IDMH
INSTITUTE FOR DISASTER MENTAL HEALTH
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The DMH Responder

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NEW YORK STATE | Office of Mental Health

NEW YORK STATE | Department of Health | Office of Health Emergency Preparedness

Welcome to the **New York DMH Responder,** our newsletter for the Disaster Mental Health community. We'll start with a personnel announcement: After 15 years of dedicated services as the Director of Emergency Preparedness and Response for the NYS Office of Mental Health, Steve Moskowitz has recently retired. While we'll miss his essential efforts in establishing and strengthening the DOH-OMH-IDMH partnership, we wish him all the best in this well-deserved next chapter. And we're delighted to welcome Denise Hotaling, Director of the OMH Bureau of Emergency Preparedness & Response, who is taking over Steve's responsibilities. Denise already has ambitious plans in the works to further strengthen Disaster Mental Health capacity in New York State and we're excited to see where her energy takes us all.

This issue of the newsletter will summarize key points from the recent Institute for Disaster Mental Health conference. **"Re-Envisioning Disaster Mental Health"** focused on the changing demands in the field of disaster management, including how responders can best meet the needs of communities they are serving and how clinicians can better serve responders themselves. Presenters covered a wide range of issues and approaches in this constantly evolving field. Highlights will be reviewed in this newsletter and the next issue, which will also include details on numerous training opportunities that will be held in Spring and Summer 2023.

As always, your feedback and suggestions for topics to cover in future issues are welcome; please email any comments to Tom Henery at DOH or Denise Hotaling at OMH.

“Every single person who's been trained in [response] organizations has been trained to manage Blue Sky Days and Gray Sky Days, but there are no more Blue Sky Days. We've been trained to be able to mobilize and respond to an emergency or a crisis; we have not been trained to absorb and manage and stay resilient in the face of crisis on top of crisis on top of crisis with absolutely no break or gap in between.”

- Jackie Bray, New York State Division of Homeland Security and Emergency Services Commissioner in IDMH conference closing remarks about the intensifying demands on the disaster response community

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Opening Remarks from FEMA Administrator Deanne Criswell

IDMH was honored to be able to open the conference with a video welcome from the 12th Administrator of the Federal Emergency Management Agency (FEMA). Deanne Criswell is the first woman confirmed to serve as the Administrator, where she leads the nation's efforts in helping people before, during, and after disasters. She brings with her an extensive career in public service, having served for 30 years at all levels of government. Her remarks, presented here in full, capture the growing complexity of disasters and the need for adaptation of mental health planning and response that were the focus of the conference:

"Good morning. I'm Deanne Criswell, Administrator of the Federal Emergency Management agency or better known as FEMA. I'm sorry that I can't join you in person today for this important and meaningful discussion. The topics of this conference are incredibly important to our mission at FEMA and we are grateful for all that you do to help people before during and after disasters. Your work and the work of mental health professionals across the country are critical to our nation's overall response to and recovery from emergencies and disasters.

"In the weeks before this conference I traveled to Puerto Rico only days after being ravaged by Hurricane Fiona where I visited Ponce, a community that just five years ago experienced the impacts of Hurricane Maria. I then traveled to Western Alaska where the small substance villages that line one thousand miles of the Bering Sea Coastline were battered by Typhoon Murbach and days after to Florida to meet with survivors of Hurricane Ian whose entire communities were devastated. Amidst all the destruction I listened to survivors. In their eyes I saw their grief and their loss. Their mental trauma was fresh, but we all know that for many of them the trauma will persist for months or even years.

"When we think about these recent disasters and others like them, the losses go beyond life and property. They take a tremendous toll on people's mental health. If we

are to re-envision disaster mental health then we will need to understand the stressors that survivors face on the long road back to recovery.We also need to address the challenges caused by new societal threats like mass shootings and school violence that have created anxiety and fear in our communities and I commend the SUNY New Paltz Institute for Disaster Mental Health for focusing on the mental health issues and challenges linked to disasters. You, along with the college and the New York State Division of Homeland Security and Emergency Services, are providing critical leadership at the forefront of this field. I applaud you for convening this conference so that we may share best practices and improve how we deliver for survivors and responders going forward.\

“Recovery involves lifting up individuals and entire communities. If we are to do that, we need to integrate mental health services into the initial response. We need to help survivors with their mental health challenges by meeting them where they are and acknowledging that sometimes the best way we can help is just by listening. This is especially true and applies in our marginalized communities where services are often limited or too far away. We need to destigmatize mental health services by helping people understand why they need counseling and support.

“We know Post-Traumatic Stress Disorder is a given after a disaster. Increasing awareness about it will enable us to direct people to the right kind of help. We have partners that provide important support networks; we need to lean on them more. Our trusted ambassadors and the faith-based and non-profit worlds help ground our mental health responses because they know their communities. As emergency responders, emergency managers, mental health providers, and clinicians ,our focus is always on the survivor, the patient, and the community in need. It's our ethos and it's in our blood.

“We must not forget our responders in this equation as you know those who deploy to a disaster can struggle with mental health challenges too. The work they do is grueling and non-stop. What they see and deal with can be devastating, and they often live in the communities they are helping, so they too may have suffered disaster losses. A study out of the University of Illinois at Champaign Urbana found that 49 percent of health and social service workers were still experiencing PTSD just one year after Hurricane Maria and just last week I participated in the United States Fire Administrators Summit on fire prevention and control where I heard testimony about the growing levels of PTSD and suicide amongst the firefighter community coming on the heels of the COVID-19 pandemic. The same is true of our colleagues in law enforcement and health care.

“One of the best examples I have seen of a provider-focused mental health program was at Elmhurst Hospital in New York City. During the peak of the COVID-19 pandemic, Elmhurst Hospital was the epicenter of the epicenter and the staff at that hospital did heroic work for months on end, treating patients, dealing with an overflowing emergency department, and tragically a lot of death. Elmhurst Hospital initiated the “Helping Healers Heal” program and made mental health counselors, peer support, and other resources available to the entire staff, even going floor by floor and unit by unit to make support available. I am as impressed today by that program as I

was then, and we need more programs like this in our organizations.

“As the nation's emergency manager, I can tell you that I do not see our response tempo declining anytime soon, so as we continue to respond to disaster after disaster we must create a safe space for these professionals and volunteers to seek help. We need to remove the stigma for them and all survivors, and we need you and your colleagues across the country more than ever to keep helping, to keep advocating, and to keep us focused on mental health. Thank you for spreading awareness about Disaster Mental Health and advancing the science on this important component of response and recovery – and thank you for being a key part of our nation's resilience every day. Have a great conference and please keep up the great work.”

Re-envisioning Disaster Mental Health: New Questions and Directions

Expanding on the conference theme, Institute for Disaster Mental Health Executive Director Amy Nitza and Deputy Director Karla Vermeulen laid out a series of questions for the audience in order to explore the future of Disaster Mental Health (DMH). They briefly reviewed the field’s history, noting that DMH has only formally been incorporated into disaster response since the 1990s. Since then, it has had an escalating presence due to factors like the attacks of 9/11, the rise in mass shootings, and the intensification of many natural disasters due to climate change. DMH initially drew on treatment for military and first responder trauma. It later incorporated developing approaches for the general public, especially Psychological First Aid. Still,

mental health was often seen as a siloed, non-essential element of disaster response until fairly recently.

More than any single previous event, the COVID-19 pandemic brought the mental health needs related to disasters to the forefront, expanding interest from virtually all segments of society while also compounding existing social inequalities. We've seen an expanded need for mental health services that is not matched by current capacity, with a dearth of adequately trained and culturally competent mental health professionals who understand the particular demands of DMH. Given the complexity of the current environment, Drs. Nitza and Vermeulen questioned whether the classic model of the disaster cycle, with distinct before, during, and after phases, remains valid in a time when community members and responders are dealing with acute disasters layered on top of pre-existing stressors in their family and work lives, a stressful political and racial climate, and the ongoing pandemic.

The presenters then talked through the classic series of "W" questions to explore the current state of DMH field:

Who is impacted by disasters?

Particularly throughout the pandemic, the usually clear line between survivor and responder was blurred, with most people experiencing both roles at different points.

Concerns among **survivors:**

- Pre-existing disparities in access to health care and other resources set members of marginalized populations up for more exposure to disasters, and for more difficult recoveries.
- There is less than ideal cultural awareness in the response community – including among mental health helpers.
- Our aging population creates more complex needs throughout the disaster cycle for older adults.
- High rates of mental health issues (depression, anxiety, substance abuse) in the general population reduces resilience and creates a higher risk of extreme reactions when exposed to disaster; this is particularly a concern for children, adolescents, and emerging adults.

Concerns among **responders:**

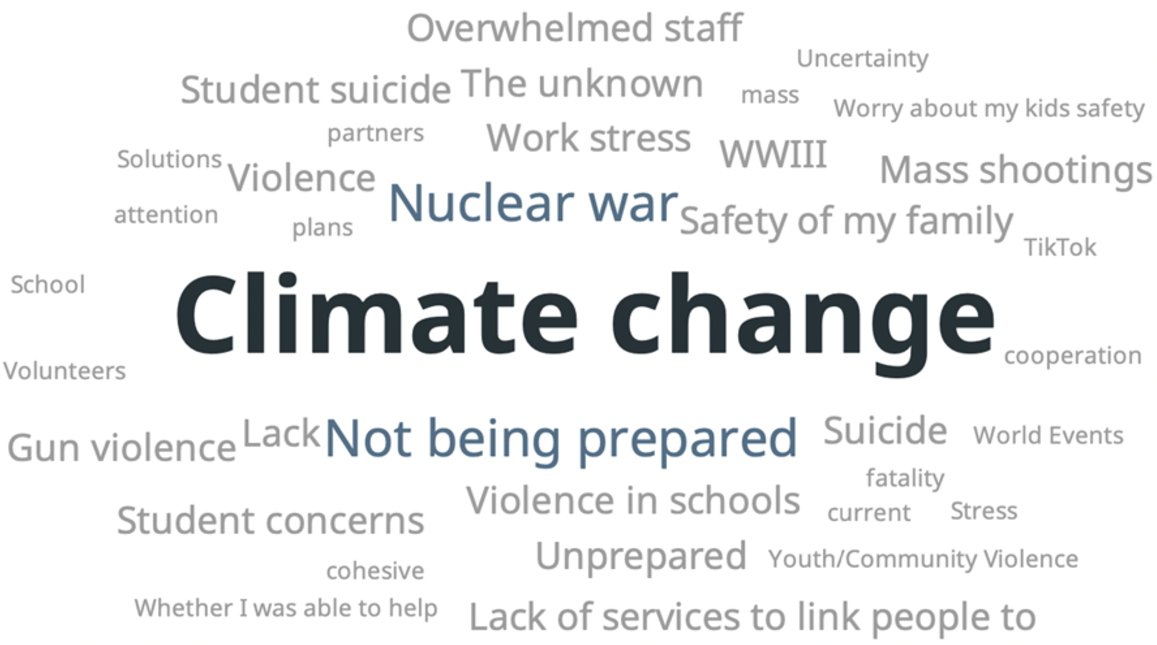
- Conflict between professional obligations and personal safety concerns.
- High rates of burnout among first responders, healthcare providers, mental health professionals, educators, etc. – clearly exacerbated by the pandemic.

On the positive side, there is a trend towards decreased stigmatization around help-seeking for work-related stress and trauma.

What do we even mean by "disaster" now?

The presenters noted that the classic "natural vs. human-caused" divide has become very blurred, as factors like human-caused climate change increase the frequency and intensity of many natural events, and decisions about where to build and live place more people in harm's way from hurricanes, wildfires, and other threats. As a result, we can no longer think of disasters as a series of isolated events. Instead, we need to plan for what are variously referred to as "slow," "creeping," or "compounding disasters" including not only climate change and COVID, but also other public health crises, inadequate access to health care/mental health care, social inequality, and systemic racism. All of these conditions cause chronic suffering and set people up for worse outcomes when acute events occur on top of ongoing issues. For example, consider COVID's disproportionate toll among people of color due to pre-existing health disparities and access to care.

At this point, Drs. Nitza and Vermeulen asked the audience to text a response to the question "what keeps you up at night?" Here are their responses in word cloud form, so more frequent responses appear in larger type:



When do disasters start? When are they over?

As the presenters noted, a core tenet of Disaster Mental Health is that people can't begin to recover from a traumatic experience until they believe it's over and they start to feel safe again. But how can that recovery process even start when that basic sense of safety can't be achieved because of other ongoing stressors and threats? We have traditionally not thought of long-term mental health reactions as part of DMH response, but maybe that needs to be rethought in terms of funding, staffing, and other support for long-term "crisis intervention" programs like NY Project Hope.

Where do disasters take place?

Once again, climate change is to blame for an increase in the number of regions that are vulnerable to damage from natural disasters, including:

- Expanding floodplains and risk in coastal regions due to rising sea levels
- More areas prone to wildfires
- Expanding “tornado alley”

Globally we’re also seeing increased frequency of human-caused events like wars and political maltreatment of citizens, leading to humanitarian crises and forced migration. Currently 100 million people in the world are displaced, and between wealthier and poorer nations and communities there is wildly unequal access to resources for preparation and recovery.

Why do disasters occur?

This is far more existential than the other questions, but it impacts mental health nonetheless. Even people who haven’t directly experienced a disaster themselves may be distressed by unanswerable questions:

- Why do people perpetrate mass shootings and other acts of intentional violence?
- Why does God/higher power allow disasters to occur?
- Why do these events get politicized?
- Why didn’t older generations do more to limit climate change?

How much, the presenters asked, does this contribute to increase in stress, anxiety, and depression in the general public and especially among young people?

Where do we go from here?

In their final question to consider, Drs. Nitza and Vermeulen turned to what can be done to ensure that mental health needs will be sufficiently and effectively addressed in this complex environment, including incorporating mental health into emergency planning, increasing diversity and representation in the disaster response community, and focusing on prevention through promoting resilience and coping skills. Their suggestions for the field:

1. Invest in training to ensure sufficient numbers of trained mental health professional to accommodate long-term needs.
2. Develop new intervention models to help survivors coping with acute-on-chronic stress, including strengthening group interventions.
3. Utilize new advances in technology to increase access to services.

4. Address structural inequalities at all stages of the process, as emphasizing resilience and “returning to pre-disaster levels of functioning” just re-enforces the status quo.

To close the session on a hopeful note, the presenters asked the audience “what solutions do you see?” Their responses:

The Buffalo Shooting Response: Community Insight into Black Trauma

Having grown up only a few blocks from where the tragic May 22nd Tops grocery store shooting occurred, Andre Stokes, MSW, began his presentation on the mental health response to the Buffalo Tops grocery store shooting by speaking about what it is like to be a member of that community himself. He speaks about watching the community grow as he got older, and about starting his professional career working in the community. These positions included working as a case manager, medical case manager, wellness counselor, and finally substance use and mental health counseling. Andre says that many of the mental health and substance abuse services that he encountered in his work were geared more towards urban communities, but that this knowledge would later prove to serve him well in the wake of the Tops shooting.

After learning about the shooing at Tops grocery store, Andre describes the drive back to Buffalo. As a member of the community, and as someone who knew the local services well, he says it was his obligation to respond and to be amongst the first people to provide mental health services on scene. While on his way to Buffalo, Andre says he called every local mental health professional that he knew and asked them to come and assist in the response. Best Self Behavioral Health, the agency that Andre is associated with, also responded to the incident and within two hours they had 11 counselors a few blocks from the grocery store ready to offer services. Additional private practice practitioners, faith-based practitioners, and non-clinical practitioners also comprised the mental health response team for this incident.

It was quickly decided the clinical team would be most effective if the clinicians resembled the community that they were serving, which initiated the creation of a Black Mental Health Response Team. This team was sent to several different locations throughout the community to provide services. This included the Merriweather Library, which was used to provide counseling, referrals, as a place of respite for the Tops grocery store staff and the Johnny B. Wiley stadium, which

provided clinical services to members of the community along with peer-to-peer services, where non-clinical members of the community with lived experience assisted in greeting people and providing assistance while waiting for a clinician to become available. These locations were staffed with clinicians from Best Self Behavioral Health, Evergreen Health Services, Spectrum Health Services, and other local crisis services.

Andre mentions that one of the goals of the mental health response was to provide referrals to local services. This can be difficult, as Andre mentions, since you must first deal with the immediate reactions of those impacted. Among the reactions that were noted by Andre and his fellow clinicians was fear, trauma, loss, and a high level of anger, specifically towards the situation, local authorities, and towards religious deities. Andre tells of how during this response, he spoke to a young Black man who has never seen a Black male counselor before, and who said that he thought counseling was “not a Black thing”. The research shows that counseling within the Black community has certain barriers, including image and comfort with being vulnerable, and social safety relating to fears around confidentiality. Andre says that this results in members of the Black community holding onto a lot of stress and anger, which unfortunately has a large impact on mental health.

During Healing Circles, a guided mediation and support group intervention that was used after the shooting to help people process their grief and trauma, some community members mentioned feeling that the incident was allowed to have happened. Specifically, these community members were unsatisfied with how the suspect was gently apprehended and taken away, citing that if the suspect had been a person of color they might not have been treated as such. Andre said that as both a member of the local community and a mental health professional, he did not have the answers to the issues that people were bringing up. Andre mentions that this is one of his favorite phrases, as mental health practitioners often times do not have the answers, but providing a place to listen to people’s concerns is helpful in itself.

In the wake of the attack, Andre mentions how community members within the neighborhood, Tops staff, and clinical staff came together to support one another. Services were offered seven days per week with different clinical skill sets and specialties, with different agencies coming together to provide direct care and creating a therapeutic relationship with community members. This was in addition to material assistance provided through the American Red Cross, Salvation Army, local food and clothing pantries, and others.

Once the Tops grocery store reopened, Andre mentions that a lot of the staff had issues in getting back to work. To help meet this need, his agency began utilizing a mobile services model which brought clinical services directly to Tops staff. With this model, instead of having a centralized location where services were being offered, clinicians were told to walk around the store on foot. By talking to the staff as they went about their jobs, Andre says that him and other clinicians were able to connect better than in a traditional therapy setting. By instructing the one or two counselors per shift to “walk around and talk to people; be a human being first” and allowing his staff to take off their counselor hat sometimes, Andre mentioned that the amount of

interaction Tops staff members had with clinicians rose. With the success of the mobile services model with the Tops staff, plus some research on the barriers for Black communities in seeking out services, Andre says that they were able to restructure the larger community approach to better meet the communities specific needs.

Andre also speaks about self-care and how to provide support for first responders, posing the question, “how do we care for the people who are caring for people?” In the Buffalo response in particular, Andre mentions taking particular care to offer additional supportive services to staff members, including:

- Using Healing Circles with staff during shifts
- Offering additional monetary support to those who are engaged with the response and recovery efforts
- Providing various types of counseling services to staff
- Additional training to review counseling techniques such as Cognitive Behavioral Therapy, Dialectal Behavior Therapy and Motivational Interviewing

In concluding his conference session by speaking about the on-going recovery from this event, Andre explains how the COO of his organization, Best Self Behavioral Therapy, was able to contract with the local County Emergency Management office to provide compensation for clinical staff members so that they could continue providing services to the community. Andre also spoke about the impact of this incident on the clinicians themselves, as they are often members of the community as well. By bringing in contract counselors, they were able to provide relief for the full-time clinical staff. Lastly, the Office of Mental Health has been able to secure funding to fill a full time position tasked with overseeing the long-term services still being provided to the community. Andre says that having this centralized point of supervision for clinical staff will better serve the local community in the long-term recovery after this tragedy.

Research Brief: Posttraumatic Stress Disorder Symptoms, Work-Related Trauma Exposure, and Substance Use in First Responders

Another conference presenter, Dr. Sarah R. Lowe of the Yale School of Public Health, has studied the impact of “Potentially Traumatic Experiences” (PTEs) on numerous populations. One recent study she co-authored examined the relationship between work-related PTEs, symptoms of PTSD, and the use of drugs or alcohol among first

responders – a group whose profession routinely exposes them to stressful experiences like experiencing or witnessing serious injuries, witnessing death, or being threatened with a weapon. Not surprisingly given the pressure of their work, first responders including firefighters, EMTs, and paramedics tend to be at risk for mental health issues including PTSD symptoms and substance misuse.

To understand the relationship between those factors, the research team surveyed 885 first responders from all 50 states as well as Puerto Rico and the Virgin Islands. 59% of respondents were male; 91.5% were White, and the average age was 37. Survey questions addressed demographic variables, job-related characteristics including occupational stress and job satisfaction, social support, and cumulative work-related PTE exposure (for example, “physical assault,” “exposure to a toxic substance,” “death of a coworker”), as well as PTSD symptoms and substance use of both drugs and alcohol.

The statistical analysis found that PTSD symptoms were significantly associated with alcohol and drug use above and beyond all the other variables, including higher levels of Potentially Traumatic Experiences, which were not directly associated with more problematic drug or alcohol use. Instead, high PTE exposure was associated with more PTSD symptoms, which in turn were associated with more substance use. According to the authors, this suggests that efforts should be made not only to reduce first responder exposure to traumatic work-related experiences, and they should also be regularly assessed for PTSD symptoms in order to reduce the risk of turning to substance abuse. As they conclude, “interventions targeted at reducing substance use in this population should thus focus on preventing the development of PTSD by helping first responders cope with the traumatic events that they inevitably experience throughout the course of their routine job-related duties.” It seems likely the same point applies to other high-stress professions like healthcare, emergency response, and mental health providers.

Source: Bonumwezi, J.L.; Tramutola, D.; Lawrence, J.; Kobezak, H.M.; & Lowe, S.R. (2022). Posttraumatic stress disorder symptoms, work-related trauma exposure, and substance use in first responders. Drug and Alcohol Dependence, 237, 1-7.

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