



WEST VIRGINIA INTEGRATED BEHAVIORAL HEALTH CONFERENCE

Disaster Behavioral Mental Health for Communities: Promoting Resilience

Colin Newlin, Braintree Solution Consulting, Inc.



**BUREAU FOR BEHAVIORAL
HEALTH AND HEALTH FACILITIES**
350 Capitol Street, Room 350
Charleston, WV 25301
304-558-0627

Agenda

- Defining “Resilience”
- Basic Overview of Emergencies and Responses (BERT, COOP, AHRP)
- Basics of Disaster Behavioral Mental Health Response
 - Response Issues
 - DBMH Responder Training
 - Lifecycle of Disasters
 - Lessons Learned



Defining “Resilience”

Resilience is the power to
cope with adversity and
adapt to challenges or
change



Core Personal Strengths of Resilience

- Self-knowledge and insight
- A sense of hope and optimism
- Healthy coping mechanisms in crisis (sense of humor, coping with negative feelings, having fun, maintaining perspective, planning actions, adaptability, managing stress)
- Strong relationships (seeking support, mobilizing skills and abilities, close attachments to others)
- Personal meaning and perspective



Core Community Strengths of Resilience

- A sense of hope and “community”
- Safe, effective and accessible resources in a crisis
- Strong relationships and communication (personal and institutional)
- *Supply Chain resilience



Promoting Community Resilience

- outreach and education on personal preparedness;
- integration of nongovernmental assets and personnel in preparedness and response protocols;
- improved plans for emergency notifications, evacuation and sheltering;
- increased citizen participation in community safety



Basic Types of Emergencies

Building Emergencies (BERT)

Continuity of Operations Plans (COOP)

All Hazards Response Plan (AHRP)



Building Emergencies (BERT)

Any event or incident that requires the evacuation or sheltering process to protect employees, persons in care, and visitors.



COOP (*internal “response”*)

Continuity of Operations:

- Ensure essential functions
- “All Hazards”
- Relocation or not



Goals of a COOP

- Continuous performance of essential functions (especially critical services to existing clients)
- Maintain communication.
- Protect facilities, equipment, records, and other assets
- Ensure the safety of personnel.
- Support the state/locality's Response Plan.
- Achieve a timely and orderly recovery



Essential Functions (to Prioritize and Assign)

- Executive Direction
- Public Information
- Access Helpline
- Financial Management
- Personnel Management
- Technological Support
- Facilities Management
- Emergency Community Services
- Emergency Psychiatric Services
- Inpatient Psychiatric Care
- Pharmacy services



Prioritize and Assign

What Happens?

Emergency and Essential Personnel

- Safety
- Communication
- Flexibility
- Responsibility



Supplies and Equipment

- 800mhz Radios
- Satellite Telephones
- Laptops
- Emergency go kits
- Psychiatric Medicine Cache
- Emergency contracts in place (e.g. snow removal)
- Emergency vehicles
- Emergency medication contract
- Emergency food
- Generators



All Hazards Response Plans (external)

Public mental health stakeholders should have an All Hazards Response Plan (AHRP) providing the framework for how they will respond to a public emergency. Private sector partners should be involved as resources in response when needed.



Categories and Examples of Hazards

- Natural Hazards—Severe weather, hurricanes, tornadoes, flooding, or earthquakes;
- Infrastructure Disruptions—utility and power failures, water supply failures, critical resource shortages;
- Human-caused Events and Hazards—urban fires, special events, civil disorder, or transportation accidents;
- Technological Hazards—hazardous materials, radiological, biological, or computer-related incidents; and
- Terrorist Incidents—bomb threats, sabotage, hijacking, or armed insurrection, which threaten life or property.



Examples of Team Responses

Emergency Response (No Disaster Declared)

- This type of response is the most common for DMH. In this discussion the major parts of the response will be covered (staff deployment, administration, financing, etc.)

Disaster Declared

- Practical elements involved with a disaster response (the types of interventions provided such as PFA, triage, record keeping, etc.)
Overview of the regional training plan and the core competencies all responders must possess.

Catastrophe

- A catastrophe is an incident that permanently interrupts or alters the continuity of the status quo in terms of impacts upon human physical and mental health, culture language, economy and environment creating irrecoverable losses.



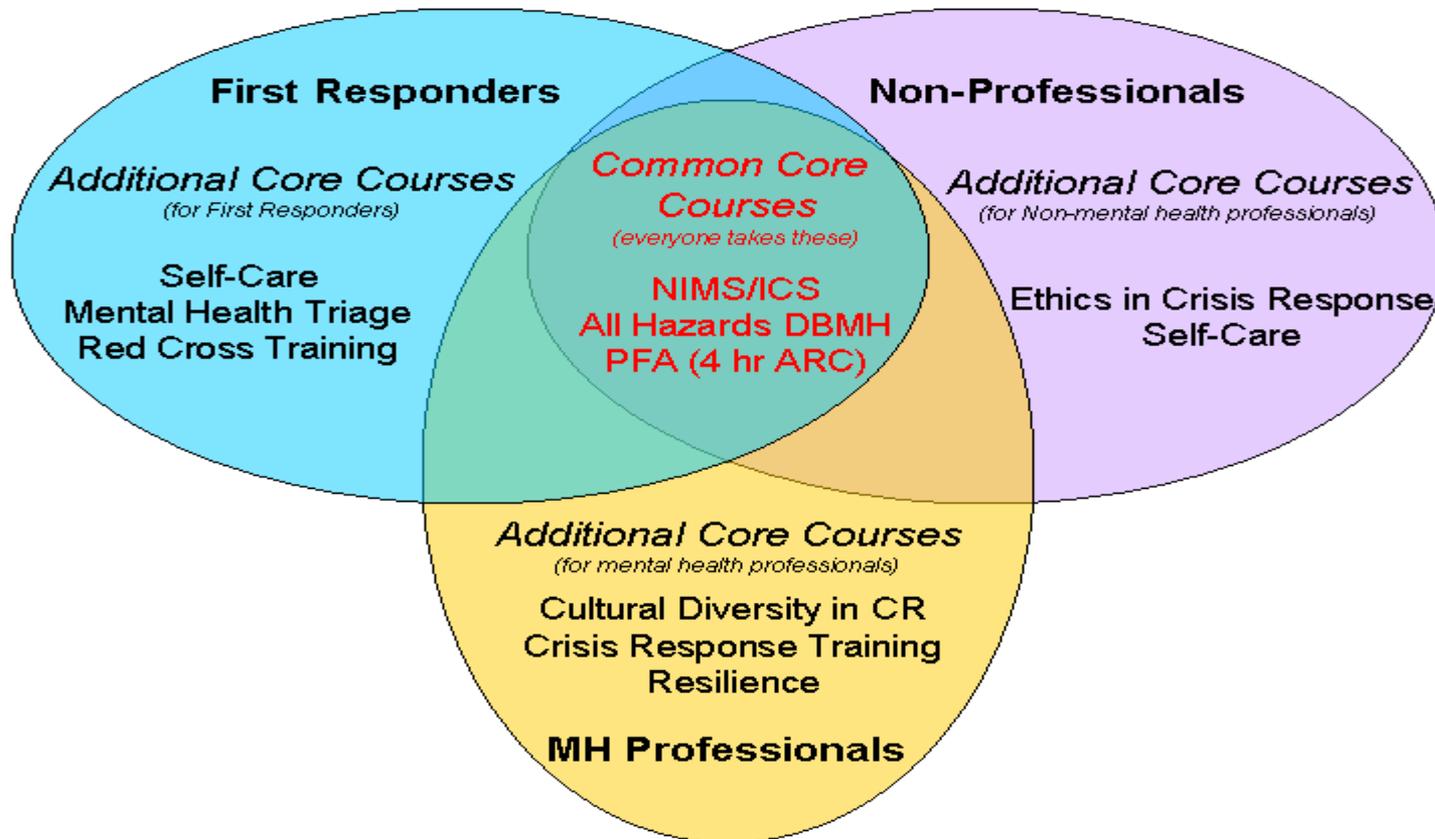
Response Teams

- Coordinate mental health activities through needs assessment and the provisioning of appropriate crisis support services and counseling for first responders, victims, families, and special vulnerable populations.
- Mental Health Response Teams (MHRTs)
 - Surge Response Teams
 - Emergency Response Teams



What do Responders Need to Know?

Core Courses for the Three Target Audiences to Receive Training



Responder Training

Per feedback from regional stakeholders and national DBMH experts, all responder groups should take 3 courses (minimal threshold for deployment):

- ❖ **NIMS –ICS-100 and ICS-700**
- ❖ **All Hazards DBMH Training (a longer version of today's session)**
- ❖ **Psychological First Aid (4 hr ARC version)**



Core Trainings for Mental Health Professionals Before Deployment

CORE TRAINING FOR PROFESSIONAL RESPONDERS	STATE LEAD RATINGS
* National Incident Management System (NIMS) IS-700 / Incident Command System (ICS) IS-100	100.0%
Crisis Response Training	92.9%
* All Hazards Disaster Mental Health Training	86.7%
* Cultural Diversity in Crisis Response	85.7%
Resilience	85.7%



West Virginia Has a DBMH Responder Certification!

Contact Joann Fleming for
information:

Joann Fleming, Disaster Coordinator
Bureau for Behavioral Health and Health Facilities
Desk: 304-356-4788
email: Joann.E.Fleming@wv.gov



Response Teams (Major Roles)

- Provide emergency and crisis behavioral mental health support to first responders, victims, families, and visitors.
- Coordinate all mental health activities and monitor mental health needs/compile assessments.



The Basics First (Maslow): Assessment of Physical Needs

- Numbers affected
- Shelter
- Food
- Wounds/Illnesses
- Infectious Disease
- Medications Available
- Fuel
 - Heat
 - Cooking
- Continued violence
- Mass fatalities



Assessment of Mental Health Needs/Risks

- Vulnerable populations
 - Previously mentally ill (often highly resilient)
 - Wounded
 - Bereaved
 - Tortured
- Medications
- Hospital Beds
 - General
 - Psychiatric



Dead bodies generally not infectious disease risk,
but are psychological toxins



Assessment of Mental Health Resources: Never Go in without a Briefing

- Personnel
 - Traditional mental health workers
 - Red Cross
 - Crisis counselors
 - Others
- Crisis counseling centers
- Clinics/Hospitals
- Medications
 - Psychiatric
 - Medical
- Language/culture



“local” vs “outsider”



The Disaster Lifecycle: Assessment Should be On-Going

- “Honeymoon” period common following disasters
- When attention and media leave, often physical and psychological needs surface
 - Feelings of bitterness, abandonment, anger at government
- Clean-up period
 - Tedious, may still be dangerous



AHRP Example:

Katrina Behavioral Health Issues

- Chronically mentally ill off medications
 - Note: psychiatric medications not in stockpile
- Displaced psychiatrists and populations
 - Volunteers needed, but not enough patients for New Orleans doctors
 - Issues of housing, transportation
- Importance of pets
- Long term issues of “diaspora”
- *Exercise at Johns Hopkins based on Katrina*



Mental Health Impact at Federal Medical Stations (Katrina)

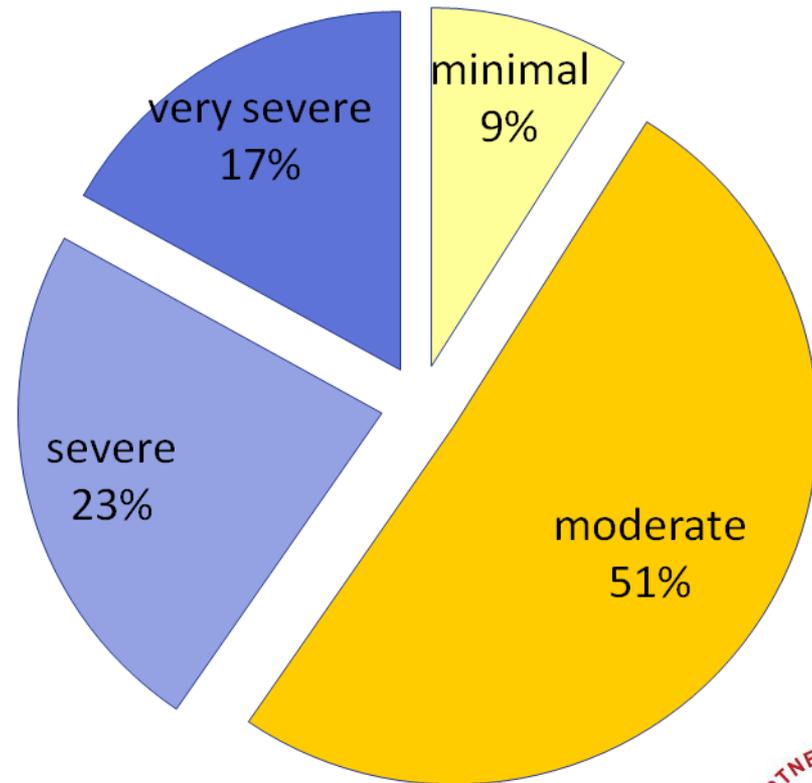
Condition	% affected (n=325)
Hypertension	40.9
Behavioral health issues	36.9
Diabetes	24.3
Heart disease	16.0
Asthma	15.1
Epilepsy	6.8
Blind/partially blind	6.2
O2 dependent	4.9
Morbid obesity	4.9

Source: G Davis, HHS



Community MH Resiliency Based on Results of Past Studies

- *Minimal* -- Effects very weak or highly transient
- *Moderate* – 51% Sample showed distress, but < 25% psychopathology
- *Severe* -- 23% psychopathology in sample
- *Very severe* -- 17% + psychopathology in sample



Source: Norris, 2008



Risk Factors

Pre-Event

- Survivor Characteristics

Within Disaster

- Exposure

Post-Disaster

- Social Support



Secondary Stressors

- Police interrogation
- Media attention
- Prolonged relocation
- Continued separation and estrangement from family and friends
- Bewilderment and Disorientation
- Uncertainty about safety of self and significant others
- Missing family members
- Continued lack of control over what is happening.



General Timelines for DBMH Interventions (FEMA)

- Psychological First Aid (0-48 hours)
- Crisis Counseling (48+ hours after)
- Ongoing Crisis Counseling/Support (Weeks/Months/Years after)
- Outreach & Education



Psychological First Aid (PFA)

A model that:

- Integrates public health, community health, and individual psychology
- Includes preparedness for communities, work places, healthcare systems, schools, faith communities, and families
- Does not rely on direct services by mental health professionals
- Uses skills you probably already have...



Goals of Psychological First Aid (PFA)

- Establish a human connection
- Enhance immediate and on-going safety
- Calm and orient survivors
- Help survivors to tell you specifically what their immediate needs and concerns are and gather additional information as appropriate
- Offer practical assistance and information



Core Actions of Psychological First Aid (PFA)

1. Contact and Engagement
2. Safety and Comfort
3. Stabilization
4. Information Gathering: Current Needs / Concerns
5. Practical Assistance
6. Connection with Social Support
7. Information on Coping
8. Linkage with Collaborative Services



Brief Summary of Lessons Learned

- Must incorporate lessons learned into time-phased planning
- Psychiatric medications
- Family Assistance Centers
- Risk communication
- Command and control
- Environmental monitoring
- Ongoing health assessment



Questions?



Contact Information

Colin Newlin

Braintree Solution Consulting, Inc.

Washington, DC

cnewlin@braintreeconsulting.com

Tel: (202)232-8212

