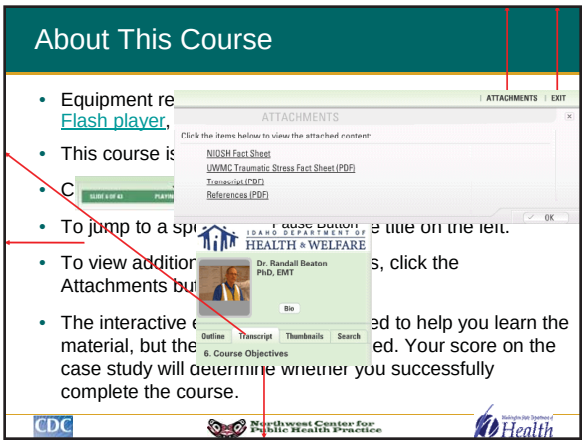
Disaster Behavioral Health: Tools and Resources for Washington State Health Professionals

Transcript

Slide 1



Welcome! Before you get started with this online course, here are a few things you'll need to know about the format and navigation. To access this online course, you need a computer with internet access and the free Flash player installed in your browser. Most browsers already have this player installed. Since this course has an audio narration, you'll also need computer speakers or headphones. The presentation is self playing, it will continue from one screen to the next unless you click the pause button located at the bottom of the screen. To resume the presentation, click the button again. Click the transcript button to see a text version of the audio narration.

If you want to jump to a specific screen, click its title in the left navigation bar.

To view additional links and materials associated with this course, click the Attachments button at the top of the screen.

There are several interactive exercises within this course that are designed to help you learn the material. Your score on these exercises is not tracked or viewed by anyone but yourself. However, your score on the final assessment (that is, the case study) will determine whether you successfully complete the course.

Slide 2

This course was developed by the Northwest Center for Public Health Practice in collaboration with the Centers for Disease Control and Prevention (CDC) and the Washington State Department of Health. The course was accredited by the CDC from July 15, 2006 until July 14, 2009. If you would like to read the accreditation statement, please pause this presentation and click the link.

Participants in this course may apply for CME, CNE, CEU, or CHES credits from the CDC. To obtain CE credits, you must complete the course and earn a passing score of 70% or higher on the final assessment (called the case study). You must also fill out the course questionnaire, and complete the CDC evaluation and application.

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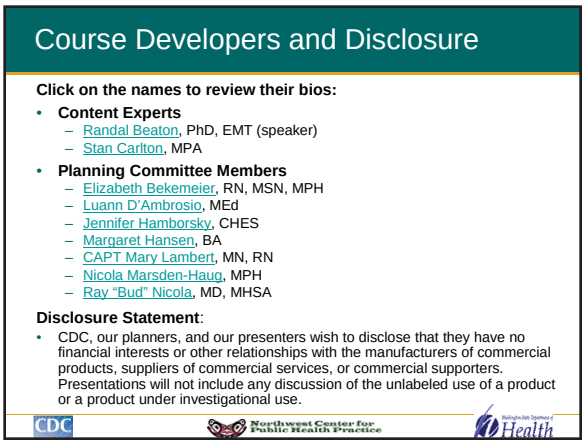
Slide 3

Dr. Randal Beaton was the primary content developer for this module. Stan Carlton, who works for the Mental Health Division of the Washington Department of Social and Health Services, also helped develop some of the content specific to Washington state.

If you would like to read their bios or the bios of any member of the planning committee, please pause this presentation and click the links.

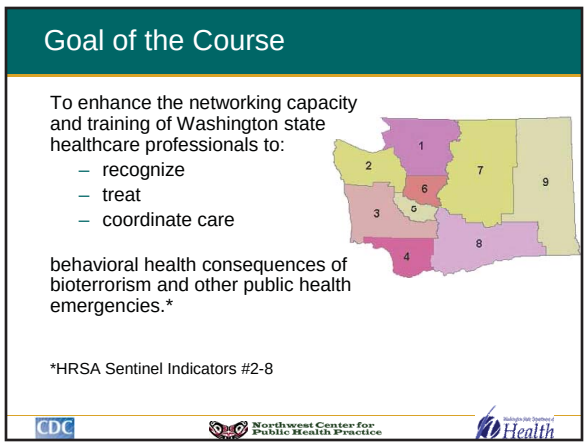


Slide 4

Hello. Welcome to the Disaster Behavior Health Online Module: Tools and Resources for Washington State Health Professionals. I am Randal Beaton, your course instructor.

Slide 5

The goal of this online course is to enhance the networking capacity and training of Washington state healthcare professionals to recognize, treat, and coordinate care of those with behavioral health consequences of bioterrorism and other public health emergencies.



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Slide 6

Before we get underway with this online module I'd like to give you a little bit of background information about myself. I am Randal Beaton, Research Professor at the Schools of Nursing and Public Health and Community Medicine, as well as Faculty Member at the Northwest Center for Public Health Practice at the University of Washington. I have a Ph.D. in psychology and am also a volunteer emergency medical technician.

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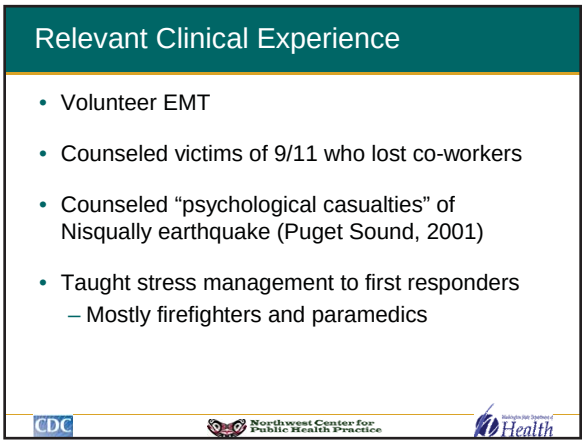
As a volunteer EMT, I've been on the scene of a number of emergencies. However it is important to note that emergencies and disasters differ in a number of important respects. For example, disasters are much larger in scope and also require different kinds of approaches in terms of planning and also treatment. For example, in counseling victims of 9/11 who lost coworkers and counseling the "psychological casualties" of the Nisqually earthquake here in Puget Sound in 2001 group crisis counseling was offered. Finally, in my private practice, I also teach stress management to first responders, primarily firefighters and paramedics who must cope with inordinate amounts of stress.



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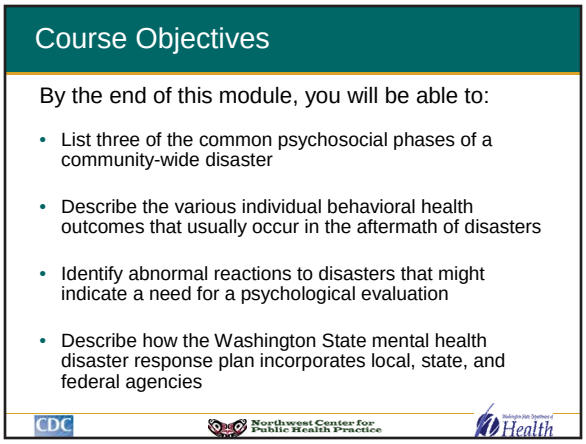
By the end of this module, you will be able to:

- List three of the common psychosocial phases of a community-wide disaster,
- Describe the various individual behavioral health outcomes that usually occur in the aftermath of disasters,
- Identify abnormal reactions to disasters that might indicate the need for a psychological evaluation, and



Transcript

- Describe how the Washington State Mental Health Disaster Response Plan incorporates local, state, and federal agencies.

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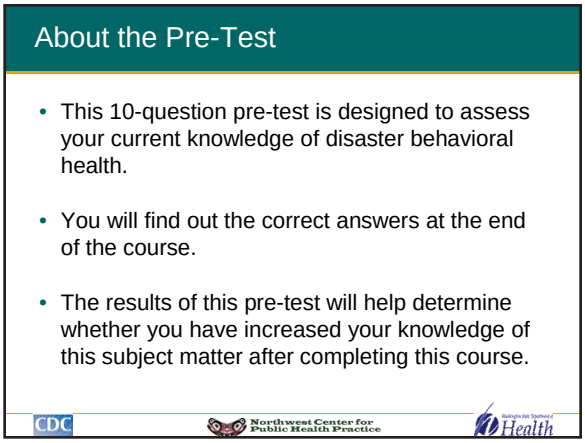
A pretest is coming up and is designed to test your current knowledge of behavioral health. You will find out the correct answers to this test at the end of the course. The results of this pre-test will help you to determine whether you have increased your knowledge of this subject matter after completing this course.



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Pre-test.

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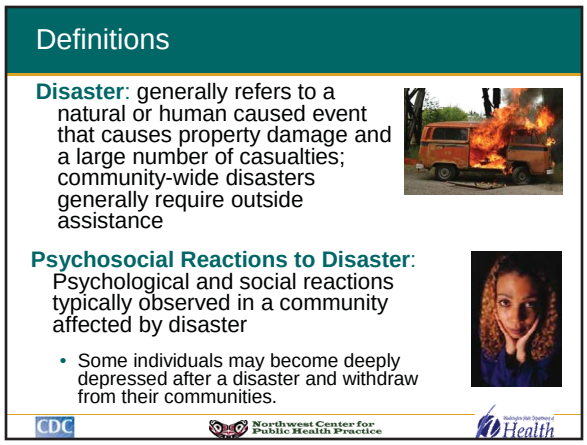
First, some definitions. Disasters generally refer to a natural or human-caused event that results in extensive property damage and a large number of casualties. Community-wide disasters, according to FEMA, generally require outside assistance.

Psychosocial reactions to disaster include the psychological and social reactions typically observed in a community affected by a disaster. For example, some individuals may become deeply depressed after a disaster and may withdraw from their communities. Other people may be completely hopeless in the aftermath of disaster, and some may become very angry.



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Disasters can and do affect the psychological, behavioral, emotional, and cognitive functioning of disaster victims, rescue workers, first responders, and first receivers. First responders include fire, police, and medic personnel on scene of a disaster

and first receivers refers to hospital personnel at emergency departments at nearby medical centers and clinics.

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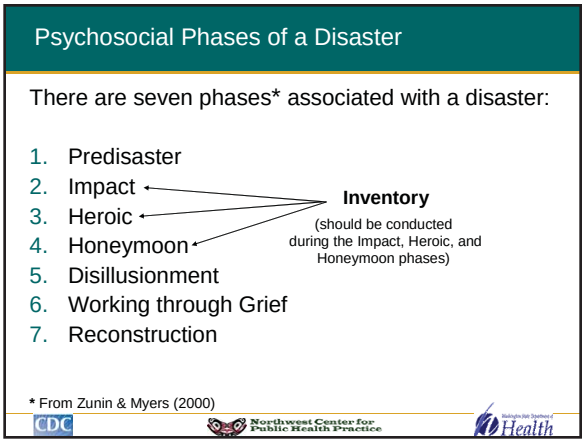
There are seven distinct psychosocial phases of a disaster according to Zunin and Myers: the Predisaster Phase, the Impact Phase, the Heroic Phase, the Honeymoon Phase, the Disillusionment, Working through Grief, and, finally, the Reconstruction Phase.

An inventory of community-wide needs needs to be conducted during the impact, heroic, and honeymoon phases. The Disaster Behavioral Health Specialists Team members need to conduct this inventory, and it is conducted early on to project the community-wide needs during the Disillusionment, Working through the Grief, and the Reconstruction Phases.



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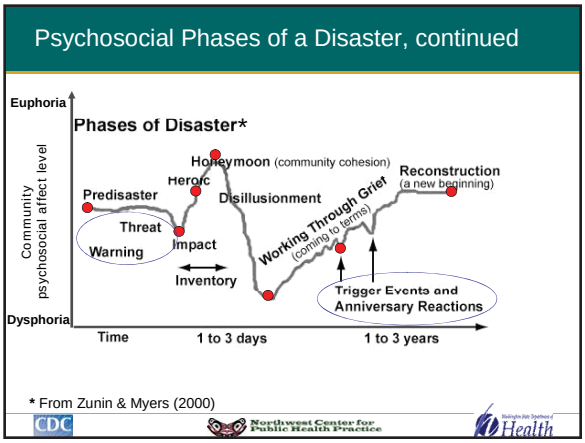
This figure highlights the psychosocial phases of a disaster according to Zunin and Myers and indicates the Predisaster, Impact, Heroic, Honeymoon, Disillusionment, Working through Grief, and the Reconstruction Phase. It also indicates that during the Predisaster Phase there may be warnings or threats and during the Working through Grief Phase there may be trigger events and anniversary reactions. These will be discussed in some detail in upcoming slides.



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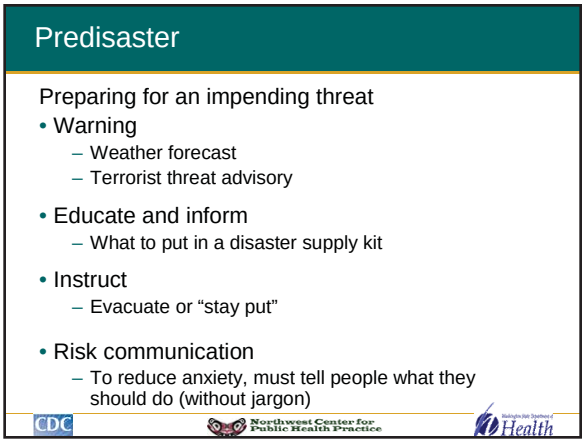
During the Predisaster Phase, public health and other health care workers and authorities have a number of distinct responsibilities and duties, for example to issue a warning such as a weather forecast or a terrorist threat advisory. Also during the



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Predisaster Phase is the time to educate and inform the public. For example you may want to tell the public what they should put in their disaster supply kit. Also this is the time to instruct the public, for example whether to evacuate or stay put. And finally, risk communication, which is focused on the imminent threat. To reduce anxiety it is also important to tell people what to do about the impending threat.

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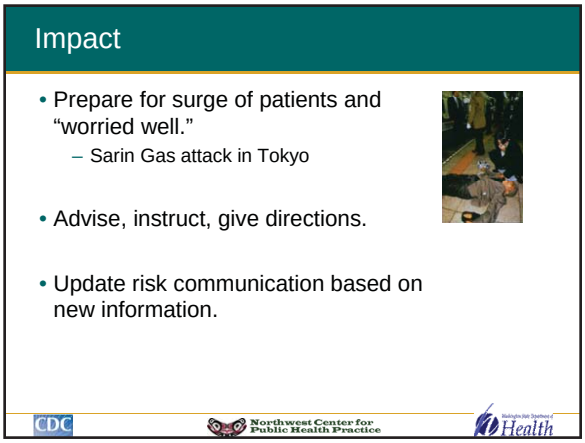
During the Impact Phase the disaster itself occurs. Now is the time to prepare for the initial surge of patients, and, in certain types disasters such as chemical and bio events, the "worried well." For example, in the sarin gas attack on the Tokyo subway in 1995 there were four times as many "worried well" victims, who thought that they were exposed to the neurotoxic agent, compared to those who actually were. During this phase it is also time for leadership to advise, to instruct, and to give very clear directions to those in the community. Finally, this is a time to update risk communication as new information becomes available.



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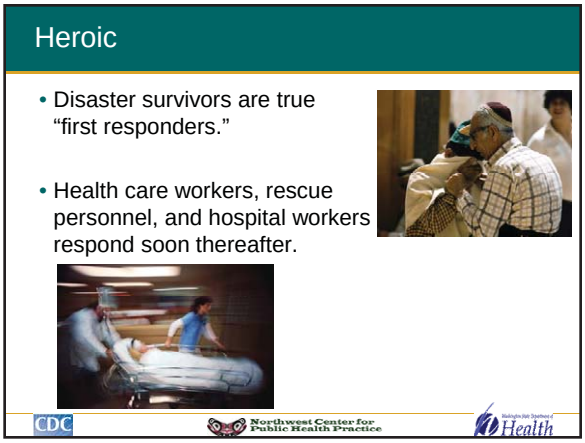
The Heroic Phase begins in the immediate aftermath of a disaster. In many cases the disaster survivors themselves are true first responders, who rise to the occasion and provide aid and assistance to disaster victims in their communities. Thereafter, health care workers, rescue personnel, and hospital workers in nearby receiving hospitals are called into action.



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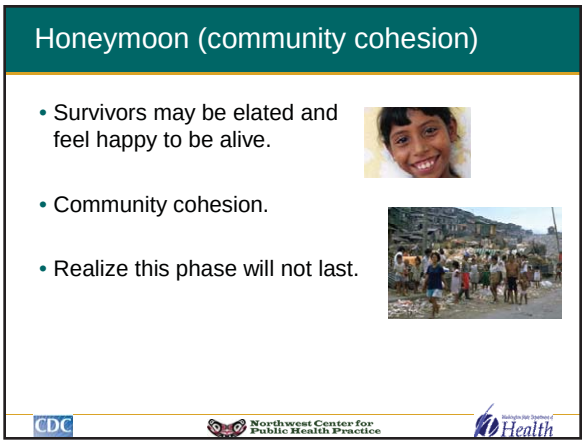
Following the Heroic Phase, the Honeymoon Phase ensues. During this phase survivors may be elated and, really, just happy to be alive. During this phase there is a great deal of community coming together and community cohesion. In general this phase is short-lived.



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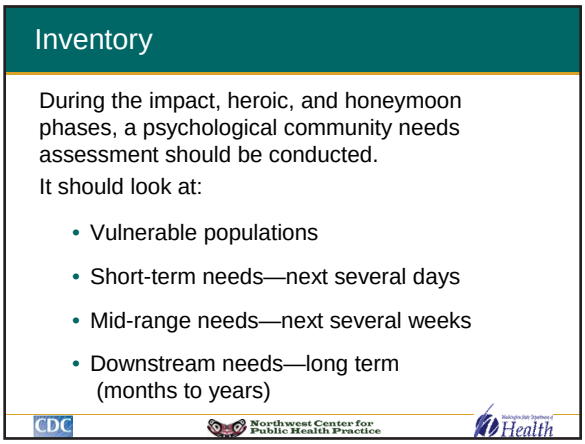
As soon as it is feasible during the Impact, Heroic, and Honeymoon Phases, a psychological community needs assessment should be conducted. This inventory should be conducted by the disaster behavioral health specialists as part of the disaster response team and should look at vulnerable members of the community and likely psychological needs of community members in general on a short term basis over the first few days following a disaster, also looking at mid-range needs over the first several weeks following a disaster, and finally also projecting downstream needs, that is long-term needs months and years following the disaster.



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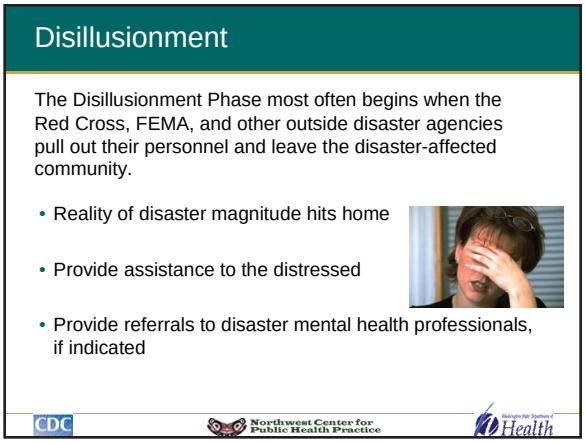
The Disillusionment Phase most often begins when the Red Cross, FEMA, and other disaster relief agencies pull out their personnel and leave the disaster-affected community. It is at this stage that the reality of the disaster magnitude really hits home. This is the phase to provide disaster relief counseling to those who might be depressed and also to provide referrals to disaster mental health professionals, if indicated.



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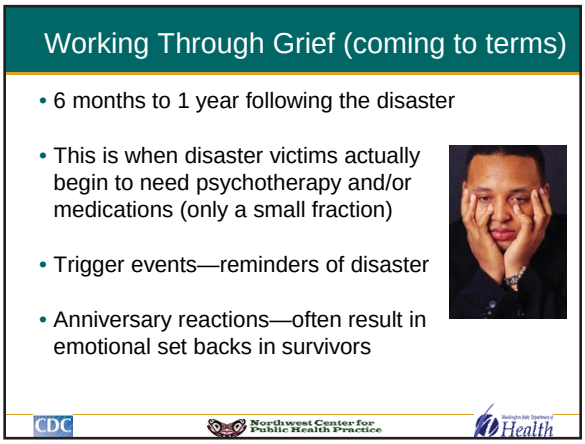

The next phase is referred to as the Working through the Grief Phase, in which disaster-affected community members come to terms with their losses. This may require six months or a year or even longer following a disaster. It is at this stage that disaster victims begin to need psychotherapy and/or medications. In the vast majority of disasters only a small fraction of disaster victims actually need or will seek out psychotherapy.

It is also at this phase that there may be trigger events—reminders of the disaster. For example, in survivors of a hurricane the sound of the wind may serve as a trigger event. There also may be anniversary reactions. For example, one calendar year following a disaster there may be an emotional setback related to this anniversary.

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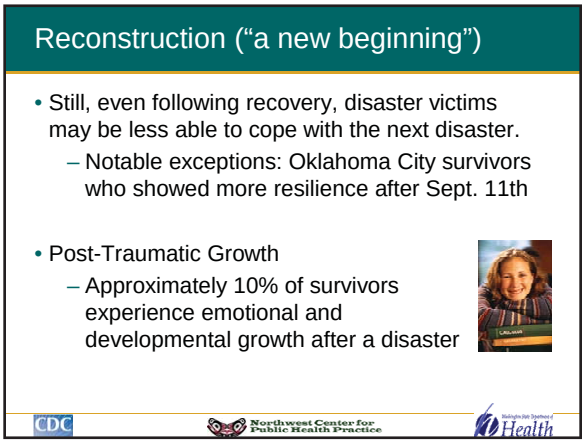

The last disaster phase is referred to as Reconstruction or "a new beginning." Still, even following recovery from a disaster, at this stage most disaster victims may be less able to cope with the next disaster. There are, however, some notable exceptions. There are reports that community members in Oklahoma City in the aftermath of the Oklahoma City bombings were more resilient and showed fewer symptoms in the aftermath of the 9/11 attacks than community members in other parts of the country.

It is also worth noting that there is the potential for post-traumatic growth in the aftermath of a disaster. Approximately 10% of disaster survivors actually experience emotional and developmental growth following a disaster.

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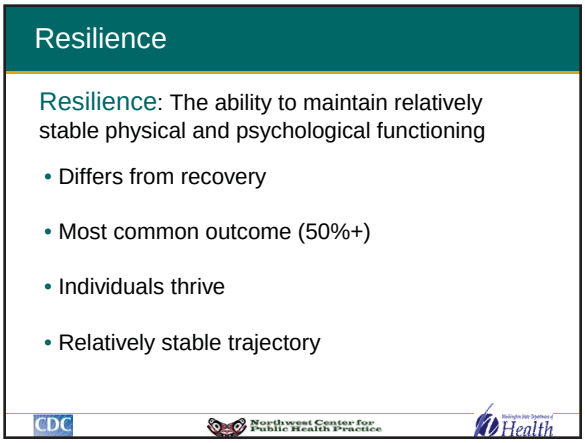
Let us first consider the most common outcome in the aftermath of disaster, namely that of resilience. Here we see the ability of disaster survivors to maintain relatively stable physical and psychological functioning. This differs from recovery; individuals are actually able to thrive, and there is a relatively stable trajectory over time.



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Interactive Exercise 1.

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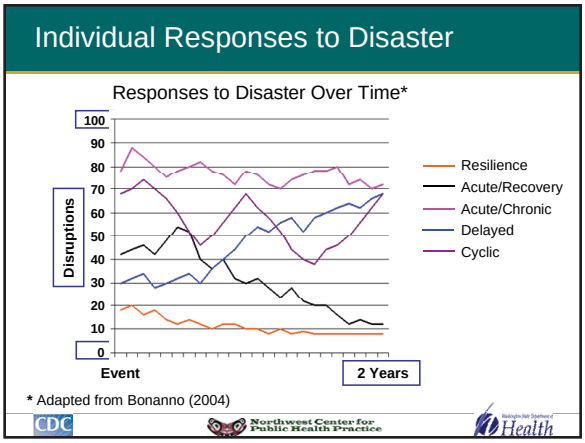
The next section of this online module deals with individual responses to disaster. This figure is adapted from Bonanno (2004) and looks over a time frame of two years from a disaster event and also looks at disruptions in a survivors behavior, from 100, which is complete disruption, to zero, which is no disruption. The first pattern that we are going to see here is resilience, where there is very little reaction and essentially a stable trend over time. The next reaction shows an acute reaction, some disruption, followed by rapid recovery. The next pattern shows and acute reaction, followed by a persisting or a chronic reaction. The next pattern, in blue, is a delayed onset reaction, for example delayed post traumatic stress disorder. And finally, a cyclic reaction, where an individual cycles in and out of a distress based on their disaster experience.



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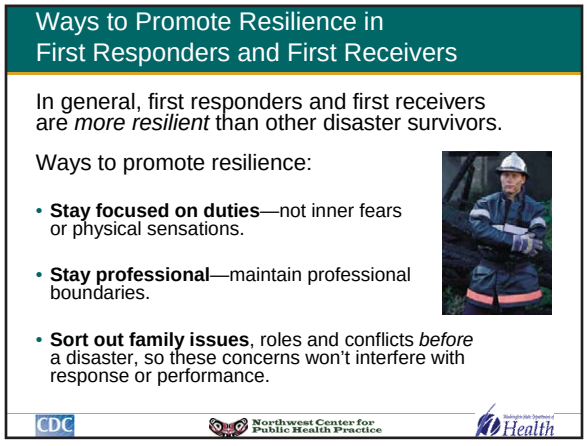
Let's now consider ways to promote resilience in first responders and first receivers. In general, first responders and first receivers are more resilient than other disaster survivor groups. Still, here are some ways to promote resilience. Stay focused on your duties—not on your inner fears or physical sensations. Stay professional—maintain your



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professional boundaries. Sort out family issues, roles, and conflicts before a disaster so these concerns won't interfere or distract from your performance.

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Here are some additional ways to promote resilience in first responders and first receivers. Drill, drill, drill; automatic, overlearned responses can be recalled under stress. Drilling also instills confidence. Self-talk: saying to yourself " I will survive" versus "I'll never get past this." And finally, the importance of social support. Co-worker camaraderie—especially in the aftermath of a disaster—seems to partially buffer the risk associated with the disaster response.

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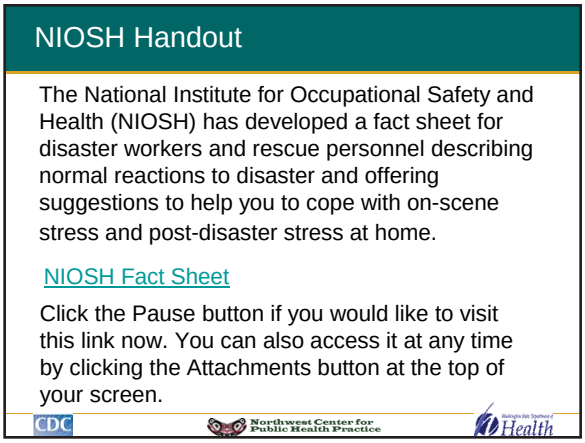
The National Institute for Occupational Safety and Health has developed a fact sheet for disaster workers and rescue personnel describing normal reactions to disasters and also offering concrete suggestions to help you to cope with on-scene stress and post-disaster stress at home. You can link to the NIOSH fact sheet below.



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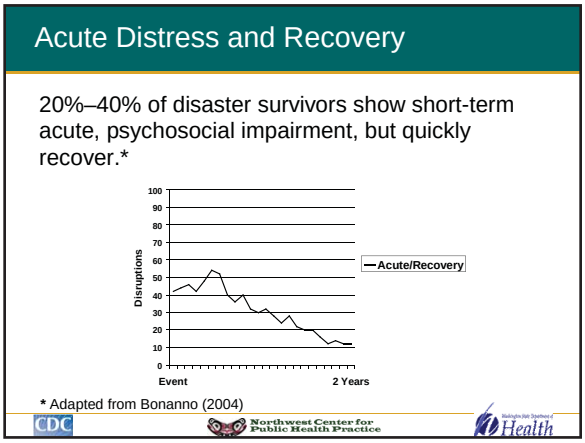
Interactive Exercise 2.

Slide 30

Approximately 40 percent of disaster survivors show short-term, acute psychosocial impairment but quickly recover. This pattern, referred to as acute distress and recovery, is the next most frequently observed pattern in disaster survivors after resilience.



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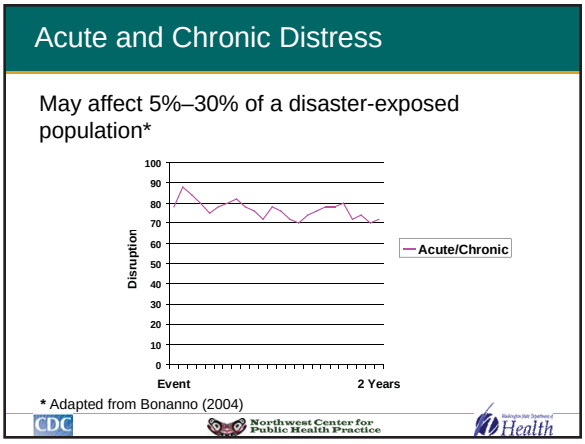
As few as five percent and upwards of 30 percent of a disaster-exposed population may experience both short-term and long-term disruptions to their behavior. This pattern, referred to as acute and chronic distress, while relatively rare, results in allocation of the lion's share of psychosocial resources in the aftermath of a disaster.



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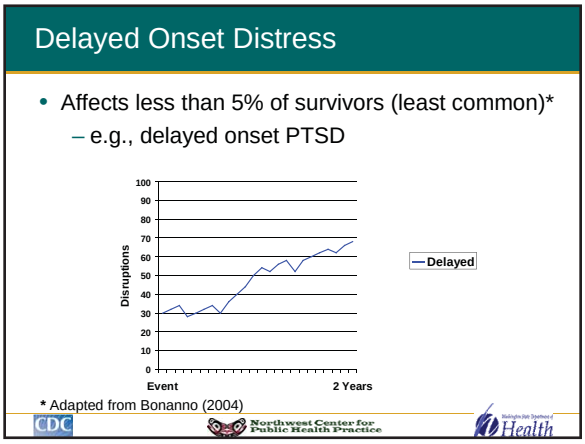
Finally, the least common pattern observed in disaster survivors is that of delayed onset distress. Generally this pattern affects less than five percent of survivors. An example would be delayed onset post-traumatic stress disorder.



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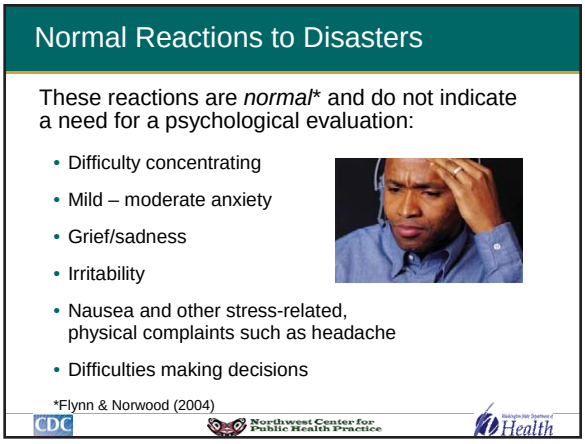
Next, let us consider some normal reactions to disasters. The following reactions are normal and do not indicate a need for psychological evaluation: difficulty concentrating, mild to moderate level anxiety, grief and sadness, irritability, nausea and other stress-related physical complaints, such as headaches, and difficulties making decisions.



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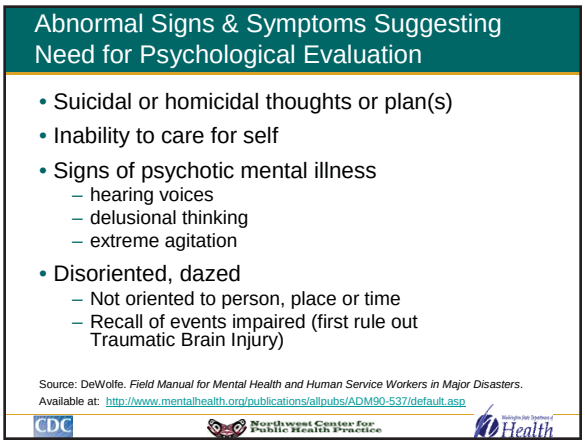
The following signs and symptoms are abnormal and suggest the need for psychological evaluation of a disaster victim: suicidal or homicidal thoughts or plans,; an inability to care for oneself; signs of psychotic mental illness, such as hearing voices, delusional thinking, extreme agitation; also disorientation, someone who is not oriented to person, place, or time; and someone who is displaying amnesia or difficulty recalling events (here it would be important to first rule out Traumatic Brain Injury).



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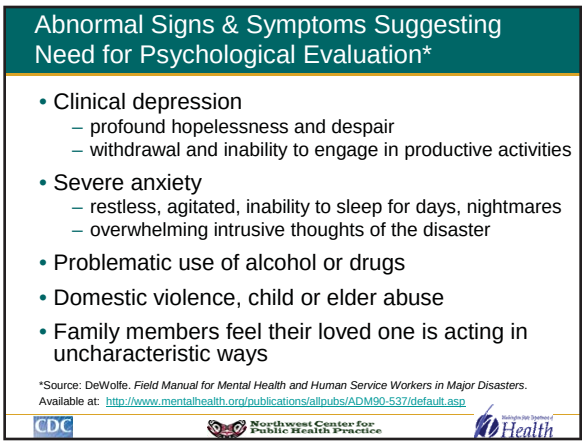
The following are some other signs and symptoms suggesting the need for psychological evaluation: clinical depression, with profound hopelessness and despair [or with] withdrawal and an inability to engage in productive activities; severe anxiety, with restlessness, agitation, inability to sleep for days, and nightmares [or with] overwhelming, intrusive thoughts of the disaster; problematic use of alcohol or drugs; domestic violence, child or elder abuse; and finally, family members feeling that loved ones are acting in uncharacteristic ways.



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Interactive Exercise 3.

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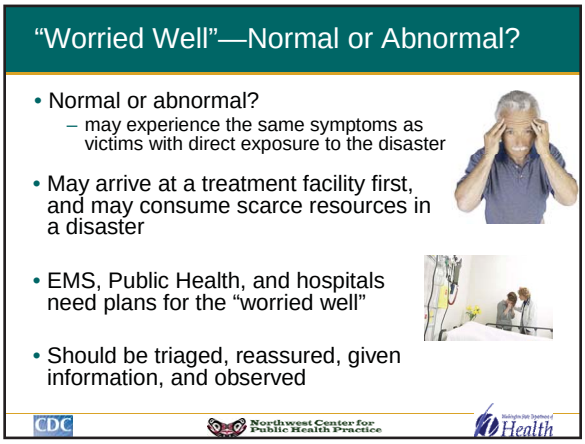
The symptoms of the so-called "worried well" are not so easy to characterize as either normal or abnormal. Worried well patients may experience the same symptoms as those reported by victims of an actual biological, chemical, or radiologic exposure. Worried well patients may arrive at treatment facilities first and they may consume scarce resources. For this reason, EMS, public health, and



hospitals all need plans for the worried well. Worried well patients need to be triaged in a timely fashion. At the very least, worried well patients need some reassurance, a relevant fact sheet, and somewhere they can be closely observed for a time in case symptoms of an actual exposure should emerge.

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Interactive Exercise 4.

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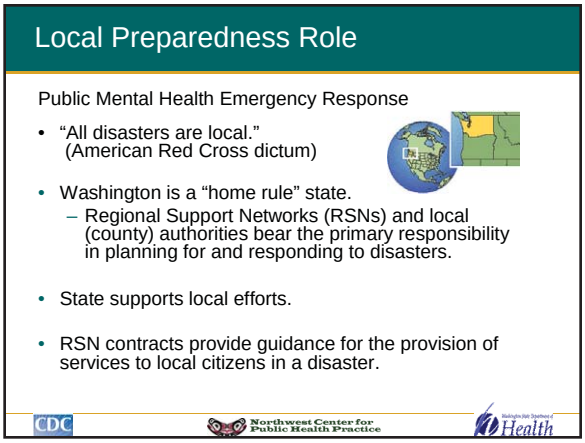
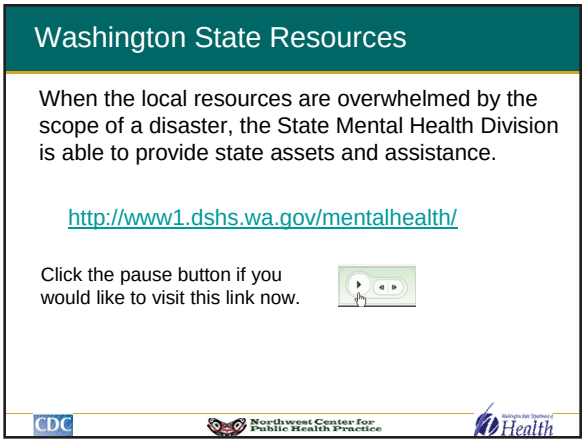
Let us first consider the local preparedness role in public mental health emergencies. According to the Red Cross, all disasters are local. Since Washington is a "home rule" state, regional support networks, that is RSNs, and local county authorities bear the primary responsibility in planning for and responding to disasters. The state supports local efforts. RSN contracts provide guidance for the provision of services to local citizens in a disaster.



Slide 40

When local resources are overwhelmed by the scope of a disaster, the State Mental Health Division is able to provide state assets and assistance.



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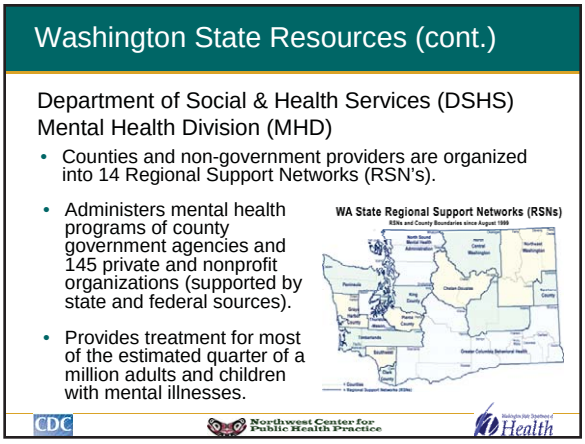
Let's consider next the Department of Social and Health Services (DSHS) Mental Health Division (MHD). Counties and non-government providers are organized into 14 Regional Support Networks or (RSNs) as shown on the map. DSHS Mental Health Division administers mental health programs of county government agencies and 145 private and non-profit organizations supported by both state and federal resources to provide treatment for most of the estimated quarter of a million adults and children in Washington State with mental illnesses.



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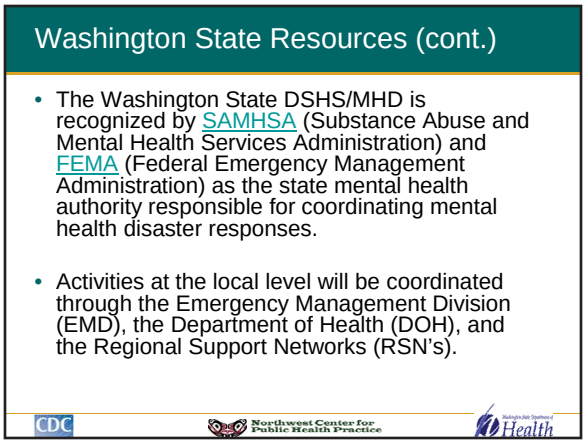
The Washington State DSHS Mental Health Division is recognized by SAMSHA and FEMA as the state mental health authority responsible for coordinating mental health disaster responses. Activities at the local level will be coordinated through Emergency Management Division (EMD), and the Department of Health (DOH), as well as the Regional Support Networks (RSNs).



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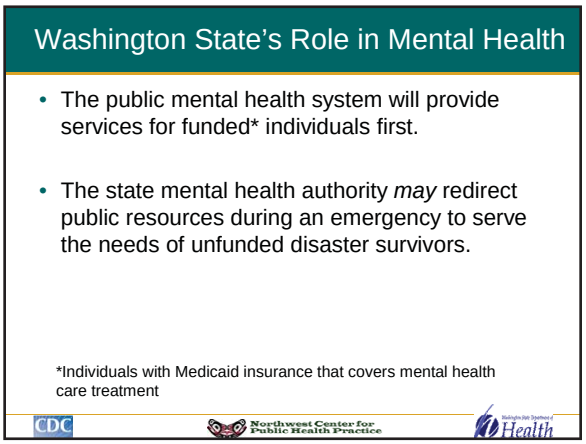
Washington State's public mental health system will provide services for funded individuals first. The state mental health authority may redirect public resources during an emergency to serve the needs of unfunded disaster survivors as well.



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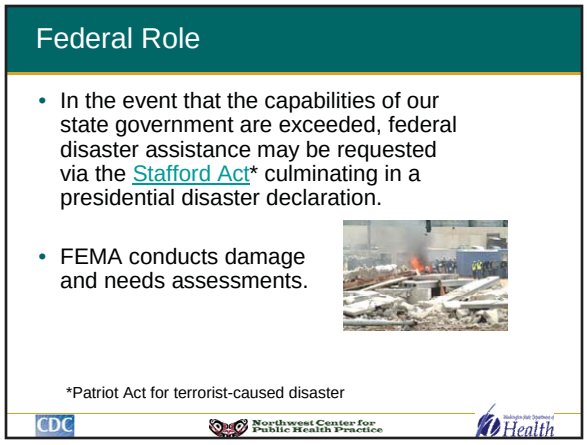
In the event that the capabilities of our state government are exceeded, federal disaster assistance may be requested via the Stafford Act, or the Patriot Act for terrorist-caused disasters, culminating in a presidential disaster declaration. The Federal Emergency Management Agency conducts damage and needs assessments.



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At the federal level, SAMHSA also provides funding for immediate crisis counseling and referral including screening assessments, counseling, and outreach for all disaster victims. SAMHSA can also fund regular service programs providing for up to nine months of counseling. Finally, Red Cross counselors may also provide assistance to disaster survivors.

Federal Role (cont.)

- SAMHSA funding:
  - Immediate crisis counseling funding and referral
  - Screening assessment, counseling, and outreach for all disaster victims
  - Regular services programs—up to 9 months of counseling services may be funded
- Red Cross counselors also provide assistance to disaster survivors.

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In summary, disasters are events that usually require outside assistance and are characterized by a surge, a need for inter-agency collaboration, and invariably, communication problems. The disaster behavioral health tasks are dependent on the psychosocial phase of the disaster. And finally, expect resilience in both disaster survivors and disaster workers.

Summary

- Disasters usually require outside assistance and are characterized by:
  - A surge
  - Inter-agency collaboration
  - Communication problems

- Disaster behavioral health tasks are dependent on the psychosocial phase of the disaster.
- Expect resilience in disaster survivors and disaster workers.

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Here is a list of useful resources. Also note there are some additional resources in the Attachments drop-down box.

Resources

Attachment drop-down box

- APA Fact Sheet on Resilience
  - http://www.apa.org/psychologists/resilience.html
- Coping With a Traumatic Event (CDC Publication)
  - http://www.bt.cdc.gov/masscasualties/copingpub.asp
- NIOSH Fact Sheet
  - http://www.cdc.gov/niosh/unp-trinstrs.html

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On the following screens you'll encounter a case study that will allow you to apply the knowledge and concepts you've just learned.

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Case Study.