Journal of Jewish Communal Service, Vol. 83, No. 1, Fall 2007

The Road to Resiliency

Building a Jewish Community Trauma Response Plan

Joel M. Carp, ACSW
Senior Vice President Emeritus, Jewish United Fund/Jewish Federation of Metropolitan Chicago

Jewish communities must be prepared to respond to traumatic events that will inevitably occur, whether they are the result of natural disasters, terrorist attacks, or a consequence of the death or severe illness of individuals in the community that reverberate throughout a community, neighborhood, and/or Jewish institutions. A mental health, resiliency-based response requires specialized training beyond the core professional education of Jewish agency clinical staff. To achieve this goal, communities must create policies and structures that support such a community plan. This article describes the experience of the Chicago Jewish community as it planned and implemented a second responder strategy designed to provide the Jewish community with the capacity to meet this challenge.

One of the consequences of 9/11 is the American Jewish community's heightened and never-ending preoccupation with community security issues. This preoccupation, however, has largely tended to focus on hardening buildings, installing bollards outside facilities, upgrading communications plans, doing what is required to make community meetings and large-scale community events secure, and implementing measures to better protect our community centers, camps, and schools. All these measures and more are necessary of course, but they are not sufficient. Little attention has been paid nationally, for example, to the need for a mental trauma resiliency and response strategy. There is no question that the Jewish community is and will continue to be a prime target for terrorists, as well as for others who are disconnected from our society and who look for targets on whom to vent their anger and hatred.

In addition, life is also filled with a range of unpredictable, recurring, severely traumatic events that affect our Jewish communities and the society of which we are a part. We must be prepared to respond not only to potential terrorist attacks but also to aberrant violent events, such as the 2006 tragedy at the Seattle Federation, hurricanes and tornadoes, and the unexpected deaths of children or adults whose sudden and increasingly frequently violent demise traumatizes schools, neighborhoods, synagogues, and other constituencies in our Jewish or general community.

To our knowledge, JUF/Jewish Federation of Metropolitan Chicago (JUF/Federaion) is the only North American Jewish federation to have devoted extensive resources to developing a community-wide trauma response and resiliency plan with the capability of responding to any trauma visited on the Chicago Jewish community, small or large. We also have the capacity to be part of an overall metropolitan area response in case an incident occurs. J-CERT, the Chicago Jewish Community Emergency Resil-

iency Team, presently involves a group of about 80 professionals who have been trained to use a variety of resiliency/trauma response models. The core group consists of a commander; four clinical leaders (two primary and two back-up); five preassigned resiliency teams, each with 10–12 team members and two team leaders; back-up team leaders; and a command group of personnel responsible for security, logistics, communications, family assistance centers, and finance.

J-CERT MISSION, GOALS, AND OBJECTIVES

JUF/Federation, in collaboration with the many agencies it supports, has taken proactive measures to, as reasonably as possible, promote the safety and security of all its collective stakeholders—staff members, clients, and visitors—while they are in our care at our various facilities (*JCERT Protocol Manual,* 2005). Furthermore, because the aftermath of terrifying events can cause debilitating trauma to the stakeholders and the Jewish community-at-large, the JUF/Federation is proactively taking steps to build community resiliency at the individual, family, and communal levels prior to a crisis. The initial response to a critical incident, defined below, must be administered quickly and effectively. To this end, our *mission* is to create a Jewish Community Emergency Resiliency Team (J-CERT) to coordinate the JUF/Federation's efforts to prepare for, respond to, and recover from critical incidents that affect the Jewish community in the Chicago metropolitan area. Our primary *goal* is to restore individual and community resiliency and control as soon as possible.

We will manage our Jewish community emergencies by doing the following:

- Providing crisis intervention and trauma assistance
- Providing emergency assistance: food, shelter, clothing, financial aid, guardianship, and assistance with funerals
- Assisting the affected agencies in gaining control of the crisis
- Providing a command structure for a coordinated response
- Coordinating communications—being the "voice" to the community-at-large

To achieve its primary goal J-CERT assists affected agencies, organizations, and communities in mitigating the impact of a critical incident through an orderly and systematic approach to handling the incident. A secondary goal is to enhance close collaboration with others in the Jewish community, as well as with local, state, and federal health, safety, and emergency personnel, to develop and maintain plans for coping with a variety of critical incidents.

CRITICAL INCIDENT DEFINED

A *critical incident* is any unplanned event that has the potential to significantly affect an organization's security and safety, its image, or its operations, or poses a significant economic or legal liability. It is a situation out of the normal routine in which the unexpected suddenly occurs. This unpredictability makes management of the incident all the more challenging, as the situation can be dangerous, dynamic, complex, and confusing. Therefore, critical incidents require extraordinary measures to protect lives, meet human needs, and achieve recovery. Three types of incidents may be considered "critical"—yet the responses will be significantly different.

Class 1 Critical Incident: Any Physical Force Exerted for the Purpose of Violating, Damaging, or Abusing the Jewish Community

The Class 1 incident involves a tragedy that requires an intervention (response) of major proportions because, by its very nature, it is meant to harm members of the Jewish community. The impact on the community is significant, requiring at a minimum, clinical/trauma resiliency team interventions and a coordinated communication

response to the media and community at large. Examples of this type of critical incident are acts of violence, in the nature of a hate crime, against an individual or an institution—such as the individual who sought to kill Jews and other minorities a few years ago, or a suicide bomber who straps explosives to himself and discharges it in a crowd, or simultaneous bombs detonating in different parts of Chicago at synagogues or other areas where Jews gather. These types of incidents may have tragic results and will require significant assistance from the J-CERT Team.

Class 2 Critical Incident: Localized Nonviolent Act of Nature and Unintentional or Accidental Incident

The most common type of critical incident, a Class 2 incident may involve a tragedy that requires an intervention (response), yet the incident was an accident and/or does not threaten anyone beyond the immediate environment. Examples of this type of critical incident include an individual who has a heart attack while swimming in a JCC pool; a young student at one of the mental health care facilities who attempts suicide; a gas water heater explodes at a facility for the elderly causing a fire and evacuation; or strong winds and icy conditions cause a school bus to veer off the road into a ravine. Any of these incidents may have tragic results and may require assistance from the J-CERT Team.

Class 3 Critical Incident: Any Localized or Regional Violent Act of Nature or Terrorism That Is Not Specific to the Jewish Community Yet Affects It

Examples of this type of critical incident are natural disasters such as an earthquake, tornado, or blizzard that creates havoc with an agency's ability to continue to serve its stakeholders. More devastating to the community at large is an act of terrorism against the Chicago metropolitan area. These types of incidents may have tragic results, and J-CERT may be called on to supply assistance to the general community and/or provide specific assistance within the Jewish community.

HOW J-CERT OPERATES

The J-CERT program comprises activities prior to, during, and after a critical incident (see Figure 1).

A great deal of thought was given to the process to be used to activate the plan. We decided to establish a toll-free hotline number that can be used to report an incident of the type that may require a response from J-CERT; we also determined that the most effective strategy was to use Federation's after-hours answering service to provide coverage 24 hours a day, 7 days a week. To assure that our J-CERT protocol is followed, we wrote a special script with explicit instructions, and it was used to train the 40 telephone operators used by the answering service. In addition, all Federation and agency personnel at all locations have been provided procedural information about how to connect someone reporting an incident to the J-CERT operator.

Once a community implements a resiliency and response plan, it is important to understand that all key personnel who are involved must be prepared to be "on call" 24 hours and day, 7 days a week. To accomplish this, individuals' level of Shabbat observance must be considered, plans must be made for coverage when key personnel are out of town or otherwise unavailable, and a uniform standard for communications equipment must be adopted. This is yet another reason why we elected to first involve and train the top professional leadership of our community, including the majority of agency and Federation executive staff.

The first call to J-CERT results in a connection to our clinical leaders who decide whether to activate the J-CERT plan. After they ascertain the facts in their conversation with the person reporting the incident, they

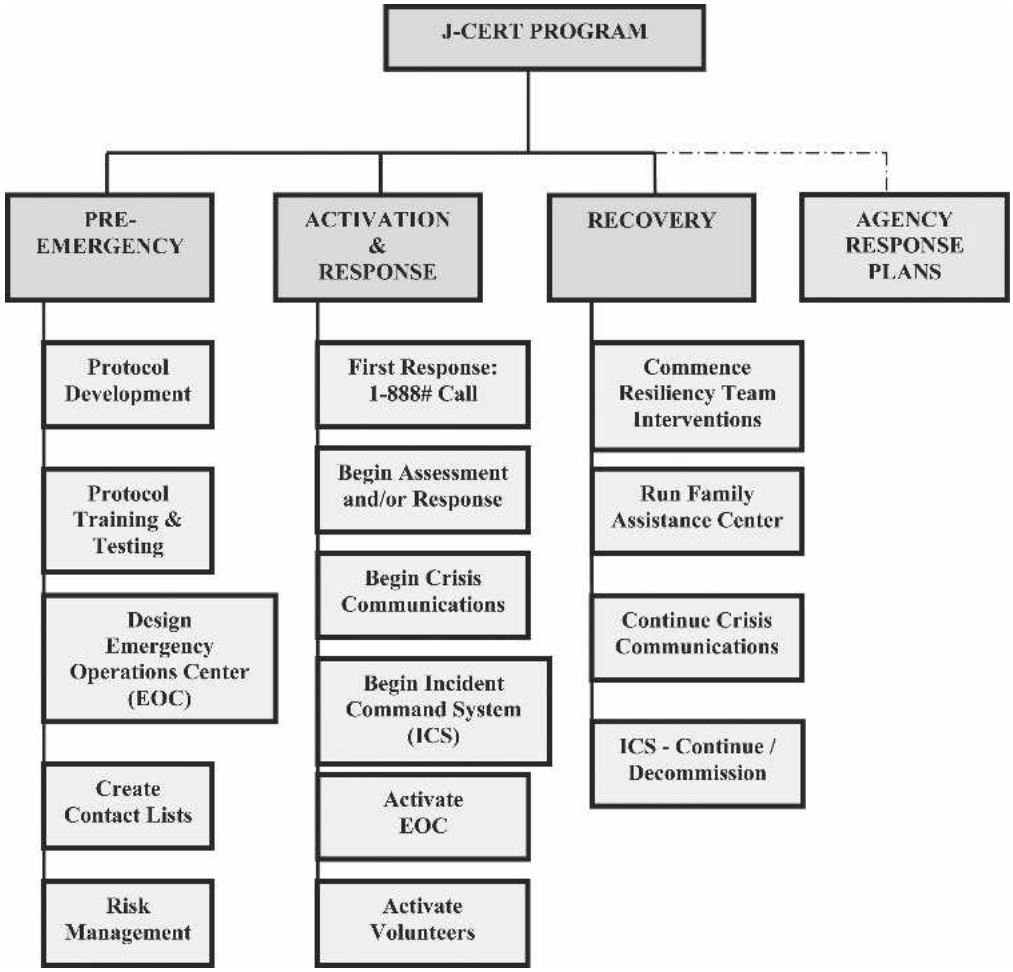

FIGURE 1. J-CERT program

bring the J-CERT commander and other J-CERT leaders into the conference call, who then advise Federation's top leadership of the incident. The clinical leaders may choose to contact team leaders and activate one or more teams before calling the command leaders, or they may elect to wait until they converse with the command leaders. The responsibility for making the decision to activate the J-CERT plan rests with the clinical leaders (see Figures 2 and 3).

Although J-CERT was formally rolled out to the Jewish community of Chicago in late 2006 using a marketing plan we developed, we have responded to several traumatic events over a three-year period before the official notification went out. As a result of a request we received, J-CERT was activated and sent a team to Florida to work in FEMA Disaster Relief Centers for a week several years ago after a third hurricane struck the same area and all the local emergency mental health resources were exhausted. We have responded to the aftermath of the deaths of children and adults who were part of our community's day schools and public schools, to a family whose young child was killed during a family outing by a driver under the influence of alcohol, and to the family of an adolescent killed by an alleged felon who was driving a stolen car involved in a police pursuit. We have been asked by the rabbinic, lay, and professional leadership of day schools and

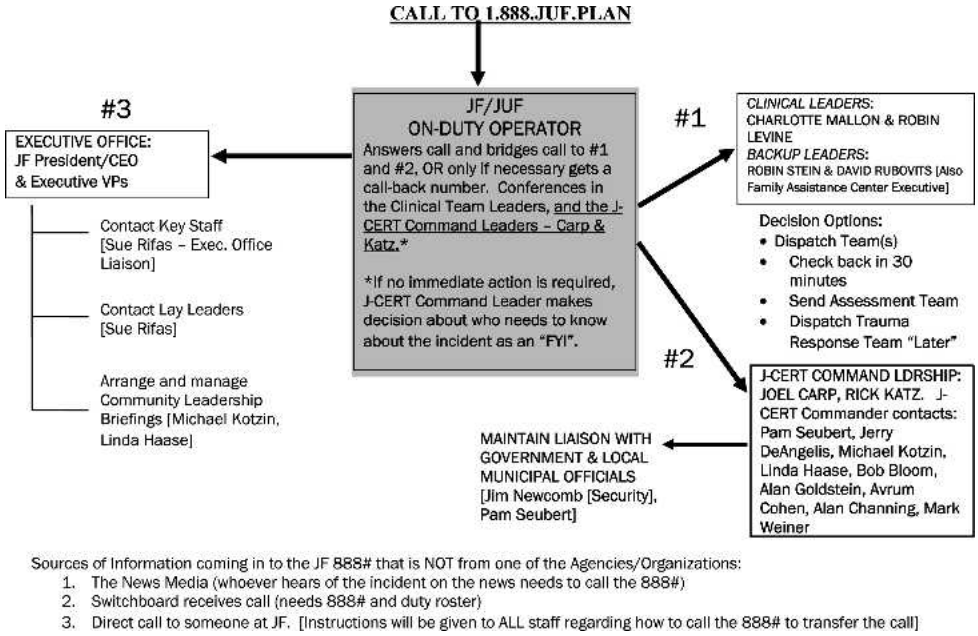

FIGURE 2. CALL PATTERN–CLINICAL RESPONSE PLAN

synagogues to come into their institutions to work with them, their faculty members, their classes, and the families and children who make up their communities. A local school system contacted us to participate in an interagency effort after the unexpected death of a young girl at a public school in our community, and J-CERT was called in by a Catholic middle school in response to the unexpected death of its principal on her way to the school's graduation celebration dinner. At the request of the United Jewish Communities and the local Hillel, J-CERT sent an assessment team to Virginia after the shootings at Virginia Tech to ascertain what service resources Jewish students and faculty might need going forward and how Jewish Family Service agencies in the state might be of assistance.

KEY ELEMENTS OF A COMMUNITY RESPONSE PLAN

The building of J-CERT has required a journey of three years of planning, designing, training, testing, evaluation, redesigning, and implementation. It has required a serious commitment from the Federation's top lay and professional leadership, the professional leaders of our agencies, and other significant community leaders; a willingness to learn and plan together; and a readiness to invest the required human and financial resources over time. Essential to the success of the effort is the designation of a project leader who has the ability to access or acquire whatever resources are necessary; the stature and relationships to engage and sustain the involvement of all the Federation, agency, and other community leaders and instrumentalities; and the vision and long-term commitment to make sure that the plan has real depth and substance. Equally critical is the need to identify and build the right team of clinical and other professionals who will provide the leadership to implement the plan protocols when an incident occurs and who understand the importance of team building.

Principal issues that must be dealt with in the process of developing a plan tailored to the needs of the community include the following:

- Developing a strategy to change the community culture to accept the reality that

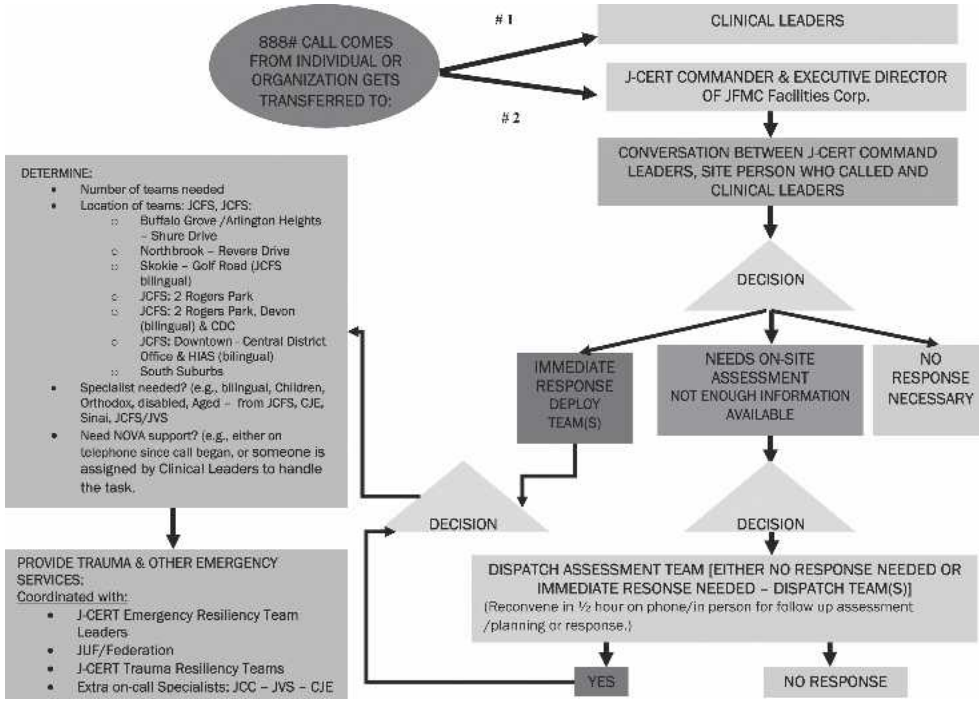

FIGURE 3. J-CERT Response Decision Tree

death, mayhem, and destruction can and will visit our community.

- Building buy-in among the top levels of professional colleagues at the agencies. Most important are the second and third levels of professionals who do the work everyday in our agencies and who actually control the deployment of all the professional resources on the ground.
- Developing formal policies for sharing confidential information, taking into account federal HIPPA regulations, personnel practices, and polices defining when people affected by traumatic events become clients of an agency.[1]
- Building a team of the key support personnel who will constitute the Command Group that creates and manage the infrastructure needed to support the work of the response/resiliency teams. Managing the needed infrastructure requires attention to logistical needs, security, equipment, technology and communications, marketing and public relations, and Family Assistance Center supplies and the creation of systems for the rapid acquisition of emergency resources for food,

[1]In Chicago when J-CERT is activated, by mutual agreement between the agencies and Federation, all agency personnel are acting as agents of the JUF/Jewish Federation. Because J-CERT is a program of the Federation all its activities are covered by Federation's insurance coverage, including liability insurance. Community members served by J-CERT are not defined as clients of the agencies. Therefore, federal HIPPA privacy laws and state of Illinois mental health confidentiality laws *do not* apply during the duration of the incident or in the course of any follow-up interventions unless the individual or family formally goes through intake and becomes a client of one of our agencies. In addition, because J-CERT was the structure we used to create a community-wide case management program for Katrina victims in Chicago, we have also executed interagency HIPPA agreements between all the agencies and the Federation. J-CERT Team members are considered to be on "work time" while responding to an incident, and all personnel practices concerning hours of work apply, including compensatory time and overtime as may be appropriate.

shelter, cash assistance, and other concreate services that may be needed in the event of an incident involving a large mass of people.

- Developing liaison and training relationships with public sector first responders; city, state, or county emergency management officials; the American Red Cross; and others. Arrangements should be made with the American Red Cross for emergency sheltering-in sites, food, and water.
- Creating a detailed marketing plan to inform and engage the entire range of Jewish community organizations and institutions when the time to "roll out" the plan is reached.
- Building the necessary databases of key contact, calling trees, and organizational information. Most important, systems and structures to maintain the data's accuracy on an ongoing basis must be created.
- Determining which communications and other technologies will best serve the community's needs and acquiring them, as well as implementing back-up systems to protect against the failure of primary communications technologies.[2]
- Creating a 24/7 phone number to enable immediate reporting, assessment, and response in the event of an incident.
- Developing the infrastructure to enable the Federation leadership to provide periodic briefings to community leaders after an incident occurs, as it is unfolding, and during the period in which the community response plan is operating.
- Building in redundancy for every leadership role in the plan.
- Developing a detailed protocol manual or handbook containing all the procedures, policies, and resources that govern and support the plan.
- Creating briefing programs on procedures and protocols for *all* personnel at *all* Jewish community agencies when the plan is ready to be rolled out to the Jewish community.
- Determining how the community plan can use professional and nonprofessional volunteers who will offer their services when an incident occurs.
- Developing "GO KIT" lists for team members containing essential items they will need during a prolonged emergency. Similarly, GO KITS containing essential operational supplies must be preassembled and stored at accessible locations around the community to support Command Center and team operations. Special "Kids Corner" kits of supplies and resources should also be assembled for use with groups of children in the event that children are temporarily dislocated.
- Meeting with local municipal government first responders and other emergency management personnel to develop working relationships and identification of sites and facilities under their control that can be used by the Jewish community in an emergency.
- Testing the plan using table-top exercises to assess its operational capability and expose its flaws, setting the stage for making necessary corrections.
- Developing a plan to build support among top-level lay leaders through initial consultation, periodic briefings about the progress of plan development, and the provision of reports about how the investment in the plan made it possible to swiftly and effectively respond to traumatic incidents affecting the community.

Because it is highly probable that the initial response of professional colleagues and lay leaders is likely to reflect both disbelief about the possibility of really bad things happening and an understandable lack of willingness to confront the aftermath of death and destruction, whether caused by

[2]A secure emergency Web site was created that contains the only complete list of all Chicago Jewish community organization sites with key contact information, tied to a mapping and directions program. All Jewish community sites are coded to note the presence of vulnerable populations (e.g., children, disabled, or elderly).

terrorists or a natural disaster, the commitment of the Federation and the credibility of the project leader are the primary tools in the early phases of development of a community plan. Clearly, there are exceptions to this assertion, especially in communities like New York, Seattle, Florida, and New Orleans that have experienced major traumatic events. However, even in some of those communities there has been a tendency to underestimate the scope, duration, and impact of the psychological trauma that people experienced. With the exceptions of New York/New Jersey and Seattle—communities that experienced a violent attack and that provided mental health trauma services—the potential for misassessment of the traumatic consequences is quite understandable in light of the absence of a mental health trauma response plan and the understandable initial, dramatic, and typically overwhelming need to deal with the physical impact of the disasters. Perhaps the most significant force working against recognition of the importance of a mental health response and resiliency plan, despite 9/11, is the tendency of federal and state public officials to discount or even totally neglect these issues in their plans.

For example, the Federation and five of its agencies were part of a multiagency collaboration of Chicago metropolitan social service agencies that served 2,800 victims of Hurricane Katrina who fled to Chicago. The United Way of Metropolitan Chicago served as convener and provided $2 million in funds raised for Katrina victim services in Chicago, which enabled the agencies to provide housing, employment, and legal advocacy services—none of which were allowable services under FEMA regulations governing a contract with the City of Chicago that funded the case management staff. J-CERT worked with nearly 900 of these displaced people– both members of the New Orleans Jewish community and African Americans from New Orleans living in poverty. J-CERT case management staff were required to deal with the psychological aftermath of the severe traumatic experiences that every one of them had to deal with at some level to be able to move on with their lives. As with all groups experiencing severe trauma, many required only modest, short-term assistance. However, we found that 30–40% required some fairly intensive therapeutic services, and we estimate that an unknown but significant number are likely to need such services for one to three more years.

As if made to order to underscore this point, as this article was being written, several newspaper reports describing the long-term medical and psychological consequences of 9/11 and Katrina were published. They provide vivid descriptions of the current physical and psychological status of 3,600 adults and children in New Orleans living in trailers, bereft of the support and services they need. More than two years after Hurricane Katrina, the effects of one of the most significant physical and mental health disasters in the history of our country continue unabated. Reports on New York/New Jersey post-9/11 note that available assistance funds for just the 32,000 rescue workers, volunteers and firefighters are running out, and it is projected that five years after the event an additional $257 million is needed to continue to serve 19,200 of them. Eight thousand Ground Zero workers with 9/11-related mental illnesses, who represent 25% of those still needing therapeutic services and mental health medications, require $58 million to fund their care.[3] It is of interest to note that Lutheran Social Services just closed its Oklahoma City mental health services in 2006, more than ten years after the attack on the Murrah Federal Building.

[3]See Bob Herbert, "Out of Sight," *New York Times*, December 12, 2006; Sewell Chan, "Health Centers Say Aid for 9/11 Workers Is Running Out," *New York Times*, December 19, 2006; Bob Herbert, "The Ninth Ward Revisited," *New York Times*, December 25, 2006; Christopher Cooper, "In Katrina's Wake: Where is the Money?," *Wall Street Journal,* January 27–28, 2007; and Shaila Dewan, "Little Progress Seen for Poorest After Hurricane," *New York Times*, February 2, 2007.

Creating an environment in which a new culture can be seeded and grown is a formidable task. Investing the time to learn what questions must be asked, formulating a planning strategy, assembling a small group of key colleagues, determining the types of additional training necessary for professional clinical staff and other personnel, and acquiring the technology and other resources needed to support a serious response and resiliency plan—all are essential precursors to development and implementation of a community plan. Before the first meeting with agency executives and federation leadership was held in Chicago, I met in New York with key executives of the UJA-Federation and New York Jewish community agency executives, the head of New York State's Mental Health Office for the New York City area, and the executive of the association of voluntary mental health agencies to ascertain what they learned from their experience during and after 9/11 about caring for people after such a traumatic event. We were interested in identifying key questions and planning issues we would need to address, including gleaning information about how the Jewish community and its structures were or were not involved and affected. I also visited several programs in Israel. In addition, I reviewed the literature in the field, including U.S. government materials, and some analysis of the strategies developed in Israel. Equally critical to the success of our effort was access to a highly knowledgeable and skilled consultant we engaged who worked very closely with me for more than two years.[4]

The project leader must be prepared to help others understand that creating a good community plan is akin to working with a large onion that one peels back. Just when you think you have reached the core and finished all the planning and preparations, you inevitably discover that there are still many important layers to go through. Many people and organizations such as Federations have little patience to support projects that are very complex, require the investment of substantial human and financial resources, and take long periods of time to create and implement before coming to fruition. The planning process is an important opportunity for team building, which is critical to the success of the project. The process of discovery and learning inherent in creating a community resiliency and response plan also contributes to team-building opportunities in ways that are significant because, if used properly, they can add an important dimension to the strengthening of the community.

When we began working on the plan for Chicago, many of my colleagues humored me, its project leader. More accurately, they tolerated my insistence on pursing the then-bizarre notion of creating such a plan. In truth, however, none of my colleagues believed we would progress as far as we have, nor have the depth of capacity to engage in the kind of trauma response and resiliency work we are doing. Three years later, however, there is a real leadership team with all sharing a deep sense of responsibility for J-CERT (see Table 1).

The project leader/planner must also keep in mind that it is vital to build a culture that can be sustained over time. People change jobs, leave agencies, and move to new geographic locations. While developing a community resiliency and response plan, thought must be given to steps that can be taken to assure sustainability. In the field of planning for human services this issue has, fortunately, been receiving more and attention.[5] Important elements in as-

[4]A great deal of gratitude is owed to Irene Rozansky, our consultant from Rozansky & Associates, LLC [info@raconsulting.net, or www.raconsulting.net] who contributed mightily to the development of J-CERT above and beyond the terms of our formal agreement.

[5]Helpful tools for planning include the *Sustainability Planning Workbook*, available from the Finance Project at www.financeproject.org and the *Sustainability Toolkit*, available from the Center for Civic Partnerships at www.civicpartnerships.org.

Table 1. Culture Change through Planning

Initial Feelings/Attitudes (3 years ago)	Feelings/Attitudes after 2 Years	Feelings/Attitudes Now
"OK, we'll go along with him. We'll humor him, but not take this too seriously."	Buy-in has grown dramatically; now there is widespread recognition of the seriousness and importance of the effort	Shared ownership among J-CERT clinical leaders and team leaders; deep commitments from team members
Reluctance to deal with the real possibilities of a violent attack on the Jewish community resulting in death and injury, and major discomfort in talking about these possibilities	Recognition that such events are not only possible, but that we might also have to deal with the real aftermath of a violent attack, as well as other disasters that could occur	As a result of several experiences responding to trauma incidents, deepening understanding of the consequences of such events
Emphasis on the first 72 hours—the American Red Cross Disaster Relief model	If required, immediate response by our most highly skilled and experienced clinical staff	Appreciation of need to differentiate responses to meet initial, intermediate, and long-term needs of trauma victims
Positive response, but otherwise "business as usual"	No more "business as usual," except for continuing to care for those in residential settings and identified emergency cases	Clarity about the necessity of making responses to traumatic situations a priority
No need for "other" emergency services (e.g., cash assistance, food, clothing, housing)	Adoption of the "Family Assistance Center" model (Chicago's "Shalom: The Welcome Center" for FSU refugees); now including assistance with funerals, adoption, and guardianship, if required	Commitment to doing whatever may be necessary to provide hard and soft services, over the short term and long term
Skeptical about the need for prerecruitment, screening, and use of mental health professionals who want to volunteer	Developing a process and protocol for use of professional volunteers, especially as "Companions" in the Family Assistance Center	Full-blown plan developed for use of professional mental health volunteers; development of greater clarity about the volunteer roles
"We're going to build this system, invest in training staff, and never use it. How are we going to sustain our readiness?"	The week of training also began the process of building a community team. Key leaders now agree that NOVA-trained staff should be brought together periodically to practice, hone, and upgrade their skills and knowledge	Creation of Training Committee, development of training priorities, quarterly meetings of all J-CERT Teams, post-incident analysis of every experience, briefings of all team members to use learning from one incident for future responses.
Major differences about team composition, no articulation of mixing teams across agencies	Agreement on creating some teams in advance, using a mix of staff and leadership from the clinical agencies	Recognition of the need to have preassigned teams. Development of five teams with back-up team leaders in case additional teams are needed, planning for training of additional team members, and rabbis

suring sustainability include a firm commitment by the Federation to provide the human and financial resources necessary over time, building in redundancy for all key leadership positions, developing internal trainers and training capacity, and making provision for the training and incorporation of new team members on an ongoing basis.

TRAUMA AND SOCIAL SYSTEMS

Responding to community trauma and disaster *is not* the same as the wonderful work that our Jewish community clinical agencies typically do every day in responding to the personal and familial crises they are used to handling. Traumatic events visited on a community often severely damage social systems as well, and because these systems tend to be hidden from view, it is easy to overlook them. Although some of the crises agency staff deal with every day are unbelievably horrific and many of the professional skills and tools that our clinical staff possesses are extremely useful and highly applicable, important additional theoretical knowledge and skill must be acquired. Since the first *intifada* in Israel, and as a result of the Oklahoma City and the 9/11 attacks, the knowledge and literature of trauma response work have expanded exponentially.[6] Community plans must incorporate resiliency strategies for both short- and long- term responses, as well as for repairing *and* preparing the foundation for individual, family, community, and institutional resiliency.

The tendency of many working in the aftermath of a mass trauma is to think in traditional terms about therapeutic goals and services, and sometimes many people who are devastated by such events do indeed need a clinical or therapeutic response. Initially, however, most people primarily need assistance with acquiring or using the capacity they already have to regain control over their lives and to function within a framework of resiliency, rather than victimhood. A resiliency strategy postulates that even in the midst of disaster people have strengths they can draw on and that even in those circumstances they can learn about strengths they have that they are not aware of, which they can use to regain control of their life. Although some people will require more intensive or longer term therapeutic services due to posttraumatic stress disorder (PTSD) or other factors, it is important to be cognizant of the fact that the nature of such events *also* traumatizes communities and organizations or institutions, as well as the individuals who are a part of them. Traumatic events often also have long-term consequences for social systems that can be "missed" when one is primarily focused on the impact on the individual or family. For example, critical to the maintenance of community systems are its lay and professional leaders. Community leaders carry roles in a crisis that require them to function on behalf of the community after an incident occurs as well as for long periods afterward, but the consequences for them as people and the support they need are often overlooked.

[6]See the bibliography at the end of this article for an illustrative list of recent books and articles. Sources of information and assistance include the National Center for Child Traumatic Stress, www.NCTSN.org and the National Center for PTSD, www.NCPTSD.va.gov, which recently published an excellent resource in collaboration with the federal Substance Abuse and Mental Health Services Administration [SAMHSA], *Psychological First Aid: Field Operations Guide,* which is available from SAMHSA's Disaster Technical Assistance Center at www.mentalhealth.samhsa.gov/dtac. SAMHSA also recently launched a new National Center for Trauma Informed Care, which can be reached at www.mentalhealth.samhsa.gov/womenandtrauma. The U.S. Department of Justice's Office for Victims of Crime, www.ovc.gov/publications, also has some very useful information. Additional important resources include the American Academy of Experts in Traumatic Stress at www.TraumaticStress.org, and the International Society for Traumatic Stress Studies at www.istss.org/terrorism/prtofessionals.htm.

CROSS-TRAINING CLINICAL PROFESSIONALS

As noted earlier, trauma response and resiliency work requires specialized knowledge and training that supplement the clinical training and experience of agency professionals. To provide training in the basic knowledge and skills needed in trauma response work, we chose to use NOVA, the National Organization for Victims Assistance. We contracted with them to send in a trainer who led their basic 40-hour, five-day course. Six months later we repeated the same course for a second group of staff. The first training cycle involved about 70 staff members, of whom about 55 were agency clinicians. The rest were Federation staff that are members of the J-CERT Command Group. Subsequently, we developed a relationship with the Donald J. Cohen-Irving Harris Center for Disaster and Trauma Response in Tel Aviv, which has provided additional training for our team for the past three years based on their resiliency model.[7] Our colleagues from Tel Aviv spend three to four days annually in Chicago working with our group and also provide consultation to us about elements of our plan.

J-CERT team members are primarily clinical mental health professionals, mostly masters-level social workers and some psychologists; most are on the staff of Jewish Child and Family Services, with some team members coming from the Council for Jewish Elderly, the Jewish Vocational Service, and the Jewish Community Centers. To assure continuity of core services to the community in the event of an emergency, and to capitalize on their significant expertise, experience, and ability to function in unpredictable environments, we chose to first train staff who are supervisors, program directors, associate/assistant executives, and executive directors. As J-CERT has matured, our perspective has also changed, and we are planning to train additional professionals from the Council for Jewish Elderly and the JCCs. We also plan to train additional JCC staff so that eventually will be a mini-team at every center facility. We are identifying 10 to 15 rabbis from the various denominations and will provide a specially designed training program enabling them to join our teams as may be required. Because of normal staff turnover, the identification of new staff from all the agencies we are incorporating into our teams, and the fact that some staff who were trained are not suited for this type of work, we conducted another major "basic" training cycle in the spring of 2007. All told, there are now about 80 agency and Federation personnel involved in J-CERT.

We have also learned that some incidents require us to bring agency personnel into our teams who are not J-CERT-trained, but who are specialists in early childhood or aging services, or who have unique relationships or language skills (i.e., in the Orthodox community, or who speak Russian). We are therefore designing a mini-course to provide additional agency clinical staff a basic understanding of the framework we are using in our work. Another area of focus is training team leaders to be able to better assess and deal with team member burnout.

All J-CERT work is documented, recorded, and posted in a special folder in Outlook on the Chicago Federation's computer network, which is accessible to all of J-CERT's leadership. The files also include handout materials and session outlines developed for use in various incidents, as well as copies of training materials so clinical and team leaders can download materials as they need them for specific types of interventions. After every incident for which J-

[7]Nathaniel Laor, MD, Ph.D., director; Leo Wolmer, Ph.D. and Daniel Hamiel, Ph.D., constitute the team from the Donald J. Cohen-Irving Harris Center for Trauma and Disaster Intervention in Tel Aviv, Israel. See the Bibliography for articles describing the Tel Aviv model. What began as a professional relationship has developed into deepening personal friendships and a sharing of experiences and resources. The JUF/Jewish Federation of Metropolitan Chicago initially developed contact with the Cohen-Harris Center during the second *Intifada* when we began to provide allocations to the Center from the Israel Emergency Fund Campaign.

CERT has been activated, it is our standard practice for the clinical leaders to conduct a debriefing for all team members. Team members who worked during an incident in turn conduct a briefing for all J-CERT members about the event and the work they did as part of our quarterly training meetings. While an intervention is underway, teams are debriefed daily by the clinical leaders. Every incident is analyzed and processed to enable us to learn from our experience and improve our performance. In addition to quarterly meetings of all our teams, separate meetings are also held with the team leaders, the clinical leaders and the commander.

The J-CERT Training Committee, consisting of the clinical leaders, several of the team leaders, and the commander, is responsible for designing and implementing all the quarterly J-CERT training meetings, arranging for additional cycles of NOVA training, defining the issues and areas of emphasis for our annual training seminar with the Cohen-Harris Center team from Tel Aviv, and monitoring the progress of a work group we established to articulate and document the J-CERT model. This group also determines which ancillary training opportunities we ought to exploit that will enhance our capacity. For example, we recently entered into an agreement with the Chicago Metropolitan Chapter of the American Red Cross to train all our team members in their one-day mental health course. Completion of the course results in certification enabling J-CERT team members to volunteer to provide emergency mental health services in local disasters, which we view as an opportunity to keep their skills well honed. Similarly, we sent two members of our Command Group to a two-day Train-the-Trainer Course provided by the American Red Cross. The course was funded by the U.S. Department of Homeland Security and designed to train 250 leaders in the nonprofit sector nationwide to lead local table-top exercises—running scenarios for nonprofit organizations to teach them how to respond in large-scale emergencies. An immediate benefit of this course was that two of our group were trained to conduct table-top exercises, which was key when we conducted a test in early 2007 of J-CERT's clinical trauma response capacity. In addition, the experience provided an opportunity for us to develop relationships with people from other organizations in the Chicago metropolitan area, as well as nationally, who are engaged in this type of work. NOVA also provides Trainer-the-Trainer courses, and we have decided to send a group of J-CERT Leaders for this advanced training so that we will have the internal capability to provide the basic NOVA course to new staff in the years ahead.

Another focus of training is the Incident Command and Control System (ICS), the process used to govern all incidents that may occur in the United States. This methodology was first developed by the U.S. Forest Service to deal with the management of forest fires, and subsequently, the unified command model was adopted by all units of local, state, and federal government. We thought it would be important for the leadership of J-CERT to understand the environment of a large-scale incident in which first responders are in charge. To provide this training we enlisted the directors of the Cook County Sheriff Department's Emergency Management Agency and the regional office of the State of Illinois Emergency Management Agency. In collaboration with our consultant they developed and provided an eight-hour course covering the basics of ICS, including basic information about how bomb threats are handled.[8]

[8]FEMA, the Federal Emergency Management Agency, provides a series of training courses for disaster managers, many of which can be accessed and taken online. Go to www.fema.gov for more information. The United States now has a National Incident Management System (NIMS) and plan. Information about the system and the plan can be accessed at www.fema.gov/nims. Another important organization is NVOAD, the National Voluntary Organizations Active in Disaster, www.nvoad.org. The United Jewish Communities is a member of NVOAD.

In selecting and implementing these types of training programs it is important to phase them in over time, allowing participants the time to absorb and integrate new knowledge and skills. It is also important to be sensitive to the reality that such integration is sometimes difficult, because it may pose conflicts between earlier and new theoretical models and presents challenges posed by the new and different expectations that trauma response work entails. Professionals need to feel supported so that they are comfortable raising questions while dealing with the process of integrating new knowledge, skills, and expectations.

CONCLUSION

Perhaps the most striking outcome of engaging in the process of developing a community trauma response/resiliency plan is that working together destroys the silos that typically exist between Federation and the agencies and even between departments and programs in agencies. Staff are proud to be part of a team that has the ability to help heal a community after a traumatic incident, and they feel equally pleased by what they learn from every experience. Lay leaders too have a special sense of pride and a feeling of greater security knowing that their Federation has gone the extra mile to make sure that when tragedy strikes, the Jewish community is prepared to respond.

BIBLIOGRAPHY

The Bibliography provided below is necessarily selective, but does include many basic resources. It consists of materials that were found useful as we proceeded with our work. It also represents the extensive array of trauma knowledge now available, especially since 9/11. An attempt has also been made to include information that is grounded in some of the experience of the Jewish community.

REFERENCES

15 nightmares for disaster planning. (2005, March 16). *New York Times,* A14.

Assessing mental health in the aftermath: A report from Louisiana. (2006, Winter). *JCC Circle,* 11.

Agency for Healthcare Research and Quality. (2006, September). *Pediatric terrorism and disaster preparedness: A resource for pediatricians.* Washington, DC: U.S. Department of Health and Human Services. Available at http://www.ahrq.gov/research/pedprep/resource.htm.

American Journal of Orthopsychiatry. (2002, October). Special issue devoted to trauma, resiliency and PSDT, *72*(4).

American Red Cross. (2006). *A reference for non-governmental organizations: Weapons of mass destruction/terrorism field guide*. Washington, DC: Author.

Auslander, B. (2003). *Social services department work following terror attacks, war and mass disasters: The unique Jerusalem experience*. Jerusalem: Municipality of Jerusalem, Social Services Department. The publication includes a CD.

Baranowsky, A. B. Gentry, J. E., & Schultz, D. F. (2005). *Trauma practice: Tools for stabilization and recovery*. Cambridge, MA: Hogrefe & Huber Publishers.

Begley, S. (2003, September 12). Is trauma debriefing worse than letting victims heal naturally? *Wall Street Journal*.

Begley, S. (2005, August 19). A spotless mind may ease suffering, but erase identity. *Wall Street Journal.*

Berger, R. (2007, June 8). Color red [Notes from Sderot]: Still trembling, anxiety and anger, frozen atmosphere. *Haaretz*.

Berger, R. (2007, April). Coping with trauma. *Haaretz*, 68–73.

Bleich, A., Gelkopf, M., & Solomon, Z. (2003). Exposure to terrorism, stress-related mental health symptoms, and coping behaviors among a nationally representative sample in Israel. *Journal of the American Medical Association, 290*(5), 612–619.

Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work, 52*(1), 63–70.

Brody, J. E. (2005, March 1). Get a grip: Set your sights above diversity. *New York Times*.

Center for Mental Health Services. (2005). *A guide to managing stress in crisis response professions*. Washington, DC: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services, Available at www.samhsa.gov.

Center for Mental Health Services. (2005). *The dialogue: A quarterly technical assistance bulletin on disaster behavioral health*. Available at www.samhsa.gov.

Center for Mental Health Services. (2005). *Mental health response to mass violence and terrorism: A field guide*. Washington, DC: U.S. Department

of Health and Human Services, Substance Abuse and Mental Health Services Administration,. Available at http://www.samhsa.gov.

Clemans, S. E. (2004). Recognizing vicarious traumatization: A single session group model for trauma workers. *Social Work with Groups*, *27*(2/3), 55–74.

Clinical Quarterly. Available from the National Center for Post-Traumatic Stress Disorder at http://www.ncptsd.va.gov

Cole, L. A. (2007). *Terror—How Israel has coped and what America can learn*. Bloomington, IN: Indiana University Press.

Do not separate yourself from the community: A response to the Columbine High School tragedy. (1999, May 10). New York: Coalition for the Advancement of Jewish Education.

Danieli, Y., Brom, D., & Sills, J. (Eds.). (2005). *The trauma of terrorism: Sharing knowledge and shared care: An international handbook*. Binghamton, NY: Haworth Press.

Danieli, Y., & Dingerman, R. L. (Eds.). (2005). *On the ground after September 11: Mental health responses and practical knowledge gained*. Binghamton, NY: Haworth Press.

DeWolfe, D. J., & Nordboe, D. (2000). *Training manual for mental health and human service workers in major disasters.* Washington, DC: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Elliott, A. (2004, September 11). Growing up grieving, with constant reminders of 9/11. *New York Times*.

Friedman, C. A. (2005). *Spiritual survival for law enforcement: Practical insights, practical tools*. Linden, NJ: Compass Books.

First aid for emotional trauma. (2006). *Harvard Mental Health Letter, 22*(9), 1–3.

Follette, V. M., & Ruzek, J. I. (Eds.). (2006). *Cognitive behavioral therapies for trauma* (2nd ed.). New York: Guilford Press.

Fox, E. B. (n.d.). *Guidelines for response to the recent tragic events in the U.S.* Available from the International Society for Traumatic Stress Studies, along with a variety of useful resources at http://www.istss.org.

Gold, S. N., & Faust, J. (Eds.). (2002). *Trauma practice in the wake of September 11, 2001*. Binghamton, NY: Haworth Press.

Groopman, J. (2004). The grief industry: How much does crisis counseling help—or hurt? *New Yorker,* 30–32, 35–37.

Gurwitch, R. H., Pfefferbaum, B., Montgomery, J. M., Klomp, R. W., & Reissman, D. B. (2007). *Building community resilience for children and families*. Washington, DC: Substance Abuse and Mental Health Administration, Available at www.NCTSNet.org

Gurwitch, R. H., Sitterle, K. A., Young, B. H., & Pfefferbaum, B. (n.d.). *The aftermath of terrorism.* Available from the National Center for Post-Traumatic Stress Disorder, http://www.ncptsd.va.gov.

Itzhaky, H., & Dekel, R. (2005). Helping victims of terrorism: What makes social work effective? *Social Work, 50*(6), 335–343.

Itzhaky, H., & York, A. S. (2005). The role of the social worker in the face of terrorism: Israeli community-based experience. *Social Work, 50*(2), 141–149.

Israel Center for the Treatment of Psychotrauma. www.traumaweb.org.

Harney, P. A. (2007). Resilience processes in context: Contributions and implications of Bronfenbrenner's person-process-context model. *Journal of Aggression, Maltreatment & Trauma*, *14*(3), 73–87.

Journal of Aggression. Maltreatment & Trauma. Binghamton, NY: Haworth Press. Available at http://www.HaworthPress.com.

Kahn, L. (2003, Fall). This sacred work. *Reconstructionist,* 43–46.

Kaniasty, K. (2005). Social support and traumatic stress. *PTSD Research Quarterly*, *16*(2), 1–3.

Kaplan, Z., Matar, M. A., Ram, K., Tamar, S., & Cohen, H. (2005). Stress-related responses after 3 years of exposure to terror in Israel: Are ideological-religious factors associated with resilience? *Journal of Clinical Psychiatry, 66*(9), 1146–1154.

Kershner, I. (2007, June 30). Rockets fray nerves in Israeli 'bull's-eye' city. *New York Times*.

Knight, C. (2006). Groups for individuals with traumatic histories: Practice considerations for social workers. *Social Work, 51*(1), 20–30.

Lamberg, L. (2003). In the wake of tragedy: Studies track psychological response to mass violence. *Journal of the American Medical Association, 290*(5), 587–589.

Laor, N., Weiner, Z., Spirman, S., & Wolmer, L. (2005). Community mental health in emergencies and mass disasters: The Tel Aviv model. *Journal of Aggression, Maltreatment & Trauma, 10*(3–4), 681–694

Laor, N., & Wolmer, L. (2002). 75 children exposed to disaster: The role of the mental health professional. In Melvin Lewis (Ed.), *Child and adolescent psychiatry* (3rd ed., pp. 925–936). Philadelphia: Lippincott Williams and Wilkins.

Laor, N., Wolmer, L., Spirman, S., & Wiener, Z. (2003). Facing war, terrorism, and disaster: Toward a child-oriented comprehensive emergency care system. *Child and Adolescent Psychiatric Clinics of North America, 12,* 343–361.

Lifton, R. J. (2005). Americans as survivors. *New England Journal of Medicine, 352*(22), 2263–2265.

Masten, Ann S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, *56*(3), 227–238.

McNally, R. J., Bryant, R. A., & Ehlers, A. (2003). Does early psychological intervention promote recovery from post-traumatic stress? *Psychological Science in the Public Interest, 4*(2), 45–79.

Michael, D. (2002, August). *Social aikido—Transforming disaster into a better future*. Available at http://www.gbn.com/ArticleDisplayServlet.srv?aid=1105.

Mollica, R. F., Sarajilic, N., et al. (2001, August 1). Longitudinal study of psychiatric symptoms, disability, mortality, and emigration among Bosnian refugees. *Journal of the American Medical Association, 286*(5), 546–554.

National Center for Child Traumatic Stress & National Center for PSDT. (2007). *Psychological first aid: Field operations guide.* Washington, DC: Substance Abuse and Mental Health Administration. May be downloaded at www.NCTSNet.org or at http://www.samhsa.gov.

National Center for Child Traumatic Stress. (n.d.). *A checklist for school personnel to evaluate and implement the mental health component of your school crisis and emergency plan.* Available at www.NCTSNet.org.

National Center for PTSD. (n.d.). *Effects of traumatic stress in a disaster situation: PTSD fact sheet*. Available from http://www.ncptsd.va.gov

National Center for PTSD. (n.d.). *Phases of traumatic stress reactions in a disaster: PTSD fact sheet*. Available from http://www.ncptsd.va.gov

National Center for PTSD. (n.d.). *Screening for PTSD in a primary care setting: PTSD fact sheet*. Available from http://www.ncptsd.va.gov

National Institute of Mental Health. (2002). *Mental health and mass violence: Evidence-based early psychological intervention for victims/survivors of mass violence: A workshop to reach consensus on best practices.* Washington, DC: Author.

Norris, F. H. (n.d.). *Risk factors for adverse outcomes in natural and human-caused disasters: A review of the empirical literature: PTSD fact sheet*. Available from http://www.ncptsd.va.gov

Norris, F. H. (n.d.). *The range, magnitude, and duration of effects of natural and human-caused disasters: A review of the empirical literature, 2002 + review update 2005*. Available from http://www.ncptsd.va.gov

Norris, F. H., Watson, P. J., Hamblen, J. L., & Pfefferbaum, B. J. (2005). Provider perspectives on disaster mental health services in Oklahoma City. *Journal of Aggression, Maltreatment & Trauma, 10*(1/2), 649–661.

Office for Victims of Crime. (2001). *OVC handbook for coping after terrorism*. Washington, DC: U.S. Department of Justice, Office of Justice Programs. Also available at www.ojp.usdoj.gov.

Pynoos, R., & Nader, K. (1988). Psychological first aid for children who witness community violence. *Journal of Traumatic Stress, 1*(4), 445–473.

Resilience. (2006). *Harvard Mental Health Letter, (23)*6, 5–6.

Responding to the needs of people with serious and persistent mental illness in times of major disaster. (1996). Washington, DC: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Available at http://www.samhsa.gov.

Rethinking post traumatic stress disorder. (2007). *Harvard Mental Health Letter*, *24*(2), 1–4.

Richman, J., Wisler, J. S., Flaherty, J. A., Fendrich, M., & Rospenda, K. M. (2004). Effects on alcohol use and anxiety of the September 11, 2001 attacks and chronic work stressors: A longitudinal cohort study. *American Journal of Public Health, 94*(11), 1–6.

The risk for PTSD: New findings. (2007). *Harvard Mental Health Letter, 23*(8), 4–5.

Ritchie, E. C., Watson, P. J., &Friedman, M. J. (2006). *Interventions following mass violence and disasters*. New York: Guilford Press.

Roberts, A. R. (Ed.). (2005). *Crisis intervention handbook: Assessment, treatment and research* (3rd ed.). New York: Oxford University Press.

Rosenfeld, L. B., Caye, J. S., Ayalon, O., Lahad, M., & Apart, W. T. (2005). *Helping families and children manage the effects of disasters* Silver Spring, MD: NASW Press.

Saxe, G. N., Ellis, B. H., & Kaplow, J. B. (2007). *Collaborative treatment of traumatized children and teens*. New York: Guilford Press.

Schein, L. A (Ed.). (2007). *Psychological effects of catastrophic disasters: Group approaches to treatment*. Binghamton, NY: Haworth Press.

Schlenger, W. M., Caddell, J. M., et al. (2002). Psychological reactions to terrorist attacks: Findings from the National Study of Americans' Reactions to September 11. *Journal of the American Medical Association,* 288(5), 581–588.

Study: Israelis resisted intifada's psychological warfare. (2006, January 11). *Jerusalem Post*.

Substance Abuse and Mental Health Administration. (2002). *Communicating in a crisis: Risk communication guidelines for public officials*. Washington, DC: U.S. Department of Health and Human Services.

United Jewish Communities. (2005). *Disaster and crisis response systems for Jewish Organizations, CD, Version 2.0.* New York: Author.

U.S. Department of Health and Human Services. (2005, September). *Terrorism and other public health emergencies: A reference guide for media*. Washington, DC: Author. For the most current information go to http://www.hhs.gov/emergency.

Welch, J. (2005, September 14). The five stages of crisis-management. *Wall Street Journal*.

Whitcomb, C. (2007, April 20). Building a better lockdown. *New York Times*.

Williams, M. B., & Poijula, S. (2002). *The PTSD workbook: Simple, effective techniques for overcoming traumatic stress symptoms*. Oakland, CA: New Harbinger Publication.

Williams, M. B., & Sommer, J. F., Jr. (Eds.). (2002). *Simple and complex post-traumatic stress disorder: Strategies for comprehensive treatment in clinical practice*. Binghamton, NY: Haworth Press.

Wilson, J. P., & Keane, T. M. (Eds.). (2004). *Assessing psychological trauma and PTSD*. New York: Guilford Press.

Wolmer, L., Laor, N., & Yazgan, Y. (2003). School reactivation programs after disaster: Could teachers serve as clinical mediators? *Child and Adolescent Psychiatric Clinics of North America, 12,* 363–381.

Young, B. H., Ford, J. D., Ruzek, J. I., Friedman, M. J., & Gusman, F. D. (n.d.). Disaster mental health services: A guidebook for clinicians and administrators. Washington, DC: Department of Veterans Affairs. Available at: http://www.ncptsd.va.gov/publications