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Welcome

Welcome to the summer 2013 issue of the New York DMH Responder, our quarterly newsletter for the Disaster Mental Health community. Most of this issue focuses on the DMH role in responding to gun violence, especially mass shootings. These events can combine multiple deaths and injuries with the added trauma of knowing the harm was intentionally caused and possibly preventable, making them emotionally devastating for both survivors and responders. James Halpern, Ph.D., of the Institute for Disaster Mental Health (IDMH) describes his experience trying to support families shortly after the massacre at Sandy Hook Elementary School, and we summarize results from an IDMH survey – which you may have participated in – on professional helper's views of gun violence. Those findings demonstrate just how complex an issue this is in our culture. We describe how the reporting requirements stipulated in the NY SAFE Act might impact you as a DMH responder and we summarize a study of what aided survivors after the Virginia Tech shootings.

We also feature an editorial by Steve Moskowitz of OMH on the challenges his agency faces in making sure disaster mental health needs are appropriately incorporated into collaborative response plans, especially in the kinds of highly complex and protracted disasters we increasingly face in New York State. Additionally we describe an upcoming training and webcast meant to strengthen responder resilience through these difficult events. 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.

Crisis Counseling after the Sandy Hook School Shooting

By James Halpern, Ph.D., Director
Institute for Disaster Mental Health, SUNY New Paltz

On December 14, 2012, Adam Lanza killed his mother, drove to the Sandy Hook elementary school, killed 20 children ages 5 to 7 and six adult educators and then took his own life. Like most of us, I was shocked and horrified and soon agreed to be one of a small group of national Red Cross workers, mobilized immediately, to provide assistance to family members, first responders, and the community. While packing and driving to Connecticut I felt considerable trepidation about how I might help parents and immediate family members.



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Crisis Counseling after the Sandy Hook School Shooting, *continued*

While I've responded to many natural disasters and to the attacks of 9/11, it was clear that the nature of this crime and the age of its victims would make supporting survivors uniquely difficult. My self-care plan included evening calls home, regular talks with an experienced colleague, music, magazines, and absolutely no exposure to television or radio coverage of the event.

Once on the scene, coworkers and I worked alongside State Troopers who were assigned to each family. Our first priority was to protect families from exposure to unwelcome sights and sounds and an extremely intrusive press. Parents were concerned for their own safety as well as the safety of their surviving children. There were bomb scares, extremists who threatened to protest at funerals, rumors of more shootings, spontaneous memorials, and vans moving furniture in and out of the school, funerals, police processions, officials, celebrities, and the world media with lights, cameras, satellite trucks and dishes. We provided as much calm and safety as possible. We advised families on how to deal with the media. We encouraged thoughtful conversation about what families hoped to gain by telling their stories to the media and the public. We provided support when authorities (state crime victims and FBI counselors) informed families about benefits. We reminded survivors to connect with trusted friends, family, and clergy, but it was far more necessary to support family members who did not want to connect with peripheral friends and family members who had not been heard from in years. Counselors gave permission to family members to keep unwelcome family, friends, and clergy at a distance. Not every phone call needed to be answered. We supported a strategy to place trusted friends between themselves and what was at times an unintentionally unhelpful and intrusive community.

Parents asked very difficult and challenging questions. Some were versions of the heartbreaking "how could this happen to my 6-year-old child," which were really not questions but expressions of shock and grief. However, often parents sought advice and counsel, asking questions such as how the events should be explained to a surviving brother or sister, and is it okay for children to watch the description of events on television, be interviewed by the press, or attend funerals or see an open casket. We emphasized the importance of caregivers providing reassurance, safety, routine, and honesty.

"Peace cannot be achieved through violence; it can only be attained through understanding."

— Ralph Waldo Emerson

We shifted back and forth between offering a compassionate presence – simply bearing witness to intense grief and suffering – and providing more direct advice, counsel, and psychoeducation. I found that there is considerable misinformation about grief and bereavement. For example, one parent was disturbed to be told that seeing the open casket would be helpful to her young surviving child in order to experience

"closure." She did not feel comfortable allowing the child to witness this sight but was afraid she might be thwarting a healthy grieving process. I was able to reassure her that such exposure was not a necessary part of the healing process. We informed survivors about the significant individual, gender, and cultural differences in length and expressiveness of mourning that could cause friction. We encouraged them to tolerate each other's patterns and styles of mourning and also to ritualize

the loss within the context of the family and the culture. We also reminded parents that grief can have a ripple effect: Surviving children have not only lost a sibling, but their parents and grandparents are grieving and are less available. We therefore encouraged them to expand their support system of trusted friends, family, and clergy.

Like most counselors my training and academic culture falls within the scientific, secular humanist tradition. Mass casualty disasters, such as the one at Sandy Hook, make it impossible for us to avoid discussions with clients about meaning, faith, spirituality, and religion. Parents and members of the community needed to talk about death, meaning, and the afterlife and we needed to be culturally competent to have these conversations at the same time that we helped family member's access spiritual/religious clergy.

I am a seasoned clinician and disaster worker and did not go into this assignment naively. Although I knew that nothing I had done previously would prepare me for a tragedy with children who had been executed, I followed my self-care plan. It was not enough. Unexpectedly, interfaith memorials intended for families, the community, and first responders, along with the presence of disaster spiritual care workers, were profoundly helpful for me. However, what was most sustaining was the constant awareness of why I was there. The dignity of the families touched by this tragedy and their sincere expressions of appreciation affirmed my belief that I was fortunate to have the privilege and honor to be of assistance.

Disaster Mental Health (DMH) Collaborative Planning

Steve Moskowitz, LMSW, Director

Emergency Preparedness and Response, NYS Office of Mental Health

The New York State Disaster Preparedness Commission (DPC) as authorized under Executive Law, Article 2-B, charges the NYS Office of Mental Health (OMH) with the responsibility for coordinating New York State's emergency mental health response and ensuring that mental health services are available for those in need. As such, OMH seeks to provide leadership in DMH planning in coordination with other State and Federal agencies, the NYS Conference of Local Mental Hygiene Directors, and the American Red Cross in New York State. As a basic premise to DMH planning, OMH recognizes the complementary roles, shared commitment, and the mutual advantage of an integrated approach to improving emergency mental health services for all New Yorkers.

In addition to planning OMH must also ensure that direct DMH service needs are met in those instances when local resources cannot meet an identified need. Through the OMH Bureau of Emergency Preparedness and Response (EPR) a cadre of DMH responders is maintained to provide immediate response to survivors following disaster. The members of this network of responders are primary OMH clinical staff working in psychiatric center and field office settings.

The Challenge

Over the past years a number of events with a high level of traumatic impact have occurred in the state. Hurricane Irene, Tropical Storm Lee, and Super Storm Sandy were among the worst weather events in state history while human caused tragedies included an airliner crash in Clarence and mass shootings in Binghamton and Webster. In each of those cases DMH response was included in both the response and recovery phases and in all of these situations DHM volunteers from a broad spectrum of response organizations and theoretical practice backgrounds provided services.

Since DMH began to grow and mature as recognized aspect of a competent emergency response and recovery much attention has been focused on practice -what we are doing and how. OMH, among others including the Red Cross and local Medical Reserve Corps (MRC) and Critical Incident Stress Management (CISM) groups have invested a great amount of energy

in the development of training material to educate and prepare competent responders in DMH. But how much energy and attention have we paid to the development of operational plans to ensure that the necessary mental health support is available in a comprehensive manner across all types of disasters across all of our state?

Among the challenges created by a lack of solid coordination is that we have no real means of ensuring that field practice is uniformly applied or that we can even know whether all of the DMH needs have been adequately addressed. Without coordination between various agencies, groups, and organizations, there is simply no way to monitor the level and quality of care, assess skills and credentials of those wishing to help, or share information about the many needs and areas where services could best be provided without getting into territorial or political battles, or duplicating efforts.

A Way Ahead

One potential resource for addressing this gap is to look to our partners in the field of Public Health. Because the physical consequences of disaster are so readily evident-destruction, injury, and death-an infrastructure for the planning and preparation in emergency public health became a necessary part of all levels of government from the local to the state to the federal.

For its part, OMH has recently initiated a series of conversations with the NYS DOH Office of Health Emergency Preparedness (OHEP) and the NYC DOHMH in an effort to better integrate DMH into existing planning mechanisms in the public health system. These discussions have led to the several concrete outcomes and are now informing the planning activities of the EPR office in its planning efforts. Specific outcomes in motion include:

- 1) OMH has identified regional Field Offices as the point of contact for active participation in the DOH and NYC DOHMH emergency planning and preparedness entities;
- 2) OMH is exploring the development of an integration of DMH trained responders into the existing ServNY volunteer management system,

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Survey Results: Professional Helper's Views of Gun Violence

By Karla Vermeulen, Ph.D., Deputy Director
Institute for Disaster Mental Health, SUNY New Paltz

Two months after the Sandy Hook school shooting, the Institute for Disaster Mental Health invited members of our mailing list to share their views of gun policies and causes of gun violence in an online survey. The views of the 258 participants demonstrate how deeply complex an issue this is both personally and professionally.

About half (132) of participants were mental health professionals (mostly psychologists, social workers, mental health counselors, and spiritual care providers) and 30 were in healthcare, 35 were in academia and 12 in government agency administration. There were six police officers, one firefighter, and five paramedics/EMTs. Many who wrote in other roles were in emergency management. 136 participants were female and 122 were male. 80.6% said they had more than a decade's experience in their profession.

gun ownership ■ Asked whether they currently own a gun, 79 (29.8%) said yes and 157 (59.2%) said no. Eleven said they don't currently but had in the past, and 18 chose not to answer. Primary motivations for gun ownership were "to protect my home and family" (29.9%), for use in target shooting (24.7%), and for use in hunting (13.0%). Several people said the gun was inherited or a family heirloom, while three cited political motivations including "It's my constitutional right, I don't need a reason" and "All the above, but the primary reason is to exercise my 2nd Amendment rights."

gun laws ■ Participants were asked how strongly they agreed with a series of statements about gun laws in the United States, on a scale from 1 (strongly disagree) to 5 (strongly agree). Reactions to some statements were widely distributed. For example, in response to "Gun laws are appropriate in general" 44.4% disagreed or strongly disagreed, 10.8% neither agreed nor disagreed, and 44.8% agreed or strongly agreed. There were similar patterns of responses to "Laws are appropriate for some types of ammunition/clips but should be tightened for other types" and "Laws are appropriate for some types of weapons but should be tightened for other types."

Other topics elicited stronger patterns of agreement, though it should be noted that in all cases the full range of responses were endorsed. In general the trends tended to favor limits on gun access. Asked whether they believed "Gun laws are overly restrictive in general," 74.6% disagreed or strongly



disagreed, 9% neither agreed nor disagreed, and 16.4% agreed or strongly agreed. In response to "If more people carried concealed weapons, society would be safer," 67.5% disagreed or strongly disagreed, 8.1% neither agreed nor disagreed, and 24.4% agreed or strongly agreed. There was strong opposition to "Teachers should be encouraged to carry guns in schools" (77.7% disagreed or strongly disagreed, 11.1% neither agreed nor disagreed, and 11.1% agreed or strongly agreed) but somewhat less opposition to "Schools should be required to hire armed guards" (65.8% disagreed or strongly disagreed, 15.4% neither agreed nor disagreed, and 18.7% agreed or strongly agreed).

background checks ■ There was also a clear trend in reactions to statements concerning background checks: 89.3% disagreed or strongly disagreed that "Purchasing laws should not discriminate based on the applicant's past" while 4.5% neither agreed nor disagreed, and 6.2% agreed or strongly agreed. Similarly, 75.6% disagreed or strongly disagreed with the statement "The current system of background checks is adequate;" 9.9% neither agreed nor disagreed, and 14.4% agreed or strongly agreed. The two statements about strengthening screening were widely but not unanimously endorsed:

- "More should be done to screen gun purchasers for mental health issues" – 14.7% disagreed or strongly disagreed, 9% neither agreed nor disagreed, and 76.3% agreed or strongly agreed.
- "More should be done to screen gun purchasers for a history of criminal activity" – 9.4% disagreed or strongly disagreed, 2.8% neither agreed nor disagreed, and 87.8% agreed or strongly agreed.

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Survey Results: Professional Helper's Views of Gun Violence, *continued*

gun violence ■ Next, participants were asked "When you think about the causes of gun violence in the United States, how strong an influence do you consider each of the following as being factors in mass or rampage shootings that cause multiple casualties in a single event?" The most influential were ranked in order as: mental illness, exposure to neighborhood violence, access to semiautomatic guns, exposure to domestic violence, access to guns in general, lack of parental oversight, exposure to violent video games, bullying, exposure to violent movies, and exposure to violent music videos. Perceived influences on individual shootings were ranked somewhat differently: exposure to neighborhood violence, exposure to domestic violence, access to guns in general, mental illness, lack of parental oversight, access to semiautomatic guns, exposure to violent video games, bullying, exposure to violent movies, and poverty.

survivor mental health needs ■ A majority (61.8%) believed that survivors' mental health needs are different following acts of gun violence than following natural disasters or unintentional events; 19.3% believed they aren't different and 18.9% weren't sure. A remarkable 128 people wrote in answers about how they differ, with many focusing on the heightened impact of intentional interpersonal violence and the perceived preventability of shootings. Comments included:

- "Acts of nature are often a shared experience of survival and perceived as rare; gun violence, even in groups, feels like more of a personal violation and threat; even in a group, those affected often feel victimized and threatened."
- "Acts of hate/anger/evil directed at individuals require special attention."
- "There may be more challenges for the patient to work toward acceptance of the incident because of questioning the 'why' it occurred. For example, an earthquake, fire, or accident are things that are just a part of life, to which anyone is vulnerable; however, gun violence seems like something that is preventable, or at the very least the risk could be lowered."

Asked for any final comments, 76 participants wrote in responses that covered a vast range of attitudes towards the role of guns in American society which included:

From highly supportive of gun ownership:

- "If more sane Americans were armed less people would die from the insane people who commit these heinous crimes. Not to mention the fact that the police usually get there after people are already dead. The 2nd Amendment is NOT about hunting or target practice; it is about protecting ourselves from tyrannical government entities. 'The government should fear its people. The people should not fear their government.'"
- "I have been a law abiding, responsible gun owner for over 30 years and enjoy recreational/competitive target shooting. I do not hunt and have never killed a living being. The current legislation and media hype punish responsible gun owners and will have very little impact on reducing individual/mass shootings."

To ambivalent:

- "This is a very difficult topic, and I really go back and forth on weighing the cost/benefits of restrictions or freedoms related to gun laws."
- "I am very proud of the US Constitution and thank God every day to be an American, but the gun violence has to be addressed. I believe freedom and security are always at odds, but right now I would be willing to give up some of my freedom for a little more safety."

To strongly in favor of stricter laws:

- "Clearly the easy availability of militia style guns and ammo is not something our founding fathers could have foreseen. I am tired of people hiding behind the 2nd Amendment while innocent people die needlessly. Private Citizens do not have a constitutional right to military style weapons that can slaughter many people in a short period of time. I am also tired of hearing people say that whatever is proposed to control the misuse of guns 'won't work.' A person's right to own militia style guns does not outweigh a living person's right to life. As far as I'm concerned, we need to revisit the Constitution and propel it into the 21st century."
- "I believe that the US needs a multi-pronged approach to reducing gun violence. I believe that changing family and social values and mores are central to the problem and I don't know that we can ever change these. The easy availability of weapons, especially assault weapons and magazines that hold many bullets makes it easy for those who are so inclined to wreak havoc. I want to see better gun control and more accessible and affordable mental health resources, but these alone will not solve the problem of violence in our society."

Many thanks to everyone who participated in the survey and expressed their thoughtful views on this critical issue.

Research Brief: Helping Virginia Tech Shooting Survivors

After the 2007 Virginia Tech mass shooting that killed 32 victims and left 17 injured, students and faculty took to technology to let their family and loved ones know that they were safe and to get information of their friend's wellbeing. Facebook pages and groups were started to memorialize victims and provide support to survivors. While social support is an important resource after trauma, for two researchers from Virginia Tech, Hawdon and Ryan (2012), it was unclear if this virtual type of contact such as texting, IMing, Facebook, e-mail, and video chat counted as social support for the students on campus. In a study of 626 Virginia Tech students who were enrolled in school when the shooting happened they found that face-to-face interaction, especially with

family members, was positively correlated with well-being five months after the shootings, while interacting with friends and family members virtually was unrelated to well-being. These findings suggest that when supporting individuals affected by a mass shooting, disaster mental health workers should encourage their clients to engage in face-to-face interactions with their loved ones and support networks.

Source

Hawdon, J., & Ryan, J. (2012). Well-being after the Virginia Tech mass murder: The relative effectiveness of face-to-face and virtual interactions in providing support to survivors. *Traumatology*, 18(4), 3-12.

Resources for Helpers after a Mass Shooting

If you're ever called upon to assist survivors after a mass shooting or other disaster you should be aware that there are many high-quality resources available online. Some can provide useful preparation for you as a helper and some are meant to be distributed to survivors. The New York State Office of Mental Health (OMH) website includes dozens of pages of psychoeducational information:

All Hazards Disaster Mental Health Resources

www.omh.ny.gov/omhweb/disaster_resources/pandemic_influenza/

Other downloadable resources of note include the following.

Institute for Disaster Mental Health

Helping Children Cope: Tips for Parents and Caregivers

www.newpaltz.edu/idmh/helpforcaregivers.pdf

Help for the Helpers: Caring for Yourself when Assisting Others

www.newpaltz.edu/idmh/helpforhelpers.pdf

The National Child Traumatic Stress Network

Parent Guidelines for Helping Youth after the Recent Shooting

www.nctsn.org/sites/default/files/assets/pdfs/parents_guidelines_for_helping_teens_after_the_recent_attacks.pdf

Guiding Adults in Talking to Children about Death and Attending Services

www.nctsn.org/sites/default/files/assets/pdfs/talking_points_about_services.pdf

Tips for Parents on Media Coverage

www.nctsn.org/sites/default/files/assets/pdfs/tips_for_parents_media_final.pdf

Tip Sheet for Youth Talking to Journalists about the Shooting

www.nctsn.org/sites/default/files/assets/pdfs/youth_journalists.pdf

American Psychological Association

Managing Your Distress in the Aftermath of a Shooting

www.apa.org/helpcenter/mass-shooting.aspx

Center for the Study of Traumatic Stress

Restoring a Sense of Safety in the Aftermath of a Mass Shooting: Tips for Parents and Professionals

www.cstsonline.org/restoring-a-sense-of-safety-in-the-aftermath-of-a-mass-shooting-tips-for-parents-and-professionals/

The SAFE Act and You: DMH Helper's Reporting Responsibilities

On March 16, 2013, the NY SAFE (Secure Ammunition and Firearms Enforcement) Act took effect. As Governor Andrew Cuomo described it, "The SAFE Act stops criminals and the dangerously mentally ill from buying a gun by requiring universal background checks on gun purchases, increases penalties for people who use illegal guns, mandates life in prison without parole for anyone who murders a first responder, and imposes the toughest assault weapons ban in the country. For hunters, sportsmen, and law abiding gun owners, this new law preserves and protects your right to buy, sell, keep or use your guns."

One component of the act, Mental Health Law 9.46, mandates that mental health professionals (defined in the law as physicians including psychiatrists, psychologists, registered nurses, and licensed clinical social workers), must report to their local director of community services or his/her designees when, in their reasonable professional judgment, one of their patients is "likely to engage in conduct that would result in serious harm to self or others." That information can then be used to determine if the individual has a firearms license; if so, the local firearms licensing official will suspend or revoke the license.

How does this impact disaster mental health responders? In your DMH role you're probably more likely to be working with victims and survivors of gun violence than identifying warning signs that necessitate reporting (though that could occur in the course your other mental health professional roles). However, the reporting duty applies outside of hospitals, clinics, and other traditional treatment settings, so if you're providing services at a shelter, disaster response center or operation, or other disaster-related locations and you encounter someone making threats of, or attempts at, suicide or serious bodily harm to themselves, or homicidal or violent behavior towards others, you are required to report them using the state's online system, regardless of whether you know they own a gun. Therefore, all mental health professionals should become familiar with the law and with the reporting procedure.

General information about the SAFE Act can be found at: www.governor.ny.gov/nysafeact/gun-reform

Mental health-specific details are at:

www.governor.ny.gov/nysafeact/mental-health-faq

And an explanatory video featuring OMH's John B. Allen describing reporting requirements and procedures is at: www.youtube.com/watch?v=kWsmajGwO4Y

Disaster Mental Health Training

"Maintaining Responder Resilience through Extreme Disasters" will be offered by IDMH November 22, 2013 @ 1-4pm. The goal of this 3 hour training is provide professionals with the skills necessary to recognize the stressors (i.e., secondary traumatization and burnout) that may place them at risk for occupational hazards and how to cope with them productively during a prolonged response. The training will be offered in person at the SUNY New Paltz campus and will also be simultaneously webcast across the state. The training will use an applied approach, teaching specific skills and providing opportunities to practice skills through exercises. Also incorporated into this training will be personal stories from healthcare and mental health providers who have been through intense or long-lasting disaster response operations and will share lessons learned about what did or did not help them cope with the demands. Further information regarding registration will be forthcoming.

Disaster Mental Health (DMH) Collaborative Planning, *continued* _____

administered by the DOH Office of Health Emergency Preparedness, a Web-based registry of individuals who make themselves available to assist on behalf of New York State during an emergency; and

- 3) OMH is actively seeking to establish mutual agreement among all relevant stakeholders in the definitions and competencies related to DMH and DMH responders.

The collaboration with DOH OHEP has already led to several meaningful outcomes intended to better integrate DMH responders into the public health community including this very newsletter—a joint collaboration between DOH and OMH now being circulated to more than 1,000 DMH and public health planners and responders as well as the development of additional training modules to augment the existing core curriculum.