

University of Nebraska - Lincoln

DigitalCommons@University of Nebraska - Lincoln

Publications of the University of Nebraska
Public Policy Center

Public Policy Center, University of Nebraska

2009

Disaster Mental Health

Denise Bulling

University of Nebraska - Lincoln, dbulling2@unl.edu

Tarik Abdel-Monem

University of Nebraska - Lincoln, tabdelmonem2@unl.edu

Follow this and additional works at: <https://digitalcommons.unl.edu/publicpolicypublications>



Part of the [Public Policy Commons](#)

Bulling, Denise and Abdel-Monem, Tarik, "Disaster Mental Health" (2009). *Publications of the University of Nebraska Public Policy Center*. 52.

<https://digitalcommons.unl.edu/publicpolicypublications/52>

This Article is brought to you for free and open access by the Public Policy Center, University of Nebraska at DigitalCommons@University of Nebraska - Lincoln. It has been accepted for inclusion in Publications of the University of Nebraska Public Policy Center by an authorized administrator of DigitalCommons@University of Nebraska - Lincoln.

Disaster Mental Health

Denis Bulling and Tarik Abdel-Monem

University of Nebraska Public Policy Center

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 prac-

tioners, like community psychologists, are likely to view emotional distress through a sociological lens that focuses on normal experiences rather than on pathological responses following 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 supports that people rely upon 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 of 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 discussion about PFA as both a tool for triage used by clinicians and as 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 United States movement toward dividing PFA into skills that can be carried out by indigenous helpers as well as trained clinicians [2].

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, like a friend or 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 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 like posttraumatic stress disorder (PTSD). 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 curriculums, 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 U.S. 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, culture in which the disaster occurred, and level of involvement of outside entities (e.g., voluntary or non-governmental 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 protections 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. Most clinicians prefer not to supervise more than 10 disaster workers at a time so that they can adequately track and manage the type of service being offered in the field.

Disaster mental health practitioners, like 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 versus 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. Negligence is behavior which 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 potentially malpractice, generally involves three factors: a treatment relationship must have existed between a practitioner and patient; the patient must have suffered an actual harm; and the cause of that harm was the practitioner's negligent behavior [5].

Establishing that a treatment relationship exists between disaster mental health practitioners and those they serve is difficult since practice is generally centered on the philosophy of normalizing symptoms rather than treating pathology. In disaster mental health there is also 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 prac-

titioners in the field. 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 like conditions [6]. 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 [7].

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 [8]. 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 [9]. 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 medicated 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 a number of protections from civil liability. 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 which 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 [10].

In the United States, additional protections from liability exist in state emergency management statutes. 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 for a temporary amount of time in or-

der 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.

Determining whether behavior is protected under Good Samaritan 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 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.

References

- [1] Everly Jr., G. S. and B. W. Flynn (2005). *Principles and Practice of Acute Psychological First Aid after Disasters*. Johns Hopkins Center for Public Health Preparedness, Baltimore, MD.
- [2] Van Ommeren, M. and S. Saxena (2004). *Mental Health of Populations Exposed to Biological and Chemical Weapons*. World Health Organization.
- [3] Brymer, M., A. Jacobs, C. Lyne, R. Pynoos, J. Ruzek, A. Steinberg, E. Vernberg, E. and P. Watson. (2006). *Psychological First Aid: Field Operations Guide*. National Child Traumatic Stress Network and National Center for PTSD.
- [4] Hodge, J., L. Gable and S. Calves. (2005). Volunteer health professionals and emergencies: assessing and transforming the legal environment. *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science* 3(3): 1-8.
- [5] Halleck, S. (1980). *Law in the Practice of Psychiatry: A Handbook for Clinicians*. Plenum, New York, p. 13-54.
- [6] Schultz, B. (1982). *Legal Liability in Psychotherapy*. Jossey-Bass, San Francisco, p. 1-44.
- [7] Schefflin, A. (2000). The evolving standard of care in the practice of trauma and dissociative disorder therapy. *Bulletin of the Menninger Clinic* 64(2): 197-234.
- [8] Simon, R. and R. Sadoff. (1992). *Psychiatric Malpractice: Cases and Comments for Clinicians*. American Psychiatric

Press, Washington, D.C., p. 4-61.

- [9] Davidson, R. and A. McFarlane. (2006). The extent and impact of mental health problems after disaster. *Journal of Clinical Psychiatry* 67(supplement 2): 9-14.
- [10] Hodge, J., L. Gable and S. Calves. (2005). The legal framework for meeting surge capacity through the use of volunteer health professionals during public health emergencies and other disasters. *Journal of Contemporary Health Law and Policy* 22: 7-71.

Further Reading

Hodge, J., L. Gable and S. Calves. (2005). Volunteer health professionals and emergencies: assessing and transforming the legal environment. *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science* 3(3): 1-8.

Inter-Agency Standing Committee (IASC) (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. IASC, Geneva.

International Federation of Red Cross and Red Crescent Societies (2003). *Community-based Psychological Support Training Manual*.

National Institute of Mental Health (2002). *Mental Health and Mass Violence: Evidence-based Early Psychological Intervention for Victims/Survivors of Mass Violence. A Workshop to Reach Consensus on Best Practices*. NIMH, Washington, D.C.

Schefflin, A. (2000). The evolving standard of care in the practice of trauma and dissociative disorder therapy. *Bulletin of the Menninger Clinic* 64(2): 197-234.

World Health Organization (2004). *Mental Health of Populations Exposed to Biological and Chemical Weapons*. p. 1-13.