# Disasters & Mental Health: Impact, Vulnerability, and Early Interventions

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**1645-1745**

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# Presenter


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- Dr. Joshua C. Morganstein is Associate Professor and Assistant Chair in the Department of Psychiatry and Assistant Director of the Center for the Study of Traumatic Stress at the Uniformed Services University of the Health Sciences in Bethesda, MD.
- Dr. Morganstein is Chair of the American Psychiatric Association's Committee on the Psychiatric Dimensions of Disaster and a Captain in the Commissioned Corps of the U.S. Public Health Service.
- He leads the Disaster Mental Health education and consultation services at the Center for the Study of Traumatic Stress and provides disaster mental health subject-matter expertise to federal, national, and global organizations.
- Dr. Morganstein advised on the United Nations' 2015 Sendai Framework for Disaster Risk Reduction and co-authored the first Curriculum Recommendations for Disaster Behavioral Health Professionals.
- He served as a co-author for "Mental Health and Well-Being" chapter in a landmark interagency report, Impact of Climate Change on Human Health in the United States and the American Psychiatric Association's Position Statement and Resource Document on "Climate Change and Mental Health".
- Dr. Morganstein authored a range of articles, chapters, and technical reports on the mental health impact of various disaster events including natural disasters, mass violence, terrorism, pandemics, and nuclear exposure.

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# Disclosures

- CAPT Joshua C. Morganstein has no relevant financial or non-financial relationships to disclose relating to the content of this activity; or presenter(s) must disclose the type of affiliation/financial interest (e.g. employee, speaker, consultant, principal investigator, grant recipient) with company name(s) included.
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# Learning Objectives

1. Evaluate the type and frequency of disasters.
2. Explain the range of adverse psychological and behavioral reactions to disasters.
3. Describe populations most vulnerable to adverse mental health effects of disasters.
4. Identify important evidence-based early interventions to mitigate adverse mental health effects of disasters.

Have you, or someone you care about, ever been affected by a disaster?

A. Yes
B. No

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# TYPES, FREQUENCY & DISASTER SYSTEMS

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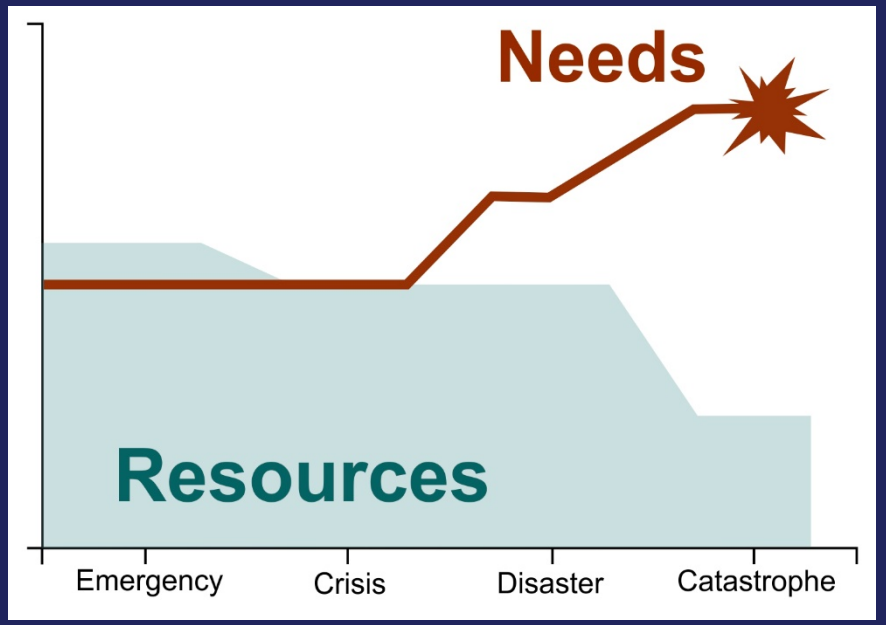
# Definition of "Disaster" Varies by Context…

- Severe disruption, ecological and psychosocial, which greatly exceeds the coping capacity of the affected community




*World Health Organization, 2002

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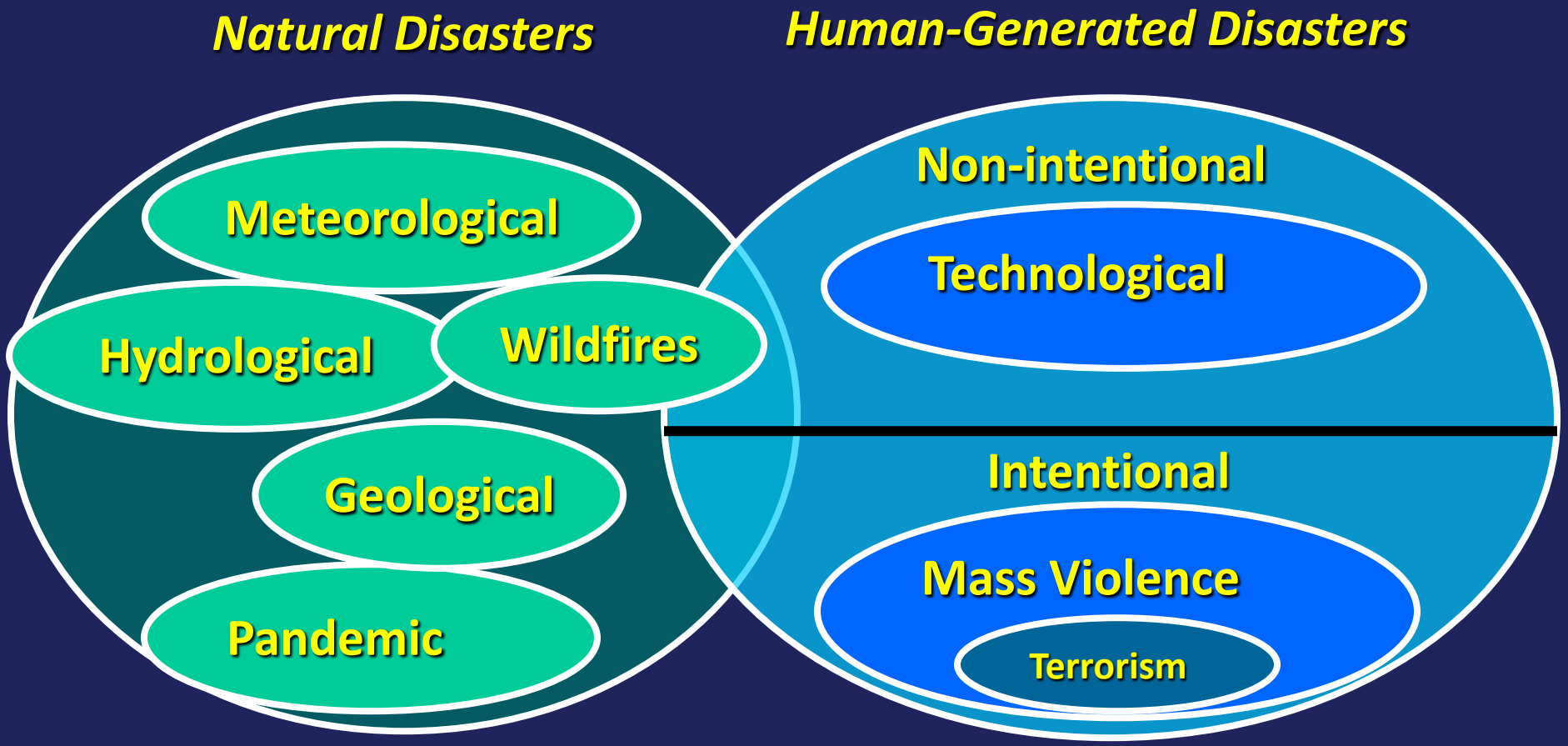
# Disaster Mental Health…

- Clinical / Research
  - Natural and human-generated events involving exposure to mass trauma
  - Produce a predictable range of adverse psychological and behavioral responses

# Categories of Disasters

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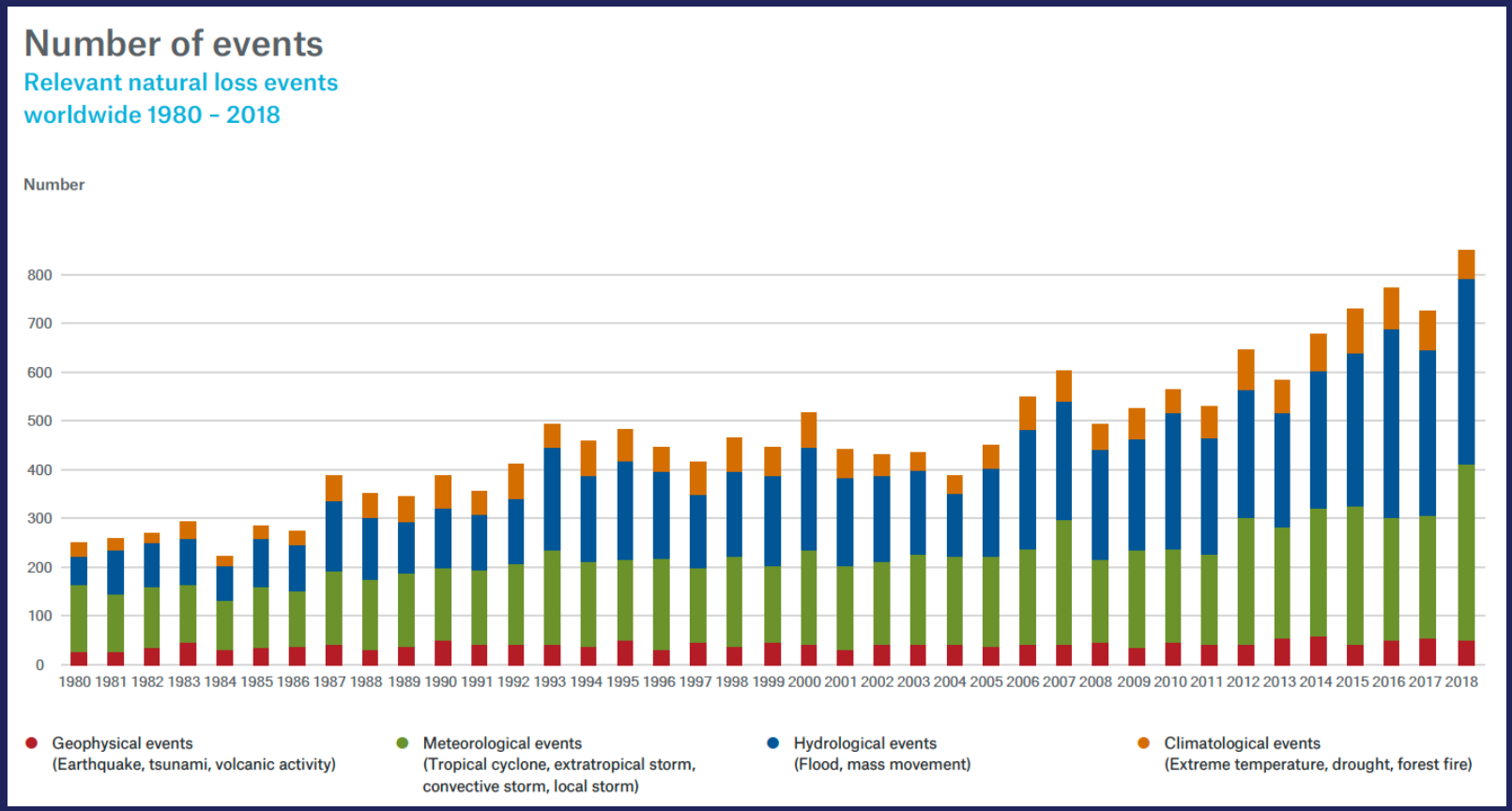
Adapted from James M. Shultz, Ph.D., DEEP PREP training

# Global Climate-Related Disaster (1980-2018)




NatCatSERVICE database, Munich Re, Accessed 15Jan2019.

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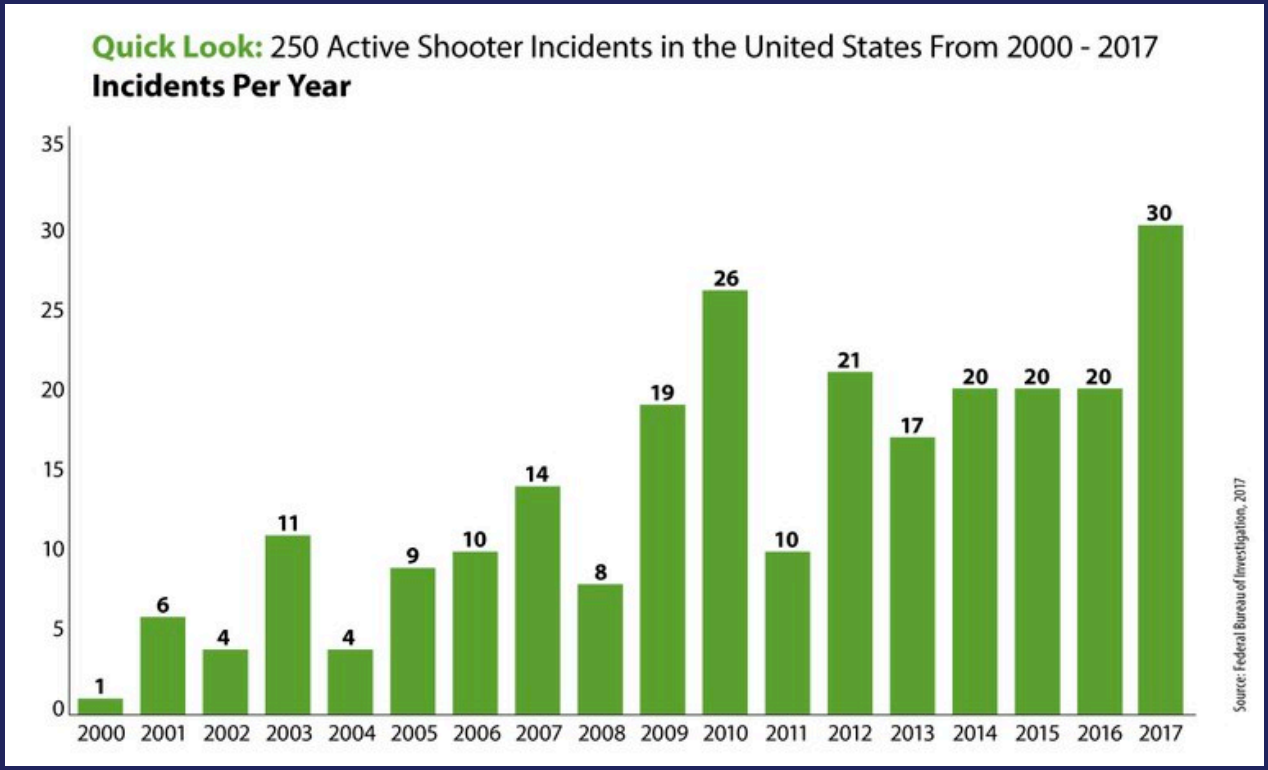
# Active Shooter Incidence – Incidents per Year




"an individual(s) actively engaged in killing or attempting to kill people in a populated area."

https://www.fbi.gov/about/partnerships/office-of-partner-engagement/active-shooter-incidents-graphics (Accessed 17Jan2019)

# ADVERSE PSYCHOLOGICAL AND BEHAVIORAL RESPONSE TO DISASTERS

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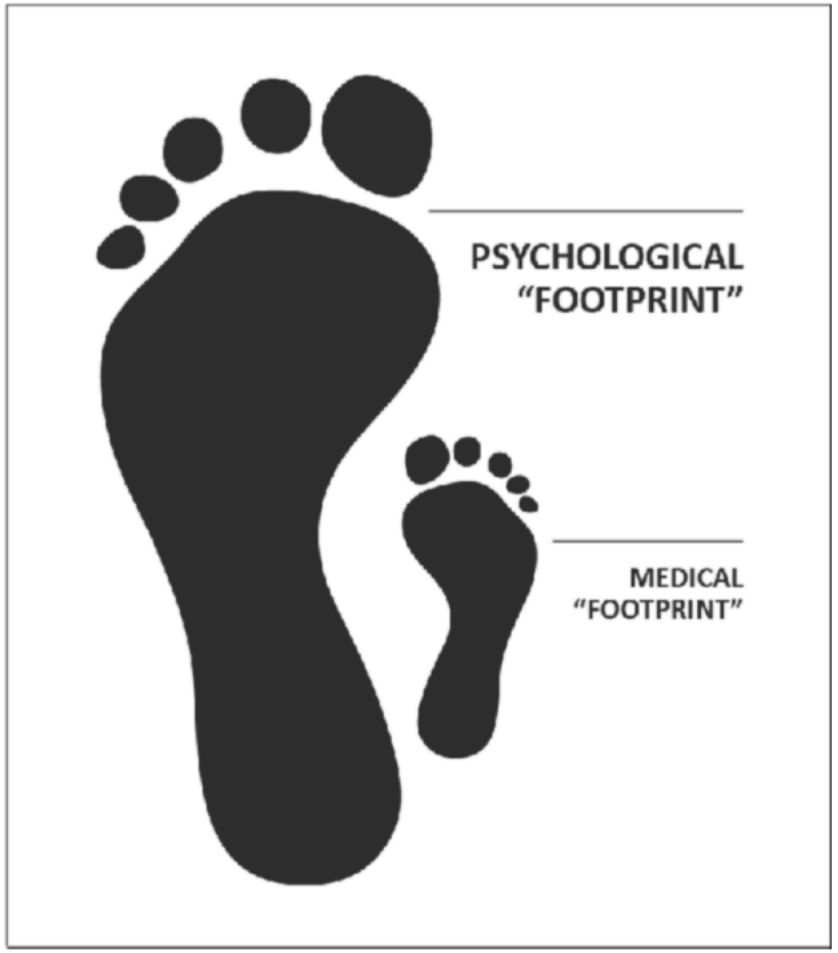
In a disaster, the size of the psychological "footprint" greatly exceeds the size of the medical "footprint."

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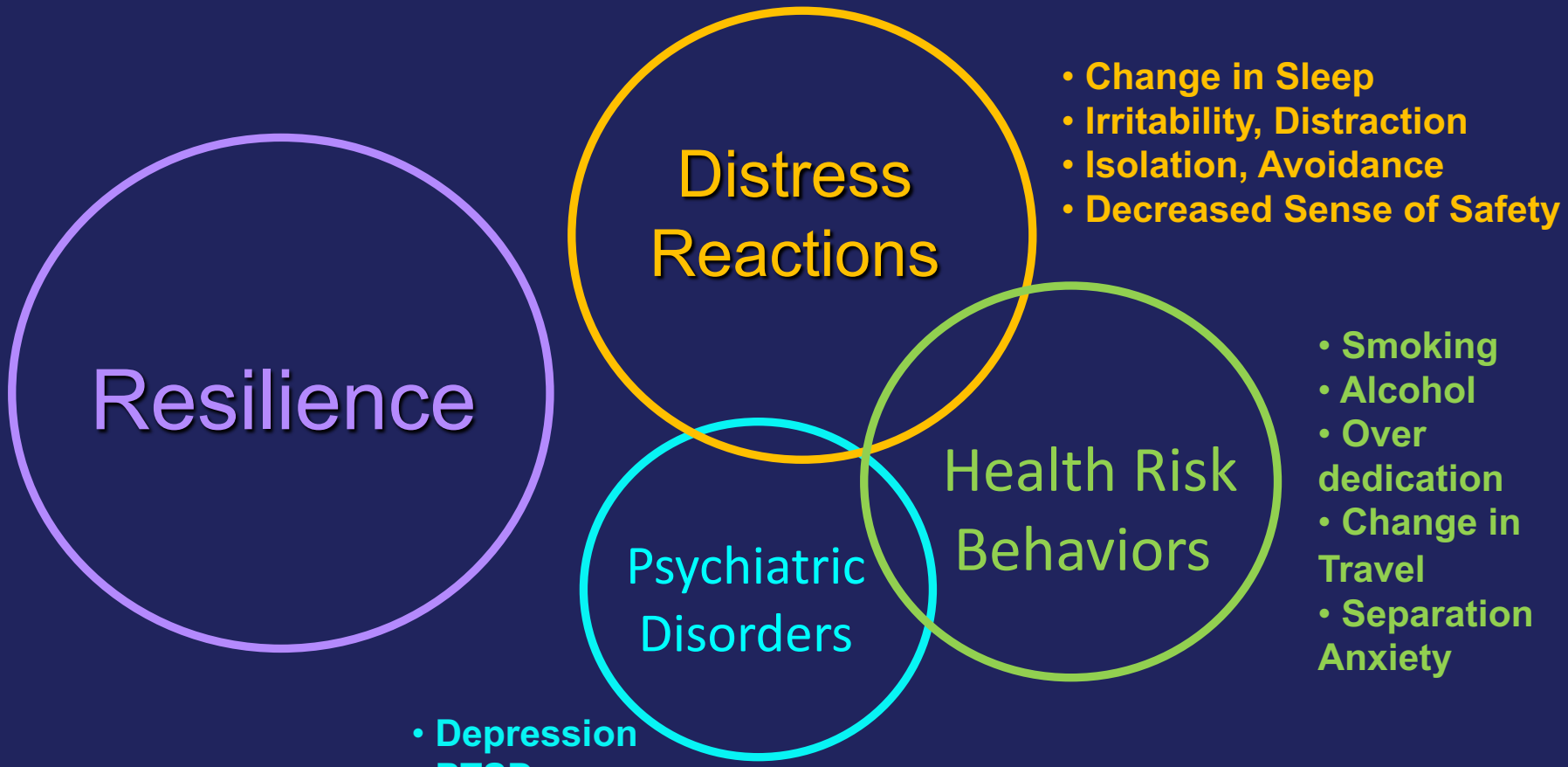
Shultz, J. M., Espinola, M., Rechkemmer, A., & Cohen, M. A. (2016). Prevention of Disaster Impact and Outcome Cascades. In *The Cambridge Handbook of International Prevention Science* (pp. 492–519).

# Psychological & Behavioral Responses to Disasters

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Ursano, R.J., Fullerton, C.S., Weisaeth, L., Raphael, B. (Eds.). (2017). Textbook of Disaster Psychiatry, 2ED. London, UK: Cambridge University Press

# Exposure & Contamination

- Chem, Bio, Rad, Nuc (CBRN)
- Novel, mysterious
- Invisible, powerful, evil
- Uncertain “site” of event
- Non-specific symptoms
- Conflicting opinions about response
- Isolation and quarantine
- Shortages & scarcity (prophylaxis, antidote, treatment)
- Medically unexplained physical symptoms (MUPS)
  - High rate of somatic sxs
  - 50:1 (seek care vs actual exposure)


McCormick et al. (2015). Mental health consequences of chemical and radiologic emergencies: a systematic review. *Emergency Medicine Clinics of North America*, *33*(1), 197–211.

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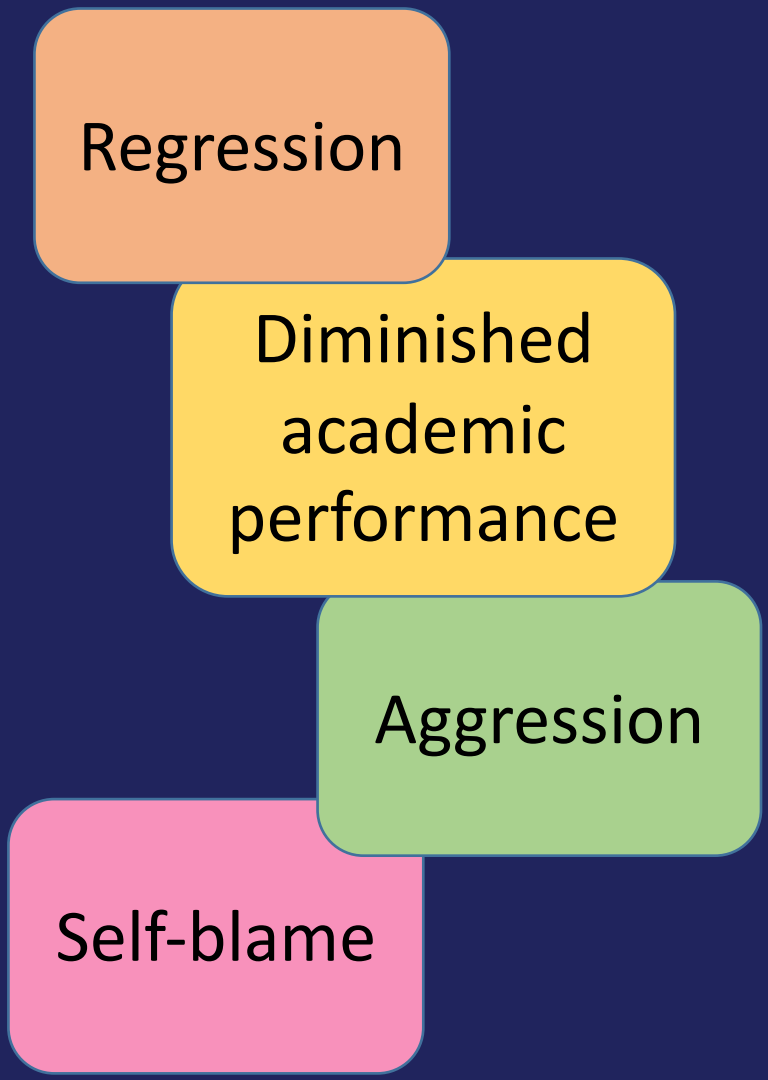
# Children & Adolescents

- Separation from primary attachment figures
- Parental distraction, preoccupation, strife
- Disruption in schedules and routines
- Induction of fear, erosion of safety
- Self blame, helplessness

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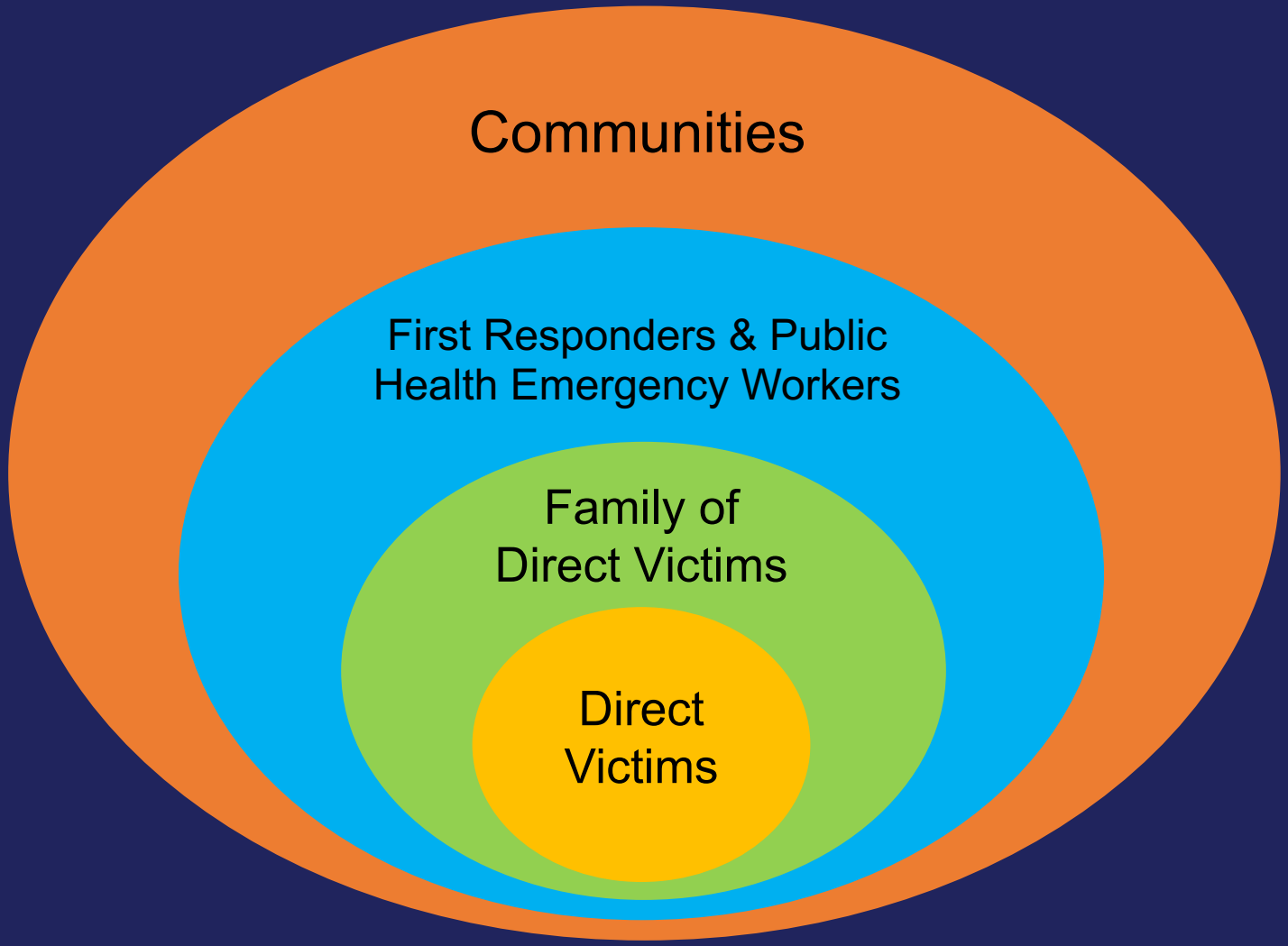
# Population Exposure to Event

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https://www.tvbeurope.com/wp-content/uploads/2019/01/pay-tv-353x199.png

Media exposure enhances transmission of fear and distress

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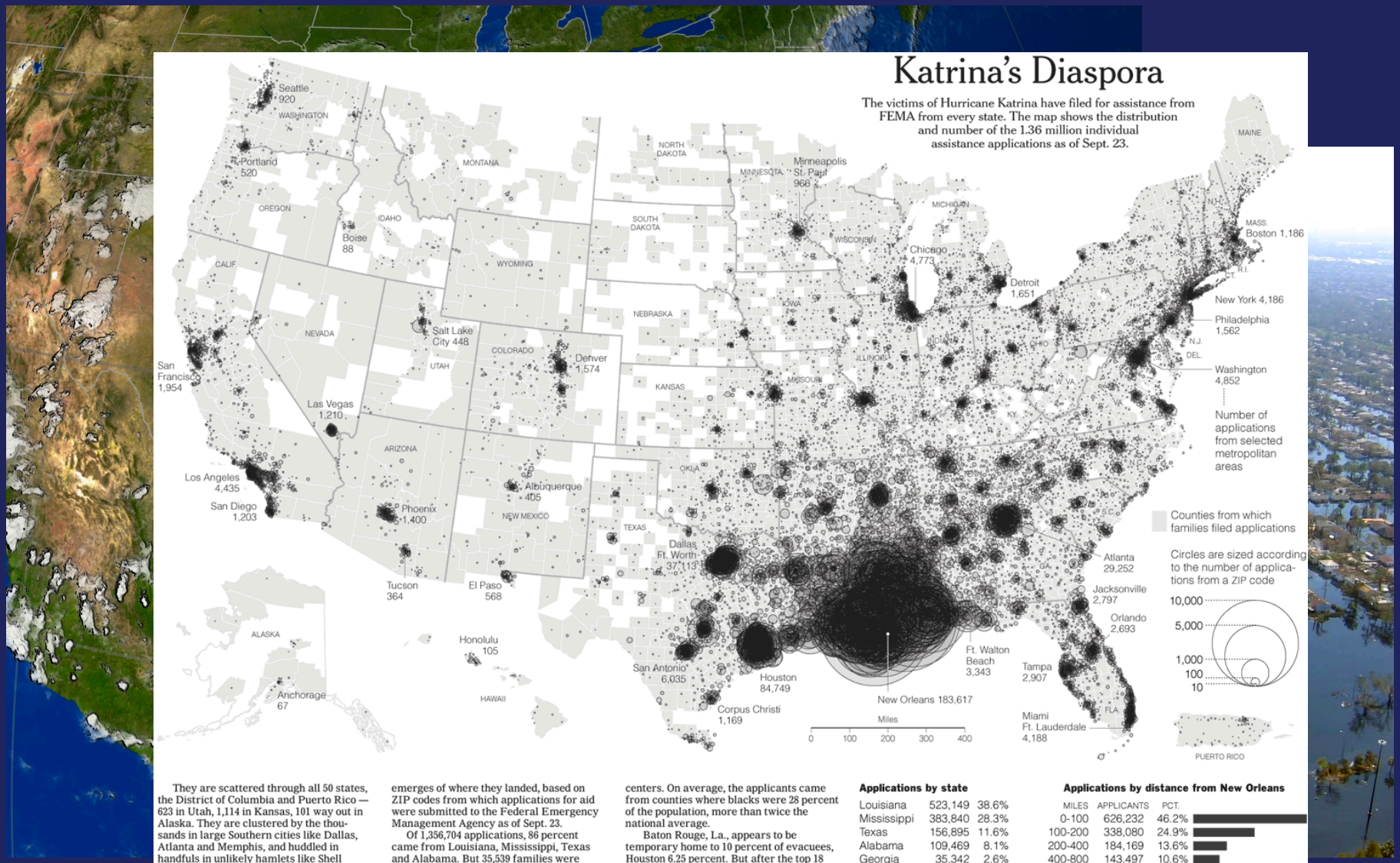
Fullerton, C. S., Mash, H. B., Morganstein, J. C., & Ursano, R. J. (2018). Active Shooter and Terrorist Event-Related Posttraumatic Stress and Depression: Television Viewing and Perceived Safety. *Disaster Medicine and Public Health Preparedness*.

Pfefferbaum, B., Newman, E., Nelson, S. D., Nitiéma, P., Pfefferbaum, R. L., & Rahman, A. (2014). Disaster Media Coverage and Psychological Outcomes: Descriptive Findings in the Extant Research. *Current Psychiatry Reports*, *16*(9), 464.



# Katrina's Diaspora

The victims of Hurricane Katrina have filed for assistance from FEMA from every state. The map shows the distribution and number of the 1.36 million individual assistance applications as of Sept. 23.



They are scattered through all 50 states, the District of Columbia and Puerto Rico — 623 in Utah, 1,114 in Kansas, 101 way out in Alaska. They are clustered by the thousands in large Southern cities like Dallas, Atlanta and Memphis, and huddled in handfuls in unlikely hamlets like Shell Knob, Mo. (pop. 1,393) and Fountain Run, Ky. (pop. 236).

Evacuees fled Hurricane Katrina and the floods that followed in caravans of cars and fleets of buses, on helicopters and chartered planes, by boat and, a few, on foot. A month after the storm, a map emerges of where they landed, based on ZIP codes from which applications for aid were submitted to the Federal Emergency Management Agency as of Sept. 23.

Of 1,356,704 applications, 86 percent came from Louisiana, Mississippi, Texas and Alabama. But 35,539 families were more than 1,000 miles from the Gulf — among the farthest: one in Nome, Alaska, 3,931 miles from the French Quarter and another in Lihue, Hawaii, 4,279 miles away.

Residents of New Orleans, a city that was two-thirds black, seem to have flocked to the nation's African-American population centers. On average, the applicants came from counties where blacks were 28 percent of the population, more than twice the national average.

Baton Rouge, La., appears to be temporary home to 10 percent of evacuees, Houston 6.25 percent. But after the top 18 hubs, applicants are spread like the wind that whipped through their old neighborhoods: none of the other 900-plus metropolitan areas has even 1 percent of the total.

Some 4,000 ZIP codes — among them Pocahontas, Miss.; Promise City, Iowa; and Hope, Mich. — had just one applicant.

**Applications by state**

| | | |
|---|---|---|
| Louisiana | 523,149 | 38.6% |
| Mississippi | 383,840 | 28.3% |
| Texas | 156,895 | 11.6% |
| Alabama | 109,469 | 8.1% |
| Georgia | 35,342 | 2.6% |
| Florida | 31,005 | 2.3% |
| Tennessee | 15,529 | 1.1% |
| Arkansas | 11,027 | 0.8% |
| California | 10,953 | 0.8% |
| Illinois | 6,430 | 0.5% |
| Others | 73,065 | 5.4% |

**Applications by distance from New Orleans**

| MILES | APPLICANTS | PCT. |
|---|---|---|
| 0-100 | 626,232 | 46.2% |
| 100-200 | 338,080 | 24.9% |
| 200-400 | 184,169 | 13.6% |
| 400-800 | 143,497 | 10.6% |
| 800-1,600 | 45,371 | 3.3% |
| 1,600-3,200 | 13,403 | 1.0% |
| 3,200+ | 232 | 0.0% |

*Distances could not be calculated for 0.4 percent of applications.*

*Sources: FEMA; Census Bureau; Queens College Sociology Department*

Matthew Ericson, Archie Tse and Jodi Wilgoren/The New York Times

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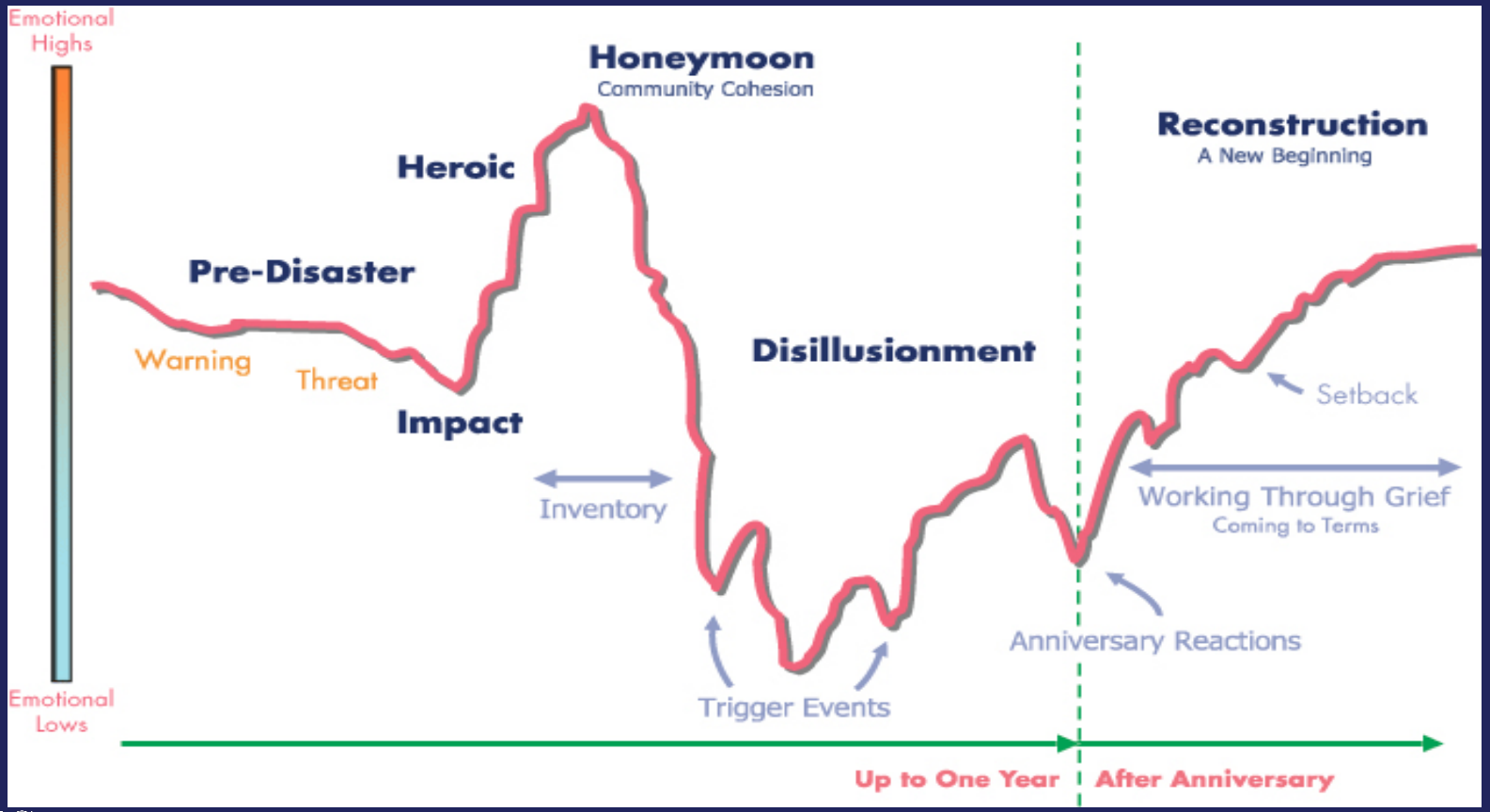
# Community Phases

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https://www.samhsa.gov/programs-campaigns/dtac/recovering-disasters/phases-disaster

It’s six month after the California Camp Fire and residents of Paradise remain without basic services or housing. They were previously very optimistic and tended to band together in their communities to help each other. Now there is significant anger toward the government for failing to restore utilities. What phase of psychological response to disaster is occurring?

A. Honeymoon
B. Reconstruction
C. Heroic
D. Disillusionment

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# Vulnerability to Disasters due to…


**PRE-EVENT DEMOGRAPHICS**

- Social Economic Status (SES)
- Age
- Gender
- Culture
- Social support

**EVENT IMPACT**

- Duration & Severity of Exposure
- Injury
- Home loss
- Displacement
- Bereavement

**RECOVERY FACTORS**

- Relocation
- Job loss
- Social support loss

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Somasundaram and van de Put (2006). Management of Trauma in Special Populations after a Disaster. J Clin Psychiatry;67(suppl 2):64-73

Norris, F. H., Friedman, M. J., Watson, P. J., Byrne, C. M., Diaz, E., & Kaniasty, K. (2002). 60,000 disaster victims speak: Part I. An empirical review of the empirical literature, 1981-2001. *Psychiatry*, *65*(3), 207–239.

# Special Populations

Dependence on Systems of Care

Cognitive & Mobility Impaired

Children & Adolescents

Economically Disadvantaged; Homelessness

Migrants & Refugees

Pregnancy & Postpartum

First Responders

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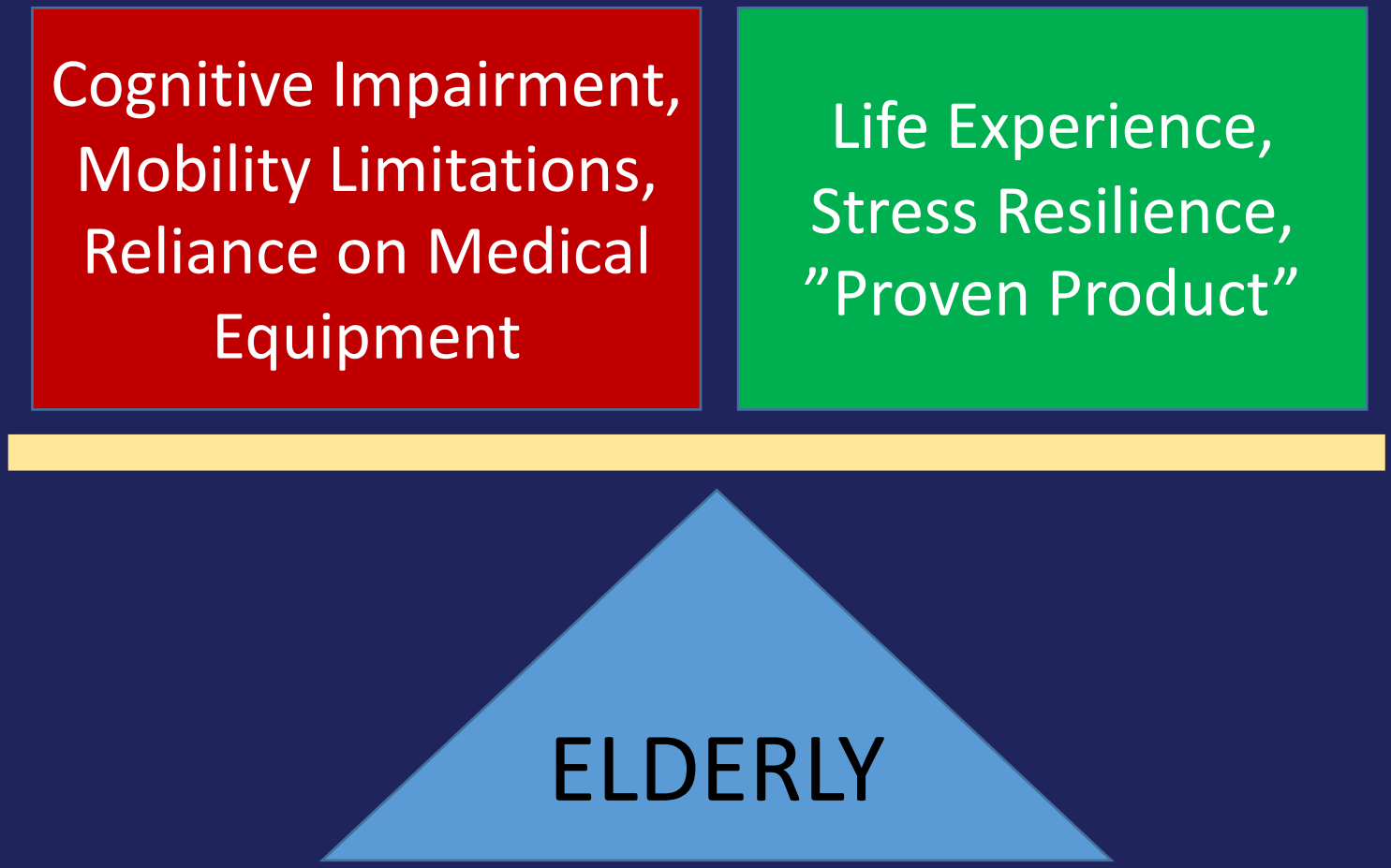
# Look for strengths/resilience in everyone…

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# INTERVENTIONS FOLLOWING DISASTERS

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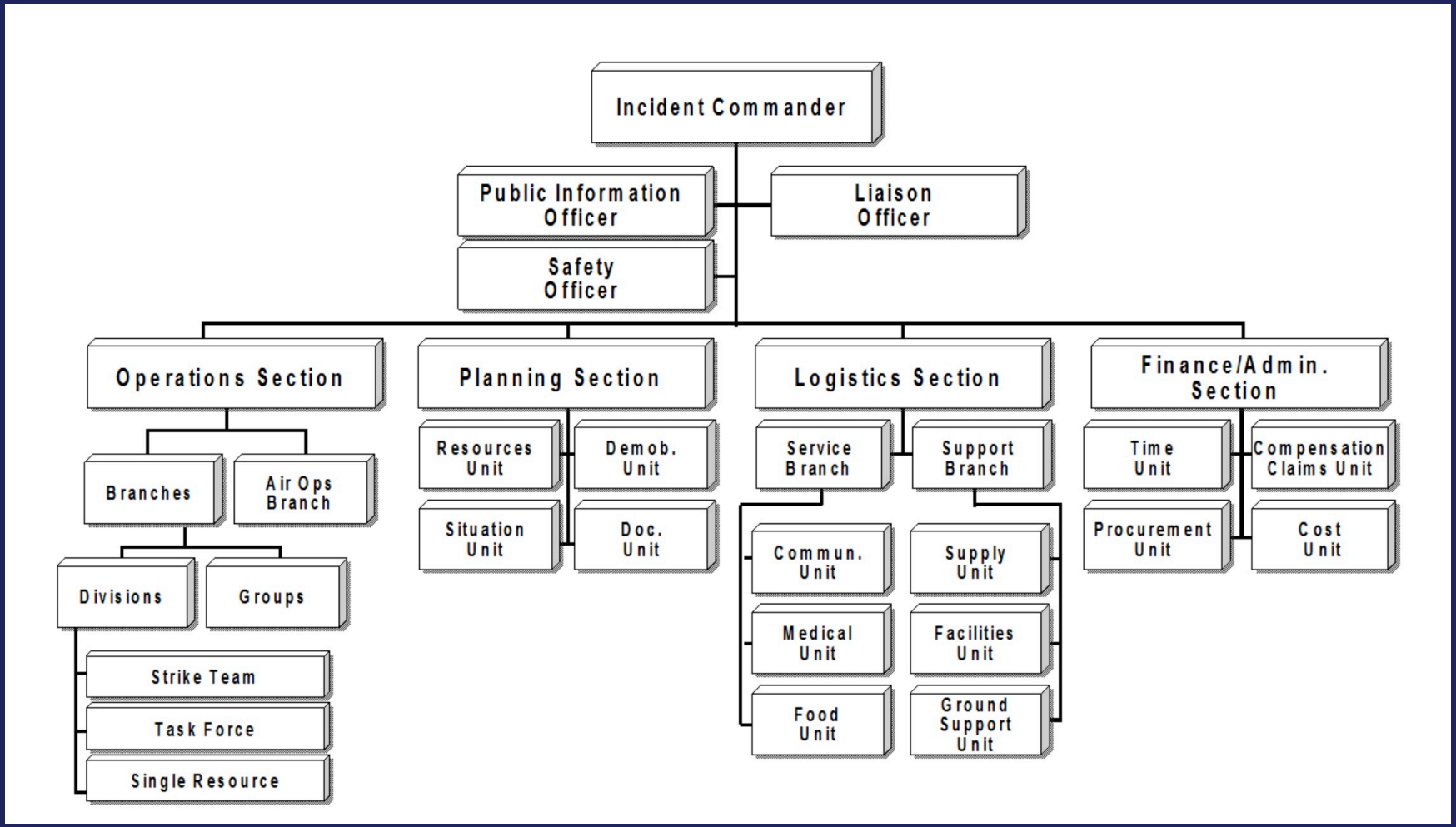
# Incident Command System




https://training.fema.gov/emiweb/is/icsresource/assets/reviewmaterials.pdf

# Disaster Cycle / All Hazards Planning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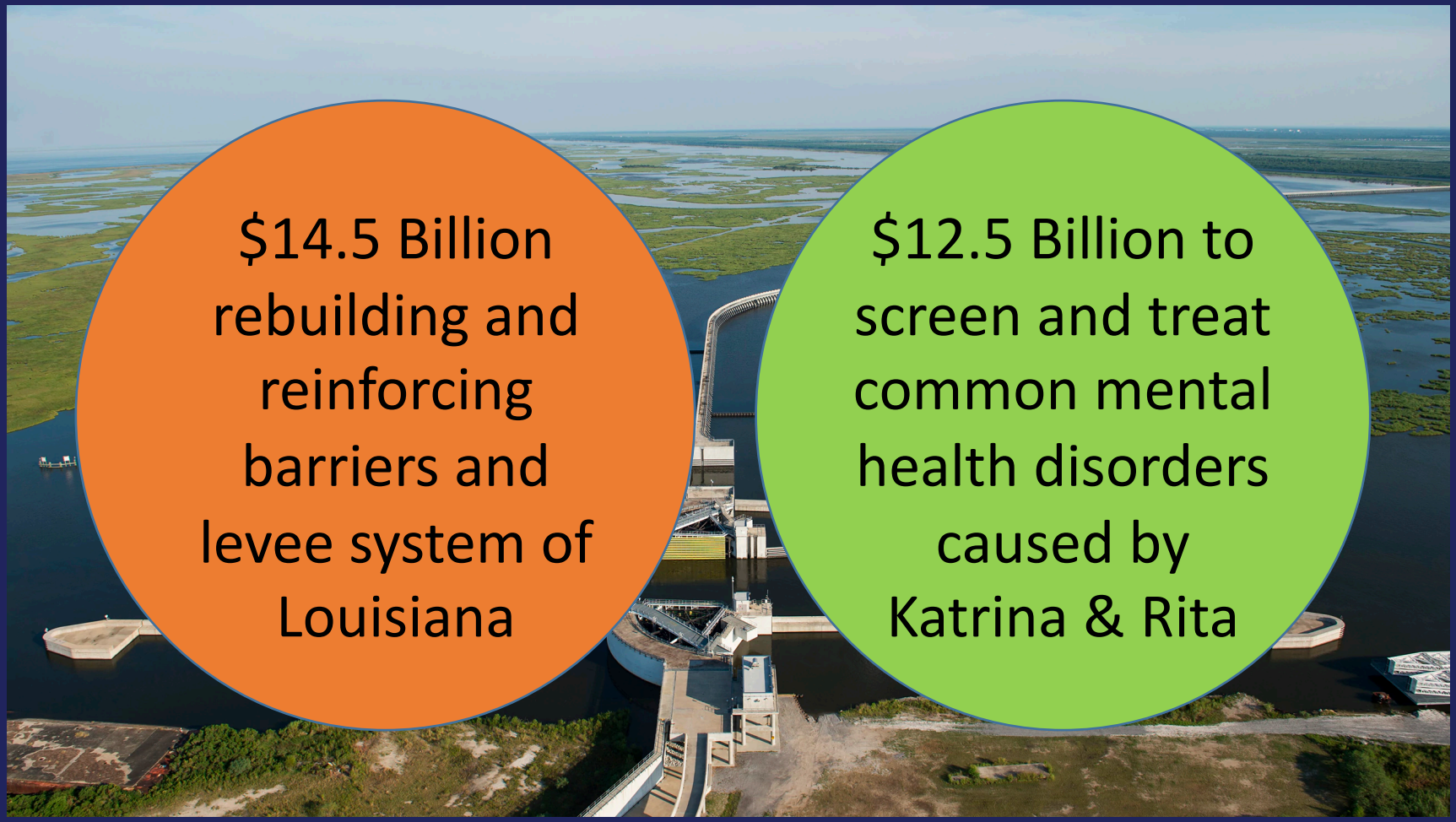
https://aretehs.com/images/Emergency-management-diagramCOLOR.png

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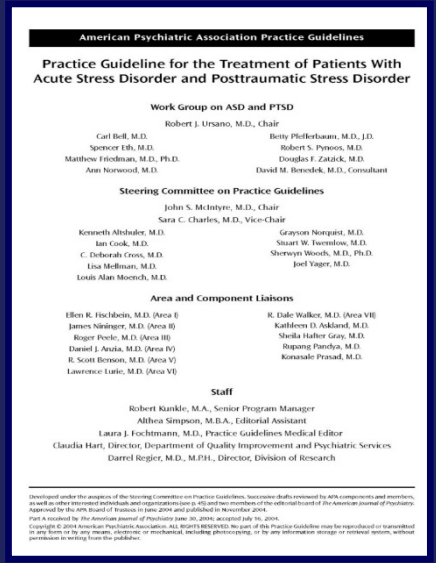
John Burnett. NPR. August 28 2015. Accessed 01Apr2018. https://www.npr.org/2015/08/28/432059261/billions-spent-on-flood-barriers-but-new-orleans-still-a-fishbowl.

Schoenbaum, M., Butler, B., Kataoka, S., Norquist, G., Springgate, B., Sullivan, G., et al. (2009). Promoting mental health recovery after hurricanes Katrina and Rita: what can be done at what cost. *Archives of General Psychiatry*, *66*(8), 906–914.

# Psychological Debriefings (CISD/CISM)

This review concerns the efficacy of single session psychological "debriefing" in reducing psychological distress and preventing the development of post traumatic stress disorder (PTSD) after traumatic events. Psychological debriefing is either equivalent to, or worse than, control or educational interventions in preventing or reducing the severity of PTSD, depression, anxiety and general psychological morbidity. There is some suggestion that it may increase the risk of PTSD and depression. The routine use of single session debriefing given to non selected trauma victims is not supported. No evidence has been found that this procedure is effective.

Rose, et al. (2002). Psychological debriefing for preventing post traumatic stress disorder (PTSD). *The Cochrane Database of Systematic Reviews*, (2), CD000560.



American Psychiatric Association Practice Guidelines

Practice Guideline for the Treatment of Patients With Acute Stress Disorder and Posttraumatic Stress Disorder

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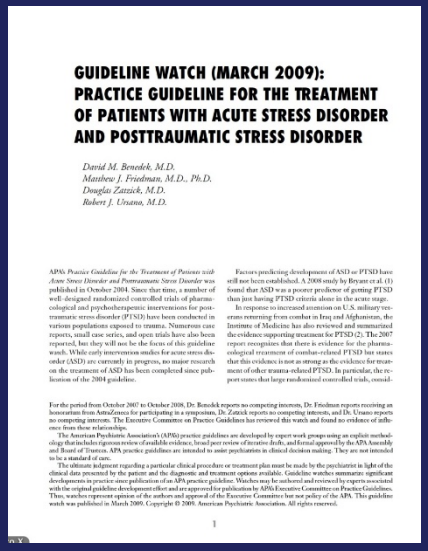
Developed under the auspices of the Steering Committee on Practice Guidelines. Successive drafts reviewed by APA components and members, as well as other interested individuals and organizations (see p. 45) and two members of the editorial board of *The American Journal of Psychiatry*. Approved by the APA Board of Trustees in June 2004 and published in November 2004.

Part A received by *The American Journal of Psychiatry* June 30, 2004; accepted July 16, 2004.





GUIDELINE WATCH (MARCH 2009): PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH ACUTE STRESS DISORDER AND POSTTRAUMATIC STRESS DISORDER

*David M. Benedek, M.D.*
*Matthew J. Friedman, M.D., Ph.D.*
*Douglas Zatzick, M.D.*
*Robert J. Ursano, M.D.*

APA's *Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder* was published in October 2004. Since that time, a number of well-designed randomized controlled trials of pharmacological and psychotherapeutic interventions for posttraumatic stress disorder (PTSD) have been conducted in various populations exposed to trauma. Numerous case reports, small case series, and open trials have also been reported, but they will not be the focus of this guideline watch. While early intervention studies for acute stress disorder (ASD) are currently in progress, no major research on the treatment of ASD has been completed since publication of the 2004 guideline.

Factors predicting development of ASD or PTSD have still not been established. A 2008 study by Bryant et al. (1) found that ASD was a poorer predictor of getting PTSD than just having PTSD criteria alone in the acute stage.

In response to increased attention on U.S. military veterans returning from combat in Iraq and Afghanistan, the Institute of Medicine has also reviewed and summarized the evidence supporting treatment for PTSD (2). The 2007 report recognizes that there is evidence for the pharmacological treatment of combat-related PTSD but states that this evidence is not as strong as the evidence for treatment of other trauma-related PTSD. In particular, the report states that large randomized controlled trials, consid-

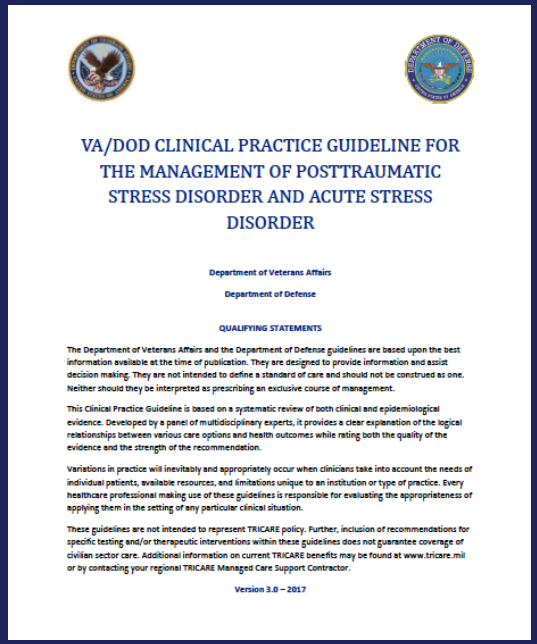
For the period from October 2007 to October 2008, Dr. Benedek reports no competing interests, Dr. Friedman reports receiving an honorarium from AstraZeneca for participating in a symposium, Dr. Zatzick reports no competing interests, and Dr. Ursano reports no competing interests. The Executive Committee on Practice Guidelines has reviewed this watch and found no evidence of influence from these relationships.

The American Psychiatric Association's (APA) practice guidelines are developed by expert work groups using an explicit methodology that includes rigorous review of available evidence, broad peer review of iterative drafts, and formal approval by the APA Assembly and Board of Trustees. APA practice guidelines are intended to assist psychiatrists in clinical decision making. They are not intended to be a standard of care.

The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available. Guideline watches summarize significant developments in practice since publication of an APA practice guideline. Watches may be authored and reviewed by experts associated with the original guideline development effort and are approved for publication by APA's Executive Committee on Practice Guidelines. Thus, watches represent opinion of the authors and approval of the Executive Committee but not policy of the APA. This guideline watch was published in March 2009.







VA/DOD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF POSTTRAUMATIC STRESS DISORDER AND ACUTE STRESS DISORDER

Department of Veterans Affairs

Department of Defense

QUALIFYING STATEMENTS

The Department of Veterans Affairs and the Department of Defense guidelines are based upon the best information available at the time of publication. They are designed to provide information and assist decision making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

This Clinical Practice Guideline is based on a systematic review of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

Variations in practice will inevitably and appropriately occur when clinicians take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.

These guidelines are not intended to represent TRICARE policy. Further, inclusion of recommendations for specific testing and/or therapeutic interventions within these guidelines does not guarantee coverage of civilian sector care. Additional information on current TRICARE benefits may be found at www.tricare.mil or by contacting your regional TRICARE Managed Care Support Contractor.

Version 3.0 – 2017

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CISD/CISM= Critical Incident Stress Debriefings/Management

# Psychological First Aid (PFA)

***The Five Elements:***

Sense of safety
Calming
Sense of Self- and Community Efficacy
Connectedness
Hope

**Landmark article:**
***Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence***
***Psychiatry, 70(4), 2007***
**Authors: Steven Hobfoll plus 19 other disaster mental health experts**


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Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., et al. (2007). Five essential elements of immediate and mid-term mass trauma intervention: empirical evidence. *Psychiatry*, *70*(4), 283–315–discussion 316–69.

# What is PFA?

- What it IS…
  - Analogous to other forms of “First Aid”
  - Population-based response “framework”
  - “Do no harm” approach; resilience vs. disease
- What it is NOT…
  - Cure or treatment for illness
- What it MAY be…
  - Mitigation strategy; reduce distress, decreases illness

# Basis for PFA

- Safety – decrease perceived threat
- Calming – reduce arousal/anxiety
- Efficacy – belief in one's ability to manage
- Connectedness – increase social support
- Hope / Optimism – better things are possible

# Safety

- It's the "C" in CAB for basic life support
- Enable people to correctly perceive future threat
- Get to a safe place and recognize is as safe
- Accurate information on continued threats
- Accurate information on safety of loved ones


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CAB= Circulation, Airway, Breathing

# Safety

- DC Sniper shootings 02-24 October 2002; survey May 2013
- 1204 random residents of Washington, DC and Maryland
- Phone survey; Response rate 56.4%
- Decreased safety >>> Increased PTSD, Depression, Alcohol use

**Table 2.** Perceived safety in community settings ($n$ = 1205, except for workplace category where $n$ = 876)

| Degree of safety | In neighborhood % (95% CI) | At workplace and surrounding area % (95% CI) | At other public places % (95% CI) | At gas stations % (95% CI) |
|---|---|---|---|---|
| A lot less safe | 21.5 (18.7–24.2) | 22.7 (19.2–26.1) | 30.6 (27.5–33.7) | 38.6 (35.4–41.9) |
| A little less safe | 35.7 (32.4–38.9) | 31.5 (27.9–35.4) | 35.3 (32.1–38.5) | 31.1 (27.9–34.2) |
| As safe as usual | 42.4 (39.0–45.8) | 45.6 (41.6–49.5) | 32.0 (28.8–35.2) | 26.8 (23.7–30.0) |
| "Don't know" and refusals | 0.5 | 0.2 | 2.1 | 3.5 |

CI, confidence interval.

Fullerton, C. S., Herberman Mash, H. B., Benevides, K. N., Morganstein, J. C.,& Ursano, R. J. (2015). Distress of Routine Activities and Perceived Safety Associated with Post-Traumatic Stress, Depression, and Alcohol Use: 2002 Washington, DC, Sniper Attacks. *Disaster Medicine and Public Health Preparedness*,*9*(5), 509–515.



Schulden, J., Chen, J., Kresnow, M.-J., Arias, I., Crosby, A., Mercy, J., et al. (2006). Psychological responses to the sniper attacks: Washington DC area, October 2002.*Amepre*,*31*(4), 324–327.

# Self & Community Efficacy

- Reinforce the belief that actions can lead to positive change
- Recognize existing skills to overcome threat and solve problems
- Facilitate connection to necessary resources
- Self-sufficiency and self-government
- Community conceived & implemented ideas (religious activities, meetings, rallies, rituals)


https://goodthinkinc.com/wp-content/uploads/2014/06/achievement_gauge.jpg

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# Self & Community Efficacy

- Community Collective Efficacy (CE) – "Willingness of community members to intervene for the common good."
  - 2,249 Florida DOH workers s/p 2004 Florida Hurricanes
  - Age, gender, marital status, storm damage/injury
  - CE, depression, PTSD
  - Higher CE a/w decreased Depression and Post Traumatic Stress Disorder (PTSD)

Fullerton, C. S., Ursano, R. J., Liu, X., McKibben, J.,&Wang, L. (2015). Depressive symptom severity and community collective efficacy following the 2004 Florida hurricanes.*PLoS ONE*. http://doi.org/10.1371/journal.pone.0130863.t002

Ursano, R. J., McKibben, J., Reissman, D. B.,&Liu, X. (2014). Posttraumatic stress disorder and community collective efficacy following the 2004 Florida hurricanes.*PLoS ONE*. http://doi.org/10.1371/journal.pone.0088467.t006

# Self & Community Efficacy

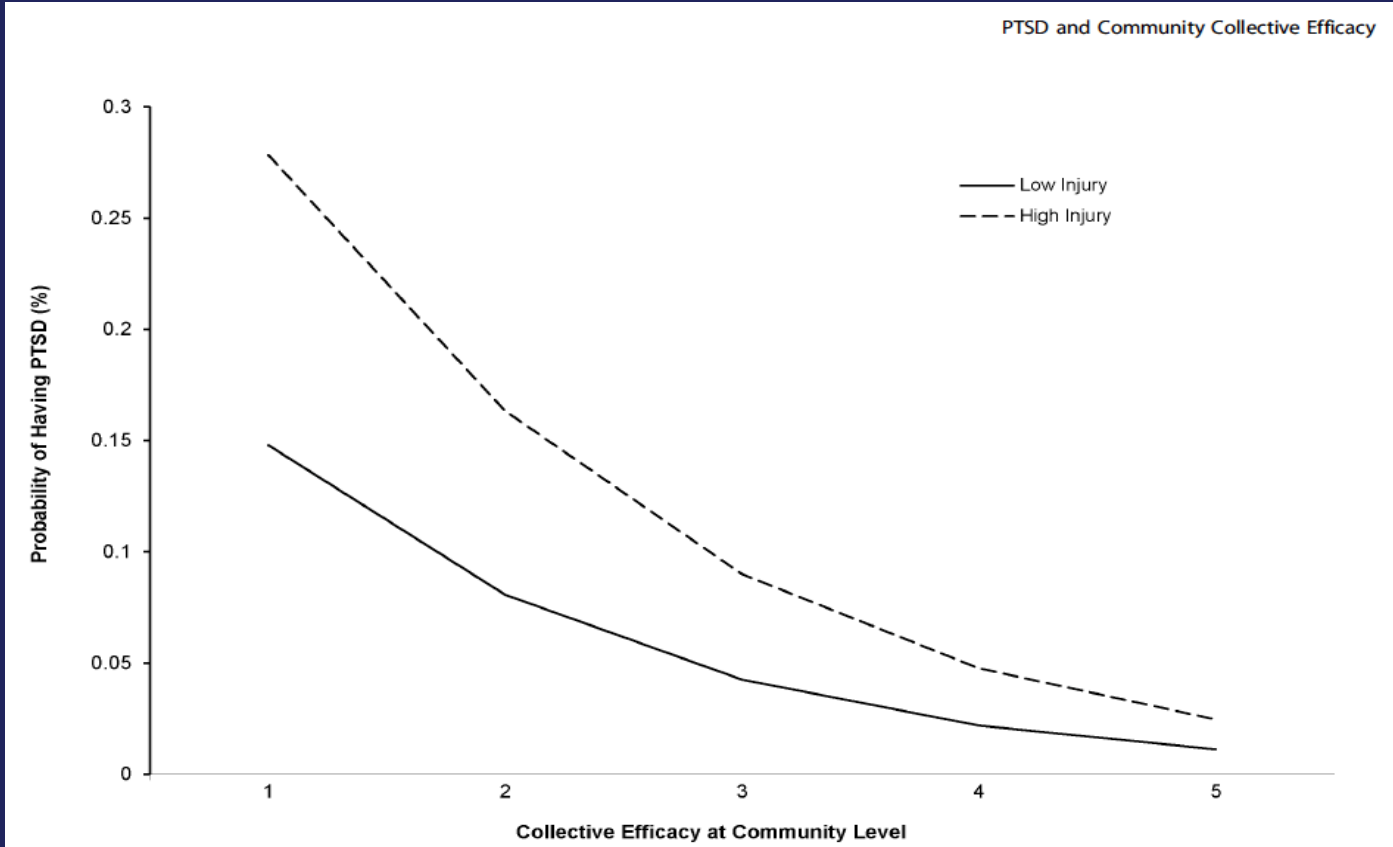


**Figure 1. Changes in probability of having PTSD over two injury/damage groups and five community-level efficacy levels.**
doi:10.1371/journal.pone.0088467.g001

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Ursano, R. J., McKibben, J., Reissman, D. B.,&Liu, X. (2014). Posttraumatic stress disorder and community collective efficacy following the 2004 Florida hurricanes.*PLoS ONE*. http://doi.org/10.1371/journal.pone.0088467.t006

# Calming

- Reduce physiologic arousal
- Promote realistic cognitive appraisal of situations and threats
- Problem-focused coping
- Grounding, breathing, relaxation
- Sleep hygiene +/- sleep aids
- Managing media exposure
- Psychoeducation: normal reactions & warning signs; health risk behaviors; where to get help

# Calming

- 1787 New York adults
- Multiple assessments post 9/11
- Study outcome = probable PTSD
- Exposure was hours watching the 9/11 "1-yr anniversary" media coverage

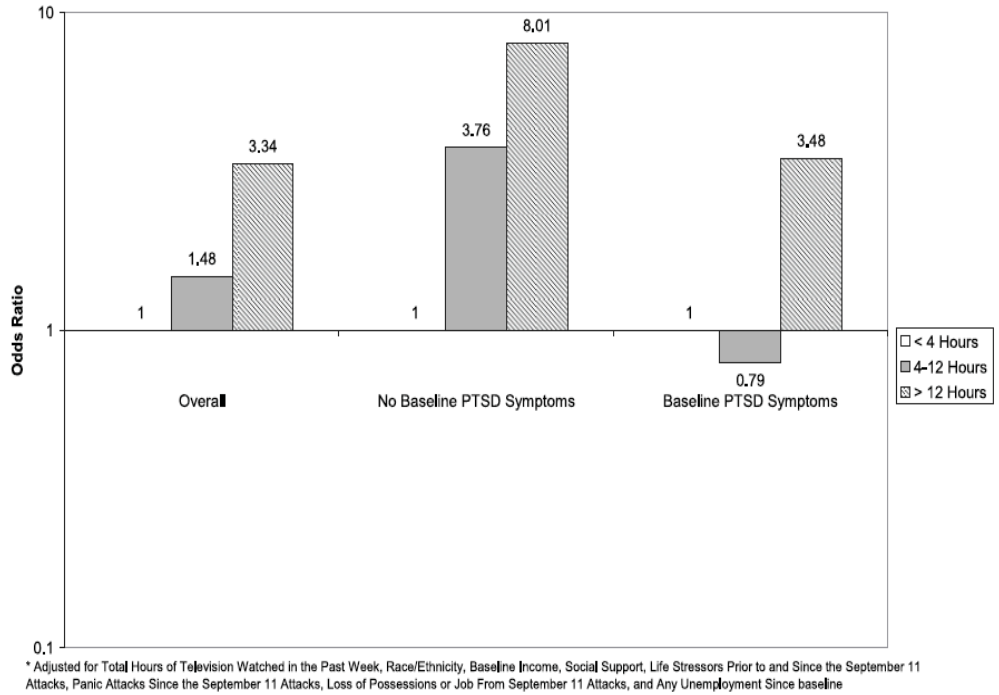


**FIGURE 1.** Odds ratios for the relation between hours of WTCD anniversary television viewing and new-onset probable PTSD in an adjusted model.*

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Bernstein, K. T., Ahern, J., Tracy, M., Boscarino, J. A., Vlahov, D.,& Galea, S. (2007). Television watching and the risk of incident probable posttraumatic stress disorder: a prospective evaluation. *The Journal of Nervous and Mental Disease*,*195*(1), 41–47.

# Social Connectedness

- Facilitate (re)connection with family/community
- Allows for:
  - Emotional understanding
  - Shared problem solving
  - Mutual instruction on coping
- Positive vs. negative support

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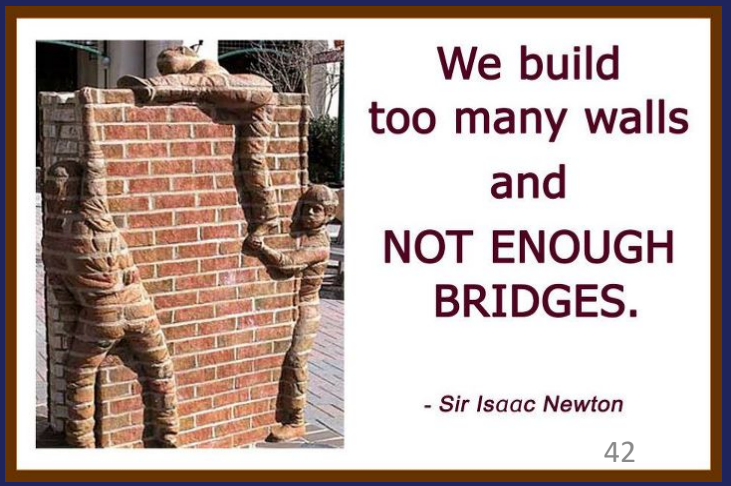
https://www.sciencebuzz.com/wp-content/uploads/2018/02/What-drives-cooperative-breeding1-850x425.jpg

# Social Connectedness

- Discuss support-seeking
  - Identify possible support persons
  - Discuss what to do/talk about
  - Explore reluctance to seek support
- Promote reconstitution of pre-existing social structures or new equivalents
- Address extreme isolation

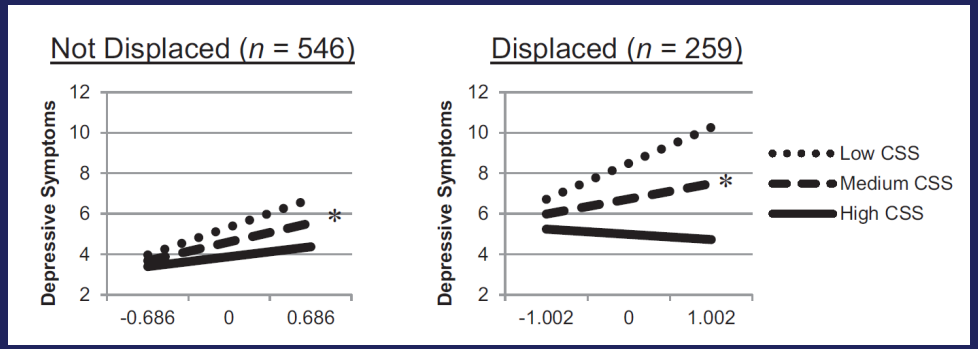



https://i.pinimg.com/originals/d8/4b/16/d84b16e8c9ca980de80d1ffdb3340afd.jpg

# Social Connectedness

- Hurricane Katrina
- 810 adults surveyed
- 18-24 months after
- Stronger social support (Crisis Support Survey) at 2 months associated with lower depressive symptoms for same exposure

https://www.history.com/.image/c_limit%2Ccs_srgb%2Cfl_progressive%2Ch_2000%2Cq_auto:good%2Cw_2000/MTU4MDczOTQxNTc4MTYzNzE2/10-hurricane-katrina-54243759.jpg

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McGuire AP, et al. Social Support Moderates Effects of Natural Disaster Exposure on Depression and Posttraumatic Stress Disorder Symptoms: Effects for Displaced and Nondisplaced Residents. *J Trauma Stress*. 2018 Apr;31(2):223-233.

# Hope & Optimism

- Activities that restore a sense of “normal”
- “I’m here. You’re not crazy. Things will get better.”
- De-catastrophizing
- Develop/publicize problem-solving programs
- Support rebuilding of local economies
- Role for community leaders:
  - Encourage link-up w/ resources, cooperation
  - Coping behaviors & hope thru role modeling
  - Memorializing and creating meaning
  - Accepting necessary life & environmental changes

# Hope & Optimism

- 2011 Tornado outbreak in Mississippi & Alabama
- 3,216 participants
- Examine relationship between:
  - Optimism
  - Quality of Life self-report
  - Mental Health outcomes
- Increased optimism ->
  - Improved Quality of Life (QOL)
  - Decreased  Depression
  - Decreased PTSD

https://oceanservice.noaa.gov/news/weeklynews/may11/tornado.jpg


https://www.weather.gov/images/safety/phil_campbell_al2011-noaa-txt.png

Carbone, E. G., & Echols, E. T. (2017). Effects of optimism on recovery and mental health after a tornado outbreak. *Psychology & Health*, *32*(5), 530–548.

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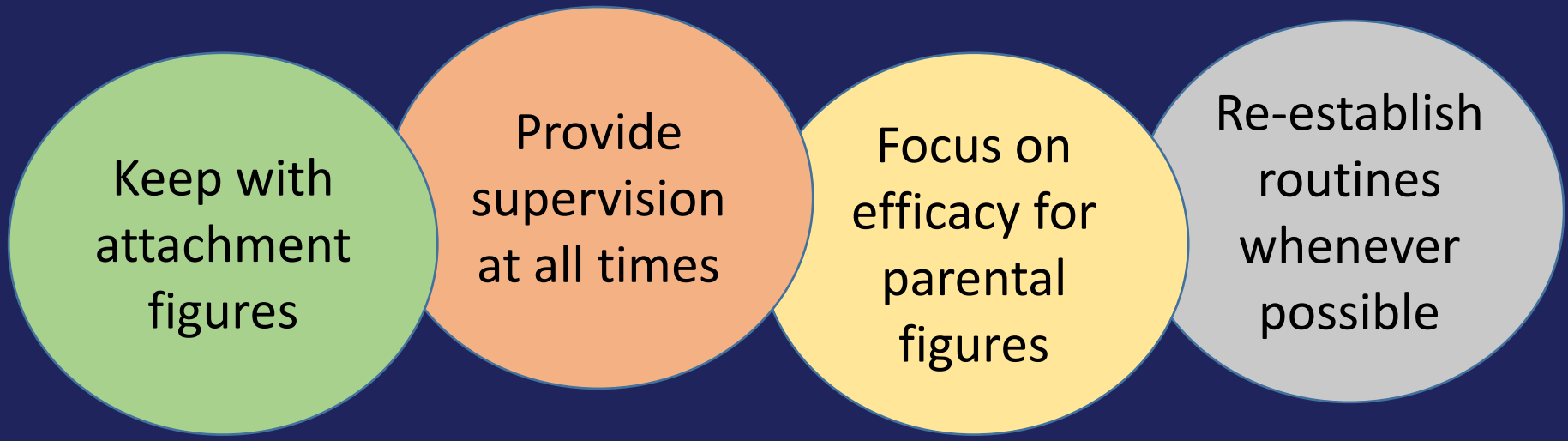
# PFA for Children & Adolescents

- Developmentally appropriate
- Needs may be less clear (behaviors >>> words)
- Heavily impacted by parental well-being

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https://www.nctsn.org/what-is-child-trauma/trauma-types/disasters

# Mobile Resource

- PFA Mobile app (Free)
  - Summaries of the 8 core PFA actions
  - Match PFA interventions to specific stress reactions of survivors
  - Get mentor tips for applying PFA in the field
  - Self-assess to determine your own readiness to conduct PFA
  - Assess and track victims' needs to simplify data collection and referrals


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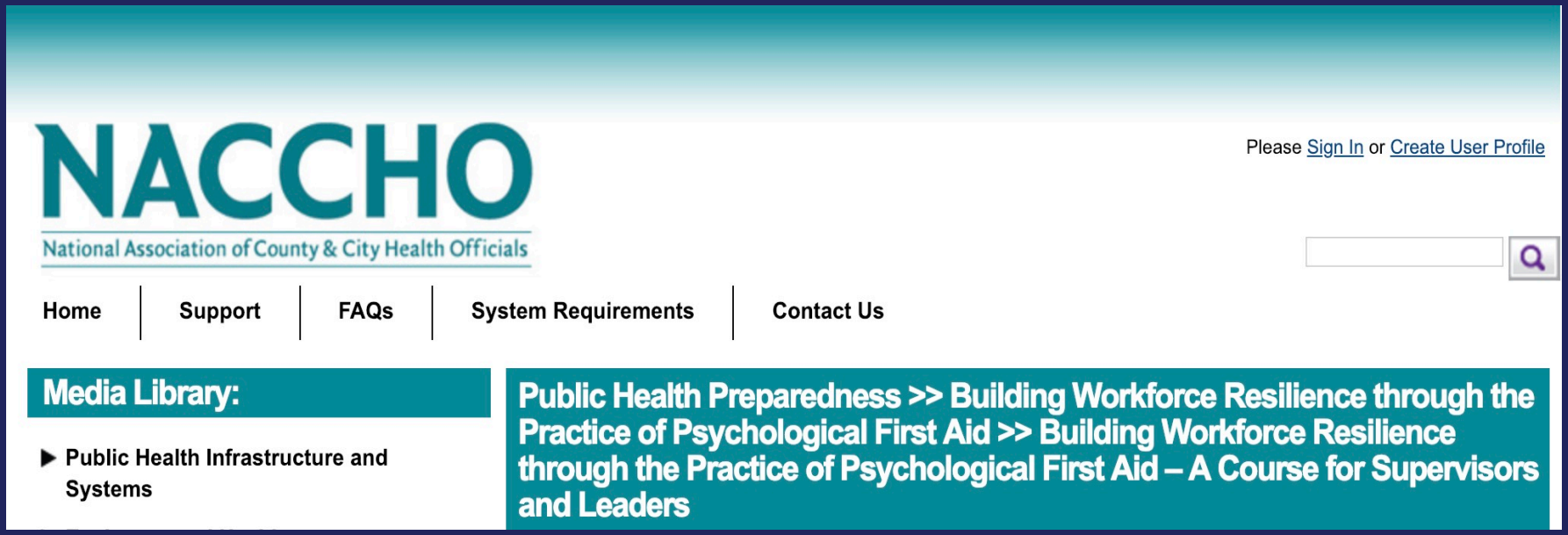
https://www.ptsd.va.gov/professional/materials/apps/pfa_mobile_app.asp

# Leadership PFA Resource

- PFA Training for Leaders and Supervisors




https://live.blueskybroadcast.com/bsb/client/CL_DEFAULT.asp?Client=354947&PCAT=7365&CAT=9403

# Immediately following a mass shooting at a mall, first responders gather a group of people without injuries. What is the most helpful intervention s/he could do at this time?

A. Ask each member of the group to describe their current emotional state.
B. Reassure the group that the shooter has been stopped and there is no further threat.
C. This group does not need attention as they have no injuries.
D. Lead the group in a session of relaxation breathing.

# Communication

"Better than any medication we know, information treats anxiety in a crisis."

*Source: Saathoff, 2002*

Communication is a behavioral health intervention

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# Communication - Rationale

The behavioral choices people make to stay in place, evacuate, seek or not seek medical care, search for loved ones, etc. *are very real life and death decisions*.

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Reynolds, B. S., & Seeger, M. (2012). Crisis and Emergency Risk Communication. Centers for Disease Control and Prevention

# Communication - Focus

***What People Want*** **To Know**
**In Addition To**
***What We Want*** **Them To Know**

**"Therapeutic rapport" on a population level**

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# Leadership Consultation

- Grief Leadership - Anticipate, identify, support
- Stress Management - ”Your own oxygen mask first”
- Communication - What, when, how

Birkeland, M. S., Nielsen, M. B., Knardahl, S., & Heir, T. (2015). Time-lagged relationships between leadership behaviors and psychological distress after a workplace terrorist attack. *International Archives of Occupational and Environmental Health*.

Jones, N., Seddon, R., Fear, N. T., McAllister, P., Wessely, S., & Greenberg, N. (2012). Leadership, cohesion, morale, and the mental health of UK Armed Forces in Afghanistan. *Psychiatry*, *75*(1), 49–59. http://doi.org/10.1521/psyc.2012.75.1.49

# PREPAREDNESS: PROVIDERS & PATIENTS

"Fortune favors the prepared mind."
- Louie Pasteur

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# Disaster Behavioral Health Curriculum

*Published 01/14*

NCDMPH National Center for Disaster Medicine & Public Health

Uniformed Services University of the Health Sciences

CSTS Center for the Study of Traumatic Stress

## Curriculum Recommendations for Disaster Health Professionals
## Disaster Behavioral Health

**Authors**
Brian W. Flynn, Ed.D., RADM, USPHS, Ret., Associate Director, Center for the Study of Traumatic Stress, Adjunct Professor, Department of Psychiatry, Uniformed Services University of the Health Sciences
Joshua C. Morganstein, MD, CDR, USPHS, Scientist, Center for the Study of Traumatic Stress, Assistant Professor, Department of Psychiatry, Uniformed Services University of the Health Sciences

**Target Audience:** Educators and trainers working with health professionals
**Purpose:** To plan education and training activities on behavioral health factors in disasters

### Introduction

The world has long been aware that a wide variety of extreme events produce psychological, social, and biological sequelae that today we label with terms such as stress, trauma, grief, and bereavement. These consequences are visited upon individuals, families, workplaces, schools, communities, and nations. They can result from a wide variety of causal factors that are both natural, human-generated or a combination of both.

For the purposes of this document, focus will be on the general topic of exposure to disasters. Disasters are defined as extreme events in which needs of the impacted population and/or area exceeds the local response and recovery resources and external resources must be utilized. Disasters can include such naturally occurring events such as floods, hurricane, fires, tsunamis, epidemics, and pandemics. They can also be human generated in terrorism, war, community unrest, mass shootings, and industrial accidents. Some disasters involve both natural and human-generated elements. Examples include a plane crash caused by wind shear, a flood caused by a dam collapse, or a wildfire sparked by an arsonist.

The field of disaster behavioral health continues to evolve following the classic paradigm of synergistic interactions among research, training, and services (Figure 1). Fundamentally the questions driving the field are:

- What do we know about the individual and collective impact of disasters?
- What approaches and interventions, to accomplish what, provided by whom, and in what contexts are most efficacious?
- How can we ensure that those involved in disaster preparedness, response, and recovery have the knowledge and skills necessary to produce optimal results?

**Figure 1**



1

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https://ncdmph.usuhs.edu/Documents/BehavioralHealthRecommendations-201401.pdf

# Disaster Behavioral Health Education Fact Sheets


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https://www.cstsonline.org/fact-sheet-menu/fact-sheet-search

# Mobile Resource

- SAMHSA Behavioral Health Disaster Response app (Free)
  - Pre-event preparation, on-the-ground assistance, post-event resources, more
  - Share resources (like tips for helping survivors cope) with others
  - Find local behavioral health services
  - Self-care support for responders


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http://store.samhsa.gov/apps/disaster

# Preparing an Organization

- Clarify your role(s)
  - Treatment, Leadership Consultation
- Organizational management
  - American Psychological Association (APA) District Branch, Non Profit Organization (NPO), other
  - Internal Expertise, Clear Messaging
- Establish partnerships
  - Healthcare, Aid / Relief Organizations
  - Community Services
- Disaster exercises/drills

# Readying Your Practice

- Identify most vulnerable patients
- Ensure adequate medication supply
- Safety of & access to health records
- Contact info for patients/personnel after disaster
- Establish links w/ primary & emergency care
- Disaster exercises/drills

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# Individual Preparedness (Patients & Providers)

- Develop / practice Family Emergency Plan
- Know Work / School Emergency Plans
- Have / use trusted sources of information
- "Emergency Go Kit"
  - http://www.redcross.org/get-help/prepare-for-emergencies/be-red-cross-ready/get-a-kit


**Not an endorsement, an option!!!**

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# Key Takeaways

- Increasing frequency of human-generated and natural disasters increase the need for disaster mental health care
- Distress reactions and health risk behaviors predominate after disaster
- Early interventions reduce adverse impacts for individuals and communities
- Education & preparation decrease distress and enhance effectiveness of community response and recovery

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# QUESTIONS

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# How to Obtain CE Credits

**To receive continuing education credit (CE), you must complete the program posttest and evaluation for each session of the event. The posttests and evaluations will be available through 3 October 2019 at 2359 ET. Please complete the following steps to obtain CE credit:**

1. Go to URL https://www.dhaj7-cepo.com/content/august-2019-dha-clinical-communities-speaker-series
2. Click on the REGISTER/TAKE COURSE tab.
    a. If you have previously used the CEPO LMS, click login.
    b. If you have not previously used the CEPO LMS click register to create a new account.
3. Verify, correct, or add your profile information.
4. Follow the onscreen prompts to complete the post-activity assessments:
    a. Read the Accreditation Statement
    b. Complete the Evaluation
    c. Take the Posttest
5. After completing the posttest at 80% or above, your credits will be recorded in the LMS. In addition, you will be able to print or download your certificate. Repeat this process for each session you wish to claim CE Credit.
6. You can return to the site at any time in the future to print your certificate and transcripts at https://www.dhaj7-cepo.com/
7. If you require further support, please contact us at dha.ncr.j7.mbx.cepo-lms-support@mail.mil