Mental Health Response to Major Crisis/Disasters

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BASED ON OBSERVATIONS: IRAQ, AFGHANISTAN, PAKISTAN, INDIA, KATRINA (NEW ORLEANS OCT 2005), HAITI, MEXICO

Goals

GOALS:

• Provide an overview of Dept of State MHS response to Haiti Earthquake (Jan. 2010).

• Enhance this model for future application through specific objectives.
OBJECTIVES: At the conclusion of the presentation the participants will be able to:

- Identify principles that drive Mental Health interventions in Disasters.
- Learn and teach Basic Stress Management Skills (RESILEINCE) for providers and victims.
- Describe common varieties of mental health conditions seen during disasters.
- Explain the most effective initial mental health interventions and follow up actions.
- Model psychological first aid.
- Know how to identify resources within the community and utilize these resources effectively.
Disaster Strikes
Haiti: Earthquake 13 JAN 2010

MICRO VIEW:

Presentation based on experience of clinical psychiatrists working within the constraints of a federal civilian organization during the initial phase of the response to the earthquake.

The point is to apply lessons learned in response to a future critical event.

Initial MED Actions: Haiti

**JOINT COORDINATED EFFORT**

- Formation of task force.
- Daily telephone conference call.
- Mobilization of Medical assets from Santo Domingo.
- The local Nurse/MD were overwhelmed.
- RMO and NP from MED Deployed along with Supplies.

**MAIN STATE/DOD/MED/EMBASSY**

- Deployment of Psychiatrist was delayed due the perception that acute medical care took precedence.
- Embassy requested immediate MHS support.
- A psychiatrist who can assist with acute medical care is best suited for deployment.
MED: Deployment of FSHP/Psychiatrist

Provided reinforcement to Carolyn V and Marco P (LES Providers) with support from Santo Domingo, MED FSHP: Kazmin

Deployed David Johnson, RMO/P (≥1 week later) * 9/11 study shows that Psychiatrist should be included in the first response team

Coordinated with DOD

Provided continuous coverage by FSHP/RMO/P for the next Six months: Swift, Imershein, Waters,
• Follow up after 8-9 months: by RMO/P visits (Panakkal, Vanelli)

(Findings are described in helpful ACTIONS during delayed phase of Disaster)

What drives MH interventions in Disasters?

Principles: Based on Phases of Disaster

Identify and plan for phases of disasters:
• System-level MH issues (response)
CRISIS PLANS
• Individual-focused MH issues (victims) and Care for clinicians (us)
CAPACITY BUILDING
RESILIENCE BUILDING
### Phases of Disaster

- Preparatory/Warning
- Impact/ Heroic
- Honeymoon
- Delayed effects
- Disillusionment
- Reconstruction
- Chronic

### PHASES—Pre-disaster (warning)/Impact

**WARNING:** Timing depends on the event

- Usually several days of warning may give people time to prepare
- Terrorism strikes without warning

**Impact/Heroic:** Stunned, confused, helpless temporarily but quickly recovers to act according to individual capacity *(capability to function in the midst of chaos)*

- **Resilience Building** *
- **Psychological First Aid (PFA)** *
- **Acute and Chronic Stress Reactions** *

* will address these later in the presentation
**Heroic**

*Altruism is prominent.*

- Throughout these first phases and afterward, people respond to demands
- Heroic action to save the lives and property of others.
- People are willing to put forth major energy to help others survive and recover.

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**Honeymoon**

*This phase generally extends from one week to six months after the disaster*

- For those most directly affected, there is a strong sense of having shared with others a dangerous, catastrophic situation.
  (quakers/nonquakers)
- For the community, there is a sense of cohesion and working together to recover.
- Relief efforts are in full swing, and hopes of a quick recovery run high.
- The emotions associated with this phase range from gratitude and hope to grief and continued disbelief.
Disillusionment

This phase can last from two months up to two years.

- The **realities of recovery** set in.
- People experience feelings of disappointment, frustration, anger, resentment and bitterness as setbacks occur and/or promises of assistance are not fulfilled; or are “too little, too late.”
- Outside relief agencies and volunteers leave and some local community groups may weaken.
- Those most affected realize they have much to do (themselves) and their lives may never be the same.
- The “shared community” feelings are lost as individuals focus on themselves.
- **Emotions:** Self-doubt, loss-grief, and isolation.

Coming to terms/Reconstruction

This phase generally lasts for several years.

- Survivors focus on rebuilding their homes, businesses, farms and lives.
- The appearance of construction and new buildings, and development of new programs and plans bolster residents’ belief and pride in community and in their own individual abilities to rebuild.
- Ups and downs occur as anniversary and other events trigger emotional reactions, and if signs of progress are delayed.
Another Version of Disaster Phases

The Phases of Disaster

- **Pre-disaster**: Community, family, and individual conditions prior to disaster.
- **Warning**: Media gives word of the impending disaster.
- **Threat**: Immediately precedes the actual impact.
- **Post-disaster**: Survivors take inventory of events.
- **Rescue phase**: Survivors and emergency workers join to save those affected by the disaster.
- **Remediation**: The American Red Cross, insurance adjusters, Federal Government, and local relief efforts take action.
- **Recovery period**: Physical structures are rebuilt, and families and individuals begin to cope.

Interventions

- Preparatory / Warning Phase
- Acute phase
- Delayed Phase
Unique Aspect of Disasters: Determines the Preparatory Actions: Individual

- Earthquake
- Weather-related Catastrophes
  - Tsunami
  - Hurricane
  - Floods
  - Fire
  - Terrorism
  - CBNRE (chemical, biological, nuclear, radiological, high-yield explosives)
- Accidents/Personal Events

General preparation for Crisis:
- Coordinate with EAC
- Practice Scenarios depending on your geographical risks (e.g. prepare for acts of terrorism in Kabul and not Tsunami)

Individual Preparedness:
- Disaster Kit
- Prepare children & family members

Individual/Family Readiness

At Home:
- Identify potential hazards in your home and fix them.
  - Bolt bookcases to the walls.
  - Don’t hang breakables above the beds.
- Get your kids to participate.
  - Practice “drop, cover, and hold on.”
  - Teach your kids to knock 3 times repeatedly if trapped since rescuers searching collapsed buildings will be listening for sounds.
- Identify safe spots in every room -such as beside or under sturdy desks and tables.
  - Keep shoes and a working flashlight next to each bed.
- Take a Red Cross first aid and CPR (cardiopulmonary resuscitation) training course.
  - Learn who in your neighborhood is trained in first aid and CPR.
  - Prepare disaster and first aid kits.
## Preparatory Phase: Systems-level

<table>
<thead>
<tr>
<th>Resources</th>
<th>Training: 2x per year</th>
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</table>
| - Identify organic medical resources e.g. FSHP, LES MD/Nurses.  
- Identify personnel with EMT/Mental Health training at Embassy/Consulate/keep a registry.  
- Identify mental health assets in local community. | - Conduct training with a realistic scenario that involves all your assets (including local resources). This can be a “table top” exercise).  
- Identify who does the triage and who are the alternates.  
- Create an SOP.  
- Keep minutes and up date SOP at least biannually. |

## Preparatory Phase:  
For Clinicians (personally & professionally)

### Train mental skills that will support an effective response during disasters:

- **Ability to identify and manage intense Internal (self-awareness) and External (situational awareness) challenges.**
- **Ability to assess needs and triage for response; this requires clear mind.**
- **Ability to make and implement plans, recognize the need to change plans, and make changes; this involves staying present.**
Preparatory Phase: Clinicians

**Resilience**: A term used to describe the dynamic process of healthy response and coping in the face of adversity. “Inoculation” by training/education, use of mental technique to manage sympathetic response (deep-breathing to manage hyper-arousal, thus separating the memory from the arousal).

Learn and teach **Basic Stress Management Skills** to community in order to build resilience. Encourage people to identify and practice techniques that *work for them.*

Applications:
- Stress management is key to effective response to disasters **AT ALL LEVELS.**
- Continuum of issues:
  - What to do during a crisis with victims who are injured/in shock/dying?
  - How to manage inner responses to witnessing traumas?
  - How to care for others after surviving disaster personally? Other...
Mindfulness is a secular mental training technique for placing and sustaining single pointed focus on a chosen object of attention in the present.

- There is a strong relationship between mindfulness practice and emotion management.
- Mindful breathing techniques can also help you become less reactive to other people's emotions through promoting mental skills:
  - Observation v. engagement
  - Response v. reaction

Mindful breathing supports taking a “Pause” to modulate emotions.
## Clinicians and Mindfulness

Do we get tired?
Really, tired?
If so, why?

## From Sympathy to Compassion

**Sympathy:**
Feeling sorry for someone else. *(Disengaged)*

**Empathy:**
Feeling that person’s pain. *(Engaged and drained)*

**Compassion:**
Feeling that person’s pain AND wanting to do something to reduce it/provide comfort. *(Engaged and activated/energized)*
Mindfulness & Compassion

Compassion requires attention and awareness to:
- What’s happening around you. (Your patient’s condition)
- What’s happening inside you. (Your feelings, motivation, triggers etc.)
- The difference between your subjective experience and objective assessment. (So you can make a plan)
- Knowing what you can do... and what you can’t.
- Taking action.

Why Begin with Mindful Breathing?

If you want to enhance compassion, it’s best to train attention and awareness under less intense conditions.
Mindful Breathing Technique

**Basic stance reduces distractions and isolates key techniques.**
- Straight back not supported by seat or wall
- Spine balanced on hips
- Legs at ease, uncrossed
- Feet squarely on floor
- Shoulders relaxed, shoulder blades drawn together to open chest
- Chin slightly tucked to straighten cervical spine
- Eyes open, relaxed gaze @ 45% downward (contact floor +/- 1 meter)
- Hands on thighs, palms down

Mindful Breathing

Breathe and pay attention to **feeling sensations:**
- Movement and path of air (abdominal breathing preferred).
- Depth and flow of breath.
- Pace of exhalation-inhalation cycle.
**Awareness of Noticing**

Breathe and pay attention to **feeling sensations** and **noticing sensations**.

- Focus on sensations.
- Observe sensations and whether you stay focused on noticing the sensations.
- Refocus on sensations.

**Counting Breaths**

Breath and count complete breaths (= exhalation-inhalation cycle) **beginning on an exhalation**

- **Focus** on counting.
- **Observe** the progression of counting (1, 2, 3...) AND whether you stay focused on counting (1, 2...#?!*).
- **Refocus** on counting, (1, 2... #?!*1, 2, 3... ).
Mindful Breathing and Sleep

Relaxation and sleep are essential for mindfulness training, and mindfulness techniques promote rest for the body and mind.

Different applications and outcomes:

- Waking state (alert, upright and with eyes open) vs. sleeping (in bed, lights out, lying down, eyes closed)
- Count breaths to sharpen mind while awake vs. distract/disengage from thinking, worrying, etc. while trying to fall asleep.
- Count to up to 21 and back to 1: Most often you will loose count and won’t recall when you fell asleep.
- Counting Sheep is a mindfulness technique.

Acute Phase: Systems-level

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<th>MED/EMBASSY</th>
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<td>• Formation of task force.</td>
<td>• Deploy RMO/Psychiatrist immediately with the initial responders.</td>
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<td>• Set up telephone conf call.</td>
<td>• MHS support is vital to the acute phase.</td>
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<td>• Mobilization of medical assets.</td>
<td>• Psychiatrist who can assist with acute medical care is best suited for deployment.</td>
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<tr>
<td>• Recognition that local Providers Nurse/MD may be overwhelmed and will need reinforcement/replacement.</td>
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<tr>
<td>• Deploy RMO and RMO/P and NP from MED along with Supplies.</td>
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Early Mental Health Intervention After Crisis

**Steps:**

- Basic Needs
- TRIAGE/SCREEN
- Psychological First Aid
- Needs Assessment
- Observation, Outreach, Information Dissemination
- Technical Assistance, Consultation, and Training
- Fostering Resilience and Recovery
- Triage and Treatment

**Basic Needs**

Provide survival, safety, and security.

- Provide food and shelter.
- Orient survivors to the availability of services/support.
- Communicate with family, friends, and community.
- Assess the environment for ongoing threats.
### Screening & Triage

Screening and triage should focus on highly symptomatic or “at-risk” individuals within the first week post-disaster and beyond.

**USE COMMON RATING SCALES to keep track of severity: PHQ 9, BECKS...**

Who is “at risk?”

**Experts agree that this group includes individuals:**
- With pre-existing psychiatric conditions or substance abuse problems
- Who are bereaved
- Who are children or elderly
- Who are injured
- Who are intensely exposed to the disaster (through proximity or long duration of exposure)
- Who have acute stress disorder or are clinically symptomatic as a result of the disaster.

After 2 months post-disaster, if symptoms have not occurred, follow-up should occur only if specifically requested for an individual.

### Watch for Persistent Problems

Some individuals will have persistent problems and a few may experience onset of psychiatric conditions that would benefit from formal psychiatric interventions. Among these consequences are:
- Acute Stress Disorder
- Concussions / Traumatic Brain Injury that may masquerade as psychiatric disorder
- Traumatic Brain Injury co-existing with psychiatric disorder
- Delirium
- Posttraumatic stress disorder (PTSD) : ACUTE / DELAYED
- Major depression
- Generalized anxiety
- Panic attacks
- Substance abuse problems
- Physical complaints
- Unhealthy lifestyles that may worsen existing medical problems.
Reduce or ameliorate symptoms or improve functioning via:

**Supportive therapy**
- Individual, family, and group psychotherapy.

**Later interventions**
- Cognitive-behavioral therapy (CBT)
- Acute stress disorder: Medications are useful

**PE (Prolonged Exposure Therapy)**
- Effective in PTSD
- Pharmacotherapy
- Short or long-term hospitalization

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No More CISD (Psychological Debriefing)

Although historically Critical Incident Stress Debriefing (CISD) has been offered to survivors and rescue workers, its benefit has not been consistently demonstrated. It may provide some psychological relief if done by experienced clinicians.

This structured intervention involves elements of:
- Introduction of goals
- Processing facts about the disaster and ensuing thoughts, emotions, and possible symptoms
- An educational component
- A conclusion.

* CISD has fallen out of favor after recent studies have found that re-telling of traumatic events may actually increase anxiety in some individuals. There is no evidence that it prevents PTSD
CISM

Critical Incident Stress Management (CISM) refers to a rather diffuse system of interventions designed to reduce emotional sequelae.

Whatever early intervention is delivered, it is important that services are:

- Based on sound, evidence-based practices that do not further harm survivors.
- Voluntary and acceptable to survivors.

Psychological First AID (PFA)

“Psychological First Aid” should be administered to:

- Identify and support survivors who are the most distressed, while ensuring that they are safe from further threat.
- Reduce physiological arousal, which may reinforce patterns of fear and increase risk for psychiatric illness.
- Facilitate victims’ accessing natural supports of family and friends.
- Educate and communicate about stress responses to catastrophes, coping, and risks for illness and services available.
## Psychological First Aid (expanded)

### Protect survivors from further harm.

- Reduce physiological arousal.
- Mobilize support for those who are most distressed.
- Keep families together and facilitate reunions with loved ones.
- Provide information and foster communication and education.
- Use effective risk communication techniques.

## Primary Objective of Psychological First Aid

The primary objective of Psychological First Aid is to create and sustain an environment of:

1. Safety
2. Calm
3. Connectedness to others
4. Self-efficacy or empowerment
5. Hope
### Do

**Promote Safety**
- Help people meet basic needs for food & shelter, and obtain emergency medical attention.
- Provide repeated, simple and accurate information on how to obtain these.

**Promote Connectedness**
- Help people contact friends or loved ones.
- Keep families together.
- Keep children with parents or other close relatives whenever possible.

Brief, simple conversations and informal on-site talks with survivors and responders can offer support, education, and problem solving techniques.

### Don’t

- **Force people to share their stories with you**, especially very personal details (this may decrease calmness in people who are not ready to share their experiences).
- **Give simple reassurances** like “everything will be OK” or “at least you survived” (statements like these tend to diminish calmness).
- **Tell people what you think they should be feeling, thinking or doing now**, or how they should have acted earlier (this decreases self-efficacy).
- **Tell people why you think they have suffered** by alluding to personal behaviors or beliefs of victims (this also decreases self-efficacy).
- **Criticize existing services or relief activities in front of people in need** of these services (this undermines an environment of hope and calm).
- **Make promises that may not be kept** (un-kept promises decrease hope).
- **Avoid mental health labeling.**
Needs Assessment

Assess the current status of individuals, groups, and/or populations and institutions/systems.

- Ask how well needs are being addressed, what the recovery environment offers, and what additional interventions are needed.

OBSERVATIONS

- Observe and listen to those most affected.
- Monitor the environment for toxins and stressors.
- Monitor past and ongoing threats.
- Monitor services that are being provided.
- Monitor media coverage and rumors.
Fostering Resilience and Recovery

- Foster but do not force social interactions.
- Provide coping skills training.
- Provide risk assessment skills training.
- Provide education on stress responses, traumatic reminders, coping, normal versus abnormal functioning, risk factors, and services.
- Offer group and family interventions.
- Foster natural social supports.
- Look after the bereaved.
- Repair the organizational fabric.

Considerations

- What does “crisis” mean in different cultures?
- What is the cultural response to an abnormal (traumatic) event?
- How do people grieve?
- What are the rituals and meanings attached to trauma?
- When is it over?
HAITI: Observations

• US Embassy POP received in house continuous RMO/P support for 6 months.

• At 9 months: Two RMO/P visits showed that among American Employees Chronic Stress from long hours of work and demands from Washington have become the main source of difficulty and NOT PTSD.

• The LES continues to suffer from lack of basic living standards, grief, and additional work load.

More to Do in HAITI

Promote Self-Efficacy

• Give practical suggestions that steer people towards helping themselves.
• Engage people in meeting their own needs.

Promote Hope

• Find out the types and locations of government and non-government services and direct people to those services that are available.
• Remind people (if you know) that more help and services are on the way when they express fear or worry.
Delayed Phase: Individuals at all Levels

- PTSD
- Chronic Stress

PTSD Risks of Specific Traumas in the US Population

About 30% of people exposed to trauma developed PTSD

(Kessler RC et al. Arch Gen Psychiatry. 1995;52:1048–1060.)
PTSD Rates Related to Specific Traumas


Post Traumatic Stress Disorder

- A characteristic set of symptoms following exposure to extreme traumatic stress.
  - Experience, witness, or confronted with actual or threatened death or injury.
  - Response involves intense fear, helplessness, or horror.
- Duration more than one month.
- Significant functional impairment.
Post Traumatic Stress Disorder: Experiencing Symptoms

Experiencing symptoms (1 necessary):

- Intrusive recollections
- Recurrent dreams
- Flashbacks
- Psychological distress with reminders
- Physiologic reactivity with reminders

Post Traumatic Stress Disorder: Arousal Symptoms

Arousal symptoms (2 necessary):

- Sleep difficulty
- Irritability
- Concentration
- Hypervigilance
- Exaggerated startle
Delayed Phase: Systems-level Issues

Experience from Haiti, Jeddah, and Nairobi suggest predictable organizational problems (and solutions) emerge during rebuilding phase after mass trauma:

Apply lessons learned

Leadership Response to Systems-level Stress

Embassy leadership style needed to improve morale/performance in high stress reconstruction environments ("Different game, different rules")

- More visible and hands-on style.
- Lower the heat: protect down-time, insure-time off for overtime worked.
- Build morale with regular work lunches, happy hours, pot lucks etc.
- Focus on what can be changed; set achievable goals, celebrate them.
- Communicate more, within and among groups; insure communication is 2-way.
- Better integrate TDYers into current work norms and teams; rapid team-building as core competence
Stress: Individual-level Issues

**Reality: Inadequate Staffing**
- USAID with 18 of 55 direct hires (33%) of requested FTEs.

**Response: Burnout**
- "We have work demands that are not humanly possible."

Communication Issues

**Need for Effective Communication**

“Communication was an issue before the quake and remains an issue.”
- Communication problems both within units and between top, middle, and bottom of embassy.

“The priorities keep changing. Sometimes we don’t even know the priorities.”
Other Challenges

LES Mental Health: Cultural Barriers
* “They have all have all lost a family member or close friend….But seeing a psychologist or psychiatrist is not the Haitian way.”

Staff Recognition
* Don’t feel their sacrifices have been personally recognized by embassy managers and leaders.

Chronic Stress: Hierarchy Issues

Bottoms
* Greater control over daily work environment than they think.
* Need to set and celebrate small achievements.

Middles
* Need to be more visible, build teams and morale.
* Support down-time.
* Understand and align strengths of staff with their tasks.

Tops
* Need to communicate strategy/vision regularly to community.
* Be more visible.
* Thank people personally.
Recommendations

Level of Stress

Disaster: Acute Stress Over Weeks

Reconstruction: Chronic Stress over Months and Years

Front Office
- Improve Communication: Regular Town Meetings, Walking the Halls, Information as Preventive Mental Health
- Thank people in person

Management
- Increase down time: Provide Time Off for Overtime worked (AWS)
- Communicate status of benefits to LES

Line Leaders
- Support Morale, insure downtime: Off site lunches, happy hours, pot lucks
- Increase sense of control and predictability; limit perception of powerlessness

Conclusion

OBJECTIVES:

- Identify principles that drive Mental Health interventions in Disasters.
  - System-level MH issues (response)
  - Individual-focused MH issues (victims)
  - Care for clinicians (us)
- Learn and teach Basic Stress Management Skills for providers and victims (and ourselves)
- Describe common varieties of mental health conditions seen during disasters.
- Explain the most effective initial mental health interventions and follow up actions.
- Model psychological first aid.
- Know how to identify resources within the community and utilize these resources effectively.
Helpful Web Links

http://www.ready.gov

http://www.fema.gov/kids/

http://www.redcross.org/
"We are Americans. We don’t walk in fear."

Colin Powell, Secretary of State, in response to terrorist attack on World Trade Center, September 11, 2001.

Thank you all for serving America and the WORLD.

Davidp@state.gov