



# NY DMH Responder

Fall 2015

Volume 8 Issue 2

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## The DMH Responder is a quarterly production of...

**NYS Office of Mental Health  
Office of Emergency Preparedness and Response**  
Steve Moskowitz, Director  
518.408.2967  
Steven.Moskowitz@omh.ny.gov

**NYS Department of Health  
Office of Health Emergency Preparedness**  
Judith LeComb, Manager  
Preparedness Training and Education  
518.474.2893  
prepedap@health.ny.gov

**Articles contributed by** the Institute for Disaster Mental Health at SUNY New Paltz  
[www.newpaltz.edu/idmh](http://www.newpaltz.edu/idmh)



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## Welcome

Welcome to the Fall 2015 issue of the **New York DMH Responder**, our quarterly newsletter for the Disaster Mental Health community. Our main article in this issue examines some of the challenges around accommodating disaster survivors' "functional needs" in shelters, Disaster Recovery Centers and other response settings. We also discuss a number of ways DMH responders can keep their skills sharp through continuing education opportunities as well as describe two upcoming training events that may interest. Our Research Brief examines the state of emergency preparedness among individuals with disabilities, which unfortunately is even worse than among the general population.

As always, your feedback and suggestions for topics to cover in future issues are welcome; please email any comments to Judith LeComb at DOH or Steve Moskowitz at OMH.



## Supporting People with Functional Needs

No one is immune to disaster but it has long been recognized that there are certain groups whose disabilities, age, or other characteristics can create particular difficulties for them during and after events. They may have limited ability to protect themselves during a disaster, more complex sheltering needs and/or more barriers to recovery. In recent years there's been a national policy shift from segregating people with these issues into "special needs shelters" and instead determining how to address their requirements within general population shelters and services through "functional needs" planning. This is admirable in terms of showing respect for individuals and adhering to the spirit of the Americans with Disabilities Act but in actual practice the change has revealed some significant gaps in preparedness as responders must learn how to adapt to complex and often unforeseen situations.

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Supporting People with Functional Needs, *continued*

The New York State Comprehensive Emergency Management Plan (CEMP), released in March 2015 by the state Disaster Preparedness Commission, provides logistical guidance for incorporating functional needs into pre-disaster planning as well as the response and initial recovery phases of a disaster and additional logistical guidance can be found in the NY-NJ-CT-PA Regional Catastrophic Planning Team's Promising Practices as well as FEMA's Guidance on Planning for Integration of Functional Needs Support Services in General Population Shelters. However, these guides contain little information on addressing the psychosocial reactions of disaster survivors whose functional needs place them at higher risk – nor do they address the stressors responders themselves may face in trying to meet those sometimes intense demands. Here's a broad overview of a few of the factors we all need to consider in completing this shift. Many of the actions needed to address functional needs can also benefit the general survivor population, as we'll discuss.

### Who Are These Groups?

Much of the planning for integrating people with functional needs focuses on individuals with physical disabilities and mental health conditions. FEMA's 2010 guide on incorporating Functional Needs Support Services (FNSS) into sheltering plans states that "children and adults requiring FNSS may have physical, sensory, mental health, and cognitive and/or intellectual



Replace assistive devices

disabilities affecting their ability to function independently without assistance. Others that may benefit from FNSS include women in late stages of pregnancy, elders, and people needing bariatric equipment. Other groups who may present particular functional needs post-disaster include unaccompanied minors who need to be reunited with family, people who cannot speak or read English, and pre-disaster homeless individuals.

An important point to remember in considering these group's psychosocial needs are some of the co-occurring issues that may compound the main disability. The World Health Organization points out that relative to people without disabilities those with them may also live with poorer general health, lower educational achievements, less economic and social participation and higher rates of poverty. All of those co-factors are likely to lead to less ability to prepare for emergencies (see the Research Brief for evidence of this) leading to worse exposure during the event and providing fewer economic and social resources to support their recovery. That makes it all the more important that every



Replace medications

effort be made to address their immediate requirements post-disaster in an effort to remove barriers and provide a supportive early recovery environment.

### What Do They Need?

Consistent with the basic premises of disaster mental health, meeting survivor's practical and logistical needs promptly is the best way to prevent extreme and lasting emotional reactions. All of the guides mentioned above include many pages of specifics on addressing a wide range of physical and medical functional needs so we'll focus on the more mental health-related aspects of a few key points:

#### Replace missing assistive devices and medications

In some cases restoring access to medications or life-sustaining treatments is a medical emergency that should of course be prioritized. Other clients risk a return of physical or psychiatric symptoms, as well as uncomfortable or dangerous withdrawal symptoms, if access to needed prescription medications isn't restored promptly.

### Address dietary needs



But in many cases the need appears far less urgent to response organizers than it feels to the survivor. How many of us would instantly become disabled and dependent if we merely lose our eyeglasses or hearing aids? That's not a matter of life or death but it shifts that individual from the category of general survivor to person with special needs, potentially making them feel helpless and frustrated and preventing them from participating actively in their recovery. While triaging these needs clearly should focus first on people with the most pressing problems, try to widen the focus as soon as possible to restore functionality to those less urgent cases.

#### Address dietary needs

Shelter managers should generally try to ensure that meals and snacks are as healthy as possible with items that are low fat, low sodium and low sugar to meet the broadest range of dietary needs. FEMA recommends striving to meet more specific needs such as meal options that are vegetarian, gluten-free, kosher, and safe for people who are

### Improve communication



allergic to peanut oil and by-products.

On the emotional side, we also recommend taking resident's ethnic and regional preferences into consideration whenever possible. Food is a main source of comfort for many people so providing meals that are familiar and palatable is a small but powerful way to show you recognize their situation and want to support their needs.

#### Improve communication

Obviously people with severe sensory impairments may have trouble receiving warnings before an event and informational briefings afterward so bringing in supports like sign language interpreters and scribes may be necessary. Other clients who may need assistance with communication include non-native English speakers (and note that even people who are generally adept in a second language may lose fluency in stressful situations), people with dementia or cognitive impairment, some people with mental illness and people on the autism spectrum. Incorporating technology, like

### Address stigma



translation or voice recognition programs on a smart phone or tablet, may be beneficial in communication with some of these groups.

Also, remember that survivors with none of those obvious communications barriers are likely to have trouble focusing on and retaining information if they're very stressed as is likely soon after a disaster so try to use simple and direct language, repeat yourself as necessary, provide printed materials as reminders, and don't assume a message has been fully absorbed.

#### Address stigma

As experiences from a number of recent disasters in New York State have demonstrated this can be one of the most challenging elements of integrating people with functional needs into a general setting. Largely because of sensationalized or exaggerated depictions of mental illness in both entertainment and news media, many community members have wildly distorted perceptions about people with mental illness being dangerous.

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## Continuing Education Resources

In 2015, the New York State Board Office began requiring LMSW and LCSW social workers to accumulate 36 hours of continuing education credits per three-year registration period (following an initial phase-in period; full details can be found at <http://www.op.nysed.gov/prof/sw/swcefaq.htm>).

While this new requirement has formalized expectations for New York social workers – and put some pressure on them to locate, complete, and pay for appropriate training opportunities – social work is far from the only health or mental health profession that recommends continuing education as a requirement for licensure. Professional organizations have long had requirements for their members to maintain competency, and helpers have ethical obligations to be sure they're equipped to support their clients regardless of formal professional standards.

No matter your reason for pursuing advanced training we have compiled a list of several agencies (most web-based or home study) where you can receive disaster- and trauma-related trainings. Many of these organizations offer a variety of continuing education credits, so make sure to clarify that the CE credits that are available will be accepted by your state board or professional organization.

### Center for Telepsychology

#### Content

CBT for anxiety and depression

#### Website

<http://www.centerfortelepsychology.com/>

#### Type of Training

Web-based

#### CEs Available

APA, NY Social Workers

### FEMA Independent Study

#### Content

ICS, Special Populations

#### Website

<http://www.training.fema.gov/is/crslist.aspx>

#### Type of Training

Web-based

#### CEs Available

CEU calculation is based on International Association of Continuing Education and Training standards

### International Society for Traumatic Stress Studies

#### Content

PTSD, Military issues

#### Website

<https://www.istss.org>

#### Type of Training

Live or Recorded Webinars

#### CEs Available

APA, ASWB

### National Center for Disaster Medicine & Public Health

#### Content

Children in Disasters, Radiation

#### Website

<http://ncdmph.usuhs.edu/KnowledgeLearning/OnlineLearning.htm>

#### Type of Training

Web-based

#### CEs Available

Accreditation Council for Continuing Medical Education, American Nurses Credentialing Center (ANCC)

### National Child Traumatic Stress Network

#### Content

Children, trauma, family

#### Website

<http://learn.nctsn.org/>

#### Type of Training

Web-based

#### CEs Available

NASW, NBCC, APA

### PESI

#### Content

Large volume of available trainings

#### Website

<http://pesi.com/Online/Courses/>

#### Type of Training

Live In-Person, Live Online, and Self-Study

#### CEs Available

Range of professions covered, including nurses, psychologists, social workers, etc.

## Psychotherapy Networker

### Content

PTSD, Military, couples, ethics

### Website

<http://www.psychotherapynetworker.org/cecourses>

### Type of Training

Web-based

### CEs Available

CEs provided through PESI-Approved list here <http://www.psychotherapynetworker.org/cecourses/ce-approvals>

## Trauma Institute of Orange County

### Content

Evidence based interventions, interpersonal trauma, special populations

### Website

<http://www.orangecountygov.com/traumainstitute>

### Type of Training

In Person

### CEs Available

NY Social Workers

## University of Minnesota School of Public Health

### Content

Disaster Planning, Health and Safety, Outbreaks

### Website

<http://www.sph.umn.edu/academics/ce/online/>

### Type of Training

Web-based

### CEs Available

CE credits depend on specific training

If you're a New York State social worker looking for more options, the full list of approved continuing education providers can be found here: <http://www.op.nysed.gov/prof/sw/swceproviderlist.htm>

For up-to-date lists of other training opportunities (which may or may not include CE credits) an excellent resource is

the New York State's Office of Health Emergency Preparedness' monthly Aware-Prepare newsletter which lists dozens of in-person and on-line training from various reputable providers. If you don't already receive this newsletter you can request to be added to distribution list by emailing [prepedap@health.ny.gov](mailto:prepedap@health.ny.gov)

## Supporting People with Functional Needs, *continued*

Their personal tolerance and patience is not likely to be at its highest in a shelter or other post-disaster setting, where the general conditions may also be activating stress reactions in the person with mental illness who has just experienced the disaster and may be dealing with their own traumatic memories. The resulting combination of behaviors on both sides can lead to shelter residents protesting the presence of someone who has every right to be there, while that individual faces the added stress of feeling stigmatized and unwelcome.

Stigma may also be directed towards individuals who are visibly ill (even if they're not contagious) or appear to be homeless or otherwise "different." And we should acknowledge that shelter staff and other responders are not immune to feeling anxiety or mistrust about clients who they fear may become disruptive or staffers simply may not

want to deal with the conflict these clients can produce among other shelter residents. DMH helpers may need to balance efforts to provide psychoeducation and calming to anxious residents and staff members while respecting the privacy and access rights of the person with mental illness.

Clearly there are many more specific aspects of integrating people with functional needs into disaster response that we don't have room to address here. This article is just an overview of a policy shift whose ramifications are still emerging for disaster mental health helpers but we hope it will encourage you to start thinking about members of your community whose functional needs should be incorporated into your plans and in your staff and volunteer trainings. Ensuring that everyone involved in disaster response understands those needs and develops basic skills to address them can help to minimize excess anxiety and conflict in an already stressful situation.

## Research Brief: Emergency Preparedness among People with Disabilities

As we described in the article on functional needs in disaster, people with physical disabilities and mental health conditions may have specific needs that will need to be addressed in shelters, Disaster Recovery Centers, and other settings. While the response community must improve our ability to support these diverse groups after disasters, one of the best ways to reduce those demands is to build preparedness among their members, enhancing their ability to avoid disaster exposure and supporting their post-event recovery. Of course, the same is true for the general population, where emergency preparedness levels often remain frustratingly low despite repeated efforts by numerous governmental agencies, the American Red Cross, and others to encourage community members to stockpile supplies, form evacuation plans, and generally improve self-sufficiency.

To understand how prepared people with functional needs are relative to the general population, Smith and Notaro (2015) analyzed data from the Behavioral Risk Factor Surveillance System (BRFSS), an annual telephone survey that was developed by the Centers for Disease Control and Prevention to track health behaviors, risk factors, and health status of non-institutionalized U.S. adults. One limitation to this survey

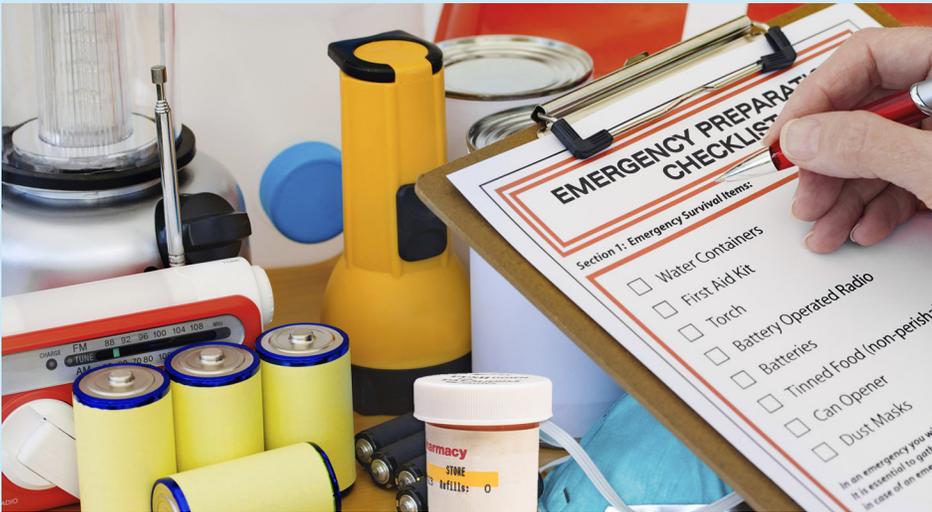


that the authors note is that disability status was assessed through broad questions that didn't differentiate temporary from long-term conditions, and the study didn't ask about compounding factors related to disability like discrimination and access to reasonable accommodations. However, it did ask various questions about emergency preparedness, including questions about household supplies of food, water, medications, radio, and flashlights. It also asked "Does your household have a written evacuation plan for how you will leave your home in case of a large-scale disaster or emergency that requires evacuation?" and "How prepared do you feel your household is to handle a large-scale disaster or emergency?"

Smith and Notaro focused on participants who replied yes to the question "Are

you limited in any way in any activities because of physical, mental or emotional problems?' They also analyzed two subsets of that group, those who said yes to the question "Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed or a special telephone?" and those whose response to the question "Now thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental health not good?" was five or more days, demonstrating at least a mild degree of mental health condition. They compared these three groups to the general sample on the various measures of preparedness.

On the positive side, those with disabilities were more likely to have a three-day supply of medications, and there were no differences in how many had



an evacuation plan – though that simply reflects the fact that levels of planning were equally low among those with and without disabilities, 22.8% and 22.9% respectively. Findings in the other categories were also troubling: Looking at statistically significant differences, the group with activity limitations was less likely to have a three-day supply of food and water, or a flashlight or radio. They were significantly more likely to say they were not at all prepared for a disaster.

Those with a disability said they would evacuate if mandated at a small but statistically significant lower rate than the general population, 92.4% versus 94.2%. Among those who said they would not follow a mandatory evacuation notice, main reasons among the disabled group included concern about leaving property (19.4%), lack of trust in public officials (16.4%), concern about leaving pets (15.8%), concern about personal

safety (6.4%), concern about family safety (6.0%), and lack of transportation (5.5%).

Patterns were generally similar when comparing the group who used specialized equipment with those who didn't, with the one positive exception that those with equipment were significantly more likely to have an evacuation plan, 26.0%, than those who don't, 22.5%. However, the opposite was true for those with a mental health disability who were less likely to have an evacuation plan than the general group, and they were less prepared on all other measures. Examining other characteristics, Smith and Notaro found that those with an activity limitation were more likely to be uncoupled, unable to work, less educated, female, and below the poverty line; those with mental health conditions shared those characteristics apart from being uncoupled, and they were also more likely to be younger and of

minority race/ethnicity.

Overall this study paints a troubling but unsurprising picture of disaster preparedness in our communities: low among the general population, and lower still among groups with physical and mental health conditions. Of course it's understandable that preparing for the abstract possibility of an eventual disaster is not a priority for people whose very real and immediate functional needs may consume all of their available resources, but it sheds light on a potential target for action early in the disaster continuum: In keeping with the "ounce of prevention" philosophy, mitigation efforts to help members of these groups become better prepared for disasters could pay off exponentially in reducing their post-disaster recovery needs.

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Source:

Smith, D.L. & Notaro, S.J. (2015). Is emergency preparedness a 'disaster' for people with disabilities in the US? Results from the 2006–2012 Behavioral Risk Factor Surveillance System (BRFSS). *Disability & Society*, 30(3), 401-418.

## Disaster Mental Health Training

### Disaster Mental Health Response to a Mass Shooting Incident: Victims, First Responders and Community

January 15, 2015 @1-4 p.m.

Once again, OMH and NYSDOH will co-sponsor training that will be simultaneously webcast throughout New York State at designated sites.

Media coverage of mass shooting events typically focuses on direct victims and their survivors but mental health providers recognize a ripple effect that impacts many other groups with more peripheral exposure to an attack whose support needs are often overlooked. This year's training, developed and delivered by the Institute for Disaster Mental Health (IDMH) at SUNY New Paltz, will address the needs of a wide spectrum of individuals who are affected by a mass shooting event; surviving victims, families of those wounded or killed, witnesses of the attack and first responders and receivers.

While the training will focus on disaster mental health interventions for these disparate groups it will also address the characteristics that may shape the immediate response to mass shootings – for example, how necessary law enforcement actions may affect survivors' experiences during the event and how the common politicization of these events may increase subsequent distress.

The training will use an applied approach, teaching specific skills and providing opportunities to practice them, in the course



of the webcast. It will also incorporate personal stories from individuals who have provided DMH services to those directly involved in a mass shooting incidents.

A training announcement, including registration and site information, will be distributed in early December. If you would like to receive an announcement please email [prepedap@health.ny.gov](mailto:prepedap@health.ny.gov).



## Interested in Improving Your Ability to Work with Military Personnel?

On February 17th, 2015, IDMH will host a "Military Culture and Deployment Cycle" training in New Paltz, NY. This course is a pre-requisite requirement for advanced clinical training taking place in May and June and a requirement to join New York's Star Behavioral Health Provider network, a free referral service for service members, veterans and their families. For further information, please contact [idmh@newpaltz.edu](mailto:idmh@newpaltz.edu).