reactions, how to help people cope with trauma, tips for special population groups, information about locations to receive help, etc., should be available for first responders.

12.6.3.1 [25](Insert department/agency responsible) will be responsible for creating responder support packets to distribute among first responder facilities.

12.6.3.2 Responder resource packets should be placed in locations where people can find them.

12.6.3.3 [26](Insert department/agency responsible) will be responsible for distributing the responder support packets.

Best Practice 13: Emergency Funding and Grant Assistance

Section 1

Best Practice #13: Emergency Funding & Grant Assistance *After a CMV/DT incident, communities, victims, and their loved ones have many needs. Numerous grants and financial resources are available to support victims and communities following CMV/DT incidents.*		
	Considerations	**Questions**
Planning Considerations	• This section of the annex focuses on the various resources available and the "grant writing team" that should be assembled to pursue these resources. It also streamlines assistance, prevents duplication of benefits, and provides an efficient referral system. • There are numerous grants/financial resources available to support victims. • Grants assist eligible survivors and service providers with the funding necessary to recover from incidents. • Many grant applications have a restricted timeframe for submission and require quick decisions. • Streamlined application and reporting processes can speed up the timeline needed to fund the services victims need. • Memorandums of Agreement (MOA) should be in place before an incident to determine which agencies/departments will assist with various grants/financial resources. • Separate financial codes should be used for grant/financial resources to track payments properly and assist with audits.	1. Which existing agencies/departments work with grants/financial resources available to support victims? 2. Which reporting processes can be streamlined to assist service providers in tracking services for auditing purposes? 3. What financial coding process will be used to track grant/financial resource payments properly and assist with audits? 4. What MOAs are already in place? Which are still needed? 5. Which established laws, policies, regulations, and standards are referenced to determine if financial operations are conducted properly?

Services	• Grant/funding opportunities include but are not limited to:
	  ○ Antiterrorism and Emergency Assistance Program (AEAP)
	  ○ Crisis Counseling Assistance and Training Program (CCP)
	  ○ U.S. Department of Education Project SERV grants
	  ○ SAMSHA Emergency Response Grant (SERG)
	• Victim services will vary across grants/financial resources.
	• Individual Victim Compensation applications are state-specific but have been streamlined in previous CMV/DT incidents to account for differing state benefits.
	• It will often be necessary to refer victims to nonprofit or private sector partners to provide victim services efficiently. These must be tracked for grant payment, reporting, and auditing purposes.
		6. How will you determine which funding opportunities to apply for?
		7. What process will be used to refer victims to nonprofit or private sector partners appropriately?
		8. How will referrals be tracked for payment, reporting, and auditing purposes?

Staffing	• To meet victims' needs during recovery, grant application writing teams identify, review, and apply for direct financial assistance for victims, family members, and local entities. • A needs assessment may be required for some grant/financial resource applications.	9. Which agencies/departments will pursue grants/financial resources following an incident? 10. Which agencies/departments have pre-identified staff who are familiar with the various grant application processes? 11. What responsibilities need to be covered? 12. How will the Table of Organization for the grant writing team be included in the overall incident management structure?
Activation	**Potential ESF Activation: 6, 8** • It is important to identify and describe the actions to take to ensure that funds are provided expeditiously and that financial operations are conducted in accordance with established laws, policies, regulations, and standards.	13. Who decides which funding options to pursue? 14. What process has been adopted to ensure that funds are provided expeditiously to victims while adhering to established rules?

Location/Material Resources		
Communication	• The information about grants/financial resources must be shared to prevent duplication of benefits. • Victims should be informed of all available benefits and services and who provides those services.	15. How will grant/financial resource information be shared with agencies? 16. As appropriate, how will victims be informed of the benefits and services available to them due to the grant processes?

Section 2

BP #13: Emergency Funding and Grant Assistance
Potential ESF Activation: 6, 8

13.1 There are numerous grants available following a CMV/DT incident. These grants assist eligible survivors by providing financial resources directly to victims and service providers to cover costs associated with providing services to victims. Common grants are listed at the end of this section.

13.2 A needs assessment is critical to the success of applications for emergency funding assistance and shall be conducted by members of the grant writing team.

13.3 A grant writing team shall identify, review, and apply for financial assistance for victims, family members, and service entities.

13.3.1 The following agencies/departments have staff who are familiar with grant application processes and have been identified to explore and pursue grants/financial resources following a CMV/DT incident.

[8, 9] **Official/Agency Name**	[8, 9] **POC Name, Phone Number, and Email**	[8, 9] **Alternate POC**

13.3.2 Within this team, the following roles shall be assigned:

Role	Responsibility(s)
Grant Application Team Lead	Coordinates with state VOCA Compensation and Assistance Administrators and all other emergency assistance providers in the state to avoid duplication of services.
Needs Assessment Lead	Identifies the whole community's needs and is critical to the success of applications for emergency funding assistance.
Grant Writer(s)	Prepare federal, state, and local grant submissions—may want to designate a lead grant writer for each specific funding source.
Agency Liaisons	Coordinate with organizations to follow a standard application and reporting process—including required performance measures.
Other Positions	**10**

13.3.3 The grant writing team will fit into the ICS structure as follows:
[11](insert table of organization demonstrating reporting lines for grant writing within ICS)

13.3.4 [12](Insert role/agency) shall decide which funding options to pursue.

13.4 The following MOUs are established to assist with emergency funding and grant applications:

[4]Involved Agencies	[4]Summary	[4]Link to Agreement

13.5 Services for victims will vary depending on successful grant applications and financial resources.

13.5.1 Services must be tracked for grant auditing purposes. Reporting procedures for service providers can be streamlined by [2](insert strategies).

13.5.2 It is often necessary to refer victims to nonprofit or private sector partners to receive services.

13.5.2.1 Referrals will be conducted using [6](insert process).

13.5.2.2 Referrals will be tracked for payment, reporting, and auditing purposes by [7](insert process).

13.6 It is essential to identify and describe actions taken to ensure that funds are provided expeditiously and that financial operations are conducted according to established requirements.

13.6.1 The following laws, policies, regulations, and standards must be followed:

13.6.1.1 [5](Insert important regulations to be followed).

13.6.2 [13](Describe processes adopted to ensure funds are provided expeditiously to victims while adhering to established rules.)

13.6.3 When a grant is awarded, separate financial codes per grant shall be used to track payments properly and assist with audits.

13.6.3.1 [3](Insert additional information on the coding process)

13.6.4 At least annually, the grant writing team shall:

13.6.4.1 Review state VOCA Compensation Program guidelines.

13.6.4.2 Review existing state statutes related to workers' and victims' compensation.

13.6.4.3 Review best practices and criteria for appropriate federal emergency funding.

13.6.4.4 Discuss the importance of identifying declarations, understanding their impact on FEMA funding, and addressing any gaps in applying for assistance.

13.6.4.5 Evaluate the recovery process to ensure services match victims' needs, and funds are disbursed appropriately.

13.7 Information regarding grants and financial resources shall be shared with both victims and service providers to prevent duplication of benefits and services.

13.7.1 Service providers will receive information through [14](insert means).

13.7.2 Victims will receive information through [15](insert means).

Grant Name	Description	Specifications/Requirements
Antiterrorism and Emergency Assistance Program (AEAP)	Through AEAP, the Office for Victims of Crime (OVC) supports victims and jurisdictions that experienced incidents of domestic terrorism or mass violence. AEAP is designed to supplement the available resources and services of entities responding to acts of terrorism or mass violence to ensure that a program's resources are sufficient and not diverted to these victims to the detriment of other crime victims. Every year, OVC can access up to $50 million from the Emergency Reserve beyond the appropriation level for the Crime Victims Fund that Congress establishes annually. The OVC Director can use these Emergency Reserve funds for AEAP.	• Administrated by the Office for Victims of Crime: Qualified applicants include state victim assistance and compensation programs; public agencies, including federal, state, and local governments; federally recognized Indian Tribal governments, as determined by the Secretary of the Interior, and published in the Federal Register; U.S. Attorneys' Offices; public institutions of higher education; and nongovernmental and victim service organizations. • Noncompetitive grant for communities that experienced mass violence. • Consultants are available to assist with needs assessment, developing community resources, and grant writing. • Funding typically covers 27 months following CMV/DT incidents if the perpetrator is deceased and up to 36 months if the perpetrator is living and there is a trial. • Dependent on the scope and scale of the incident, Victim Compensation Funds can be augmented in an AEAP grant or, in extreme situations, an additional fund may be established.
Crisis Counseling Assistance and Training Program (CCP)	The mission of the program is to assist individuals and communities in recovering from the psychological effects of disasters through the provision of community-based outreach and educational services. It supports short-term interventions to assist disaster survivors in understanding their current situation and reactions, mitigate stress, promote the use or development of coping strategies, provide emotional support, and	• Must be a presidentially declared disaster with Individual Assistance (IA) funding provided. • Within the application, the requester must identify a nonfederal entity to administer CCP.

	encourage links with other individuals and agencies who may help survivors in their recovery process. Services are provided at no cost and are available to any survivor who has been impacted by the disaster. These services are delivered in accessible locations, including survivors' homes, shelters, temporary living sites, and places of worship. Services can be provided in a group setting or one-on-one.	
Immediate Services Program (ISP)		• Application is due 14 days after a presidential major disaster declaration that includes Individual Assistance. • FEMA provides funds for up to 60 days of services immediately following the approval of IA for a disaster. • FEMA awards and monitors the ISP federal award in coordination with SAMHSA.
SAMSHA Emergency Response Grant (SERG)		• No presidential declaration is required. • Mental health or substance abuse emergency exists and results from the mass casualty incident. • Enables public entities to address mental health and substance abuse when existing resources are overwhelmed by an emergency and other resources are unavailable. • Provides training opportunities in mental health and substance abuse intended to increase the capability and capacity.
Project SERV	Administered by the U.S. Department of Education, this program funds short-term and long-term education-related services for local educational agencies and institutions of higher education to help them recover from a violent or traumatic event in which the learning environment is disrupted.	• Project SERV includes Immediate Services grants, which support efforts to provide services and reinstate an environment conducive to learning for up to 60 days after the incident. • It also includes Extended Services grants, which support longer term recovery for up to 1 year after an incident.

Best Practice 14: Resilience Planning

Section 1

Best Practice #14: Community Resilience *A Resiliency Center (RC) or program will focus on the longer term needs of victims and/or the local community—depending on the funding secured. The RC provides a safe and supportive healing environment for individuals and groups seeking improved emotional and physical health related to the CMV/DT incident.*		
	Considerations	**Questions**
Planning Considerations	• All community resilience partners, including victim services, should be part of the committee responsible for resilience planning efforts. • Each community should consider the following: ○ Is an RC productive for the community? ○ Do community leaders and organizations support the RC concept? ○ Can funding be secured for an RC? • Resources within these centers are free to victims. • RCs are often funded with federal AEAP funding, which covers between 27–36 months, depending on whether there is a trial. See Best Practice 13. • Some communities will develop funding to keep the RC open beyond this time. • When the RC closes, services will be transitioned back to community-based services.	1. Who should be included in the resilience planning process? 2. What funding avenues will finance resiliency programming and the center(s)? 3. Has an assessment been conducted of existing behavioral health services and service gaps? This may be needed for funding requests.
Services	• Services provided at an RC include: ○ Case management— Including referrals, housing, childcare, legal guidance ○ Advocacy— Including crime victim compensation,	4. How will the jurisdiction determine which services will be available at the RC? 5. Who will provide the identified services? 6. How will the provision of services be tracked? Who is responsible?

	assistance with workers' compensation, information about and navigation through the criminal justice system and trials ○ Wellness and Support— Including coping skills, peer support, alternative wellness therapies (art therapy, meditation, acupuncture, etc.), planning and preparing for commemorations ○ Behavioral Health ○ Vocational Rehabilitation— May address problems returning to pre-incident jobs, counseling, and guidance on job placement ○ Legal/Financial Guidance— May assist with workers' compensation, visas, evictions, and employer intersession ○ Training— Including psychological first aid, suicide prevention, hotline information for domestic violence • A Hospitality Center may need to be activated during a criminal justice system trial. Not all victims will want to participate in the trial process, so the Hospitality Center may be open in conjunction with the RC. See Best Practice 15. • All services must be culturally responsive. This might require "just in time" training on cultural awareness, functional and access needs, undocumented persons, underserved, and isolated populations. • Service provision should be tracked. This provides documentation for	7. How will the jurisdiction ensure services are not duplicated when multiple providers are available? 8. Who is responsible for conducting needs assessments while the RC is open? 9. How will success be measured? Who is responsible for this? 10. How will cultural awareness be ensured? Who is responsible? 11. Who is responsible for coordination and collaboration regarding observances and permanent memorial sites? 12. Who will collaborate with individuals providing criminal justice support to victims? See Best Practice 15.

	reimbursement and additional funding options. • Needs assessments should be conducted periodically to determine changing needs.	
Staffing	• The RC should be operated by an agency not involved in the incident response. It is very difficult for victims to access care and services from an involved organization, especially if there are active lawsuits. • Both traditional and nontraditional partners are key to assisting with staffing. • Typical roles that are needed can be found in Appendix A. • Take care to hire staff for the RC that reflect the diversity of the community impacted by the incident. • Staff care is essential to the effective working of an RC. Enact processes to minimize staff burnout, compassion fatigue, and vicarious trauma.	13. What agency in the community might be willing to manage the administration of the RC? 14. What agency(s) could be responsible for finding staff to fill the roles identified in the staffing chart in section 2? 15. What additional roles may be needed? 16. What additional responsibilities might need to be covered? 17. Who will be responsible for ensuring service providers are encouraged to practice self-care for vicarious trauma?

Activation	**Potential ESF Activation: 6, 8, 15** • There are four types of RCs: 1. brick and mortar, 2. virtual, 3. hybrid, and 4. first responder. The community should determine the type(s) of centers most appropriate for their community based on the community dynamics and the incident. • Ideally, an RC will open the next business day following the closure of the FAC. • RCs are typically funded to open during business hours and some evenings and weekends. • More than one RC may be necessary depending on the size and scale of the incident and any populations with specialized resource needs. • Census data and geo-mapping may be useful tools when determining populations with specialized resource needs. • If a virtual RC is opened, the center website should have a public-facing page and a password-protected page for victims to access.	18. What process will determine the type(s) of RCs needed? 19. What process will be used to transition from an FAC to an RC? 20. What staff roles will be needed to bridge the FAC and a fully operational RC? What agencies might be able to assist with this transition staffing? 21. What process will be used to identify populations with specialized resource needs? 22. What agencies/departments can build and maintain a virtual RC website?
Location/Material Resources	• Brick and mortar RCs are semi-permanent and should be in a physically accessible facility with adequate parking and transportation options that is an appropriate distance from the incident site. • Modifications can be made to the facility chosen for the RC to make it suitable for service delivery. Often these modifications are to create a trauma-informed space for victims.	23. What facilities can serve as potential RC locations? 24. What modifications will be needed to make the location suitable for service delivery? 25. Which agencies/departments can furnish or procure furnishings for a center(s) to include tables, chairs, etc.? 26. Which agencies/departments can procure office supplies, including computers and printers?

	• RCs should not be located in or near facilities operated by agencies believed to be responsible for the incident. • RCs are intended to be naturally therapeutic, so furnishings for the center should reduce stress and promote comfort.	

Communication	• Individuals may not consider themselves victims and may think of themselves as survivors. Be mindful of how people perceive themselves while speaking with them. The term "victim" will always be used within the criminal and legal systems.
	
	<u>WHILE CENTER IS OPEN</u>
	• Victims must be aware of the transition from the FAC to the RC.
	• Communications from the RC often include the following:
	  ○ Available services
	  ○ Predictable reactions to the incident (for the first year, yearly marks of the incident date, activating scenarios/ events)
	  ○ Important investigative dates and where to access information
	• Outreach at an RC can include visiting places where victims come together, such as hospitals, shelters, faith-based structures, businesses, etc.
		27. How will victims' names and contact information be shared with the RC?
		28. How will victims be informed of the transition to an RC?
		29. Which agencies/departments will be responsible for developing an outreach strategy?
		30. Who is responsible for developing the transition plan for the closure of an RC?
		31. How will the transition plan for the closure of an RC be shared with victims?

	CLOSING OF RC • Communities often struggle with the consideration of closing an RC. • Share the transition plan with victims well before the closure of an RC. • Communications regarding the closure of an RC should thank people and be optimistic about progress and turning services back over to local providers. • Communication about future services to all victims and families should be done early and continuously during the transition process.	

Section 2

BP #14: Resilience Planning
Potential ESF Activation: 6, 8, 15

14.1 Community resilience is defined as the sustained ability of communities to withstand, adapt to, and recover from adversity.

14.1.1 Community resilience may include the Resiliency Center(s) (RC), Hospitality Center, and long-term memorialization of an incident.

14.2 It is essential to ensure that all community resilience partners, including victim services, are involved in the committee responsible for resilience planning efforts.

14.2.1 The following departments/agencies/organizations will be included in the resilience planning process.

[1]**Planning Group Members**	[1]**Point of Contact (POC) Agency, Phone Number, and Email**	[1] **Alternate POC**

14.3 A determination will be made regarding establishing a Resiliency Center based on:

14.3.1 Support for the RC concept by a broad group of community leaders and organizations.

14.3.2 Securing funding.

14.4 There are four types of RCs—brick and mortar, virtual, hybrid, and first responder. Determine the most appropriate type of center(s) for the community based on community dynamics and the size and scale of the incident.

14.4.1 *Brick and mortar:* Brick and mortar RCs are semi-permanent and should be housed in a physically accessible facility with adequate parking space and transportation options. The facility should be located an appropriate distance from the incident site.

14.4.2 *Virtual:* A virtual RC is accessible online rather than in person.

14.4.3 Hybrid: A hybrid center will include both a brick and mortar facility and a virtual component.

14.4.4 *First responder:* A first responder RC should be located separately from a victim RC. The center can be brick and mortar, virtual, or hybrid. First responders for an incident include traditional first responders and initial onsite persons who tend to victims until traditional responders—coroners, hospital personnel, etc.—arrive.

14.4.5 There may be a need for more than one type of RC and more than one brick and mortar structure.

14.5 Resources and services within Resiliency and Hospitality Centers are free to victims.

14.5.1 The following funding avenues will be explored to determine options for covering Resiliency and Hospitality Centers' costs.

14.5.1.1 [2](Insert funding avenues)

14.5.1.2 An assessment of existing behavioral health services and service gaps shall be conducted as required for funding requests.

14.6 Resiliency Center Services. An RC shall provide resources and tools that strengthen people's ability to empower themselves and allow people to experience vitality and healing. The key to success is through the work of our healing professionals from a variety of organizations. Our services focus on helping clients to tap into their innate resiliency; creating resilience through services, programs, and community events designed to promote healing and integrative wellness; provide education; and bring people together in meaningful dialogue.

14.6.1 The RC opens at the closing of the FAC.

14.6.2 The jurisdiction shall plan for a holistic approach with diverse services based on needs, access, and comfort. All services need to be culturally responsive.

14.6.2.1 [10](Insert role/agency) is responsible for ensuring cultural awareness for service providers by (just in time or other method used).

14.6.2.2 Some populations may have specialized resource needs. Census data and geo-mapping may be useful tools when determining the locations of populations with specialized resource needs. [21](Insert additional processes used to determine populations with specialized resource needs.)

14.6.3 The standard/planned services for an RC and the agencies/departments responsible for providing services include, but are not limited to:

[5] Service	[5] Providing Agency	[5] Agency POC	[5] Backup POC
Case Management			
Childcare			
Victim Advocacy			
Victim Wellness and Support			
Behavioral Health			
Spiritual Care			
Alternative Wellness Therapies			
Vocational Rehabilitation			
Legal Assistance			
Financial Assistance			
Training			

14.6.3.1 Long-term community resilience services may also include the memorialization of an incident. Memorials and special events are addressed in BP #10.

14.6.3.1.1 [11](Insert agencies/departments responsible) will be responsible for coordination and collaboration for observances and permanent memorial sites.

14.6.3.2 [4](Insert method/guidelines) will determine which services will be available at the RC.

14.6.3.3 The RC should support the efforts of those providing criminal support to victims. See Best Practice 15. This will be done by [12] (Insert agency/department responsible).

14.6.3.4 [7](Insert agency/department responsible) will ensure there is no duplication of services when multiple service providers are available to provide the same services by (insert method used).

14.6.3.5 Victims' needs will change over the time the RC is open, necessitating the need to conduct periodic needs assessments to determine changing needs. [8](Insert agency/department responsible) will be responsible for conducting periodic needs assessments while the RC is open.

14.6.4 Appropriate service provision documentation is needed for reimbursement and other funding options. [6](Insert role/entity) is responsible for tracking services at the RC according to the following procedures.

14.6.4.1 [6](Insert procedures, requirements, and guidelines)

14.6.5 It is important to measure the success of services provided at Resiliency and Hospitability Centers. Satisfaction surveys provide one method to evaluate success.

14.6.5.1 [9](Insert agencies/departments responsible) will be responsible for carrying out the process used to measure the success of services.

14.7 **Organization Chart/Staffing.** Both traditional and nontraditional partners are key to assisting with staffing.

14.7.1 [13](Insert agency/department) is willing to manage the administration of the RC.

14.7.2 The following roles shall be filled for the RC. [14](Insert agency/department) is responsible for finding staff to fill the roles of the RC and Hospitality Center.

Role	Responsibilities
Program Director	Development and oversight of RC/program
Case Managers/Navigators	Conduct needs assessments with victims and links to needed services
Community Outreach Coordinator	Ensures community awareness of services, identifies needed services in the community, and facilitates agency involvement in the RC
Clinical Coordinator	Oversees all behavioral health resources available through the RC; ensures appropriate training of behavioral health providers
Media Specialist	POC for all media interactions with the RC
Resource Coordinator	Develops materials and service resources for use at the RC; ensures incorporation of needed alternative interventions (yoga, mindfulness, supportive gatherings)
[15]Other	[16]Other

14.7.3 Service providers must practice self-care for vicarious trauma while providing services. [17](Insert agency/department responsible) will be responsible for ensuring service providers are encouraged to practice self-care for vicarious trauma.

14.8 **Activation.** Gaps in access between a Family Assistance Center (FAC) and an RC can create unnecessary issues for victims, so it is beneficial to create a transition process. Ideally, an RC would open the next business day following the closure of an FAC.

14.8.1 To avoid a gap in access and services, [19](insert process utilized to bridge the transition from an FAC to an RC) will ensure the continuation of services.

14.8.1.1 [20](Insert roles/agencies) are responsible for ensuring a smooth transition.

14.8.2 [18](Insert process that will be used to determine the type(s) of RCs needed for an incident) will be used to determine the type(s) of RCs needed for an incident.

14.8.2.1 Identifying populations with specialized resource needs will assist in determining the number of RCs needed to provide adequate services to victims.

14.8.2.2 If a virtual RC will be activated, the following agencies/departments/organizations have the capabilities to build and maintain a virtual RC website.

[22]Official/Agency Name	[22]POC Name, Phone Number, and Email	[22]Alternate POC

14.9 Location/Material Resources

14.9.1 Brick and mortar RCs should meet the following standards.

14.9.1.1 Is in a physically accessible building.

14.9.1.2 Has adequate parking and transportation options.

14.9.1.3 Is located an appropriate distance from the incident site

14.9.1.4 Is not in or near facilities operated by agencies believed to be responsible for the incident.

14.9.1.5 Has necessary utility and communications capabilities.

14.9.2 While incident sites will vary, the following is a list (and/or link to a GIS map) of pre-planned brick and mortar facilities for RCs.

[23] Facility Name	[23] Facility Address	[23] Size/Area of Facility	[23] Facility POC Name, Phone Number, and Email	[23] MOU Dates	[24]Modifications Required

14.9.3 RCs are intended to be naturally therapeutic. Furnishings should reduce stress and promote comfort.

14.9.3.1 The following agencies/departments can furnish or procure furnishings for the RC, including tables, chairs, couches, art, etc.

[25]Official/Agency Name	[25]POC Name, Phone Number, and Email	[25]Alternate POC

14.9.4 Office supplies are also required for RC operations. The following agencies/departments can furnish or procure office supplies for the RC and the Hospitality Center, including computers, printers, pens, paper, etc.

[26] Official/Agency Name	[26] POC Name, Phone Number, and Email	[26] Alternate POC

14.10 Communication. Clear communication is needed with victims, families, and the public.

14.10.1 Victims must be aware of the transition from the FAC to RC to ensure there is not a lapse in services.

14.10.1.1 [28](Insert method for informing victims of the transition from the FAC to the RC) will be used to inform victims of the transition from the FAC to the RC.

14.10.2 [27](Insert method used) will be used to share victim names and contact information with the RC.

14.10.3 For the duration of the RC activities, outreach will be an essential component of the center. [29](Insert agencies/departments that will develop the outreach strategy) will be responsible for developing an outreach strategy for the RC.

14.10.4 Communities are often upset and struggle with considering an RC closing, so communication is key to providing a less stressful transition.

14.10.4.1 [30](Insert agency responsible for developing a transition plan) will be responsible for developing a transition plan to close an RC.

14.10.4.2 The transition plan should be positive and uplifting. The plan should thank people and be optimistic about the progress made and the ability to turn services back over to local providers.

14.10.4.3 [31](Insert communication avenue) will be the primary conduit for sharing the transition plan with victims. The earlier the plan is shared, the more time victims will have to adjust to the center's closing.

Best Practice 15: Criminal Justice System Support

Section 1

Best Practice #15: Criminal Justice System Victim Assistance *Should the alleged perpetrator survive the CMV/DT incident and be brought to trial, victims and family members will need support as the case moves through the criminal justice system.*		
	Considerations	**Questions**
Planning Considerations	• The Crime Victims' Rights Act (18 U.S.C. § 3771. Crime victims' rights) identifies victims' rights and services that must be provided during any federal criminal justice process. • Each state has victims' rights laws that dictate what must be provided to victims during state criminal justice proceedings. • Federal criminal justice agencies have statutory responsibilities related to victims' rights and services in connection with terrorism criminal cases. • If the incident involves victims from multiple jurisdictions, states, or countries, ensure collaboration with all needed representatives (state officials, U.S. consulates, etc.). • The prosecutor and lead law enforcement agency will have identified who the legal victims of the crime are, and those are the people who will receive assistance related to the criminal justice process. CMV/DT incidents may involve multiple justice systems: juvenile, criminal, military, Tribal, and federal. These systems have different rules and procedures, and victim support programs may look very different for each system. • The criminal justice process can be re-traumatizing for many victims. • Participation in the judicial process helps many victims and survivors of mass terrorism to	1. What laws impact what victims receive in the jurisdiction? 2. What department/agency will coordinate with federal and state criminal justice agencies to maintain current information for an incident? 3. Who will coordinate with the prosecutor's office and law enforcement officials to create a shared awareness of who is legally considered a victim of the crime?

	regain some sense of control, but unfortunately, this doesn't typically provide the "closure" that people hope it will.	

Services	• Victims and family members should have access to updates on incident hearings, criminal justice proceedings, and victims' rights. These are standard services provided by system-based advocates; however, the volume of victims in CMV/DT incidents may exceed normal capabilities. Other agencies or grant funding (see Best Practice 13) may be available to assist.
	• Often, victims don't want to be in the same room as the defendant, or all victims do not fit in a courtroom. Hospitality Centers allow victims to view the trial proceedings from an alternate location using a live feed.
	• Hospitality Center services support victims' needs resulting from the trial. Services can change throughout the day and the entire trial process and may include:
	  ○ Legal and emotional debriefing
	  ○ Victim services such as advocacy, mental health and spiritual support
	  ○ Media management
	  ○ Art and music therapy (as space allows)
	  ○ Facility dogs for support (as time and space allow)
	• Pay particular attention to increasingly challenging times during the process, including victim impact statements and while waiting for a verdict.
	• A needs assessment is beneficial to determine the needs of victims who wish to participate in the trial.
		4. What existing department/agency(s) has the necessary experience to augment system-based victim advocates to manage the workload created by a CMV/DT incident?
		5. Who will conduct a needs assessment for victims who wish to attend the trial?
		6. Who will be responsible for case management for victims with identified needs during a trial?
		7. Who will share criminal justice process information with victims who do not want to participate in the trial?
		8. How will system-based advocates responsible for the identified victims incorporate other advocates and victim service professionals into the existing system of care during critical trial dates?

	• Case managers can assist individual victims with identified needs such as lodging and transportation connected to the trial dates. • Not all victims want to participate in the trial. • Watch the video *How To Design and Implement a Hospitality Center*.	
Staffing	• The services to assist victims navigating the criminal justice system will be based in the prosecutor's office. • With large groups of victims (typical of a CMV/DT), the victim advocates at the Resiliency Center can collaborate with the prosecutor's office advocates to support and inform victims. • Local victims may wish to receive support through their existing support systems, including the Resiliency Center, if there is one. • Victim advocates, behavioral health providers, and faith-based leaders who received trauma-informed training should be present at the Hospitality Center. • The typical roles needed at a Hospitality Center can be found in Appendix A.	9. Initial Resiliency Center services may not include distinct support for the criminal justice process. Who will collaborate with the Resiliency Center to provide this service? 10. Have you developed a reporting organizational structure that provides clearly defined roles for a Hospitality Center? 11. What roles are needed? 12. What responsibilities need to be covered? 13. How will volunteers be vetted if they are working in a Hospitality Center?
Activation	**Potential ESF Activation: 6** • The investigation and prosecution of the offender(s) can take two or more years. • If there is a prosecution of the offender(s), the judge determines who is allowed in a courtroom and how the trial proceedings are transmitted. • Some courts have ordered the closed-circuit transmission of trial proceedings to one or more locations to benefit large numbers	14. Who will coordinate and determine when to activate a Hospitality Center if needed during a trial? 15. How will victims be notified of the activation of a Hospitality Center? 16. How will staff be notified of the activation of a Hospitality Center and the reporting date, time, and location?

	of victims in mass violence and terrorism cases.	
Location/Material Resources	• Hospitality Centers should be a safe and secure environment where legal briefings, media management, and trial information-sharing services occur. Victims gathering in the center can also support each other. • Meals are sometimes served on the days of the trial to reduce stress for victims and maximize the time they are together to support each other. • Federal victim funds cannot be used to provide food. • Some expenses may be eligible for AEAP funding. • Consider providing security (law enforcement or private) to accompany survivors and family members to and from the courthouse, auxiliary facility, victim waiting/hospitality room, or parking lot. • Hospitality Centers are sometimes referred to as Safe Haven locations	17. If the courthouse will not accommodate a Hospitality Center, which facilities near the courthouse are suitable for supporting a Hospitality Center? 18. What funding streams can be used to support the resources needed at a Hospitality Center (e.g., housing, food, security, transportation)? 19. Who will procure lodging near the courthouse for victims if needed? 20. Who will provide needed transportation for victims at a Hospitality Center? 21. Who will provide security for victims at a Hospitality Center? 22. What agency will provide custodial services if they are required?
Communication	• The system-based advocates will often distribute a fact sheet outlining the victims' criminal justice system. • The system-based advocates will provide ongoing notifications regarding criminal case investigations, prosecution, adjudication, and prisoner status (post-conviction/corrections victim services). • Consider using a password-protected link on a website, or a password-protected website, with information about the trial	23. What will need to be added or changed in the specific information that the prosecutor's office shares with victims due to this being a CMV/DT incident? 24. How will the jurisdiction coordinate with another community to support a Hospitality Center if the trial moves to a different locality? 25. How will ongoing notifications related to the case be shared with victims? What agency can assist the prosecutor's office if needed?

	process that only victims can access. • If there is a prosecution, victims often have numerous questions. • If a Hospitality Center opens, there needs to be coordination of services between the Resiliency Center and the Hospitality Center. • If space is available in a courthouse, it is recommended that there be a room for the press separate from the room for the victims.	26. How will you keep the media separate from the victims who do not want to speak to the press?

Section 2

BP #15: Criminal Justice System Support
Potential ESF Activation: 6

15.1 The Crime Victims' Rights Act (18 U.S.C. § 3771. Crime victims' rights) identifies victims' rights and services that must be provided during any criminal justice process.

15.1.1 As a case moves through the criminal justice system, victims and family members will need help with the return of personal effects, victim impact statements, media management, support during trials (e.g., financial assistance, housing, transportation), and access to ongoing notifications regarding the investigation and matters involving prosecution, adjudication, sentencing, and prisoner status.

15.1.2 The following federal and state laws impact victim services.

15.1.2.1 [1](Insert relevant law and short description)

15.1.3 (Insert department/agency with responsibility) has the experience necessary to ensure victims' rights are upheld during the criminal justice process.

15.1.4 Because terrorist acts are federal crimes investigated and prosecuted by federal law enforcement officials, federal criminal justice agencies have statutory responsibilities related to victims' rights and services in connection with terrorism criminal cases.

15.1.5 [2](Insert department/agency with responsibility) will be responsible for coordinating with federal and state criminal justice agencies to maintain current information for an incident.

15.1.6 It is important to coordinate with the prosecutor's office and law enforcement officials to develop a shared definition of "victim" in relation to the incident. [3](Insert department/agency with responsibility) will be responsible for coordinating with these offices and officials.

15.1.7 If the incident involves victims from multiple jurisdictions, states, or countries, incorporate key state government officials into the criminal justice process.

15.2 **Services.** During the response phase, criminal justice-based victim service personnel assist investigators with victim and family interviews.

15.2.1 Victims and family members should have access to and updates on incident hearings, criminal justice proceedings, and victims' rights. These are standard services provided by system-based advocates; however, the volume of victims in CMV/DT incidents may exceed normal capabilities.

15.2.1.1 [4](Insert department/agency with necessary experience) has the experience necessary to augment system-based victim advocates to manage the workload created by an incident.

15.2.2 Some parts of the criminal justice system are especially challenging for victims, such as during victim statements and while waiting for a verdict. Additional support is often needed during these times.

15.2.2.1 System-based advocates responsible for the identified victims will incorporate other advocates and victim service professionals into the existing system of care during critical trial dates by [8](insert process used to incorporate advocates and victim service professionals).

15.2.3 (Insert department/agency with responsibility) will be responsible for assisting investigators with victim and family interviews during the response phase.

15.2.4 If there is a prosecution of the offender(s), a needs assessment will be beneficial to determine the needs of victims who wish to participate in the trial.

15.2.4.1 Not all victims will want to participate in the trial. [7](Insert department/agency with responsibility) will be responsible for sharing criminal justice process information with victims who do not want to participate in the trial.

15.2.4.2 [5](Insert department/agency with responsibility) will be responsible for conducting the needs assessment for victims who wish to attend the trial.

15.2.4.2.1 Case managers can assist individual victims with identified needs such as housing and transportation. [6](Insert department/agency with responsibility) will be responsible for case management for victims with identified needs during a trial.

15.2.5 A Hospitality Center may be opened to allow victims to view trial proceedings from an alternate location through a live feed. Hospitality Centers also allow victims to support one another during trial proceedings.

15.2.5.1 This is beneficial when victims do not all fit in the courtroom or do not want to be in the same room as the defendant.

15.2.5.2 Standard Hospitality Center services may include:

15.2.5.2.1 Legal briefing
15.2.5.2.2 Emotional debriefing
15.2.5.2.3 Advocacy
15.2.5.2.4 Mental health
15.2.5.2.5 Spiritual support
15.2.5.2.6 Media management
15.2.5.2.7 Art and music therapy
15.2.5.2.8 Facility dogs

15.3 **Staffing.** This section describes staffing beyond the traditional staffing provided by system-based advocates for victims of crime.

15.3.1 The roles for a Hospitality Center include:

Role	Responsibilities
Hospitality Center Director	Oversight of Hospitality Center operations
Volunteer Coordinator	POC for volunteer recruitment and assignment; responsible for just-in-time training; may work with volunteers providing advocacy, behavioral health, or spiritual support
Resource Coordinator	Organization of all material and programmatic resources and services
Media Liaison	POC for information distribution about the Hospitality Center; responsible for maintaining a media-free location for victims and families
[11]Other	[12]Other

15.3.2 These roles have the following reporting structure.

[10](The organizational chart identifying reporting structure for a Hospitality Center should be inserted here if needed.)

15.3.3 [14](Insert position/agency) is responsible for filling and coordinating needed positions.

15.3.4 Any volunteers working in a Hospitality Center shall be vetted by [13](insert vetting process).

15.3.5 Local victims may wish to receive support through their existing support systems, including the Resiliency Center, if there is one.

15.3.5.1 [9](Insert position/agency) will collaborate with the RC to ensure victims at the RC have the necessary criminal justice support, and that information is coordinated.

15.4 Activation. [14](Insert position/agency) will determine if and when to activate a Hospitality Center to support victims during the prosecution of a living offender.

15.4.1 Victims will be notified of the activation of the hospitably center by [15](insert method used to notify victims).

15.4.2 Hospitality Center staff will be notified of the activation of the Hospitality Center and the reporting date, time, and location by [16](insert method used to notify staffing members).

15.5 Location/Material Resources. The Hospitality Center should provide a secure, convenient, and accessible location that meets the physiological needs of victims and helps address their emotional needs.

15.5.1 There may be times when the courthouse will not accommodate a Hospitality Center. The following is a list (and/or link to a GIS map) of facilities near the courthouse that may fill the needs of a Hospitality Center.

[17]Facility Name	[17]Facility Address	[17]Size/Area of Facility	[17]Facility POC Name, Phone Number, and Email	[17]MOU Dates

15.5.2 Meals may be provided to victims to reduce stress.

15.5.3 The following funding streams may be available to support resources needed at a Hospitality Center.

15.5.3.1 Federal victim funds may not be used to provide food.

15.5.3.2 [18](Insert potential funding streams)

15.5.4 [19](Insert department/agency with responsibility) will be responsible for procuring housing near the courthouse as needed.

15.5.5 [20](Insert department/agency with responsibility) will be responsible for providing transportation for victims at a Hospitality Center as needed.

15.5.6 [21](Insert department/agency with responsibility) will be responsible for providing security for victims at a Hospitality Center as needed.

15.5.7 [22](Insert department/agency with responsibility) will be responsible for providing custodial services as required.

15.6 Communication. ([25]change following paragraph if incorrect) System-based advocates will provide victims and families with fact sheets and ongoing notifications regarding criminal case investigations, prosecution, adjudication, and prisoner status as part of their standard process.

15.6.1 Additional strategies to keep victims informed include [25](insert strategies).

15.6.2 Should system-based advocates in the Prosecutor's Office require additional assistance due to the scope and scale of the incident, [25](insert how capacity will be increased and what agencies can assist).

15.6.3 Some standard information may need to be adjusted because it is a CMV/DT incident. This includes:

[23]Description of Communication	[23]Timeframe Released	[23]Change(s) Required

15.6.4 If a trial is moved to a different location, coordination with another community to support a Hospitality Center will be done by [24](insert agency/position and/or process).

15.6.5 Victims may not want to speak with the media. [26](Insert department/agency with responsibility) will be responsible for keeping the media separate from victims who do not want to speak to them by [26](insert strategies).

Best Practice 16: Training and Exercise

Section 1

Best Practice #16: Training and Exercise *Jurisdictions should incorporate victim services into existing emergency management exercises. Exercises should not stop once a threat is neutralized but, instead, extend through the provision of services to victims and families.* *REFERENCE: ICP TTA Victim Services Exercise Guide & Scenario Templates*		
	Considerations	**Questions**

Planning Considerations	• Most jurisdictions will have some form of a training and exercise section written into their All-Hazards plan. In that case, this section may refer to the specific section of the plan.
	• Leverage existing training and exercise funding sources to focus on including victim services in exercises.
	• Developing, executing, and evaluating exercises that address emergency management and victim service priorities help ensure victims' short- and long-term needs are fully identified and addressed.
	• Jurisdictions are highly encouraged to use/implement the guidance outlined in the ICP TTA Victim Services Exercise Guide & Scenario Templates.
	• Involving senior agency leaders early in an exercise's design/development phase helps obtain agency/ organizational buy-in to support the exercise. This should include:
	  ○ Agencies, departments, and organizations involved in the exercise
	  ○ Director of County Victim Assistance
	  ○ Police Chief and Sheriff
	  ○ Emergency Management Director
	  ○ Senior Domestic Security personnel
	  ○ Community-based organizations, including behavioral health providers and VS providers
	  ○ Faith-based organizations
	• Exercises are designed to test plans and procedures, not people.
		1. How will you track the inclusion of victim response for mass violence in your Integrated Preparedness Program?
		2. Who in your jurisdiction already assists with exercise design/development, execution, and evaluation?
		3. Which agencies in your jurisdiction already assist in exercise-relevant training?
		4. Who is responsible for tracking training documentation for recommended training courses?
		5. What funding sources can you leverage for exercises that include victim services?

Services	• Victim care components can be added to existing exercises and drills to maximize learning across disciplines.
	• A victim service multi-year exercise program might include:
	  ○ Drills
	  ○ Table-top exercises
	  ○ Functional exercises
	• After Action Review/Improvement Planning (AAR/IP) documents generally include an exercise overview, an analysis of capabilities, and a list of corrective actions following an exercise.
	• Based on corrective actions identified in an AAR/IP, plan revisions may be necessary.
	• AAR/IP information should be used to communicate the next steps to the VS Committee and EM.
	• Future training may be needed to inform service providers of updated plans.
		6. Who will be responsible for developing exercise After Action Reports/Improvement Plans?
		7. Who will be responsible for victim service plan revisions needed to correct actions identified in the AAR/IP?
		8. Who will be responsible for training on victim service plans following plan revisions?

Staffing	• The exercise planning team manages and is responsible for exercise design, development, conduct, and evaluation. • The exercise planning team will need to expand to include people with expertise in victim services to facilitate functional exercises. • Players/participants vary depending upon the exercise objectives. Find more detailed information regarding exercise participants in the ICPTTA Exercise Guide and HSEEP materials.	9. Who should be included on a victim services-related exercise planning team? 10. Who in your jurisdiction serves as, or can serve as, a designated training/exercise director for victim services? 11. Who in the jurisdiction has experience filling exercise control structure needs such as controllers, evaluators, facilitators, safety officers, and notetakers. Are they willing to do so for victim care scenarios?
Activation	**Potential ESF Activation: 2, 5, 6, 7, 8, 15**	
Location/Material Resources	• Exercise locations will vary depending on the type of exercise. • Exercise resources vary by type of exercise. They may range from newsprint and markers to full-scale location set-ups.	12. What facilities are available to host discussion-based exercises? 13. What locations are available to host operations-based exercises? 14. What agency can create exercise materials (e.g., exercise guides or manuals)?

	• Existing jurisdiction staff responsible for exercises will be able to provide guidance in developing exercise materials and plans.	
Communication	• Interoperable communications equipment is needed for operations-based exercises. • Exercise documentation, such as situation manuals, player handouts, facilitator guides, evaluator handbooks, and feedback forms, can communicate exercise-specific information to participants.	15. How will exercise-related information be shared among the participants? 16. How will exercise-related information be shared with the public? 17. If the exercise incorporates victim service participants solely, how will the information and evaluation information be shared with emergency management?

Section 2

BP #16: Training and Exercises

Potential ESF Activation: 2, 5, 6, 7, 8, 15

16.1 An exercise is an event or activity—delivered through discussion or action—to develop, assess, or validate plans, policies, procedures, and capabilities that jurisdictions can use to achieve planned objectives. An effective training and exercise program ensures jurisdictions can link victim service responses effectively with emergency management.

16.2 Exercise program management involves a collaborative approach to identify and achieve the program priorities. An effective program maximizes efficiency, resources, time, and funding by ensuring a coordinated and integrated approach to building, sustaining, and delivering capabilities.

16.2.1 A multi-year exercise program helps develop a schedule for individual exercises and training that focuses on priorities outlined by a jurisdiction.

16.3 **Existing Infrastructure.** Incorporate victim service exercises into existing exercise structures.

16.3.1 The following departments/agencies within the jurisdiction may be able to provide exercise subject matter expertise because they currently assist with exercise design/development, execution, and evaluation:

[2]Agency/Department	[2] POC Name, Phone Number, and Email	[2] Alternate POC

16.3.2 Training courses support exercises by providing training specific to control structure functions such as controllers, evaluators, and facilitators. Exercise participants may also need training before the exercise. The Homeland Security Exercise Evaluation Program provides additional information on exercise training.

16.3.2.1 The following departments/agencies within your jurisdiction currently assist is exercise-relevant training:

[3]Agency/Department	[3] POC Name, Phone Number, and Email	[3]Alternate POC

16.3.2.2 [4](Insert role/agency) is responsible for tracking training documentation for recommended training courses.

16.4 **Planning Committee.** Typically, planning team members are not exercise players; they are trusted agents. However, if resources are limited, the planning team members may act as both planners and players but must be careful not to divulge sensitive exercise information.

16.4.1 The following departments/agencies will assist in the design/development of a victim services-focused exercise by participating in exercise planning meetings:

[9] Agency/Department	[9] POC Name, Phone Number, and Email	[9] Alternate POC

16.4.2 When exercise materials, such as situation manuals, exercise guides, evaluation forms, and presentations, are needed for an exercise, [14](insert agency/department) may assist with preparing these materials.

16.4.3 The following funding sources can be leveraged for exercises that include victim services:

16.4.3.1 [5](insert funding sources)

16.4.4 The inclusion of victim response for mass violence will be tracked as part of the jurisdiction's Integrated Preparedness Program by [1](insert role/agency and/or process).

16.5 **Staffing.** Exercise control structure may include an exercise director, controllers, evaluators, facilitators, safety officers, and notetakers.

16.5.1 Individuals in the jurisdiction who have previous non-mass violence-related experience may fill necessary roles.

16.5.2 The roles and responsibilities of staffing for an exercise control structure for a mass violence exercise include:

Role	Responsibility(s)	Providing Agency	Agency POC	Backup POC
[10] Exercise Director				
[11] Safety Officers				
[11]Controllers				
[11]Evaluators				
[11]Facilitators				
[11]Notetakers				

16.6 **Location/Material Resources**. Exercise location and required resources will vary based on the type of exercise.

16.6.1 Existing jurisdiction staff responsible for exercises can provide guidance in developing mass violence-specific exercise materials and plans.

16.6.1.1 [14](Role/agency) is responsible for creating all exercise materials, including exercise manuals, guides, and player resources.

16.6.2 The following facilities may be considered for discussion-based exercises.

[13]Facility Name	[13]Facility Address	[13]POC Name and Contact Information

16.6.3 The following facilities may be considered for operations-based exercises.

[14]Facility Name	[14]Facility Address	[14]POC Name and Contact Information

16.7 **Exercise Evaluation.** Exercise evaluation processes assess a jurisdiction's ability to meet identified objectives and capabilities by documenting strengths, areas for improvement, capability performance, and corrective actions. These items are recorded in an After Action Review/Improvement Plan.

16.7.1 [6](Insert department/agency responsible) will be responsible for developing exercise AAR/IP following an exercise.

16.7.2 [7](Insert department/agency responsible) will be responsible for victim service plan revisions needed to correct actions identified in the AAR/IP.

16.7.3 [8](Insert department/agency responsible) will conduct stakeholder training following plan revisions.

16.8 **Communication.** Communication is required with control staff, exercise participants, and the public.

16.8.1 Interoperable communications equipment is needed for operations-based exercises.

16.8.2 If the exercise incorporates victim service participants solely, [17](insert the organization responsible) will be responsible for sharing the exercise and evaluation information with the emergency management via [17](insert the information sharing process).

16.8.3 Exercise-related information will be shared among participants through [15](insert methods)

16.8.4 The following outlets may be used to broadcast exercise-related information to the public.

[17]Outlet Name	[17]Outlet POC Name	[17]Outlet Contact Information

Appendices

Appendix A: Roles and Responsibilities

Key Roles in FRC

Role	Responsibilities
Lead Agency Manager	Provides oversight of all operations; supervises Activity Leads (see Appendix B for Table of Organization)
Security/Safety	Lead for site safety and security of staff and victims/loved ones
Logistics/Mass Care	Lead for site set-up and maintenance, Lead for feeding and sheltering (if needed)
Planning	Daily Incident Action Plan (IAP) development for the site; plans to transition FRC to FAC
Liaison to Incident Command	Information conduit to and from IC, EOC, and JFSOC
Registration	Implement the registration process for those impacted by the incident and their families/loved ones; work with Liaison to Centralized Tracking to implement a process to contribute data
Witness/Victim Interviews	Law enforcement presence to interview newly identified victims and witnesses of the incident.
Health Triage and Support	Basic first aid; support for non-emergent health concerns; medication replacement (if lost in the incident or unreachable due to incident)
Liaison to Centralized Victim/Patient Tracking	Key POC for the transmission of information about victims/patients/loved ones to and from the service site; must have strong communication with LE, hospitals, and the ME/coroner
Notification Team	Implements plan for notifications to include involvement in the incident, injury, missing status, and death notifications
Staff Management	Oversees assignment of staff (mental health, spiritual care, victim advocates, etc.), just-in-time training, job inductions, and demobilization of staff
Communications Lead (PIO or Liaison)	Manages communication among IC/EOC, JFSOC, and service sites; orchestrates briefings for victims and loved ones on a periodic basis
Media Management	Responsible for keeping media out of service sites or contained away from victims and families

Key Roles in FAC (in addition to FRC roles that will likely continue)

Role	Responsibilities
Services/Community Partners Coordinator	Organizes onsite partners who are offering services; develops FAC protocols; holds daily staff briefings at each shift change; deconflicts financial resources to avoid duplication
Planning Section	Daily IAP development for the site; transition to Resiliency Center or program; maintenance of records
Childcare Team	Mass casualty-trained team to be with children while adults receive services

Key Roles for Financial Donation Management (during response)

Role	Responsibilities
Lead Administrator	Experienced person who can pull all the pieces together, draft the protocols, advise the steering committee, and oversee other staff roles
Finance	Track donations, send thank you letters/tax receipts, disburse payments to victims, and ensure that records are in order for audit review
Victim Specialist	Proactive outreach about funds to families of deceased and injured, answer questions, and guide victims through the fund process
Communications	Email updates, copyedit protocols before publication, update the victim informational website
Technology	Technology contractor or in-house staff to build an online application portal and the electronic workflow for review and validation of individual applications

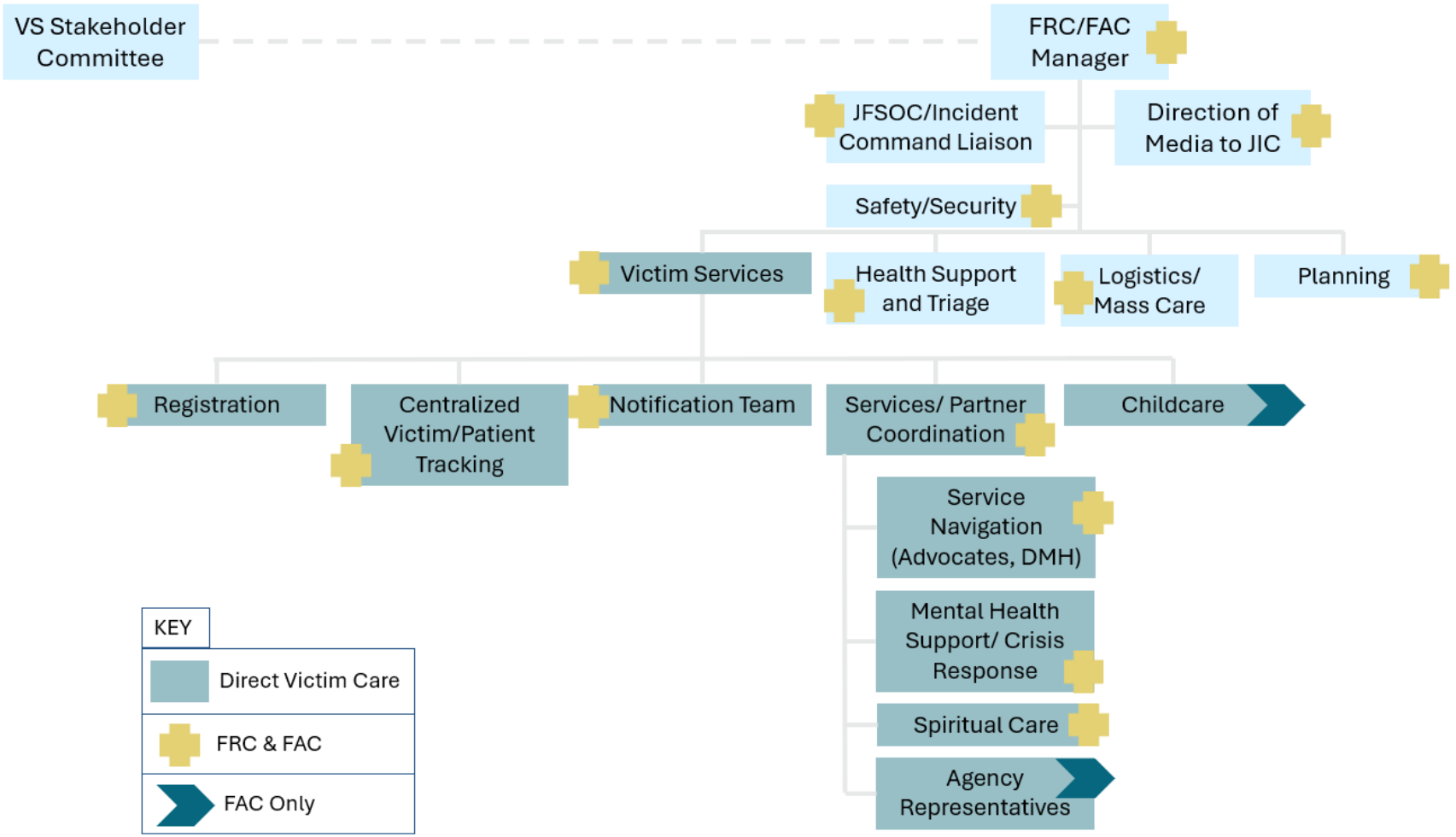
Key Roles in Resiliency Center (RC)

Role	Responsibilities
Program Director	Development and oversight of RC/program
Case Managers/Navigators	Conduct needs assessments with victims and links to needed services
Community Outreach Coordinator	Ensures community awareness of services; identifies needed services in the community; and facilitates agency involvement in RC
Clinical Coordinator	Oversees all behavioral health resources available through the RC; ensures appropriate training of behavioral health providers
Media Specialist	POC for all media interactions with the RC
Resource Coordinator	Develops material and service resources for use at the RC; ensures incorporation of needed alternative interventions (yoga, mindfulness, supportive gatherings)

Key Roles in Hospitality Centers

Role	Responsibilities
Hospitality Center Director	Oversight of Hospitality Center operations
Volunteer Coordinator	POC for volunteer recruitment and assignment; responsible for just-in-time training; may work with volunteers providing advocacy, behavioral health, or spiritual support
Resource Coordinator	Organization of all material and programmatic resources and services
Media Liaison	POC for information distribution about the Hospitality Center; responsible for maintaining a media-free location for victims and families

- Appendix B: Sample FRC/FAC Table of Organization



Appendix C: Definitions

501(c)(3) Agency	501(c)(3) agencies are commonly referred to as charitable organizations and are described in section 501(c)(3) of the Internal Revenue Code. These organizations are tax-exempt and eligible to receive tax-deductible contributions.
Agency-Based Victim Advocate	Agency-based victim advocates work in community agencies that deal with crime victims, including programs focused on sexual assault, Child Advocacy Centers, domestic violence, and human trafficking—also known as community-based victim advocates. *See "System-Based Victim Advocate" next.*
After Action Review (AAR)	After Action Review is a qualitative summary designed to identify potential corrective actions following exercises or real-world events. A final report is created once participants reach a final consensus. The After-Action Report can serve as a draft Improvement Plan (IP) to incorporate lessons learned.
Behavioral Health	Behavioral health encapsulates mental health, addiction, psychiatry, and overall physical wellness such as sleep, nutrition, exercise, etc.
Casualty	Refers to both those who are injured and those who are deceased.
Closed Victim Group	When all potential victims are known. For example, an incident occurs at a workplace where the employer can provide a list of all employees on the worksite at the time of the incident; that is a closed victim group. Tracking victims can be accomplished using basic accountability processes. Tracking requires communication between facility personnel, LE agencies, EMS, and hospitals. *See "Open Victim Group" next.*
Collateral Source Benefit	An alternative source of payment or reimbursement that may include expenses paid through insurance, donations, or civil lawsuits. Regulations regarding collateral source benefits vary from state to state and can impact Crime Victim Compensation.
Community Emergency Response Team (CERT)	Volunteers who are educated about disaster preparedness for the hazards that may impact their area and are trained in basic disaster response skills, such as fire safety, light search and rescue, team organization, and disaster medical operations.
Community Organizations Active in Disaster (COAD)	Community Organizations Active in Disaster or Citizen Organizations Active in Disaster are local group organizations or citizens that coordinate emergency human services while working with partner agencies, including the local emergency management agency and social service agencies, during all stages of a disaster.

Compassion Fatigue	A broadly defined concept that can include emotional, physical, and spiritual distress in those providing care to another. It is associated with caregiving in cases where people are experiencing significant emotional and/or physical suffering.
Crime Victim Compensation	Crime Victim Compensation is available in all states to assist in meeting the needs of victims of crimes committed in the state. Each state has unique laws and procedures that dictate the level and type of available services and methods for accessing the funds.
Criminal Mass Violence/Domestic Terrorism (CMV/DT)	Many definitions exist for mass violence, but the FBI and OVC (DOJ) definitions will be used for this annex. Jurisdictions may determine what definition they will use. The FBI defines mass violence crimes as criminal acts in which four or more people, selected indiscriminately, are killed. (Not including the perpetrator(s)). OVC defines mass violence as an intentional violent criminal act that results in physical, emotional, or psychological harm to a sufficiently large number of people and will deplete existing VOCA resources in the state and negatively impact services for all victims of crime in the state if additional resources are not allocated.
Disaster Mortuary (DMORT) Services	Supplemental teams that support local mortuary services to identify victims and reunite victims with their loved ones in a dignified, respectful manner.
Emergency Operations Center (EOC)	The physical location where the coordination of information and resources to support incident management (on-scene operations) activities normally occurs. An EOC may be a temporary facility or located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction.
Emergency Support Function (ESF)	The grouping of governmental and certain private sector capabilities into an organizational structure to provide capabilities and services most likely needed to manage domestic incidents.
Emotional Support Animal	These animals are not trained to provide support but rather develop a relationship with a single person to provide constant support. Therefore, they are not appropriate supports to deploy during a CMV/DT incident.
Facility Dog	Dogs bred to remain calm with specific training to manage large numbers of emotionally impacted individuals. As a result, they are appropriate for use during a mass casualty incident.

Family Assistance Center (FAC)	The Family Assistance Center focuses on services for victims and loved ones near an incident site. FACs are designed to meet victims' and family members' immediate and short-term needs: safety, security, physiological needs (food, sleep), information (about the victim recovery and identification process and the investigation), and crisis/grief counseling. In addition, family members may be interviewed to gather antemortem information about the victims and submit DNA samples to facilitate victim identification.
Friends & Relatives Center (FRC) ***Formerly known and Family and Friends Reception (FRC) or Reunification Center or Information Notification Center (INC)***	The Friends and Relatives Center (FRC) is the immediate location that is set up for those impacted by the incident and their loved ones to exchange information regarding the incident and available services. It is located near the incident site but far enough away to limit the sights and sounds of the incident and response. It is a central location to gather information from victims and loved ones to facilitate notifications (incident involvement, injured, missing status, and death notifications). Information about the incident and response will be available. The FRC will transition to the FAC if ongoing services and information are needed.
Fatality	The cessation of life.
Goodwill Ambassador Program	A program that connects registered volunteers with volunteer opportunities in their community.
Hospitality Center	Hospitality Centers are set up during key points of the criminal justice process—including trial and sentencing—and are open to victims and loved ones. Hospitality Centers can offer closed-circuit video links to the proceedings and supportive services outside of the courtroom that can include victim advocacy, mental health and spiritual care support, mass care (feeding), etc.
Incident Command (IC)	The ICS organizational element is responsible for the overall management of the incident and consists of the Incident Commander or Unified Command and any additional Command Staff activated. It is often located with an EOC during the initiation of a response.
Incident Command System (ICS)	A standardized approach to the command, control, and coordination of on-scene incident management, providing a common hierarchy within which personnel from multiple organizations can be effective. ICS is the combination of procedures, personnel, facilities, equipment, and communications operating within a common organizational structure designed to aid in managing on-scene resources during incidents. It is used for all kinds of incidents and applies to small, large, and complex incidents, including planned events.
Joint Information Center (JIC)	A facility in which personnel coordinate incident-related public information activities. The JIC serves as the central point of contact for all new media. Public information officials from all participating agencies co-locate at the JIC or coordinate virtually.

Joint Family Support Operations Center (JFSOC)	A JFSOC provides logistical support to victim-serving locations such as the FRC, FAC, and the transition to the Resiliency Center. It is a central location (typically within the FAC) where participating organizations come together to monitor, plan, coordinate, and execute a response operation specific to victims and loved ones that maximizes the use of all available resources. It is designed to address communication and the sharing of information challenges after an incident.
Legal Victim	Following a CMV/DT incident, the prosecutor and lead law enforcement agency will determine who is considered a legal victim of the incident. This determines who is eligible to receive state or federally funded victim services. The criteria to be classified as a legal victim varies from incident to incident. Legal victims are eligible for long-term support and notifications related to ongoing criminal procedures related to the CMV/DT incident.
Liaison	A staff member who is responsible for coordinating with representatives from cooperating and assisting agencies or organizations.
Mental Health	Mental health is narrower in scope than behavioral health and looks at emotional health and mental health treatment.
Navigator	Navigators work with victims and loved ones who participate in the FAC. Each individual or group entering the FAC is assigned a navigator. They conduct a needs assessment and assist with accessing available services at the FAC. Navigators can be victim advocates, disaster-trained mental health responders, disaster-trained spiritual care providers, and others trained in psychological first aid with experience working with people in crisis.
National Center for Missing and Exploited Children (NCMEC)	A national nonprofit clearinghouse and comprehensive reporting center for all issues related to preventing and recovering from child victimization. Following a CMV/DT incident, NCMEC can assist with protecting the rights of unaccompanied children and ensuring all laws/rules are followed when connecting children back to their guardians.
National Incident Management System (NIMS)	A systematic, proactive approach to guide all levels of government, NGOs, and the private sector to work together to prevent, protect against, mitigate, respond to, and recover from the effects of incidents. NIMS provides the whole affected community with the shared vocabulary, systems, and processes to deliver the capabilities described in the National Preparedness System successfully. NIMS provides a consistent foundation for dealing with all incidents, ranging from daily occurrences to incidents requiring a coordinated federal response.
Nongovernmental Organization (NGO)	A group based on the interests of its members, individuals, or institutions. The government does not create an NGO, but it may work cooperatively with the government. Examples of NGOs include faith-based groups, relief agencies, organizations that support people with access and functional needs, and animal welfare organizations.

Open Victim Group	When all potential victims are not known, imagine an incident occurring at a public concert, movie theater, or shopping mall, this is an open victim group. Victims are far more complex to track. A detailed system(s) is needed to investigate and document information on those involved, hospitalized, missing, and known to be deceased. Tracking requires communication between facility personnel, LE agencies, EMS, and hospitals. *See "Closed Victim Group" next.*
Peer Support Team	Peer support teams consist of first responders trained to provide support to other first responders. Many departments or jurisdictions have existing peer support teams that will provide support after a CMV/DT incident.
Public Information Officer (PIO)	The PIO interfaces with the public, media, and other agencies with incident-related information needs. The PIO gathers, verifies, coordinates, and disseminates accessible, meaningful, and timely information on the incident for both internal and external audiences. The PIO participates in or leads the Joint Information Center.
Respite Area	It serves as an area to provide some relief for responders at an incident scene.
Steady State	A time in which a jurisdiction is operating under normal day-to-day conditions. The jurisdiction is not actively responding to a CMV/DT incident.
System-Based Victim Advocate	System-Based Victim Advocates work in the criminal justice system, including police departments and prosecutors' offices. They have extensive experience working with criminal incidents and services typically needed by victims. *See "Agency-Based Victim Advocate" next.*
Table of Organization	The outline/structure of the primary activities or functions necessary to respond to incidents effectively. The structure identifies the primary needs of an incident. As incidents became more complex, difficult, and expensive, the need for additional organizational managers became evident.
Therapy Dog	A dog that is trained to support one person or a small group of people who are experiencing emotional stress. Therapy dogs become overwhelmed by the number of emotionally needy people during a CMV/DT response and should not be used.
Unified Command (UC)	Unified Command is a process allowing all agencies with geographical or functional responsibility for an incident to assign an Incident Commander to a Unified Command organization. The Unified Command then establishes a common set of incident objectives and strategies for all agencies.
Victims of Crime Act (VOCA)	Passed by Congress and signed into law by President Ronald Reagan on October 12, 1984. VOCA established the Crime Victims Fund to support state efforts to assist victims of crime. Funding comes from fines collected from

	federal offenders—not taxpayer dollars. Each state has its own laws that dictate how its federal allocations will be spent and a VOCA Administrator who determines program protocols and priorities.
Victim Services (VS)	Victim services is a broad term that encompasses service providers and services that assist with identifying and responding to the needs of victims of the CMV/DT incident. They include but are not limited to victim advocacy, victim compensation, immediate mental health and spiritual care support, long-term behavioral health interventions, linkage navigation, alternative interventions (e.g., mindfulness, yoga), and supportive gatherings.
VOCA Administrator	Each state has a VOCA Administrator who is responsible for the distribution and administration of yearly VOCA funds. They can be instrumental in accessing trained victim advocates from outside the impacted jurisdiction if needed for the response, be involved in developing services to meet the needs of the victims of the incident, and likely administer AEAP funds if requested.
Voluntary Organizations Active in Disaster (VOAD)	A community organization made up of public, private, volunteer, and nonprofit agencies and organizations that may be active in all phases of disaster. A VOAD enhances the ability of all communities involved to mitigate, prepare for, respond to, and recover from disasters.

Appendix D: Acronyms

A

AAR/IP	After Action Review/Improvement Planning
AEAP	Antiterrorism and Emergency Assistance Program

B

BP	Best Practice

C

CERT	Community Emergency Response Team
CMV/DT	Criminal Mass Violence/Domestic Terrorism
COAD	Community Organizations Active in Disaster
CCP	Crisis Counseling and Assistance Program

E

EOC	Emergency Operations Center
EOP	Emergency Operations Plan
EM	Emergency Management
EMS	Emergency Medical Services
ESF	Emergency Support Function

F

FAC	Family Assistance Center
FAQ	Frequency Asked Questions
FBI	Federal Bureau of Investigation
FEMA	Federal Emergency Management Agency
FERPA	Family Educational Rights and Privacy Act
FRC	Family and Friends Reception Center
FRC	Friends and Relatives Center

H

HIPPA	Health Insurance Portability and Accountability Act
HSEEP	Homeland Security Exercise and Evaluation Program

I

IC	Incident Command/Incident Commander
ICS	Incident Command System
ICM	Incident Management System
ICPTTA	Improving Community Preparedness to Assist Victims of Mass Violence and Domestic Terrorism: Training and Technical Assistance Program
INC	Information & Notification Center

J

JFSOC	Joint Family Support Operations Center
JIC	Joint Information Center

L

LE	Law Enforcement
LEPC	Local Emergency Planning Committee

M

ME	Medical Examiner
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding

N

NCF	National Compassion Fund
NCMEC	National Center for Missing and Exploited Children
NIMS	National Incident Management System
NGO	Nongovernmental Organization
NTSB	National Transportation Safety Board

O

OVC	Office for Victims of Crime

P

PIO	Public Information Officer
POC	Point of Contact

R

RC	Resiliency Center

S

SAMSHA SERG	Substance Abuse and Mental Health Services Administration Emergency Response Grant

V

VOAD	Voluntary Organizations Active in Disaster
VOCA	Victims of Crime Act
VS	Victim Services

Appendix E: Emergency Support Functions (ESFs)

ESF	Support Actions or Capabilities
ESF #1 Transportation	Coordinate the opening of roads and manage aviation airspace for access to health and medical facilities or services.
ESF #2 Communications	Provide and enable contingency communications required at health and medical facilities.
ESF #3 Public Works & Engineering	Install generators and provide other temporary emergency power sources for health and medical facilities.
ESF #4 Firefighting	Coordinate federal firefighting activities and support resource requests for public health and medical facilities and teams.
ESF #5 Information & Planning	Develop coordinated interagency crisis action plans addressing health and medical issues.
ESF #6 Mass Care, Emergency Assistance, Temporary Housing, & Human Assistance	Integrate voluntary agency and other partner support, including other federal agencies and the private sector, to resource health and medical services and supplies.
ESF #7 Logistics	Provide logistics support for moving meals, water, or other commodities.

ESF #8 Public Health & Medical Services	Provide health and medical support to communities and coordinate across capabilities of partner agencies.
ESF #9 Search & Rescue	Conduct initial health and medical needs assessments.
ESF #10 Oil & Hazardous Materials Response	Monitor air quality near health and medical facilities close to the incident area.
ESF #11 Agriculture & Natural Resources	Coordinate with health and medical entities to address incidents of zoonotic disease.
ESF #12 Energy	Coordinate power restoration efforts for health and medical facilities or power-dependent medical populations.
ESF #13 Public Safety & Security	Provide public safety needed security at health and medical facilities or mobile teams delivering services.
ESF #14 Cross-Sector Business and Infrastructure	Be informed of and assess cascading impacts of health or medical infrastructure or service disruptions, and de-conflict or prioritize cross-sector requirements.
ESF #15 External Affairs	Conduct public messaging on the status of available health and medical services or public health risks.