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Produced by the SAMHSA Disaster Technical Assistance Center

# the Dialogue

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Mass Violence: Planning, Responding, Recovering

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Cover photo: ORLANDO, FL/USA. OCTOBER 1, 2016. Place where Omar Mateen, killed 49 people and wounded 53 others in a terrorist attack/hate crime inside Pulse, a gay nightclub in Orlando, Florida, United States. Photo by Miami2you / Shutterstock.com.

*The Dialogue* is a quarterly technical assistance journal on disaster behavioral health which is produced by the Substance Abuse and Mental Health Services Administration (SAMHSA) Disaster Technical Assistance Center (DTAC). Through the pages of *The Dialogue*, disaster behavioral health professionals share information and resources while examining the disaster behavioral health preparedness and response issues that are important to the field. *The Dialogue* also provides a comprehensive look at the disaster training and technical assistance services SAMHSA DTAC provides to prepare states, territories, tribes, and local entities so they can deliver an effective behavioral health (mental health and substance misuse) response to disasters. To receive *The Dialogue*, please go to SAMHSA's home page (<https://www.samhsa.gov>), click the "Sign Up for SAMHSA Email Updates" button, enter your email address, and mark the checkbox for "SAMHSA's Disaster Technical Assistance newsletter, The Dialogue," which is listed in the Newsletters section.

SAMHSA DTAC provides disaster technical assistance, training, consultation, resources, information exchange, and knowledge brokering to help disaster behavioral health professionals plan for and respond effectively to mental health and substance misuse needs following a disaster.

To learn more, please call 1-800-308-3515, email [dtac@samhsa.hhs.gov](mailto:dtac@samhsa.hhs.gov), or visit the SAMHSA DTAC website at <https://www.samhsa.gov/dtac>.

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## In This Issue



PHOTO: Stuart Effeft / Shutterstock.com.

On May 22, 2017, yet another incident of mass violence shocked the world. Twenty-two people died, and many more were injured, after a suicide bomber detonated an explosive device at a concert in Manchester, England. Unfortunately, incidents such as this are becoming all too common.

The U.S. Department of Justice's Office for Victims of Crime (OVC) uses the following definition of mass violence:

*An intentional violent criminal act, for which a formal investigation has been opened by the Federal Bureau of Investigation (FBI) or other law enforcement agency, that results in physical, emotional, or psychological injury to a sufficiently large number of people to significantly increase the burden of victim assistance and compensation for the responding jurisdiction as determined by the OVC Director.*

The inclusion of emotional and psychological injury in the definition is notable. The behavioral health impacts of mass violence events can be far-reaching. Those immediately and directly affected include victims, their loved ones, and those who were close to the incident when it occurred. The effects may spread, touching lives, worldwide, as people with no personal connection to the event relive it via social media, television, and newspaper reports. These violent acts can occur anywhere and happen without warning, causing disorder, anxiety, fear, and grief. The unpredictable nature of mass violence often results in a stressful environment for survivors and responders.

This special double issue of *The Dialogue* focuses on the lessons learned from past incidents of mass violence. The authors describe how planning efforts contributed to effective community response and recovery in events across the country. Events include the Orlando Pulse nightclub shooting and the Boston Marathon bombing,

as well as events in Colorado and Virginia. The writers are a diverse group, including disaster behavioral health and trauma experts, emergency management professionals, and local community health center leaders and staff. They illustrate that there is still no “one size fits all” approach to planning and response—describing plans that range from relatively small organizational emergency operations procedures to comprehensive, statewide disaster behavioral health initiatives. Ultimately, the authors bring unique perspectives to bear on mass violence events and are leading on-the-ground efforts to shape how communities anticipate and manage the resulting behavioral health impact.

Although mass violence events are tragic, many communities and organizations have come back stronger and more resilient. These events have encouraged disaster behavioral health professionals nationwide to address issues surrounding response planning. Many areas are now implementing robust all-hazards disaster behavioral health plans and holding large-scale mass violence planning exercises that engage a number of organizations and agencies. By conducting these

exercises, responders are better prepared to handle and recover from an actual mass violence event. The exercises help them develop relationships and plans that build bridges between traditional emergency management functions and disaster behavioral health providers to facilitate healing and recovery

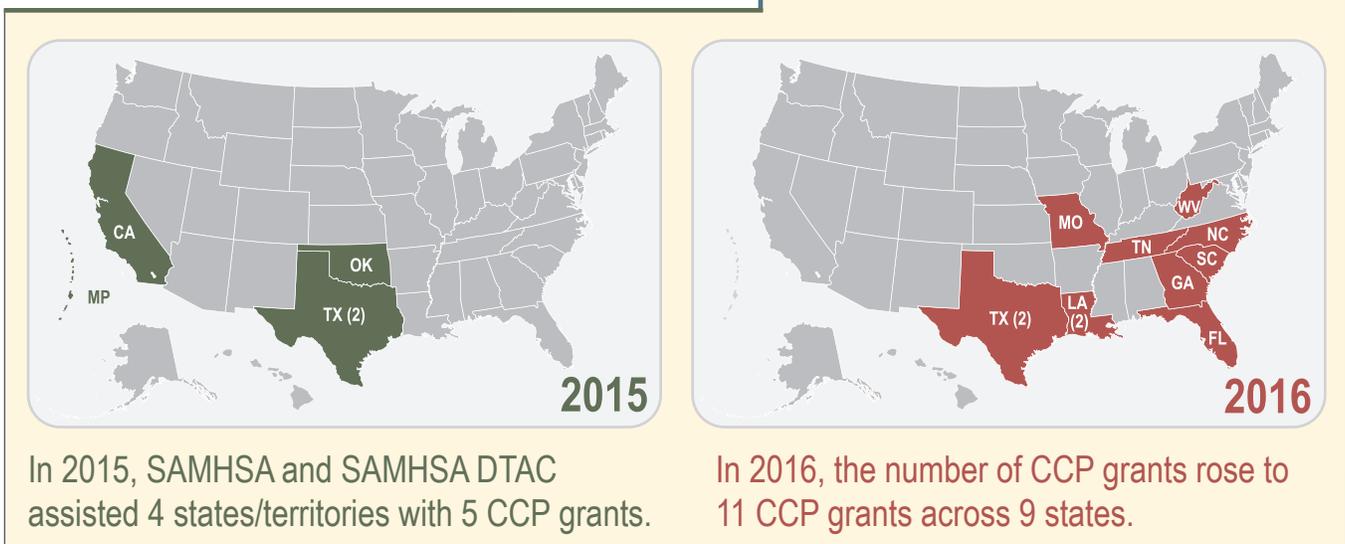
Has your community experienced a disaster or mass violence incident that has influenced subsequent behavioral health responses? Please share your experiences with us. We encourage you to contact us with lessons learned or if you would like to learn more about how you can help your community prepare or respond.

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## TECHNICAL ASSISTANCE SNAPSHOT



## Contributors



**Eric Alberts, CEM, CHS V, FPEM, CHEP, FABCHS,**

is a dedicated emergency manager who is passionate about the field in which he

works and protecting those he serves. He began his career in emergency management in 2002. Mr. Alberts has responded to emergencies of all types and sizes including a terrorist attack, four hurricanes, tropical systems, communicable disease outbreak, severe weather, wildfires, multi-type vehicle accidents, and mass casualty incidents. He is currently the Corporate Manager of Emergency Preparedness for the Orlando Health, Inc. hospital system in Central Florida. He is also a member of the Department of Health and Human Services – National Disaster Medical System - FL-6 DMAT (Disaster Medical Assistance Team) as a Logistician, SMRT-5 (State Medical Response Team) as the Deputy Planning Chief, member of the Regional Domestic Terrorism Task Force All-Hazards Incident Management Team (AHIMT), and State of Florida Division of Emergency Management AHIMT as a Qualified Liaison Officer.



**Deborah S. Blalock, M.Ed., LPCS, CPM** has been employed

by the South Carolina Department of Mental Health since 1993. In August 2004,

Mrs. Blalock became the Executive Director of the Charleston Dorchester Mental Health Center, one of the largest of the department's 17 mental health centers. Prior to becoming the Executive Director, she was the

center's Director of Acute Services. In that role she was responsible for services that directly focused on people in crisis such as a Mobile Crisis Team, South Carolina's first Mental Health Court, a Crisis Stabilization Center, and services in local detention centers. Mrs. Blalock has extensive training in crisis negotiation, crisis intervention, and critical incident management.



**Curt Drennen, Ph.D.**, is a licensed psychologist with the Colorado Department of Public Health and Environment. He is currently the Community

Outreach Branch Supervisor within the Operations Section of the Office of Emergency Preparedness and Response. In this role, he is working in partnership with a diverse stakeholder group to improve the state's capacity to respond to the psychosocial impact of disaster and public health emergencies. He has 23 years of experience in the fields of mental health and psychology with an emphasis in public psychology and administration, emotional intelligence, servant leadership, systems conflict management, crisis intervention, and behavioral health disaster management. Dr. Drennen has led six Colorado Crisis Counseling Programs and one SAMHSA Emergency Response Grant, and has provided CCP training to at least six other states.



**Russell Jones, Ph.D.**, is a Professor of Psychology at Virginia Tech University and a clinical psychologist who specializes in clinical child

psychology, trauma psychology, and issues related to disaster and terrorism ([www.firetrauma.com](http://www.firetrauma.com)). He is an expert in the behavioral sciences. His research concerns the topic of childhood stress and coping with common stressful life events as well as major traumas (for example, natural and technological disasters as well as interpersonal violence). His major areas of study include disaster preparedness, posttraumatic stress disorder, depression, and posttraumatic growth. He and his students at the Stress and Coping Lab have been engaged in a program of research investigating the mental health impact of the 4/16 shootings at Virginia Tech. More recently, he has been examining the impact of racial trauma as well as the transmission of historical trauma on people of color.



**Veronica A. Kelley, LCSW**, is the Director and Alcohol and Drug Administrator for the San Bernardino County Department of Behavioral

Health. Ms. Kelley is a member of the Governing Board for the California Association of Behavioral Health Directors Association (CBHDA), sits on the Executive Committee, and serves as the co-chair for the Substance Abuse Prevention & Treatment Committee as well as the Cultural Competence and Social Justice Advisory Committee. She represents CBHDA on the State Department of Health Care Services DUI Advisory Board and the California Mental Health Policy Council.



**April Naturale, Ph.D.** is a traumatic stress specialist who directed the mental health response to the 9/11 terrorist attacks in New York. Dr.

Naturale helped launch SAMHSA's National Suicide Prevention Lifeline, directed the BP Deepwater Horizon Oil Spill Distress Helpline, and led the 9/11 10th Anniversary program. Dr. Naturale continues to provide crisis management and clinical intervention services, curriculum development, and field training in the aftermath of disasters, mass violence, and terrorist events. At ICF International, Dr. Naturale is a Senior Technical Specialist where she previously served as Program Director for SAMHSA DTAC and the World Trade Center Health Program's Outreach and Education project. Currently, she is the lead architect of the Boston Marathon bombings behavioral health response and is training humanitarian aid workers with the European Union. She also provides posttraumatic stress and suicide prevention training to emergency response clinicians and the National Guard in Kiev, Ukraine.

## Recent Technical Assistance Requests

In this section, read about recent questions SAMHSA Disaster Technical Assistance Center (DTAC) staff have answered and technical assistance requests to which they have responded. Send your questions and comments to [dtac@samhsa.hhs.gov](mailto:dtac@samhsa.hhs.gov).

**Request:** A state disaster behavioral health coordinator reached out to SAMHSA DTAC through the DTAC email at [dtac@samhsa.hhs.gov](mailto:dtac@samhsa.hhs.gov). The individual requested a literature review on the use of pharmaceuticals in the treatment of posttraumatic stress disorder (PTSD).

**Response:** SAMHSA DTAC provided a brief synopsis of findings following the conclusion of the literature review. The consensus among studies that looked at the efficacy of pharmacological PTSD treatment is that while drug research has shown promise, there is no single source that provides a high success rate for the mitigation or prevention of the development of PTSD symptoms in trauma survivors with pharmacological use. SAMHSA DTAC also sent the state behavioral health coordinator links and summaries to selected peer-reviewed and federally funded publications. Below are some selections:

- Jonas, D. E., Cusack, K., Forneris, C. A., Wilkins, T. M., Sonis, J., Middleton, J. C., . . . & Olmsted, K. R. (2013). Psychological and pharmacological treatments for adults with posttraumatic stress disorder (PTSD). *Comparative Effectiveness Review*, No. 92. <https://effectivehealthcare.ahrq.gov/ehc/products/347/1436/PTSD-treatment-adult-executive-130403.pdf>
- Watts, B. V., Schnurr, P. P., Mayo, L., Young-Xu, Y., Weeks, W. B., & Friedman, M. J. (2013). Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. *The Journal of Clinical Psychiatry*, 74(6), 541–550. <http://www.ncbi.nlm.nih.gov/pubmed/23842024>

- Tips Hruska, B., Cullen, P. K., & Delahanty, D. L. (2014). Pharmacological modulation of acute trauma memories to prevent PTSD: Considerations from a developmental perspective. *Neurobiology of learning and memory*, 112, 122–129. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4051832/>

**Request:** SAMHSA DTAC received an email from an emergency manager requesting a literature review on the incidents of child abuse following disasters.

**Response:** There are mixed conclusions on the presence of increased incidents of child abuse following a disaster. However, there are some studies with strong evidence of a positive association. This is an area consistently under-researched as it is sometimes believed that children are resilient and do not face as many adverse effects following disaster events. Below is a resource for information on various topics concerning children's well-being and the effects that disasters can have on them.

- Peek, L. (2008). Children and disasters: Understanding vulnerability, developing capacities, and promoting resilience—An introduction. *Children Youth and Environments*, 18(1), 1-29. ■

## Since Columbine: Evolution of Colorado's Disaster Behavioral Health Response

By **Curt Drennen, Psy.D., RN**, Community Outreach Branch Supervisor, Office of Emergency Preparedness and Response, Colorado State Department of Public Health and Environment

*“Yesterday, my life entered the most abhorrent nightmare anyone could possibly imagine.”*

Sue Klebold, April 21, 1999

I recently read *A Mother's Reckoning: Living in the Aftermath of Tragedy* by Sue Klebold (2016), the mother of Dylan Klebold, a perpetrator of the Columbine High School violence. She writes about pain, trauma, reconciliation, and return to health. I recommend this book, simply because it gives us, those in the field of disaster behavioral health, a very important perspective on the events that we plan for, train for, and unfortunately, too often respond to.

It is somewhat clichéd to say that every disaster is different—but it is true, and that truth is magnified in incidents of mass violence. These human-caused events are unpredictable, varied, and devastating, not only to the direct victims/survivors, but to whole communities.

### In the Beginning—Columbine High School Response

The initial response to the shooting at Columbine was chaotic and confused. The most effective work happened as a partnership among the school- and district-based mental health professionals, the community

mental health center, and county and state victim advocates. But a host of volunteers, some with tremendous clinical acumen, descended onto the grounds of the school as well as Clement Park (a large urban park surrounding the school) to provide support running the gamut from crisis counseling to Critical Incident Stress Debriefing to Eye Movement Desensitization and Reprocessing (EMDR) therapy to “rebirthing”.

A critical lesson learned when Denver hosted the trial for Timothy McVeigh (Oklahoma City bomber), but unfortunately did not implement, is the importance of relationship-building and the development of cross-system knowledge. During the trial, victim advocates and public mental health staff built relationships and a strong understanding of each other's systems and the capacities and strengths of those systems. During the Columbine response, those relationships came back into play, allowing leadership to have instant trust and creating a fair and balanced division of responsibilities.

The National Institute of Mental Health proposes helping survivors with the following in the days after a disaster:



Getting food



Getting a safe place to live



Getting help from a doctor or nurse if hurt



Contacting loved one or friends



Keeping children with parents or relatives



Understanding what happened



Understanding what is being done



Knowing where to get help

SOURCE: *Helping children and adolescents cope with violence and disasters: What parents can do.* (2015). <https://www.nimh.nih.gov/health/publications/helping-children-and-adolescents-cope-with-violence-and-disasters-parents/index.shtml>

## Improving Capacity With Training

Since that day in 1999, Colorado has purposefully grown its capacity to respond to the psychosocial impact of mass violence. The three years following Columbine included some major events: September 11, 2001, and the largest series of wildfires in Colorado's history. During this time, a three-year school and community recovery program called Columbine Connections was implemented by the local mental health center, Jefferson Center for Mental Health. Lessons learned from these experiences led to the building of a strong disaster behavioral health response system. These lessons include:

1. Behavioral health response to disaster or community crisis is not therapy.
2. When critical events happen, people want to help; they just don't know how to get it.
3. Disaster behavioral health is larger than any one system.
4. Preparation is absolutely critical to an effective response.

We chose to start our efforts with planning and training. With

support from a 2003 Substance Abuse and Mental Health Services Administration (SAMHSA) Disaster Mental Health Planning grant, Colorado built its first robust behavioral health emergency operations plan. With a small local grant, we began educating our providers, helping them to understand that just because they are outstanding clinicians, does not mean they are prepared to respond to individuals in crisis. Colorado built two core trainings to guide knowledge development. The first training provided information on how to respond as a part of the larger system. It also addressed being a part of the larger emergency management system and provided guidance on early intervention. The second training focused on recognizing trauma and building a trauma-informed system of care. We then took these trainings to every community mental health center in Colorado and offered them several times over the next two years. We continue to update these trainings based on our direct experiences as well as current research.

## Successful Partnerships

Following Hurricanes Katrina, Rita, and Wilma, Colorado welcomed over 14,000 evacuees, and participated in the first multi-state national Crisis Counseling Assistance and Training Program. In October of the following year, a man entered Platte Canyon High School, holding a room full of girls hostage for the day. The incident resulted in the death of one of the students, Emily Keyes, and the perpetrator. In December, Colorado started an effort to build a partnership across systems to improve disaster behavioral health response. The two-year effort that followed resulted in the formation of the Colorado Crisis Education and Response Network (CoCERN), a partnership of the public behavioral health system, the American Red Cross, the Salvation Army, victim advocates, and a variety of professional organizations with support from state public health and emergency management. This partnership set the structure for disaster behavioral health response in the areas of cooperation, resource management, communication, and standards of practice. The Colorado

## LESSONS LEARNED

### TRAINING

April 20, 1999

Columbine High School shooting

*Colorado began to work on the capacity to respond by improving the disaster behavioral health trainings provided to community mental health centers.*

### PLANNING/DEFINING ROLES

July 20, 2012

Aurora Cinemark Theater shooting

*Colorado began to work on defining specific missions that behavioral health teams can implement based on the event and environment.*

### PARTNERSHIPS

November 27, 2015

Colorado Springs  
Planned Parenthood shooting

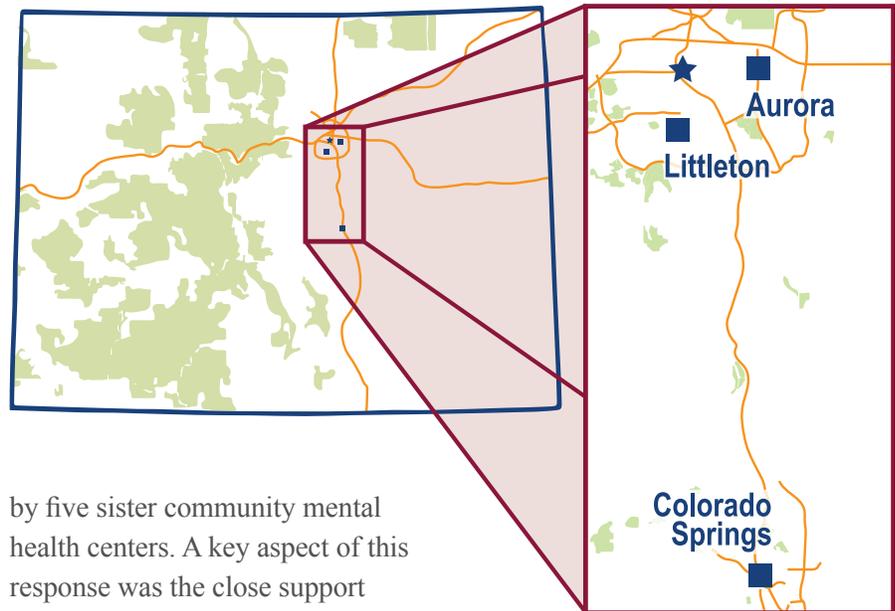
*Improved partnerships at the state level and the clear role of disaster behavioral health led to a successful response.*

Standard of Practice for individuals wanting to participate in disaster behavioral health requires the following trainings: the Federal Emergency Management Agency (FEMA) Independent Study (IS)-100 course, Introduction to Incident Command System (ICS); FEMA's IS-700 course, National Incident Management System; Psychological First Aid; and the Colorado Field Response Training or the Red Cross Disaster Mental Health Fundamentals.

With the CoCERN partnership in the middle of its development, Colorado experienced a major tornado in May 2008 that challenged the system. Lessons around communicating, identifying missions, and articulating boundaries were quickly integrated into organized processes. Then between 2010 and 2015, Colorado experienced an unprecedented series of natural and human-caused public health and mass violence events. Each event brought new challenges and stretched our understanding of what it means to respond to community crises.

## Defining Disaster Behavioral Health—Aurora Cinemark Theater Shooting Response

By July 2012, our systems had built a great deal of institutional knowledge around a behavioral health response. When the Aurora Cinemark Theater shootings happened, Aurora Community Mental Health hit the ground running and was backed up



by five sister community mental health centers. A key aspect of this response was the close support provided by their Emergency Support Function (ESF) 8 lead, Tri-County Public Health. Tri-County provided communication and logistical support as the mental health centers deployed teams of trained disaster behavioral health responders. As a result, teams responded to 77 requests for community support serving over 1,830 individuals. The agency's phone bank saw a 111 percent increase in call volume in the three months after the shooting with over 11,000 calls, and they served an additional 1,100 people through walk-in clinics.

However, an event such as the theater shooting is not a singular event. Aurora's response continued for the next several years. In partnership with the city and the state, the mental health center implemented a SAMHSA Emergency Response Grant (SERG) focused on community outreach, trauma education, and trauma

treatment; assisted victim advocates in providing direct support to survivors, first responders, and others affected by the shooting during the criminal justice proceedings and the trial of the perpetrator; and launched a community resilience center called Aurora Strong.

It became clear that disaster behavioral health needs to better define itself, its purpose, and its mission. Colorado began to clearly articulate the purpose of disaster behavioral health: to support adaptive functioning by decreasing stress and fear in both survivors and responders. This clear articulation of the role of disaster behavioral health has continued to evolve with a document that defines specific missions that behavioral health teams can implement based on event and environment. We have found this articulation of possibility leads to continued development

of partnerships with local ESF 8 leadership and emergency management.

## Working To Improve Partnerships among Response Organizations—Colorado Springs Planned Parenthood Response

Recently, Colorado Springs experienced our latest mass violence event. While smaller in scale than Aurora or Columbine, the shooting at Planned Parenthood on November 29, 2015 illustrated the variety of ways disaster behavioral health personnel respond to an event. The development of partnerships at multiple government levels and with various types of organizations, including Victim Advocates, encourages a more efficient and successful response.

The mission of Victim Advocates is to support victims' navigation of the criminal justice system. This event resulted in community victims, but also responder victims. However, because of strong relationships at

***After the Aurora Cinemark Theater shooting, the state mental health centers saw a 111 percent increase in call volume with 11,000 calls, and they served an additional 1,100 people through walk-in clinics.***

the state level, support and guidance could easily be provided to local leadership, encouraging creative partnership to address the impact of this event. While the response was relatively short-term, the partnership involving law enforcement victim advocates, the community mental health center, AspenPointe, and El Paso County Public Health (as the ESF 8 lead) resulted in an immediate response that was impressive. Two sequential efforts were launched to support victims and the community as well as law enforcement personnel and their families. In the form of a mini-disaster assistance center, 3 days of direct care were provided to support victims and the larger community followed by

2 days strictly for law enforcement and their families. Over the 5 days, the response team provided food, networking, therapy animals, gifts, and informal counseling, and the Colorado Acupuncture Medical Reserve Corps provided the National Acupuncture Detoxification Association auricular acupuncture protocol for stress.

Because of this successful response, the CoCERN partnership is furthering the emphasis on relationship-building among its partners, especially offices of victim advocates, the public behavioral health system, and local public health agencies.

## A Passion for Supporting Disaster Behavioral Health

Disaster behavioral health requires an ongoing commitment to planning (developing emergency operations and continuity of operations plans); training (ICS, Psychological First Aid, roles, self-care, and limitations); exercises; and relationship development. Disaster behavioral health also requires advocates and leadership who battle against both the inertia of systems and the negative perceptions of behavioral health. One of the reasons I am passionate about building strong disaster behavioral health systems is that responders, survivors, and the larger community gain an experience with behavioral health professionals and systems that can have a positive impact. ■



**The average active-shooter incident lasts 12 minutes.**

**Thirty-seven percent last less than 5 minutes.**

SOURCE: Nicoletti, J. (2012, December). *Detection and disruption of insider/outsider perpetrated violence*. Lecture, Colorado Emergency Preparedness Partnership.

## The Aftermath of the Virginia Tech Shootings

By Russell Jones, Ph.D., Professor of Psychology, Virginia Tech University

Due to the nature of the event and the location, Virginia Tech did not have a “roadmap” to follow to guide response and recovery efforts in the aftermath of the shooting on campus in 2007. As such, initial efforts involved the provision of immediate comfort and stability as well as meeting the acute needs of family, friends, and coworkers. In the moments and days following the shootings, Virginia Tech framed its own recovery and identified steps to move forward. In my opinion, many of these initial steps led to an extraordinary level of safety and stability for those affected by the shootings.

At the outset, I should say how much I was moved by the flood of expressions of love, concern, support, and expertise shown by individuals, agencies, and organizations and by local, state, and federal partners.

### Acute Aftermath

Immediate actions were taken to assist and support the families of students and faculty who were injured or fatally wounded, as well as the Virginia Tech community at large. Many university departments spearheaded these efforts. For example, the Division of Student Affairs established a group of family liaisons. These Virginia Tech staff members served as contacts for

families of the injured and deceased. Their assignments were to contact family members of the deceased and injured and to provide a wide range of help primarily serving as a contact between them and the university. These liaisons were tasked with a host of helping behaviors that ranged from contacting funeral homes and transporting the deceased to addressing more immediate needs such as finding lodging for the night.

In the short term, arrangements were made for attendance at the 2007 graduation ceremony the following month for affected students who were scheduled to graduate. Arrangements were also made to provide more long-term help, which included researching procedures for accessing victim compensation. Simultaneously, the Family

Assistance Center, housed at the Inn at Virginia Tech, not only provided lodging for the families, but also served as an initial information hub. Media centers were also established with the primary goal of protecting families from their encroachment at this difficult time.

### University-wide Counseling

Virginia Tech’s Cook Counseling Center initiated several efforts to meet the emotional and physical needs of students, including additional hours of service immediately after the event. Within 30 minutes, two therapists from Cook Counseling Center arrived at West Ambler Johnston dormitory, the site where the first two students were killed, to help friends and other students who lived in the dorm with

From 2000 to 2013, 39 of the 160 mass shooting incidents in the United States have taken place in educational environments.

SOURCE: DOJ, FBI. <https://www.fbi.gov/file-repository/active-shooter-study-2000-2013-1.pdf>



adjusting to the tragedy. Special care was also provided to survivors who were in Norris Hall at the time of the shootings. Critical Incident Stress Management activities were also carried out by local and regional emergency medical services providers for those exposed in Norris Hall. Wounded individuals were taken to local hospitals for immediate attention. Virginia Tech's Schiffert Health Center assisted in this process.

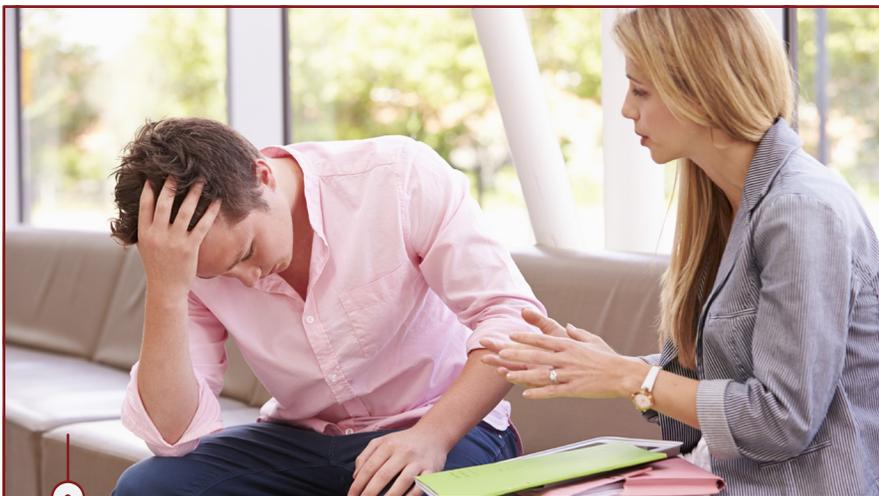
Counselors targeted other highly exposed individuals, including

roommates of those killed, classmates and victim's professors in other classes they attended, and students who shared membership in Virginia Tech's clubs, sororities, fraternities, and other organizations.

During the recovery process, psycho-education was provided across campus. Experts from national, state, local, and university departments distributed information and made themselves available to every level of the university. To meet a variety of needs of faculty and staff, Virginia Tech's Human

Resources Department tasked their Employee Assistance Providers with assisting in the recovery process.

University staff anticipated that people who attended the upcoming graduation would experience an increase in anxiety and sorrow. The Cook Counseling Center staff members attended the ceremony to provide counseling and recovery resources to those in need. Hokie United, Residence Life, Human Resources, and the Cranwell International Center representatives were also on hand to help.



**SAMHSA** offers the following coping tips for college students dealing with a disaster or other trauma:

- **Talk about it.**
- **Take care of yourself.**
- **Give yourself a break—turn off the television/radio.**
- **Avoid using alcohol, drugs, and tobacco.**
- **Get back to your daily routines.**
- **Get involved in the community.**
- **Help others.**

SOURCE: *Tips for college students: After a disaster or other trauma.* (2013). <https://store.samhsa.gov/product/Tips-for-College-Students-After-a-Disaster-or-Other-Trauma/SMA13-4777>.

PHOTO: Monkey Business Images / Shutterstock.com.

## Interagency Cooperation and Support

The Department of Criminal Injuries Compensation Fund arrived and provided their expertise to help the distressed families. Throughout the day and days following the shootings, state and local police were available to provide announcements of death and injury. A 24-hour call center was also initiated to aid in the response effort. The Virginia Department of Emergency Management provided manpower to work with university personnel to aid in this effort.

Dr. Mark McNamee, the University Provost, secured grant funding from the U.S. Department of Education during the acute phase of the recovery period. The primary goal of this grant was to develop a model for identifying, assessing, and responding to students, faculty, and staff whose behaviors might suggest risk for perpetrating violence. Given the department's

extensive history of developing and implementing programs to assist students facing a variety of challenges, it was hoped that many of the initial recovery efforts would be sustained while new efforts would be implemented in a timely fashion. Key partners identified to assist with the actual administration and implementation of the grant included the University Provost, the Division of Student Affairs, the Human Resources Department, the Virginia Tech Police Department, Virginia Tech professors and researchers in psychology and sociology departments, and several off-campus partners (such as the Community Services Board). It was decided that the Cook Counseling Center would serve as the primary vehicle for students to gain access to mental health services on campus, while services for the faculty and staff would be provided by Human Resources.

## Culturally Informed Care and Response Efforts

Culturally competent care is a key component of any recovery effort. The Virginia Tech community is composed of people of a variety of races and ethnicities, including Caucasians, Koreans, African American, and Hispanics. It was determined that special attention should be given to the Asian population, given that the shooter was Korean.



In the aftermath of a shooting, the **American Counseling Association** provides the following tips to help survivors cope:

- **Attend to self-care.**
- **Pay attention to your emotional health.**
- **Try to recognize when you or those around you may need extra support.**
- **Avoid overexposure to media.**
- **Maintain contact with friends and family.**
- **Focus on your strength base.**
- **Talk to others as needed.**

SOURCE: Dailey, S. F. *Coping in the aftermath of a shooting*. <https://www.counseling.org/knowledge-center/coping-in-the-aftermath-of-a-shooting>

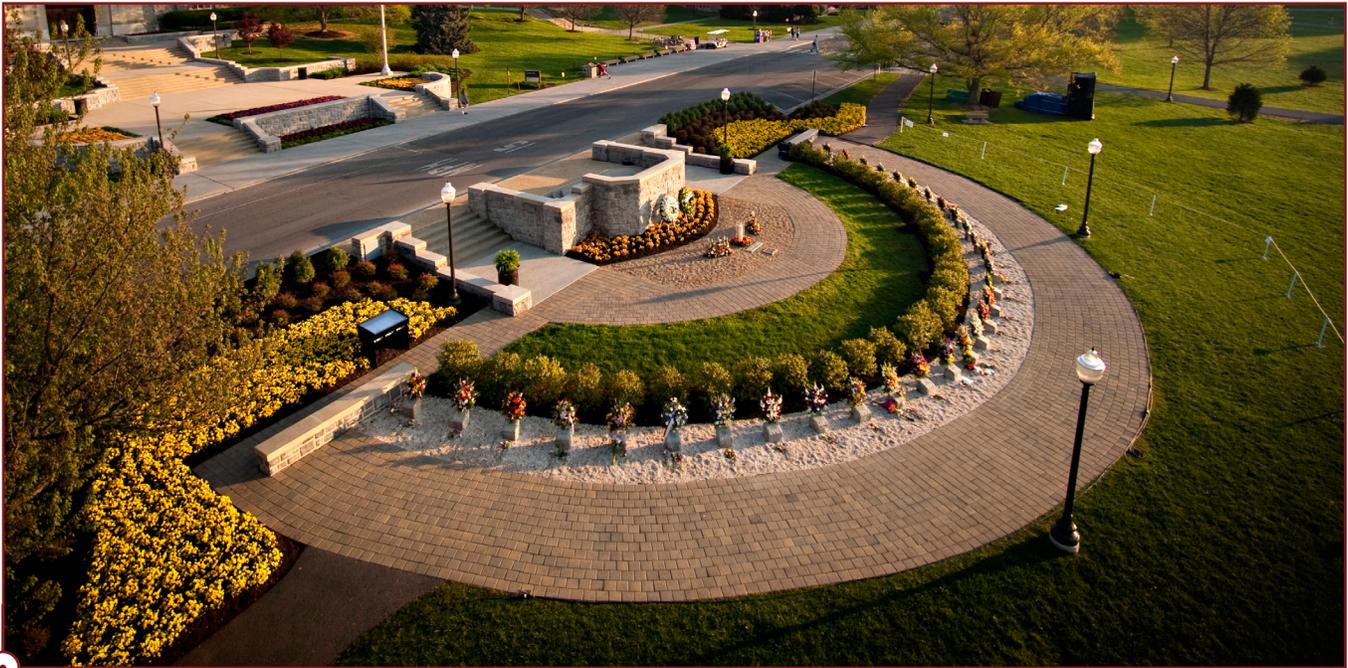
PHOTO: Photographee.eu / Shutterstock.com.

The Cranwell International Center made impressive efforts to ensure the safety of and provide support to the Asian student population on campus and in the surrounding community. One-third of the April 16 victims were international students. Cranwell Center staff and volunteers called every international student. Additionally, phone cards were given to assist students' communication with their loved ones. These efforts were facilitated through partnerships with several university organizations,

including the Asian American Student Union and Multicultural Program and Services.

## LESSONS LEARNED

Several recommendations were spelled out in the report of the Virginia Tech Review Panel to the Governor of Virginia, including that universities and colleges develop plans, establish a joint information center and create a family assistance center following a criminal mass casualty, provide scheduled briefings



**Visitors to the Virginia Tech campus can visit the April 16 Memorial in honor of the victims of the shooting.**

PHOTO: John McCormick.

to victims' families, ensure the availability of short- and long-term counseling, and coordinate provision of training in crisis management (2007). The Virginia Tech community's outstanding recovery efforts were due in part to a high degree of social support prior to, during, and after the shootings among members of the Hokie Nation. One of the greatest strengths of the Virginia Tech recovery effort was the fact that a solid infrastructure for both the university and the surrounding community had been established in previous years. The timely and insightful support from many community partners contributed to the recovery and transition efforts.

The openness to strategies based on our "best science" further enhanced and facilitated the recovery effort. The knowledge obtained from members of the Virginia Tech community as well as a host of local, state, and federal agencies and organizations proved to be invaluable.

The trauma literature provided helpful insight. The adoption and integration of knowledge on several topics proved to be quite beneficial. These topics included the integration of public mental health surveillance/monitoring strategies with mental health assessment efforts, evidence-based treatments for traumatic stress, dissemination of evidence-based interventions, and conducting assessments and intervention-based efforts with people of color.

The high quality and quantity of culturally sensitive actions initiated by the Cranwell International Center at Virginia Tech was yet another ingredient in the success of the response efforts. Due to the efforts of many professionals at the Cranwell Center and throughout the university, culturally competent care was provided to many individuals, particularly members of the Asian community.

I am hopeful, as are thousands of others, that this senseless act of violence will inspire countless members of the Hokie Nation to uphold the university's motto, *Ut Prosim* (That I May Serve). ■

Virginia Tech Review Panel. (2007, August). *Mass shootings at Virginia Tech, April 16, 2007: Report of the Review Panel*. Retrieved from <https://governor.virginia.gov/media/3772/fullreport.pdf>

## Lessons Learned From the Boston Marathon Bombing Victim Services Program

By **April Naturale, Ph.D.**, Senior Technical Specialist, ICF International

The Boston Marathon bombing terrorist event of April 15, 2013, resulted in the death of three people and injury of several hundred more. Over the next several days, after a massive law enforcement effort ending in Watertown, Massachusetts, one of the suspects was killed, and the other was captured. Each year, the Boston Marathon is highly publicized and

draws runners, supporters, and spectators from all parts of the globe. Graphic reports and videos of the bombing and survivors appeared in various media continuously for an extended period. This intentional, human-caused mass violence incident accompanied by graphic, gruesome, and extensive media exposure exacerbated the behavioral health risks of those exposed.

The Massachusetts Office for Victim Assistance (MOVA) implemented a disaster response program with Antiterrorism and Emergency Assistance Program funds from the U.S. Department of Justice's Office for Victims of Crime. MOVA funded victim services and behavioral health agencies within the affected areas as well as the Boston Police Department, Boston Public Schools, and the Watertown School system. The program is continuing through September 2017 to work directly with survivors, responders, and their family members, many of whom are still experiencing long-lasting negative psychological effects.

The overall goals of MOVA's marathon bombing response program were to provide timely relief with immediate and ongoing victim assistance via victim navigators whose role was that of case managers and victim advocates, helping survivors identify their needs and access the services available to them. The overall objectives were to help guide individuals and the community onto a recovery path, increase opportunities to support and build resilience, and increase the capacity of the community to continue to address these concerns in the future. Services

The **National Child Traumatic Stress Network** suggests the following tips for talking to children about mass violence:



**Start the conversation.**



**Encourage your child to ask questions, and answer those questions directly.**



**Listen carefully to find out what the already know.**



**Limit media exposure.**



**Gently correct inaccurate information.**

SOURCE: *Talking to children about mass violence*. [http://www.nctsn.org/sites/default/files/assets/pdfs/talking\\_to\\_children\\_about\\_mass\\_violence.pdf](http://www.nctsn.org/sites/default/files/assets/pdfs/talking_to_children_about_mass_violence.pdf)

PHOTOS: Iakov Filimonov, imtmphoto, Lopolo, and BrunoRosa / Shutterstock.com.

have varied according to the disaster phases and have included crisis response; consequence management; crime victim compensation; criminal justice support (such as support for victim participation in criminal justice proceedings); crisis counseling; emergency transportation and travel; compensation for medical and mental health costs, lost wages, and funeral expenses; temporary housing; emergency food and clothing; repatriation of remains; victim advocacy, outreach, and education; victim notification; and vocational rehabilitation. A behavioral health response plan was developed to provide disaster-specific treatment interventions, and a large-scale media and communications effort provided outreach, information, and education to the broadly affected community.

***“There is a need for greater awareness of the negative physical, social, emotional, spiritual, and financial impacts of crime, particularly terrorism.”***

Services provided have been informed by a needs assessment, along with survivor and family forums, victim compensation, and other provider reports and direct contact with survivors. Targeted outreach was possible due to the coordinated effort of federal, state, and local agencies. MOVA planned to reach those victims/survivors

at highest risk of developing serious behavioral health problems, including survivors with injuries, amputations, burns, traumatic brain injuries, or loss of hearing or vision; families of homicide victims; close friends and coworkers of victims; school-aged children exposed to the bombing and the Watertown lockdown and shootout; and those at the next levels of exposure, such as first responders exposed to the fear, chaos, and injuries involved in the event, as well as their family members; survivors with prior trauma or mental illnesses, medical problems, or limited mobility or other functional and access needs.

## Successes

A continuum of care working group was initiated, bringing together over 30 agencies that interacted with survivors. The working group included state and city responders, federal law enforcement, community providers funded through the Victims of Crime Act, American Red Cross personnel, and members of the private sector. The group discussed and analyzed the types of services needed, both short and long term. They identified service gaps and made recommendations about how to address them. This working group provided an opportunity for members to learn about each other as well as a platform to discuss issues and activities.

There was an expressed need for behavioral health support from survivors and their families starting

with the immediate days of the attack throughout the following four years with a significant increase in requests just prior to and at the time of the anniversaries. MOVA staff provided a compassionate presence and support during and after public anniversary activities such as the ceremony held at the Old South Church and the memorial on the campus of the Massachusetts Institute of Technology for Sean Collier, the university police officer who was killed by those responsible for the bombing. Staff also sent out SAMHSA’s Disaster Tip Sheets about what to expect leading up to the anniversary and suggestions for coping activities. Many survivors responded to a direct email campaign with comments about how helpful it was to have information about coping, recommendations to plan ahead, and the suggestion to be with others. They also noted how comforting it was to see the victim advocates at the anniversary events.

MOVA developed a media plan to provide messages of support, hope, recovery, and resiliency. Messaging was delivered via major television networks, and actual survivors used scripts in which they talked about their own experiences of the event, their reactions, and what they felt had helped them most.

## LESSONS LEARNED

We learned that victim services response should be immediate and systemic; thus, political, law enforcement, and emergency



*Individuals demonstrate their solidarity with the victims of the Boston Marathon bombing by displaying a Boston Strong flag during the 2014 race.*

PHOTO: Provided by April Naturale.

management leadership needs to be informed about what victim service agencies can offer in the wake of a tragedy. Victim services agencies must be represented on state, city, and local community emergency management planning committees before and after incidents. We also learned that due to the nature of disasters, it is crucial to hire project staff as soon as the determination to provide response services is made. Establishing new contracts was time consuming, and thus reaching out to behavioral health providers with existing contracts to provide crisis intervention and behavioral health support was more efficient. One challenge encountered was ensuring the administration of disaster and trauma-specific, evidence-based interventions targeted to the needs of the affected population.

We found it difficult to create and implement self-care activities for staff when they were not already part of how the office operates. Many staff working in the response had a shared experience of trauma. Creating more formal and informal opportunities for staff to discuss and address their own experiences would likely have reduced some of their concerns and distress.

There is a need for greater awareness of the negative physical, social, emotional, spiritual, and financial impacts of crime, particularly terrorism. Providing broad public education on the signs and impacts of traumatic events can help to reduce stigma and increase help-seeking.

The Boston Marathon bombing response was exemplary, from the extraordinary immediate medical

care in the field and the nearby hospitals that saved lives, to the self-sufficiency with which the city picked itself up and continued its regular activities and more. Still, many of the experiences of the victims' families, survivors, and various responders echoed those of prior terrorist events and mass shootings. We all need to share our lessons learned and recommendations so that we can identify best practices and learn from each other. We are Boston Strong, but every community that experiences these types of events can work together to support the needs of survivors. ■

## Tragedy in the Sanctuary

By **Deborah S. Blalock, M.Ed., LPCS, CPM**, Executive Director, Charleston Dorchester Mental Health Center/  
South Carolina Department of Mental Health

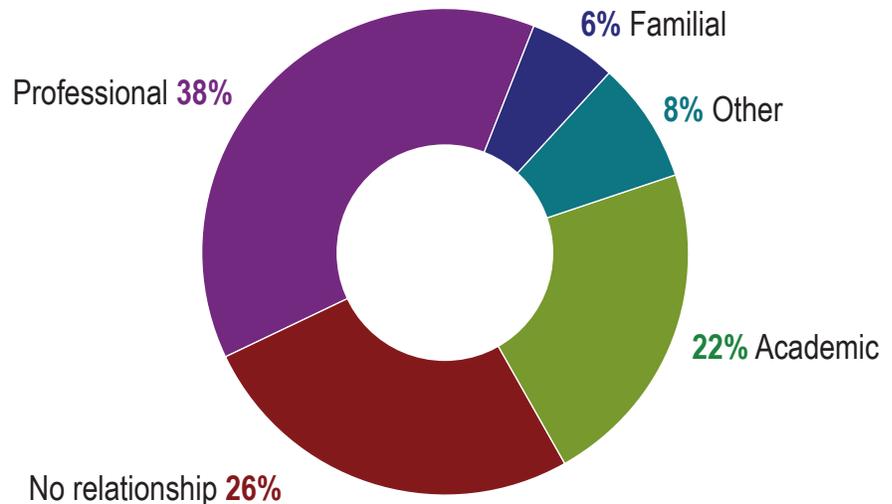
On June 17, 2015, the unthinkable occurred . . . a self-avowed white supremacist entered Emanuel African Methodist Episcopal (AME) Church in Charleston, South Carolina, and after attending Bible study with church members, opened fire, murdering nine. Because of a longstanding relationship with the Charleston Police Department (CPD), a Charleston Dorchester Mental Health Center (CDMHC) mental health professional embedded with the CPD was immediately deployed to the family staging area to offer support to the five survivors and nine victims' families. Thus began CDMHC's journey with Emanuel AME—a journey that taught all of us many lessons about responding to and recovering from an event like this one.

### LESSON LEARNED

#### Relationships established before disaster strikes are invaluable.

It is critical to build partnerships prior to an incident that you can rely on during the response and recovery phases. You should work to identify key partners you can turn to in the event of a disaster. Ideally this would be done before a disaster and would cover a wide range of scenarios.

### Relationship Between Active Shooter and Victims



SOURCE: New York City Police Department. *Active shooter: Recommendations and analysis for risk mitigation, 2012 edition.* <http://www.nypdshield.org/public/SiteFiles/documents/Activeshooter.pdf>

CDMHC assisted the Federal Bureau of Investigation (FBI) Victims' Assistance Team in establishing a Family Assistance Center and established a Church Assistance Center for church members unrelated to victims. The church's entrance became a memorial site where hundreds came to grieve and show love for the victims and survivors. Many were overcome by grief and in need of support. CDMHC deployed its RV, a mobile mental health clinic, to the site to offer support, as well as water and snacks. CDMHC also staffed a phone bank on a local news show to address the community's concerns.

### LESSON LEARNED

#### A human-caused disaster is different from a natural disaster.

Survivors may view a human-caused disaster in a different light than a natural disaster, and the recovery process may follow a different trajectory. We as disaster Responders need to keep this in mind while aiding survivors.

Emanuel's leadership recognized CDMHC as a partner 2 days after the shooting. CDMHC assisted the church in a funeral planning meeting with the victims' families. The congregation of approximately 550 had to plan, with limited resources, nine funerals, including

one for its pastor and three others for ministerial staff. This meeting was highly emotionally charged, and staff had to use their de-escalation skills many times. As requested, CDMHC attended numerous prayer vigils. Church leadership asked CDMHC to attend worship services the Sunday after the shooting. The church, usually hosting 100 people on Sundays, was filled past its 1,200-person capacity on the first Sunday after the shooting. Worshippers were overcome with shock, sadness, and horror as they entered. Center staff attended Sunday services for 7 months, and they offered support at every wake and every funeral and at the church's weeklong children's vacation Bible school. The CDMHC provided support for many responders, including the coroner's

office, law enforcement, emergency medical services and fire personnel, clinical staff, and even members of the media.

## LESSON LEARNED

### Clinicians' needs must be addressed regularly.

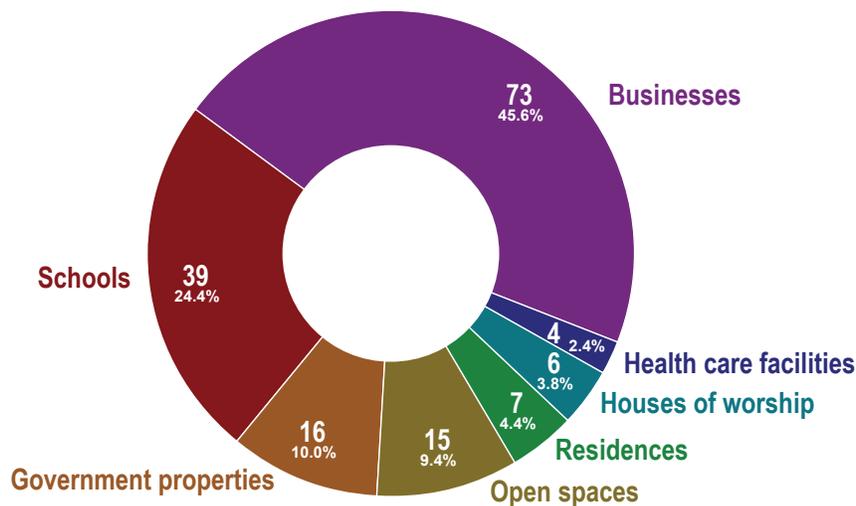
Self-care is important no matter what the disaster. For responders to be able to properly assist survivors, they must address their own personal needs. Response staff must be continually monitored for signs of stress and compassion fatigue.

CDMHC knew it had to further its reach to touch more affected by the tragedy. The center partnered with the Medical University of South Carolina's National Crime Victims Research and Treatment Center (NCVC) to bolster capacity and

expertise. Together, the agencies created informational flyers for the church. The Substance Abuse and Mental Health Services Administration also created customized informational brochures which were distributed. The partners created and distributed a needs assessment survey to church members. While returning church members became very familiar with the counselors, many members had not returned, out of sadness and fear, and they had to be reached. Counselors attended ministry meetings, including the Women's Ministry, Seniors' Ministry, and Children's Church. The clinical team facilitated a weekly grief support group that is still meeting, and helped plan and attended 2 weeks of memorial events with family members and survivors.

## Things To Think About When Planning for Active Shooter Incidents: Location

Number of incidents, 2000-2013



SOURCE: U.S. Department of Justice (DOJ), Federal Bureau of Investigation (FBI). (2013). A study of active shooter incidents in the United States between 2000 and 2013. <https://www.fbi.gov/file-repository/active-shooter-study-2000-2013-1.pdf>

*From 2000 to 2013, six mass shooting incidents have taken place in the United States in places of worship, resulting in 21 deaths.*

SOURCE: DOJ, FBI. <https://www.fbi.gov/file-repository/active-shooter-study-2000-2013-1.pdf>

## LESSON LEARNED

**In a church shooting, clinicians must be skilled in addressing spirituality.**

*When assisting disaster survivors, responders need to be aware of any factors that may play a role in the recovery process as well as how to*



***The Emanuel African Methodist Episcopal Church congregation continues to move forward in the recovery process.***

PHOTO: Provided by Deborah S. Blalock.

*improve acceptance of resources and materials among survivors in the affected community. They must be sensitive to the beliefs of the survivors.*

From the beginning, we knew race was wound very tightly in this tragedy. We had to make sure that we were not afraid to face the issue of race head on. We could not send two Caucasian clinicians to any function. If one was Caucasian, one had to be African American. We had to pay attention to the needs of those we were there to serve.

## **LESSON LEARNED**

**If race is a factor, it must be faced immediately.**

I was worried that my race would hinder me from comforting those I was there to serve. I am Caucasian. The family members, the members of the church, and the leadership of the church accepted me, welcomed me. I am honored to say that I think they trusted me. Their strength, their resilience, their forgiveness, is real.

## **LESSON LEARNED**

**Cultural competency is crucial.**

*You will be more likely to succeed in outreach activities if you engage key members of the community to improve access to and credibility among survivors.*

The NCVC received a grant from the Office for Victims of Crime to fund community efforts serving those affected. The grant has funded an Empowerment Center on church property housing the five (two NCVC, two CDMHC, and one Berkeley Mental Health Center) counselors and case managers. The grant funds were instrumental in supporting the survivors and families during the perpetrator's federal death penalty hearings and trial. A victims' support team was created. It included victims' assistance staff from CPD, the Charleston County Sheriff's Office, the FBI, and the U.S. Attorney's Office; clinicians from NCVC and CDMHC; and, for the first time in a federal trial, a spiritual support team of clergy, in this case comprising members from the South Carolina Law Enforcement Assistance Program, Emanuel AME, St. Michael's Episcopal Church, and many other local churches. The team was in the trial daily from its start on November 28, 2016, through its conclusion on January 5, 2017.

## **LESSON LEARNED**

**Mental health support must be for the long haul.**

*Long-term recovery survivor needs must be identified, and a plan put in place to address them.*

This experience has been profound for all involved . . . one that shall never be forgotten. ■

## Terror Attack at Work

By **Veronica Kelley, LCSW**, Director, Behavioral Health, San Bernardino County Department of Public Health

On December 2, 2015, in Southern California, the Environmental Health Services (EHS) Division of San Bernardino County's Department of Public Health (DPH) was holding their annual General Education Meeting. At a little after 11 a.m., two masked terrorists, later to be identified as a radicalized EHS staffer and his wife, ran into the facility hosting the meeting, the Inland Regional Center, and killed 14 people and wounded 22 others.

Shortly after the shooting took place, the local law enforcement agency requested, along with the administration of DPH, assistance from the Department of Behavioral Health (DBH). As DBH staff were deployed, we discovered the survivors

of the shooting were not the only group that required our assistance; the disaster responders were also deeply affected by the incident.

### Pre-incident Planning Led to a Successful Response

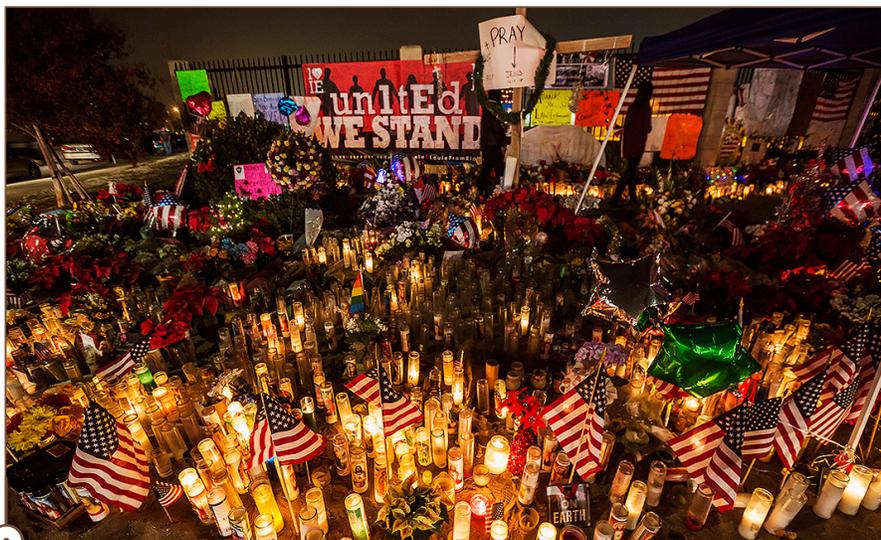
Our response was successful in part due to existing emergency plans and prior staff training. Thanks to a well-developed infrastructure and community crisis response programs (funded through the Mental Health Services Act in California), DBH could immediately deploy Community Crisis Response Teams throughout the county upon request from the San Bernardino Police Department and county sheriff. This request allowed DBH to deploy teams, even while many

of our clinic and administration sites were on lockdown due to the shooting and active pursuit of the assailants, to 10 county departments and nine community organizations. Deployment locations included the sites that EHS survivors were brought to from the triage area, the site where family could pick up a loved one, and the coroner substation.

We also developed a liaison model of support for all the EHS staff and affiliated staff such as Public Health and Land Use Services staff, who worked hand in hand with EHS and who lost many coworkers that day. Based on the fire department model utilized when a fallen firefighter's family is supported by colleagues, working in teams of two, 60 people were deployed as liaisons. These staff members were the points of contact for the families of the victims as well as the survivors and affiliated county staff. Liaisons assisted with timesheets, workers' compensation paperwork, death benefits paperwork, funeral arrangements, and general support. These teams remain active to this day.

### Adapting Response Plans To Fit the Immediate Need

DBH has extensive experience in addressing the needs of the community and survivors after incidents such as fires and other



*The community of San Bernardino showed support to the victims of the shooting and their families with candles, uplifting messages, flowers, and the American flag.*

PHOTO: Ted Soqui Photography, 2015.

natural disasters. This terrorist attack was vastly different from a fire; however, we had experience working under very stressful circumstances and could adapt our response to fit the incident.

DBH's primary focus is on treating serious and persistent mental illness for the Medicaid population. However, in the aftermath of this incident, we utilized our crisis response skill set to address all issues that came up, including the immediate trauma response and retraumatization that occurred because of other terrorist attacks and related events. Having a system in place since 2005 to address community trauma, such as suicide and violent crimes, greatly enhanced our department's ability to be fluid and effective in providing crisis intervention to our brothers and sisters in county government.

## Helping the Helpers

This horrifying terrorist attack was perpetrated by one of our own, which added to the level of stress and anxiety among survivors and responders. All our behavioral health first responders were at risk for retraumatization and even vicarious trauma. We made special concessions to ensure that responders attended to self-care, brought in staff from neighboring counties to do Critical Incident Stress Debriefing for our staff, and tried to be proactive in sharing trauma tips from the Substance Abuse and Mental Health Services Administration (SAMHSA)

## RESPONSE STATISTICS

***DBH deployed 200 clinical boots on the ground in the first 48 hours after the event and provided over 10,000 counseling/supportive contacts, both by telephone and in person. These contacts were provided 24/7 following the event, for a total of 1,344 hours of continuous behavioral health crisis care through February 2016 (care is still being provided).***

related to such incidents. Helping the helpers has been critical as the trauma remains; our coworkers are still affected, but we as a county are surprisingly resilient and SB Strong!

## LESSONS LEARNED

**Be prepared.** *Having an infrastructure that works with law enforcement and other first responders is critical. This enabled DBH to respond immediately, while we awaited mutual aid from other local counties, the state, and our federal partners.*

**Be flexible.** *Not all emergency situations are the same. Be prepared to allow the team to adjust to the special needs of each incident.*

**Do not underestimate the impact of trauma on you.** *Our staff were immediately affected but carried out their duties as needed. Monitor staff stress levels. Allowing time for self-care is essential!*

**Be open to many interventions.** *There is no one perfect method of*

*crisis intervention. Assess the situation, and determine the appropriate interventions for the current need.*

**Understand trauma.** *Traumas vary, and in this case the trauma was complex. Trauma can be acute or chronic and lead to other, more negative effects such as vicarious trauma and compassion fatigue for behavioral health first responders.*

**Don't forget the children.** *Remember that children are not small adults. Their needs should be addressed differently from those of adults.*

**Not all crisis response is clinical.** *We found that simply being present, acknowledging the horror, and providing physical comfort was at times as effective as a more clinically focused intervention.*

**Be prepared for a long recovery process.** *We have found that trauma responses have escalated after the year mark. As trauma and stress are cumulative, you need to be vigilant about trauma response and affiliated issues such as depression, anxiety, and posttraumatic stress disorder in the years and months following the event.*

**Use resources available.** *SAMHSA has a wealth of written brochures and tip sheets on trauma that we used, reproduced, shared with our community partners, and left with survivors and victims' families. Having a tip sheet to leave that an affected person could use for guidance was very helpful. We also used social media in all its forms to share the same information. ■*

INTERVIEW

## Disaster Behavioral Health Challenges Encountered During the Response to the Pulse Nightclub Shooting in Florida

By Eric Alberts, CEM, CHS V, FPEM, CHEP, FABCHS, *Corporate Manager, Emergency Preparedness, Orlando Health*

In the early morning hours of June 12, 2016, 49 people were killed and 53 wounded by a shooter at Pulse nightclub in Orlando, Florida. The *New York Times* identifies this incident as “the worst mass shooting in U.S. history.”<sup>1</sup>

Many of the people injured in the attack—44—were treated at the Orlando Regional Medical Center (ORMC), which is less than a mile from Pulse. Of those 44, 35 survived.

*The Dialogue* recently spoke with Eric Alberts, who manages emergency preparedness for Orlando Health, a large health care organization that includes ORMC. He spoke about responding to the Pulse shooting, its ongoing effects, and lessons learned that may help others supporting behavioral health before, during, and after incidents of mass violence.

***Did you have a behavioral health response plan in place prior to the event? How have things changed since Pulse?***

Before Pulse, we tried to include behavioral health components in our exercises, and we have general policies that address behavioral health. Pulse highlighted the need for behavioral health planning efforts and inclusion of behavioral health in exercises. We just did our 2017 annual full-scale community exercise, and because of Pulse, we had Employee Assistance Program (EAP) staff at two Orlando Health hospitals: ORMC and Arnold Palmer Hospital. They were there to talk with people who needed it, and there was a room set up where people could go for counseling. I was concerned about posttraumatic stress disorder and flashbacks. In the exercise, of course the injuries are fake, but police, fire, rescue, and Federal Bureau of Investigation (FBI) staff are there, and it looks and feels like a real incident. We wanted to make sure that we had behavioral health care there for our staff.

ORMC staff members have dealt with recent incidents in addition

to the Pulse nightclub shooting, including an incident in which a City of Orlando police officer was shot and killed and another police officer died as a result. Again, Orlando Health was concerned, and the EAP was on hand to provide assistance for our team members, too. It’s the new normal. Things have definitely changed since Pulse.

***How did you provide behavioral health support to your staff and survivors of the event?***

We had different levels and layers. We have chaplains throughout our hospitals that team members can talk to at any time. We also have our own EAP team. Immediately after Pulse, we had our EAP team come and they provided group and individual sessions for a few days. There were over 1,200 EAP sessions.

***What were the biggest challenges (related to behavioral health preparedness and response) you and your staff faced?***

One was trying to compassionately care for the families. They often

<sup>1</sup> Alvarez, L., Pérez-Peña, R., & Hauser, C. (2016, June 13). Orlando gunman was ‘cool and calm’ after massacre, police say. *The New York Times*. Retrieved from [https://www.nytimes.com/2016/06/14/us/orlando-shooting.html?\\_r=0](https://www.nytimes.com/2016/06/14/us/orlando-shooting.html?_r=0)

didn't know where their loved one was, and then, when they figured out where they were, they weren't sure what to do. They could be deceased, in critical condition, or okay. At ORMC we had to figure out how to provide services. Some families didn't know before the incident that their loved ones were in the LGBTQ (lesbian, gay, bisexual, transgender, and queer/questioning) community. Others knew and were accepting.

Those in the hospital were quite shocked as well. Many families came here from out of the area and did not bring anything with them. They wanted to know where they could stay, where they could find something to eat, how they could get home, even where they could charge their phones. We provided \$500 worth of cellphone chargers alone. It's things like that that people don't think of. Our team members were trying to care for the patients, in the most acute situations, which was taking all of their focus, and then the families got involved. It was an emotional time for them.

Also, some of our staff knew people who were shot. The night of the event at Pulse, I finally got home from my shift and saw prayer requests from our church for a member whose grandson was in the club during the shooting. He was there with his girlfriend to learn to salsa dance. He came to our hospital and unfortunately ended up being one of the deceased. I didn't have confirmation that he was one of the deceased, so I couldn't tell his



PHOTO: cleanfotos / Shutterstock.com.

grandfather that he didn't make it. I went into work the next day, I confirmed that he was one of the deceased, and I went to the open casket funeral.

When you're part of the response effort, it really does affect you. People think these bad situations will occur at a big mass gathering far from hospitals. Pulse was no more than half a mile from ORMC. You have to broaden your scope and realize what's surrounding you.

***Did you have any special training or resources to help effectively respond to the event?***

I have a bachelor's degree, nine certifications, and I've taken over 200 courses, which prepared me to be able to respond to this type of incident. I have responded to emergencies of all different types and sizes over the years. We also have regular exercises in our facilities. With that background and experience, you fall into place; you just do what you need to do. It's

different when you experience a real incident, but still you just go with your training. We held our yearly full-scale community exercise in March 2016, with the scenario of an active shooter in Orange County Middle School. The Pulse nightclub shooting happened in June. A lot of our staff said the exercise helped save lives. You have to get past the initial fear and go back to your training, methods, processes, and plans you remember in your head.

***Were there any partners that played a key role in your ability to prepare for, respond to, and recover from this event? If not, whom would you recommend organizations develop partnerships with?***

A ton of folks and agencies responded. The local jurisdiction, the City of Orlando, was a huge assistance. The FBI also played a role in our full-scale exercise, which is how we understood how we would respond together. We've continued to broaden that partnership. For our latest full-

scale community exercise just last week, six FBI agents came just for ORMC in the exercise. We continue our partnership to plan, train, and exercise together.

### **How did you coordinate and work with other responders and stakeholders?**

That is a continual, ongoing process, through planning, training, and exercises. We continue to coordinate and collaborate with them. We learned from Pulse that you can't know just one person in a particular agency—you need to know two or three. You need to know a couple of layers of individuals who work in those agencies. It's a continual process, not a one-time thing. Someone gets a business card, puts it away, and thinks he or she is done. If someone doesn't know you well and trust you, he or she won't answer a phone call or email.

### **How did you and your staff cope with the event?**

Our staff is compassionate, and we care about each other. We pay attention to each other. We have camaraderie, and we help to care for each other. Otherwise you feel isolated. For Pulse, we had approximately 500 people who responded, so we were not alone. They still talk about that experience. It all comes down to being open, talking to each other, and trying to care for each other.

### **How has this event changed your behavioral health emergency response plan?**

After the incident, our EAP team developed a written crisis plan. It's about a page and a half and pretty simple, but it brings to light that they have a role in crisis management or emergency response.

**Days after the shooting, the Employee Assistance Program (EAP) conducted over 1,200 sessions at the two Orlando hospitals treating victims.**

### **What are EAPs?**

**Helpful Tip to Include in Disaster Response Plans:** “An Employee Assistance Program (EAP) is a voluntary, work-based program that offers free and confidential assessments, short-term counseling, referrals, and follow-up services to employees who have personal and/or work-related problems.”

SOURCE: U.S. Office of Personnel Management. <https://www.opm.gov/faqs/QA.aspx?fid=4313c618-a96e-4c8e-b078-1f76912a10d9&pid=2c2b1e5b-6ff1-4940-b478-34039a1e1174>

### **From your experience, what would you suggest other professionals include in their behavioral health emergency response plans?**

I would just suggest they have behavioral health plans in the first place and don't ignore behavioral health. If you ignore it, you will have major problems: employees leaving, lawsuits, or even workplace

violence, if people aren't given the proper treatment. Take it seriously because it could come back and cause something serious if you don't. Just because you have never been through a serious incident before with major behavioral health effects, and you think you can't know the issues until you go through that kind of an incident, you can still leverage lessons learned from others and try to apply those practices to your efforts. The information I provided within this article, Katrina, and 9/11 provide valuable lessons learned—learn and implement lessons from those experiences. Don't ignore them.

### **Are there any other lessons learned or other information you'd like to share?**

I am not a medical clinician; I am administrative, but that doesn't mean I can't help save lives as well. I don't provide direct patient care or EAP counseling sessions, but I helped ensure the correct stuff was in place to do that during and after Pulse. HICS (the Hospital Incident Command System) saved lives when we had Pulse. To me that is extremely humbling, because I am not a clinician. It fuels the fire for me to want to keep doing this work and keep helping others in hopes of helping the efforts of saving lives. The trauma surgeon can't do this alone. It still takes an administrative person, EAP counselor, security officer, and emergency manager to help with all those efforts. ■

## RECOMMENDED RESOURCES

### Disaster-Specific Resources: Mass Violence or Riots

This part of the Disaster-Specific Resources installment of the SAMHSA Disaster Behavioral Health Information Series features resources about mass violence. The collection includes websites, tip sheets, toolkits, manuals, and videos about incidents of mass violence and their mental health and substance use (behavioral health) effects, school crisis response, coping with reactions to an incident of mass violence, and supporting children in coping.

Access the installment section at <http://bit.ly/2oWAAE3>.



### Mass Violence and Terrorism

SAMHSA's National Child Traumatic Stress Network (NCTSN) provides links to tip sheets and information about how incidents of mass violence may affect children and families, how parents and other caregivers can support children in coping, and helping children and adolescents who were injured in mass violence incidents. Also included are materials for school staff and pediatric providers.

Access this part of NCTSN's website at <http://bit.ly/2pNdFA0>.

### Psychosocial and Mental Health Interventions in Areas of Mass Violence: A Community-based Approach

In this guide, author Kaz de Jong and Médecins Sans Frontières provide information and suggestions for supporting people around the world who have survived human-caused disasters, including incidents of mass violence and terrorism. Sections of the guide explain how the traumatization process works; describe interventions; and cover special topics, including training, monitoring, and evaluation.

Access the guide at <http://bit.ly/2qu9Hsb>.

### Acts of Violence, Terrorism, or War: Triggers for Veterans

In this article, the National Center for Posttraumatic Stress Disorder explains the ways in which veterans may react slightly differently from the rest of the population to incidents of mass violence, terrorism, and war. Authors present research findings about how these incidents may affect veterans differently, and they provide suggestions for veterans for coping with their reactions, finding additional help, and supporting children and members of their communities.

Access the article at <http://bit.ly/2qts1g8>.

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The SAMHSA Disaster Behavioral Health Information Series contains resource collections and toolkits pertinent to disaster behavioral health. Installments focus on specific populations, specific types of disasters, and other topics related to all-hazards disaster behavioral health preparedness and response. Visit the SAMHSA DTAC website at <https://www.samhsa.gov/dtac/dbhis-collections> to access these materials.

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