

5th Annual

2007 Medical Reserve Corps National Leadership and Training Conference



FORGING POWERFUL PARTNERSHIPS



April 17–20, 2007

Providence, Rhode Island



DISASTER BEHAVIORAL HEALTH

*Medical Reserve Corps
National Leadership Conference
April 20, 2007*

RADM Brian W. Flynn, Ed.D.
Assistant Surgeon General (USPHS, Ret.)

Adjunct Professor Of Psychiatry
Associate Director
Center for the Study of Traumatic Stress
Dept of Psychiatry
Uniformed Services University of the Health Sciences

Topics To Be Covered:

- I. Defining Behavioral Health
- II. Why is it central to health/medical concerns?
- III. Historical perspective
- IV. Current Behavioral Health status/ issues
- V. Where do MRC Behavioral Health resources fit in?
- VI. Opportunities
- VII. Invest in prevention

I. Defining Behavioral Health

Disaster Behavioral Health “refers to optimal healthy human function within family, community, and occupational roles during extreme events such as natural disasters and acts of terrorism.”

(Source: Shultz, Espinel, Flynn, Hoffman and Cohen, DEEP PREP, 2007, p. 32)

**Goes beyond “Mental Health”--
Includes substance abuse, etc.**

Focuses on behavior

Implies wide range of intervention opportunities

Reduces Stigma

II. Why is Behavioral Health Central to Health/Medical Concerns?

Quote:

“I understand and empathize with your concerns about mental health in an overwhelming public health emergency.

However, the issues I have to deal with, and the decisions I have to make, in the first twenty-four hours are life and death issues.

The mental health concerns, while important, do not rise to that level of importance.”

Source: Public Health Official, CDC conference, January 2004

Bottom Line Message:

**The Nature, Scope, Centrality, and Cost of
Psycho-Social Issues for Victims and
Workers is Not Well Understood and/or
Believed**

Contrary To Popular Belief...

**Behavioral Health Issues Are
Life And Death Issues**

**Behavioral Health Footprint Is Larger
Than The Medical Footprint**

Case Example: SCUD Missile Attacks

Site: Israel, Gulf War, 1991

Perpetrator: Iraq

Agent: Scud missiles with possible poison gas payload

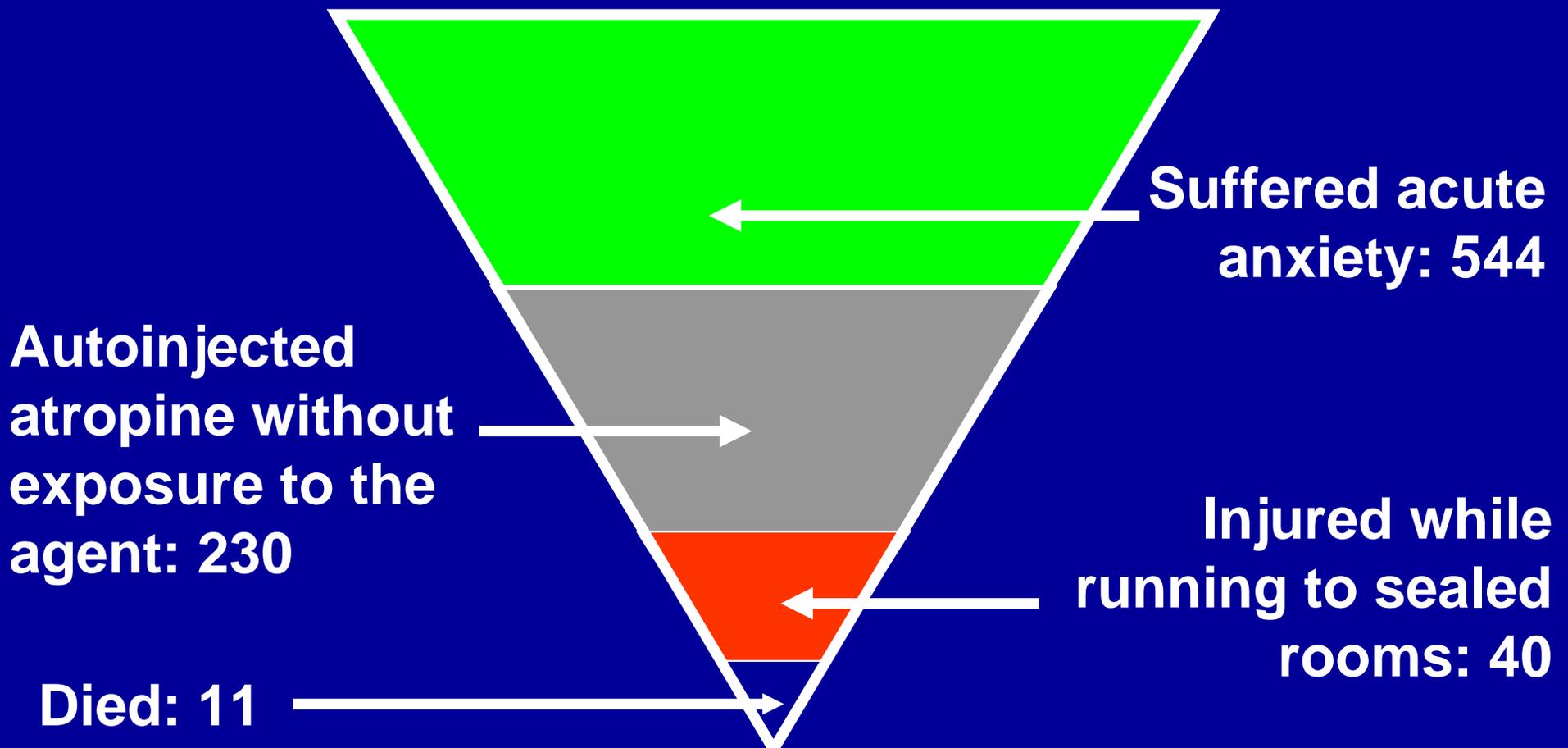


Case Example: SCUD Missile Attacks

- January 18 - February 28, 1991
- 23 missiles attack alerts
- 5 false alarms
- 1,059 ER visits
- 234 direct casualties (22%)
- 835 behavioral and psychological casualties (78%)

Source: Karsenty et al. 1991

Scud Missile Attack, Israel, 1991



- 7 suffocated in their gas masks
- 4 fatal heart attacks

Source: Karsenty et al. 1991

Scud Missile Attack, Israel, 1991



Lessons learned:

- 1. More fatalities from fear behaviors than from missile impact.***
- 2. More hospitalizations for psychological responses than for medical injury.***
- 3. Psychological/Medical= 4:1***

Case Example: Sarin Gas Attack

Site: Toyko Subway, March 20, 1995

Perpetrator: Aum Shinrikyo cult

Agent: Sarin Gas

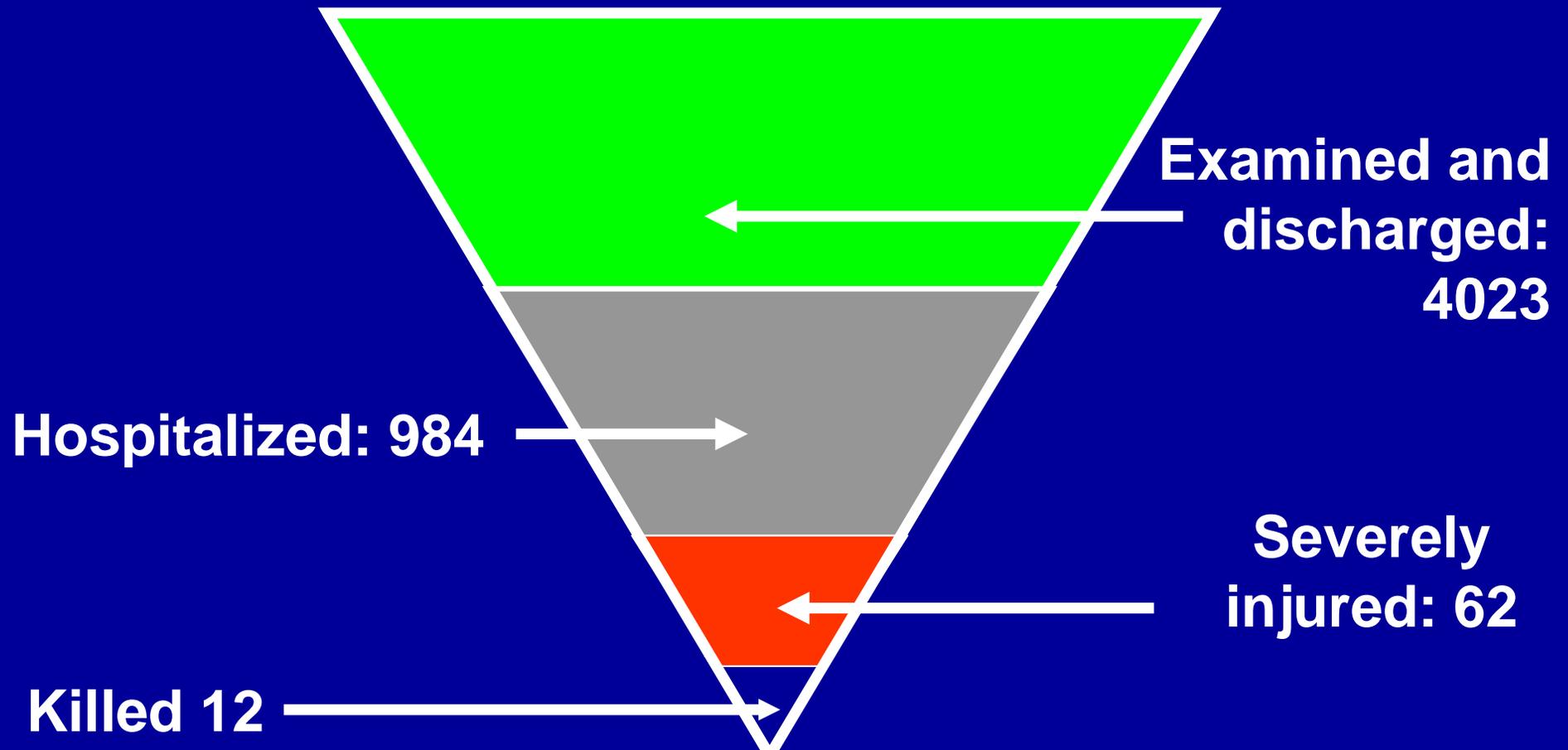


Sarin Gas Attack, Tokyo, 1995

- 1,370 mild to moderate injuries
- 1,046 admissions to 98 HCOs
- 17 critically injured
- 12 deaths



Sarin Attack on Tokyo Subways



Source: Norwood, 2002

Sarin Gas Attack, Tokyo, 1995

- 5,510 patients visited 280 medical facilities
- >4,000 had no evidence of physical harm

*Lesson learned:
Psychological
casualties surge upon
HCOs in numbers
greatly exceeding
medical casualties.*

4:1



Case Example: Radiological Contamination

Site: Goiania, Brazil, 1987

Perpetrator: None (non-terrorist)

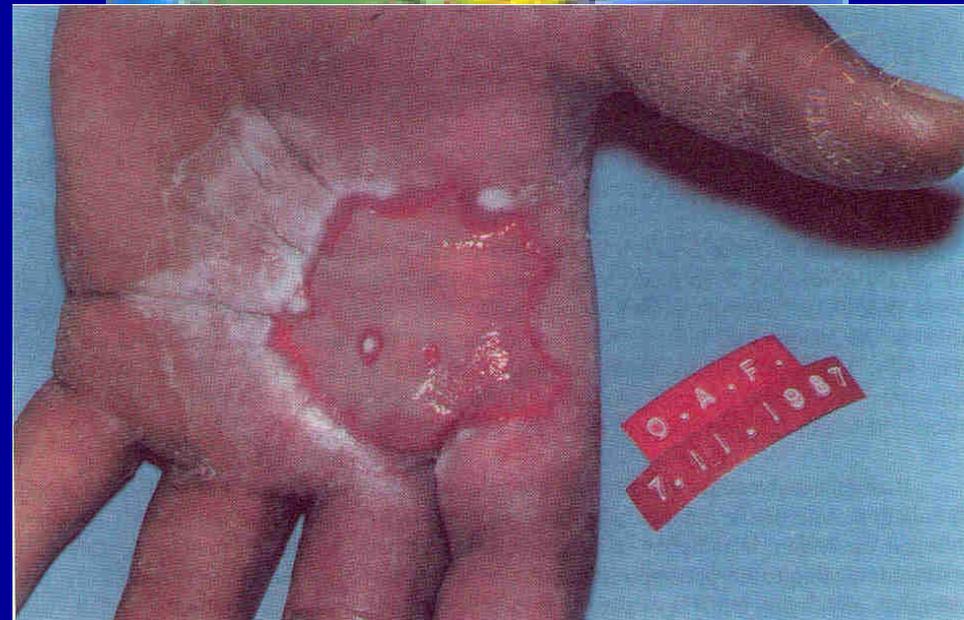
Agent: Cesium 137 from abandoned radiotherapy device—1,600 Curies released



Radiological Contamination, 1987

- **249** contaminated
- **125,800** people sought medical examinations
- Of the first 60,000 screened 5,000 uncontaminated persons presented with symptoms of vomiting, diarrhea, and rashes

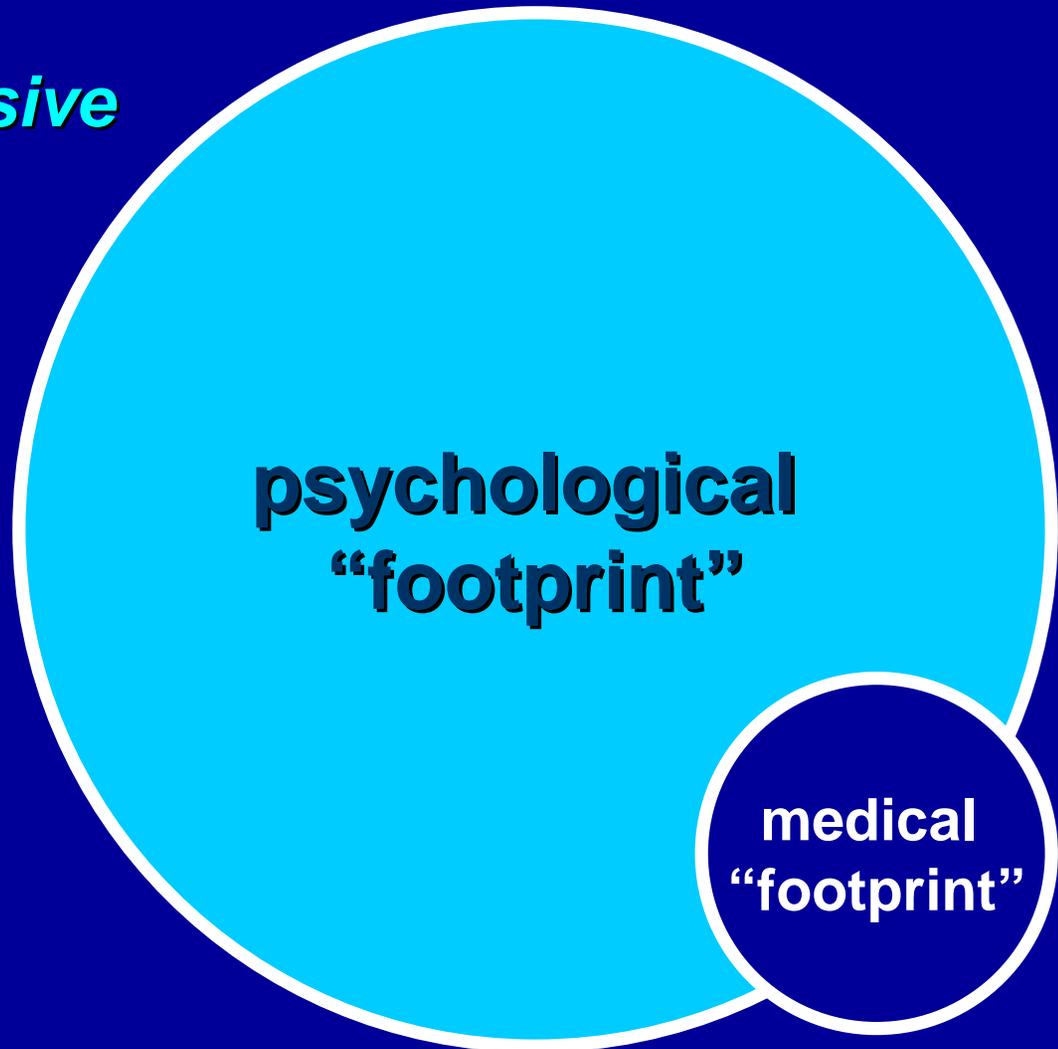
500:1



Psychosocial Consequences of Disasters

Widespread and pervasive

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



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



III. Historical Perspective

History...

- While “traumatic stress” (using other terms) has been recognized for centuries, most US government focus in the disaster context began in early 70s.
- Integration of behavioral health into both health/medical response and emergency management has been slow...
 - Stigma
 - Relative funding focus
 - Limited evidence base
 - Competing perspectives
 - Funding some services but little preparedness
 - Relatively unorganized/competing response groups

History...

- Experience grew through
 - Federal Crisis Counseling Program
 - Red Cross Disaster MH program
 - Guild training/promotion/experience
- Emergence of NGO responders
 - NOVA
 - CISD/CISM
 - Others

IV. Current Behavioral Health Status/Issues

Current Status...

- Stigma--diminishing
- Relative funding focus—Continues as a major problem
- Competing perspectives—Continuing but improving
- Funding some services but little preparedness—Continues as a major problem

The Evidence Base...

- Some parts of the evidence base grew
 - More about risk and protective factors
 - Less about early intervention efficacy
 - Very little about intervention models, preparedness strategies, differential models for event type (e.g., natural, terror, WMD, pandemic, etc.)

Response Resources...

- Growing in numbers (NDMS, MRC, State Crisis Teams, DoD, etc.)
- Still less integrated than optimal...but improving
- All Behavioral Health resources struggle with maintain skills, function, readiness through pre-event times

Response Resources...

- Behavioral Health response is becoming more organized and formalized
- The SUV crisis is diminishing...

~~Spontaneous
Uninvited
Volunteers~~

Exciting Developments...

- Growing understanding of the centrality of Behavioral Health
- Rapidly expanding resources
- Increased sharing among stakeholders (especially states)—Also NDMS/MRC
- Strengthening evidence base for cognitive behavioral approaches to treatment of disaster related disorders
- State/local BH disaster plans are increasingly present/integrated...still a long way to go

New Ideas?

“Without a great deal of forethought, prolonged training, and the development of systematic performances, drills, and tests of all participants, no community can prepare itself to provide those additional health services that will be essential for civilians subject to disasters. When the average community prepares itself for disasters, the effort of each citizen and every profession must be fitted into a coordinated system. Whoever guides each part of the whole must have a clear concept of the working of all the other parts.”

Source: William Wilson (Col. MC, USA)
U.S. Armed Forces Medical J., Vol 1, No.4

April 1950

Evolving Early Interventions...

- Moving toward meeting basic needs a legitimate Behavioral Health intervention (rediscovering history)
- Moving toward “less is more”
- Moving away from “debriefing” models to Psychological First Aid models—MRC BH resources are in the forefront by adapting NCTSN/NCPTSD model
- Continue to need to evaluate PFA models

Psychological First Aid (PFA)

- Consistent with research evidence on risk and resilience following trauma
- Applicable and practical in field settings
- Appropriate for developmental levels across the lifespan
- Culturally informed and delivered in a flexible manner

Psychological First Aid (PFA)

- PFA does not assume that all survivors will develop severe mental health problems or long-term difficulties in recovery. It is based on an understanding that disaster survivors/ others affected by events will experience a broad range of early reactions (for example, physical, psychological, behavioral, spiritual).
- Can be understood and applied by a wide range of people

Continuing Challenges...

- Parity (in all its *definitions...especially funding*) for Behavioral Health
- Expansion of the evidence base
- Application of the evidence base
- Integration and continuity of practice for all behavioral health resources
- Need for developing models of preparedness and response for “new” types of events (e.g., pandemic)

V. Where Do MRC Behavioral Health Resources Fit In?

MRC (And Its Behavioral Health Resources) are Uniquely Positioned...

- In place/legitimized/sanctioned
- Values driven (honest brokers)
- Seasoned/experienced
- Know local resources/needs/ culture/ challenges
- Leadership structure in place
- Broad membership skills/perspectives
- Members available to make contributions both inside and outside MRC

Roles For Behavioral Health Professionals...Let's Change The Default Settings

- Psychological first aid
- Needs assessment
- Monitoring the recovery environment
- Outreach and information dissemination
- Technical assistance, consultation, and training
- Fostering resilience, coping, and recovery (such as facilitation natural support networks)
- Triage
- Treatment

Source: National Institute of Mental Health (2002). *Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims of Mass Violence. A workshop to Reach Consensus on Best practice.*

In Addition...

- Consultation to leadership
- Consultation regarding communications...educational, risk, crisis
- Consultation to MRC/other health leadership regarding **worker stress**
 - Screening/selection
 - Education
 - Policies/procedures
 - Needs assessment
 - Referral

VI. Opportunities

Opportunities During The Planning/Preparedness Phase...Locally

- Assist local health/EM promote personal/family preparedness
- Consult and assist in organizational preparedness for wide variety of organizations
- Assist in cataloging preparing for treatment integration
- Training/education (professional, community, special populations)
- Consultation/liaison (case, organizational, system)
- Promote community behavioral health (the public system can't)
- Promote administrative behavioral health

One Idea...

- Select a retirement community
 - Help educate residents
 - Help residents prepare
 - Help establish community wide plans in case of disaster
 - Identify unmet health/BH needs
 - Enlist residents a full participants
- When an event strikes...
 - Plans in place
 - Roles sorted
 - Trust/familiarity established

Opportunities During The Response Phase...

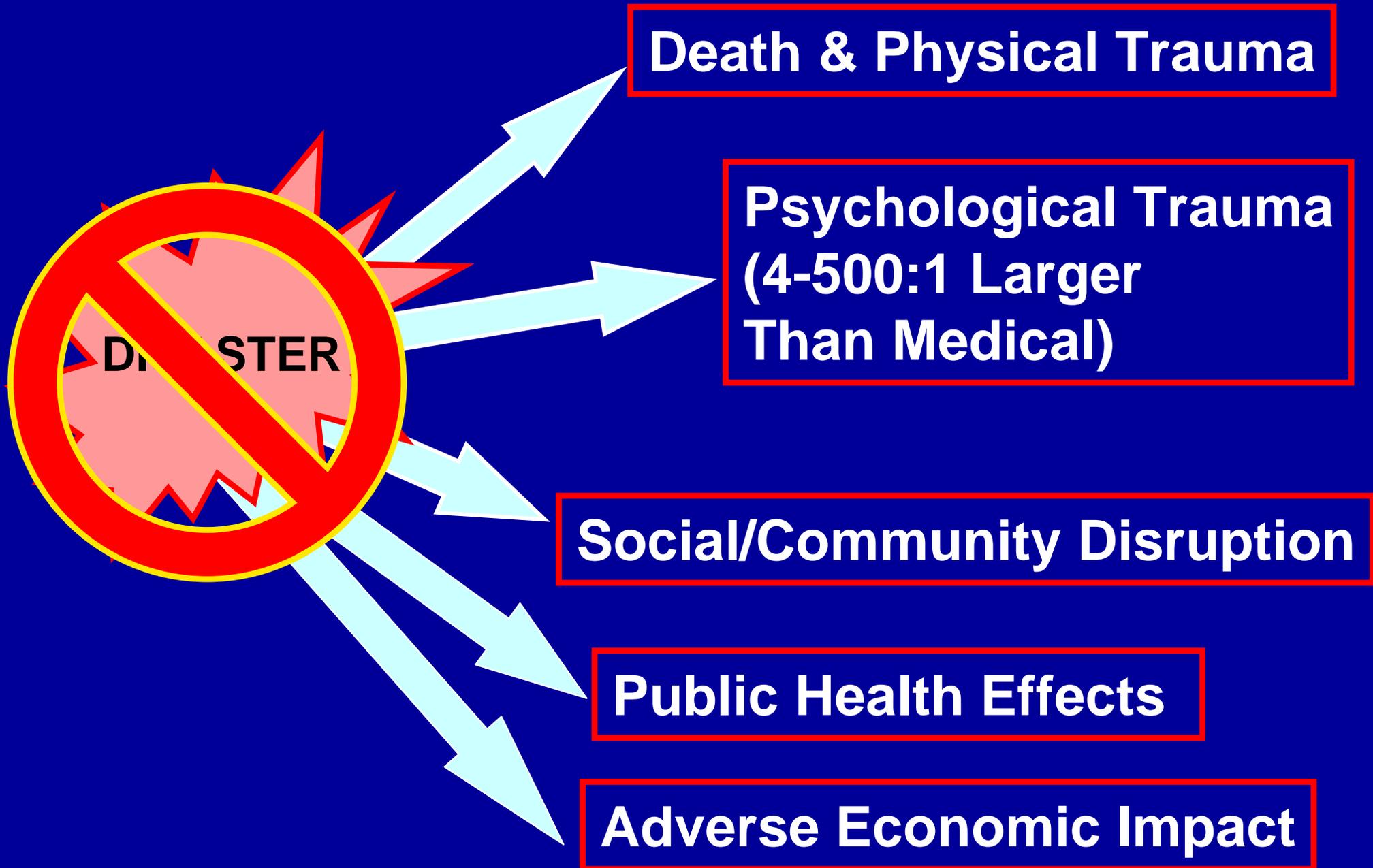
- **Response**
 - Immediate/integrated emergency response
 - Screening/triage
 - Surveillance (adaptation monitoring)
 - Risk/crisis communication
 - Responding to emerging service surges/gaps
 - Reaching/servicing groups (e.g., SMI, cultural competence, children, family separation/reunification, etc.)

Opportunities During The Recovery Phase...

- **Recovery**
 - Reestablishing/maintaining institutions/services
 - Treatment of those with psychiatric diagnosis
 - Facilitating community healing
 - Ongoing adaptation monitoring/needs assessment
 - Adjusting inequities/gaps in needed mental health services
 - Advocating for appropriate behavioral health services

VII. Invest In Prevention

Preventing The Disaster...



Levee Design/Community Planning...



Mine Safety...



Liquid Natural Gas (LNG) Tankers Close To People...



East Africa Embassy Bombings: Same Time/Same Bomb



Nairobi:

- Many deaths
- Many injuries
- Many psychological casualties



East Africa Embassy Bombings: Same Time/Same Bomb



Dar Es Salaam:

- Few deaths
- Few injuries
- Minimal psychological casualties

The Difference? Architecture!

The MRC (And MRC Behavioral Health Assets) Are Unique and Extraordinary National Resources...

Capitalize On Quality, Quantity, And Uniqueness

**Use Behavioral Health Assets Creatively
As A Model For Other Organizations**

**Seize the Opportunity To Demonstrate
Public/Private Partnerships**

**Promote A Genuine Public Health
Approach To All Disaster Medicine/Health**

Contact Information:

BRIAN W. FLYNN, ED.D.

P.O. Box 1205

Severna Park, MD 21146

Phone: 410-987-4682

Email: Brianwflynn@aol.com