



TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS
INFORMATION GATEWAY

FLORIDA'S INTEGRATED DISASTER BEHAVIORAL HEALTH RESPONSE: The Pulse Nightclub Shooting



Photo courtesy of Brett Roberts, American Red Cross

The state of Florida frequently responds to hurricanes and flooding, and these disasters take a prolonged emotional toll on community members. Disaster behavioral health (DBH) services are provided through regional systems of care coordinated by the state through contracted systems that serve as “managing entities.” In June 2016, when a gunman killed 49 people and wounded 53 at Orlando’s Pulse nightclub, the state responded to an event unlike any it had faced before. Dr. John Hick (ASPR TRACIE’s Senior Editor) interviewed the following state DBH professionals who were part of the response to this horrific incident to learn more about Florida’s experiences with this and other catastrophic incidents:

- Michael L. Haney, PhD, NCC, CISM, LMHC: Clinical Director, Florida Crisis Consortium
- Jimmers Micallef, FCCM: Chief, Substance Abuse and Mental Health Contracts, Florida Department of Children and Families
- Mark O’Neill, PhD, CPM: State ESF-8 Plans Chief, Bureau of Preparedness and Response, Florida Department of Health

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■ Jimmers Micallef (JM)

The Department of Health (DOH) is the state lead when the Emergency Operations Center (EOC) is activated. The Florida Department of Children and Families (DCF) is the designated state mental health and substance abuse authority. DCF works through a contracting structure with seven regional systems of care or “managing entities.” Our agency contracts with managing entities, who then subcontract with local substance abuse and mental health service providers — the community resources that the local emergency management community would turn to.

Dr. Haney describes the Florida Crisis Consortium in this [YouTube video](#).

■ JH

Is the Florida Crisis Consortium a public or private entity?

■ Michael L. Haney (MH)

The consortium is a public/private partnership of all the organizations in Florida involved in disaster response, and it was formed after the 2004 hurricane season, when Florida was struck by four major hurricanes and a tropical storm. We realized then that there was a large lack of coordination and cooperation among disaster response groups, so we pulled everybody together. Any group involved in disaster response can come to the table. We also recruit, train, and credential our multidisciplinary volunteers through DOH — we

currently have about 60 relatively active volunteers right now, and we try to maintain regular contact with them. During the planning phase, we do our best to carry out a series of activities, including all-hazards training and exercises.

■ JM

In 2004, all 67 counties in the state were under multiple declarations. Some providers were not able to reopen for their own clients, let alone take on additional clients or services. We created a series of ad hoc units serving different communities, funded under several FEMA Crisis Counseling Assistance and Training Program (CCP) grants that ran for some time. Once the grants closed, we created the consortium, operationalizing a mechanism by which we could identify in advance who we could expect to deliver counseling services and provide these individuals with training on risk assessments and the administrative challenges of implementing a new program. Today we have, at minimum, an annual review with each managing entity and its designated DBH providers, where we work through both the administrative implementation issues and programmatic issues associated with FEMA CCP.

■ MH

During an event, I look at the clinical issues and triage all of the requests that come into the state EOC and then gather Jimmers' DCF perspective on things like disaster recovery centers and community grant funds that can be used to provide support services. Consortium members arrive on scene about 72 hours after an event and stay for about three weeks or until community resources stabilize. It's important to note that the mission of our consortium members is to provide psychological first aid — not “do mental health.” While some volunteers have a clinical background, the primary role of the team is to consult with the local EOC on mental health issues, conduct a site assessment, identify gaps, and work with local partners to fill them. Sometimes that means Critical Incident Stress Management (CISM) teams for first responders; and some of our clinical volunteers are affiliated with CISM teams around the state (and may also be first responders), so they may be assigned. We also get requests to work with emergency room or triage staff who are exposed to a lot of trauma.

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I don't think the stigma that is attached to community mental health is the same for law enforcement and CISM because it's peer-driven and much more widely accepted.

— Michael Haney

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Relevant ASPR TRACIE Resources and Topic Collections:

- [Mental/Behavioral Health Topic Collection \(Non-Responders\)](#)
- [Responder Safety and Health Topic Collection](#)
- [Tips for Retaining and Caring for Staff After a Disaster](#)
- [DBH: Resources at Your Fingertips](#)
- [EPAP Fact Sheets](#)

■ JH

How are community-based teams set up under DCF?

■ JM

The managing entities do not provide direct services, but they direct DCF funding to local subcontractors who provide community and residential substance abuse and mental health care. As part of the managing entities' contract with us, they must also identify in every county a lead provider to be our emergency response designee. All providers are engaged with emergency management, but when a county experiences an event, we rely on the one preselected provider. If this provider cannot follow through because the incident has affected it, we arrange for another region to provide assistance. The managing entities also participate in drills and trainings to help establish capacity.

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Consortium volunteers are the responders of last resort.
— Michael Haney
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■ JH

Tell me more about the state's experience with the Pulse Nightclub shooting.

■ JM

This incident did not receive a presidential declaration. DCF looked to the Orlando region's pre-identified business partners and designated DBH providers to assist, and they were already engaged in the response at hospitals and family centers when we reached out to see how we could support them.

■ Mark O'Neill (MO)

The Florida Crisis Consortium was put on standby by the state ESF-8 Emergency Coordinating Officer. She worked with other ESF-8 stakeholders to activate and provide material support, including FEMORS, the Florida Emergency Mortuary Operations Response System. In the end, Orlando and Orange County were able to handle the attack with local resources and mutual aid and did not require a state-level activation. The state, beginning with Gov. Rick Scott, was ready to provide whatever the locals needed. When I checked the incident command structure for the Orange County Health Services Department, I saw that it already had a mental health group identified. The health department positioned itself locally to handle victim-related issues very quickly. I contacted others, including Jimmers, in accordance with our plan, but for the most part, I watched while locals took care of things with some state support from DCF.

■ JH

What specific DBH challenges — for both responders and survivors and loved ones — were you aware of?

■ MH

I recently attended a panel at a state conference where responders talked about the Pulse shooting. They all spoke to the resources that were made available to them and the community very quickly, and commended the strong social support system in Orange and surrounding counties. It's an ongoing process — many families were initially reluctant to accept support and services, but as time goes on, many families are coming forward to ask for help.

■ JH

What kind of funding did you use to help with the DBH response?

■ JM

DCF reprogrammed the first \$500,000 from state funds set aside for June, July, and August. We were able to redirect these funds to groups we don't traditionally work with — including the LGBTQ community, groups that serve young adult Latinos, and Hispanic family counseling providers — to help them expand their capacity. While we were conducting our needs assessment, we identified the SAMHSA Emergency Response Grant (SERG) program — considered “funds of last resort” from the federal government. SERG funding is only provided when no other funding is available. It took a while to get through the system, but three weeks ago we were awarded \$500,000 for a year's program of targeted services that we're using to keep the effort going and to ensure that there are DBH services for those who need it, at least until the anniversary of the event.

■ JH

Tell me more about Family Assistance Centers — are they still operational?

■ JM

The City of Orlando and Orange County opened Family Assistance Centers (FACs) in response to the incident. With the initial money mentioned earlier, DCF was able to pay for therapists, case managers, and critical social workers who staffed the FACs. These centers eventually evolved into the Orlando United Assistance Center, where the city, the Orange County government, and United Way are working together to provide mental health support and timely information to people affected by the Pulse shooting.

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*The existing model gets adapted to meet
the circumstances.*

— Jimmers Micallef

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■ JH

From a DBH perspective, what was the most challenging aspect of the response?

■ JM

I'm hearing that many of the first responders — and this includes law enforcement and EMS teams from other agencies who came to help — are still having a hard time coping with such an intensely painful crime scene and set of circumstances, like spending hours hearing cell phones ringing in a room full of bodies. We can always use additional DBH support for first responders. I've also heard that there has been a conscious effort to provide support to members of the mortuary who handled the bodies.

■ JH

What keeps you up at night?

■ MH

This sounds horrible, but it's the lack of response and lack of events. It's hard to maintain interest when you're not doing response. It's been a challenge in terms of keeping volunteers engaged. Resources, funding, the ability to support the team and do the training and exercises (which are often cut when budgets are constrained). We currently don't have any independent grants at the moment, so we're dependent on state and federal funding.

■ MO

I worry about the effects of a bioterrorism or high-severity-index pandemic event — we haven't planned adequately for an event like that.

We look at what happened during the anthrax attacks of 2001 and how the mental health effects taxed the system — even though it wasn't a mass fatality incident — we just know we have to coordinate what we have among the people who know what's there.

■ MH

One of our strengths is that we have very strong lines of communication and partnership between DOH and DCF, and that makes a big difference.

John Hick Commentary

Although our interview concentrated on the systems that Florida has in place, it's critical to keep in mind that mass casualty and mass fatality events can affect mental health for a long time and last far beyond the rest of the response, in many cases. Survivors, family members, and responders all need initial support, including psychological first aid (and similar techniques), a clear understanding of normal stress responses, and frequent encounters with peers to “check in” with each other.

Florida did an excellent job of leveraging its existing systems to identify the key stakeholder LGBTQ and Latino groups it could work with to ensure that there were trusted peers to assist with support and follow-up. Expecting responders or survivors to feel comfortable with Employee Assistance

Programs and other personnel who have not experienced their trauma, are not in their community, and do not understand their context can be challenging, and usually that contact needs to be bridged by a peer.

Florida benefits from a very strong regional system through which existing service providers are funded. These providers help coordinate other public and private entities so that when a disaster occurs, there is a robust local response that can also be supported by inter-regional resources. The ability to redirect funds at the state level and use emergency funds from federal sources speaks to the need for flexibility and a good understanding of the options. Notably, following a federal declaration, communities have only a few weeks to propose a budget and services for the response. This can be extremely difficult, and a system for target population impact assessment and needs analysis is critical to ensuring that appropriate resources are requested and defensible.

As emphasized, local support and the traditional sources of support are best — so broad integration of programs with training in psychological first aid and other techniques with responder, health care, faith-based, and other communities is crucial.

Issues often occur with authorities and roles at the Family Assistance Centers. Community planning with jurisdictional law enforcement, emergency management, medical examiner/coroner, American Red Cross, and other organizations can help greatly to define the mission, scope, potential locations, information sharing (including victim information for reunification), and communications support, and help reduce the potential for confusion and anxiety for responders and families. Plans should be exercised and understood by health care coalition members so that there is good understanding of who will do what and when.

As providers and planners, we must understand that the stresses of specific incidents affect different providers in very different ways and that we must do a better job of tracking our responders for days, weeks, months, and even years after incidents to ensure that they receive the support and services they need to be healthy and resilient. Early engagement of providers in after-action reviews (not focused on emotion, but on generating a common situational understanding and examining the response itself) can help greatly to reduce stress by offering engagement in improvement processes as well as an opportunity to ask questions and receive answers about specific operational areas of concern.

Finally, we need to promote health and resilience in our community and among our responders. The public domain is filled with individuals who are intensely committed to their profession, often at the risk of damage to their private lives. Understanding that success on the job relies not only on performance but on the person and his or her ability to manage stress and maintain health is critical to a healthy daily life and is a major contributor to healing after a critical event.

Health care coalitions have the right stakeholders together to take a whole-community approach to behavioral health issues and are encouraged to leverage that ability to develop operational mental health plans that are not an afterthought when a response occurs.



Jack Herrmann, Deputy Director ASPR Office of Policy and Planning

On June 12, 2016, I watched as CNN reported on a mass shooting that happened hours earlier at Orlando's Pulse Nightclub, a bar that I had been to many times over the years. It was unfathomable to think that such a tragic event could occur in a place I knew so well — immediately I wondered, "What if I had been there?" I watched coverage of first responders arriving, the injured being carried to ambulances, and scenes of distraught family members looking for their loved ones; scenes that are becoming unfortunately too familiar. In more than 20 years as a disaster mental health volunteer with the American Red Cross on such events as the plane crash of TWA Flight 800; the terrorist attacks on the World Trade Center on September 11, 2001; and Hurricane Katrina, these scenes bring back many memories.

Later that morning, I was contacted by the Red Cross to see if I was willing and available to go down to Orlando and coordinate the organization's mental health response to the Pulse shooting. I arrived at 10:30 a.m. on Monday, was briefed by the local and regional Red Cross leadership, and then headed to the makeshift Family Reception Center, which was located in a local community center. There were people everywhere; cars were parked on the lawn, side streets, or anywhere drivers could find a space. The media were set up outside the building, people were milling about, and it seemed as though one of the first rules in situations such as this — to secure the perimeter of the Family Reception Center — had been violated. Once inside, I found it hard to discern family members from first responders (except for those in uniform) or staff. After multiple attempts to determine who was in charge, I was able to finally connect with my colleague from the Federal Bureau of Investigation's Office for Victim Assistance. Because this was a suspected terrorist incident, the FBI was the lead for the response, which included coordinating the provision of family assistance services. Over the years, and as a result of previous incidents, the FBI and Red Cross have established good partnerships.

The Red Cross and the FBI worked together with the City of Orlando on a plan to meet the behavioral health and other needs of the victims and their families. On Wednesday, June 15, the City of Orlando opened the official Family Assistance Center at Camping World Stadium. More than 30 federal, state, local, and community-based agencies provided a range of services for surviving victims and their families, as well as for families of the deceased (e.g., transportation, social services, medical examiner services, and funeral services). The [FBI Office for Victim Assistance](#) provided information about support that victims and their family members were entitled to under law, and the Red Cross, along with the county mental health agency and community-based organizations, provided mental health and spiritual care services.

The Family Assistance Center stayed open for approximately eight days before it transitioned to a smaller community assistance center. Support for the community at large included candlelight vigils and memorial services, mental health and spiritual care support offered by community- and faith-based agencies, and identification of funds to help those who were affected by the incident.

Lessons Learned

Events such as the Pulse mass shooting present a variety of challenges for first responders, the health and behavioral health care systems, governmental officials, community-based agencies, and, of course, the victims and their families. Having a good behavioral health plan and exercising and drilling that plan are key to ensuring the best response and outcomes. Tips for an effective behavioral health response include:

- Know your partners: Federal, state, and local agencies (governmental and nongovernmental) should know each other before an incident occurs and negotiate what roles they will play and responsibilities they will have in a mass casualty incident, and know the authorities that exist (which may be event-dependent – e.g., the Red Cross role after an aviation incident).
- Train first responders and other key personnel so they are prepared with the knowledge and skills needed to respond to these events, including psychological first aid training for peer support. Community based behavioral health and spiritual care providers should be specially trained in DBH so they can provide immediate support to survivors and their family members.
- Pre-identify and define the roles of: Family Reception Centers and Family Assistance Centers (and their locations), health care facilities, and local Red Cross chapters. Anticipate the needs of survivors and their families and determine ahead of time which agencies and what services will need to be available.
- Understand that a community's recovery from an incident such as a mass shooting is not a short-term event. Those affected, directly or indirectly, must understand that recovery can take years and elected officials; county, city, and community-based agencies; and others need to be prepared for the long haul.
- Consider that the media can be key partners in helping communicate behavioral health issues to the community at large. Community media can be excellent partners in this process. National media may be much more difficult to manage. Regular briefings and access to selected supervisors for interviews is far superior to allowing them to attempt to gain unstructured access to family members or responders. Protecting family members and survivors from unwanted media attention is an important consideration for Family Reception Center and Family Assistance Center planning.

Jack Herrmann, MEd, NCC, LMHC, Deputy Director, ASPR Office of Policy and Planning

