The Christmas Massacre

A Case Study in Assessment and Assurance

Mid-America Regional Public Health Leadership Institute
Year 11 (2002-2003)

Quint – "C"

Lewis Lampiris, Mentor
Kelly Cunningham
Lorraine Harris
Cheryl Johnson
Berlinda Tyler-Jamison
Karyn M. Warsow

Abstract

A. Title: The Christmas Massacre

B. Functional Area Focus: Assessment and Assurance

C. Major Subject Involved
Environmental Assessment
Post Traumatic Stress Disorder
Coalition Building

Ancillary Subjects
Community Response
Political Response

D. Setting of the Case

1. Type of Health Department/Agency/Facility
State Department of Public Health
County Health Department
Consortium of Human Service Agencies (i.e., hospitals, law enforcement, fire departments, school districts, etc.)

2. Relevant Geographic and Demographic Information
The state of Confusion is diverse, both in its geography and its population. It is one of the largest states in the country, extending 450 miles from north to south and 250 miles east to west. The 2000 census reported a population of 12.4 million, with 85% of residents living in urban areas and 15% in rural areas. The racial distribution includes 73% Caucasian, 15% African American, 12% Hispanic and 12% other racial groups.

3. Divisions and Personnel (Positions) Involved: State Department of Public Health

Relevant Staffing:

Medulla Oblongata, Executive Director
Behavioral Sciences Division, Region 13

Terry Isst
Violence Prevention/Terrorism Unit

The State of Confusion Department of Public Health was created in 1877 to regulate medical practitioners and to promote sanitation. Today, it is responsible for protecting the state's 12.4 million residents, as well as countless visitors, through the prevention and control of disease and injury. The Department's nearly 200 programs touch virtually every age, aspect and cycle of life.

The State of Confusion is divided into counties, including Denial County Health Department, Repression Health Department, and four counties without health departments that utilize the State of Confusion Health Department. Local Health Departments review the frequency and source of institutional calls regarding the suspected disease patterns and are ultimately responsible for contacting the State to request an evaluation. The current system is set-up discordantly, in which community-based civilian hospitals and community-based agencies lack an effective mode of communication between each other and, as a result, are

unaware of each other in terms of outbreaks and the incidence of disease. The division of Infectious Disease at each hospital is responsible for continuous review and follow-up of all patients diagnosed with community-based and nosocomial active infections. A structure is in place to reflect reporting of communicable diseases mandated for entry into the State database, which oversees incidence and disease patterns. There is a deficiency in the time lag between diagnosis and time of reporting from the health care provider and/or health care facility. However, there is no such system in place for the reporting of psychological disorders.

Local Health Department

The Denial County Health Department was established in 1956 by referendum as a state-certified public health department. The department consists primarily of five divisions: administrative services, behavioral health services, community health services, environmental health services and primary care services. It has a budget of $37 million, which supports 60 separately funded programs and a staff of more than 850 professionals. The County has 644,000 residents, of whom 67,000 are uninsured, and 75,000 are underinsured with a disproportionate amount of underserved populations in various cities.

Relevant Staffing:

Percy Severation
Environmental Health Division, Director

Connie Fabulation, MD
Community Health Division, Director

Kate Cholamine, MPH
Public Health Information/Education Division, Director

Denial County Hospital

Denial County Hospital is located in the Forebrain of the northern suburbs. It is an academic healthcare system comprised of six entities, which includes three hospitals; Parietal, Temporal and Occipital Hospital. As an integrated delivery system, the Corporation also includes a Medical Group, Home Services and Research Institute. For seven consecutive years, Parietal and Temporal Hospitals have been named amongst the Top 100 nationally and among the Top 15 Major Teaching Hospitals.

Denial County Hospital is committed to preserving the overall health of the surrounding communities and has implemented a syndromic surveillance system to detect signs and symptoms of communicable and psychological disease without any obvious mode of exposure. This program, conducted in partnership with the Denial County Health Department, is based on an intensive educational program aimed at increasing medical staff awareness to enable accurate detection of the differences between diseases that have a similar clinical presentation.

Relevant Staffing:

Abraham Maslow, PhD
Chairman, Department of Psychiatry

Norm Epinephrine, MSW
Case Management

Sara Bellum, RN
Department of Epidemiology/Biostatistics

Introduction

Disaster is not only defined by an act of God, but by those crisis situations that arise due to rogue and state sponsored terrorist groups organized for economic, political, criminal, religious and occult causes. One vital aspect of trauma that is often over looked is the mental health impact that ensues. On-site training, in the form of debriefing and interventions, which focuses on the acute psychological response to trauma, has been implemented to prepare first responders. However, addressing the acute stress that develops within the first few weeks to 6 months after a disaster is paramount to linking acute stress and early intervention along a continuum for ongoing and long-term intervention for those who develop post-traumatic stress disorder (PTSD). Critical incident stress management is based on a psycho-educational model including education and assessment, reduction of the impact of the critical event and accelerating the recovery of normal people experiencing painful, but normal reactions to an abnormal event. Recognizing the need to educate the public regarding short-term and long-term trauma should take into consideration: 1) prior experience with the same or a similar event; 2) the intensity of the disruption; 3) the emotional strength of the individual; 4) individual feelings that there is no escape, which sets the stage for panic; and 5) the length of time that has elapsed since the event occurred.

It is an essential role of public health to ensure the health and well being of the population. This assurance guarantees that community facilities are safe from any hazards or threats. In response to the September 11, 2001 attacks on New York City, terrorism preparedness has become a major priority of federal, state and local agencies. Developing and implementing effective debriefing programs and regulatory standards will not only increase communication and community capacity required to respond to a terrorist act of violence in a timely manner, but also facilitate a coordinated response partnership between collaborating agencies to ensure the safety of the public. This case study will investigate the public health core functions of assessment and assurance associated with the survivor's and rescuer's response to a terrorist attack as it relates to the post psychological and physiological reactions to a compromised quality of life.

Case Study

It's a frigid snowy afternoon the day after Thanksgiving in the Windy Lake City (WLC). Hoards of holiday shoppers move down the Marvelous Mile like a swarm of bees instinctually making their way to the hive. There is an unconscious effort by each person to ignore the foreboding undercurrent reminiscent of 9/11 and to focus on the task at hand; to find that perfect gift for that perfect someone. Salvation Army Bell Ringers dressed in their crisp blue suits and starched white shirts accented with vibrant red ties are standing outside of the WLC Department Store. Loving couples are walking hand in hand in a frivolous attempt to keep warm, secretly thankful for the opportunity to be close. A group of carolers from a local congregation are slowly making their way down the street as the message of love and faith fills the air with song. There is a homeless man covered in a dirty brown coat, one could swear it use to be a lively green, but seemingly dimmed by the experience of living. He gazes eagerly into each store window, oblivious to the people around him moving away in fear and some is disgust. Memories of his past life surface as he is consumed by the hope and creative depictions of jolly ole Saint Nick sheepishly peering from behind a decorated Christmas tree to watch the children's eyes glow as they discover their gifts. In the next window,

elves are hard at work making toys at the North Pole, a truck for Johnny and a dolly for Suzie. On the street, mechanical reindeer seemingly move to the motion of each passer-by. Inside the store, children are waiting impatiently with their parents to see Santa Claus. Each child has a list of Christmas wishes in hand. The line of people appears endless as it bends and twists amongst the different aisles of merchandise. Signs displaying the deals of the season, scarves and mittens 25% off, a Coach wallet on sale for only $199.99, tables covered in crimson velvet and stacked with boxes of costume jewelry, and designer cologne…"Mommy why does Santa look like he's ready to throw up?" The young woman looks over to see the man dressed as Kris Kringle with glistening beads of sweat running down into the silky white of his beard. She notices him strangely looking at the store clock, which reads 11:58….There is a little girl with Shirley Temple curls wearing a deep purple taffeta dress and black patent leather shoes trustfully placed by her father on Santa's lap…11:59…the little girl begins to cry as she looks into the eyes of this American icon…KABOOM!!!!!!!

The WLC Department Store lay in a mass of rubble with thousands of innocent people losing their lives and several hundred injured and trapped. Out on the street, the bliss of the holiday is overtaken by the ominous looming of debris and dust from the explosion. Pedestrians in shock begin to slowly rise from the ground as the reality of the event materializes. Further down the street, hundreds of people run aimlessly in panic. Terror devours the Windy Lake City. Screams echo and bounce from building to building.

First responders begin arriving at the scene within minutes of the blast. The media is quick to record every detail on tape. This is BIG news! The cameraman shakes with excitement as he positions the camera. The reporter describes the scene with morbid enthusiasm. A nation watches in anticipation.

Children trapped beneath the rubble cry out in pain for their parents. Torn from their source, mangled body parts are spewed in every direction. These images create a permanent imprint on the men and women called by their profession to aid in the effort and those who feel morally obligated to do their part. A police officer consumed by the sight knells down next to a young college student covered in blood. She is missing a leg and the side of her face has been sheared away…there is no pain. Tears fill his eyes as the girl stares up at him blankly. She dies in his arms, but not alone. He is there for her. A nurse rushes to the scene to help, but is overwhelmed by the site and screams out in horror. Just as the assessment of the tragedy begins…12:15pm…KABOOM!!!

Down the street there is another explosion of equal intensity. The team of first responders and local citizens stand motionless in disbelief. The reverberations move like thunder. The ground beneath their feet vibrates. Then there is silence. The staleness of the air is quickly filled with confusion and terror. People push and shove one another as they struggle to elude the tragedy. They run futilely, without discernment for the victims that lay under their feet. Stepping over the bodies and jumping over pools of blood, terrified pedestrians race to escape the impending doom by boarding the train. A team of first responders flees to the scene of the second explosion. What they encountered upon their arrival seems like a nightmare…12:30pm…KABOOM!!!!

The main train station and several cars heading out of the city along the track explode. Wreckage falls in every direction crushing and injuring people on the street. The peace that was once Christmas will be remembered as a day of massacre.

Assessing the Aftermath

The bombs were succinctly detonated at 3 different locations at 15-minute intervals. It was later discovered that a band of rogue militant terrorist had gained employment as Santa Claus at the 2 downtown locations of the WLC Department Store. The origin of the blast was determined to be packages of RDX high explosives strapped to the lining of the Santa costumes, in addition to booms strategically positioned along the railway station.

As the law enforcement agencies (police and FBI), fire department, medical providers (emergency medical technicians) and concerned citizens arrived on the scene, they quickly went into action to assist the victims. These first responders suppressed their personal reactions of shock and horror and effectively assumed their role as rescue workers. Hour after hour they worked diligently until all the bodies were retrieved from the debris and the injured were sent to the hospital. The area was secure.

A voluntary Critical Incident Stress Debriefing (CISD) session took place 2 days after the incident to provide first responders with the opportunity to gather honest answers to their questions and to provide a sense of security. The main goals of the intervention was: (a) to educate individuals about stress reactions and ways of coping adaptively with them, (b) to instill messages about the normality of reactions to potentially traumatic event, (c) to promote emotional processing and sharing of the event, and (d) to provide information about, and opportunity for, further trauma-related intervention if it is requested by the participant.

Identifying the Problem

It’s April 23, 2003, approximately 5-months after the terrorist attack on the Windy Lake City. The Denial County Health Department, a local health department certified by the State of Confusion Department of Public Health is holding its monthly meeting to begin the work of developing its C-Plan. The C-Plan is a series of planning activities conducted within the local health department jurisdiction, resulting in the development of an organizational capacity assessment; a community health needs assessment and a community health plan. The committee members represent a broad range of professional disciplines, including local schools; the University of Confusion at Windy Lake City School of Public Health; law enforcement, medical and hospital representatives; business and economic development groups; mental health and social service providers; the faith community; unions; senior groups and the cooperative extension service.

During a 15-minute break in the meeting, individual members of the committee begin talking amongst themselves. Connie Fabulation and Percy Severation spoke to several other committee members regarding the increase in the number of first responders and citizens seeking out psychological services within the community. Others were discussing the stoic media coverage of last years Christmas Massacre and the manner in which the media preyed upon the public's justified paranoia of terrorism by exacerbating the crisis environment with inflammatory speculation, false leads and conspiracy spinning. Terry Isst exclaimed with passionate conviction, “They intentionally created a climate of fear among the populace. The media should be regarded as second hand terrorist! They consumed the attack scene like vultures, eager to report the breaking the news. What they succeeded in doing was misconstruing details of the event.”

The meeting is about to reconvene. In the interest of time, the Director, Connie Fabulation, decided to stick strictly to the agenda. She instructed members of the committee to divide up into teams and compose a priority listing of health disparities identified in their district and to come to a consensus as to what priorities

constituted a health concern. Each team met separately for about 60-minutes. Some of the topics discussed by the individual teams included the high rate of teen pregnancy, lack of transportation for the elderly, medical and social services, insurance coverage for the working poor, an unusually high incidence of psychological disorders, interpersonal violence and the increasingly high rate of school truancy and dropouts. As the teams presented their priority listings to the entire group it was obvious to Dr. Abraham Maslow, Chairman of Psychiatry, Denial County Hospital, that there was a common thread woven through the discussion; Post Traumatic Stress Disorder (PTSD).

The Debate

As the meeting continued, random comments filled the stagnant air regarding the level of employee and student distractibility, lack of productivity, unexcused absences, increases in substance abuse and noticeable signs of depression and anxiety, compounded by the unspoken need to maintain business as usual. It was evident by the team discussions that the community's collective mental health and quality of life had been affected and that the public was potentially at risk. A human resource representative made the observation that the Employee Assistance Programs (EAP) were reporting a surge in the usage of on-site mental health services and requests for educational materials relating to the recognizable signs and symptoms of a vast array of psychological disturbances. The Director of Occupational Health from one of the hospitals stated that there had been an increase in the number of disability claims, as well as worker's compensation claims. Many parents admitted that they were struggling with their own fears and those of their children when seeing an Easter Bunny. The Committee members stared blankly at one another. It was apparent that although the general public may not have been at the actual location of the terrorist attack, the extensive media coverage with the constant replay of the attack and the ongoing war on terrorism had created an unending repetition that inflamed turmoil within the community.

A teacher from the elementary school angrily said in agreement, "Images of candy and colored eggs should be what my first graders think about when they see the Easter Bunny, not their possible deaths. We must do something!" Members of the Committee heard the teacher's "call for action", yet there was silence. It appeared that no one was willing to step forward to lead an initiative aimed at addressing the problem of Post Traumatic Stress Disorder (PTSD). Never before had Windy Lake City been so vulnerable to a collective mental breakdown and no one knew what to do. The bewilderment and frustration experienced by the individual committee members were unspoken, yet present. There was a break in the silence when the hospital social worker, Norm Epinephrine, volunteered to facilitate the process to develop a model of PTSD intervention and support. It was decided by the C-Plan Committee that a coalition would be organized and composed of a multidisciplinary team of community leaders. The coalition would discern the need to quantify the scope and depth of the psychosocial impact of what the media was calling the Christmas Massacre and to develop strategies to address their findings.

Coalition Building: Alliances between Constituencies

Recognizing that the PTSD problem would probably require a broad-based public and private sector response, Norm Epinephrine assembled a Steering Committee of C-Plan members, including the Director of the Local Churches United, Kate Cholamine Public Health Information/Education Division, law enforcement representatives and the Director of the local Combined Front. This team will be responsible for organizing the PTSD Coalition. Through a unanimous vote, it was decided that the coalition should include the Director of the Denial County Health Department, the State of Confusion Health Department, chairmen from various disciplines of the University and affiliated teaching hospitals, a representative from the Chamber of Commerce, directors of various community-based organizations and directors of state and

local agencies. The objectives of the coalition will be to determine the most appropriate assessment objectives aimed at documenting the scope of PTSD in the community, develop a coordinated plan of intervention by utilizing existing resources, secure funding to support the increase demand of mental health services and to develop a strategic plan to overcome barriers to access of care.

It took 2 months to assemble the PTSD Coalition. During this first "Kick Off" meeting, Norm Epinephrine introduced himself and the members of the Steering Committee. He thanked everyone for agreeing to participate and stressed the importance of a personal commitment on behalf of each member to ensure the success of the PTSD Coalition. With a passionate voice, Norm said, "It is our moral obligation to help the residents of Windy Lake City begin their emotional healing following the Christmas Massacre. We can only accomplish this by quantifying the prevalence of PTSD in the community and then implementing effective strategies to address the problem." Norm continued the meeting with a review of the proposed structure and objectives of the Coalition. It was agreed that members, who choose to participate, would be divided into 4 individual task force subcommittees based upon relevant professional expertise. In 6 months the PTSD Coalition would reconvene and the Task Force members would share the results of their findings. The results of these independent investigations will ultimately fulfill the objectives of the PTSD initiative.

Coalition Sub-Committees: Task Force Development

The 4 individual Task Force sub-committees were convened to operate as an independent panel of experts aimed at investigating the factors contributing to the PTSD endemic.

1. Data Collection and Management
   - *Expected Outcome*: Quantification of PTSD in the community
2. Fund Developments and Resource Allocation
   - *Expected Outcome*: Secure fiscal resources to support the increased demand for mental health services that PTSD will generate for area agencies
3. Coordinated Psychosocial Intervention Services
   - *Expected Outcomes*: Development of a coordinated intervention plan, utilizing existing and tailored services
4. Communication
   - *Expected Outcome*: Based on the Seven Cardinal Rules of Risk Communication, inform the public of the prevalence of PTSD in the Windy Lake City through the C-Plan intervention strategies and the publication of a biannual progress report.

After 6 months of intensive research, each subcommittee had completed a systematic review of the information available at the community level. A final report, including recommendations for program development and implementation was drafted and presented to the PTSD Coalition at the next meeting. The reports are as follows:

Task Force: Data Collection and Management

There is no comprehensive data source within the Windy Lake City community. The data matrix includes a conglomeration of uncoordinated ICD-9 and Medical Diagnostic codes from hospital discharge records; aggregate employment and turnover data; morbidity and mortality data; social service agencies data and data provided by the local chapter of the Combined Front. Data is also available from area school districts, the Federal Bureau of Investigation (FBI), State Uniform Crime Reports, Confusion Department of Public Health (CDPH), as well as, from a community survey published in the local newspaper and subjective

assessments from area clergy regarding their congregations. The collection, analysis and dissemination of data vary from institution to institution, making it difficult to determine any trends over a specific period of time. The State of Confusion Department of Public Health, assisted by the Center for Disease Control and Prevention (CDC), conducted an analysis of these data and based on DSM IV criteria confirmed 1900 cases of PTSD, 340 cases of clinical depression and 160 cases of panic disorders. The suspected epidemiological origin was traced back to the terrorist attack of November 28, 2002; the Christmas Massacre.

Potential Barriers:

- Lack of available fiscal resources
- Availability of qualified staff, dedicated to gathering and analyzing the data
- Paralysis analysis, which is common when studying large quantities of information from multiple data sources
- Non-uniformity of the data. Given the diversity of the information and the varied definitions of each indicator used by the different sources of data, it will be difficult to statistically define the community's mental health status

Recommendations:

1. Identify potential funding sources to support data collection efforts and statistical analysis
2. Coordination of a database system to properly assess the incidence rate of PTSD in the community will be necessary. The database system will be utilized to identify similarities between reported cases and to clinically confirm the victims.
3. Specific variables will have to be identified to validate the psychological and social victimization of Windy Lake City on the health of the community.
4. Hospitals will need to implement an effective and efficient system of syndromic surveillance.
5. Sara Bellum, Division of Epidemiology/Biostatistics, will provide technical support and the necessary personnel to complete the following: compile and analyze the data related to the identification of PTSD in non-healthcare settings, evaluate and implement an infrastructure of mental health service delivery and address confidentiality issues.

Fund Development and Resource Allocation

A thorough community assessment and documentation of need with demonstrative outcome measures will be critical to justify any budget request. Funding will require a partnership between the for-profit business community, corporate philanthropy, charitable business contributions, private and public sector foundations, as well as state governmental funding sources, since categorical block grants allocated by the federal government are not available. Special attention will need to be given to educate constituents of the PTSD problem in the community and to instill a sense of ownership. An additional source of funding is available through the Community Reinvestment Act, a federal requirement that FDC banking institutions invest monies in the social initiatives of the community it serves. The Combined Front, a political source of support in the business community due to its "charity of choice" role, has volunteered to be proactive in facilitating the PTSD funding initiative.

After identifying the level of support required to support the varying range of PTSD interventions recommended by the Psycho-social Task Force, the Fund Development Task Force was able to raise 85% of its financial goal for Year One, with a commitment for the same level of funding for Year 2 from 60% of those who agreed to fund services in Year One. The Mayor of Windy Lake City went to the State Capitol to

lobby for emergency funds from the State. Due to the looming economic crisis of the State budget, only $100,000 was available to support the PTSD program. The Simmer County Health Department identified $60,000 that could be reallocated and justified to support the salary of a full-time community health educator.

To successfully sustain fund development, it will be necessary to identify PTSD as a community problem, in addition to evaluating the level of supports services already in existence. A fund development plan requires participation from the public and private sector and should be responsive to the range of services identified by the Task Force on Psychosocial Intervention Services.

Potential Barriers:

- Funding cycles for grant awards have been completed for the current calendar year
- State of Confusion is experiencing the largest deficit in the State's history and is currently cutting its budget. Monetary support from the government for a new initiative would be minimal or non-existent
- Grant allocation to multiple organizations rather than to just a few could be cumbersome for potential funding sources and serve as a disincentive for support
- The stigma associated with mental illness or emotional disturbances make it difficult for the residents of Windy Lake City to "own" the problem thus, making it difficult to create the climate of sympathy and goodwill needed to encourage funding sources to support this project
- The business community, as a funding source, is not accustomed to funding not-for-profit organizations since the Combined Front charity is the recognized "charity of choice." There is a potential risk that the Combined Front may view any grassroots attempt to raise funds for agencies as a threat
- Human service agencies compete and have difficulty in sharing resources with one another, which sends a disjointed message to funding sources
- Different funding sources have different missions and funding histories and also compete

Recommendations:

1. Select a Host Fiscal Agency within the Coalition, under whose tax exempt status the coalition could operate and receive grant awards on behalf of and transfer to each provider agency. This simplifies the process for the granting agency and conveys a unified, coordinated message.
2. Ensure participation of the director and/or board president of Combined Front Charity in the Coalition.
3. Develop a PTSD anti-stigma public relations campaign to be incorporated into the community education plan.
4. Identify members of the coalition who can function as advocates to formally and informally lobby decision makers of the potential funding sources.
5. Engage in a Cooperative Covenant with prospective provider agencies to clearly identify areas for collaboration.
6. Cooperative funding sources should be advised of the positive public recognition they will receive should they choose to support the PTSD initiative.
7. Negotiate to include grant writing as a part of the technical support offered by Sara Bellum and the University of Confusion at Windy Lake City.

Coordinated Psychosocial Intervention Services

Members of the Task Force quickly recognized just how overwhelming it would be to assess the impact of PTSD in the community. It would be imperative to educate the public and coordinate the appropriate level of mental health services.

It is determined that there have been many unidentified victims of the November 28, 2002 terrorist attack on Windy Lake City. These victims have been forced to deal with the sudden loss of life due to an unexpected traumatic event. Survivors' reactions may become more intense as the amount of disruption to their lives increases. Strength and type of reactions varies with each person and depends upon several factors such as: prior experience with the same or a similar event; the intensity of the disruption; the emotional strength of the individual; individual feelings that there is no escape, which sets the stage for panic; and the length of time that has elapsed since the event occurred. Disaster survivors may go through distinct emotional phases following a disaster: 1) *Impact phase*. Survivors do not panic and may, in fact, show no emotion. They do what they must to respond to the situation and keep themselves and their families alive. 2) *Inventory phase* immediately follows the event. Survivors assess damage and try to locate other survivors. During this phase, routine social ties tend to be discarded in favor of the more functional relationships required for initial response activities such as searching out family members and seeking medical assistance. 3) *Rescue phase.* Emergency services personnel are responding and survivors take direction from these groups without protest. They trust that rescuers will address their needs and that they can then put their lives back together quickly. 4) *Recovery phase*. Survivors may believe that rescue efforts are not proceeding quickly enough. That feeling, combined with other emotional stressors (e.g., dealing with insurance adjusters and living in temporary accommodations), may cause survivors to pull together against those who are trying to help them.

The initial reactions to a traumatic occurrence are psychological in nature and manifest as shock, disbelief and denial. A person may then experience states of confusion, exhaustion, sleeplessness, irritability or anger, self-blame and/or blaming others, fear of recurrence, feeling numb, or overwhelmed, helplessness, memory and concentration difficulties, sadness, depression, grief denial and mood swings. The intensity, timing and duration of these responses will vary from person to person and can be acute or mild, immediate, delayed or cumulative in intensity. Physiological symptoms are directly correlated with the psychological reaction to the traumatic event. These may include: loss of appetite, headaches, chest pain, diarrhea, stomach pain, nausea, increase in alcohol or drug consumption, hyperactivity, nightmares, inability to sleep, fatigue and low energy levels. If the symptoms described above are severe or last longer than 6 weeks, the traumatized person may need professional counseling.

<u>Potential Barriers:</u>

- The demand exceeds the capacity of mental health providers, as first responders, schools and members of the community become educated and seek services out of fear of being at risk for PTSD.
- The demand for mental health services may represent a relatively small percentage of the affected population.
- Citizens may be refusing to seek services due to the stigma associated with mental health issues.
- Individuals have been subtly coerced by their employers to attend the debriefing session, raising the possibility that choice and control were taken away from some traumatized people, which is likely to create frustration, anger and resentment, as well as intensify the experience of victimization.

- Difficulty in coordination of services and data gathering for further research.
- The new HIPAA regulations may inhibit the exchange of information.

Recommendations:

1. Encourage first responders and affected community members to seek mental health services
2. Establish outreach intervention sites throughout the community
3. Utilize community educational resources to inform first responders and the public of PTSD
4. Develop consistent educational in-services throughout the community, based on a foundation statement, which identifies the problem and corrective actions
5. Initiate psychosocial services with identified PTSD victims (i.e., first responders and children)
6. Based on a professional commitment, establish a collaborative multidisciplinary relationship
7. Quarterly meetings of the Social Services Alliance as the basis for coordination of those services
8. School social work cooperative as coordinator of school services
9. Develop a continuum of care aimed at coordinated series of mental health and social services

Communicating the Results

The residents of Windy Lake City can understand risk information, but they may not agree or be satisfied with the information presented. It is important that spokesman of the PTSD Coalition speak clearly and with compassion, but not to allow communication efforts to prevent acknowledging the tragedy of the injuries or deaths that have occurred. Recognizing community input and citizen involvement is important because (a) people are entitled to make decisions about issues that directly affect their lives; (b) input from the community can help the agency make better decisions; (c) involvement in the process leads to greater understanding of and more appropriate reaction to a particular risk; (d) those who are affected by a problem bring different variables to the problem-solving equation; and (e) cooperation increases credibility.

Potential Barriers:

- A lack of coordination of information amongst local and state agencies
- Miscommunication or wrong information disseminated by the media

Recommendations:

The Coalition members agreed to implement a proposed plan of communication based on the guidelines established by the Agency for Toxic Substances and Disease Registry (ATSDR).

Seven Cardinal Rules of Risk Communication

1. Accept and involve the public as a partner.

The goal is to produce an informed public, not to defuse public concerns or replace actions.

2. Plan carefully and evaluate efforts.

Different goals, audiences and media require different actions.

3. Listen to the public's specific concerns.

People often care more about trust, credibility, competence, fairness and empathy than about statistics and details.

4. Be honest, frank and open.

Trust and credibility are difficult to obtain; once lost, they are almost impossible to regain.

5. Work with other credible sources.

Conflicts and disagreements among organizations make communication with the public much more difficult.

6. Meet the needs of the media.
The media are usually more interested in politics than risk, simplicity than complexity, danger than safety.
7. Speak clearly and with compassion.
Never let efforts prevent acknowledgment of the tragedy of an illness, injury, or death.

Conclusion

The Coalition reconvened 6 months following its first meeting. Each individual Task Force Chairman reported the results and suggested recommendations of their independent investigation of the PTSD problem in the Windy Lake City community. This was the *beginning*, not the *end* of the Coalition's work! Community response to the PTSD problem must be viewed as a continual process and not an isolated event to be resolved. The Coalition membership recognized the interdependency of this determinant to the success of the PTSD initiative.

Norm Epinephrine, Head of the Steering Committee, was excited as the fragmented tasks and concerns emerged from the recesses of his imagination…A host agency, an integrated human service agency response, employer support, the stigma of PTSD, more services, more money, a uniform data set, a coordinated public campaign…This was so much to deal with at one time…

Where Do We Go From Here?

After exhausting deliberation, the Simmer County and State of Confusion Departments of Public Health and the C-Plan Committee made an executive decision that the 2006 C-Plan would focus on PTSD in the community. Kate Cholamine, Public Health Information/Education Division Director, and Abraham Maslow, Chairman of Psychiatry Department of the community's largest mental health center, suggested that it was imperative to include representatives from the media. This would hopefully facilitate a working relationship with the media and ultimately improve the quality of information disseminated to the public.

The Simmer County Health Department and the State of Confusion Department of Public Health initially were neither effective nor efficient in handling the sequelae of Post Traumatic Stress Disorder following the terrorist attack. Several lapses of communication, lack of proper education, poor surveillance and deficient funding and policy development identified in the scenario resulted in the delay of successful management of the psychosocial endemic. However, there is always some good that comes from the threat of evil. Through intensive strategic planning and negotiation, a cohesive program is proposed to anticipate the occurrence of unexpected events that could threaten the health of the community.

Study Questions

1. Who do you think is responsible for the coordination of data surveillance network?
2. How was the media an advocate of terrorism?
3. Was the allocation of funding streams inhibited by political agenda setting? How?
4. Identify the windows of opportunity in the case study that could influence policy development.
5. How does the concept of Federalism influence the overall success of the psychosocial interventions or is it the stigma of mental disease or both?
6. What are the barriers and/or proponents to a private and public sector partnership for funding PTSD services?
7. What strategy should be implemented to sustain the coalition as it moves into the next phase of its operation?
8. Under what organizational structure should the coalition operate?

9. What strategies could have been implemented to foster an effective media message?
10. Are leadership skills transferable across systems?

APPENDIX A

Terrorism

Terrorism is the intentional use of, or threat to use violence against civilians or against civilian targets, in order to attain political aims.

1. The essence of the activity—the use of, or threat to use, violence. According to this definition, an activity that does not involve violence or a threat of violence will not be defined as terrorism (including non-violent protest—strikes, peaceful demonstrations, tax revolts, etc.).
2. The aim of the activity is always political—namely, the goal is to attain political objectives; changing the regime, changing the people in power, changing social or economic policies, etc. In the absence of a political aim, the activity in quest will not be defined as terrorism. A violent activity against civilians that has no political aim is, at most, an act of criminal delinquency, a felony, or simply an act of insanity unrelated to terrorism. Some scholars tend to add ideological or religious aims to the list of political aims. The advantage of this definition, however, is that it is as short as possible. The concept of "political aim" is sufficiently broad to include these goals as well. The motivation—whether ideological, religious, or something else—behind the political objective is irrelevant for the purpose of defining terrorism. In this context, the following statement by Duvall and Stohl deserves mention: Motives are entirely irrelevant to the concept of political terrorism. Most analysts fail to recognize this and, hence, tend to discuss certain motives as logical or necessary aspects of terrorism. But they are not. At best, they are empirical regularities associated with terrorism. More often they simply confuse analysis.
3. The targets of terrorism are civilians. Terrorism is thus distinguished from other types of political violence (guerrilla warfare, civil insurrection, etc.). Terrorism exploits the relative vulnerability of the civilian "underbelly"—the tremendous anxiety and the intense media reaction evoked by attacks against civilian targets. The proposed definition emphasizes that terrorism is not the result of an accidental injury inflicted on a civilian or a group of civilians who stumbled into an area of violent political activity, but stresses that this is an act purposely directed against civilians. Hence, the term "terrorism" should not be ascribed to collateral damage to civilians used as human shields or to cover military activity or installations, if such damage is incurred in an attack originally aimed against a military target. In this case, the responsibility for civilian casualties is incumbent upon whoever used them as shields.

APPENDIX B

Rogue Militant Terrorist

Rogue militants are renowned for their range of detonating methods. From time pencils and electronic timers to radio waves, they have used almost all known methods of detonation. However, recent trends demonstrate the common use of timer devices that enable the militant to be as far as possible from the place of the incident so as to prevent even a chance encounter. Having surplus resources at their disposal, the militants use the most sophisticated and effective of all detonators. It has been documented that the militants have in their possession a gadget similar to the conventional 'double impulse fuse', which enables them to initiate automatically, in the same impoverished explosive device (IED), a second blast a few minutes or hours after the first. Thus the first blast essentially works as bait to lure the security forces to the vicinity, when the second blast occurs.

The type of assemblage is the crucial part of the IED, as the device has to be fool proof and the container chosen to disguise the deviousness of the device. The most widespread model of the IED uses readily available and deceptive containers such as steel cans, plastic buckets and drums that effectively mislead the security forces and the public. Therefore, there have been IEDs assembled inside pressure cookers, fire extinguishers, household utensils, packets in car, bus, scooter, cycles, gas cylinders, etc. Fire extinguishers, pressure cookers and gas cylinders are favored because of the additional splinter effect they can cause due to their thick metal sheeting.

Barring the most complicated assemblies, most of the IEDs are rather simple and require no expertise other than some training, but require access to resources. The use of RDX (high explosive) and sophisticated detonating methods point to another form of support, not only in training but also in material supply.

APPENDIX C

Second Hand Terrorism

Preying upon the public's justified paranoia of terrorism and by exacerbating a crisis environment with inflammatory speculation, false leads and conspiracy spinning, the media creates a general climate of fear among the American and international populace. This climate of fear is what terrorists strive to create. Yet, it is the media that is responsible for this atmosphere of fear. Does that make this tragedy an act of second-hand terrorism? In the drama that terrorists create, is the media culpable in its effects? The media and terrorism hold a special relationship, as Ted Koppel, ABC anchor, has said, "Let me put forward the proposition that the media, particularly television, and terrorists need one another, that they have what is fundamentally a symbiotic relationship. Without television, terrorism becomes rather like the philosopher's hypothetical tree falling in the forest: no one hears it fall and therefore it has no reason for being. And television without terrorism, while not deprived of all interesting things in the world, is nonetheless deprived of one of the most interesting."

Behind the media's attention to terrorism is, of course, public interest in it. However, the media is potentially responsible in spreading "propaganda" and fostering fear when it invokes its freedoms with a blind eye, without responsibility to the democracy that secures those freedoms. Critics of the press, those who would lay most guilt on the media, claim that staged events such as terrorist acts have transformed the First Amendment from an institution preserved in the interest of the community to a euphemism for the privilege of reporters to consume their synthetic commodity while disguised in the "cult of objectivity." However, the nature of modern global communications makes it very easy for any spectator to get sucked into any human drama unfolding in real-time. Intrusive reportage, when a reporter ceases passive observation of an incident and becomes part of its dynamic, is the point of fault at which the media are guilty of second-hand terrorism. Responsibility in reporting can be even more a "contribution to the maintenance of a democracy" than can a mindless invocation of the First Amendment.

APPENDIX D

PTSD Coalition Members:

- Director, Chamber of Commerce- representation and access to the business community (i.e. private sector)
- Medical Chief Executive Officers, 2 medical centers in the community that provide healthcare resources

- President, County Board of Health
- Chiefs of Fire and Law Enforcement
- President, Human Resource Association
- Mayor
- Senior Managers
- Congressional District Representative
- Director, Local Churches United
- Local Public Health Department
- Director, United Way
- President, Teacher's Union
- School Superintendent
- President, Private Foundation
- University of Confusion's School of Public Health
- Medical Director, Mental Health Center
- Chair, Media Roundtable
- Director, State Social Service Agency
- President, Community Services Consortium

Task Force Members: Data Collection and Management

- President, Human Resources Association
- Congressional District Representative (advocate for legislation of PSTD initiative)
- President, Private Foundation (grant applications)
- President, Teacher's Union (provision of aggregated data on PTSD-related behavior changes)

Task Force Members: Fund Development and Resource Allocation

- Director, United Way
- Senior Manager
- Medical Chief Executive Officers
- Mayor
- President, County Board of Health (resource allocation and funding)

The members of this task force were recruited because it was recognized that funds to support an increase in the demand for existing, as well as, "repositioned" services for the PTSD victims would require a public/private sector partnership, with more of the burden for funds being placed on the private sector.

Task Force Members: Coordinated Psycho-social Intervention Services

- Law Enforcement
- Director, Public Health Department
- School Superintendent
- Medical Director, Mental Health Center
- Community Service Consortium (organization of private and public social service agencies)

Task Force on Risk Communication

- Medical Chief Executive Officers
- Law Enforcement

- Director, Public Health Department
- President, County Board of Health.
- State of Confusion Department of Public Health

APPENDIX E

C-Plan Development: Background

Section 600.400 of the Confusion Administrative Code (CAC) defines the C-Plan as the Confusion Project for Local Assessment of Needs, a process developed by the Department to meet the requirements set forth in Section 600.410. C-PLAN is a series of planning activities conducted within the local health department jurisdiction, resulting in the development of an organizational capacity assessment; a community health needs assessment and a community health plan. More specifically, the Public Health Practice Standards, outlined in Section 600.400 of the CAC requires local health departments, as a condition of certification, to conduct the following activities:

1. Assess the health needs of the community by establishing a systematic needs assessment process that periodically provides information on the health status and local needs of the community.

2. Investigate the occurrence of adverse health effects and health hazards in the community by conducting timely investigations that identify the magnitude of health problems, duration, trends, location and populations at risk.

3. Advocate for public health, build constituencies and identify resources in the community by generating supportive and collaborative relationships with public and private agencies and constituent groups for the effective planning, implementation and management of public health activities. The local health department shall develop and strengthen communication with units of government, health-related organizations, health providers, citizens and news media.

4. Develop plans and policies to address priority health needs by establishing goals and objectives to be achieved through a systematic course of action that focuses on local community needs and equitable distribution of resources, and involves the participation of constituents and other related governmental agencies. Develop a community health plan that addresses at least three priority health needs during each certification period.

5. Manage resources and develop organizational structure through the acquisition, allocation and control of human, physical and fiscal resources, and maximizing the operational functions of the local public health systems through coordination of community agencies' efforts and avoidance of duplication of services.

6. Implement programs and other arrangements assuring or providing direct services for priority health needs identified in the community health plan by taking actions, which translate plans and policies into services.

7. Evaluate programs and provide quality assurance in accordance with applicable professional and regulatory standards to ensure that programs are consistent with plans and policies, and provide feedback on inadequacies and changes needed to redirect programs and resources.

8. Inform and educate the public on public health issues of concern in the community, promoting awareness about public health services availability, and health education initiatives which contribute to individual and collective changes in health knowledge, attitudes and practices towards a healthier community.