NEW YORK STATE | Office of Mental Health | Department of Health

NY DMH Responder

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In this Issue...

The DMH Responder
is a quarterly production of...

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Welcome

Welcome to the Summer 2017 issue of the **New York DMH Responder**, our quarterly newsletter for the Disaster Mental Health community. For this issue, the newsletter partners at NYS Department of Health, Office of Mental Health, and the Institute for Disaster Mental Health at SUNY New Paltz are following the tradition we established last summer by revisiting and updating some of the most useful and relevant articles we've published since our first edition was produced in Winter 2011. The pieces we've selected focus on some of the main populations who are impacted by any disaster: children, older adults, and people with functional needs that may complicate their disaster experience and recovery. And what about our needs? We end with two items summarizing the impact of helping on the helpers, including common stressors and the long-term consequences – positive and negative – of being a disaster responder. We also sadly say farewell to the driving force behind this newsletter, DOH's Judith LeComb, as she retires. Until her successor is announced, please send feedback about this newsletter to Steve Moskowitz at OMH.

Congratulations and Farewell to Judith LeComb


Inside this issue...
Welcome

Some of you may recall this first issue of the DMH Responder Newsletter back in the Winter of 2011. From that modest beginning, the Responder has gone out faithfully each quarter to more than 1,000 recipients across the state and nation, bringing clinical insights, best practices, current research, and timely resources to individuals in the fields of both mental and public health. Later this month we will be bidding congratulations and farewell to our friend and colleague Judith LeComb as she retires from her position of Manager of Preparedness Training and Education at the NYS Department of Health Office of Health Emergency Preparedness. Since the inception of the Responder, Judith has provided much of the initiative, energy, and commitment that has made the newsletter the consistent and quality resource that it has become over the past six years. Best wishes, Judith... you will be missed!

Subscription to NY DMH Responder

If you would like to be added to the mailing list for this quarterly newsletter please email *prepedap@health.ny.gov*

Note: This article first appeared in the Fall 2015 edition of the *Responder*. The issues addressed remain a significant challenge in planning and response, so we revisit it to remind readers to incorporate these functional needs in your own emergency plans.

Supporting People with Functional Needs

No one is immune to disaster, but it has long been recognized that there are certain groups whose disabilities, age, or other characteristics can create particular difficulties for them during and after events. They may have limited ability to protect themselves during a disaster, more complex sheltering needs, and/or more barriers to recovery. In recent years there's been a national policy shift from segregating people with these issues into "special needs shelters" and instead determining how to address their requirements within general population shelters and services through "functional needs" planning. This is admirable in terms of showing respect for individuals and adhering to the spirit of the Americans with Disabilities Act, but in actual practice, the change has revealed some significant gaps in preparedness as responders must learn how to adapt to complex and often unforeseen situations.

The New York State Comprehensive Emergency Management Plan, released in March 2015 by the state Disaster Preparedness Commission, provides logistical guidance for incorporating functional needs into pre-disaster planning as well as the response and initial recovery phases of a disaster, and additional logistical guidance can be found in the NY-NJ-CT-PA Regional Catastrophic Planning Team's Promising Practices, and FEMA's Guidance on Planning for Integration of Functional Needs Support Services in General Population Shelters. However, these guides contain little information on addressing the **psychosocial reactions** of disaster survivors whose functional needs place them at higher risk – nor do they address the stressors responders themselves may face in trying to meet those sometimes intense demands. Here's a broad overview of a few of the factors we all need to consider in completing this shift. Many of the actions needed to address functional needs can also benefit the general survivor population, as we'll discuss.

Who Are These Groups?

Much of the planning for integrating people with functional needs focuses on individuals with physical disabilities and mental health conditions. FEMA's 2010 guide on incorporating Functional Needs Support Services (FNSS) into sheltering plans states that "children and adults requiring FNSS may have physical, sensory, mental health, and cognitive and/or intellectual disabilities affecting their ability to function independently without assistance. Others that may benefit from FNSS include women in late stages of pregnancy, elders, and people needing bariatric equipment." Other groups who may present particular functional needs post-disaster include unaccompanied minors who need to be reunited with family, people who cannot speak or read English, and pre-disaster homeless individuals.

An important point to remember in considering these groups' psychosocial needs are some of the co-occurring issues that may compound the main disability. The World Health Organization points out that relative to people without disabilities, those with them may also live with poorer general health, lower educational achievements, less economic and social participation, and higher rates of poverty. All of those co-factors are likely to lead to less ability to prepare for emergencies, leading to worse exposure during the event, and providing fewer economic and social resources to support their recovery. That makes it all the more important that every effort be made to address their immediate requirements post-disaster in an effort to remove barriers and provide a supportive early recovery environment.

What Do They Need?

Consistent with the basic premises of disaster mental health, meeting survivors' practical and logistical needs promptly is the best way to prevent extreme and lasting emotional reactions. All of the guides mentioned above include many pages of specifics on addressing a wide range of physical and medical functional needs, so we'll focus on the more mental health-related aspects of a few key points:

Replace missing assistive devices and medications: In some cases restoring access to medications or life-sustaining treatments is a medical

continued on page 3

Supporting People with Functional Needs, *continued*

emergency that should of course be prioritized. Other clients risk a return of physical or psychiatric symptoms, as well as uncomfortable or dangerous withdrawal symptoms, if access to needed prescription medications isn't restored promptly.

But in many cases the need appears far less urgent to response organizers than it feels to the survivor. How many of us would instantly become disabled and dependent if we merely lose our eyeglasses or hearing aids? That's not a matter of life or death, but it shifts that individual from the category of general survivor to person with special needs, potentially making them feel helpless and frustrated and preventing them from participating actively in their recovery. While triaging these needs clearly should focus first on people with the most pressing problems, try to widen the focus as soon as possible to restore functionality to those less urgent cases.

Address dietary needs: Shelter managers should generally try to ensure that meals and snacks are as healthy as possible, with items that are low fat, low sodium, and low sugar to meet the broadest range of dietary needs. FEMA recommends striving to meet more specific needs such as meal options that are vegetarian, gluten-free, kosher, and safe for people who are allergic to peanut oil and by-products.

On the emotional side, we also recommend taking residents' ethnic and regional preferences into consideration whenever possible. Food is a main source of comfort for many people, so providing meals that are familiar and palatable is a small but powerful way to show you recognize their situation and want to support their needs.

Improve communication: Obviously people with severe sensory impairments may have trouble receiving warnings before an event and informational briefings afterward, so bringing in supports like sign language interpreters and scribes may be necessary. Other clients who may need assistance with communication include non-native English speakers (and note that even people who are generally adept in a second language may lose fluency in stressful situations), people with dementia or cognitive impairment, some people with mental illness, and people with autism. Incorporating technology, like translation or voice recognition programs on a smart phone or tablet, may be beneficial in communication with some of these groups.

Also remember that survivors with none of those obvious communications barriers are likely to have trouble focusing on and retaining information if they're very stressed, as is likely soon after a disaster, so try to use simple and direct language, repeat yourself as necessary, provide printed materials as reminders, and don't assume a message has been fully absorbed.

Address stigma: As experiences from a number of recent disasters in New York State have demonstrated, this can be one of the most challenging elements of integrating people with functional needs into a general setting. Largely because of sensationalized or exaggerated depictions of mental illness in both entertainment and news media, many community members have wildly distorted perceptions about people with mental illness being dangerous. Their personal tolerance and patience is not likely to be at its highest in a shelter or other post-disaster setting, where the general conditions may also be activating stress reactions in the person with mental illness who has just experienced the disaster and may be dealing with their own traumatic memories. The resulting

continued on page 4

Supporting People, *continued*

combination of behaviors on both sides can lead to shelter residents protesting the presence of someone who has every right to be there, while that individual faces the added stress of feeling stigmatized and unwelcome.

Stigma may also be directed towards individuals who are visibly ill (even if they're not contagious), or appear to be homeless or otherwise "different." And we should acknowledge that shelter staff and other responders are not immune to feeling anxiety or mistrust about clients who they fear may become disruptive, or staffers simply may not want to deal with the conflict these clients can produce among other shelter residents. DMH helpers may need to balance efforts to provide psychoeducation and calming to anxious residents and staff members while respecting the privacy and access rights of the person with mental illness.

Clearly there are many more specific aspects of integrating people with functional needs into disaster response that we don't have room to address here. This article is just an overview of a policy shift whose ramifications are still emerging for disaster mental health helpers, but we hope it will encourage you to start thinking about members of your community whose functional needs should be incorporated into your plans, and in your staff and volunteer trainings. Ensuring that everyone involved in disaster response understands those needs and develops basic skills to address them can help to minimize excess anxiety and conflict in an already stressful situation.

Research Brief: Lack of Physical Activity Adds to Children's Post-Disaster Issues

In September of 2008, Hurricane Ike made landfall in Galveston, Texas, devastating the area. Eight months post-disaster, researchers studied the effects of hurricane exposure and post-traumatic stress symptoms on area children's sedentary activities, such as watching TV, playing video games, or being on a computer. The children in this study reported an average of 5.91 hours per day engaged in sedentary activity after school. That was much higher than children's national averages of 6.0 sedentary hours total per day including sedentary time during school hours. Boys reported higher sedentary levels than girls, and African-American and Hispanic students engaged in more sedentary activity than white children.

These numbers are hypothesized to be the outcome of increased post-traumatic stress symptoms, parent stress, destroyed playgrounds and unsafe or perceived unsafe environmental conditions, and other stressors that may inhibit children's playtime.

These findings should be used to inform a variety of services involved in children's care after a disaster. If you're responding to a disaster, try to find out what parks or playgrounds are safe in the area to give as resources to stressed out parents. If you're working in a shelter, consider activities that will get children moving such as basketball, or musical chairs or duck-duck-goose for younger children. In the longer term, healthcare professionals might consider screening children for chronic health problems that may result from a lack of exercise such as obesity and Type 2 diabetes in post-disaster areas. Lastly, communities should try rebuilding parks, playgrounds, and other community recreational areas as quickly as possible. Just as we've recognized the need to get children in disaster-impacted areas back to school as quickly as possible to support their cognitive and social development, we also need to facilitate active play as a key factor in physical health and stress reduction.

Source:
Lai, B.S., La Greca, A.M. & Llabre, M.M. (2014). Children's sedentary activity after hurricane exposure. *Psychological Trauma: Theory, Research, Practice and Policy,* 6(3).

Note: Like people with functional needs, children are another group who can be disproportionately impacted by disasters. The next two articles, both published in Summer 2014, address children's emotional and physical needs as important aspects of post-disaster activities.

Federal Preparedness Goals for Assisting Children

Mega-disasters like Hurricane Katrina drew particular attention to the under-served needs of children in disaster, leading to the creation of the National Commission on Children and Disasters. According to its official website, the Commission is an independent, bipartisan body established by Congress and the President to identify gaps in the nation's disaster preparedness, response, and recovery for children and to make recommendations to close the gaps. For its 2010 Report to the President and Congress, the Commission "examined and assessed the needs of children in relation to the preparation for, response to, and recovery from all hazards, including major disasters and emergencies." The resulting report includes findings and recommendations concerning child physical health, mental health, and trauma; child care in all settings; child welfare; elementary and secondary education; sheltering, temporary housing, and affordable housing; transportation; juvenile justice; evacuation; and relevant activities in emergency management.

Their recommendations regarding children's mental health needs included:

1. HHS should lead efforts to integrate mental and behavioral health for children into public health, medical, and other relevant disaster management activities.
2. HHS should enhance the research agenda for children's disaster mental and behavioral health, including psychological first aid, cognitive-behavioral interventions, social support interventions, bereavement counseling and support, and programs intended to enhance children's resilience in the aftermath of a disaster.
3. Federal agencies and non-Federal partners should enhance predisaster preparedness and just-in-time training in pediatric disaster mental and behavioral health, including psychological first aid, bereavement support, and brief supportive interventions, for mental health professionals and individuals, such as teachers, who work with children.
4. DHS/FEMA and SAMHSA should strengthen the Crisis Counseling Assistance and Training Program (CCP) to better meet the mental health needs of children and families.
5. Congress should establish a single, flexible grant funding mechanism to specifically support the delivery of mental health treatment services that address the full spectrum of behavioral health needs of children including treatment of disaster-related adjustment difficulties, psychiatric disorders, and substance abuse.

For more detail on these mental health goals and other recommendations, the entire report can be downloaded for free at: http://archive.ahrq.gov/prep/nccdreport/nccdreport.pdf

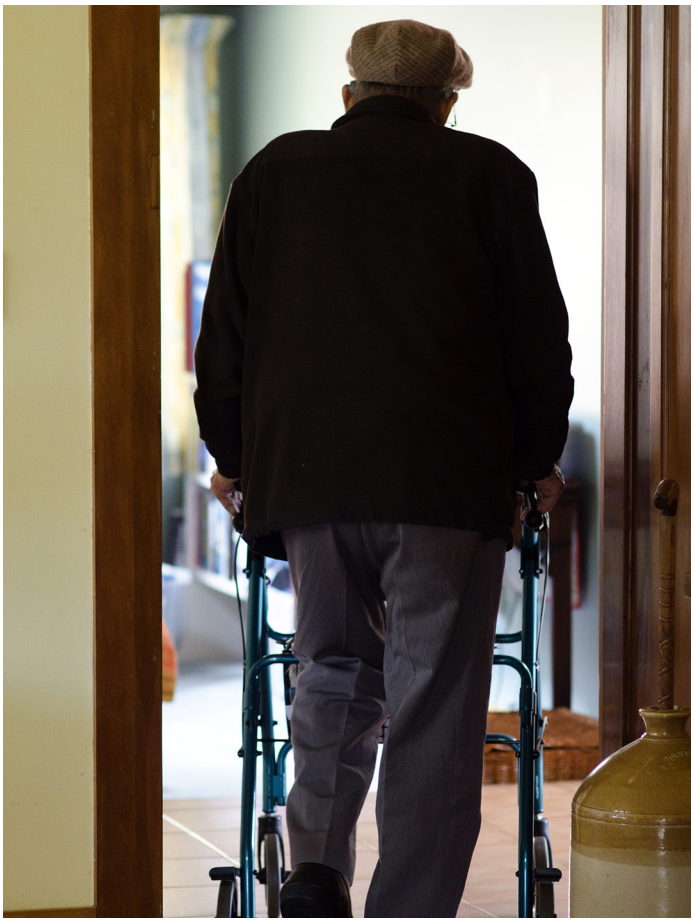
Note: At the other end of the age spectrum from children, older adults are another population who can be vulnerable to disaster's impact, but who also have many strengths that can be emulated in times of crisis. This article was first published in 2011, in the very first year of the Responder, and its points are more relevant than ever as the Baby Boom population bubble moves into later life.

Assisting Special Populations: Older Adults

While the disaster-related needs of children and families have been recognized for some time, until recently far less attention has been paid to the needs of older adults. But demographic trends mean that this population is growing rapidly, so attending to their vulnerabilities – and capitalizing on their strengths – will be essential in coming years. This issue is global: According to the World Health Organization, the number of people age 60 and over will double between 2006 and 2050 to nearly 2 billion, or 22% of the world's population. It's also local: The New York State Office for the Aging reports that the state already has the third largest population in the country age 60 and older, and the Baby Boom generation's entry into this category will expand its ranks drastically over the next few decades. The "oldest old," those over age 80, will merit particular attention.

Of course, many older adults are robust and face no additional challenges around disasters than younger cohorts, but many do experience limitations such as health problems or poverty that increase their needs and may complicate their recovery. **In other words, being older is not in itself a risk factor, but other conditions that often accompany older age may be.** For example:

- Decreased physical mobility and agility, compounded by reduced bone density, increase the risk of injury during disasters; diminished temperature regulation increases sensitivity to hyper- and hypothermia during extreme weather conditions.
- Chronic medical conditions may require medication, treatment, and monitoring that may be difficult to access post-disaster.
- Decreased acuity in vision, hearing, smell, and touch may prevent older people from receiving a warning, or detecting or avoiding danger.
- Reliance on personal assistive devices (such as hearing aids or a walker) for communication or mobility; these may be lost in a disaster, leaving the person dependent on others.
- Cognitive decline, including age-related dementias such as Alzheimer's disease, may limit older people's ability to understand warnings or take care of themselves, especially in unfamiliar or chaotic settings post-disaster.
- Extremely resistant to evacuating, preferring to take their chances at home rather than face the uncertainty and disruption of leaving.
- Particularly vulnerable to sudden changes in eating and sleeping conditions affecting their emotional stability and well-being, so displacement from home is especially difficult. Some may function fine as long as they can follow a set routine, but disruption of this routine caused by the disaster can result in cognitive reactions (confusion, difficulties with memory) as well as anxiety and emotional distress.
- Don't have time left to rebuild or replace what was lost, causing additional grief.

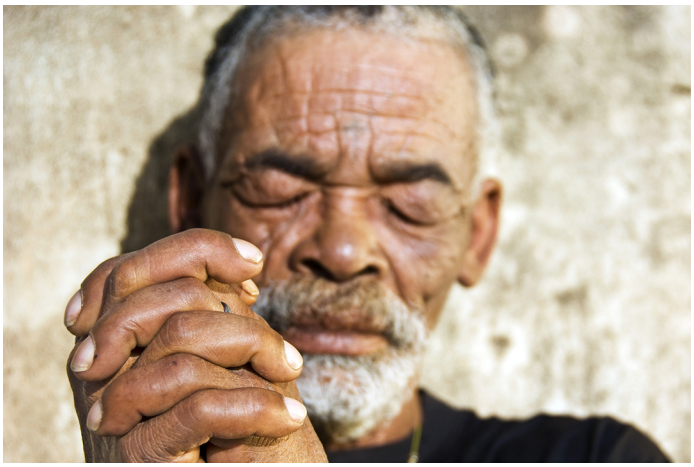


continued on page 7

Assisting Special Populations: Older Adults, *continued*

- May feel (accurately or not) like they are a burden on others, and they may fear that the disaster will lead to a loss of independence.
- May be completely reliant upon their caregivers (whether family members or professional staff in a care facility) for everything from information about the disaster to rescue and recovery, and may be unfamiliar with or lack access to information technology.
- Particularly reluctant to accept mental health counseling, perceiving the need for such services as weakness or failure.

While these logistical risk factors need to be recognized and incorporated into planning, it's equally important to recognize this population's strengths. Most research finds that older adults do not tend to report worse psychological responses to disasters than younger people. Part of that finding may reflect under-reporting of distress out of resistance to accepting professional mental health services or a desire not to be a burden on others, but it also appears to reflect the resilience earned over a long lifetime of experience: Few people reach older age without undergoing some kind of loss or trauma, so they have learned coping mechanisms they can activate after disasters.



The following are key goals to incorporate into preparedness and response plans for your community:

- See to older adults' practical and physical needs first, including limiting interruption in medical treatments that are needed to prevent further physical or cognitive decline.
- Minimize environmental stressors (for example, exposure to noise and confusion in a shelter) and reestablish a sense of routine as quickly as possible, including providing appropriate foods and a quiet place to rest.
- Connect survivors with a positive support network (family members, neighbors, peers) to limit feelings of isolation.
- Assist with recovery of physical possessions.
- Do outreach to find people in need, and probe (gently) for signs of distress to be certain they're not minimizing or hiding their need for assistance.
- Recognize older people's strengths and resilience and involve them in assisting others if possible – they may have useful skills to contribute such as helping with childcare or other practical tasks, and they may have expertise about the community that can be a valuable resource in rescue and recovery efforts.

Additional Resources for Assisting Older Adults

Centers for Disease Control and Prevention
Emergency Preparedness and Older Adults
http://www.cdc.gov/aging/emergency/index.htm

The American Red Cross
Disaster Preparedness: For Seniors By Seniors
https://www.redcross.org/images/MEDIA_CustomProductCatalog/m4640086_Disaster_Preparedness_for_Srs-English.revised_7-09.pdf

Substance Abuse and Mental Health Services Administration
Psychosocial Issues for Older Adults in Disasters
https://store.samhsa.gov/shin/content/SMA11-DISASTER/SMA11-DISASTER-03.pdf

Note: Our Fall 2017 issue of the Responder will focus on the fifth anniversary of Hurricane Sandy, which impacted so many residents and responders throughout New York State. As preparation for that, we'll revisit this piece from Summer 2015 which examined the long-term effects of participating in the mental health response to Hurricanes Katrina and Rita in the Gulf Coast in 2005.

Research Brief:
Long-Term Impact of Disaster Response on Counselors

As any readers who have participated in a disaster response operation well know, trying to meet survivor needs while maintaining one's own personal and professional life can be stressful and exhausting – but also deeply satisfying. The demands on DMH responders after Hurricane Katrina and Hurricane Rita a month later certainly demonstrated that point at a massive scale. Lambert and Lawson (2013) sum up the main issues mental health helpers faced:

- Counselors from the impacted regions may have been forced to relocate; if they were in the area they were usually juggling their own losses with the needs of clients, including uncertainty about whether their agencies would survive the disruption.
- Unprecedented evacuations meant that existing counseling clients were often scattered across great geographical distances, and even locating them was difficult, let alone trying to resume treatment.
- Records were often destroyed or inaccessible, and insurance companies were unreachable.
- Mental health professionals who came to the region to volunteer their services were stretched thin addressing both survivors' needs and vicarious trauma among other volunteers and responders.
- Helpers in cities that received large populations of evacuees had to balance the new population's acute post-disaster issues with ongoing needs among the original community, compounded in some cases by resistance to the newcomers.

While many mental health helpers did all they could to rise to these challenges, it certainly exposed them to the occupational hazards of burnout and compassion fatigue, as well as to the potential for compassion satisfaction and posttraumatic growth. To explore these outcomes after about four years had passed, Lambert and Lawson surveyed 125 professional counselors who had volunteered through the American Red Cross to assist clients affected by Hurricanes Katrina and Rita. Participants completed the Professional Quality of Life Scale which assesses compassion satisfaction, compassion fatigue, and burnout; the Posttraumatic Growth Inventory which assesses positive changes in realms including New Possibilities, Relating to Others, Personal Strength, Spiritual Change, and Appreciation of Life; and the K6+ scale which screens for psychological distress and mood disorders.

Survey participants were 72.8% female, with a mean age of 49 years and average professional counseling experience of 14 years. They were primarily White (86.8%), followed by Black (9.1%) and Hispanic (3.3%). About one-third were in private practice, followed by those working in a community agency (23.6%), college or university (22.7%), K-12 school setting (11.8%), hospital or residential setting (10%), or other. Within the group surveyed, 39 (31.2%) reported that they lived in the affected area and had been personally impacted to some degree. This group of "survivor volunteers" was compared with the other "responder volunteers" who did not experience personal harm from the storms, and all were compared a normative national sample of counselors.

The researchers found no differences between groups in terms of indications of mental illness, with only one participant indicating signs of a serious mood disorder, while 10.4% met the cutoff for a moderate mood disorder, which was lower than rates among the general population of storm survivors. Looking at professional resilience, 9.9% of participants' scores indicated that they were at risk of burnout and a similar percentage (9.2%) scored low on compassion satisfaction. These rates were slightly but not significantly worse than results among a

continued on page 9

Research Brief:
Long-Term Impact of Disaster Response on Counselors, *continued*

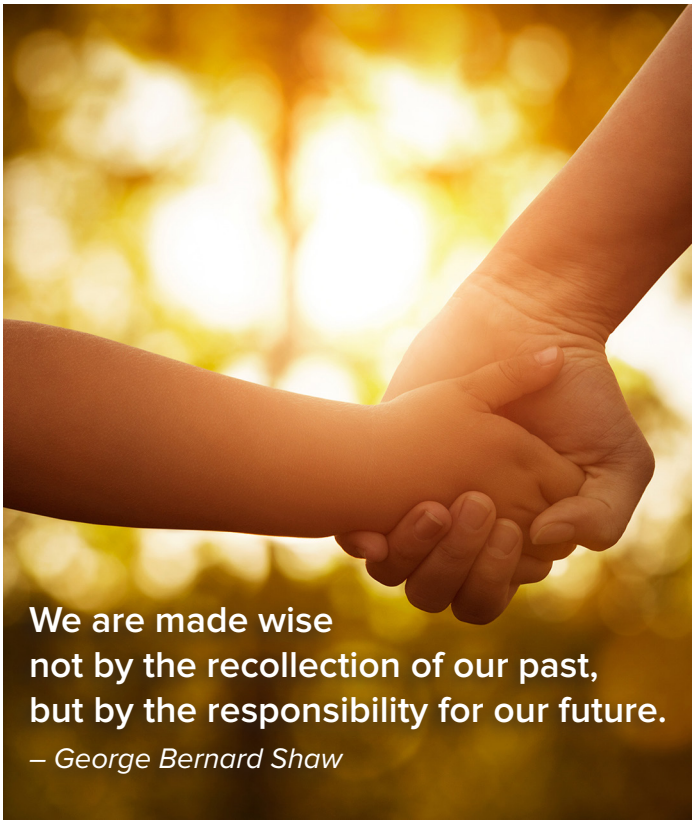
national sample of American Counseling Association members (Lawson & Myers, 2011). More troubling, 22% of those who responded to Katrina or Rita showed signs of compassion fatigue compared with 10.3% among the non-responder sample.

There were no differences between survivor volunteers and responder volunteers on any of the measures of professional resilience, but there were in some subscales of the Posttraumatic Growth Inventory. Interestingly, survivor volunteers reported significantly more growth in the realms of Relating to Others and Personal Strength (both $p<.01$) and in New Possibilities and Appreciation of Life (both $p<.05$). Only Spiritual Change showed no difference between groups, and it had the least growth overall.

Finally, Lambert and Lawson asked participants about their self-care practices during the response and in the past 30 days. They found a modest but significant correlation between higher levels of self-care during deployment and better current compassion satisfaction, as well as lower current burnout. More recent self-care activity also correlated with lower rates of current mental illness symptoms.

The study has many limitations, including the small, homogenous sample and the sole use of self-report measures, but the finding that survivor responders did not have significantly higher rates of negative long-term outcomes than volunteer responders is somewhat surprising and gratifying. The different rates of posttraumatic growth between groups is particularly noteworthy because it suggests a kind of silver lining to the dual experience of surviving and responding to an event: Those who elected to go help others also experienced high levels of personal growth, but those who suffered losses themselves and really had no choice in whether to participate ultimately experienced even more long-term growth in several areas. That finding may be of little comfort while one is in the throes of a response in their own disaster-stricken community, but at least it presents some promise of a positive outcome over time.

Source:
Lambert, S.F. & Lawson, G. (2013). Resilience of professional counselors following Hurricanes Katrina and Rita. *Journal of Counseling & Development,* Vol. 91, 261-268.



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Save the Date

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