

# Giving a heads up

In this regular column, disseminating examples of best practice as researched by the US Department of Homeland Security, **Anna Torsney-Weir** and **Jennifer Smither** focus on the subject of mental health in disasters

**I**N ADDITION TO CAUSING STRUCTURAL and physical damage, disasters often have a negative impact on the mental health of those who are unlucky enough to experience them. For those suffering from a pre-existing mental health condition, a calamitous event can exacerbate symptoms and make it even more difficult for them to find safety and support.

It has been found that responders should try to mitigate negative mental health outcomes by creating special needs and general population shelter operations plans that include considerations for those with mental health disorders. Additionally, emergency managers should establish processes and procedures that provide psychological support for all individuals involved in a disaster, including responders.

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**■ Teams of mental health experts should accompany other responders and establish psychological support mechanisms for victims, emergency responders, hospital personnel, and the public following a radiological incident**

In Goiânia, Brazil, in September 1987, two men stole a radiotherapy unit source from an abandoned medical clinic and sold it in parts to a junkyard as scrap metal, not knowing that the unit contained approximately 20 grams (1,375 Curies) of Caesium-137 (Cs-137). Weeks later, after concern about widespread sickness, the authorities were finally alerted to the incident. Of the 112,000 people monitored for radiation exposure, 249 were found to be contaminated and four died as a result. This incident remains the cause of the highest levels of Cs-137 contamination ever clinically recorded.

The Goiânia accident affected all segments of the population psychologically, including victims of the release, hospital personnel treating those victims, emergency personnel involved in first response and decontamination operations, and the general public.

Because Goiãnian authorities did not establish psychological support mechanisms for these populations, victims reacted with fear, anxiety, and aggressive behaviour. Medical personnel working with contaminated victims experienced anxiety and psychosomatic symptoms that

mimicked radiation syndrome – symptoms such as headaches, fever, and vomiting. Behavioural disturbances, depression, insomnia, and gastric problems also became common among doctors and nurses working with contaminated patients.

The magnitude of the incident overwhelmed the understaffed local emergency response teams. Most responders had been trained only in responding to radiological incidents in laboratories and reactor plants, and were not prepared to handle the significant human element of this accident. Responders found disposing of toys, photographs, and other objects of sentimental value particularly challenging.

Pre-existing psychological support mechanisms would have significantly mitigated the negative mental health outcomes in this incident. It has since been noted that emergency managers should consider establishing such mechanisms. One way of accomplishing this is to ensure that teams of mental health experts are integrated with all groups involved in a radiological emergency from the onset of incident response.

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**■ It's been agreed that after an emergency, residents with mental illnesses should have access to a special needs shelter with a quiet room to help them remain calm**

As mentioned in the previous issue (*CRJ* 3:4), severe windstorms in Washington and Oregon, USA, and British Columbia, Canada, in December 2006, necessitated the opening of American Red Cross shelters for those left without power in their homes.

Several of these shelters were voluntary special needs shelters that featured accommodation and technology not necessarily available in the general population shelters; features such as heightened medical attention and equipment. These shelters attracted many with mental illnesses.

An after-action report written by the Washington Military Department highlighted portions of the response that most affected people with disabilities and other special needs.

Many individuals with mental illnesses, who generally require consistent routines and

familiar faces, experienced a high level of stress because of the excitement and crowds, and therefore could not relax in the shelter. To help these people remain calm, the after-action report recommended that shelter staff members should create a voluntary quiet room at special needs shelters, to allow individuals a place in which to calm themselves.

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**■ Research has shown that shelter operators should consider cataloguing and securing medication that individuals with mental illnesses bring into a general population shelter. This will prevent other shelter users from stealing medication, either to use themselves, or to sell to others**

Although the American Red Cross established special needs shelters in response to the December 2006 windstorms, many residents with special needs did not require constant medical attention, and so choose to stay at general population shelters.

Shelter users brought their usual prescription medications with them so they could continue to take them. However, shelter staff members realised that the psychotropic medications brought by those with mental illnesses could be stolen and misused by others. Some of these medications, such as stimulants and benzodiazepines, were often illegally resold and abused.

The shelter staff noted that they needed to keep a record of all medications brought to the shelter by individuals with mental illnesses. As a result, it is also now recommended that staff members should secure psychotropic medications, when not in use, to avoid the possible theft and resale of this medication. **CRJ**

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