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Exploring Responses to Community Violence Trauma Using a Neighborhood Network of Programs

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Abstract: Responses to community violence should include interventions not just for those who are offenders but also for those who are victims of the violence and community members who are affected by the violence. In this study, one city's public health response to victims of community violence using a neighborhood trauma team network (NTTN) is explored. Neighborhood trauma teams provide victims and their families with psychological first aid, logistical guidance, and referral to long-term therapeutic services. These teams also provide referral and community meeting support for community residents exposed to violence. To better understand program operations and identify the strengths and challenges of this response model, semi-structured interviews with lead program staff were used as well as a review of program documents. The results show that the NTTN has a clear purpose in meeting immediate client needs, but ambiguity exists in the network's role in community healing and in community violence prevention. The NTTN response is mapped onto a social–ecological framework of violence prevention to contextualize this community-based public health response in the broader public health–criminal justice setting in which it operates. Implications for NTTN function and coordination are discussed.

Keywords: community violence responses; trauma; public health; socio-ecological framework; cross-sector partnerships

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1. Introduction

Community violence, defined as violence outside the home in a public space among individuals who may or may not know each other, is widespread and disproportionately affects urban neighborhoods (Armstead et al. 2021). In the United States, community violence in the form of homicide is the leading cause of death among young people (Centers for Disease Control and Prevention 2020). One U.S. state estimates that nearly two-thirds of adults in California have been exposed to community violence as direct victims or witnessed the immediate or aftermath of such incidents (Wintemute et al. 2022). It comes as no surprise that violence itself has been identified as a public health problem (Dahlberg and Mercy 2009; World Health Organization 2022). Responses to the crisis have increased in recent years with governments providing funding to craft interventions (see, for example, Council on Criminal Justice 2021; Murray et al. 2021). At this time, the bulk of the knowledge about responses to community violence is primarily focused on the offender and the criminal justice system, often with various criminal justice-related interventions identified to address the problem (e.g., Abt 2019; Roman et al. 2020). Notwithstanding the need to address offenders, comprehensive approaches to community violence reduction must also focus on victims' and community members' traumas resulting from that violence.

Research shows that unresolved personal trauma can result in negative outcomes such as mental health problems, substance use problems, school/employment failure, and crime and violence (Sharkey 2018). Even when not a direct recipient of the violence, exposure to community violence can increase fear of crime at the individual level, as well as decrease social cohesion and undermine legitimate economic activities at the community

level (Sharkey 2018; Stacy et al. 2017). From a public health perspective, individual and community trauma must be addressed to reduce health inequities and to promote well-being and social justice. Relatively recent community-based initiatives created to address the needs of direct victims and residents exposed to community violence include hospital-based violence intervention programs and community trauma response teams. Little is known, however, about the operations of programs assisting victims and communities in this broader context of responses to violence (Bonne et al. 2022; Jennings-Bey et al. 2015). Knowledge of how programs operate, successes and challenges, as well as the inter-coordination of work are needed to understand what works and what does not with regard to effectively addressing the needs of victims and community members.

To advance knowledge of community violence responses to victims and communities, we investigate a neighborhood trauma team network that is activated after firearm shootings. The operations, successes, and challenges of the network are examined. We explore how this public health response fits into the violence prevention landscape. The results of this exploration can help inform the development of similar programs, approaches to victims of community violence, and violence prevention generally.

1.1. Existing Community Violence Responses

A search was conducted in June, July, and September of 2023 for published studies on community violence response programs. The Web of Science, EBSCO, JSTOR, Google Scholar, and Google search engines were used. The investigation revealed few community violence intervention programs that simultaneously address victim and community needs. Existing published programs seem to be located in the United States where marginalized urban populations experience a disproportionate share of gun violence compared with other locations and other industrialized nations (Small Arms Survey 2022). Table 1 lists these programs and key features.

Table 1. Community Violence Programs for Victims and/or Community Members.

Program Name	Location	Components/Features
Columbus CARE Coalition	Columbus, OH	→ Trauma-informed community support. → Direct engagement with victims and community members. → Canvassing and community outreach. → Volunteer working groups.
Network of Neighbors' Trauma Response Network	Philadelphia, PA	→ Trauma-informed care. → Volunteer responders trained in psychological first aid. → Coordination of services/resources. → Post-traumatic stress management interventions.
Charlestown Trauma Response Team	Charlestown, MA	→ Referral to treatment resources. → Trauma-informed care. → Psychological first aid. → Support for the community using social activities.
Hospital-Based Violence Intervention Programs	Various locations in the United States	→ Evaluation of violence-related injury. → Community resource connections. → Referrals to services.
Trauma Recovery Centers	Various locations in the United States	→ Clinical case management. → Psychological distress support. → Referrals for therapy and medical treatment.

One program that most closely aligns with the program examined in this study is the Columbus CARE Coalition in Columbus, Ohio. This program aims to create a trauma-informed community by supporting and educating residents who have experienced

community violence. The CARE Coalition includes the Community Trauma Response Team (CTRT), which provides individuals with trauma-informed care and resources following a violent or traumatic event in their neighborhood (City of Columbus, Ohio 2023). This coalition directly engages with victims based on reports of community trauma present in their neighborhoods. When neighborhood violence or trauma occurs, the CARE Coalition reaches out to the victims and immediate family members to offer their support services and engages the residents by canvassing the area, asking community members if they need help processing their trauma, connecting them to resources, and facilitating community healing conversations. Community members can volunteer to be a part of working groups that focus on community building, trauma-response training, and community outreach. Although there is little published about the operations or outcomes of the CARE program, a 2018 community survey affirmed the need for this type of program that works to reduce community traumas and build resilience (City of Columbus, Ohio 2023).

Other published accounts of community violence response programs address either solely the victims' needs or the community's needs. Community violence interventions that serve neighborhood residents respond to trauma from exposure to violence rather than service direct victims. One example is the Network of Neighbors' Trauma Response Network in Philadelphia, which uses a trauma-informed healing approach as a way to restore a sense of community safety and instill hope in community residents after a violent and/or traumatic event (City of Philadelphia 2023). The network is run by two staff members and a cohort of trauma responders who are residents of a variety of neighborhoods in the city. These volunteer trauma responders are given extensive training in trauma-informed care and provide coordination of resources and services for community residents. The network offers post-traumatic stress management interventions that include incident briefing, topic-specific stabilization group sessions, and psychological first aid (PFA) to secure the immediate safety of an individual when support is needed following a crisis (City of Philadelphia 2023).

Similarly, the Charlestown, Massachusetts, Trauma Response Team (TRT) was created to support the community through traumatic incidents occurring in their neighborhood including community violence and substance abuse-related situations. When the team responds to community violence incidents, they offer psychological first aid and provide treatment resource referrals to residents (Charlestown Coalition 2022). TRT responders receive training in administering PFA and using trauma-informed care in their interactions. Additionally, the TRT supports the community with the creation of social activities meant to foster community connections that can indirectly lead to a reduction in community violence.

Alternatively, hospital-based violence intervention programs (HVIP) seek to address the needs of victims of community violence with services, triage, and community resource connection starting when victims are at the hospital. A network of HVIPs exists throughout the United States through the Health Alliance for Violence Intervention that shares innovations and best practices in a public health approach (see https://www.thehavi.org/community-violence, accessed on 12 July 2023). While more evaluations are needed (Affinati et al. 2016), one outcome evaluation of an HVIP in Philadelphia, PA, found that the program was successful in reducing violence-related injury over an eight-year period (Bell et al. 2018). Meanwhile, trauma recovery centers (TRCs) serve victims of violence, often from marginalized areas where traditional forms of therapeutic care are not well known or difficult to access. There are over 50 TRCs located across the United States (National Alliance of Trauma Recovery Centers 2022). TRCs use evidence-informed practices in their clinical case management to address the psychological distress of trauma victims and provide strategies for recovery. Case management is catered to the victims' needs including referrals to different types of therapy, medical treatments, and forms of legal assistance. Studies have found that TRCs provide underserved victims with better knowledge of the services available to them and have led to positive survivor outcomes (Houston-Kolnik 2017). For example, a study in Long Beach, California, found that 95% of participants felt better emotionally and 52% described a decrease in depressive symptoms

after 16 TRC sessions, which can be indicators of trauma reduction (National Alliance of Trauma Recovery Centers 2020). Considering these programs as a whole, there are several key features that are a part of community violence responses addressing the needs of victims and community residents: psychological first aid, trauma-informed care, and collaborative structures. These features are discussed more fully in the next sections.

1.2. Key Response Features

While many community violence response programs have not been formally evaluated, many seem to use psychological first aid (PFA) to address immediate trauma. PFA is a disaster relief technique that was carried over to community violence responses to assist individuals experiencing stressful situations. The main goals of PFA are to ensure safety, promote calmness, and build resiliency by assessing immediate needs, listening to victims, providing emotional support, and linking victims to services, such as therapy, for further help following an incident (First Aid Platform 2021). A benefit of PFA is that it can be delivered by trained volunteers and does not rely solely on clinicians who may not be able to serve all those in need in the immediate aftermath of a traumatic event. Some community violence intervention programs offer PFA training to community volunteers who can then administer the intervention. Research shows that quality PFA empowers victims to access resources and promotes resilience through the emotional support provided by those who administer it (Wang et al. 2021).

Another key feature of community violence responses is the use of trauma-informed care as a primary technique to address the needs of victims and neighborhood residents. Trauma-informed care recognizes that past traumatic events may influence behaviors and how present situations are experienced. Individuals are trained on how to provide services in ways that minimize negative experiences. This technique may be administered using a healing-centered approach that focuses on individual strengths and personal reflection. The goal is to facilitate healing by focusing on a holistic sense of well-being rather than solely focusing on isolated symptoms or a traumatic incident (Ginwright 2018). Victim referrals to counseling and support groups and coordinating community vigils and healing circles are key features of these programs.

Finally, the community violence responses reviewed demonstrate that there are collaborative structures consisting of a variety of program staff, volunteers, and sometimes government stakeholders. Program staff tend to consist of clinicians and/or local health agencies that support the existence of a program and volunteers. Volunteers range from a few key individuals in the neighborhood to a large portion of the collaborative arrangement who act as the foundation of the organization, like the Network of Neighbors or the Charlestown Coalition. Other community stakeholders including social services, healthcare professionals, and community organizations such as churches, youth centers, and cultural centers may be resources for victims and community residents. These types of cross-sector partnerships help to maximize resources, share expertise, and create a comprehensive support system for the community members they serve.

1.3. Other Trauma Response Initiatives

Given the lack of literature on community violence responses for victims and communities, violence response initiatives focusing on sexual and domestic violence trauma can be informative. While such programs primarily prioritize supporting individual victims, examining their designs provides valuable insights into trauma response teams within the broader scope of the violence response literature. These programs also use PFA, trauma-informed care, and collaborative partnership structures.

Sexual assault response teams (SARTs) were established in the United States in the 1970s to increase the awareness of and access to victim services, while also attempting to minimize the potential harm using formal help. SARTs do this by fostering collaboration among medical, legal, and mental health systems to support victims and provide evidence for the legal process in the least intrusive way. Core members of SARTs include rape victim

advocates, program staff, police, and prosecutors. While a review of SART programs found that they increase victims' service referrals and can sometimes increase victim participation and satisfaction with the legal process, challenges include role confusion, role conflict, and the need for collaborative training. While these challenges are difficult, one recommendation is to increase training, opportunities for cross-collaboration, and information sharing (Greeson and Campbell 2012). Similar difficulties in establishing clear roles and responsibilities across agencies were observed in a study conducted on the Child Trauma Response Team (CTRT) in New York. The CTRT works with the police, criminal justice and law offices, and a crime victim's organization to provide coordinated, trauma-informed responses to children exposed to intimate partner violence. Stakeholder interviews revealed the need for better cross-communication to decrease confusion amongst partnership collaborations, increase relationship building across teams, and imbue a strong understanding of partners' roles in the coordinated response model (Stylianou and Ebright 2021).

Similarly, with regard to domestic violence, community-coordinated responses (CCRs) aim to facilitate coordination and communication among various stakeholders to improve victim safety, satisfaction, support, and access to resources. Partnering entities include social services, healthcare providers, women's-based community organizations, and criminal justice agencies. A systematic review CCRs found that most studies demonstrated increased victim access to services, higher overall satisfaction with the services provided, and decreased post-traumatic stress disorder (PTSD) and depressive symptoms among victims (Johnson and Stylianou 2020). Additionally, increased conviction rates and longer probation sentences for offenders were found. The review identified a typical coordinated response structure where law enforcement agencies collaborated with at least one other stakeholder organization to provide support to victims; however, the specific response models used varied across the studies. To establish a comprehensive, best-practice CCR model, researchers recommended that teams prioritize activities such as documenting practices, developing logic models, and implementing fidelity measures to ensure consistent and effective service delivery.

Supporting the victim and raising awareness of services are important pieces of these responses to violence, though they also come with challenges, particularly with role confusion and conflict. Meanwhile, research on community violence responses that explore the operations, goals, and overarching connection to violence prevention work is needed to understand their particulars and how they may be similar to work in the sexual assault and domestic violence arenas. Further, these violence response models also should be grounded in a conceptual framework that links to the health and well-being of individuals, families, and communities.

1.4. Conceptual Framework

The socio-ecological framework can root the work of violence prevention into broader networks of individuals, families, and communities to connect with health goals. This framework is the result of Bronfenbrenner's (1979) research on human ecology. He posited that complex relationships exist between an individual and their environment, thus shaping the individual's actions and impacting the actions of others in their existing environments. Influenced by that human ecological work, a public health approach to violence prevention identifies four key spheres of influence: individual, relational, community, and societal (Centers for Disease Control and Prevention 2022b; World Health Organization 2022). At the individual level, working with those who have committed offenses, especially those who are at the center of violence, is critical. Traditional community violence prevention programs and street outreach workers focus solely on those individuals, but as we know, the aftershocks of violence are pervasive, affecting victims, their families, and communities (Centers for Disease Control and Prevention 2022a). Using a socio-ecological model emphasizes the importance of addressing the complexity of influences in different domains of life. This includes tackling trauma and encouraging healing for victims and families at both the individual and relational levels and addressing the needs of neighborhood

residents at the community level. Finally, understanding the underlying causes of violence and implementing policy changes and reforms at the societal level is critical.

Examining current community violence responses with such a socio-ecological framework can help understand and contextualize interventions. Utilizing the perspectives of stakeholders, community members, and practitioners is a critical initial step in a systematic exploration of such responses. We now turn to an empirical exploration of one city's response to community violence victimization and trauma utilizing feedback from initiative providers to examine program goals and operations.

2. Materials and Methods

2.1. Description of Study Site and Initiative

The current study was part of a larger research and evaluation project on the Neighborhood Trauma Team Network (NTTN) in Boston, Massachusetts. The City of Boston has six neighborhood trauma teams in the areas of the city where the most community violence occurs. Each site team consists of mental health clinicians, family partners, and community partners coordinated and funded by the citywide health commission. Site partners meet as needed, and the health commission organizes a monthly meeting for all network partners. The goal of the NTTN is "to support the healing journey of families and communities impacted by community violence"). The NTTN partners go about their work in multiple ways that are authentic to the neighborhood in which they operate and that leverage existing services and collaborations to benefit those impacted by violence.

At the individual level, victims and those at the scene receive psychological first aid, follow-up therapy, and referrals. Family members of victims also are able to access these services provided by community-based organizations. The community is canvassed with literature for those who are experiencing trauma as a result of the violence incident and want to seek help. Additionally, the neighborhood team may be part of the coordinating health commission's work in organizing community meetings with community and city leaders to discuss the incident and broader issues that may have precipitated the incident that affects community health in order to problem-solve community violence. As a relatively new response to community violence, research and evaluation is needed on the NTTN.

2.2. Data Collection and Analytical Strategy

Researchers examined NTTN documents, including an operations handbook, a logic model, and a de-identified database review of incidents and responses. Because the NTTN documents showed that databases and program outcomes need better alignment in order to track the outputs and outcomes identified in the logic model, this study's results focus on provider feedback.

Researchers sought input from NTTN providers using interviews. The provider interviews were requested from neighborhood lead clinicians and family and community partners at each NTTN site. The interview schedule asked participants open- and close-ended questions about how well the NTTN logic model matched with their work, how well they felt supported in their work by team members and the health commission, and how well communication and coordination occurred among team members and with the health commission. The latter series of questions was adapted from the relational coordination survey, which has been shown to be a valid and reliable measure of communication and coordination (Gittell 2016). The other survey questions were developed from the logic model and in collaboration with the health commission NTTN staff. Researchers then used the review and interview results to explore the connections to a public health-informed community violence response framework.

Provider interviews were conducted by the lead researcher primarily via Zoom with one interview conducted over the phone. Data were gathered from March 2022 to June 2022. Of the 18 lead providers at NTTN sites, 13 were interviewed, resulting in a 72% response rate, which is very good for this type of survey with individuals connected to a partnership

(Hutchinson and Sutherland 2019). There were responses across each of the six NTTN sites and across all provider types.

Close-ended questions were analyzed using descriptive statistics. Because the initiative has six sites and three leads in each site, there was not enough data to conduct meaningful higher-order quantitative analyses. Open-ended responses were handwritten and typed and were coded as soon as possible after the interview by the two researchers. A grounded theory approach was used to analyze qualitative data. Following the work of Braun and Clarke (2012), the two researchers independently examined the data and created open codes. Each researcher reviewed again to group codes into themes. Researchers then met to discuss and create final themes aligned with qualitative data analysis best practices (Guest et al. 2012). Qualitative responses were used to enhance the understanding of the quantitative questions and to provide context for community violence and trauma services in general.

3. Results

To examine the alignment of program documents identifying purposes of the network with provider perception, providers were asked their perspectives on the purposes and outcomes of the NTTN. To examine the interorganizational collaboration among the network, communication and coordination questions were asked, examining provider perspectives within the network and with the lead organization. Results for each of these are presented. To gain a better understanding of the community violence context within which providers operate, respondents were asked about their perceptions of the root causes of community violence. Responses included violence stemming from structural and institutional racism, lack of opportunities, and longstanding conflicts between groups. One interviewee said that conflict arises because people do not have the skills to address their trauma, *"When you have trauma, the only thing you know how to do is offer it back"*. Respondents understood community violence as a holistic problem that had multiple causal levels and the need for engagement at each socio-ecological level—individual, relational, institutional, and societal levels. In particular, providers noted that schools (n = 4) and communities (n = 4) were places where violence prevention services could be best implemented. It is within this context that provider perspectives on the network goals and communication and coordination can be understood.

3.1. Perspectives on NTTN Goals

The program logic model identified ten outcomes of the NTTN. The logic model is a living document that is meant to be revisited as needed by the NTTN. At the time of the interviews, the outcomes were: (a) an increase in community awareness of NTT services; (b) an increase in community referrals to services; (c) an increase in community residents feeling supported physically, psychologically, and socially; (d) an increase in the capacity of the community to support residents going through trauma; (e) providing support for clients' healing journeys; (f) a reduction in client trauma; (g) a reduction in community trauma; (h) an increase in community efficacy (meaning willingness and ability of community members to help residents in need; willingness and ability to provide services/resources to the community); (i) a reduction in community violence; and (j) an increase in the capacity to interrupt violence.

The NTTN outcomes were not always agreed upon by stakeholders. The interview results show that 38% (n = 5) of respondents commented that interrupting violence was not within the scope of the NTTN and pointed to streetworkers as collaborating partners for that work; however, they were not part of the network. Streetworkers' focus was to engage with group-involved individuals to help steer them from violence by promoting well-being. Additionally, two respondents commented that reducing client trauma and reducing community violence were outside the control of NTT services, while another respondent commented that it is difficult to assess if there is less client trauma because clients are often dealing with multiple forms of trauma. On the whole, respondents felt

that client support, community support, awareness of NTT services, and referrals were central to their jobs.

Five interviewees discussed other areas where trauma support was needed. These included shots fired (where there is no direct victim), suicides, domestic violence, accidental deaths, and immigration trauma that comes with immigrants from war-torn countries as well as from how they are treated in the U.S. Others (n = 4) noted that there were not enough resources to address community violence as it is, so the network needed to stay with what they currently accomplish with additional resources.

3.2. Connection among Teams

Overall, there was a strong link among NTT partners in their catchment areas; they expressed an ability to navigate the system for their clients, and they understood the NTT process. Among providers in the network, communication and coordination averaged between 3.31 ("*others in the network know what you do*") and 4.31 ("*others in the network respect what you do*" and "*share your goals*"), normed as high moderate based on relational coordination survey norming results (see Table 2) (Gittell 2016).

Table 2. Relational Coordination among NTTN sites.

As a Whole, How Well Do You Feel the NTTN	Average	Standard Deviation
Engages in frequent communication	4.08	0.86
Engages in timely communication	3.85	0.80
Engages in accurate communication	3.92	0.76
Engages in problem-solving communication	4.15	0.99
Others in the network know what you do	3.31	1.44
Others in the network respect what you do	4.31	0.86
Others in the network share your goals	4.31	0.75

Almost universally, those responding to the NTTN survey felt that their biggest strength was their team and their personal connections with each other and with their community. Most respondents also felt that their experience, their ability to deliver culturally appropriate services, and their diversity of staff strengthened their capacity to work with clients and the community. Respondents also mentioned access to resources, commitment, passion, and flexibility as important strengths of their team. As one interviewee stated, *"I feel supported knowing that I have a good group of people I can call on when I need help. They are reliable and have lots of experience. I feel more empowered with them; more motivated. They have my back"*.

Of the seven different aspects of communication and coordination asked on the survey, the respondents were more neutral when asked if people knew what they did, demonstrating the need to understand what team members do in each site. Some (n = 5) felt like NTTN work was hampered because relationships were not well connected across sites and with others working in the community violence response space. Four other interviewees noted that communication issues stemmed from a lack of clarity about roles and responsibilities. As one interviewee stated, *"Communication is an issue. There are times where there are multiple individuals on a case and it is confusing when there are multiple [people] in same role. Need to know who's working on it"*. Similarly, another longstanding provider stated, *"Get us all on the same page with roles and responsibilities. We were supposed to do this pre-Covid and didn't. Not clear who is doing what. [An] example is housing. If someone [one site] is doing it, then we all have to do it"*.

This consistent menu of services across sites was mentioned by two respondents as a way to cut down on competition among sites and "service-shopping" by families, whereby a family that has roots in two NTT sites, may choose what NTT to access based on who can offer them the most services. Sites may not necessarily know that the family is utilizing other NTT site services until much later in the process. This results in conflict and role confusion.

3.3. Connection with the Organization Lead

Meanwhile, communication and coordination were generally high between providers and the Boston Public Health Commission (BPHC) parent organization (See Table 3) with scores ranging from 4.00 (engaging in frequent communication and problem-solving communication) to 4.85 (respecting what the provider does). Over half of the respondents (n = 7) identified key personnel turnover (in BPHC and the NTTN) over the last few years as a barrier to working more collaboratively, citing that network partners needed to build relationships to best continue/enhance NTTN work.

Table 3. Relational Coordination with Lead Organization.

How Well Do You Feel the BPHC	Average	Standard Deviation
Engages in frequent communication	4.00	0.82
Engages in timely communication	4.15	0.80
Engages in accurate communication	4.08	0.86
Engages in problem-solving communication	4.00	1.00
Knows what you do	4.54	0.52
Respects what you do	4.85	0.38
Shares your goals	4.46	0.52

4. Discussion

This study examined an underexplored but growing area of intervention within community violence: responses for victims and communities affected by the violence. While there are seemingly few programs that address both victim and community needs under the same umbrella, there are still fewer examinations of program operations and empirical investigations of worker perceptions of those operations. An analysis of one program serving high-violence neighborhoods in Boston served as an entry point for examination. The results of this study show that there was widespread agreement among providers on some of the goals of the NTTN including providing support to victims and communities, raising awareness of services, and reducing individual trauma. There was less agreement among providers on program goals including reducing community trauma, reducing community violence, and increasing community capacity to intervene in violence. Those goals are likely not achievable by the NTTN alone; and logically, providers were less likely to identify those goals as core to the mission of the network.

Communication and coordination as measured using the relational coordination survey was generally good across the network of providers and very good to excellent between the providers and the lead health commission agency. Many providers commented that they had excellent working relationships and deep respect for providers with whom they worked closely within their neighborhoods. Issues arose across sites with regard to the lack of standardization of roles and communication with client load and services offered. These cross-functional challenges commonly arise as a result of siloed work groups (Mendenhall and Berge 2010). At the same time, lead agencies can address those cross-site differences through things like communication, coordination, and clear role identification (e.g., Gittell 2016; Greeson and Campbell 2012). Given the positive perceptions of the health commission by providers, cross-functional work appears to be an area where positive gains could be quickly realized.

Within the broader public-health-informed violence intervention context, attention to the needs of victims and community members is necessary to support health and well-being and meet violence prevention goals of addressing the trauma caused by such actions. The NTTN is one example of a secondary prevention program that works with neglected populations in recognition that community violence ripples throughout each socio-ecological domain. From a violence intervention perspective, solely working with offenders while ignoring the needs of victims and communities is not likely to result in healthy people and healthy long-term outcomes. Investments must be made in others affected by community violence.

This study was exploratory in nature, so no definitive conclusions about best practices for the operation of programs serving victims and communities can be made. Further, this study took place in one location, and there may be unique dynamics of community violence that occur in Boston; although research shows that community violence has similarities across locations (e.g., Matei et al. 2022; Papachristos and Kirk 2015). Another limitation of this study is that the primary data source was providers. Client and community member perspectives and experiences were not included, and those may be different from providers. While outcomes could not be assessed with their current data tracking indicators, the NTTN was scheduled to update their databases and logic model as a living document at the time of this writing. Future work can examine outcome-based indicators of success. Database indicators of health and well-being as well as the perceptions of clients and community members are potentially rich sources of future research to better understand the awareness and impact of services.

Boston's response to community violence that focuses on victims and communities can be a helpful resource to other locations attempting to create such programs. These programs would do well with a national network of community violence trauma response teams who can support and learn from each other. Similar network models exist nationally and internationally, such as crisis intervention teams that seek to bring together and share knowledge from those working in the law enforcement–mental health–substance abuse team spaces (e.g., https://www.citinternational.org/What-is-CIT, accessed on 20 June 2023). Such networks can build capacity, knowledge, and support among practitioners as they grapple with the devastating effects of community violence.

A socio-ecological framework is a way to understand the larger context of victim-centered work in relation to violence. As a way to move forward in this city and for locations crafting such programs, theory of change tools can be incorporated into the development process of future programs and utilized to examine the operation among initiatives that currently respond to community violence. A theory of change, or ToC, can be described as both a process and a product (Taplin et al. 2013). It is a process of creating programs and initiatives by defining long-term goals and working backward to map out the steps needed to reach the desired outcomes. It is a product that serves as an evaluation tool to assess whether the achieved outcomes align with the program's goals and allows for the restructuring of current processes by designing an 'outcomes pathway', similar to a logic model. The pathway maps the desired long-term and intermediate outcomes, providing measurable evidence and interventions to achieve established outcomes. The ToC can be valuable for understanding the underlying mechanisms by which the intervention is expected to meet its goals (Breuer et al. 2015).

On a broader level, community violence intervention and prevention conversations must be framed holistically, taking into account victims of violence and residents who are exposed to that violence. Working with all those involved, from those committing violence to those experiencing violence, directly and indirectly, are critical pieces to fully addressing community violence. The impact of violence is documented as far-reaching (Sharkey 2018), and while focusing on those committing the violence is well-warranted, we must not be short-sighted and must respond to the needs of all those affected by those events. The health and well-being of people, neighborhoods, and cities depend on it.

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