Disaster Mental Health: Core Concepts

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A disaster is a incident that causes damage, destruction, and/or loss of life that exceeds local response capacity

Since 2000, there were an average of 341 climate-related disasters per annum, up 44% from the 1994-2000 average and well over twice the level in 1980-1989. Centre for Research on the Epidemiology of Disasters, 2015

Between 1994 and 2013, on average, 218 million people were affected by natural disasters per annum. **Centre for Research on the Epidemiology of Disasters, 2015**

There is always an adverse mental health outcome associated with a disaster!

New Orleans on August 29, 2005

FL Keys


Photo Credit: GS Everly, Jr

DISASTER MENTAL HEALTH

- First text: B. Raphael, *When Disaster Strikes*, 1986
- Field largely founded in 1992
- American Red Cross DMH initiative in 1991-1992
- First national call-out 1992, Hurricane Andrew

THE NEED

In the wake of any disaster there will be a SURGE in demand for psychological support.

SURGE MAGNITUDE

- **In *When Disaster Strikes,* Beverley Raphael (1986) noted, "…in hours after a disaster, at least 25% of the population maybe stunned and dazed, apathetic and wandering—suffering from the disaster syndrome—especially if impact has been sudden and totally devastating … At this point, psychological first aid and triage … are necessary"**
- **[Raphael, B (1986). When disaster strikes. NY: Basic, p. 257]**

The Need to Enhance Surge Capacity is Self-evident.

The only question is HOW?

Traditional reliance upon external resources are often inefficient and ineffective

JHU model builds a resilient infrastructure

PHASES OF A DISASTER

Pre-event **Impact** **Heroic** **Disillusionment** **Reconstruction**

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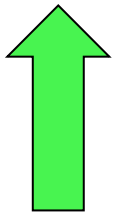

Proactive
Planning

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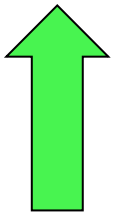
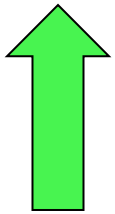


Proactive



Reactive DMH

Planning Failures…

“Failing to plan is planning to fail.”

- Winston Churchill

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Shocking!

Mixed Messages


Don't
BE
HAPPY
worry


YVES
LÉVESQUE
PLUS PASSIONNÉ QUE JAMAIS


SOUR

FACTORS THAT INCREASE PSYCHOLOGICAL TOXICITY

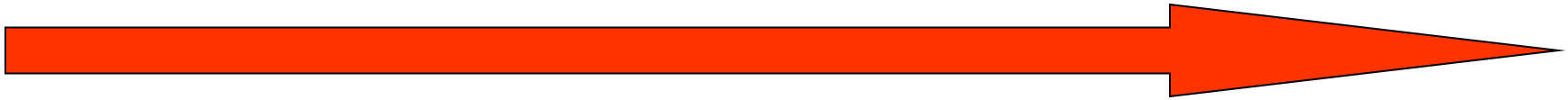
protracted incidents,
domestic dislocation,
mistrust of leadership,
lack of predictability,
inadequate recovery resources,
human-caused,
child-related,
poor communications,
misleading communications,
preventability of the event,
a large number of fatalities

WHAT CAN YOU DO?

The Johns Hopkins'

RESISTANCE, RESILIENCE, RECOVERY

An outcome-driven continuum of care



Create Resistance **Enhance Resiliency** **Speed Recovery**

Kaminsky, et al, (2005) RESISTANCE, RESILIENCE, RECOVERY. In Everly & Parker, Mental Health Aspects of Disaster: Public Health Preparedness and Response. Balto: Johns Hopkins Center for Public Health Preparedness.

RESISTANCE IS INCREASED BY BUILDING COHESION

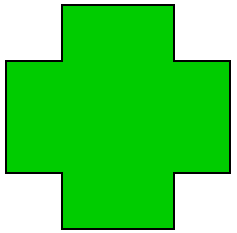
- **Command and Control** – Community leadership must exert authority and direction during and after community adversity. The implementation of "resilient leadership" principles (IOM, 2013))
  - Optimism
  - Decisiveness
  - Integrity
  - Crisis Communication
    - (Everly, Strouse, & Everly, 2010)

- **Context** – This refers to an “atmosphere” of shared constructive pro-social values within the community. A review of the “Broken Windows” research may be useful here.

- **Connectedness** – This refers to the inclination and ability of subgroups within the community to communicate. Based upon TRUST! Pre-existing relationships are essential.
- It leads to **Collaboration and Cooperation**

RESILIENCE

- Strengthen the psychological infra-structure of the community
- Enhance the intrinsic response capacity via Psychological First Aid (PFA) training:
  - EMTs/ Paramedics
  - Educators
  - Police
  - Firefighters
  - PUBLIC HEALTH PERSONNEL



- ***Psychological first aid*** **may be defined as a compassionate and supportive presence designed to stabilize and mitigate acute distress and assess the need for continued mental health care** **(Everly and Flynn, 2005)**

Think of it this way,

As physical first aid is to the practice of medicine, psychological first aid is to the practice of psychotherapy.

RECENT EVIDENCE SUGGESTS THAT

- **1. Crisis intervention (Psychological First Aid - PFA) can increase the belief in one's personal resilience and preparedness, as well as enhance community resilience.**

- Everly, GS, Jr, McCabe, OL, Semon, N, Thompson, CB, & Links, J (2014). The Development of a Model of Psychological First Aid (PFA) for Non-Mental Health Trained Public Health Personnel: The Johns Hopkins' RAPID-PFA. *Journal of Public Health Management and Practice, online*
- McCabe, OL, Semon, N., Thompson, CB, Lating, JM, **Everly, GS, Jr.**, Perry, CJ,
- Moore, SS, Mosley, AM, Links, J. (2014). Building a National Model of Public Mental Health Preparedness and Community Resilience: Validation of a Dual-Intervention, Systems-Based Approach. *Disaster Medicine and Public Health Preparedness*, DOI: 10.1017/dmp.2014.119
- McCabe, OL, Semon, N, Lating, JM, **Everly, GS, Jr,** et al. (2014). Developing an Academic-Government-Faith Partnership to Build Disaster Mental Health Preparedness and Community Resilience: Program Description and Lessons Learned. *Public Health Reports., 129, S4, S96-106.*

2. Psychological crisis intervention is superior to multi- session psychotherapy post disaster, for reducing acute distress, and

3. Psychotherapy acute post disaster may delay or complicate recovery.

- Boscarino, J., Adams, R., & Figley, C. (2011). Mental Health Service Use After the World Trade Center Disaster: Utilization Trends and Comparative Effectiveness. Journal of Nervous and Mental Disease, 199, 91-99.

4. The Johns Hopkins model of PFA has been shown to reduce acute anxiety

- **Everly, GS, Jr,** Lating, JM, Sherman, M. & Goncher, I. (2016). The potential efficacy of a model of psychological first aid. *Journal of Nervous and Mental Disease,* 204, 3, 233-235.

PFA is currently the “first, and most favored, early intervention approach” during or immediately after a crisis, according to the National Institute of Mental Health

Shultz, J. M., & Forbes, D. (2013). Psychological First Aid. *Disaster Health, 2*(1), 3-12. doi:10.4161/dish.26006

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