
Disaster Mental Health Services

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Abstract

The traditional medical roles of doctor and patient are not particularly well suited to disaster scenarios for reasons to be discussed later. Certain federal, state and local medical entities provide disaster mental health services along medical occupational lines, I.e., social workers, psychologists and psychiatrists. These degree-based distinctions have little practical value at a disaster site with the exception of a rare individual who might require psychiatric medication. My personal experience has been as a member of a Disaster Medical Assistance Team (DMAT), a unit of the National Disaster Medical System (US Public Health Service) as well as a disaster mental health volunteer with the American Red Cross.

The American Red Cross, the official lead disaster relief agency in the U.S., utilizes a different (non-medical) model of mental health services. All state licensed mental health professionals are considered as (generic) mental health workers, with no distinction, for example, between psychiatrists and (licensed) counselors.

Regardless of which occupational training the mental health professional received, there typically is little, if any, formal graduate school training for activities at a disaster site.

Therefore the American Red Cross requires all professional applicants for volunteer disaster mental health work to undergo 16 hours of course work. Classes include, but are not limited to: the emotional impact of disaster, roles of direct services, and defusing and debriefing. Attendees get some "hands-on" experience by role-playing various disaster scenarios. Clearly, regardless of professional designation, the victims will receive identical services from any and all Red Cross disaster mental health workers. (1)

In the Red Cross organization, top priority for mental health services is to Red Cross volunteers as well as other disaster responders. The premise being that unless responders

function well, the relief operation may be compromised.

The second priority is providing services to victims (referred to as clients) and their families. In a medical model, victims would be referred to as "patients," as least semantically indicating that they have become "sick." Both the Red Cross as well as the US Armed Forces considers persons who are severely stressed as having NORMAL reactions to abnormal situations. Only individuals who develop significant mental symptoms are deemed to be mentally ill.

Contrary to the role of traditional mental health workers, within the Red Cross there are numerous functions they perform in addition to the customary mental health diagnostic and therapeutic activities.

Stress management is probably the single most important function. Training in stress prevention/reduction is offered to other Red Cross volunteers and takes place in local Red Cross chapters. At a disaster site, mental health workers serve as "stress troubleshooters," and monitor

all activities and interactions that might be stressful. For example, noticing that workers are becoming irritable due to long shifts would be brought to the attention of the supervisory staff. Supervisor-staff conflicts would be mediated by a mental health worker. Of course, formal mental health symptoms would be noted, evaluated, and appropriate referrals made.

At the conclusion of an especially stressful episode or day, debriefing would take place, conducted by mental health workers trained in that activity. Furthermore, all Red Cross volunteers are expected to be debriefed at the conclusion of their assignments.

Additional functions of Red Cross mental health personnel include (2):

- Participating in staff meetings
- Assisting with the work of other functions
- Advocating improvement of mental health conditions within the setting
- Provide consultation within and across functions
- Assessing stress level of supervisors and providing interventions appropriately

Of secondary priority are mental health interventions for clients (victims) and their families, including support during their grieving as well as amelioration of other stresses due to loss of property, etc.. Debriefing is done when appropriate and referral to local mental health resources is performed.

At the recent Egypt Air crash site, about 50 Red Cross mental health workers (including the author) were deployed. Assignments included assistance to grieving families as well as mental health support for all Red Cross volunteers and other responders, such as the FBI.

In contrast, at Ft. Dix, New Jersey, where up to 4000 Kosovo refugees were processed, only one nurse with some mental health experience was available. Actually, she was assigned to more pressing medical duties. Many refugees had been raped and had other horrendous experiences, requiring interventions, debriefing, etc. Yet when the author volunteered, he was told that no psychiatrists were needed, since several Public Health Service psychiatrists were on the scene to perform forensic immigration related evaluations. Apparently psychiatrists were not deemed relevant to performing 'counseling' or other direct services to the refugees. An example of the limitation of strictly utilizing the traditional medical model of services and thereby not seeing the forest through the trees!

Red Cross mental health workers at a disaster site are adequately supervised to avoid intrusive or unwanted interventions or ethical lapses such as soliciting private clients. The latter is more likely to occur when local non-Red Cross mental health volunteers appear at a disaster site.

CONCLUSIONS

1) Disaster assistance organizations that rely on a system of medical, degree based mental health providers should consider the Red Cross' "generic" mental health provider approach. State licensed mental health professionals should be considered equally utilizable, regardless of degree.

2) All mental health providers should undergo appropriate disaster relief training before being deployed to a disaster site. For example, sending a child psychiatrist, psychoanalyst, or pharmacologically oriented psychiatrist to a disaster site without relevant disaster training would be useless at best or harmful at worst. (3,4,5,6,7,8,9)

3) On site supervision by a seasoned (disaster) mental health professional would ensure appropriate job functioning and enhance professional and/or ethical judgments.

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