New York DMH *Responder*

In This Issue...

and more...

Welcome

Welcome to the Spring 2012 issue of the **New York DMH *Responder***, our quarterly newsletter for the Disaster Mental Health Community. This issue focuses on the role leaders can play in maintaining calm and minimizing distress during and after disasters. As we experienced during the response to tropical storms Irene and Lee, crises often push people into roles of expanded responsibility, so this information will be useful even if managing others isn't usually part of your role.

Leaders' part in maintaining resilience was also a focus of the recent Institute for Disaster Mental Health at SUNY New Paltz annual conference, along with the need for self-care and care for staff psychosocial needs. Lessons from the conference are summarized in this issue. We also discuss plans for the next round of trainings in Disaster Mental Health around the state.

The final article in our year-long series on **assisting special populations** examines the special needs of people with physical disabilities in disaster. Because of limited mobility, sensory limitations, or reliance on assistive devices, people with disabilities may be at higher risk of injury or exposure during disasters and may face additional recovery challenges. The article summarizes the issues which you should be prepared to address with this population. And our **Research Brief** summarizes the resource demands faced by caseworkers who assisted people with disabilities after Hurricane Katrina.

As always, your feedback and suggestions for topics to cover in future issues are welcome. Please email any comments to Judith

Leadership in Crisis

As every disaster demonstrates, important decisions must be made quickly during crises, despite uncertainty and time pressure. There is often ambiguity in terms of cause and effect, as well as urgency to resolve the situation as quickly as possible. In addition, the stakes involved can be extraordinarily high, with survivors' lives and welfare potentially at risk.

Managers can play an essential role in minimizing harm and restoring calm, but leading during a crisis may require a different approach than managing under normal conditions. Even if managing others is not a part of your job description, you may find yourself thrust into a leadership role by extraordinary circumstances. Here are some suggestions for managing effectively during a crisis.

Leadership Styles

As anyone who's ever held a job knows, leaders demonstrate very different styles, and depending on circumstances and personalities, one approach can be more effective than another. An **autocratic** leader keeps control over staff by following regulations, policies, and procedures faithfully. This type of leader goes "by the book" and closely supervises staff. Autocratic leaders who rely on punishment to control staff, allowing little or no participation, can create a climate that is both distressing and nonproductive.

Laissez-faire leaders delegate tasks to staff with little or no direction. This approach can be effective when staff is highly educated, competent, and motivated to succeed on their own. This "hands-off" approach is most successful when the leader provides direction, support, and guidance when staff asks for or needs it; it's least effective if the leader is too withdrawn, which can lead to a lack of efficiency and satisfaction.

A **democratic leader** shares decision-making with staff members, encourages discussion, debate and sharing of ideas, and helps staff to feel good about their contributions. This leadership style appears to be most effective in generating better ideas and creative solutions from staff members.

However, there may be circumstances where there's insufficient time for discussion and debate. In such situations leaders may need to be more autocratic. As this suggests, a flexible style – democratic when possible, laissez-faire with highly motived staff, and more autocratic when there is little or no time to spare – may be most effective. When disaster strikes, a common mistake is to be either too hands-off or too overcontrolling. If you're too laissez-faire, staff will be looking to you for further guidance. If you're too autocratic, staff will feel bullied, and if you're too democratic, there may not be time to accomplish

Assisting Special Populations: Helping People with Physical Disabilities After Disasters

Note: This article concludes our year-long series on addressing the needs of populations whose members face specific challenges before, during, and after disasters. Please see previous issues for articles on helping older adults, children and families, and people with serious mental illness.
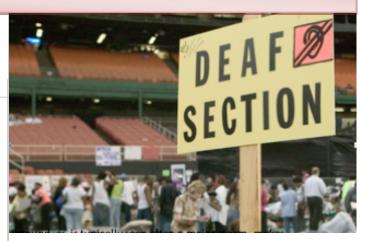
While individuals with physical disabilities should be viewed as people first, with similar needs and rights as the general population, many do face special challenges that must be acknowledged in disaster response plans. Their psychological reactions to a disaster may not differ from the typical symptoms we expect to see in anyone who has experienced a traumatic event, but in some instances symptoms may be related to the disability and will require additional measures to help the person return to pre-event functioning.

According to the US Census Bureau (2006), more than 20 percent of the U.S. population self-reports a disability, and about 30% of the nation's families include at least one member with a disability. The range of possible physical disabilities is wide, in both type and extent of impairment. Physical disabilities can be broadly categorized by the type of functional impairment they cause.

Mobility impairments may limit a person's ability to walk or run, drive, stand or sit, or otherwise perform typical activities of daily life. They may be caused by spinal injury, an injured limb or muscle, a condition like arthritis that causes severe pain, a congenital condition like cerebral palsy, or myriad other problems. Many people with mobility impairments rely on assistive devices such as wheelchairs, canes, and the like, and those whose impairment causes pain may be dependent on painkillers to improve functioning. It can be difficult for members of this group to take protective action before or during a disaster, increasing the risk of additional injuries and distress. Mobility impairments also may make sheltering and recovering post-disaster difficult: Is a shelter accessible to someone who uses a wheelchair or who can't climb stairs? Does the person rely on medical equipment that's been lost or damaged, or that requires electrical power that's not functioning? Does the loss of needed medications increase pain or other symptoms, or cause withdrawal symptoms? Environmental conditions post-disaster also may exacerbate mobility issues. For example, extensive debris on the ground, as is typically seen after a major storm, makes neighbor-

hoods impassable to people using wheelchairs and creates great challenges for those who walk with difficulty. This may prevent people from being able to return home or limit access to temporary housing, and it may prevent people from reaching work, essentially worsening the functional impairment and increasing dependence on others for aid.

Sensory impairments primarily affect vision and hearing. People with sensory impairments may be reliant on family members or neighbors to alert them about disaster warnings, and to assist them with evacuating or taking other protective actions. Like mobility impairments, vision and hearing limitations can make life in shelters difficult, and people with sensory disabilities may require additional help such as a sign language translator.

Illness is not necessarily categorized as a physical disability, but it clearly can create related difficulties during and after disasters. If someone is sick – either from a chronic condition like cancer or an acute one like influenza – do they have the energy or strength to take protective action? Does a disaster disrupt necessary treatment like chemotherapy or dialysis, or access to needed medications like insulin? If a person has a contagious condition like influenza, how can they be sheltered without exposing others? And even if a condition is not communicable, there is often stigma around visible illness, with irrational but very real fears about contagion or contamination that may make other survivors hostile towards the ill person. Environmental conditions post-disaster can also intensify many illnesses. Dust from collapsed buildings and smoke from wildfires, burned structures, or intentional burning of debris can cause respiratory problems, as can the mold growth in homes that often follows floods. Of course, these threats can make previously healthy people sick as well, but they may provide a particular threat to those with pre-existing illnesses – which also may be less able to participate in cleaning up their homes to get rid of the source of the hazard.

Disabilities can also be categorized as chronic (long-term or permanent), acute (currently present but perhaps temporary), or intermittent (sometimes present, sometimes not). While those with chronic disabilities would appear to face the biggest difficulties, they may actually have adapted effectively to their limitations and be better able to function than someone with a more acute impairment.

Regardless of cause or temporality, all of these disabilities increase the risk of exposure to disaster, and they create additional challenges in the recovery process. However, it's also essential to recognize the strengths and abilities these survivors *do* have. You can support their recovery by mobilizing whatever resources are needed to restore the pre-disaster adaptation and independence of people with physical disabilities, just as you should for members of other special populations.

Assisting People with Physical Disabilities:

- Ensure that shelter conditions are appropriate, without physical barriers like steps, and with accommodations like special sleeping arrangements for those with limited mobility.
- As soon as possible, restore access to needed pain medication and replace assistive devices such as crutches or hearing aids. In some cases, doing so will essentially cancel out the disability, restoring the person's ability to function independently.
- Restore caregiving services, such as an aide for personal hygiene or a sign language interpreter. Note that this may be extremely challenging if the event has caused widespread disruption in the area: Potential helpers (paid professionals or volunteers) may have been killed or displaced, or may be so busy dealing with their own losses or helping the newly wounded that they are unable to assist others. Still, the loss of assistance with physical needs translates to a loss of independence for the survivor with a disability, so working to restore needed personal services will have a psychosocial as well as a practical benefit.

Leadership in Crisis

Continued from Page 1

urgent tasks. Be flexible and adjust your leadership style according to circumstances.

Making Effective Decisions and Judgments in Crisis Situations

Given the ambiguity and urgency disasters produce, it can be very difficult for managers to assess information and make decisions effectively. In addition, because leaders in crisis situations are under severe time pressure, they often have less time to acquire and process information. *Self-efficacy*, an individual's beliefs about his or her abilities to accomplish a specific task in a specific context, is one good predictor of competent leadership in a crisis. What may be most helpful in these circumstances is for you to be confident that you have the knowledge, skill, and ability to lead others effectively.

Self-efficacy can be changed through practice and training. You can increase your self-efficacy in the following ways:

- Try to be more open-minded, exploratory, and adaptive when responding to difficult decisions.
- Think about your successful previous experiences in challenging circumstances. This can create a greater level of confidence.
- Your ability to think divergently – the ability to generate multiple alternative solutions to problems – can help you to be more creative in dealing with ambiguous and challenging crisis and decisions.
- If possible, try to get the formal authority you require to lead others in the crisis situation. Clarifying your role as an authority can increase confidence in your efficacy to lead.
- Get as much experience as you can both in leadership and in dealing with crisis situations. Leaders with experience feel more confident.
- If you lack the experience (or even if you have considerable experience), it's extremely helpful to practice crisis scenarios. The degree to which you've practiced and rehearsed crisis response protocols such as tabletop or actual live drills can increase your sense of self-efficacy.

> "The task of leadership is not to put greatness into humanity, but to elicit it, for the greatness is already there."
>
> *-John Buchan*

Finally, to maximize your ability to guide the recovery after difficult events, remember the following keys to leadership in crisis:

- Get as much information and advice from as many sources as you can.
- Try to get as many of your staff (or those you are suddenly called upon to manage) as possible involved in assisting with the crisis. Ask for their support, and let them know your plans and intentions.
- Be open to viewing staff and the crisis situation with new perspectives and flexibility.
- Lead by example. If you participate in menial tasks, other helpers are more likely to take on whatever needs to be done. And if you practice good self-care, others are likely to follow.
- Give every responder something challenging and important to do. Everyone wants and needs to feel both valuable and appreciated for their contribution.
- Empower and show confidence in those you give responsibility to. Don't point out weaknesses in staff members in front of others.
- Don't be afraid to change course or change your mind if your approach isn't working.
- Never forget to congratulate yourself and others for a job well done.

Research Brief: People with Disabilities in Katrina

Hurricane Katrina disproportionately impacted older adults and people living in poverty, but it also impacted many Gulf Coast residents with physical disabilities. Stough, Sharp, Decker, and Wilker's (2010) examination of long-term recovery needs 20 months after the disaster sheds light on the extensive challenges this group faced.

The researchers interviewed 54 case managers and case management supervisors for the National Disability Rights Network (NDRN), the largest provider of legally based advocacy services to people with disabilities in the US. All worked in Louisiana, Mississippi, Alabama, Texas, and Georgia. The managers represented a collective total of 2,047 families which included a person with a physical or intellectual disability and which had been displaced by Katrina.

Their results demonstrate how resource-intensive recovery can be when disabilities complicated survivors' needs:

- Eighty-three percent of case managers and all supervisors agreed that disaster case management for people with disabilities required "*qualitatively different case management practices* that were more intense, of longer duration, and that included more frequent contacts with the client" due to the multiplicity of their service needs.
- Specific disability expertise was required by case managers in order to locate needed supports.
- The resulting intensive and time consuming needs meant that caseloads needed to be reduced to be feasibly managed by each individual manager.

It was also evident that many of the clients with disabilities faced pre-disaster circumstances that further disadvantaged them in the recovery. For example, they were less likely to be homeowners than clients without a disability, which meant that FEMA trailers and homeowner assistance was not available to them. They were also more likely to have pre-existing medical needs, and less likely to be employed. Many lost needed medical equipment, accessible housing, or other accommodations that had enabled them to function, and replacing these needs was extremely difficult. Obtaining appropriate housing was reported as especially challenging given the tremendous number of displaced people overall. A final distressing point is that many caseworkers reported having to work against negative attitudes and biases towards people with disabilities as they searched for needed resources in the community.

Of course the scope of Katrina was far beyond most disasters, but this study still sheds light on the specific demands that will be faced by those assisting people with disabilities after a significant event.

Source:
Stough, L.M., Sharp, A.N., Decker, C., & Wilker, N. (2010). Disaster case management and individuals with disabilities. *Rehabilitation Psychology, 55,* 211-220.

Disaster Mental Health Training Update

Disaster Mental Health training is currently being planned for 2012-2013 by both OMH and DOH. During fall 2012, DOH will sponsor an in-person training at SUNY New Paltz entitled "Mental Health Response to Mass Casualty Incidents." The purpose of this three-hour training is to prepare healthcare responders for the particular challenges and stressors, both personal and professional, involved in responding to Mass Casualty Incidents (MCIs) involving multiple deaths or injuries. Topics will include an overview of MCIs (event types and characteristics; likely response settings), early interventions for MCIs (Psychological First Aid, crisis intervention, talking with survivors about loss), longer term issues (memorials, anniversary reactions), and the need for self-care. This in-person training will be simultaneously webcast for individuals who are not able to attend the in person training and also archived on the NYSDOH Learning Management System for individuals who are not available the day of training.

Training date and registration information will be distributed when details have been finalized. Details about OMH's training plans will also be provided in the next newsletter.

What's YOUR Critical Response?

Your feedback, comments, ideas for future topics, or suggestions on how to improve DMH training are welcome.

Email to:
prepedap@health.state.ny.us
and/or
Steven.Moskowitz@omh.ny.gov

IDMH Conference Report

The 9th annual Institute for Disaster Mental Health (IDMH) at SUNY New Paltz conference, held on April 20, was a great success and reached many professionals who are involved in the response community in New York State. *Building Capacity: Managing and Mitigating Responder Stress* was sponsored by the New York State Office of Emergency Management (SOEM) and the NY/NJ Preparedness and Emergency Response Learning Center (PERLC). In the wake of hurricanes Irene and Lee and the enormous stress that these disasters inflicted on our responder community, the conference focused on building responder capacity and resilience through effective stress management and self-care strategies. Some highlights from the keynote presentations:

Charles Figley, Ph.D., a pioneer in the fields of compassion fatigue and the need for self-care, spoke about "Mitigating Occupational Hazards of Disaster Response." He noted the importance of leaders understanding the stressors disaster responders face. He also pointed out many similarities between disaster and war deployment: both responders and service people get a lot of training and preparation; they're away from home and family; they're exposed to a range of traumatic stressors; they work long hours in difficult conditions for an extended period; expectations are to withhold self-care and endure the conditions; and they face varying levels of danger and uncertainty with periods of boredom. Similarly, both groups share protective factors related to individual traits (intelligence, trait resilience meaning they're adaptive and adventurous, competence at adapting to stress, self-confidence, and a sense of humor) and to situational factors including training to increase trust and cohesion in the response unit. Leaders can foster responder resilience through actions demonstrating they are caring, inspiring, skilled, and personable and by acting as role models.

Then **Richard Tedeschi, Ph.D**., spoke about a field he helped develop, discussing "Posttraumatic Growth: Psychological Reconstruction in the Aftermath of Disaster." His premise is that disasters and crises challenge or shatter people's assumptions that the world is benevolent, predictable, and controllable. The resulting losses and sense of vulnerability can lead people to reassess their beliefs, potentially leading to posttraumatic growth that results in positive changes in the domains of New Possibilities, Relating to Others, Personal Strength,

Appreciation of Life, and Spiritual Change. Dr. Tedeschi noted that Christianity, Islam, and Buddhism all acknowledge the role of suffering in life, and that posttraumatic growth has been found across cultures. But he also fully acknowledged the cost of this growth, which comes as a result of intense suffering. Helpers can try to assist survivors in the process from loss to growth by serving as "expert companions" who listen openly and tolerate survivors' positive illusions as they make meaning of their experience. Doing so can result in vicarious posttraumatic growth for the helper.

In the final presentation **Rob Yin, L.I.S.W**., and **Valerie Cole, Ph.D**., of the American Red Cross discussed "New Strategies for Reducing Responder Risk: From Pre-Deployment Screening to Post-Deployment Support." They focused on the role leaders can play in supporting staff resilience, including recognizing the "False Disaster Dichotomy" that implies managers must choose where to designate limited time and resources – either to serve disaster survivors or to provide support to responders. Instead, they emphasized the need to translate "either/or" into a sequence that includes both: Support responders first, so they can then provide services to clients. That includes taking time up front to screen staff and volunteers for their fitness for duty; assigning them to roles and tasks they're competent to handle; and monitoring their stress throughout the deployment cycle to ensure they're functioning effectively. The Red Cross has developed tools including a "Readiness to Deploy" self-screening questionnaire and a triage tag to track demand and supply of mental health assistance during response operations. While additional research on the effectiveness of these tools is needed, they made it clear that the Red Cross is paying careful attention to the importance of protecting the health of its workforce.

Between in-person attendance, web-based broadcasts sponsored by PERLC, and a DVD recording, IDMH anticipates that the training will reach over 1,000 responders, professionals, and paraprofessionals critical to effective disaster response and management in New York State and beyond. SOEM sponsorship funded free attendance for more than 60 representatives from OMH, DOH, and SOEM. This provided a valuable opportunity for the representatives of the different agencies to network and to learn together the skills they will need to implement when the next disaster strikes our state. If you missed the event or would like to revisit the presentations, all slides can be downloaded at:

http://www.newpaltz.edu/idmh/conference.html