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Welcome

Welcome to the winter 2016 issue of the **New York DMH Responder**, our quarterly newsletter for the Disaster Mental Health community. This issue focuses on the all-too-present topic of responding to mass shooting events which was the subject of a training sponsored by DOH and OMH in January that generated unprecedented interest: It was attended by over a thousand participants at more than 40 public health, hospital, and mental health sites statewide. Lessons from that training, which was presented by two disaster mental health experts who were deeply involved in the response to the Sandy Hook school shooting, are summarized in this issue, along with some personal reflections by people involved in shooting responses. Our Research Brief examines the impact of the Aurora, CO, shooting on staff members in the hospital that received the largest number of wounded survivors – all of whom were saved since the ED had prepared carefully for mass casualty incidents.

As always, your feedback and suggestions for topics to cover in future issues are welcome; please email any comments to Judith LeComb at DOH or Steve Moskowitz at OMH..



**When we meet
real tragedy in life
we can react
in two ways –
either by
losing hope
and falling into
self-destructive
habits, or by
using the challenge
to find our
inner strength.**

– *The Dalai Lama*

Training Highlights: Responding to a Mass Shooting Incident

On January 15, 2016, the Institute for Disaster Mental Health at SUNY New Paltz hosted the annual DOH and OMH sponsored training webcast which focused on Responding to a Mass Shooting Incident. The training was developed and presented by two experts with extensive involvement in the response to the Sandy Hook School shooting as well as other disasters. **Kathy Dean, MSSW**, is the Coordinator of the Center for Trauma, Response, Recovery and Preparedness, where she's responsible for maintaining the readiness of Connecticut's Disaster Behavioral Health Response Network. She oversees statewide training initiatives to prepare behavioral health professionals and preparedness partners for disaster response and ensures effective coordination with health systems preparedness partners and traditional first responders. **Jim Siemianowski, LICSW**, is the Director of Quality for the Connecticut Department of Mental Health and Addiction Services. Jim has served as the state's disaster mental health coordinator for the past 15 years

and coordinated the state's mental health response and recovery efforts after 9/11 and in recent natural disasters in the state.

Kathy and Jim's presentation examined both commonalities and contrasts with other types of disasters so that DMH responders state-wide can think about how to adapt their previous training and response experience to the specific characteristics of this particularly intense kind of event. The training also featured video vignettes with three people who were involved in the response to the 2009 shooting at the American Civic Association immigration center in Binghamton: Peggy Steinberg, ACSW, LSW, Director of Social Work at Lourdes Hospital; Alan J. Wilmarth, Administrative Director, Behavioral Health at UHS Hospitals; and Raymond M. Serowik, NRP, Interim Director of Emergency Medical Services Coordinator, Broome County Office of Emergency Services. They addressed the impact of the event from the emergency responder and hospital staff perspectives.

Key points from the training

These incidents are criminal acts so **law enforcement** plays a major role in the response. Their immediate focus may need to be on capturing the perpetrator and removing the threat rather than attending to the wounded. The site will need to be treated as a crime scene and bodies processed as evidence, which can delay the identification process and release of remains to families. And surviving victims may need to be interviewed as legal witnesses, potentially reawakening distressing memories repeatedly.

Media attention will be intense, especially initially, and reporters on-site are not likely to be very sensitive to survivor's emotions. In the rush to get the story out quickly, inaccurate information may be disseminated. Exposure to reminders of the event through media coverage has the potential to retraumatize survivors and media depictions that focus on mental illness of perpetrators can increase stigmatization among the general public.

These events are often **politicized**, particularly regarding mental illness and gun control policies. They also generate difficult decisions related to allocating donated funds and planning public memorials that will satisfy multiple constituents who may have very different needs and preferences.



Survivors who were wounded may face a lengthy recovery process with lasting physical problems. Those who weren't wounded but who witnessed the death or injury of others and believed they were in imminent danger themselves are likely to experience a shattered sense of safety, traumatic grief and anger and survivor guilt that they lived when others didn't. Family members of victims and survivors are also likely to struggle with anger and traumatic loss.

Professional responders and receivers face specific challenges in fulfilling their duties in a mass shooting. For first responders the scene is likely to be very chaotic, with extensive exposure to dead and wounded people. Law enforcement professionals will need to ignore the needs of the wounded until it's certain that the threat is over. If the perpetrator commits suicide to avoid arrest these professionals are deprived of the ability to fulfill their mission. Hospital-based first receivers need to shift gears instantly to prepare to treat an unknown number of severely wounded people – sometimes only to learn that there are few or no surviving victims who they can actually help. And, importantly, if the event is still unfolding it's unclear whether the shooter has been captured or killed, or there may be multiple shooters involved and these professionals must do their jobs knowing they may be at risk themselves.



While these characteristics make mass shootings particularly challenging for all involved, Kathy and Jim emphasized that the same principles that underlie all disaster mental health interventions do apply to these events. Specifically, they cited the “Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention” outlined by Hobfoll and colleagues in a 2007 article in the journal *Psychiatry*:

- Promote sense of safety
- Promote calming
- Promote sense of self/collective efficacy
- Promote connectedness
- Promote hope

DMH responders need to think about ways to adapt these principles to the extreme post-disaster conditions a mass shooting will produce. For example, responders can strive to provide a sense of **physical and psychological safety** through these actions:

- Offer safe havens
- Provide routines and structure
- Enforce security protocols
- Make necessary environmental accommodations

- Recommend limiting conversations about the event
- Recommend limiting exposure to media triggers
- Educate regarding evocative nature of triggers
- Offer opportunities for reality testing
- Provide a child-safe area with assigned staff

They can try to promote **connectedness** – which is particularly important after an act of intentional malevolence that can shatter survivors' trust in humanity – in these ways:

- Reunite affected populations with loved ones
- Offer space conducive to informal interactions
- Offer formal opportunities for providing information/hearing concerns
- Convene groups, vigils, reunions, commemoratives
- Strengthen social support skills
 - Identify viable support systems
 - Reconnect with past supports
 - Establish new supports
- Underscore each individual journey is unique

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The Role of Disaster Behavior Health (DBH) Following a Mass Shooting Incident

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INTRODUCTION

Mass shootings create special challenges for disaster behavioral health responders. While it is difficult to reach agreement on a precise definition for mass shootings, these are intentional acts focused on killing or injuring as many people as possible. These tragedies are often of short duration and usually occur in a single location. They occur without warning, victims are typically randomly selected, and survivors experience high degrees of traumatic exposure. (Shultz et al., 2014)

Uncertainty and chaos are major characteristics of mass shootings, especially in the immediate response stage. The criminal nature of these shootings place additional stress on victims because they are also witnesses to the event. The massive media coverage can re-traumatize victims while shaping the world's view of these events. The sudden nature of these events also means responders are unable to pre-plan their response as they do in many natural disasters. The response is complicated because it often involves multiple responders representing multiple jurisdictions, responding at multiple community sites.

Mass shootings can and do involve high degrees of traumatic exposure that may be linked to long-term negative effects.

However, it is important to remember that the degree of exposure varies considerably during a mass shooting. Certain factors like loss of a loved one, prior trauma, mental illness, and lack of social or familial supports may increase the risk for long-term psychological problems while other factors can help to promote resilience.

While mass shootings may seem overwhelming to behavioral health responders, it is important to recognize that we know a great deal about trauma in general and are learning a great deal about responding to these types of tragedies. This already existing knowledge base should serve as a foundation for our disaster behavioral health response efforts.

CYCLES OF MASS SHOOTINGS

Mass shootings follow a predictable sequence of events that at first may seem completely out of control. Law enforcement surrounds the scene intent on stopping the shooter(s) and securing the scene. Once it is confirmed the shooter is disarmed, dead or no longer on-site, victims are evacuated from the shooting site. The wounded are transported to area hospitals and survivors who were not wounded are moved to a site where they can be reunited with

loved ones. Victims will likely be interviewed by law enforcement as they begin to conduct their investigation. These actions can begin within minutes of the first shots fired and continue for several hours.

What follows include formal death notifications, funerals, and memorials. After the immediate tragedy, victims may withdraw



and scatter as work or school is postponed while community or business leaders struggle with when and where to resume operations. Once that decision is made this cycle continues as people return to work or school and begin to attempt to return to previous routines. This tragically predictable pattern highlights decision points that may require behavioral health input and also suggests intervention points.

POINTS OF INTERVENTION

A number of intervention points are obvious as victims and family members move through this cycle. DBH responders, if they can be quickly deployed, may be available to victims and their families at the reunification center. They may also be deployed to hospital reception centers when casualties are being transported to local hospitals and families are anxious to learn about their loved one's condition and their location.



Disaster Behavioral Health responders will be present at a family assistance center and are likely to participate as part of death notifications team involved in formally notifying families that one of their members has died. These teams may include local clergy or faith leaders, law enforcement, and mental health responders.

In the immediate aftermath, community drop-in centers may be opened up as a way to assist

the community to grieve. As victims and survivors scatter or withdraw, the family assistance center may remain open or be established to provide grieving families an opportunity to be supported in a private setting, away from the public eye. The center can provide information to families about the range of supports that may be available to them.

Disaster Behavioral Health staff serving as liaisons may also be directly linked to surviving families or victims as a way to provide regular support



and monitoring until longer-term supports can be put in place. During this period of time the community may hold observances or memorials where behavioral health supports may be needed. When decisions are made regarding resuming work or school, DBH responders may be called upon to advise and support this very difficult transition period. Over time, businesses, schools, and the community will require

longer-term behavioral health interventions to assist them in the recovery process.

Disaster Behavioral Health responders are usually active during the immediate response and early recovery efforts. This distinction is important because immediate goals differ significantly from behavioral health goals further into recovery. Early goals focus on triage and assessment of the most impacted, support for grieving families and communities, linkages to resources and immediate supports, and psycho-education. While these early interventions are always trauma-informed, DBH responders in the immediate and early recovery phases would not be providing formal trauma treatment.

The early response is heavily influenced by the psychosocial impacts of mass shootings. Mass shootings produce catastrophic losses on multiple levels: loss of life and loved ones, loss of physical capacities if somebody is wounded, loss of a sense of safety, loss of the world as we know it, loss of support systems, and the loss of routines and structures that serve to anchor us in the world. In some instances, they may result in the actual loss of school or work setting as decisions are made to resume operations in a new location. Mass shootings also result in high levels of individual and community arousal, a feeling that is palpable to those exposed to the aftermath.

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Training Highlights, *continued from page 3*

Kathy and Jim also outlined some of the stressors DMH responders will encounter in mass shootings, including high stress and long hours, unfamiliar circumstances and coworkers, chaos in the work environment, uncertain and changing work expectations, role confusion, and above all, exposure to intense distress in others. This means that the need for self-care is even stronger than in other types of disasters, so it's essential that all helpers plan and actually apply stress management techniques that work for them.

An archived version of the webcast is available on DOH's Learning Management System at <https://www.nylearnsph.com>. Search the course catalog for OHEP-DMHRec-2016 to find the video.

Resources for Dealing with Violence and Trauma

*Recommended by Kathy Dean
and Jim Siemianowski*

National Child Traumatic
Stress Network (NCTSN)
www.nctsn.org

NCTSN Psychological First Aid
[http://www.nctsn.org/content/
psychological-first-aid](http://www.nctsn.org/content/psychological-first-aid)

National Center for
Post-Traumatic Stress Disorder
www.ptsd.va.gov

Center for the Study of
Traumatic Stress
www.cstsonline.org

SAMHSA Disaster Technical
Assistance Center
<http://www.samhsa.gov/dtac/>

The Role of Disaster Behavior Health, *continued from page 5*

ESSENTIAL ELEMENTS

A framework described by Hobfoll and a collection of authors provides guidance on how to address these effects of mass shootings. These authors described five essential elements of immediate and mid-term mass trauma intervention. (Hobfoll et al., 2007). While not focused specifically on mass shootings, these core elements provide an excellent framework for early disaster response efforts. When one considers the effects mass shootings have; shattered sense of safety, devastating loss, disruptions of social networks, high degrees of physiological arousal, it is understandable that these actions can be used to help promote recovery. The elements are:

- Promote safety
- Promote calming
- Promote efficacy
- Promote connectedness
- Promote hope

SELF-CARE

Mass shootings can and do have negative impacts on DBH responders who will frequently be exposed to the pain of victims and survivors as they struggle to deal with their losses. DBH responders may learn about horrible details related to the tragedy as survivors “tell their stories”. DBH leadership and responders are jointly responsible for ensuring that DBH responders are not harmed by their participation in a response to a mass shooting.

Before agreeing to respond, DBH team members should take stock of their current situation. For example, it is important to consider if recently suffered losses or trauma or exposure to a similar trauma in the past will be re-awakened by this type of deployment. It is also important to take into account one's current physical health and any medical issues that would interfere with the ability to safely respond or if current family or “life” issues requiring focus and attention would need to take priority. Upon making the decision to respond, it is important to carefully consider the components of a personal self-care plan. It is imperative that responders remain mindful of the tools that have sustained them through stressful times or during personal difficulties in the past. Responders must be deliberate and prepared to tap into these self-care activities, even when they may not seem pleasurable or sustaining.

CONCLUSION

Disaster Behavioral Health responders are challenged by mass shootings for a number of reasons. The unexpected, catastrophic deaths, injuries, and the high degree of traumatic exposure can result in a response that is difficult to manage and coordinate. The rapidly unfolding nature of these disasters seems to move at a dizzying pace. It is important to recognize that even in what appears to be chaos there is predictability and a growing knowledge base that DBH responders can harness and use to help promote recovery.

Research Brief: Impact of a Mass Shooting Response on ED Staff

Following the mass shooting in a movie theater in Aurora, CO, in July 2012, the University of Colorado's Anschutz Medical Campus received 23 wounded victims over about 30 minutes. One was deceased upon arrival; the remaining 22 survived thanks to the efforts of the emergency department staff who activated their disaster response plan in order to mobilize all available resources. According to Richard Zane, MD, FAAEM, chair of emergency medicine at the University of Colorado School of Medicine, having those disaster plans in place and well-practiced was key to the ED's ability to handle the sudden influx of critically wounded patients. Quoted in the Emergency Department Management newsletter, Zane said that balancing planning with flexibility is essential: "Although we prepare for disaster and mass-casualty care you never prepare for specific events because preparedness is 80% generic... and you have to accept that the last 20% is going to be enigmatic or variable."

Zane also noted impact of the intense response on hospital staff who confronted this horrific event in their own



community and the need for mental health support for personnel. Some staff members needed support immediately while others had a delayed reaction several months later. Additionally, variations in individual's preferred type of support meant that hospital administrators needed to provide a variety of resources including peer support, spiritual care, grief counseling and access to psychologists and psychiatrists. Preferences for individual versus group support also varied. "The important thing is that you make these resources available and that you publicize how to access them," said Zane. "Create different types of venues and access and be vigilant in making these resources available on an ongoing basis." Administrators should take note of these lessons in the payoff resulting from dedication to preparedness – and the need for attention to post-response mental health support for staff members who perform heroically when they're most needed, but who pay an emotional toll.

Source

Mass shooting in Colorado: practice drills, disaster preparations key to successful emergency response. *ED Management: The Monthly Update On Emergency Department Management*, 24 (2012), 109-12.



Upcoming IDMH Conference: Effective Response to Mass Transportation Disasters

The 13th Annual Institute for Disaster Mental Health conference, "Effective Response to Mass Transportation Disasters" will be held at SUNY New Paltz on April 15, 2016. Selected keynotes and workshops will focus on traumatic loss and grief, the role of National Transportation Safety Board after transportation disasters and the role of spiritual care in supporting survivors.

Sponsorship by the NYS Division of Homeland Security and Emergency Services will pay the \$200 conference registration fee for emergency management professionals, first responders, mental health/psychological professionals, social workers/social services providers, health professionals, spiritual care providers, members of media, disaster volunteers, and academic staff and students of certain disciplines. Please visit www.newpaltz.edu/idmh for more information about conference programming, and visit <http://www.newpaltz.edu/idmh/idmh-conferences-and-trainings/conference.html> to register. The number of DHSES-sponsored seats is limited so please register quickly if your role makes you eligible for one.