A Multi-Systemic Psychosocial Support Model for Responding to Disasters and Mass Violence

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The previously scheduled program has been interrupted for this breaking news story:

APA Stunned by Revelations in the Hoffman Report. On Eve of Annual Convention, Crack Team of Trauma Psychologists Deployed to Toronto to Heal the Survivors
Learning Objectives

Participants will be able to:

1). Iteratively map the “dose of exposure” terrain in the aftermath of a disaster.

2). Dynamically map the currently and readily available resources for responding to the anticipated psychosocial needs.

3). Match existing resources to the anticipated and manifest psychosocial support needs with cultural sensitivity and responsiveness to change across time.
Presenter Background

Early Career:
• Faculty at the Disaster Mental Health Institute, Univ. of S. Dakota
  – Major Product: Handbook of International Disaster Psychology (Edited 4 Vols.)
  – Activities: Research and Training Consultations with World Health Organization (WHO), International Society of Red Cross and Red Crescent Societies (IFRC), etc.
  – Rapid Assessment of Refugee Mental Health Needs
  – Development of Trainers and Training Curriculum for Community-Based Psychological Support
  – Major Experiences: 1999 – Tornadoes (Oklahoma); 1999 – Hurricane (N. Carolina); 2000 – Terrorism (Kenya); 2000 – Massive Flood (Venezuela); 2001 – National PFA Conference (Cuba); 2001 – Terrorism (New York); 2002 – Consultation at IFRC (Switzerland); 2002 – IFRC Training of Easter European Delegates (Hungary)
Presenter Background

Mid-Career:
• Faculty Administrator at Fielding Graduate University (now adjunct faculty)
  – Main Product: Encyclopedia of Psychological Trauma (Lead Editor, with Elhai & Ford)
  – Activities: Member of the NCTSN
    • Terrorism and Disaster Center
      – Hurricane Katrina Research
      – Manual for Working with Displaced Populations
      – Disaster Research Training Program
    • UCLA – National Center for Child Traumatic Stress
      – Terrorism and Disaster Network
      – Psychological First Aid (Development and Training)
      – Skills for Psychological Recovery (Development and Training)
      – Task Force on the Core Curriculum on Childhood Trauma
      – Research: Wildfire Research Team (UCSB & Univ. of Iowa)
Personal Lessons Learned

• Almost nothing in graduate school (clinical psychology) prepared me for the American Red Cross model of Disaster Mental Health (RC – DMH)
  – Paramilitary attitudes and culture (“swaggering lifers”)
  – Reliance on heroics rather than servant leadership and robust adaptive personnel systems (just like in the movies)
  – Stigmatized identity of DMH mission and personnel
  – Small army of licensed mental health clinicians (advance to the rear)
  – Minimal workforce training and preparation (intro to RC and intro to DMH)
  – Minimal grasp of “community psychology” and “public health model”
  – No clear and consistent model of service delivery or outcome objectives
  – Inadequate feedback loops for program evaluation or product improvement
  – Inadequate efforts to mitigate occupational hazards (i.e., secondary or vicarious traumatic stress, and compassion fatigue)
Section 2: Introduction to the Elements of the Disaster Mental Health Response

The elements of the disaster mental health response form a continuum of services from identifying mental health needs (individual triage and mental health surveillance: element 1) to providing clinical interventions appropriate to clients and workers in the disaster setting (promoting resilience and coping and providing targeted interventions, elements 2 and 3, respectively). In practice, these elements are fluid. In a single encounter, you might practice several elements at the same time or move from one element to another without intermediate steps. Although these services are most often offered during a disaster response, some will also be offered during preparedness and recovery phases as well.

**Element 1: Identification of Mental Health Needs**
- DMR and non-DMR workers use PsySTART and other factors to prioritize DMR contacts
- DMR leads use combined data to allocate resources

*For all clients and workers*

**Element 2: Promotion of Resilience and Coping**
- Non-DMR workers use PFA
- DMR uses:
  - Enhanced PFA
  - Psychoeducation
  - Community Resilience Support
  - Community Resilience Training

*For most clients and workers*

**Element 3: Targeted Interventions**
- DMH only:
  - Secondary Assessment and Referrals
  - Crisis Intervention
  - Casualty Support
  - Advocacy

*For high-risk clients and workers*
Current ARC-DMH seems improved

<table>
<thead>
<tr>
<th>Number</th>
<th>Element</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td><strong>Identification of mental health needs</strong></td>
<td>When providing DMH services, it is important to identify mental health needs and prioritize clients and responders at greatest risk. This section introduces strategies to use limited time and energy effectively through individual psychological triage and mental health surveillance of community needs.</td>
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<td>2</td>
<td><strong>Promotion of resilience and coping</strong></td>
<td>As the second element in the continuum of disaster mental health services, you will be assisting clients and other Red Cross workers to cope effectively with the stress related to the disaster. You will learn how to use your clinical skills to go beyond the basic PFA actions and provide EPFA. Other interventions aimed at promoting resilience and coping include psychoeducation, community level support and community resilience training.</td>
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<td>3</td>
<td><strong>Targeted interventions</strong></td>
<td>In this section, you will find the interventions that are frequently used for high-risk clients and those who need extra support, specifically secondary assessments, referrals, crisis intervention, casualty support and advocacy. Please note that the first two elements (triage/mental health surveillance and promoting resilience and coping skills) also contain guidance that is relevant to serving higher-risk clients.</td>
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Current ARC-DMH seems improved

Approved interventions

The only interventions approved for Red Cross DMH are those specifically listed in this section:

Element #1: Identification of Mental Health Needs:
- Individual psychological triage
- Mental health surveillance

Element #2: Promotion of Resilience and Coping:
- EPFA
- Psychoeducation
- Community resilience support
- Community resilience training

Element #3: Targeted Interventions:
- Secondary assessment
- Referrals
- Crisis intervention
- Casualty support
- Advocacy

Appendix A lists, defines and discusses all approved interventions. No other types of interventions (play therapy, critical incident stress debriefing (CISD) or eye movement desensitization reprocessing (EMDR), for example) may be conducted during a disaster response. Red Cross DMH workers may not provide any intervention that is not approved.
Literature Review


• Expert and key informant based consensus and evidence informed description of principles and practices for supporting resilient recovery from potentially traumatic experiences.

• Framework stipulates eight “core actions”: contact and engagement, safety and comfort, stabilization, information gathering, practical assistance, connection with social supports, information on coping support, and linkage with collaborative services.

• Includes many handouts, and comes in versions addressing the particular context of schools, religious professions, and in a number of translations.

• Also: 6-hour interactive PFA online course and a PFA Mobile app.
Literature Review


• After extensive review of evidence for mass-trauma interventions, these essential elements were identified:
  – 1) a sense of safety
  – 2) calming
  – 3) a sense of a) self–efficacy and b) community efficacy
  – 4) connectedness
  – 5) hope.
Literature Review


• Describes a competency-based model for PFA training developed in conjunction with the Centers for Disease Control and Prevention and the Association of Schools of Public Health.

• Established a consensus set of 6 KSA (knowledge, skills, attitudes) core competencies:
  – 1. initial contact, rapport building, and stabilization;
  – 2. brief assessment and triage;
  – 3. intervention;
  – 4. triage;
  – 5. referral, liaison, and advocacy;

• Proposal is that these results could serve as a curricular basis for fulfilling the aims of the Pandemic and All-Hazards Preparedness Act of 2006 (i.e., to train public health practitioners to promote public health preparedness and response by teaching these competencies to lay-providers).
Literature Review


• Reviewed published studies regarding the use of PFA, finding none had any data and that there were no empirical studies of efficacy or effectiveness.

• Recommends that emergency interventions should focus on well-established risk factors: a) peri-traumatic dissociation and b) perceived inadequacy of social support.

• Cites NATO, TENTS and IASC recommendations that favor
  – “social” and “community” focused interventions over “individual” and “psychological” targets (i.e., public health model and community psychology),
  – but with capabilities for detecting clinical needs and referral to more adequate services.

• Supports the principles underlying PFA.
Literature Review


- Belgian Red Cross (Flanders) tried to ensure that its volunteers were trained in the best way possible.
- Reviewed 5 bibliographic databases and found no published evidence regarding the effectiveness of PFA.
- Conclusion: No empirical evidence to develop guidelines.
Literature Review


• Laments lack of empirical evidence for PFA
• Acknowledges the difficulties of conducting such studies in most real-world situations
• Recommends a phasic framework for establishing and evaluating PFA within high-risk organizations.
  – Pre-event:
    • Phase 1: PFA-consistent organizational policies & procedures
    • Phase 2: PFA promotion and staff training
  – Post-event:
    • Phase 3: PFA response
    • Phase 4: Monitoring and follow-up of staff

- Describes a pilot evaluation of training provided to managers and peer-supporters in a high-risk organization according to the Phased PFA model proposed by Forbes et al. (2011).
- Trainees demonstrated small but significant gains in
  - PFA and PTE content knowledge
  - Self-reported increased sense of confidence in being prepared to respond to incidents
Literature Review


- Used qualitative focus groups to generate anticipated mental health needs, displacement-related challenges, and secondary adversities.
- Identified concerns were as might be expected (coping with exposures, unemployment and financial pressures, housing and transportation difficulties, material losses, exacerbation of pre-existing psychological conditions).
- A major concern was that providers lacked cultural competence to work with a displaced population from a very different cultural background and milieu (encountering the “other”).
- There were also expressions of apprehension regarding the challenges of working with survivors who typically engaged in illegal or unethical behaviors (negative stereotype of these evacuees).
Literature Review


• Examined the capacity of a disaster mental health workforce to provide three evidence-supported intervention types:
  – psychological first aid
  – skills for psychological recovery
  – intensive mental health treatments

• From 32 to 42% of this workforce self-reported a composite of perceived skills, experiences, and confidence in being able to deliver these interventions.

• Recommendation is for increased attention to workforce capacity-building.

- Best published evaluation of the training effect, but no data on the intervention effect.
- Examined efficacy of 2.5-day national PFA training program in preparing mental health field workers to work with Syrian refugees.
- Content knowledge and skills measured at pre, immediate post-training, and after one month suggested a durable training effect.
Literature Review Conclusions

Numerous areas of improvement are needed:
• Overall workforce preparedness for providing psychosocial support remains inadequate
• Emergency phase psychosocial support interventions are well defined, but their effectiveness remains in question
• Despite exceptions like the Red Cross, the models of service delivery are not well defined
• Models of service delivery are not well researched
• Cultural variation in the accessibility, acceptability, credibility, sustainability, and effectiveness of disaster interventions are not well researched (i.e., what is cultural competence?)
• Differential effectiveness of approaches to training are not well researched
• Quality assurance of provider competence is unexamined
Case Example: Santa Barbara Response Network

Grassroots organization (501c3) founded in 2009 in response to community-level potentially trauma events that fell through the cracks (not covered by Red Cross, Victim’s Assistance, Hospice)

- Suicides
- Community violence
- Violent accidents

Intervention:
- Psychological First Aid

Training and Preparation:
- Volunteers are taught incident command system (ICS) and PFA in accordance with the NCTSN/NCPTSD materials
- Role plays and incident simulations
- Exceptional performance leads to leadership roles
Case Example: Santa Barbara Response Network

Model of Service Delivery:
• Trained PFA teams of commensurate size deploy by invitation to locations where psychosocial support is considered appropriate and accessible
• Where appropriate a proximal base of operations is established as a “Compassion Center” and staffed with trained volunteers
• To accomplish information gathering and other outreach goals pairs and trios of volunteers (no solos) are deployed as “Compassion Patrols”
• Executive consultations are provided to leaders of affected systems and responsive systems
• Public health approaches are employed for disseminating information on coping and resilience behaviors
Case Example: Santa Barbara Response Network

Dose of Exposure and Needs Assessment:

• Meeting is held of key informants from affected and responsive systems
• Anticipated doses of exposure are mapped in accordance with the estimated severity of event impact
• Concentric circles and spatial locations are used to represent higher and lower anticipated doses of exposure (e.g., inner and outer relational circles)
• Distinct systems and individuals are identified to take responsibility for investigating actual impacts and needs within each circle (accountability)
• Assumptions are revised based on rapid feedback to allow tailoring of the response
• Needs maps are dynamic and revised at least daily
Case Example: Santa Barbara Response Network

Resource Mapping:

- First iteration is based on generic assumptions and familiar resources
- Second iteration is responsive to key informant feedback on more specific characteristics of the critical event
- Subsequent iterations are responsive to changing needs across time and discovery of emergent resources
- Cultural factors are actively identified through culture-brokers, allowing improvement of the cultural acceptability and credibility of resources and services
- Resource maps are dynamic and revised frequently
Incident Example: Killing Spree in Isla Vista, 2014

- Six UCSB students killed and over a dozen other community members injured
  - Crime scene of almost a square mile
  - Grisly details included multiple stab wounds to 3 victims
  - Intense news media coverage of killer and his hateful internet manifesto
  - Political battle erupts over gun violence and gun rights

- University of California campus and broader system profoundly affected

- Citizens and government of the county profoundly affected

- Unusual characteristics of Isla Vista require careful planning
  - No official governance or leadership
  - Not all students
  - Underserved Latino community
Response Example: Killing Spree in Isla Vista

- Meeting of response planning representatives within hours
- First iteration of exposure dosage and needs map is constructed
- Systems and individuals are assigned as agents to initiate contacts, gather information, and inform the response
- First iteration of resource map is constructed
- Systems and individuals are assigned to gather information about additional resources
- A PFA team is formed and deployed for the first of the memorial vigils
- Locations for the Compassion Center are identified
- Law enforcement and other partners are enlisted to support the deployment of PFA Compassion Patrols in the affected neighborhoods
Response Example: Killing Spree in Isla Vista

- Volunteers are recruited and trained in PFA and the incident management system
- Bilingual/bicultural teams are formed for Latino neighbors
- Experienced volunteers are paired with newbies
- Coordination is managed with UCSB catchment system to avoid duplication and ensure concerted cooperation
- Daily feedback is incorporated into operations and disseminated in daily briefings
- Beyond the immediate aftermath, Compassion Center activities are geared toward community psychology and advocacy for non-violent and compassionate approaches to conflict-resolution
- Compassion Center re-opens at original location for a week of anniversary remembrance and social support
Subsequent Incident Responses

A father murders his mother and father, his two young sons, and kills the family dog.

- Response model used for Isla Vista is employed and tweaked to better serve the affected schools and neighborhoods

A high school student is killed in a fiery car crash

- A compassion center is established the next day and staffed by school personnel after a brief orientation training
- An executive consultation is held with school officials to prepare for dealing with parents, students, staff, news media, and subsequent public events and memorials

A student at the same high school commits suicide

- The school staff reactivate their compassion center with minimal need of external support
- Compassion center in a box
Skills for Psychological Recovery (SPR)
Psychological 2nd Aid

Skills for Psychological Recovery (SPR)

Basic Goals and Objectives:

1. Protect the mental health of disaster survivors
2. Enhance survivors’ abilities to address their needs and concerns
3. Teach skills to promote the recovery of children, adolescents, adults, and families
4. Prevent maladaptive behaviors while identifying and supporting adaptive behaviors
Skills for Psychological Recovery (SPR)

Core Skills:

– Building Problem-Solving Skills
– Promoting Positive Activities
– Managing Reactions
– Promoting Helpful Thinking
– Rebuilding Healthy Social Connections
Occupational Hazards of Trauma Exposure

Secondary Traumatic Stress:

“emotional duress that results when an individual hears about the firsthand trauma experiences of another. Its symptoms mimic those of PTSD”

Vicarious Trauma:

“transformation in the self of a trauma worker or helper that results from empathic engagement with traumatized clients and their reports of traumatic experiences. Its hallmark is disrupted spirituality, or a disruption in the trauma workers' perceived meaning and hope”

Compassion Fatigue:

“gradual lessening of compassion over time”
Frame of Reference Hazards

Trauma-Drama:
Frame of Reference Hazards

Heroes – Victims – Villains
Conclusion

1. Providing community-based psychosocial support requires a distinct skill set from those of counseling and psychotherapy.
2. Community psychology is an accessible and acceptable approach to providing non-stigmatizing and empowering support in PTEs.
3. PFA is a readily learned and accessible intervention by MHPs and at the lay-level.
4. PFA is a scalable method of providing all-hazards psychosocial support.
5. Local capacity building for responding to PTEs is possible and sustainable, but challenging.
6. Mapping exposure dosage, needs, and resources supports a deliberate and strategic response and helps to detect, monitor, and respond to what might otherwise be overlooked.
7. We still need to develop non-RCT methods for evaluating the comparative effectiveness of early interventions.
8. Clinicians are advised to carefully take stock of their psychological and emotional vulnerabilities and mindfully self-monitor their reactions.

Questions and Comments?