Lessons from the Field: Toward the Way Forward in Mental Health Disaster Response

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Please note that the featured article is not the verbatim transcription of the author's presentation at the SDPA Conference on "Preparing for the Unthinkable: Mental Health Provider Roles in Disaster Recovery." The transcription has been edited for content, length, copy, and grammar for the purposes of this publication.

Dr. Schreiber, a child psychologist and expert on disaster response, discussed current issues in disaster response from a national perspective, based on his work as the CPA Disaster Response Network Coordinator (DRN) and a Red Cross volunteer, and his vast experience deploying to major national disasters for many years. The CPA DRN is based on the local jurisdiction of the 57 counties in California. He drew attention to the DRN member from San Diego, Dr. Deborah Hopper, who is the current Chair of the SDPA Disaster Psychology Committee.

Dr. Schreiber noted a number of concerns for the direction of the disaster response field related to mental health (second responders). Often, disaster response operations tend to be "one size fits all," when in reality, individuals vary in their needs, based on many factors. It is still not completely clear where mental health professionals fit in with disaster response, per se. The focus remains on acute response, rather than prevention or the aftermath.

Dr. Schreiber pointed out that as clinicians, we tend to focus on individuals rather than populations. Disaster work is optimized by a clear understanding of population groups in the ways in which people respond to disasters. Certain subgroups of the population tend to respond differently to disasters than others, e.g., those who have faced disasters in the past. 30-40% of disaster victims can develop new mental health disorders after experiencing such an event. Yet, many people are resilient and able to return to their baseline functioning after enduring "transitory distress." Symptoms may resemble post-traumatic stress disorder, but much of the symptomatology is sub-clinical. People tend to

fear disaster recurrence, which may trigger symptoms again, but this fear tends to fade over time.

When disaster strikes, a large number of mental health providers and volunteers of varying motive and skill simply show up, and they need to be coordinated. There are increasing efforts to automate this process online. The response to the recent Hurricane Harvey was so large, that it crashed the online mental health volunteer system. Over 5,000 volunteers deployed to this event, even though the site was quickly taken down when capacity was reached. Dr. Schreiber, due to his experience, is often responsible for the assessment and coordination of mental health volunteers on site. It is necessary to appropriately "vet" these individuals before sending them into the field to manage the affected public. Once selected, volunteers may need guidance or targeted training. Much of what has been learned about disaster response and its aftermath comes from a 12-year follow up study after 9/11, conducted by the National Institute for Occupational Safety and Health (NIOSH) within the Centers for Disease Control and Prevention.

There are two main pathways after a disaster: (1) the Acute Disaster Response and (2) the Later Response, both significant to recovery. The severity of the disaster is also important. Extreme, widespread disasters are a great equalizer since most people are greatly challenged simply due to local conditions. In a more moderate intensity disaster, individuals with prior trauma, depression, mental health issues or recent stress may be particularly at risk.

Following the disaster, anyone exposed to an event is now considered vulnerable in future disasters, since experiencing the event will comprise a new mental health risk factor. He noted that most mental health providers are trained to "chase tears" during a disaster, but the most helpful effort may actually be to identify those survivors who are at highest risk and steer them toward the appropriate services. He labeled this phenomenon "triage vs. secondary assessment." The interventions for these high risk individuals may vary greatly, depending on their needs. Generally, only 25% of those affected receive timely care, a statistic that can be improved with targeted training.

Dr. Schreiber noted that American disaster response teams have not learned from their international colleagues who seem to do a better job connecting victims with appropriate resources. He perceives a huge gap in the US between provider capability and awareness that further mental health intervention is available and may be helpful post-disaster. With low awareness and few referrals for follow-up services, mental health care services for many people after disasters is inadequate. He emphasized the need for systematic secondary screening of victims and the "alignment of intervention intensity" to relative risk and resilience among population groups, thereby countering the "one size fits all"

approach. He called for the development of strategies to treat population groups for the identified reactive pathways after a disaster to further extend secondary prevention efforts.

Another important element is to protect volunteers (and first responders) from undue exposure to traumatic scenes. Repetitive, sensational media coverage is a hazard for disaster workers as it may detract from efficacy on the job. Dr. Schreiber stated that he avoids consuming any disaster-related media while deployed, in order to preserve his energy and focus for what he must do at the scene. Obviously, one will invariably be exposed to incidental trauma while on site, but the policy of limiting one's media consumption will serve to minimize the emotional repercussions of this work. Although the majority of first responders are resilient during/after the disaster, approximately 10% may develop adverse mental health sequelae. Some of them may have had predisposing risk factors, such as recent emotional stress or depression.

As Dr. Schreiber summarized, recovery intervention efforts do work and are worth undertaking. After 9/11, there was a $100 million effort to conduct crisis counseling, which was unprecedented. From a Public Health perspective, even if individuals are only slightly impaired, and their work, only mildly affected, when this impact is multiplied across the population affected by a large scale disaster, the economic loss and human suffering is substantial and significant. Unfortunately, no matter how much care is taken, we are bound to miss many people after a disaster who need and might benefit from intervention. Identifying and reaching everyone who needs assistance after a disaster is one of the biggest challenges going forward.