

Disaster Mental Health

People have always given aid and comfort to each other during times of disaster. However, attempts to structure and professionalize this assistance are fairly recent developments. Disaster mental health, as an evolving field of practice and study, is a collection of interventions and practices that are designed to address incident-specific stress reactions, rather than ongoing or developmental mental health needs. Traditional mental health practice is based on a medical model, with a clinician seeing a patient in an office setting. Disaster mental health introduces a paradigm shift, requiring that practitioners (clinicians and indigenous helpers) work with individuals and whole communities in the field rather than in an office.

This is similar to the clinical conceptualization of community psychology. Disaster mental health practitioners, similar to community psychologists, are likely to view emotional distress through a sociological lens that focuses on normal experiences rather than on pathological responses following a disaster.

Different mental health disciplines (e.g., social work, psychology, and psychiatry) have varying levels of exposure to systemic interventions used in community psychology models and practices. The difference in how disaster mental health practice is viewed is critical to the development of organized systems of intervention that address individual and collective mental health needs after a disaster. If disaster mental health is viewed from the sociological standpoint, intervention systems are more likely to reflect the kinds of support that people rely on in day-to-day living. If disaster mental health is approached using a medical model, intervention systems are designed to identify and treat maladaptive or pathological reactions to disaster. Disaster mental health interventions have evolved from both these traditions.

Disaster Mental Health Interventions

Disaster mental health interventions typically include screening for symptoms of major disorders, outreach, and public education activities. The goal of these

activities is to normalize stress reactions while both identifying those who may be at risk for developing more severe symptoms and avoiding any actions that may induce adverse outcomes [1]. This set of interventions is often called *psychological first aid* (PFA) and is gaining popularity as a skill set that can be taught to anyone and applied in a variety of situations.

The use of the phrase psychological first aid appeared infrequently in journal articles of the 1980s, and was typically described as a clinical intervention. In the 1990s, the American Red Cross began deploying licensed mental health personnel to carry out disaster mental health activities as part of their array of volunteer services offered after a disaster. More recently, the social science literature has begun to reflect on PFA as both a tool for triage used by clinicians and a set of skills that can be taught to other disaster responders to mitigate or normalize the psychological effects of disaster or a critical incident.

The international community (e.g., World Health Organization; United Nations) refers to the set of activities that make up PFA as psychological support, mental health, or psychosocial programming. The international view seems to predate, yet parallel the emerging US movement toward dividing PFA into skills that can be carried out by indigenous helpers as well as trained clinicians [2]. In the United States disaster mental health is also referred to as disaster behavioral health in recognition of the use of a diverse workforce carrying out interventions to build resilient behaviors and coping skills for individuals and communities.

Most disaster mental health interventions include the practice of encouraging survivors of disaster-related trauma or grief to talk about their experience. The effectiveness of this practice has been tested and debated in the literature, but is still considered central to all disaster mental health work. The PFA approach encourages people to talk with someone they trust, such as a friend or a family member. Medical models of intervention that rely on the special expertise of a clinician also encourage people to talk, though in a more guided format such as in the context of a cognitive behavioral approach. Disaster mental health practitioners in the field generally do not provide treatment for disorders; instead, they provide triage or screening for problematic symptoms and refer to other clinicians, preferably based in the local

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community, who can then provide ongoing treatment services.

Research has not shown an undisputable link between most of the interventions presently used in disaster mental health and the prevention of major problems such as posttraumatic stress disorder (PTSD) (*see also Posttraumatic Stress Disorder*). There have been efforts to gain expert consensus regarding potential best practices, but to date there are no universally accepted standards of care in disaster mental health. The field of disaster mental health has yet to standardize nomenclature and identify specific competencies that workers must have to function effectively as disaster mental health practitioners across jurisdictions. The lack of specific competencies has led to the development of a number of training curricula, philosophies, and systems across voluntary and nongovernmental organizations that prepare workers to respond to the psychological, social, emotional, and spiritual needs of people after disasters or humanitarian emergencies. The American Red Cross and the US Department of Veterans Affairs National Center for Posttraumatic Stress Disorder both have PFA curricula and guides that are widely used in the United States [3].

The international disaster response community, unlike the United States, has focused less on competencies of clinical responders and more on widespread preparation of indigenous populations to provide psychological support to one another. Clinicians often serve as trainers or supervisors to indigenous helpers in mixed workforce models of service provision.

A broader evolving clinical role in disaster mental health is related to risk communication. This is assisting public officials to construct concise messages that can be relayed to the public via media about the disaster, its risks, and potential consequences. Risk communication in the context of disaster response is a mechanism for communicating vital information that may increase compliance with directives, inform the public about common reactions to the event, and help people gain some control over their lives after a disaster.

Who Provides Disaster Mental Health?

The division of labor between mental health clinicians and indigenous workers in a disaster mental health response varies according to the availability of

clinicians, type and duration of disaster response, the culture in which the disaster occurred, and the level of involvement of outside entities (e.g., voluntary or nongovernmental organizations). The current lack of accepted standards for preparation of a disaster mental health workforce, both clinical and indigenous, is a glaring gap in the development of organized disaster mental health response. This is compounded by the lack of rigorous research on the effectiveness of interventions commonly used in disaster mental health.

Until there is hard science to support the field, a division of labor between clinical and indigenous personnel will be guided by history, culture, and context. The practice of disaster mental health within an ecological framework recognizes that one part of a system cannot be fully understood in isolation; and that each individual, family, and community's level of distress or resilience is influenced by a complex interplay of systems and events. The use of natural helpers within the local communities to augment the disaster mental health response creates community resilience that may ultimately mitigate negative psychological or social effects of some disasters. The role of indigenous helpers in an organized disaster mental health workforce is typically as culture brokers. They are often peers to those affected by the event (disaster or humanitarian emergency) and are therefore trusted sources of information. In organized systems of intervention, clinicians provide some supervision for indigenous workers.

Legal Issues and Disaster Mental Health Practice

Many disaster mental health practitioners are volunteers. Some are associated with specific aid or relief organizations and enjoy legal protection offered by the organization. Others volunteer their services more spontaneously after a disaster [4]. In the United States, state emergency response statutes typically immunize volunteers from civil suits arising from actions that may even be seen as negligent, so long as their conduct is provided gratuitously in the context of an emergency response. In the case of volunteers, it is likely that clinicians would be more vulnerable to any legal action than indigenous workers. Clinicians who provide supervision to indigenous workers have the additional concern that they may be held responsible for the actions of those they supervise. Clinical

supervision under disaster response or relief conditions can be challenging, given the inherent chaos of the situation. Clinicians in the United States are asked to observe the incident command system span of control rule that determines how many organizational elements can be directly managed by a single individual. Span of control ratios may vary depending on conditions, but a ratio of one supervisor to five reporting units is recommended so that services offered in the field can be tracked and managed [5].

Disaster mental health practitioners, similar to traditional purveyors of clinical service, are concerned about potential legal problems related to liability and malpractice. Historically, establishing legal liability for harms caused by mental health practitioners has been difficult. Demonstrating a causal link between a patient's psychological injury and a practitioner's act or omission can be a major obstacle. A central problem is distinguishing between the harm caused to a disaster survivor by virtue of experiencing the disaster vs. that potentially caused by a practitioner. Additionally, without practices that are widely accepted to guide disaster mental health intervention choices, it is difficult to establish a legally recognized standard of care.

In the United States, establishing negligence is the dominant legal theory employed to assert liability against mental health practitioners (*see also Medical Malpractice*). Negligence is behavior that falls below a legally recognized standard of care employed by a reasonable person in similar circumstances. Negligent conduct is not as culpable as gross negligence or intentional wrong doing, but it can serve as the basis for a successful malpractice lawsuit in many jurisdictions. Establishing negligence, and potential malpractice, generally involves three factors: a treatment relationship must have existed between a practitioner and the patient; the patient must have suffered an actual harm; and the cause of that harm was the practitioner's negligent behavior [6].

Establishing that a treatment relationship exists between disaster mental health practitioners and those they serve is difficult because the practice is generally centered on the philosophy of normalizing symptoms rather than treating the pathology. Many disaster mental health interventions are offered in the field with little documentation about the content of the interaction. In disaster mental health there is thus a noticeable absence of billing, medical records, or other formal indicia of such a relationship. The

treatment relationship is probably most pertinent for clinicians who serve as the agent accepting referrals from disaster mental health practitioners in the field following the immediate disaster event. The treatment relationship is more likely to exist in the traditional clinical circumstances (e.g., seeing a person or family in an office for a scheduled appointment). Upon creation of such a treatment relationship, the mental health practitioner's conduct toward the patient – whether that be an act or omission – must fall under the recognized reasonable standard of care for treatment of similar conditions [7]. Generally speaking, the more experimental or unproven a treatment is, the less likely it will be considered an acceptable exercise of a professionally recognized standard of care [8].

In addition, in establishing that a treatment relationship existed, a case of malpractice could not proceed unless the plaintiff could prove that they experienced injury or harm [9]. This may take the form of a deteriorating mental or physical health condition, excessive alcohol or drug abuse, job loss or decline in job performance, and divorce or strained familial relationships. All these things could also be considered reactions to the stress of experiencing the disaster event [10]. Connecting such harm to negligent acts or omissions of a disaster mental health clinician instead of to the disaster experience would be difficult. This is known as the *proximate cause* – the cause that directly produced the harm and without which it would not have happened. The etiology of many mental illnesses is still unknown to the medical community. A plaintiff's poor mental health or emotional well-being could be the cause of a practitioner's substandard conduct, the natural development of his condition, or the influence of other factors.

Disaster mental health practitioners enjoy protection from civil liability in a number of ways. These immunities are driven by policy concerns to encourage responders to provide help to people in need without fear of lawsuits. In the United States, Canada, Japan, and some European nations, there are "Good Samaritan" statutes that encourage medical professionals to come to the aid of injured persons. Generally, they shield practitioners from negligence liability if they render care that is free, in good faith, as part of a direct response to emergencies, and does not amount to reckless behavior [11].

In the United States, additional protection from liability exists in state emergency management statutes.

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Such laws are usually triggered by an official declaration by a state executive. These laws anticipate that some degree of disorder will characterize the immediate aftermath of a disaster and its response. They usually waive professional licensure and regulation requirements temporarily for a short duration of time in order to facilitate rapid response to an emergency situation. Importantly, they also typically bar civil suits against responders and their organizations that acted in good faith as part of a response effort, so long as their acts or omissions did not constitute reckless behavior or intentional wrong doings. In 2006, the Uniform Law Commission drafted the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) [12]. The law partially immunizes qualified volunteer health practitioners, including mental health practitioners, from liability arising out of disaster response activities. The UEVHPA has since been passed in some form in 12 states. On the federal level, there are various forms of statutorily provided qualified immunities. For instance, the Federal Volunteer Protection Act provides limited protections for qualified volunteers that work for nonprofit or government entities [13].

Determining whether behavior is protected under Good Samaritan laws or other volunteer laws and immunities in emergency management statutes is a matter of reasonableness. If a responder's actions were consistent with a good-faith effort to provide assistance in an emergency context, courts will generally shield such behavior from liability. If, however, a person departs from a good faith and reasonable effort to assist in response activities, or engages in objectively reckless behavior, then liability protection ends.

Legal exposure for disaster mental health clinicians and indigenous workers has not been significantly tested to date. Although the application of disaster mental health interventions is widespread, evaluation of the long-term effectiveness of their various forms of implementation will benefit from ongoing empirical documentation.

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Further Reading

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