The National Society for Social Work Leadership in Health Care

Health Care Social Work Leadership in Crisis and Disaster Response

Exemplars in Practice Series

William J. Spitzer, P.h.D./DCSW
Editor

The National Society for Social Work Leadership in Health Care

Health Care Social Work Leadership in Crisis and Disaster Response

Exemplars in Practice Series

William J. Spitzer, Ph.D./DCSW
Editor

The Dietz Press

The Select Practice Series:
Social Work Leadership in Health Care

published by:

The Dietz Press / Owen Printing Company
930 Winfield Road
Petersburg, Virginia 23808

Cover credit: *Colin W. Spitzer*, design and layout.

Copyright © National Society for Social Work Leadership in Health Care, 2008

Printed February 2008

HEALTH CARE SOCIAL WORK LEADERSHIP IN CRISIS AND DISASTER RESPONSE

PREFACE

Throughout history, crises and disasters have occurred with traumatic impacts on life and property. Often unexpected and without warning, these events have taxed individuals and communities as they make effort to both address the immediate circumstance and put into place satisfactory preventative/response mechanisms to future threats. The nature and scope of crises and disasters are literally without boundary, with the potential to affect anywhere from one individual or family to entire communities or nations. Particularly within recent history, the United States has experienced particularly devastating natural disasters including floods, hurricanes, wildfires, earthquakes, tornadoes and major snowstorms. Unfortunately, we have also experienced the present-day viral HIV/AIDS pandemic, military conflicts and calamities such as the Murrow Federal Building, World Trade Center and Pentagon bombings, structural fires like the Rhode Island night club disaster and various major transportation related mishaps.

Health care social work has a commendable history of demonstrating leadership in crises and disaster response. Roberts (*2000*) perceives crisis intervention as providing a challenge, opportunity and turning point. This text highlights both issues and techniques associated with crises and disaster response. In so doing, the authors provide both support to Roberts' notion about the significance of crisis intervention and evidence as to the crucial roles played by social work in striving to safeguard public health and welfare.

O'Donnell's leading discussion focuses on the ethical challenges associated with planning for a pandemic flu that could theoretically involve 90 million cases and nearly two million deaths. Acknowledging and expanding upon issues addressed by the NASW Code of Ethics, O'Donnell notes the lead role often assumed by social work in crisis planning and response. She identifies issues with education, community coordination and delivery of support services, emphasizing that our historic professional focus on the care needs of individuals, families and communities proves a catalyst for action. *Wade* and *Kettley* use lessons learned from the 2003 Severe Acute Respiratory Syndrome (SARS) pandemic to prepare for the prospect of an influenza outbreak. In the context of the Modular Emergency Medical System (MEMS) approach employed by the University of Michigan Health System, Wade and Kettley discuss the social work leadership role and its essential, proactive commitment to early planning.

Little emphasizes that provision and delivery of mental health services should be a part of any community's or organization's disaster plan. She examines how to assess the impact of disasters and how individuals respond to the stresses of such events. Consistent with Roberts' observation, Little notes that, while challenging, crises provide critical opportunities to demonstrate professional responsibility and leadership. Using the example of the methamphetamine crisis in the United States, *Maxwell* discusses the profound impacts experienced by families, systems and health care and underscores the advocacy and community planning elements of social work practice. In the context of Operation Iraqi Freedom, *O'Connor* offers a particularly poignant portrayal of the varied stresses endured by military personnel during combat and describes the US Army Combat Stress Model as an effective intervention technique. He notes the value of basic social work tenets including a focus on client centeredness, negotiating relationships and dealing with ambivalence. *Kirkpatrick* completes our text by examining a major community tragedy and the crucial, multi-facetted response of social work.

Roberts, Albert R. (ed.). (2000). *Crisis Intervention Handbook: Assessment, Treatment and Research, Second Edition*. Oxford University Press.

William J. Spitzer, Ph.D./DCSW - Editor

EDITOR'S NOTE

Unless otherwise stated, the information and views expressed herein are exclusively those of the authors and not necessarily those of employing agencies, the National Society for Social Work Leadership in Health Care, Fernley and Fernley, Inc. or the Editor.

Inquiries about article data, content and conclusions should be directed to the identified author(s) of that particular submission.

Requests for additional copies and questions pertaining to either the National Society for Social Work Leadership in Health Care or its Annual Educational Conference should be directed to:

National Society for Social Work Leadership in Health Care
c/o: Fernley and Fernley, Inc.
100 North 20th Street
4th Floor
Philadelphia, Pennsylvania
19103-1443

COPYRIGHT NOTICE

Copyright © 2008
By the National Society for Social Work Leadership in Health Care

The National Society for Social Work Leadership in Health Care is pleased to make *Health Care Social Work Leadership in Crisis and Disaster Response* available.

Please note that all rights are reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise without the prior permission of the National Society for Social Work Leadership in Health Care.

HEALTH CARE SOCIAL WORK LEADERSHIP IN CRISIS AND DISASTER RESPONSE

OVERALL DESCRIPTION:

This text presents the underlying concepts and select intervention approaches utilized by social work professionals in response to community crises and disasters.

LEARNING OBJECTIVES:

Readers will be able to:

1. Identify and describe the principal ethical issues faced by professionals responding to the challenges of a community pandemic flu crisis.

2. Recognize key mechanisms and principles used by social work professionals as they sought to bridge a major health system and the community during a large scale crisis.

3. Identify the role of mental health professionals in disaster preparedness and response.

4. Understand the impact of the methamphetamine crisis on user populations and the factors that should be taken under consideration during professional intervention.

5. Describe the experiences and intervention approaches of a social work professional delivering psychosocial services to military personnel in an active combat zone.

6. Understand the crisis management steps taken by a trauma center social work department responding to a major community fire with substantial casualties.

ETHICAL CHALLENGES FOR SOCIAL WORK LEADERS IN PLANNING FOR A PANDEMIC FLU

Patricia O'Donnell, Ph.D., LICSW

INTRODUCTION

Social work leaders have historically been integral members of their institutions' disaster response planning committee/task forces. In coordination with peer leaders, they develop and implement procedures and protocols to manage responses that consider the total needs of patients, staff and the community. Their departments have also been tasked to develop protocols supporting overall institutional responses to disasters. Department policies on how staff will be contacted during off hours; assignment of staff to select duties; the nature of communication patterns; and reporting requirements subsequent to a disaster have been resolved. For the most part, these plans are geared for short term disasters such as natural disasters and accidents. Generally social workers are assigned to tasks of maintaining family contact centers and facilitating patient discharges in order to rapidly open beds for disaster victims. These standard disaster plans, however, will not meet the needs generated by a pandemic flu due to the long term and extensive nature of such events. The immediate and significant challenge to social work leaders is to adapt current plans in a manner that facilitates response to pandemic flu events (*NASW, 2007*).

PANDEMIC FLU

A pandemic flu refers to an outbreak of a new flu virus capable of spreading around the world. The disease spreads easily from person to person as there is little natural immunity. Vaccines are not available to protect against pandemic flu because the new virus strain must first be identified before a vaccine can be produced…a process which can take up to six months. Currently, there is no human flu pandemic. In contrast, a seasonal flu is caused by viruses already circulating among people. Most individuals have some immunity and vaccines are available to help prevent the flu (*Fairfax County, 2007*).

Pandemic flu events occur every few decades. There are multiple waves of disease outbreaks over a period of a year or longer, with each wave potentially lasting six to twelve weeks. Hospitals quickly fill their limited bed space and continue to face a surge phenomenon in their Emergency Departments with each new outbreak. If the next pandemic event is similar to the 1918 flu strain, medical consequences would include: 1) an attack rate in the United States of 30%, resulting in 90 million cases; 2) of those infected, about 50% would seek medical care; 3) mortality figures ranging from 209,000 to 1,903,000 deaths, and; 4) an outbreak in a community lasting about 6 to 8 weeks (*Bartlett, 2006*). Disruptions would result affecting the entire community as health care and other services become strained and businesses and schools are forced to close. Essential government services such as sanitation, water, power may be affected by lack of personnel. Public health officials may need to implement protocols for isolation

(separating those who are sick from those who are healthy) and quarantine (separating and restricting the movement of persons not yet ill, but flu-exposed and therefore may potentially infectious).

Most current institutional disaster response plans are focused on short term events with an expectation of regular staffing and supplies. A health care institution's pandemic preparedness plan should include how the institution will meet the overall care needs of the community, supply and support staff for essential services and make decisions on the distribution of limited resources over the long term. The American Public Health Association, the United States Center for Disease Control, and local/state Health Departments have mandated that hospitals collaborate with community agencies in developing their response plans (*APHA, 2007; CDC, 2007, SSWLHC Member Resource Eblast, 2007*). Hospital social work leaders must collaborate with their colleagues in the community to maintain the profession's dual focus on the individual good and the common good so as to ensure sensitivity to the needs of both in any joint plans.

ETHICAL ISSUES

Social work leaders as members of pandemic flu planning committees will be faced with multiple challenges in developing and implementing response plans. As social work is a values-based profession, social workers must consider how the values of the profession, the institution, and the community inform these policies. Social workers are trained to not just consider the immediate effects of policies, but the long term consequences for their department employees, institution, and the community at large. Ethical issues associated with the challenges of a pandemic flu include:

- *How will "surge" events be managed?*

Other resources in the community could be utilized to spare hospitals and emergency departments from demands for services that could be fulfilled in shelters, schools, and nursing homes, and other facilities. What criteria will be utilized to decide who receives what services in what location? What ethical principles would guide these decisions?

- *Are professional staff members required to work putting themselves at risk?*

Most health related codes of ethics and some state laws require that professional health care workers place a priority on the needs of the community and not on personal or family concerns in executing their professional duties. If exceptions are made to this requirement, are the rules reasonable and fair? This obligation is tagged to ethical and moral concepts of professionalism and licensing requirements. Two recent studies revealed that health care workers were less likely to report to work in a pandemic event if they were concerned that the hospital could not protect them….even the additional incentive of triple pay was not significant in their decision (*Irvin, 2007*). The second study found workers would be more willing to report to work if their commute to work

was safe and timely. Other factors influencing decisions to report to work were a low perceived likelihood of contacting the illness, the availability of protective gear, presence of family support and a belief that their work contribution would be helpful (*Kruus, 2007*).

There is little question that health care workers will be at risk from exposure during a pandemic flu outbreak. The question arises as to who they may infect. Many argue that, based on the risk of exposure, health care workers and their families should receive the highest priority for vaccines when available to ensure workers' continued availability and to allay any fears for their family members. Institutions should consider establishing plans for employees' families when employees may not be available to their families for days or weeks at a time or if workers succumb to disease. As practice standards may be relaxed to alternate levels of care, institutions may need to offer liability protection for workers during crisis periods.

- *What criteria will be established to manage scarce resources such as vaccines and ventilators?*

Criteria for allocating scarce resources should be predicated on professional evidence-based standards with clear statements as to when exceptions will be made. Expected critical decisions include the manner in which vaccines are distributed when available and the protocols for dealing with shortages of mechanical ventilators to support critically ill patients. While most professionals logically agree to the concept of triage and associated sets of criteria, they balk at the prospect of actually having to decide which patients will not benefit in the long term from ventilator care and should therefore be weaned from continued use to help other patients with higher likelihoods of survival. Further, in surveying hospital material managers, Notation (*2007*) found that while 68% of respondents had devoted resources to developing a comprehensive pandemic-specific disaster plan, 79% reported they could continue operations without external resources for less than one week. Of concern is the distinct possibility that hospital supplies may be disrupted by a lack of drivers willing to make necessary deliveries.

- *How will isolation or quarantine regulations be enforced?*

Local communities need to be educated by regional authorities about the legal aspects of isolation and quarantine regulations and understand the consequences for violating established regulations. Hospital security must be prepared to enforce the regulations in cooperation with local authorities. Will health care professionals be comfortable identifying individual patients who meet the criteria for isolation and quarantine? How will quarantining affect patients' psychosocial needs?

ETHICS IN PLANNING

The National Association of Social Work (NASW) Code of Ethics (*1999*) provides guidelines for ethical social work practice based on a set of commonly held

values including service, social justice, the dignity and worth of the person, importance of human relationships, integrity, and competence. The guidelines are organized into a set of obligations and duties to clients, colleagues, practice settings, the profession, and society at large. The NASW Code further addresses social workers' overall obligation to promote the common good in addition to individual services and to represent each to the needs of the other. The demands of the common good will often rise above the need of the individual patient in the pandemic flu response.

Article 6.03 states that, during public emergencies, social workers should provide appropriate professional services to the greatest extent possible. This would certainly support social workers reporting for duty during a pandemic flu. In addition, *Article 3.09 (a)* states that social workers generally should adhere to commitments made to employers and employing organizations. However, *Article 3* states further that social workers should ensure that employing organizations' policies are non discriminatory. Social work leaders would be obligated to raise concerns if policies are not appropriately addressing the need of vulnerable populations such as hospital patients or exhausted fellow workers. Respect for the individual patient is imbedded in values of service and individual dignity and worth. How do we protect the needs of the individual when they conflict with the needs of the institution or community?

Ethical principles based on societal and professional values provide further guidance in evaluation of conflicting duties and obligations. However, as with the guidelines offered by the NASW Code of Ethics, it is often difficult to establish a priority or hierarchy in ethical analysis of dilemmas. Dolgoff, Loewenberg, and Harrington (*2005*) developed an Ethical Principles Screen (EPS) that facilitates the ethical reflection and decision process. The screen includes a hierarchy of principles and applications:

1. Protection of Human Life – no consideration of quality of life or costs
2. Equality and Inequality – all persons in equivalent situations should be treated in the same way
3. Foster Self-Determination, Autonomy, Independence and Freedom – violate when potential harm to others
4. Least Harm – avoid or prevent harm
5. Quality of Life – choice will sustain or promote improved quality of life
6. Privacy and Confidentiality – prime obligation unless violating will protect another from violence and harm
7. Truth Telling – full disclosure of all relevant information, promotes trust, minimizes surprises

Social workers can apply the EPS as one method of furthering the decision-making process. In regards to managing the surge phenomenon, the principles of Protecting Life, Equality and Inequality, Least Harm, and Truth Telling would support establishing triage criteria determining who is admitted to a hospital versus being referred to another community resource. These principles meet the social worker's interest in promoting the common good, preventing further harm to the institution and community, and ensuring the transparency of decisions to all. In evaluating whether employees must

report to work, the principles of Protecting Life, Equality and Inequality, Least Harm, and Truth Telling support decisions that require employees come to work. At the same time, the Principles of Least Harm, Protecting Life, Quality of Life and Truth Telling support institutions' obligations to the employees' family welfare. Decisions to establish an allocation system for distribution of scarce resources are supported by the principles of Protecting Life, Equality and Inequality, Least Harm, Quality of Life, and Truth Telling as resources would be used judiciously to promote the overall community welfare. Again, transparency in application is critical to acceptance of the decisions by professionals and the community. Isolation and quarantine decisions are supported by the principles of Protecting Life, Equality and Inequality, Least Harm, and Truth Telling. Equitable, humane enforcement is essential for professional and community acceptance of the regulations. During pandemic flu response planning, Self Determination and Privacy principles would be largely in conflict with decisions that de-prioritize individual needs to allow a focus on meeting the needs of the larger community.

The principles of bioethics based in societal and professional values can also serve as a resource in ethical reflection and decision making. Beauchamp and Childress (*2001*) identify Beneficence, Nonmaleficence, Respect for Autonomy and Justice as primary principles utilized in analyzing and resolving ethical dilemmas based in health care. Beneficence refers to an action taken on behalf of others such as protecting rights, preventing harm, and rescuing persons in danger. The principle does not prioritize the good of the individual versus the common good. It would support policies requiring health care workers report for duty and fulfill their obligation to place the interests of those in need of expert care over the workers' personal needs. Beneficence also supports provision of services to those workers that would promote their personal welfare. Finally it would support isolation and quarantine plans protecting the general population, but would also require that the dignity of those in isolation and quarantine be respected in any plan.

The principle of nonmaleficence asserts the obligation to not inflict harm. It differs from beneficence in that beneficence brings duties to prevent and remove harm. Rules associated with nonmaleficence include: 1) not killing; 2) not causing pain or suffering; 3) not incapacitating; 4) not causing offense, and; 5) not depriving others of the goods of life. It may be argued that the principle of nonmaleficence would not support policies restricting access to services and resources or isolation and quarantine policies as they deprive others of the goods of life. The same issue is associated with the principle of respect for autonomy. Autonomy encompasses the concepts of liberty (independence from controlling influences) and agency (the capacity for intentional action). Restrictions to services, resources, and freedom would not be supported by the principle of respect for autonomy.

The principle of justice obliges professionals to offer fair opportunity for people to access services and resources and to judiciously and fairly distribute goods we have available. Justice would direct us to utilize proven criteria for access and distribution decisions, maintain transparency in the process and be accountable for our decisions.

Ethical principles such as the role of government in preventing harm, preserving individual liberty and protecting the public from harm; proportionality in response; reciprocity for those who are exposed to great burden; and global solidarity, are grounded in larger social values. The universal tenet that all should be affected and treated in the same way is the base for the principle of equity. Society through government should do all it can to prevent harm and protect members of society while maintaining individual dignity and freedom (*University of Toronto Bioethics Centre, 2005, Kinlaw & Levine, 2007*). Over-reaction to a crisis, suspicion of unequal treatment and poor use of resources build distrust in government's ability to address individual and community needs. The procedural values of reasonableness, transparency, inclusiveness, responsiveness, and accountability should serve as a template for ethical decision making. Relevant questions arise as to whether:

- Decisions are based on evidence, principles and values made by credible and accountable leaders?
- Decision-making processes are open to scrutiny and publicly accessible?
- All appropriate stakeholders are engaged in the decision making process?
- Decisions be revisited and revised as warranted?
- Mechanisms exist to assure decision makers are accountable for their actions or inactions?

Conflicts will arise when the principle of utility trumps the principle of equity. Utility directs that options maximizing the good for the majority are the right choice. Individual staff members may suffer crises of conscience when asked to sacrifice the needs of an individual to meet the needs of a larger segment of patients. In judiciously using resources, the utilitarian perspective may direct that services and resources be limited to those most likely to benefit. Decision makers likely face difficult choices. Should mechanical respirators, for example, be available to all patients or only to those who have a higher likelihood of surviving the disease and returning to the community?

ETHICS IN IMPLEMENTATION

Social work will often take the lead in coordinating education, community collaboration, and planning for necessary support services for staff and community members affected by the pandemic. Ethical reflection through this phase will utilize the procedural values and principles of reasonableness, transparency, inclusiveness, responsiveness, and accountability.

Education

Education should be multi-media, updated and repeated on a regular basis, with communication written to the level of understanding of intended audiences. Information should be provided on the obligations of staff, patients, and community members as delineated in pandemic response plans and include the rationale for such plans, including anticipated benefits and consequences. Multi-media material including CDs, lectures,

"talking points" handouts and postings on organizational web sites would ensure wide accessibility and consideration of varied learning styles. If staff members are mandated to report to work, then plans for family support should be outlined as well as any penalties staff may face for not reporting. Such an approach promotes the values of reasonableness, transparency, inclusiveness, and accountability. Workers should not be surprised when called into work in the event of a pandemic. Community members should be aware of available services and how to access them. Social workers should actively participate in the writing, producing, and presentation of this information.

Participation in drills and training are educational activities that social workers should support. Information gathered in drills can enhance response plans and contribute to updated training and education. All appropriate community agencies and members should be included and debriefed. Social workers can follow a standard format for debriefing, but their sensitivity to body language and observation skills will make the reports more robust and useful.

Community Collaboration

Hospital-based social workers maintain active roles in their communities by volunteering on community boards, making presentations to community groups, and participating in joint planning efforts that benefit patients and their families. Social workers can cross boundaries between competing agencies and institutions to foster cooperation and mediate potential conflicts. With a professional emphasis on group processes, social workers seek to insure all relevant parties are included in discussions and to gain consensus. This is a particularly important for hospitals needing to identify alternate care settings for patients not considered critical under pre-established hospitalization criteria during pandemic flu events. The values of reasonableness, transparency, and inclusiveness drive the community collaboration process.

Support Services

A variety of psychosocial services should be integral to planning for a pandemic flu event. Social work awareness of the most vulnerable staff members and community citizens can expedite appropriate planning. Social workers can provide support for these populations by engaging other professionals and leaders and advocating for them in planning details. The APHA (*2007*) recommends that such community events as speeches, ceremonies, memorial services and collections be used to help individuals manage both the distress of loss and coping with unexpected deaths of family, friends, and neighbors and the fear of the unknown and possible future losses. Social workers can partner with administration, chaplaincy, and marketing staffs to preplan appropriate efforts in their communities.

Consistent, clear, and comprehensive communication between hospitals and surrounding communities will both promote community solidarity in support of the hospital and mitigate the distress of community citizens. Communication tools include use the Internet, TV/radio bulletins, focused interviews, and general telephone reports.

Information must be timely and accurate. Playing down or denying the severity of pandemic situations will only build mistrust. Extensive literature on disclosure of unanticipated outcomes and medical errors verifies that direct and prompt information provides comfort and support to all involved parties. Educational programming should include simple instructions for identifying symptoms and managing illnesses at home. Instructions should be repeated and readily accessible. Social work skill in varied communication techniques can provide models to administration and other professionals.

Support for hospital workers includes all levels of staff, begins at the onset of required work schedules and considers needs beyond the hospital. Frequent work breaks off patient care units, readily available meals and snacks, comfortable sleep rooms for those staying at the hospital and ready communication with family are among the practical supports that should be provided for staff and physicians. Informal and formal psychological support should also be afforded. Being present to listen and acknowledge a colleague's concerns is appreciated and effective in managing distress. Social workers already incorporate this in their repertoire of staff support in their day to day work.

Support services should be focused on the safety and care of staff families. These services can include child care, elder care, pet care and home maintenance assistance if staffs are unable to return to home due to the nature of an outbreak. Video conferencing can be particularly helpful for children unprepared for separation. Psychological and behavioral support services to staff in managing collateral stress should be proactively offered even when staff is able to return home. Post event intervention to detect possible residual psychological effects of crises should be offered to staff and families as soon as possible. Institutions should remain open to other possible support requests from staff. Each of these interventions is supported by the procedural values of reasonableness, transparency, inclusiveness, responsiveness, and accountability.

CONCLUSION

Active participation by social work leaders in development and implementation of pandemic flu event response plans has benefits extending beyond the usual professional satisfiers of "being helpful and making a difference." Social work staffs become more empowered within their institutions and professional respect builds as a result of incorporating social work values in pandemic response plans (*Miley & DuBois, 2007*). With its professional focus on the care needs of individuals, families and the community at large, social work can provide ethically competent leadership that proves invaluable to the planning and delivery of crucial services during pandemic flu events.

REFERENCES

American Public Health Association. (2007). *Pandemic Flu: Get the facts*. Retrieved from Internet

Bartlett, J.G. (2006). Planning for avian influenza. *Annals of Internal Medicine*, 145(2), 141-144.

Beauchamp, T.L. & Childress, J.F. (2001). *Principles of Biomedical Ethics, 5th Ed*. New York: Oxford University Press.

Centers for Disease Control and Prevention. (2007). *PandemicFlu.gov*. Retrieved from Internet.

Dolgoff, R., Loewenberg, F.M., & Harrington, D. (2005). *Ethical Decisions for Social Work Practice, 7th Ed*. Belmont, CA: Brooks/Cole-Thomson Learning.

Fairfax County, VA (July 2007). *Caring for yourself and others: Seasonal and pandemic Influenza: A Preparedness Guide for the Fairfax-Falls Church Community*. Fairfax: Fairfax County Virginia Health Department.

Irvin, C., Cindrich, L., Patterson, A.L., & Southall, A. (2007). Hospital personnel response during a hypothetical influenza pandemic: Will they come to work? *Academic Emergency Medicine*, 14(5), Suppl.1, S13.

Kinlaw, K. & Levine, R. (2007). *Ethical guidelines in pandemic influenza*. Atlanta, GA: Centers for Disease Control and Prevention.

Kruus, L., Karras, D., Seals, B., Thomas, C., & Wydro, G. (2007). Healthcare workers response to disaster conditions. *Academic Emergency Medicine*, 14(5), Suppl.1, S189.

Miley, K. & DuBois, B. (2007). Ethical preferences for the clinical practice of empowerment social work. *Social Work in Health Care*, 44(1/2), 29-44.

National Association of Social Workers. (1999). *Code of Ethics*. Washington, DC: author.

National Association of Social Workers. (2007). *Input offered for vaccine response*. Washington, DC: author.

Novation (2007). *Novation survey on pandemic flu preparedness shows hospitals will run out of supplies in less than one week*. Retrieved from Internet.

Social Work Leadership in Health Care (2007). Member Resource Blast e-mail. Retrieved from Internet.

University of Toronto, Joint Centre for Bioethics. (2005). *Stand on guard for thee: Ethical considerations in preparedness planning for pandemic influenza*. Toronto, CA: author.

Patricia O'Donnell, PhD., LICSW is Director, Center for Ethics, Inova Health System, Springfield, Virginia. She may be reached at 703-321-2658 or by e-mail at patricia.o'donnell@inova.org.

A HOSPITAL-BASED SOCIAL WORK RESPONSE TO THE THREAT OF AN AVIAN FLU PANDEMIC

Kathleen M Wade, PhD, LMSW, ACSW
John R.Kettley, LMSW

INTRODUCTION

Disaster planning and emergency preparedness has assumed a new meaning and a higher priority since the tragic events of September 11, 2001. The development of an infrastructure for an immediate response to bioterrorism and natural disasters is of paramount importance in our country's new definition of crisis management. Federal funding has been allocated to state agencies in an effort to organize a comprehensive disaster response structure at a local and state level. The emergence of hospital and community partnerships to develop emergency systems in the event of a disaster has occurred throughout the country. Organizing a disaster response system requires crossing traditional and territorial boundaries such as; hospital and community; local, state, and federal agencies; and disaster organizations with separate responsibilities and funding mechanisms. Although barriers to disaster preparedness exist, protocols have been developed to facilitate strong linkages across these disparate boundaries and geographic regions.

In general, disaster preparedness involves developing a clear chain of command, a common language understood by all, and a structured organizational chart which defines scope of responsibility by job roles and functions. Depending on the type and level of the disaster, different plans are activated. Disaster drills using various internal and external crisis management scenarios are created to practice the appropriate level of response. Post drill debriefings are held to incorporate lessons learned into planning for future crises. Also, lessons learned from previous pandemics are utilized to better prepare for future responses. One example of this is using what was learned from the 2003 pandemic outbreak of Severe Acute Respiratory Syndrome (SARS) to help plan and prepare for the impending threat of an avian influenza pandemic.

LESSIONS LEARNED FROM SEVERE ACUTE RESPIRATORY SYNDROME PANDEMIC

The Severe Acute Respiratory Syndrome (SARS) pandemic provides some lessons learned in preparing for an influenza pandemic. In describing the scope of SARS, Davis (*2006*) states, "The first pandemic of the twenty-first century had generated 8,500 cases in 26 countries; nearly 11 percent of SARS patients (916) died worldwide, although mortality in some cases was closer to 20%" (*p. 76*). During the SARS pandemic there were serious communication breakdowns, a lack of coordinated response, contradictory

reports on how many people were affected, as well as limited information being propagated regarding the diagnosis and treatment of this virus (*Davis, 2006*).

The brunt of the impact of SARS was experienced by hospitals and health care workers. Health care systems were overwhelmed due to limited bed availability, including a lack of negative pressure isolation rooms for the maximum infection control measures necessary for this contagious, airborne disease. Over time, the heavy toll taken on health care workers became apparent. This was especially true with physicians. When the lack of medical personnel became so great additional physicians had to be imported from the US to Canada to deal with the crisis. "The Ontario government had to import, more or less clandestinely, several hundred United States doctors to make up for the shortfall caused by ill or frightened physicians" (*Davis, p. 77*).

Additionally, there was a paucity of standardized practices and policies which created a huge void, adding further to the overwhelming burden SARS took on the health care system. An infrastructure bringing hospitals, communities, and disaster response organizations together was an essential component lacking in the response to this pandemic. Although many of the SARS lessons learned were helpful in planning for future pandemics, there are major differences between SARS and the avian flu that will present additional challenges to our emergency preparedness.

One important difference in terms of screening for the illness is that SARS is infectious only after symptoms such as fever and coughing ensue, where as influenza can be spread during the asymptomatic stage. An infected person can shed large amounts of virus and is highly contagious days before the actual onset of symptoms. As a result, influenza is more transmissible (*Davis, 2006*). One of the major take away lessons from SARS is the health care system will be the focal point for the avian flu pandemic.

AVIAN FLU

According to the Centers for Disease Control (*CDC, 2006*), a pandemic is a global disease outbreak. A flu pandemic occurs when a new influenza virus emerges for which people have little or no immunity, and there is no vaccine. The disease spreads easily from person-to-person, causes serious illness and can sweep across the country and around the world in a very short time (*CDC, 2006*).

Avian influenza, otherwise known as bird flu, is a viral infection caused by the avian influenza virus which occurs naturally among the wild bird community. The birds carry it in their intestines, but the virus is not normally fatal to them. However, the virus is very contagious, affecting mostly waterfowl and domestic birds like chickens and turkeys. The virus is spread to a non-infected bird by contact with an infected bird's nasal secretions, saliva, and feces directly or from contaminated surfaces (*CDC, 2006*).

There are subtypes of the influenza A virus due to variations of proteins found on the surface of the virus. All of these subtypes have been found in the bird population.

There are two main types of bird flu based on pathogenic potential. The low pathogenic form only has mild, if any, symptoms in birds. However, the flu type with high pathogenic potential can affect entire flocks of birds, and is known to have a high mortality rate (*CDC, 2006*). While influenza A viruses normally only affect birds, there are several strains known to affect humans, causing symptoms very similar to a human influenza. The severity and variety of symptoms generally depend on which virus is contracted. Influenza A virus (H5N1) is an example of this. It is highly contagious among birds, and infections have occurred in humans. In these human cases, the infections occurred during direct or close contact with contaminated birds or surfaces. There are more than 200 confirmed cases of H5N1 infections in humans (*CDC, 2006*). This is the largest number caused by an avian flu strain. More than half of those infected with H5N1, mostly children and young adults who were healthy before infection, have died. The virus has very rarely spread as a result of human-to-human contact. The recent cases in Asia, Africa, and Europe have led to mass culling of birds to halt further infection.

WHAT IS INFLUENZA?

According to the Centers for Disease Control (*2006*), there are three conditions that need to be met to consider the influenza A virus a pandemic:

- It must be a new subtype for which there is little or no human immunity
- It must infect humans and cause illness
- It must be easily spread and sustainable among humans.

Currently, the H5N1 virus fulfills the first two criteria, namely; humans have little immunity to a virus that initially infected only birds, and several Influenza A viruses, including H5N1, are already known to cause illness in humans. The worldwide concern caused by H5N1 comes from the fact that viruses are known to mutate and change very readily. "If H5N1 virus was to gain the capacity to spread easily from person-to-person, an influenza pandemic worldwide outbreak of disease could begin" (*CDC, 2006*).

Throughout recent history, there have been cycles of influenza pandemics. Most of the pandemics were thought to have started in Asia, where there is a high population of people living in close quarters with domestic birds and livestock. This gives animal viruses more opportunity to infect humans (*Barry, 2005*). There have been pandemic influenza outbreaks seen in 1918, 1957, and 1968. The largest loss of life occurred in the 1918 influenza pandemic. Patients experienced typical flu symptoms and a fever over a three to five day period, followed by recovery. However, a secondary bacterial infection in the lungs was discovered post-mortem in deceased patients. In later influenza outbreaks, such as the 1957 outbreak, secondary bacterial infections were more controlled by a flu vaccine and other antimicrobials (*Kilbourne, 2006*).

The likelihood of another influenza pandemic is high. One only has to look at another present-day viral pandemic, HIV/AIDS, to get an idea of how it will affect the

world's population. Over the last quarter-century, HIV/AIDS has infected an estimated 39.4 million people, and has taken the lives of an estimated 23 million (*Barry, 2005*).

ASSUMPTION FOR HEALTH PLANNING

According to Fauci (*2006*), "We cannot be certain when the next influenza pandemic will emerge, or whether it will be caused by the H5N1 or an unrelated virus, however, we can be certain that an influenza pandemic will eventually occur" (*p. 76*). There are several assumptions health planners in the United States are using in planning for the avian flu pandemic. First, the general population will be highly susceptible to the virus. A key indicator for whether a pandemic outbreak is likely will be efficient and sustained person-to-person transmission. Another assumption is that 30 % or more of the population will be affected. Higher rates will occur among school-aged children and lessen with age. Working adults will account for 20 % of those infected with the virus. Overall, 50% of those infected with the virus will seek medical care. Others at high risk include: infants, older adults, pregnant women, and persons with chronic illness. The percent of the population requiring hospitalization and dying from the virus will be based primarily on the virulence of the virus strain (*Davis, 2006*).

In a moderate outbreak, similar to what occurred in 1957 and 1968, it is estimated 209,000 people would die and 865,000 require hospitalization. However in a 1918 type outbreak which is viewed as severe, it is estimated approximately 2 million people would die and 10 million would require hospitalization. Over 45 million would require outpatient medical care and it is estimated over 90 million, or 30% of the population would have symptoms of the illness**.** In a severe pandemic outbreak, absenteeism due to being ill, caring for an ill family member or fear of being infected could reach 40% of the work force. It is expected that a community outbreak could last from six to eight weeks with multiple episodes possible (*Davis, 2006*).

THE NATIONAL RESPONSE

In 2005, the World Health Organization (WHO), in conjunction with its member countries, developed a strategic action plan for a pandemic avian flu outbreak. The plan consisted of three phases. The first phase was pre-pandemic which focused on reducing the world-wide opportunities for human infection and strengthening the early warning systems. The second phase was emergence of a virus with the focus on the containment and delayed spread at the source of the virus. The final phase was declaring the pandemic and its world-wide spread with focus on reducing morbidity, mortality, and social disruption, along with establishing research centers to guide the most effective response measures (*World Health Organization, 2005*).

On November 1, 2005, the President of the United States issued the National Strategy for Pandemic Influenza which identifies roles of the Federal, State and local government in response to an avian pandemic influenza. This strategy clarifies the role

and responsibilities of governmental (Federal, State, regional, local) and non-governmental organizations and provides an organizational structure in the event of outbreak of avian flu (*National Strategy, 2005*). This in turn provided the health systems with the necessary infrastructure to develop a large scale response to avian influenza.

THE HOSPITAL RESPONSE

Planning for the avian flu requires a coordinated response on a local, national, and international level. Coordination between hospitals, community agencies and disaster response organizations requires a great deal of cooperation and collaboration in order to plan and successfully implement a comprehensive disaster plan.

A pivotal role in responding to avian flu will be played by the health care system (*Davis, 2006*). This is particularly worrisome given the last two decades of deliberate cuts within health care. Hospital and bed closures have decreased the availability of inpatient beds. Severe health care staffing shortages, especially for nurses, will increase the demand for other health care professionals to be trained in patient care. Due to the contagious nature to influenza, inpatient isolation beds and access to ambulatory care sites will be required to provide the necessary care for those affected with the virus. Hospitals will play a key role in caring for those infected, triaging care and services for those believed to be infected, and responding to the needs of the worried well. Yet, today's reality of the health care system is that relatively few beds are available for current patients requiring acute care. Hospitals are already stressed beyond their limits, both for isolation beds and for emergency services. Adding to the critical staff shortages is the specific knowledge of how many staff will be absent from work as a result of the virus.

Depending on the severity of the pandemic, employee absenteeism can range from 30 to 40% of all staff. Absenteeism related to illness, caring for an ill family member; in addition to fear of becoming infected can further immobilize the response of the health care system. The duration of "peak weeks", or those when the infection rate of influenza is highest, will require ongoing staffing and supplies that are virtually impossible to meet. As hospitals have downsized their budgets, the procurement of supplies and equipment has gone to "just in time" ordering. Ordering medical/surgical equipment and basic supplies such as masks, gowns and gloves are done on an as needed basis, as opposed to stocking them for future use. Therefore, the availability of these critical items to prevent the spread of infection may not be accessible on a large scale basis when most needed.

BRIDGING THE HEALTH SYSTEM AND COMMUNITY

One model that can be used to formulate, organize, and coordinate a hospital and community partnership in response to a large-scale event is the Modular Emergency Medical System (MEMS). Although hospitals will bear the brunt of a pandemic such as

avian flu, many other sites will be needed to help care for the physical and mental health needs of others not requiring acute care hospitalization. The MEMS acts as a standard of operations when providing care to a mass casualty event in which multiple care delivery sites are needed.

Today most hospitals are focused on cost effectiveness, systems efficiencies, and quality improvements in patient care and clinical outcomes. Managing scarce resources and bed availability creates a serious challenge when planning for a surge of incoming patients. In fact, the majority of care delivery sites lack the ability to support surge capacity during a mass casualty event. MEMS bridges that gap by integrating Neighborhood Emergency Help Centers (NEHC) with the goal of directing non-symptomatic and non-critical casualties away from Emergency Departments. Hospitals are planning the opening of Acute Care Centers (ACC) to function as alternative care sites for patients needing admission into an inpatient hospital setting. ACC sites will treat patients that do not require mechanical ventilation and transfer more acutely ill patients to the hospital when a bed becomes available. The combining of NEHC, ACC, and hospitals allows for successful triaging and the provision of medical care in patient-surge events in which hospitals would be unable to meet the capacity demands. Diagram 1 shows how the MEMS model functions within a community (*Modular Emergency Medical System, 2002*).

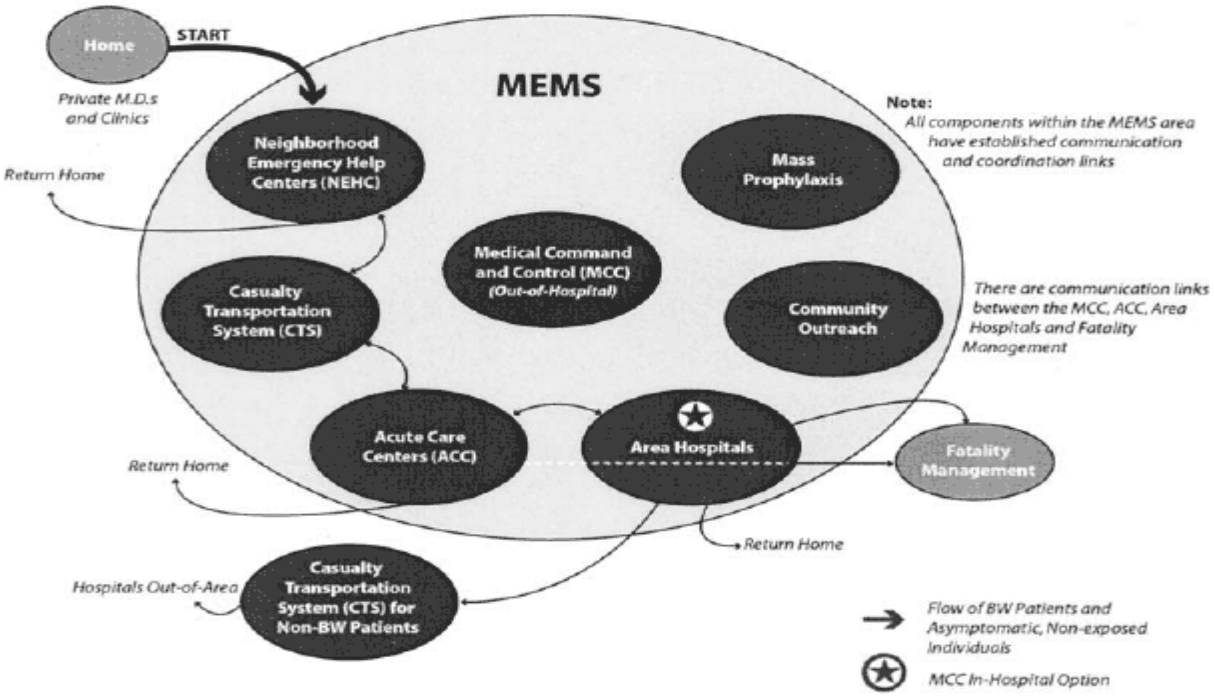


Diagram 1

Source: *Department of Defense. Modular Emergency Medical System: Expanding Local Healthcare Structure in a Mass Casualty Terrorism Incident. 2002*.

The benefit of MEMS is that it can be tailored to the needs of each community. The system can be expanded or contracted in modular units as appropriate. MEMS identifies predetermined sites for screening patients, caring for the ill, and methods for sharing information and communicating between sites. It clearly outlines the provision of care and staffing needed at specific sites, as well as the type of health care professional required to provide the care. Diagram 2 represents a Conceptual Medical Command Structure for a biological or a mass casualty incident useful for developing a chain of command by roles and functions necessary to respond to a large scale disaster. This model is currently implemented within the University of Michigan Health System.

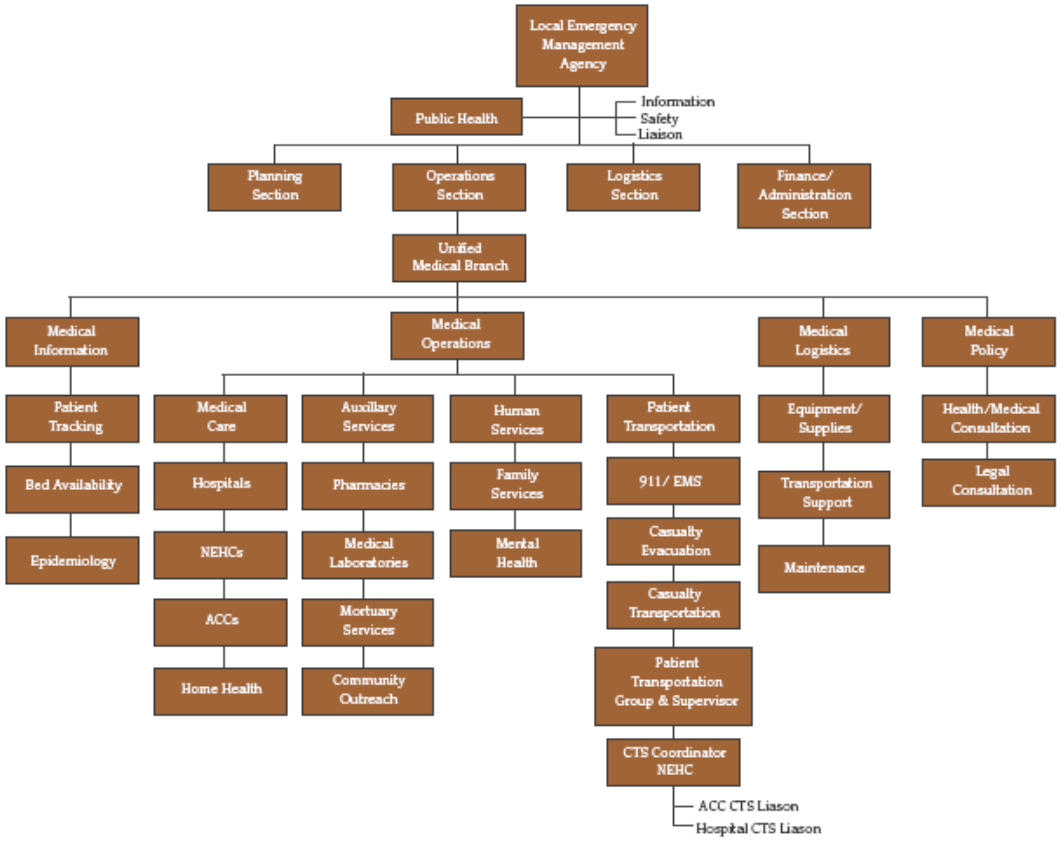


Figure 2. Conceptual Medical Command for a Biological Incident Response

Diagram 2

Source: *Department of Defense. Modular Emergency Medical System: Expanding Local Healthcare Structure in a Mass Casualty Terrorism Incident. 2002.*

THE UNIVERSITY OF MICHIGAN PLAN

At the University of Michigan, President Mary Sue Coleman charged a task force with developing a preparedness plan to respond to an avian influenza outbreak. This

group was responsible for integrating plans across the campus and health centers with the ultimate goal of safe guarding the health and safety of students, staff, and faculty; while securing the academic and business operations of the University.

The University of Michigan Hospital and Health System have been actively planning for potentially serious contagious infectious diseases since 2003, as a result of the Severe Acute Respiratory Syndrome (SARS) outbreak. SARS had a significant impact on the health care system in Toronto, Canada. Given the close proximity to Toronto (approximately 300 miles), and the frequent travel of students and staff between both locations, strategies were developed to identify patients with SARS or those who may have come in contact with the virus. The task force, in conjunction with hospital leadership, recommended the implementation of a centralized incident command structure to manage both internal (power outages) and external disasters (tornados). This structure follows the same chain of command as in Diagram 2.

The hospital is also an active member of the Region 2 South Bio-Defense Work Group which is charged with developing policies, practices, and bringing together all community agencies and health care systems for strategic planning in the event of a large scale disaster. Hospital social work is represented on several Region 2 committees to help bridge the hospital and community disaster response.

THE ROLE OF SOCIAL WORK

Social workers have played a role in crisis management in times of epidemics and pandemics. In fact, the health care reaction to SARS was not unlike the response to HIV/AIDS early in the epidemic. HIV/AIDS was being transmitted through a virus but there was inadequate knowledge of the routes of transmission, how the virus spread, and what isolation precautions were warranted. SARS had many similarities. Fear of contagion, fear of the unknown, personal safety issues, refusal to treat patients, and delays in treatment or refusal to treat were very similar in the health care response to both diseases. Yet social workers remained on the frontlines providing critical services during both of these crises. Social workers are often deployed to provide crisis intervention, grief counseling, individual and group debriefings, and outreach to the community. Within the health care system, social workers play a critical role in discharge planning, community outreach/referrals and patient and family interventions.

Although social work has been at the forefront of health care professionals responding to natural and bioterrorist disasters, they are often not acknowledged as a key component in the disaster planning process or institutional plan for disaster preparedness. As previously stated, social workers have much to offer in the development and implementation of a disaster plan within any organization. Their skills, knowledge, and expertise provide a wealth of talent that can be utilized throughout the organization. This is especially relevant within a health care setting preparing for a large scale disaster, such as avian flu.

The next section will describe the efforts of one social work department in becoming an integral member of the hospital's disaster response team and providing institutional leadership on the strategic planning task force. Positioning social work to provide clinical and administrative leadership requires attending disaster planning meetings and training staff for key roles that can be assumed in response to any type of disaster.

University of Michigan Social Work

The Department of Social Work at the University of Michigan has actively participated in all phases of planning for disaster preparedness within the hospital. The process of ensuring involvement in key committees, assuming leadership roles within the organization, and defining specific roles for social work required established goals within the social work department and a commitment of administrative time and resources to disaster preparedness.

Historically, the hospital had acknowledged social work as an important resource for aiding in the aftermath of crises. Social workers provided counseling and support for patients, families and staff alike in times of acute distress. Yet, involving social work in planning and preparing for a large scale disaster was not seen as essential. There were two strategies employed to integrate social work into hospital-wide disaster planning committees. First, social work developed a communication plan and fan out process which was practiced simultaneously during each hospital or county-wide disaster drill. The second strategy was to offer assistance to the hospital-wide committee around planning for patient and family needs. This assignment was currently unfilled and lacking in the overall command structure, creating a seat at the table for social work. After several meetings with a strong social work presence, it became apparent to the group that social work could be of value. The Director of Social Work was asked to assume a senior leadership position as a member of hospital disaster operations and assigned as the lead for Human Services in the Incident Management System (IMS). This position plays a pivotal role within the command operation and is activated when a disaster is declared. Also, a social work manager who had been a visible leader in a past internal disaster became a standing member of the hospital disaster committee and a member of the university-wide Task Force Planning Group.

Getting to the Table

One of the first steps in disaster planning and preparedness for social work is 'getting invited to the table', that is, being included in strategic meetings with key personnel during the early phases of planning. During crises, social work becomes involved from a reactive stance filling traditional roles previously established. It is essential for social work to be proactive while giving a voice to the multitude of skills and roles they can play in crisis management and disaster planning. There are several ways to assert the social work profession earlier in the planning stages, thereby assuming

more of a leadership role and maximizing social work visibility throughout the organization.

There were several strategies used to help position social work into these important roles. The following were the primary areas of focus:

- Developing a policy and procedure manual
- Staff training and education
- Building clinical and administrative relationships with key disaster personnel
- Collaborating with Spiritual Care, Psychiatry, Employee Assistance/ Wellness Program and other important stakeholders
- Defining key social work roles and functions necessary for any type of disaster

Developing a Policy and Procedure Manual

Prior to becoming involved with the hospital-wide disaster planning group, the Social Work Department developed a small working group to write policies and procedures for the department. Initially, developing plans for patients and families was the entire focus of the group. In the event of a disaster, social work leadership would delegate staff to a predetermined area (the hospital cafeteria) to provide services to patients and families. A bag carrying essential items, such as cell phone, flash lights, important phone numbers, tissues, etc. was centrally located for easy access to this location. It soon became clear to social work leadership that this plan was inadequate when faced with a disaster of pandemic proportion and a formalized social work disaster committee was formed.

The task of this group was to complete a gap analysis of what was needed in terms of preparing for a large scale disaster. This was accomplished through discussions with staff, hospital personnel, and by understanding the disaster plan for the institution. Upon completing this project, the group worked on departmental policies including a fan out procedure for the department and training requirements for both staff and management. The social work disaster committee continued to meet until the policy and procedure manual was finalized. The group then provided training to the rest of the management team, including individual tours of designated areas such as; trauma/burn unit, emergency services, and the hospital command center.

A fan out communication list was developed of key personnel, as well as a triage process for alerting management and staff of a disaster. This process was tied into the hospital-wide communication system ensuring our notification and involvement. Management pagers were programmed through the telecommunications department with an emergency group page number readily accessible in the event of a disaster. The managers were added to the hospital disaster group page triage system which is a part of

the senior leadership notification system. Although the management team remains on page after hours, there is a designated manager on call who is the first point of contact within our system. Also, the emergency room social work position which is staffed 7 days a week, 24 hours a day has become a primary source to initiate the management team page.

Next, social work needed to secure an operations or staging area to be the hub of its disaster operations. In this situation the most reasonable space was an office referred to as the Guest Assistance Program (GAP). The GAP provides non clinical services such as; meal tickets, parking, and lodging under the direction of social work. The office is centrally located in the hospital and close to the hospital incident command center. It contains phones, computers, and tangible items useful in a disaster. In the event of a power outage, communication devices are available as well as easy access to the hospital cafeteria and communication center. It has also been an area used to deploy social work staff and volunteers in various capacities without their interference in the incident command center. A person is designated as the liaison between the command center and the GAP, allowing the managers to get the most recent, and correct information about what is happening. An alternative location has been identified in the event of contagious diseases, such as bird flu. This space is in the hospital but more removed from direct hospital operations. It is also large enough to house cots and a family reception area.

Training and Education

Staff training determined to be essential by the disaster planning committee was arranged, at the work site and at no cost to participants. Funds obtained from hospital disaster training funds were available as a result of state monies received by the organization for disaster preparedness. Training was scheduled for all social work staff interested in attending. Schedules were arranged for adequate patient care coverage and multiple dates were planned around staff availability. Training was voluntary and held during the work day. The majority of staff opted to attend the training. The department offered training slots to other departments such as psychiatry, nursing, and emergency room staff. This allowed staff to practice their skills with their non social work colleagues, especially since this would most resemble their work environment. Also, training funds were allocated to social work with the understanding that other health providers would be welcome.

The first training offered was on Critical Incident Stress Management (CISM). CISM is defined as a "comprehensive, integrative, multicomponent crisis intervention system" (*Mitchell and Everly, 2000*). It can be used throughout the spectrum of a crisis from the pre-crisis preparation phase, to the acute crisis phase and ending with the post-crisis phase. CISM can be used with individuals, groups, organizations, or at a community level. Its primary purpose is to mitigate symptoms and stabilize the crisis. This training spanned two full days and used both didactic and experiential instruction tools.

The second training was offered by the American Red Cross. The multiple trainings were arranged to maximize the number of providers who could attend, again offered at no cost and on site at the hospital. The volunteer training, aimed at mental health providers, included certification for future Red Cross disaster deployments. Social workers trained by the Red Cross have used this training to lead debriefings for first responders following local disasters, while some chose to be deployed to New Orleans following Hurricane Katrina.

Future training will utilize the National Incident Management System (NIMS) training which can be individually completed for certification using their online system. NIMS was developed to ensure that "responders from different jurisdictions and disciplines can work together better to respond to natural disasters and emergencies, including acts of terrorism (http://www.fema.gov/emergency/nims/nims_training.shtm). The National Integration Center (NIC) Incident Management Systems Division established under the auspices of Homeland Security provides oversight of the National Incident Management System. "The Center oversees all aspects of NIMS including the development of compliance criteria and implementation activities at federal, state and local levels. It provides guidance and support to jurisdictions and incident management and responder organizations as they adopt the system." (http://www.fema.gov/emergency/nims/nims_training.shtm). NIMS training has become an integral component to organizational training programs for disaster preparedness.

Building Clinical and Administrative Relationships with Key Disaster Personnel

A strong leadership presence is essential for inclusion into the institutional disaster planning process. Senior social work leaders are in a unique position to develop relationships with disaster personnel and offer their expertise as a committee member or lead for disaster preparedness groups. Leadership can also be assumed throughout the department, not just those who function in a management capacity. Medical and psychiatric staff with experience in Emergency Services, Trauma/Burn, Bereavement, Intensive Care, Employee Health Services, and Psychiatry is also positioned to take lead roles in disaster planning.

Many organizations are already performing desk top drills and full scale drills using multiple volunteers acting as casualties. Depending on bed capacity within each health center, alternative plans for treatment facilities and staffing are being made for a surge of patients with acute and chronic illness. In most cases, ACC's to care for acutely ill patients outside of the hospital have been designated. Additionally, staffing plans, operations including roles and functions, and disaster leadership have already been determined. Volunteering for committee participation on one or more groups makes it possible to define how and when social work will be involved. The Social Work Department has representation on most of the institutional disaster committees; senior leadership/command center, pandemic influenza, ACC and discharge planning.

Strong Collaboration with Spiritual Care, Psychiatry, Employee Assistance/ Wellness Program and Other Important Stakeholders

The Director of Social Work worked closely with key stakeholders, especially where roles and functions could potentially overlap. Several departments such as Psychiatry and Pharmacy were consulted during this process. It was important to work collaboratively around issues related to psychiatric assessments and medication dispensing. In a disaster, these areas provide crucial resources for patients, families and staff during and after the crisis. A psychiatric service to augment urgent mental health care and pharmacological treatment is important to providing the full range of services patients and families require when they are in crisis. Also, coordination with Community Mental Health is essential for linkage between in and outpatient psychiatric care. The Red Cross is another resource that should be utilized to help in a disaster. Developing integral relationships with an understanding of each other's procedures, scope of service, and disaster plans should be done, and in person when possible. The goal is to develop a disaster plan using different scenarios that help delineate lines of authority and communication methods. Plans resulting from these scenarios should be documented and shared with staff.

The Employee Assistance Program is lead for responding to crisis intervention and mental health needs of hospital employees. Discussions around how to maximize mental health resources and work collaboratively were key to understanding each other's role and function during a disaster. The Pastoral Care Department provides spiritual care and guidance to patients, as well as staff. They were mobilized early in the process and are a part of the group page for disaster alerts. They are an essential component to the fan out procedure in a crisis situation. They established a plan with religious and spiritual members of the Community Interfaith Council to respond in the event of a large scale incident.

The coordination between social work, discharge planning and home care services is crucial. There have been times when beds were urgently needed but unavailable. Discharge planning is an essential component to any disaster plan. Arranging for home care services and coordinating with community services is especially important when inpatient beds are at a premium.

Developing the Roles and Functions for Social Work

The roles established for social work in a disaster vary depending on the type and scope of the incident. Internal disasters generally have a smaller scope and are usually activated on a short term basis. Staff may function in a debriefing role or help expedite discharges to make room for emergent admissions. In a large scale disaster, such as the avian flu, the roles and duration of activation can increase exponentially. The primary roles and functions within the hospital are numerous, especially given the rate of absenteeism expected.

Most social work staffs are already skilled in crisis intervention and supportive counseling. Grief and loss counseling is another area of expertise for social work. End of life and palliative care has always been a major role for social work and would be crucial given the mortality projections from those most knowledgeable about influenza. Multiple casualties will require social workers to be available to patients who are dying, grieving family members, and staff caring for the dying.

Social workers currently working in the Emergency Department (medical and psychiatric), ICU's and Trauma have a unique set of skills and experiences which may be best suited to lead crisis intervention services. They are familiar with how to deal with multiple crises and have first hand knowledge of how to work with first responders, such as police and emergency medical personnel. Mental health screening and triage are essential skills needed in most crises. Roles are likely to include setting up patient screening, triage, and a tracking system for families. This generally falls to social work, as evidenced during the aftermath of 9/11 and in response to SARS. Families were desperately searching for their loved ones and either calling or coming to the hospital. In the case of a contagious disease this is further complicated by strict isolation precautions for fear of spreading the virus.

Critical Incident Stress Management (CISM) for debriefings and crisis management is another important role for social work. In a disaster response for avian flu, social workers will be working with families although much of the contact may be on the phone, depending on the contagion factor. For example, any type of gathering during the SARS pandemic was forbidden. Family meetings, small group meetings, and interdisciplinary meetings were banned. Families were not allowed to visit the hospital unless their family member was actively dying. Strict isolation precautions were enforced for families and staff alike.

Discharge planning, care management, and knowledge of community resources are other key functions critical to the operations of most disasters, whether it is an internal or external disaster. Staff deployment may be based on the unique skills of the individual, as well as the roles that are needed to be filled. For example, inpatient medical social work staff would be deployed when discharges were essential to creating beds for incoming patients. Outpatient medical and psychiatric social workers could be deployed to screen patients, provide crisis intervention counseling, bereavement services, and help with a family reception center if activated. It is important to remember the specific staffing demands when planning for absences expected with avian flu. This can be very challenging, especially over an extended period of time. Additional staff may not be able to come to work due to isolation precautions enforced by the hospital. Therefore, social work leadership must establish short and long term staffing plans for any disaster response. In the case of avian flu, contingency plans should be made for a severe outbreak with a surge of patients at various care sites and with the expectation of staffing shortages.

CONCLUSION

It is clear an influenza pandemic will occur. This is confirmed by the World Health Organization, National Academy of Sciences, and the U.S. Centers for Disease Control and Prevention (*Barry, 2006*). There is also agreement that the death toll will be significant and we will not be prepared. Even now, according to the Centers for Disease Control reports, influenza kills over 360,000 Americans, which is triple the AIDS death toll (*Barry*). "Vaccines even in the best case scenario would not be available in the quantities needed" (*p.462*).

Now is the time to act. Social workers are on the frontlines and will most assuredly be impacted by avian flu on a variety of levels. There will be staff ill prepared to perform disaster roles due to a lack of training. There will be social workers unable or unwilling to respond to the crisis for fear of exposure, or as a result of caring for ill family members. What is known is that social workers have a repertoire of skills that will urgently be needed during this pandemic. Social workers in hospitals, and the community, should be preparing themselves and advocating for obtaining the many resources required to be leaders in a disaster response. This includes disaster training, policy and practice guidelines, and discussions about role and function prior to the actual crisis situation. It should also include whatever resources are required to meet the basic and tangible needs of patients, such as food, clothing; as well as infection control items like gloves and gown, and masks. Planning and preparation are our best defense. It is also the best option to safe guard the health and well being of social work staff.

REFERENCES

_____. *Altered Standards of Care in Mass Casualty Events*. (April 2005). Prepared by Health Systems Research Inc. under Contract No. 290-04-0010. AHRQ Publication No. 05-0043. Rockville, MD: Agency for Healthcare Research and Quality.

Barry, John M. (2005). *The Great Influenza: The Story of the Deadliest Pandemic in History*. United States of America: Penguin Books.

Centers for Disease Control and Prevention. (June 2006). *Key Facts About Avian Influenza (Bird Flu) and Avian Influenza A (H5N1) Virus.* [cited 2007 Mar 04], from CDC database. http://www.cdc.gov/flu/avian/gen-info/facts.htm

Centers for Disease Control and Prevention. (June 2006). *Questions and Answers About Avian Influenza (Bird Flu) and Avian Influenza A (H5N1) Virus.* [cited 2007 Mar 04], from CDC database. http://www.cdc.gov/flu/avian/gen-info/qa.htm

Department of Defense. *Modular Emergency Medical System: Expanding Local Healthcare Structure in a Mass Casualty Terrorism Incident. 2002*. [cited 2007 Mar 04]. Available at: http://accem.org/pdf/mems_copper_book.pdf.

Davis, M. (2006). *The Monster at our door: The global threat of avian flu*. New York, New York: Owl Books

Fauci AS. Pandemic influenza threat and preparedness. (January 2006) *Emerg Infect Dis*: Vol. 12, No. 1. [cited 2007 May 15]. Available at: http://www.cdc.gov/ncidod/EID/vol12no01/05-0983.htm.dfff

Joint Commission Resources. *Guide to Emergency Management Planning in Health Care*: pp 205-212. Illinois: Joint Commission Resources.

Kilbourne ED. Influenza pandemics of the 20th century. (January 2006). *Emerg Infect Dis*: Vol. 12, No. 1. [cited 2007 May 15]. Available at: http://www.cdc.gov/ncidod/EID/vol12no01/05-1254.htm

Mitchell, J.T. and Everyly, G.S. (2000). Critical incident stress management and critical incident stress debriefings: Evolutions, effects and outcomes. In: B. Raphael and J.P. Wilson (eds). *Psychological Debriefing: Theory, Practice and Evidence* (pp71-90). New York: Cambridge University Press.

National Center for Posttraumatic Stress Disorder. *Treating Survivors in the Acute Aftermath of Traumatic Events.* (2007, May). [cited 2007 June 01]. Available at: http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_shalev.html?opm=1&rr=rr59&srt=d&echorr=true.

Region 2 South Bio-Medical Defense. 2003. [cited 2007 Mar 04]. Available at: http://2south.org/public/index.php.

The White House. *National Strategy for Pandemic Influenza*. 2005. [cited 2007 Mar 04]. Available at: http://www.whitehouse.gov/homeland/pandemic-influenza.html.

United States Department of Health and Human Services. *Pandemic Planning Assumptions*. (September 2006). [cited 2007 Mar 04]. Available at: http://avianflu.gov/plan/pandplan.html

World Health Organization. *Responding to the avian influenza pandemic threat: Recommended strategic actions. 2005*. [cited 2007 Mar 04]. Available at: http://www.who.int/csr/resources/publications/influenza/WHO_CDS_CSR_GIP_05_8-EN.pdf.

Kathleen M. Wade, PhD, LMSW, ACSW is Director of Social Work & Associate Hospital Administrator, University of Michigan Health System & Assistant Dean, Hospital Social Work, University of Michigan School of Social Work. She may be reached at 734-764-8052 or at kmwade@umich.edu

John R. Kettley, LMSW is Manager, Psychiatric Emergency Services, University of Michigan Health System. He may contacted at 734-936-5900 or jkettley@umich.edu

.

THE ROLE OF MENTAL HEALTH PROFESSIONALS IN DISASTER PREPAREDNESS AND RESPONSE

Virna Little, LCSW, Psy.D

INTRODUCTION

The provision and delivery of mental health services should be a part of any community's or organization's disaster plan. Disaster preparedness and response have become an unfortunate reality, and the creation of readiness teams and plans have become a frequently reviewed topic by senior managers and community leaders. It is imperative that mental health professionals prepare and train community members for disaster response. There is currently sufficient literature and resources which can provide information, resources, and support for mental health professionals to prepare for a disaster. Professional mental health and social work organizations need to prioritize this issue and incorporate disaster mental health training and clinical guidance during local and national conferences and meetings. Social service leaders need to educate the administration of their organizations about the important role of mental health in a disaster preparedness planning and response.

Disaster preparedness is also another forum in which leaders of an organization are reminded of the critical role that social workers play, as well as an additional opportunity for social workers to interact with administration in a team environment. Social workers a can ensure that mental health provision is a part of their community's disaster plan, and assist in the response preparedness of the professionals in their community.

It is critical to review the roles of social service professionals and to understand the appropriate response times for mental health services. In most instances, the first priority for a community must be the safety of all its residents, and to ensure that basic needs such as food, shelter and medical care are met. This does not exclude the possibility of a role for mental health providers simultaneous to the provision of these services, but mental health providers must comprehensively review the needs that individuals may have and assess when it is appropriate to begin to coordinate mental health services, to ensure both the safety of the community and the safety of responders.

There is much research in the mental health community surrounding the provision of disaster mental health services as well as a national "train the trainer program" for disaster mental health service delivery. Evidence based approaches have been developed which can be easily adapted by mental health professionals with varying skill levels, i.e.: Psychological First Aid (*Young, 2006*). There is much to learn from survivors of disasters, as we review and continue to track the mental health needs of those affected by both national disasters like 9/11and local disasters, such as flooding. The strength and resilience individuals display at the time of a disaster, as well as in the months or years following a disaster is amazing. Equally amazing is that most individuals do not develop a serious or even diagnosable mental health condition following a major disaster. In fact, research

supports the fact that most individuals cope with disaster and continue on with their lives without anxiety or trauma related complications. Thus, the role of the social work professional at the time of the disaster is often focused on reducing immediate suffering, identifying those who are at risk for developing an ongoing disorder, and providing care for those with existing conditions exacerbated by the disaster.

This chapter intends to provide a brief overview of the provision of disaster mental health services, to inspire social work professionals to become a part of disaster readiness programs in their organizations and communities, and to encourage them to seek formal training in the area of disaster mental health delivery. It is important for social work professionals to realize disasters are not rare events; millions of people die each year in disasters and millions more are affected. The United Nations devoted their 1990 initiatives to disaster readiness, and dedicated the decade to disaster reduction.

DEFINING A DISASTER

In order to begin the process we must first visit the very idea, concept and definition of a disaster. If we limit the definition of disaster and design responses for large scale human-made or natural catastrophic events we are limiting the opportunities social work professionals will have to contribute to their organizations and communities. For general purposes, a good working definition of disaster is an event which exceeds local or community resources and/or capacity. In a disaster, there are two primary phases, response and recovery. From a mental health perspective, these phases include 1) the ability of the community to respond to immediate needs in order to ease suffering, and 2) providing ongoing therapy services for the months and even years required for recovery (Herrmann, 2006).

In many communities, the existing mental health system is at capacity, and additional, immediate need from the community would exceed resources and capacity. Therefore, I propose that social work professionals align with a different theory for the definition of disaster; one which classifies those affected by disaster as a mechanism for defining disaster. If social work professionals recognize the concept of personal disaster, they will begin to view disaster preparedness from a macro and micro view- an approach which will strengthen skills, enhance comfort levels and improve capacity when services are needed or required for situations on a community or national level. This transition and change in definition will provide an alternative approach to situations social workers are faced with daily and will enhance major disaster preparedness skills.

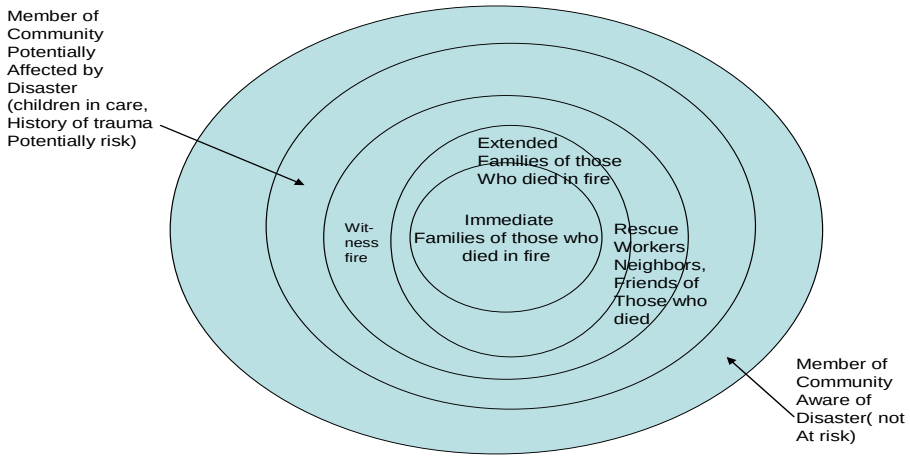
ASSESSING IMPACT

There are many factors that social work professionals need to review and understand when preparing for mental health delivery following a disaster; the extent to which the disaster has an impact on property and belongings, loss of life, decrease in available services, and ability to function can impact the numbers of individuals involved

and the need for services (*Figley, 1995*). Many factors impact the severity and prevalence of mental health conditions, and the intensity and duration of services in both the response and recovery phases; the extent that individuals or communities had prior warning and/or understanding of the impending event(s), whether or not individuals or families had the ability to stay out of harm's way, whether they have experienced the inability to escape, or witnessed first hand the loss of life and property. These factors should be important considerations in the development of any mental health disaster response plan.

Our experience with disasters suggests that human caused disasters, like terrorist attacks, create a higher need for both mental health responses and recovery services, as well as an increased prevalence of mental health conditions (*Green, 1993*). It also becomes imperative to review the extent of those impacted by the disaster, directly and indirectly. For example, a large fire in a community daycare center which causes the death of children and workers will require a response for the families who lost loved ones. Second to those who experienced a loss may be those who witnessed the fire, those who tried to help at the scene, or rescue workers. Lastly you may have individuals whose children attend the center or individuals who work in the center. Other families whose children attend daycare centers will also be impacted by this disaster.

The level of impairment individuals and communities experience following a disaster varies greatly, and each disaster requires a complete review of all those who may be impacted and the level of immediate and recovery services they may require. There are many ways professional mental health responders can approach this process. Many times following a disaster mental health professionals will create a list which numerically orders and prioritizes those impacted by the disaster and describes the anticipated level of immediate and follow-up services deemed appropriate. A more visual approach is to draw a diagram listing each of the categories of individuals in relation to the disaster.



The utilization of a diagram often assists mental health professionals designing or planning a disaster response to identify individuals who may be in need and plan individualized responses for each affected group. A response for families who lost children might include individual and group grief counseling, whereas responses for other groups would be very different. A nighttime vigil and memorial service might be planned for community members who knew those directly affected to help process the sense of loss, normalize responses to tragedies like the fire, and facilitate coping, healing and closure. Community members who learn of the disaster but who were not directly impacted would benefit from community sessions sponsored by the fire department on fire safety, teaching children how to respond when there is a fire and talking about fire safety in daycare settings. It is important to note that not all responses must be conducted by mental health professionals, and it is both critical and therapeutic for mental health professionals to call on many community members to help provide and coordinate response and recovery disaster services. The individuals, professions or organizations that may be of assistance during disaster response should be identified and contacted during disaster planning and preparedness exercises.

Mental health professionals must additionally take into account individual variations in each of the categories in order to meet the needs of all involved, and identify individual persons who may need additional services. There may also be individuals within a category who require individualized responses based on individual experiences during the disaster. For example, a rescue worker who was unable to reach a child who was alive and calling for help may require different services then other rescue workers. It may be helpful to speak with supervisors of rescue workers to learn about a worker's history: i.e.: a rescue worker who recently experienced a death in another fire or experienced their first death may require a higher level of intervention. It is also important to note the difficulty of coordinating responses to the categories simultaneously.

There are special populations which need to be taken into consideration when planning responses. The very young or very old may have special needs, as would individuals who do not speak English as a primary language. Social work professionals need to be familiar with and account for the role culture plays into disaster response, as different cultures have different histories and experiences surrounding disasters, as well as culturally specific responses and rituals. Calling on community leaders from different cultural and ethnic groups can be critical in the successful response to a disaster. Now is the time to identify these leaders and involve them in disaster planning, not at the time of disaster.

Lastly, one cannot discount the "natural" groups that are formed in times of disaster, such as individuals placed in shelters or staging areas which can be not only therapeutic in nature, but serve as a forum for more formal interventions. These are often groups of individuals impacted in varying levels, who did not know each other prior to the disaster, but who form relationships and deep bonds following a disaster. Often these groups are disrupted as services are organized or the disaster continues, thereby contributing to the vulnerability of the group members in the face of the disaster. During the process of providing mental health services to groups affected by disaster its important

for professionals to watch for individuals in the group who may be experiencing more complex or severe reactions than other group members, and to ask group members to do the same.

PROFESSIONAL RESPONSIBILITY AND OPPORTUNITY

The ability to respond to and coordinate mental health services for a disaster like the childcare center fire, or other larger disasters is a difficult task. Unfortunately the training of social work professionals does not include extended or comprehensive information on disaster preparedness or response. As a result, many social work professionals feel overwhelmed with the responsibility and task of designing and/or implementing disaster services. This response is not only detrimental to the profession, but harmful to the organizations and communities we serve. The ability to view disaster on a personal level with clients can assist clinicians in expanding comfort levels for disaster response. Research tells us that increased training and preparation helps with response, adjustment and prevalence of long term affects. (*McFarlane, 1993*)

Senior managers who prioritize disaster preparedness are providing a great service to their profession, organization and community. These managers allow supervising staff to attend "train the trainer" disaster preparedness sessions and relay information to all staff members, encourage staff to be active in organizational and community disaster preparedness meetings and events, and make disaster planning part of regular staff meetings. Conducting an exercise at a staff meeting in which a disaster is discussed, a diagram is developed, and responses and resources are planned is critical for the success of those social work professionals to assist in the event of a disaster. During these exercises a review of recent disasters and responses can be helpful, as well as a review of disasters in the community and responses that worked or those that were not that effective.

The importance of sharing information in these exercises should not be underestimated, and individuals should be assigned to provide groups with updated information. In the event of a disaster, information is critical and permits responses and plans to change as information is received Examples of critical communications include the numbers of people impacted, a flood that is now causing fires, or violence following a natural disaster. Often one individual is assigned to be a liaison with rescue workers, listen to the radio or watch newscasts with the sole responsibility of providing up to date information to response teams.

HOW INDIVIDUALS RESPOND TO DISASTERS

As we progress in our readiness programs and social work professionals learn to call on resources to respond to disasters, it is equally important to train them on the varied responses individuals have to disasters, and events that may exacerbate those responses, requiring more advanced and ongoing treatment for long term effects. Most individuals experience high levels of stress during a disaster, which gradually reduces to normal

functioning. This by no means suggests that disaster survivors do not recall the event, reference the disaster related events or do not change in some way following a disaster. However, most individuals are able to return to a pre-disaster level of functioning without impairment and/or long term effects (*Green, 1993*). The level of resilience demonstrated by individuals following a disaster often astounds most helping professionals. Often individuals report being stronger and feeling more connected to their families and communities following a disaster. Individuals who assisted in the disaster and helped others often feel a sense of self-worth that was not present prior to the disaster. Many will report they feel a renewed sense of strength for having survived a disaster. In fact, social work professionals can often assist patients in identifying coping skills and strengths used during times of disaster to help them cope with stressors following times of disaster.

During and shortly following a disaster there is commonality to how individuals respond on both a physical and emotional level. Many report difficulty sleeping, concentrating, somatic complaints (all over body pain, headaches), irritability, difficulty eating or over-eating. They report problems with relationships, perhaps not wanting to socialize, or conversely, reporting that they are unable to be alone. The loss of control experienced by disaster survivors is predominant is determining the intensity and longevity of the impact of the disaster on their functioning in most cases. In assisting social work professionals prepare for working with disaster survivors, it is helpful to give them a scenario and role-play the impact it would have on their own lives. Imagine if the organization they were currently working for ceased to exist, or their block was destroyed in a fire today while they were at work and their home, belongings and important papers were destroyed. What short term and long term impacts would this have on them? What would be the range of emotions they would experience? What physical affects? How would they fare financially? What if a family member or spouse was severely disabled in the disaster? Most importantly, what can they do today to help them prepare for a disaster?

While most individuals will handle the disaster through the use of existing coping strategies, resources and strengths there are some individuals who are not able to return to their previous level of functioning. (*Green, 1993*) There are several risk factors which increase the prevalence of mental health disorders following a disaster. Women are more likely to have lasting psychological effects from a disaster, especially single mothers and married women who carry the majority of the caretaking responsibilities. (*Kessler, 1992*). Those with a history of trauma, such as family violence survivors or refugees from violent countries are more likely to have lasting effects. Middle-aged individuals often display more stressors following a disaster, and children are also at great risk (*Gordon & Wraith, 1993*). The amount of disruption the disaster causes in the life of a survivor is a predictor of mental health,. Residence and financial stressors experienced following a disaster can also contribute to long term mental health concerns. A pre-existing mental health condition is often exacerbated by a disaster, especially mood disorders like anxiety or depression. Lack of information and support systems before, during and after the disaster not only increases the likelihood of a mental health condition following the disaster, but the severity of the condition.

In contrast, there are some factors which seem to decrease the risk for the development of a mental health diagnosis following a disaster. The primary factors which decrease the potential negative effects of a disaster are formal and informal support systems before, during and following a disaster. Another strength is the experience of having overcome a disaster previously, such as a Florida family who had survived severe hurricanes prior to Hurricane Andrew. Information is also critical, including information on the disaster itself such as duration or impact, and information on available services such and when to expect them. Information and support reduce the times that individuals feel helpless and out of control, and therefore reduce the prevalence of the long term effects those prolonged periods seem to create.

Individuals without information or supports are more likely to develop Acute Stress Disorder, the most common mental health condition observed during times of disaster. Acute Stress Disorder is a diagnosable mental health condition which becomes apparent within a short time of experiencing disaster related circumstances, usually within a few days but up to the first month (DSMIV.) The symptoms included hypervigilance, arousal, and intrusive thoughts which are clearly related to disaster experiences. Individuals who experience Acute Stress Disorder appear to be at higher risk for the development of Post Traumatic Stress Disorder (PTSD) (*Gore-Felton, 1999*).

There is extensive yet surprisingly unclear research as to the prevalence of PTSD in disaster survivors. Most support the idea that most individuals do not meet the diagnostic criteria for PTSD when reviewed months or years after a disaster. However, there are disaster survivors who do experience long term affects, especially those in the high risk categories discussed earlier. These individuals experience nightmares, exacerbated startle response, hypervigilance, flashbacks and anxiety, all diagnosable symptoms according to criteria (DSMIV). Those with increased stressors, large or significant losses, and decreased support systems are also at risk for co-morbid conditions such as depression with PTSD. While not as common, individuals can develop depression following a disaster (*Freedman, 1999*) without developing PTSD.

Social work professionals who are not in positions where they conduct diagnostic assessments or utilize the DSMIV should familiarize themselves with these diagnoses. Familiarity with the common diagnoses seen following a disaster will decrease the anxiety that mental health responders experience in stressful situations, and increase their proficiency in times of crisis. In order to appropriately respond in times of disaster, social work professionals need to be familiar with both the diagnostic criteria for commonly seen diagnoses, but with modalities appropriate for disaster survivors. Individuals who demonstrate altered mental status, or cognitive or behavioral disturbances, should be referred or accompanied to medical evaluations and supportive services - a form of mental health triage.

Psychological First Aid has become the modality most supported by the research and most frequently taught for disaster survivors (*Young, 2006*). Psychological First Aid offers reassurance, comfort, non-threatening personal contact and communication to survivors. This modality seeks to reduce the prevalence of disorders through offering

support, discussed earlier as a risk factor for the development of a future mental health diagnosis. The supportive techniques of Psychological First Aid have replaced Critical Incident Debriefing (CID) and Critical Incident Stress Debriefing (CISD) as the first intervention of choice in disaster situations. Current research indicates that CID and CISD are not effective in decreasing the prevalence of PTSD in disaster survivors, and actually exacerbate symptoms and further traumatize survivors. (*Herrmann, 2006*)

In short, the development of Psychological First Aid has sought to address the immediate needs of disaster survivors and is often taught by referencing three basic "ABC "components: arousal, behavior and cognition. Aroused individuals should be comforted and provided with basic needs, behavioral concerns should be assessed, and assistance provided to help individuals regain some sense of control. Cognitive disturbances should be evaluated with a mini- mental health status assessment, offering support and assisting the person with reality based concerns and tasks, putting the reality of the current situation into context. Information should be provided briefly and specifically, as individuals who are overwhelmed or limited will not remember nor understand large amounts of information. Information is critical and must be provided with consideration of such factors as age and current abilities. As part of disaster preparedness, organizations should sponsor Psychological First Aid training for staff or community social work professionals.

Social work professionals should not feel rejected if individuals decline assistance or care, some individuals are not ready or able to interact with others, and some are from a culture in which mental health services or discussing problems is not common practice. Many times individuals will feel they are not as "bad off" as others affected and will decline services. Mental health responders should simply let survivors know they are there if needed or how to find them, as well as seeking approaches to individuals that will facilitate support. Providing responder and recovery mental health services during times following a disaster is difficult, and often affects the mental health teams in many of the same ways survivors are affected. It is important to seek guidance and support if possible, and to watch for signs of stress or trauma in fellow responders and in your self.

CONCLUSION

Disasters are complex events requiring complex and comprehensive responses. This brief chapter is intended to provide inspiration for social work professionals to seek further training, encourage disaster preparedness in their homes, places of work and their communities. This chapter has sought to remind social work professionals that they work with individuals and families who experience personal disasters on a daily basis, utilizing skills such as offering support, guidance and comfort. Social work providers should recognize that these same skills, with preparation, can be applied to larger and catastrophic disasters. The brief foundation and overview in this chapter is meant to inspire discussions and motivate clinicians to expand their expertise in disaster mental health provision. It is imperative social work professionals realize and embrace the critical role they can play in a disaster, particularly in decreasing the long term emotional effects of disasters on the individuals and families in their communities.

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders (4th ed)*. Washington, DC.

Bryant, R. A., & Harvey, A.G. (2000). *Acute Stress Disorder. A Handbook of Theory, Assessment and Treatment*. Washington D.C: American Psychological Association.

Cardena, E. & Spiegal, D. (1993). Dissociative reactions of the San Francisco Bay Area Earthquake of 1989. *American Journal of Psychiatry*, 150, 474-478.

Figley, C., Giel, R., Borgo, S.,Briggs, S. & Harotis-Fatouros, M. (1995). Prevention and treatment of community stress: How to be a mental health expert in the time of disaster. *Extreme Stress and Communities: Impact and Intervention*. London: Kluwer Academic Publishers.

Freedman, S. A. et al. (1999). Predictors of chronic post traumatic stress disorder. *British Journal of Psychiatry*, 174, 353-359.

Freedy, J.R., Saladin, M. E., Kilpatrick, D. G., Resnick, H. S & Saunders, B. E. (1994). Understanding acute psychological distress following natural disasters. *Journal of Traumatic Stress*, 7, 257-274.

Gordan, R. & Wraith, R. (1993). Responses of children and adolescents to disasters. *International Handbook of Traumatic Stress Syndromes*. New York, Plenum, 561-575.

Gore-Felton, C., Gill, M., Koopman, C. & Spiegel, D. (1999). A review of acute stress reactions among victims of violence: Implications for early interventions. *Aggression and Violent Behaviour*, 4, 293-306.

Green, B.L. (1993). Identifying survivors at risk: Trauma and stressors across events. In J.P. Wilson & B. Raphael (Eds.), *International Handbook of Traumatic Stress Syndromes*. New York: Plenum Press.

Herrmann, J. (2006). *Disaster Mental Health: A Critical Response*. Rochester, NY: University of Rochester.

Kessler, R. J. & Brown. D. (1992). *Coping with Trauma, Theory, Presentation and Treatment*. Amsterdam Press.

Litz, B.T. & Gray, M.J. (2004). *Early Intervention for Trauma and Traumatic Loss*. New York: Guilford Press.

McFarlane, A.C. (1993). *Stress and Disaster: Extreme Stress and Communities: Impact and Intervention*. London: Kluwer Academic Publishers.

New York State Office of Mental Health. (2004). *Grief Counseling Resource Guide*. Accessed on: www.omh.state.ny.us/omhweb/grief

Norris, F.H., & Alegria, M. (2005). CNS Spectrums. Vol. 10, No. 2 (Feb), p.132.

Young, B.H. (2006). In Elspeth Cameron Richie, P. Watson, M. Friedman (Eds.), *Interventions Following Mass Violence and Disasters: Strategies for Mental Health Practice*. New York: Guilford Publications.

Virna Little, Psy.D, LCSW-r, SAP is Vice President for Psychosocial Services and Community Affairs, Institute for Urban Family Health, 16 East 16th Street, New York, New York 10003. She may be reached by telephone at 212-633-0800 ext 1337 or by e-mail at: vlittle@institute2000.org.

THE METHAMPHETAMINE CRISIS: IMPACT ON FAMILIES, SYSTEMS AND HEALTH CARE

Carol Frazier Maxwell, LCSW, ACSW

INTRODUCTION

The methamphetamine crisis is rampant across the country. Its impact on society is significant, causing problems with child welfare, domestic violence, law enforcement, health care, and the list could go on. Arkansas found itself in a crisis situation in the late 1990's when methamphetamine abuse was having a major impact on many of its systems. Arkansas hospital social workers were among many professionals working with children and adults with medical and social problems stemming from meth use or exposure. Social workers had important information to impart to facilitate social action and legislative change to make overall meth use more difficult and make childrens' exposure to meth more punishable. This article provides a background on methamphetamine production, its physical impact upon users and children, and practice recommendations for health care social workers.

METHAMPHETAMINE PRODUCTION

Methamphetamine is known by many street names including: meth, speed, ice, chalk, crank, fire, glass, and crystal. It is a toxic, addictive stimulant which dilates the pupils and produces temporary hyperactivity, euphoria, a sense of increased energy, and tremors.

Meth production, while involving many chemicals such as muriatric, hydrochloric and sulfuric acids, does not require a chemistry education. In fact, most meth cookers probably do not realize how toxic and explosive the chemicals are that they are handling. Creating meth is a "reduction process", the reduction of pseudoephedrine or ephedrine to methamphetamine. It takes 680 tablets of over the counter (OTC) pseudophed for one ounce of meth. One pound of meth produces seven pounds of waste. Common materials found at the scene of meth lab busts are acetone, denatured alcohol, "heet", camp fuel, solvent, Drano, Red Devil lye, blenders, and propane tanks, in addition to pseudoephedrine tablets. Some of the common reduction compound methods are Red Phosphorous and Iodine and another called "Nazi" which is lithium and anhydrous ammonia. These items are both toxic and explosive.

METHAMPHETAMINE IMPACT ON SYSTEMS

It is difficult to actually know the true impact meth use has on child welfare and law enforcement systems due to challenges in data collection and tracking. While many law enforcement officials agree that "violence repeatedly goes hand in hand with

methamphetamine; it's a trademark of the drug" (*Arkansas Democrat Gazette, 8/28/99)*, exact data to understand the impact is lacking. Numbers tracking the impact of methamphetamine on children in Arkansas do not exist. Some pediatricians refer to meth as the worst drug ever for child welfare, but many treatment counselors share that research is too scant to back up that conclusion. Methamphetamine remains Arkansas' number one drug concern since appearing seven years ago, yet law enforcement and social services agencies cannot provide data on the impact to children, such as foster care placements, numbers of children found at meth labs, etc (*Arkansas Democrat Gazette, 1/22/06*). While hard data is not available, anecdotal information from judges and court volunteers cites the rise in meth use as causing the dramatic rise in foster care placements. Federal DEA statistics note that children are found at meth lab seizures approximately one-third of the time (*Arkansas Democrat Gazette, 1/22/06*).

Many states have taken aggressive steps to decrease the potential for meth lab creation. One such step in Arkansas, following other surrounding states, was to take legislative action to restrict the sale of OTC pseudoephedrine cold pills to pharmacies and requiring the purchaser to sign for them. There was also a limit on how many could be purchased at one time. Before the law was enacted, Arkansas had a peak in 2003 of 1,208 meth lab seizures. Since the law was instituted, the crime lab data shows that meth lab seizures in Arkansas dropped 48%. However, the super labs from Mexico and the western part of the country funnel their supply into the state.

There have been other attempts to decrease the production and sale of meth and to make the population aware of its dangers in Arkansas and surrounding states: education; legislation; formation of a Drug Endangered Children Coalition; medical and developmental follow-up of children exposed to meth; and prevention and treatment.

METH USE IMPACT ON CAREGIVERS

Being aware of the impact meth use has on adults can help prepare society for the potential negative impact on children and the agencies that support children. Adults who use meth will experience a binge and crash cycle. They also may experience heightened physical and sexual aggression. Additionally, adults may also have long term changes in brain chemistry.

Meth users are more likely than other substance abusers to be involved with DHS (*Hohman, et al., 2004*). 53% of children with abusive head trauma had parental substance abuse (*Ricci, et al, 2003*). 80% of women in treatment for meth addiction report interpersonal partner violence (*Cohen, et al. 2003*). By self-report, 3-5% of women admit to using illegal drugs during pregnancy. Anonymous screening test results are 3-6 times higher than self-report results. Prescription drug use and abuse is more difficult to monitor and detect. It is important for social workers and other professionals to be aware of these facts to heighten awareness of the potential impact these issues may have on the user's children.

PREGNANCY RELATED IMPACTS

Fetuses exposed in-utero to maternal drug use risk prematurity, intra-uterine growth restriction, intra-cranial hemorrhages, and withdrawal. These could also result in poor feeding, hypertonia, irritability, altered sleep/wake cycles, and seizures. Some states have child protection laws that allow for reporting and intervention when a mother exposes her baby to illegal substances in-utero. However, many states do not and reporting and intervention is only allowed at the time of birth if a child tests positive for an illegal substance at the time of delivery. Once again, a good social history can be instrumental at identifying a mother and baby at risk from substance abuse so appropriate help and intervention can be initiated in a timely manner. This intervention by social workers can occur in pre-natal clinics, health department outreach programs, neonatal intensive care units and other contexts.

Additional areas for concern related to adult meth use include domestic violence, adult abuse, poverty, inter-generational drug use, treatment access barriers and the prospect of overwhelmed child protection systems.

IMPACT OF METH USE ON CHILDREN

Given the facts about the impact of drug use on adults, children who live in or are exposed to meth labs are at greater risk for abuse, neglect, injuries from fires related to explosions, exposure to hazardous lifestyles such as prevalence of firearms in the home, and social and school problems. Negative effects to children of methamphetamine use by adults are not always visible or readily apparent. One particular issue of concern is neglect due to parents' inability to care for their children while high from meth use or obsession with cooking meth for sale or use. Because they may look appealing to consume, children often get into chemicals that are meant for meth processing, such as the red phosphorous that looks like Kool-Aid. Parents store these items in any available container, which may include "sippy" cups or coke bottles and then leave them where they are accessible to small children.

The high potential for sexual abuse represents another meth-related concern for children. Adults who use meth have a sense of euphoria and heightened sexual arousal. Children who are unsupervised, or whose parents may be stoned, may be at risk for sexual abuse. Also, with many people coming and going in active meth labs, the lack of close supervision potentially exposes children to more opportunities for abuse.

A third area of risk related to child abuse is exposure to meth during pregnancy. A fetus of a mother who uses meth while pregnant has the same risk as other babies exposed to illegal substances during pregnancy. However, due to the relative newness of the methamphetamine crisis in America, the long term effects to children who test positive for meth at birth is still unknown and needs continued monitoring and research.

Children can be exposed to significant violence when living with or visiting with family members who use or make meth. Ongoing exposure to firearms and weapons is common for these children, as is having their home or meth lab booby-trapped to stop law enforcement or others from getting too close without being noticed. Exposure to drug paraphernalia is routine, as is witnessing the arrest of a parent. Parents being arrested and taken to jail while the child is taken away by strangers adds to the trauma of violence.

A concern with far reaching implications is the impact to child protection systems. Removing a child from a dangerous home and putting them into a safe place is just the beginning of assessment and intervention. Social workers recognize complications associated with removing a child from parents, even parents who have neglected or abused their child. The child may still seek to remain with their parent, even if the situation was unsafe or unsavory because that is what is familiar. The unknown is often viewed as scarier than the known. Law enforcement and the child protection systems are often not equipped to address immediate or long term consequences from the rising methamphetamine crisis. Law enforcement and related agencies are often overburdened with the time and costs of expensive clean up of toxic residue from a meth lab seizure. Child welfare agencies often lack sufficient numbers of foster parents to meet placement demands. Substance abuse treatment and monitoring resources are insufficient for parents who are court ordered or who voluntarily seek help. The court system is overwhelmed with the increase in cases coming before the court related to the meth crisis. State Medicaid or CHIP programs are experiencing a financial burden as they pay for expensive medical care for children with illnesses or injuries related to their meth exposure. The stress on these systems due to the rise in meth use around the country has a far reaching effect.

In addition to the child protection systems, the health care industry is also negatively impacted by the meth crisis. Health care providers must be observant for the numerous medical side effects and health risks that meth may have on children. These symptoms may include eye irritations, injuries related to ingestion such as esophageal damage, nausea and headaches, respiratory problems, delayed brain development for speech and learning, long term internal organ injury, burns from explosions, and weapon related injuries. It generally requires skillful and observant health care professionals to determine that the injury or illness is a direct result from meth exposure since symptoms could present as other illnesses or injuries. While many Emergency Departments around the country are insufficiently educated as to meth-related health issues, these are often the first places children will present for treatment.

It is imperative that health care providers, child protection agencies, law enforcement, and first-responders partner together for education about appropriate intervention with children on the scene of a meth lab seizure/bust/explosion. It is recommended that children found at an active meth lab be decontaminated on the scene before being transported away from the area. Often times child protection personnel will transport children in their car to Child Protection Services offices, hospitals, or relative homes. If the children were in an active lab, the chemicals on their clothes and in their

belongings, including that teddy bear the caseworker allowed the child to take for comfort, have now been transferred to the caseworker's car and wherever else the children were taken. While it can be traumatic to decontaminate a child on scene and difficult to refuse to let the child take their favorite blanket or stuffed animal with them, it is dangerous to continue to expose the children (and now the caseworker, health care providers, and others) to the toxic chemicals that remain in the children's clothes and belongings.

After decontamination, children should be assessed for chemical burns, spills, or other injuries that might require documentation as well as immediate medical intervention. If children have injuries, or if they are being removed from an active meth lab, it is strongly recommended that they be taken to an appropriate medical facility for evaluation, including possible drug testing through urinalysis or hair sampling. Other tests and x-rays may be warranted depending upon the child's physical appearance and history provided. Health care social workers can play an important role in gathering a social history from the caseworkers, family members or other agency personnel so as to better guide medical staff in determining medical interventions. Social workers can use their knowledge of child development and the effects of drug exposure to begin developing a plan to meet a child's emotional needs.

CASE EXAMPLE OF INTERVENTION

A 5 year old boy presented to the hospital Emergency Department (ED) with extremity, oral, and mucosal burns. It was reported by mom that she found him in the kitchen with a bottle of "Liquid Fire" so she assumed he drank it. The child was admitted to the Pediatric Intensive Care Unit (PICU) for assessment and management of his injuries and establishment of an airway due to his esophageal injuries.

As the assessment of the child progressed, well-healed pattern scars were noted on his side and back. Mom could not supply a history for these injuries. The PICU staff began to be more suspicious of the story and consulted the child abuse team. The information mom gave about the "Liquid Fire" now changed to sulphuric acid, but still without specific details of how the child obtained such liquid, how much he drank, and why she thought he did that. The Social worker called in a report to the state child abuse hotline but the hotline did not accept the report. There were not enough details to support the suspicion of abuse. The Social worker contacted the local sheriff's department and requested they check the home for potential meth production.

The sheriff's department went to the home where drug paraphernalia and materials for making meth were found. There also was no running water nor were there drains in the home. A sibling was in the home, so child welfare agencies were asked to become involved and the children were taken into state custody. Both children tested positive for meth in hair samples. Eventually the patient was able to be released from the hospital with a trach and the need for close medical care. Several months later, the case went to court. The patient finally had his trach removed and he was able to testify that

his mom had given him the acid to drink. The alert and proactive social worker was the one who did not just accept the hotline's initial decision to not take a report. She took the team's concerns and pursued them to the limits the law allowed, ultimately giving the child and his brother justice for their abuse and neglect.

RECOMMENDATIONS FOR SOCIAL WORK

Social workers often find it challenging to be involved in advocacy work but the impact of such effort can be life altering. When social workers share what is known about the clientele with whom they work, and what challenges they face, change can occur. Social workers help give voices to the child who has been neglected or abused, to the woman who has been victimized, and to the substance abuser who wants help but cannot access any.

In Arkansas, when the meth crisis was at its peak, social workers played an important role in promoting legal changes to the sale of pseudoephedrine which was having a direct role in meth production in our state. Collaborating with legislators, business owners, health care providers and community leaders, social workers worked to promote social action. Using patient and family stories to help leaders and policymakers understand the crisis, social workers sought common goals and solutions in deterring use of methamphetamine in the state. Social workers need to take what is known and what they have learned from patients and families, and actively work to affect social and political change.

REFERENCES

Hohman, M., R. Oliver, and W. Wright (2004). Methamphetamine Abuse and Manufacture: The Child Welfare Response. *Social Work: A Journal of the National Association of Social Workers,* 49(3), 373-381.

Ricci, L., A. Giantris, P. Merriam, S. Hodge, and T. Doyle (2003). Abusive head trauma in Maine infants: medical, child protective, and law enforcement analysis. *Child Abuse & Neglect,* 27(3), 271-283.

Cohen, J.B., A. Dickow, K. Horner, J.E. Zweben, J. Balabais, D. Vandersloot, and C. Reiber (2003). Abuse and Violence: History of Men and Women in Treatment for Methamphetamine Dependence. *American Journal on Addictions*; 12(5): 377-385

Minton, M. (2006, January 22). Parents' drug use has kids suffering. *Arkansas Democrat Gazette.*

Hill, P. and R. Pilcher (1999, August 28). Police determined to 'reclaim' county from meth's grasp. *Arkansas Democrat Gazette*

ADDITIONAL RESOURCES

- Drug Enforcement Agency website: www.dea.gov
- Substance Exposed Newborns Conference; http://ala.berkeley.edu/training/annual_conference.html

- Drug Endangered Children's National Alliance; www.nationaldec.org
- www.damadd.com
- http://www.colodec.org/index.asp
- http://www.ojp.gov/ovc/publications/bulletins/children/welcome.html
- http://dawninfo.samhsa.gov/old_dawn/pubs_94_02/shortreports/files/DAWN_tdr_amphetamine.pdf
- http://www.naco.org/Template.cfm?Section=Special_Surveys&Template=/ContentManagement/ContentDisplay.cfm&ContentID=16925 (2005 report)
- http://www.naco.org/Template.cfm?Section=Special_Surveys&Template=/ContentManagement/ContentDisplay.cfm&ContentID=18837 (2006 report)

Carol Frazier Maxwell, MSW, LCSW, ACSW is Director of Social Work, Family Services and Interpreter Services at Arkansas Children's Hospital, 800 Marshall Street, Little Rock, AR 72211. She may be reached at 501-364-6531 or by e-mail at: maxwellcf@archildrens.org

SOCIAL WORK IN A WAR ZONE: EXPERIENCES AND REFLECTIONS OF AN ONCOLOGY SOCIAL WORKER DEPLOYED IN OPERATION IRAQI FREEDOM

Lieutenant Colonel Neil O'Connor, ACSW, LCSW

DISCLAIMER

The content of this article reflects the opinions and experiences of the author, and does not represent the official opinions or views of the United States Army, the Department of Defense, or the United States Government.

This chapter deals with the crisis of war, and a social worker's experience with that crisis. In addition to describing an experience differing from what most of us face in our professional lives, I intend to share reflections about human responses to threats and the practice implications I perceive as a result of the experience. Please bear in mind that like many descriptive, anecdotal reports, this report has a fixed time and place. My social work and other mental health professional brothers- and sisters-in-arms preceding and following my tenure will have had different experiences, perceptions, and responses.

PRE-MOBILIZATION

Prior to my deployment to Iraq, I had been an Army Reserve social work officer for twenty-one years. During that time, I had been assigned to two different units: a combat support hospital of over four hundred personnel, and a combat stress control medical detachment of twenty-four personnel. The clinical roles in both units engaged much of my civilian health care social work training and experience during the annual two week training exercises. During the monthly drill weekends, however, there was little call or opportunity for clinical social work skills practice. Therefore, the leadership in both units provided opportunities to learn and operate in the various staff sections of the organizations, to include the personnel, operations, and supply sections, and as hospital executive officer, the equivalent of a civilian hospital COO. Nine straight years of tactical field exercise training in both units more than prepared me for "living somewhat roughly" in the maturing theater which was Iraq upon our arrival. Underpinning my military training and experience was the reason the Army had offered me a commission in the first place: long practice as a health care social worker in several civilian community and teaching hospitals, of which the thirteen years immediately prior to mobilization had been spent as an oncology specialist. The experience gained in working with people facing life changing and life threatening illnesses gave me a solid foundation upon which to work with soldiers experiencing significant emotional and physical trauma in Iraq.

THE BEGINNING

The time frame for my experience and these events was a fourteen month period from December 2003, through February 2005. I was notified on 3 December 2003 of a "By Name Request" by the 785th Medical Company (Combat Stress Control) for my assignment to fill a social work officer vacancy in their unit; an express package containing my orders arrived 4 December, with a reporting date to the 785th of 8 December. This allowed me only forty-eight hours (due to an intervening weekend) to suspend my civilian job duties, notify my civilian supervisors and clinic staff; arrange the assumption of client coverage and field student responsibility to my clinic social work colleague; pack and remove personal effects from my office; and say a few hasty good byes to oncology clients I had been actively working with the prior several months. Saying good bye to people I had good reason to doubt would survive my deployment proved very difficult for both client and social worker.

Training

Upon reporting and transferring to the 785th, I was provided an initial equipment issue and handed orders to report to our mobilization base in central Wisconsin on 13 December. I used the next five days to prepare my family as much as possible for my absence, as well as close out my duties at my original reserve unit. On 13 December, my spouse and I made a seemingly interminable trip north to the mobilization base, where I began my active duty assignment and commenced the next step of the journey to and through Iraq.

We trained as a unit at the mobilization base from mid December through early February 2004. The overarching objective was to meld the roles, duties, and responsibilities of mental health clinician and soldier. While our primary mission was to provide combat stress prevention and treatment services to soldiers, we also owned an obligation to be able to protect our soldier-clients as well as ourselves and our unit colleagues. Using the unit's internal resources and expertise, the unit psychiatrists, psychologists, and social work officers developed, presented, and trained the unit soldiers and each other in combat stress doctrine, assessment and treatment techniques, consultation skills, and self care. We all received new training in perimeter security, vehicle/personnel search, and convoy defense techniques, especially in the defenses against the (then) new use of Improvised Explosive Devices. Sustainment training in our personal weapons, chemical defense equipment, and land navigation meant long days in wintry conditions. We received additional equipment which required new training in operation and maintenance.

Throughout the various types of training, we were forming and developing the teams which we would deploy across the country of Iraq upon arrival. Many of these

teams were small, four person "prevention teams" comprised of two clinical officers and two enlisted mental health technicians. Their role would be the provision of assessment, education, and brief treatment of affected soldiers in forward operating areas. Larger, restoration teams would occupy larger bases and provide multi-day restorative treatment, which included a differential diagnosis process aimed at identifying those soldiers whose mental health issues would require evacuation from the theater of war. By the end of this training period, the unit was certified as ready and we prepared for deployment to theater.

Transition

We left Wisconsin in early February aboard chartered flights to Kuwait. Once settled at a forward base in the Kuwait desert, we began a month of specific training focusing on survivability, convoy operations, and basic defense. This time period also allowed more clinical skills training and additional opportunities to fine tune team assignments. The company leadership began its coordination with our predecessor unit for our assumption of the combat stress control mission in Iraq. Unfortunately, I was evacuated from Kuwait after a week for urgent hernia surgery at Landstuhl Army Hospital in Germany. While I recuperated, the company completed its final training and coordination, and moved north by ground and air to a large logistical base in central Iraq, known by its code name LSA Anaconda. There the teams received their vehicles, loaded their equipment, and moved to their assignments on smaller bases throughout the length and breadth of Iraq. The company headquarters, minus the operations, supply and maintenance sections, moved to Baghdad where it remained until the company redeployed in 2005. I rejoined the unit in mid-March, following a successful surgical and recovery experience. By that time, our teams had all reached their assignments, they had performed the handover with our predecessors, and the 785th assumed the combat stress control mission in support of all US forces in Iraq.

OPERATIONS IN IRAQ

The eighty medical soldiers of the 785th replaced approximately one hundred and thirty soldiers from three different units, but with only a small reduction in the total number of supported US soldiers in country. Our teams covered bases from Mosul in the north to Talil/Nasiriya in the south; from far eastern Iraq to the area around Fallujah and Ramadi. Prior to our arrival, it was deemed relatively safe for US military personnel to travel in small, light convoys between bases and cities. Within 2 weeks of our assuming the mission, travel was tightly restricted to organized, heavily armed convoys as a matter of force protection. For teams whose operational methods depended on the ability to move to where the soldiers in need were stationed, this restraint meant a significant rethinking of our mission and its execution. Our ability to move also varied with the security conditions in different geographic areas, as well as the availability of convoys which we could accompany. Most teams tried to adhere to the concept of forward support by exploiting available convoy operations, but also had to adapt to a more static,

community clinic model which we had not anticipated. Our alternate means of transportation was helicopter, but the limitations inherent in air travel included weather, priority of our missions compared to other missions and a far more limited number of locations accessible by air than by ground.

In response to the dramatic increase in hostile activity during April 2004, an active duty combat stress detachment saw its tour extended, and they returned from Kuwait to augment our efforts in the Najaf region. The senior medical command recognized the need for additional combat stress resources, so in June of 2004 two additional detachments arrived as the active duty detachment was released from its extended tour. Based on a plan developed by our operations section, the two additional detachments took over the bases in the far north and south central portions of Iraq, allowing the 785th to coalesce on the middle third of the country. This, in turn, allowed us to increase the size of our teams, as well as place teams in central Baghdad, eastern Iraq, and actually have a reserve team which could move to any location where increased operations were planned. That unit deployment structure continued at least until this most recent rotation, providing far forward combat stress services to many more soldiers than we could have provided during the early months of our deployment.

The teams became heavily dependent on telephonic and computer communications systems, especially as the Army as a whole embraced computers as a primary means of data communication. Since the teams' organic communications equipment was minimal, the teams worked to develop close relationships with their supported units, thereby gaining access to reliable communications systems. Our stature as the only mental health assets in a large area assisted with these relationships; local commanders were generally pleased to have "their own" combat stress teams in the area of operations. Facilities and living quarters ranged from austere (tents in the beginning) to comfortable; many, but not all, of us lived in trailer like structures or converted local buildings during the last half of the deployment. Finally, the threat from enemy fire ranged from rare to daily, depending on both the sympathies of the local population as well as the current operations by allied forces. In some locations, our teams experienced little to no hostile fire. In others, alert sirens and moving to secure bunkers was a daily (and nightly) occurrence for much of the year. We all found ourselves adapting to this danger in different ways and along different time lines. These experiences informed, and I believe, enhanced our abilities to both relate, and provide insightful treatment, to the soldier-clients who presented for our services.

ENVIRONMENT AND STRESSORS

Located approximately 60 miles northwest of Baghdad on a former Iraqi Air Force base, Logistical Support Area (LSA) Anaconda was the primary aerial and ground supply hub for US operations in Iraq. Home to over 20,000 Army and Air Force personnel, it was commanded by a one star general and protected by an Army National

Guard Infantry Brigade. Over the course of the year, Anaconda developed amenities to include a post exchange store, a theater for first run movies (at no cost to the soldiers), fitness and recreational facilities, mass transit systems, active sports leagues, and, eventually, several familiar fast food outlets. Health facilities included a joint Army/Air Force combat support hospital of about fifty beds, an aeromedical evacuation facility (provided medical evacuation from Iraq back to Germany), at least three general medical outpatient clinics, and four sources of mental health support: our company's facility, small mental health sections attached to two of the medical clinics, and an Air Force Life Skills team stationed with the Air Force living area. Housing and work spaces evolved from 100% tentage to converted concrete buildings and large "trailer parks" of residential trailers housing from two to six soldiers, depending upon configuration.

Anaconda was located in the middle of the lush central Iraq agricultural area, located between the Tigris and Euphrates rivers. Having arrived in the middle of the night, I was astonished during my first daylight helicopter flight to see miles of irrigation canals surrounding acres of green vegetable and tan wheat fields. Each morning saw long lines of Iraqi citizens waiting for screening and clearance in order to work jobs on the base. At the same time, during the initial months of our deployment, teams of US soldiers from the various units on the base fanned out with Army Corps of Engineer personnel and civil affairs teams to work on local reconstruction projects including schools, sewage and water treatment facilities, and medical clinics. The medical units on base also provided medical assistance teams to conduct primary health care clinics, immunizations, and minor treatment.

Located in the so-called "Sunni Triangle", Anaconda had constant enemy fire directed against the base, largely in the form of mortar and rocket rounds. The roads leading to Anaconda were heavily used by supply convoys, combat patrols, and the local populace, providing a dense collection of opportunities for the use of hostile fire and explosive devices. During the year I spent on Anaconda, the base averaged over one mortar or rocket strike per day. Some weeks saw no activity; other weeks felt like we'd lived them inside the concrete culverts we used as shelter. News articles from the time mentioned the soldiers' nickname for the base, 'Mortaritaville', and acknowledged the USAF directive that all aircraft landing there would keep engines running during unloading/loading operations (*Bowman, 2004*). Over that time span, eight soldiers were killed in action (6 during one rocket strike in June 2004), and several dozen wounded across the base itself. The National Guard infantry brigade providing base security lost two soldiers killed in action during routine security patrols outside the base. But high numbers of casualties, both killed and wounded, were borne by the transportation companies based at Anaconda. One company, alone, lost six soldiers during the year's convoy operations; most lost at least one soldier during that time, and all had soldiers evacuated for serious wounds received during the convoys.

As one might expect, then, hostile fire was the leading stressor experienced by those living at Anaconda. The indirect nature of much of the hostile fire meant its

sources were hidden, and unable to be confronted and resolved. The constant vigilance, whether on a convoy or walking across the base required significant emotional and physical energy. A continuous visual scan for shelter and/or danger became second nature during the most innocent of activities. If a soldier was assigned convoy or local security duty, this meant daily trips outside the protection of the main base into cities, villages and onto roadways where attacks were sudden and lethal. The strain of these daily missions was readily observed on the soldiers' faces and in their most casual conversations. There were frequent "lockdown" periods due to either incoming fire or after soldier casualties, in which all outgoing communication traffic was suspended until next of kin could be notified. The communication blackout would be followed by a flood of worried emails from home, concerned about the sudden, unexpected silence and filled with unspoken fears about what the silence could have meant.

Environmental stressors took their toll as well. Most soldiers were not accustomed or acclimated to temperatures approaching 140 degrees, nor for the unrelenting sun which baked the land for weeks on end. From May through October, the winds were hot, and blew a fine talc-like dust into everything, including one's mouth. The gradual equipping of most buildings, and thankfully all of the living trailers, with air conditioning helped offset some of the heat stress. But convoy and security operations occurred throughout the year, without the relief of conditioned air. As summer eased into fall, and what passed for winter, the days were an often pleasant, dry mid 80's. Rains were infrequent during the latter part of the year, but when they arrived, they stormed with a fury and force hard to believe. The ever-present dust turned to a slick, oily mud, and water stood, feet deep in places, for days. Those of us to the more temperate Midwestern climate found ourselves amazed and pummeled by the force of Iraqi weather.

Some stressors were operational in nature. First, many of the missions assigned to the combat and logistics soldiers required daily exposure to active combat, extreme weather, and uncertain knowledge of terrain and opposition capability and intentions. In the absence of information, stress breeds. Resources always felt strained, with delays in their arrival over dangerous supply routes. Organizational barriers were commonplace, with rules and interpretations seemingly in constant flux. One could never quite feel "caught up" with the changes, with a resultant perception that accomplishment of any objective was at best a hope. Many soldiers experienced frequent changes in duties in response to operational necessity or new concepts of the overall mission. Soldiers trained for support duties often found themselves riding "shotgun" in civilian cargo trucks. Infantry units executed missions ranging from attack and hold to peacemaking and civil support. These operational stressors added to the soldiers' stress burden, affecting, as it did, their sense of mission and what soldiering meant to them.

Individual physical stressors included one's personal equipment load. During the most intense periods of hostile fire, soldiers on Anaconda were required to wear all of their protective equipment: helmet, armored vest, weapon(s) and ammunition, and water, in addition to the basic uniform and boots. Totaling anywhere from 40-60 pounds

depending on the specific equipment, this physical stressor manifested itself in strained backs, legs, and shoulders. There was an irresolvable tension for some between protection and risk of injury, especially for the older soldiers quite commonplace in these deployments. There was a need to build or rebuild everything, from offices to housing to streets; the Iraqi infrastructure had suffered not only during the invasion of the prior year, but also from years of resource diversion by the central government away from common infrastructure needs to military preparedness and, frankly, personal enrichment. While easier during my deployment, following, as it did, the initial invasion forces, there remained an incredible amount of basic construction and repair to accomplish. Much of this work fell to the soldiers of Anaconda as additional duties, and at the same time, much was performed under the tight protective equipment rules mentioned above.

There had long been a perception that units which trained together would fight together. This perception proved less than accurate as units were mobilized, and then needed extensive cross-leveling, or personnel fills, from other, non-mobilizing units. Many units had cross-leveling in excess of 50%, including my unit. The stress of deployment, added to involuntary assignment into a unit strange to the soldier, without the relationships, confidence, and inter-dependencies born from years of training and working together, posed difficulties for many of us as we concurrently adapted to the stressors already listed. Differences in food, routine, assignments and relationships all affected the soldier's perceptions. For example, I was very familiar with the operational requirements of the four person team I intended to lead. But I had trained with specific individuals, knew their strengths and needs, they knew mine, and we had adapted to each other and the mission, forming a true team. Cross leveling meant that I entered a new team, and in far less time, had to make the same personal and professional adaptations which previously occurred over years, and make those adaptations as the team headed into a dangerous environment. That the large majority of soldiers were able to encounter, adapt, and work beyond these issues speaks highly of the basic attitudinal and skills training imparted to soldiers in their careers.

TEAM OPERATIONS AT ANACONDA

There were four discrete functions engaging the 20-27 person team based at Anaconda. An *administrative section* actually supported the entire company across Iraq. The *operations section* tracked unit and military operations across the country, formulating plans, and advising the commander of change, opportunities, or issues it perceived from patterns of US and enemy activity. This included the anticipatory placing of teams in support of Army units about to commence focused operations in a given area. The *supply section* ensured that the company had the uniforms, equipment, and supplies it needed to perform its daily operations. Using a combination of military supply channels and a cash-based system using local Iraqi contractors, everything from ink cartridges to construction materials was located, obtained, and delivered by this section. The company *maintenance section* performed preventive and routine repair services on unit vehicles, generators, and large equipment items, often flying mechanics to forward

locations to keep the teams' vehicles running. Both of these sections combined to prepare and pack the unit for redeployment home at the end of the mission.

The second function was that of the Combat Stress Prevention section, comprised of a social work officer, eventually a psychiatric nurse officer, and from one to four enlisted mental health technicians. The mission of the Prevention Section was assessment, education, and brief in-unit treatment related to combat and operational stress issues. The team's primary method was regular rounds of the supported units on our base and the surrounding, smaller bases, meeting with small unit leaders, providing educational briefings on suicide prevention, stress relief, "buddy" aid for stress reactions, leadership responsibilities in stress prevention, and other topics determined as needs by the unit leaders.

The Restoration/Fitness Team function addressed the needs of soldiers who needed to be pulled "off line" for restorative and recuperative treatment. Led by a psychiatrist or psychologist, and staffed by mental health technicians and occupational therapists and aides, this team provided a three to five day residential treatment program aimed at restoring the physical and emotional coping strengths of the soldiers. If needed, this team could also sub-organize to provide additional prevention or crisis intervention teams.

The fourth function was unanticipated by the company when it first arrived, but proved to occupy most of our energies during the deployment: community mental health services. Differing from either the prevention or restoration functions, but staffed by members of both those teams, the community mental health function served the routine needs of the soldiers stationed at Anaconda, ranging from simple adjustment reactions to military life to dependency/addiction assessment to exacerbations of acute psychiatric conditions. The team strove to keep soldiers safely on the job through the delivery of regularly scheduled therapeutic appointments and medication monitoring, but also provided a critical function in the screening and evacuation of soldiers needing longer term, in-depth mental health treatment. The numbers of soldiers needing community mental health services exceeded the capacity of the mental health assets organic to the area's combat and other medical units, so the 785th assumed part of this mission in just about every location it placed a team. At Anaconda, this mission was aided by the co-location of the Restoration Team and the ownership of a building large enough to house both clinical offices as well as the residential areas needed for both missions.

The teams at Anaconda worked six days per week, twelve hours per day, with a professional services officer on call every night. Our catchment area was the entire Anaconda base, as well as smaller bases in a thirty mile radius around Anaconda. The members of the team shifted as the needs of the overall company shifted; if certain specialties were needed in another location, personnel would be reassigned and swapped to ensure meeting the new need as well as the existing needs. In addition to the clinical

duties, all team members had additional duties assigned either by the team leadership or by the base leadership, to include perimeter and work party security, building and grounds maintenance, and other duties as assigned. The team remained fairly intact throughout the year, and no team members were lost to hostile fire.

MY ROLES AND RESPONSIBILITIES

My original assignment had been as the leader of a four person prevention team, described earlier, and deployed to a large US base near the city of Taji in central Iraq. During the unit's final training in Kuwait, and my absence in Germany, personnel changes in the unit influenced the company commander's decision to reassign me as the company Operations Officer, as well as the senior officer/officer-in-charge (OIC) of a combined Prevention, Restoration, and Support team at the central support base at LSA Anaconda.

Each of the roles drew upon social work practice skills and experience. As the Operations Officer, my tasks were to assess, develop, recommend, and execute unit operations plans. One basic facet of social work practice is awareness of the practioner's and client's environment. In Operations, we maintained a constant awareness of what the Army as well as other actors was doing around us. Based on those observations, and reasonable projections of events, we could then develop and recommend changes in team assignments, locations, and supports, much as the clinician assess and develops a treatment plan with and for a client. Eventually, I was also tasked with developing and executing the unit's redeployment from Iraq back to our home station, a very complex and involved piece of discharge planning, so to speak.

As Site Officer In Charge (OIC), I supervised, lead, and supported twenty-seven soldiers made up of clinicians and administrative soldiers. While clinical supervision was delegated to the team psychiatrist and psychologist, the overall leadership of the clinical practice group was my responsibility. Supervision of the non-clinician team members (mechanics, supply personnel, and administrative specialists) drew on the years I'd spent working in the various staff sections of the units to which I'd been assigned. With a basic knowledge of their skills and duties, I could ensure that their efforts meshed with and supported both the local Anaconda team as well as the company tams spread across Iraq. As the team OIC and senior mental health clinician, it was my responsibility to liaise with the base leadership at Anaconda and with other tenant units. This included advising the commands on mental health trends and issues noted by our clinical staff, consulting on stressor reduction or limitation, and assisting in the development of mass casualty response plans. This combination of supervision and basic level community organization also drew on the skills gained over years of social work practice.

Finally, the Social Work role was practiced within the Army's Combat Stress Control framework. My primary clinical duty was to lead and work within a combat stress prevention team. The team's mission, briefly, comprised of education on stressors and reduction to the military units in our thirty mile catchment area. We also provided brief interventions within the unit areas, especially after traumatic incidents and losses. And as in any other community mental health setting, I had a traditional clinician's role, carrying a small caseload of soldiers for ongoing support and treatment, as well as participating in the clinical supervision, training, and evaluation of the clinical staff.

ARMY COMBAT STRESS MODEL

The US Army developed its principles of identifying and treating combat stress in the mid-1980's. Based on work and research by the British Army in WWI, and Israeli experiences during their wars of the 1960's and 1970's, the US Army developed an intervention model based upon intervention both temporally and physically close to the stressor events. The basic organizing principle for the Army is summarized in the acronym PIES, or Proximity, Immediacy, Expectation, and Simplicity. Proximity is defined as intervention as close to event, and the event's environment, as possible. This meant that combat stress intervention activity took place where the soldiers were based, at minimum, and not in a rear support area. The intent of the proximity principle is to help the soldier in their current environment, thereby normalizing the environment, the stressors, and the reactions, instead of emphasizing the injury by movement through a medical evacuation system. Immediacy builds upon the Proximity principle, with the expectation that intervention and education soon after a traumatic event would reduce the long term negative affects of the event. In general, intervention was attempted no later than 48 hours post event, and as often as possible within 24 hours. Expectation was a subtle, but powerful piece of the package: from first contact with the soldiers, the combat stress personnel evinced a quiet, confident expectation that they and the soldier could work together to help the soldier feel better. No cure or rosy outcome was ever promised, merely the intent and objective of improvement in the soldier's perception of self and their reaction. Simplicity meant the use of simple techniques: basic cares (sleep, hydration, companionship), as well as active listening and basic reframing. The PIES acronym served to remind combat stress clinicians that their efforts needed to focus on the timely intervention and return to duty of the stressed soldier. PIES tended to de-medicalize the stressor and reaction, and help the soldier draw upon their own coping and healing skills.

Combat Stress Model: Intervention and Treatment

The current model addresses prevention and treatment through the use of two differently staffed and organized teams, Prevention and Restoration/Fitness. As mentioned before, the Prevention team is comprised of four staff, two mental health officers (currently a social worker and/or clinical psychologist and/or psychiatric nurse)

and two enlisted mental health technicians, graduates of the Army's Mental Health Technician Program at Fort Sam Houston, Texas.

This team seeks to prevent stress effects through education on the types, effects, and resolutions of the stressors encountered by soldiers, whether those stressors were combat, organizational, or personal in origin and presentation. Through advance contact with supported units, the Prevention Team is able to develop a normalized working relationship with the unit's soldiers, enhancing their effects when intervening post trauma, while decreasing the possible stigma of a mental health presence and activity. The advance contacts focus on educational briefings on stress, suicide prevention, communication, and home issues. Brief one to one contacts and small group listening sessions are also part of the team's practice. Critical Event Defusing (CED) after unit losses or traumatic events are also the Prevention Team's responsibility, providing supportive intervention in the immediate aftermath of a unit loss. Finally, command consultation is provided to senior leaders with unit climate assessment surveys, education on the early signs of combat and operational stress, leader responses to these signs, and guidance on the disposition of soldiers whose behavior places themselves and/or the unit at risk. The team's treatment work is generally immediate and unit based, with brief supportive interventions focused on helping the soldier identify and relieve stressors, while strengthening their coping responses. If the soldier does not respond with in one to two days, the Prevention Team can refer the soldier back to the Restoration/Fitness Team, below.

Combat Stress Model: Restoration/Fitness

The Restoration/Fitness Team is a multi-disciplinary team consisting of a psychiatrist, psychiatric nurse, occupational therapy officer, occupational therapy aide, and the same type of mental health technicians found on the prevention teams. This team's interventions occur over a three to five day period of rest, replenishment, restoration of coping skills. In keeping with the Proximity principle, this team attempts to locate as close to the supported unit as possible, though in Iraq this often meant distances of sixty to seventy miles, depending on the location of the forward operating bases. Restoration teams supported two to four Prevention teams, so their catchment areas could actually be larger. The team interventions included work hardening and military skills emphasis, to both assist in the team's assessment of the soldier's stress level, as well as prepare the soldier for return to duty within that three to five day period. The team also conducted daily group and individual treatment, as well as educational classes on anger management, problem solving, relaxation, meditation, journaling, and other self help skills for the soldier. Drug therapy was provided if determined necessary by the psychiatrist, but was mainly confined to anti-depressives and sleep aids. An important role of this team was the differential diagnosis of stress reaction vs. acute mental illness. Stress reactions could be treated in theater; most mental illness treatment was best conducted outside of theater, and necessitated an evacuation back to a military medical facility in Germany or the US. Most soldiers coming to the Restoration/Fitness team

returned to duty within the three to five day period, and received follow up by the prevention teams as needed.

CASEWORK EXAMPLES

I will describe three case examples which will illustrate the range of our intervention during the 785th's year in Iraq. The descriptors are composites, with identifying information removed or obscured. Each of these represents hundreds of similar efforts by the soldier-clinicians of the 785th, and it is my hope that they inform the reader of the nature and effects of the services provided by the combat stress units in Iraq.

Classic Individual Combat Stress Reaction

The first example is that of a classic combat stress reaction. The soldier, in his late 20's, presented with intermittent trembling of hands and arms, sad facial expression, hyper-vigilant behavior, and complaints of "not feeling well", with vague somatic references on questioning. An infantry soldier assigned to a unit outside the Anaconda compound, he had been referred and brought to the team's clinic by his first sergeant, (a senior non-commissioned officer). The first sergeant described the soldier as one of his best, but that his effectiveness and duty performance had been slipping over the last few weeks. The soldier was brought in when he had difficulty getting ready for an assigned combat patrol.

On initial interview, this soldier described several traumatic convoy incidents over the prior several months. He had directly observed the deaths and severe injuring of fellow soldiers, among them several friends. He mentioned, without detail, several close calls of his own. He was at the clinic, he reported, because "First Sergeant said I had to go". He commented that he really belonged back with his unit, and asked how soon he could return. During this part of the interview, someone in another part of the clinic building dropped the heavy lid of a chest style freezer used to chill water for the team and the soldiers at the clinic. The solid concrete walls of the building muffled the sound to a soft, dull boom. The interviewer turned towards the sound then turned back to the soldier to find him on the ground under the chair in which he'd been sitting. The soldier returned to the chair with the interviewer's help, and without prompting, informed the interviewer "that's what the IED (Improvised Explosive Device) sounds like from inside an armored vehicle". This strong startle reaction to unexpected noise is a classic symptom of combat stress.

On further questioning, the soldier stated that he was receiving about 5 hours of interrupted sleep over a 24 hour period, for the last several weeks. He identified acceptable water intake, but had resorted to eating only snack foods from care packages,

and rarely went to the dining facility for actual meals. He admitted to isolating himself from his squad mates. He summarized by saying that he just did not feel like himself, and that he most feared letting his fellow soldiers down.

Consistent with the Simplicity principle, the interviewer oriented the soldier to the clinic area and the Restoration Team concept, assured him he would feel better with his work and our help, and showed him to his sleeping area inside the clinic's building. On consultation with the psychiatrist, a prescription sleeping medication was provided, and the soldier was allowed to sleep for seven hours. On awakening, he was accompanied to the nearest dining facility with a team mental health technician and two to three other soldiers who were part of the residential Restoration program. On return, he was re-interviewed for a complete personal history, recent combat experiences, and additional detail of his symptoms. He was noted to be calmer, far less vigilant, and when unexpected noises occurred, little reaction beyond turning in the direction of the sound and quietly commenting on it. Over the next four days he engaged in group education on stress reactions, coping skills, and journaling. He received daily 1:1 therapy sessions with the team psychiatrist and the mental health technicians. The occupational therapy team engaged the soldier in work hardening activities, to include routine military tasks (personal weapon and equipment maintenance, physical fitness training), work projects on the local base, and supervised group activities. The team enforced proper hydration, meals, and sleep plans. After the four day stay, the soldier was deemed fit to return to duty. He self-reported significant improvement in his emotional and physical state, with noticeable objective improvement with his interactions and activities. Both he and his First Sergeant received an exit briefing from one of the technicians, covering his treatment and progress, and providing instruction on symptoms and personal cares to prevent recurrence.

Critical Event Intervention

The second example is a Critical Event Defusing (CED), an intervention extensively used with squads (10-12 soldiers) and platoons (15-30 soldiers) following a traumatic event in which members of the team were killed or wounded. This particular example is a composite based upon several events in which I participated with one of our senior mental health technician sergeants. Most of our work was with platoon sized groups of soldiers belonging to Army transportation companies. Because of its role as the major supply base in Iraq, Anaconda had over a dozen of these companies located within its boundaries. These companies organized, executed, and guarded the hundreds of supply and equipment hauling convoys which occurred each day. Driving lightly armored cargo trucks, with internal security provided by company soldiers in heavily armed HumVees, these companies suffered high rates of soldiers wounded and killed in action. One company in particular lost 6 soldiers to enemy fire during their year in Iraq. Attacks on the convoys often involved burning and dismemberment of soldiers, with survivors a direct witness to the events. The rising level of attacks throughout 2004,

combined with the high visibility of the convoys and their light armor, placed these soldiers at higher risk than most.

We would usually present the CED within 48 hours (Immediacy principle) of the unit's loss of which the company leadership would inform us within hours of the occurrence. The 48 hour time period usually allowed time for the affected unit to return to Anaconda, and we conducted the CED's in the company area as opposed to our clinic area. The CED differs from the Critical Incident Stress Debriefing model in that a detailed group retelling of the incident is replaced with a shorter, group led description of the incident, mainly to familiarize the clinicians with the precipitating event. The CED had a longer focus on an emotional state inventory (both at time of incident and at time of defusing), and as much time as the team needed spent with an initial grieving process of the team's loss.

The adaptation to the CED model was a result of soldier input: on our second trip back to a particular company, they asked us, directly, if we had to "go through all that detail again; we just finished an AAR (After Action Review, the standard Army practice after any combat or significant event)". We acknowledged that our intent was to help them, and we proceeded with their expressed preference to focus on their loss and their reactions to that loss. Particular focus was placed on the emotional inventory at "incident" and "present" for two reasons. First, it allowed for basic identification and ventilation of those feelings, normalizing their experience with their close soldier colleagues, making it "OK" to feel grief, sadness, anger, and other reactions. Second, it allowed soldiers to reflect on their own reported changes in emotional state which occurred over even a short period of time, and to support our teaching point that change would continue to occur due to the passage of time, the efforts of our teams and their colleagues, and their own natural healing. We would then move into a semi-structured grieving process, asking the group questions about their lost soldier(s): What will you miss about him/her? What did they teach you? What were they like? We also asked for an example of something the lost soldier did/said which bothered their colleagues. This question drew a surprisingly positive response, as it allowed the soldiers to grieve the complete person they lost, not just the "good" soldier of polite memory.

We ended the sessions with some brief education on symptoms, coping strategies, when to seek help, and encouraging informal, unit based "buddy aid". We would follow up with the individual soldiers and teams and company leadership over the next few weeks. We also, frequently, attended the unit's memorial services for their lost soldiers. In summary, we found that these interventions helped assure the supported soldiers of the benefits of the combat stress team, and frequently resulted in additional referrals for other issues and reasons. It also allowed us to monitor, and gently intervene, with unit leadership as we became familiar with their reactions to loss.

Unit Climate Survey

The final example is of an intervention the Army refers to as a Unit Climate Survey. The survey is both a written questionnaire as well as a group interview process, conducted with platoon-sized groups, and focusing on the command climate of company level units (120-200 soldiers) and above. These survey sessions can be either internally or externally directed, for identified or suspected issues, or when a commander desires a detailed look at the state of his/her command from the line soldier's viewpoint.

In this example, the commander of a medical company requested a command climate survey within days of assuming command of the company in theater. Army policy requires a routine survey within ninety days of command assumption, and this commander was diligent in requesting and supporting that process well within the time limit. Using a standard Army command survey questionnaire, members of our Anaconda prevention team interviewed approximately 95% of the company soldiers over a four week period.

Following completion of the written tool, the team then conducted listening sessions with the group, seeking detail on their written responses, and for issues not identified or covered by the questionnaire. Following the data collection, the team summarized the questionnaire responses and the verbal interview topics, analyzed the responses, and presented the commander with a written report which contained recommendations for response to the issues raised. We also offered our assistance with specific recommendations which fell into our purview, such as education about stress and coping, etc. In this particular situation, the new commander was universally well received, and the significant issues were those of living quarters and the physical infrastructure of the company area. Given the critical nature of the company's mission, the commander was able to effect change with the base leadership, using the survey's results as supporting data. The intent of the Command Climate Survey is to reduce or prevent stress through identification of, and intervention with, the "normal" issues arising in units. By intervening when issues are perceived as "normal", acceleration of resolvable issues into crises can often be avoided.

PERSONAL AND PROFESSIONAL REFLECTIONS

About one month into my time at Anaconda, the base had been the recipient of multiple mortar and rocket attacks each day, and analysis by our small operations team concluded that the attacks were quite random in terms of impact, time of day, and size. This randomness, combined with the potential lethality of the attacks, crept into all of our consciousnesses over those weeks. One morning I awoke with the simple, solid conviction that I could not get out of bed or leave the building in which I was then staying. No amount of self talk, "rational" comparison of alternatives, self-reminders of my role as leader, or simple guilt could dispel the conviction that I was not able to cope

with the randomness of the danger which lurked outside those concrete walls. It slowly dawned on me that all of the oncology clients I'd worked with had faced a similar, omnipresent awareness of a mortal danger. Their solution, described in different ways by each of them, was to focus effort on performing the simplest tasks, literally a step at a time, until one's focus was less on the danger and more on the responsibilities and events of their lives. By intense focus on their example, I was able to get out of that bed and get back to the current responsibilities I owned.

Parallels with Oncology Clients

As I moved forward from that "bad morning" (and in subsequent discussions, found all of our team had at least one), I began to notice parallels, not equivalencies between my experience in this war zone and the experiences reported to me by clients and family members in my civilian practice. I also began to reflect more on what I would take back, as a professional, when I returned to my "normal" life as an oncology social worker. The first new perception was readily apparent: the intense energy and commitment it took to experience the involuntary confrontation with one's own mortality. I now had a small idea of what it took for people to get up and continue living each day after their diagnosis. I also became aware of how difficult it was to simply consider talking about, much less actually admitting aloud, that fear and sense of hopelessness to another person.

Second, the affects of one's initial perception of total external control and lack of choice weighs heavily in the mind. We are used to considering ourselves to be self determining actors. When a lethal disease or circumstance enters our lives, that sense of control and mastery melts in the face of the perceived threats. Self-emphasizing the small things we can control (in my case that day, getting to the shower trailer!) allows one to rebuild that sense of control, and begins to answer the question "How will I get through this?" The gradual redevelopment of the senses of mastery, control, and perception of choice come from those small steps. Back in my clinical practice, now, I listen harder for the cues which suggest a struggle with this phase of their experience, and gently inquire about what the client perceives and how they believe they are managing.

As the year progressed, and I received more communications from home, I noticed another parallel with my clients' reported experiences: family members and other support persons may experience a more constant, low level stress during the period of threat. Reflecting on it myself, and with several clients after my return, this observation may have its root in the differing tasks and situational awareness facing the person under threat and their supports. The person under threat, whether disease, or in war, knows there are certain actions and perceptions they can employ to counter the threat. For the oncology client, those actions include the various forms of treatment, exercise, dietary changes, self education, support groups, and other activities. For the soldier, parallel actions include exercise, focus on work, utilization of armor and other

personal protective equipment, maintaining awareness of potential threat and shelter, and other activities which reflect a situational awareness vital to survival. Note that both groups are direct actors in their situations. Contrast that with family members and supports, who are indirect actors. They cannot take the treatments, use the protective equipment, or have direct knowledge of what they do every day to counter the threat.

For these indirect actors, the threat exists without immediate and present knowledge, or the means of direct, active resolution or mitigation. The actions they can take may be perceived as insufficient. In conversations with my spouse, she commented that all of what she did not know about my situation made the fear and its burden seem bigger. So, on my return, I found myself making more time available to support persons to discuss their perceptions and fears, while suggesting to clients that they may see this reaction in their supports, and that it was a normal part of the reaction to the illness threat.

Again, I note these as parallels to the cancer, or other life threatening disease, experience, not equivalencies. I still do not "know" what it is like to have cancer. I do have a better perception of the energy, strength, and challenges of living through that experience, based on my own reactions and recovery in Iraq. I use those experiences to inform, but not determine, practice approaches. They have sharpened my hearing, but not given me definitive answers.

WHAT WILL SOCIAL WORKERS SEE?

More of us will see veterans of Iraq and Afghanistan within a year or two of their service than we saw veterans of earlier conflicts, with the exception of the first Gulf War. The reason is straightforward: in both conflicts, the percentage of National Guard and other Reserve Component personnel is higher than in other conflicts. We in the Reserve Components tend to return to our communities following discharge from active service, and will seek our physical and psychological health care from those providers we used in the past. It may help us, as social workers, to consider some of the issues we may encounter when working with returning veterans and their families.

Somatic Issues

We may encounter a noticeable increase in lung and respiratory tract diseases from several sources. First, high levels of tobacco use were noted throughout the theater. One of the most frequent requests for service to our prevention teams was for smoking cessation classes and pharmacological support with transdermal nicotine patches and oral bupropion. Prior smokers reported increased use from pre-deployment levels, and many non-smokers reported that they started smoking, both in response to the stresses of deployment and combat. One could make a reasonable estimate that increased smoking

may result in increased levels of lung cancer, emphysema, and chronic obstructive pulmonary disease. Supporting that estimate is the widespread exposure of military personnel to sand, dust and dirt from storms as well as the buildings in which they lived. On Anaconda, there was daily exposure to smoke from the base's burn pit, where all manner of refuse was simply burned, unsorted, around the clock. All of these may contribute to higher rates of lung disease, especially if risk behaviors, such as smoking, continue post deployment. The tobacco use may also contribute to an increased level of mouth and other oral cancers. Long term sun exposure, despite precautions taken by many soldiers, will elevate skin cancer rates among this population. While known chemical exposures during the Iraq and Afghanistan operations are reportedly low, the possibility of other illnesses borne of unknown factors remains. The lesson of the dioxin exposure in Viet Nam persists, and we are well advised to monitor somatic complaints and symptoms in the veteran populations of these current war operations.

Social workers will very likely receive referrals for emotional and behavioral issues experienced by clients who are veterans of these conflicts. One source of these issues may be retained, inappropriate self protective behaviors. Aggressive driving, strong startle reactions to loud or percussive noises, and rapid escalation in response to perceived threats all may bring veterans to our attention. The advantage current veterans have over Viet Nam veterans is that the time period from war zone to home is now measured in weeks; that time allows many of the adaptive, protective behaviors to be slowly shed and more appropriate, civilian behaviors to become re-engaged. Allowing the veteran to identify both the behavior and its origins will be key to our assistance in helping veterans resolve the issues the behaviors pose.

We will encounter residual anger at losses of friends and colleagues, perceived mistakes on the part of the soldier as well as others (especially the soldier's leadership), and very possibly anger at a perceived futility of effort as the wars continue without positive change or result. Ventilation of the anger, providing a safe opportunity for the veteran to describe and reflect upon their perceptions and experiences (especially with other veterans), and discussion of possible lessons learned will help defuse and redirect the energies involved in the anger reaction. The discovery of meaning in the experience may contribute to anger resolution, and allow the veteran to integrate the conflicts as well as the rewards of their service.

As this particular conflict continues, I expect to note a mix of pride in one's effort, sacrifice, and comrades, mixed with questioning one's actions and the ultimate purpose of their service. The longer a conflict exists without noticeable benefit to those involved, the more past participants may begin to question their part in that conflict. Helping the veteran focus on what claimed their loyalty during the conflict period is an excellent start. For many of us, mission and unit were the most important determinants of our service. As a social work officer, my mission of helping soldiers cope with their situations was easy for me to accept and continues to give me a quiet pride in my service. We also tend to "fight" for the soldiers in our unit, those immediately around us.

Reengaging those memories may help the veteran in conflict reconnect with their purpose and motivation, when the global objectives of a conflict seem to be unattainable.

Finally, we may see mobilization of the defenses used by veterans and family members during the combat service used when faced with serious illness. "Retail therapy" was a frequent precipitator of self referral, as soldiers noted the tendency of themselves and family members to use purchases as a coping mechanism. Veterans may resort to stoicism and under reporting of symptoms which served to get them through threats in the war zone. Family members may express frustration and fear over the indirect access they have over the treatment and resolution of the triggering medical event. But we also might keep in mind that the illness which may cause less than adaptive behaviors to resurface may also call back successful adaptive behaviors. Helping veterans and families become aware of their strengths as well as the issues will be an important contribution by social work.

PRACTICE IMPLICATIONS

In considering the my experiences and those of others with whom I served, I perceive some general practice implications for all of us in the health care field, whether one is a social worker or not. First, as suggested above, the threat of illness may echo the war threat, and bring back the various reactions and coping behaviors used by veterans and families during the actual conflict period. Supporting adaptive behaviors and exploring alternatives to non-adaptive ones will apply to all processional practices in the health care setting. Second, illness may pose an additional insult to self image, especially if the veteran returned with permanent changes in appearance, function, or abilities. Closely related to this issue will be provider reactions to visible trauma. Are we prepared to walk into a consult on a young person and immediately see the effects of traumatic amputation, burns, and other war injuries? Again, the high percentage of National Guard and Reserve Component personnel in these current conflicts means we will see more veterans, and more veterans with visible, significant war injuries than we may have seen in the past, when veterans remained inside the Veterans' Administration system far longer than at present. Recall, as well, that these veterans prefer to return to their homes and their regular supports, including health care. If our initial reactions are supportive acceptance, we will greatly increase the perception of support we convey to that veteran and their family.

As we encounter these veterans, we will also face challenges in the area of teaching self care and treatment to amputees, burn survivors, and others with significant loss of function. While similar in physiological ways to many people in our current practices, the psychological component of the injury and loss is significantly different. It is likely the veteran may be questioning the connection between illness onset and the war and/or their prior injuries. Sensitivity to those potential issues will be crucial to providing support to these clients.

EFFECTIVE PRACTICES

I left my year in Iraq convinced, by experience and observation that much of our effort at intervention worked well for the soldiers who received our care. This individual, micro-perception appears to receive some support by the Army's Mental Health Assessment Team report, which noted, among other measures, fewer reported mental health symptoms, more use of mental health resources, and fewer suicides as measured between the invasion phase OIF-I and the follow on OIF-II (*US Surgeon General, 2005*). The different operational nature of the two time periods cannot be over-emphasized: the invasion force was attacking into an unknown situation, uncertain length of deployment, and once transitioned to stabilization efforts, experienced relatively primitive living and support conditions. OIF-II, on the other hand, benefited from deployment into a more known situation, with matured living and support facilities, and a predictable deployment and return schedule. From a combat stress control standpoint, by mid-deployment OIF-II had more combat stress personnel in place and more widely distributed than the prior operation, which, along with a proactive, "support forward" ethic by the CSC unit commands, meant support was more readily available to the soldiers of OIF-II.

A simple conclusion I brought out was that talk works for people affected by trauma but requires an active, engaged listener. Many of us have heard the complaint, "What good does talking do?" from clients, family members, and some of our colleagues. During my year in Iraq, I watched talk allow a stressed soldier to slowly identify and accept their current emotional state, and begin to see a path towards improvement and resolution. That powerful image has remained with me as I re-entered oncology practice, and continues to inform my efforts today.

I also observed the healing effects of time, sleep, and expectation. The passage of time allows traumatized people a chance to reflect, even without professional support, and to inventory what they are feeling. I re-learned to ask if "time was right" to discuss issues with people, and to slow down my expectations to accommodate the client's need. The profound effects of sleep deprivation, and conversely, the restorative nature of sleep, were observed many times throughout the year. I more frequently ask about sleep patterns now in my practice, and raise the issue with the medical teams as a possible lever to effect change. The Expectation principle of the PIES acronym may seem to present a wishful thinking element into practice. On the contrary, quietly asserted it projects a confidence in the intervention to the client, and sets a realistic level of expectation, of feeling better, as opposed to "cure". Translated into current practice, it means engaging the client in the possible, and asserting the likelihood of solutions to many, if not all of the issues they face.

We frequently told soldiers that they were experiencing, a "Normal reaction to #%@^$ situation", with the current vulgarity replacing the special characters. This often elicited a chuckle, but as importantly, reassured them that the intense emotions and

thoughts experienced were a normal human reaction to very nasty, upsetting, and in terms of their prior life, abnormal events. The comment tended to defuse the perception that perhaps the event was partly their fault as well; "Stuff happens,", or its scatological equivalent, contains a healing power which I did not appreciate until this experience.

The truism "Groups work, but not for everyone" was also borne out by this experience. We attempted to offer group education as well as defusing for all who were interested. But we also made specific effort to identify affected soldiers who were not attending the group sessions, and arrange quiet, private contacts with them through their leaders. These soldiers appreciated the effort, and many would report to our clinic on their own for follow up care of for assistance with other issues. Critical to the success of that effort was the adaptation of a low key, accessible demeanor to encourage the reticent. Many of our affected soldiers were of mid to lower rank, and most of them were enlisted. It took focused effort on the part of the professionals, most of whom were officers or senior enlisted, to offset the initial soldier reticence in the face of rank, and establish a sense of ease and openness required for effective support.

We found it important, in working with the soldiers, to openly acknowledge the slow, daily effort of coping with their losses, their risks, and their fears. The amount of effort this required surprised many people, including the professional and technical staff on our team. Experienced by the soldier as an additional task and in some cases, stressor, acknowledging the demand and the effort gave the soldier credit for unseen and not always appreciated work on their part. It also helped, we found, to encourage soldiers to look back to a disturbing incident or crisis, and measure the differences in what they were felling and how they were responding to their situations. This reinforced our original expectation of "you will feel better", and validated the idea that"better" may not always mean" resolved".

REFLECTIONS: A WORK IN PROGRESS

The experience of practicing social work in a war zone has strongly informed and significantly changed my perceptions of the emotional affects of severe and terminal illness. While partly due to the experience of my own reaction and recovery, equally important was observing the positive effects of applying the Army's combat stress control principles, and social work practice experience, upon soldiers in acute need. Having a better grasp of the effort, work, and demand of response to severe illness has opened different avenues to explore with the clients and families I serve, encouraging their own reflection and acknowledgement of their internal struggle and success.

My year reinforced some basic social work tenets of client centeredness, working "the middle", and tolerating ambivalence. Client centeredness been central to my practice, but experiencing how each soldier, and now, person with cancer, defines, relates

to, and engages their situation strongly reinforced the utility and dignity of that approach. As social workers, we find ourselves in "the middle" between client and their environment, dictating to neither, but involved and interacting with both. The middle, in Iraq, was reflected that I could not, in the end, direct how a soldier would accomplish their work; I had to work in between the solider and his/her leadership, their mission, and the myriad competing demands of an army at war. Negotiating and facilitating those relationships and the soldier's healing provided me invaluable exposure to the challenges and rewards of middle work.

Finally, ambivalence is central to the social work experience, given our ethic of client centeredness and direction. The situations calling for our assistance are rarely neat, organized, and controllable, and rarely have determined or clearly quantified outcomes and resolutions. Social work labors in an atmosphere of uncertainty and potential, using possible solutions as opposed to fixed ones. Despite the military's penchant for regulation and structure, the experience of war is fraught with ambivalence, uncertainty, and flux. I learned that social work, and social workers, can survive and thrive in that environment through strong commitment to their clients, and a firm grasp on skills and experience. We are called to where people hurt, to assuage the pain and help the mending. That call will continue to sound as our soldiers and their families return to their homes and re-encounter the normal, routine issues of health, illness, life and death. Social work will respond.

REFERENCES

Bowman, Tom. (2004). Long an Iraqi target, no U.S. help in sight. *The Sun*, Baltimore, MD; October 11, 2004.

Operation lraqi Freedom (01F-11) Mental Health Advisory Team (MHAT-II) Report; 30 January 2005. Chartered by The U.S. Army Surgeon General. Refer to e-mail: http://www.armymedicine.army.mil/news/mhat/mhat_ii/OIF-II_REPORT.pdf

Neil O'Connor, ACSW, LCSW is a Lieutenant Colonel in the Medical Service Corps of the United States Army Reserve and Senior Clinical Social Worker in the Oncology Clinics, University of Wisconsin Hospitals and Clinics in Madison Wisconsin. He may be reached by e-mail at: neil.oconnor@charter.net.

TRADITIONAL ROLES FOR A DEPARTMENT OF SOCIAL WORK IN RESPONSE TO A COMMUNITY TRAGEDY

William J. Kirkpatrick, LICSW

INTRODUCTION

On February 20, 2003, a devastating fire erupted in a small nightclub, The Station, in West Warwick, Rhode Island. It touched off the single most devastating event in the state's history. Although the nightclub was legally licensed for a capacity of two hundred and fourteen people, four hundred thirty-nine patrons were in the building at the time of the fire, of whom ninety-six died at the scene. One hundred ultimately died. Due to existing Rhode Island law at the time of the fire, the building was not required to have a sprinkler system. Ultimately, this disaster ranks as the fourth deadliest nightclub fire and the ninth deadliest public assembly fire in the United States (*Providence Journal, 2003*).

The crowd was at the club that night to see a popular rock band, Great White. At the beginning of the first song, a pyrotechnic display was set off as part of the band's act. The display immediately ignited sound proofing foam that covered the ceiling and walls. The ceiling was less than 8 feet high and flames quickly spread throughout the club, setting off a panic, trapping many and resulting in the multitude of injuries and death. Controversy still swirls around the events of the night, with charges and countercharges of whether the club had been adequately inspected questions of why so many people were allowed inside, and questions about whether the band had permission to set off the pyrotechnic display. Ironically, one of the clubs owners had been a reporter for a local TV station, and had done a story/expose on flammable foam used in insulation and soundproofing, the very type of foam that caught fire at the club. Post event analysis attributed most if not all of the deaths to the fact that club was significantly more crowded than permitted by its license and patrons, though initially moving calmly towards exits, began to panic because of the rapid spread of flames and smoke, and unfamiliarity with the location of exits. (*USDHLS, 2003*)

RESPONSE TO THE DISASTER

Two hundred fifteen patients were evaluated at area hospitals and seventy-nine patients were admitted. Of that total, eight patients were transferred from the local trauma center to other Level I trauma centers in the region. Twenty-eight of the patients admitted were intubated (placed on respirators to aid breathing) for inhalation injury. For those patients admitted, the extent of the total body surface burn ranged from 20% to over 40% and the average age of the patients was 31 years old. First responders found many of the dead near exit doors trying to escape. As the initial alarm was sounded in the local area, a small inn across the street from the club was established as the first emergency scene triage area. Victims who escaped were directed to that site, and people rescued by

responders were sent there for triage. One of the initial problems encountered was that as the alarms spread and requests for mutual assistance were made, the scene began to be clogged with numerous rescue vehicles. A quick decision by an on scene firefighter with disaster preparedness experience led to a system in which ambulances would be stopped at a staging area and called up one at a time to pick up a patient. Staging was important and worked very well according to on scene first responders (*P. Ginaitt, personal communication to author, May 16, 2007*). Ambulances were required to park 100 yards away and bring stretchers to the building, then exit by another road out, thereby assuring that the scene was not blocked or clogged. In the triage area, one emergency medical services (EMS) person conducted triage as all other EMS personnel were deployed. He "commandeered" five nurses responding to the scene and had them assist with assignments.

While a basic communication structure existed between hospitals, there was no appreciation of the need to diligently monitor telephones or radios at the time. As a consequence, communication broke down quickly. A local fire captain used his cell phone to contact the hospitals to determine their capacity, describe injuries and assign transport to the hospitals. In the aftermath, many individuals arrived at the on scene triage area, then left to look for friends and families. There was no accountability initially for identifying or tracking individuals until the State Police established security. Besides ambulance transport, individuals also self-reported to hospitals or were transported by other victims who chose not to wait for ambulances.

There are 39 cities and towns in Rhode Island, but there are more than 39 fire departments and over 88 Emergency Medical Service (EMS) providers. Some small towns have more than one fire service, and some are volunteer-based. There were dozens of communication systems and dozens of potential incident commanders. Prior to the Station fire, the state wide emergency preparedness system and planning structures were well intentioned, but ineffective (*P. Ginaitt, personal communication to author, May 16, 2007*). Given that Rhode Island is the smallest state, significant "turf" battles exist within a highly competitive health care environment, with strong focus on hospital market share. After the Station fire, significant changes were introduced, not the least of which was a greater degree of inter-hospital cooperation. The existing EMS and "diversion system" revealed numerous weaknesses. Local ambulances, for example, had a tendency to transport patients directly to hospitals familiar to the EMS, despite the need for triaging to the regional trauma center. This resulted in a number of patient transfers between hospitals that may have been avoided in a more efficient system.

Another system weakness became apparent when the hospital closest to the scene very quickly requested that the only helicopters in the region respond to that hospital. This presented problems when patients needing to be transported to burn units in Boston area hospitals had to be transported by land vehicle because the helicopters could not be redirected once deployed. A community hospital nearby treated most of the people who had minor injuries and walk-ins, while most of the remaining patients were transported to the state's level I trauma center, Rhode Island Hospital.

As noted, communication barriers were revealed in terms of ambulance, police, fire and other agency personnel using different emergency protocols and radio frequencies. These practices made it impossible to get an accurate count of the number of people in the club, how many were still in the club, how many were transported to hospitals via ambulances, how many escaped and went home or how many subsequently walked in to seek treatment. The inability to obtain this information impacted the immediate and subsequent triage and treatment of patients, and proved to be a logistical nightmare in terms of identifying all of the victims and establishing their location. Enormous stresses were experienced by families and loved ones seeking to locate victims. At the same time, significant pressure was experienced by first responders and hospital personnel as they attempted to identify victims, locate families and reunite them.

CRISIS MANAGEMENT

Early attempts to contact other area hospitals to determine and verify names of treated and/or admitted patients were met with resistance from workers citing patient privacy and confidentiality concerns. By coincidence, all of the local health facilities were gearing up to implement the Federal Health Insurance Portability and Accountability Act (HIPAA) privacy rule, scheduled to become effective in April 2003. The heightened sense of needing to protect information was finally overcome as everyone involved seemed to come to the realization that the unique aspect and scope of this event should allow HIPAA to be set aside in order to "do the right thing" for patients and families.

As the night wore on and most of the patients had been transported to area hospitals, the state emergency management team established an emergency center, moving it from the inn across from the scene to a large hotel a few miles away. This facilitated families, first responders and other helpers being moved away from the scene and set the stage for an impressive array of state, federal and local agencies to set up resources at the hotel to provide immediate family support. This center continued to operate for several weeks in the aftermath. In the days following the event, a resource guide entitled "Stations of Support" was created and disseminated throughout the state to provide specific referral information for providers. This became valuable to hospital-based staff as efforts were made to reduce duplication of provided services.

As the first alarms were sent out, several things happened quickly at the trauma center. All patients currently in the emergency department were assessed to determine if they could be immediately discharged, immediately admitted or transferred to other hospitals. Patients who could be moved off of the trauma/burn nursing units were transferred to other units. All surgical residents (physicians in training) were summoned to the emergency department and several additional emergency medicine physicians were summoned from home. As the event unfolded in the late evening just prior to the change from the second to the third shift of workers, second and third shift staff were on hand and most of the essential staff from the second shift remained on duty.

Within thirty minutes of the first alarm, the hospital's emergency disaster plan was put in to effect. Rhode Island Hospital utilizes the Hospital Emergency Incident Command System - HEICS (*California Emergency Medical Services Authority, 2006*). At that time, there were two clinical social workers on duty in the emergency department, one for the acute psychiatric service and one attending to the emergency/trauma service. With the arrival at the hospital of the social work administrative staff, there were five social workers on site and two supervisors were subsequently instructed to respond onsite. The Department of Clinical Social Work administration (the director and two managers) are part of the hospital emergency response team, with the director serving as "Director of Human Services" in the HEICS plan. This role has responsibility for organizing, directing and supervising those services associated with the social and psychological needs of patients, staff and their respective families, and assisting with discharge planning. This required coordination between multiple departments, including clinical social work, case management, chaplaincy services, volunteer services and acute psychiatry services.

IDENTIFICATION AND NOTIFICATION

The primary role of clinical social work in the emergency/trauma service is to provide crisis intervention and supportive counseling services to patients. Frequently the work is with patients who are victims of a trauma or other life threatening event, and involves offering families a variety of services, including end of life care and support. (*Dziegielewski, 2003*) With growing awareness of the disaster magnitude, the expectation was that there would likely be serious injuries and multiple deaths. Staff anticipated that they would need to deliver difficult news to families.

The immediate social work response included an initial assessment meeting in the emergency department social work office to determine what staff was onsite and to arrange for additional staff to report to the hospital. It was crucial to also identify how many patients had arrived, determine if families or friends had arrived, initiate an emergency hot line to receive and triage calls and establish a family waiting area in a space larger than the existing emergency department waiting room. It became necessary to move from stretcher to stretcher in an effort to identify patients and compile a master list of patients and families. That information had to be matched with the list compiled by the emergency department registration staff.

Patient identification rapidly became challenging for several reasons. Patients were being triaged, treated and moved so quickly that it was difficult to determine who had come in to the emergency department and where they were transferred for subsequent care. Many of the victims had their clothes burned off and some had no identification or damaged ID. The emergency department was crowded and it was literally hard to move through the crowd. All areas of the emergency department had a pall of smoke or haze arising from patients transported from the disaster scene. Two clinical social workers were assigned to hot lines, two moved from room to room and two staff serviced the family waiting area.

Post event analysis within the hospital identified both weaknesses and strengths of the emergency management plan. There were numerous unintended consequences as a result of actions and activities occurring throughout the night. One unintended consequence involved the location of families in a waiting area. Initially, families were redirected from the emergency department waiting room to the lobby of the outpatient building. It rapidly became clear that while there was not a great distance away from the emergency department, establishing communications between areas was difficult and contributed to families feeling isolated and separated from loved ones. A decision was made to relocate families to the lobby of the children's hospital, which was in close proximity to the emergency department. While regular visitors to the hospital entered through that lobby the following morning, a large number of families associated with the disaster were still waiting there to hear news of their loved ones. Once the clinical social work staff were deployed, the Director's role throughout the night evolved to working side by side with registration staff, serving as a link between staff who were attempting to register patients, create a medical record and maintain an accurate census of those treated, admitted and discharged, and with those who were checking with emergency department staff, hot line staff and checking with other hospitals to acquire and share information.

Problems emerged as a result of the many variations of names and the false identification of patients. By default, the list maintained by the Director became the temporary official list of those treated in the emergency department, as well as those who were released, admitted or transferred. Forty-two of the forty-three patients that were admitted were identified by the morning, and most families of those patients were either notified or were in the waiting room next to the burn units. Approximately one hundred people were in the family area (lobby of the children's hospital) waiting for definitive word on the status of their loved ones. Some had arrived from the disaster scene or the support center at the hotel near the scene. Many had driven back and forth to other hospitals or frantically called every hospital in an effort to find love ones. With increasing broadcasts of the disaster story, the hot line received thousands of calls, locally, nationally and even internationally. Some callers offered information, some sought the location of victims and some calls were made by the State emergency management team seeking to verify the number of patients at the trauma center. Given the statewide and regional scope of the disaster, accurate status reports on patients treated and admitted became critical for all involved parties.

CRISIS INTERVENTION AND PSYCHOLOGICAL SUPPORT: EXPERIENCES AND IMPLICATIONS

By the morning after the disaster, it became evident that people waiting in the lobby of the children's hospital were not going to get good news. Once the master list had been established of identified patients, it became the job of the social work director to go to the lobby and read that list to the waiting crowd. When the list was read, some became grief stricken as a result of not hearing the name of their loved one as they had exhausted efforts to locate them anywhere else. Clinical social workers immediately intervened with support and comfort, staying with families until they made the decision to leave the

lobby. Others kept searching, some immediately returning to the scene, the community center near the scene or other hospitals. Some returned to the trauma center later that day or the next, still seeking and searching.

There were countless interactions and interventions throughout the first hours of the disaster. Every effort was made to attend to all involved parents and family members. The parents of one victim briefly treated at Rhode Island Hospital and subsequently transferred to a Boston area burn center became lost in the turmoil and uproar of the night. They were quietly anxious and agitated as they awaited word on whether their son had been located. There was concern that his name may have been misspelled and there was another patient being treated with a similar name. As the social workers reviewed information about families who had been contacted about their loved ones location, one staff member recalled that this particular patient may have been transferred to a Boston trauma center. A social worker contacted that facility, but the hospital spokesperson "could not release any patient information due to confidentiality". Fortunately, another social worker remembered that the patient had been accompanied by a nurse to the other facility. The now off duty nurse was contacted and she confirmed the patient transfer. The information was conveyed to the parents who called the trauma center and confirmed that their son had indeed been admitted.

Aside identifying patients and notifying family members as part of routine hospital admissions and registration protocols, the clinical role of emergency department/trauma center social workers frequently includes rapid response to several needs. First, social workers provide psychological support following a traumatic event or crisis (*Everly, 2000*). Arrangements also need to be made that ensure families are included as soon as possible in decisions about the care and treatment of their loved one. Screenings are conducted for psychological and emotional needs that require immediate follow up treatment and the social workers continue on to identify and assist in meeting the myriad of concrete needs of patients and families.

In the aftermath, the initial period of crisis management, locating and notification of families occurred within the first six to eight hours after the fire. The announcement to the waiting room of family and friends, of the patients who had been admitted to the hospital took place by mid morning of the following day and at that point the event entered a second phase of clinical intervention and management. The routine of the day gave way to an assessment of current social work cases in the hospital, staff on site and a triage of existing cases in order to re-assign/re-deploy staff to the burn unit. Cases were assigned to each worker and double and triple staffing on the second and third shift was established and maintained for two weeks.

Initially, the majority of the clinical work involved dealing with family members only, as most of the burn patients were unresponsive and on ventilators. The work involved dealing with shock and the initial coping and adjustment to the devastating injuries. Many families were confronted also with the news that because of the critical nature of the extensive burn and inhalation injuries, that some patients were at high risk for death. The majority of the burn victims were young, many with children. This event

had a significant impact on families. Grandparents were suddenly faced with the prospect of assuming care for their grandchildren - essentially re-parenting their children. Some parents were forced to leave their jobs, or move to be closer to their children and grandchildren. They had to deal with rent payments, car payments and other day to day tasks, while in the midst of coping and wondering if their loved one would live or not, and what will happen in the future.

Early assessments of families and some of the conscious patients revealed a significant level of dysfunction, with clear exacerbation of issues such as untreated mental illness and substance abuse. It has been estimated that 90% of Americans will be exposed to a traumatic event as defined by the American Psychiatric Association and that 9% will subsequently develop post traumatic stress disorder symptoms (*Everly, 2000*). The importance of timely and appropriate intervention in the aftermath of a crisis is an essential aspect of emergency mental health treatment. A crisis occurs when a stressful life event overwhelms an individual's ability to cope effectively. Crisis intervention strategies have developed and evolved from the research on grieving by Erich Lindemann (*1944*) following a devastating nightclub fire in Boston, and in research and writing about the context of battle (*Flannery, 2000*). Key principles that have emerged in research and writings about crisis emphasize immediate intervention, stabilization of victims, assistance with understanding the event and the use of resources to victims that promote problem solving, independence and self-reliance. (*Everly & Mitchell, 1999)*

Many stories emerged of patients struggling with profound survivor guilt (*New York Times, Science Times, 2001*) and re-traumatization. Some reported experiencing regret about going to the club, feeling responsible for someone else's injury or death and sensing that if they did not go to the concert, their loved one would still be alive. Family members and strangers in the community were eager to provide help. Gifts of food were delivered, while local school children painted pictures and made get well cards for all of the patients. Many wanted to donate blood in a gesture to make a positive contribution rather than experiencing a feeling of helplessness or powerlessness. Others reported post-traumatic symptoms of re-living the event, or of wanting to find ways to avoid thinking or dreaming about it. Because of the magnitude of the event, it was necessary to place four patients per hospital room. As a result of the cramped, close proximity of patients and visiting families, each patient and family were repeatedly exposed to the details of the emerging emotional and psychological issues experienced by all patients in the room.

The common cycle that emerged for clinical social work staff was to experience the same re-exposure as they focused on intervening with each family. Staff heard stories, assisted with emotional and concrete needs, provided crisis intervention and counseling. Then, as that family's loved one began to wake from their chemical induced coma/sedation, the process would begin again. One staff expressed it as essentially like "starting over from ground zero". The social workers were compelled to deal with their own personal and professional issues, with some reporting trouble in separating professional duties from personal experiences.

Support for staff became a significant issue and need. Guided by Figley's (*1995*) theoretical framework about compassion fatigue, a graduate student in the department during the academic year following the fire conducted a research project on staff experiences as a result of the fire and subsequent interventions. Standardized interviews revealed that staffs were secondarily traumatized by their exposure to grief, loss and the witnessing of physical horror. They struggled with their own cognitive, emotional, behavioral and physical reactions to events and the need to develop coping strategies.

Rhode Island is a small state, described by some as a state of little villages "with three degrees of separation versus six". Many knew victims or families; some were related to, or had friendships with, victims' families. Several weeks after the event, some staff felt compelled to visit the site of the fire that had been converted in the aftermath to a makeshift memorial. One social worker described a situation shortly after the event in which she had the sensation of smelling smoke - the same pervasive smell that permeated the ED and much of the hospital as victims arrived and were treated. She was seemingly unable to get the smell out of her nose. A few days later as she was going to work, she was still experiencing that smell and when she went home that particular day, she learned that a neighbor's house had caught fire that morning and burned down. The social worker had actually smelled the smoke long before the fire was obvious and an alarm sounded, but thought she smelled the smoke from the Station Fire nightclub and had just connected it to the lingering smell from that fire. Her neighbor's house became a literal reminder of the event. It became what Gabriel (*2001*) would refer to as a re-traumatization.

Most of the victims of the fire were young, many with children. Over eighty children lost at least one parent in the fire. Two social workers were familiar with one of the burn victims - an employee of the hospital whose office was three doors down from their office. She had been transferred to another trauma center with very severe burns. The employee commented that the pre-fire time was the best time of this person's life. She had met someone and had become engaged, but her fiancé perished in the fire. Her brother-in-law stepped in as the primary decision maker as she had three young children. A surgeon at the other trauma center advised him to prepare a statement to read to her children because of her poor prognosis. She survived however and was ultimately discharged home. Six months later in the late Fall, her brother-in-law was wearing a coat because it had started to get cold. It was the coat he was wearing at the time of his conversation with the surgeon. At that time he had placed the note meant for his sister-in-law's children in the coat pocket. As he was driving to work six months later, he found the note, stopped his car and called his sister in law to read it. He sat in his car by the side of the road crying as he read the note to her. One of the workers later saw this patient in a supermarket but did not immediately recognize her. She described her first feelings in the early stage of assisting as a sense of being overwhelmed. She lamented, "how could I do anything for these people…this is the hardest thing I have done in my 17 year career".

The next day, an older couple came to the hospital looking for their son. Although they had been told at the scene and at the family assistance center near the scene that he had been sent to Rhode Island Hospital (RIH), when they first arrived at RIH, they were informed that he had been sent to another local hospital. Having called both hospitals

only to be told there was no record of him being seen at either hospital, the parents were understandably agitated by the time they arrived in the RIH social work office. With the parents looking on, the social worker began the process of locating their son. He contacted the family assistance center and was given the same instructions he had been sent to RIH. The social worker checked the RIH records and then called the other hospital, only to receive the same answers. Several more calls were made to try to locate or rule out the location of their son. The parents sat with the social worker throughout the process, heard exactly what the social worker was saying and were able to respond to and with whom he had contacted. When the social worker finished the telephone calls, the mother quietly said "I don't think my son is alive". The social worker agreed with her, the parents hugged, thanked the social worker and left. He had led them through the process of searching and eliminating possibilities to help bring them to their own inevitable conclusion that their son had died.

Several days after the event, an older couple came to the social work office and asked about donating money. Their son had died in the fire, his funeral was the next day, and they wanted to make a financial donation to the RIH burn unit. In telling their son's story, they shared that he had worked for a small company locally, was in his early 30's and lived with his parents. He was a great admirer of the band Great White and was very eager to attend the concert, although he was scheduled to work that day. He did everything to switch hours with other workers and finally succeeded at the last minute.

He went to the concert with a good friend and when the building went up in flames, they were holding hands to help each other to an exit or window. They made their way to a window and as he helped her through the window, she reached back to help him, but she could not find him. She was overwrought with grief and continues to have significant posttraumatic issues. The social worker contacted the hospital's development office to explain the couple's wishes and was told the office would send a form to them. The social worker regarded that as insufficient and asked that someone speak with the couple in person. Although he met with resistance, he continued to advocate for their having a human contact when making this donation. He succeeded in arranging for a meeting in which the couple could discuss their donation. In describing this experience, the social worker recalled how important it was for this couple to have a human experience, find meaning in the outcome and have a personal experience with the hospital beyond the painful association with their son's death. (*M. Robbins, personal communication to the author, October 7, 2003*)

The primary clinical social worker on the Trauma Intensive Care Unit (TICU) was out of town for a weekend visiting with family when she saw the news reports the day after the fire. Feeling shock, she felt compelled to return to Rhode Island to assist. Though most of her career dealt with trauma, she was initially overwhelmed by the magnitude of the event and its implications. The TICU received the most severely burned victims; none were alert or verbal, most patients required ventilator equipment. She was confronted with a "mass of very distraught families" needing to see their loved ones and wanting to talk with the doctors. They were in shock, tearful and appeared ill themselves. The question became "Where do you start?" She just began with one family at a time.

She introduced herself, helped get them information, assisted in getting them dressed in the special protective clothing needed to enter the patient rooms and helped prepare them for what they were about to see, hear and smell.

As much as they tried to get prepared, it was still a shock and trauma to initially see their family members on ventilators, with several nurses and physicians and respiratory therapists surrounding the bed dealing with red, swollen skin that was sloughing off. Many family members became faint, or vomited; some ran out of the room. Some could only tolerate being in the room for thirty seconds before having to leave. For each patient and their family, the social worker had to steel herself to be prepared "for who knows what". Family members were helped after they left the room by talking about the experience if they wanted and processing what they had seen, while also dealing with their feelings and questions. Few if any had experienced anything like the sights, sounds and smells of an Intensive Care Unit and saw it as grotesque.

The TICU rooms contained four beds and were crammed with equipment and people. Temperatures were kept very high because burn injuries destroy the skin, leaving the patient's body unable to self-regulate temperature. The social worker continually had to triage who was most in need of assistance while the nurses would often call out for social work response to a specific room with a needy family member. The social worker described it as "a sea of emotions". When she finally left late that first night, she felt guilty. She perceived her crisis work as being in three stages. Initially families had to be helped to cope and adjust to the reality of the event and the devastating injuries. Then, as the patients became conscious and were weaned from the medications and vents, they would ask, "What happened to me?" Every patient ultimately remembered the event, with some able to recall it in greater detail. Each patient had a story they needed to tell…the sights, sounds and smells of the nightclub…the screams, the crush and pile of people, becoming unconscious, believing that they were going to die. The third stage of the social worker's experience emerged as the families went through the crisis a second time with them…reliving everything all over again.

One patient thought he had saved his girlfriend by pushing her out of the window and believing he was sacrificing his life for hers. He passed out and later found that she never made it out and instead, had died. The survivor guilt was immense. Many of the families already knew other peoples' stories, other patients' losses, other families' issues, and harbored this knowledge while trying to deal with their own grief. These families then had to face the prospect of informing their own family member about unpleasant outcomes. Everyone knew someone or had a relative that died in the fire.

At one point subsequent to the event, the social worker contacted the Phoenix Society - a group of burn survivors who volunteer their time to visit burn victims and their families. The Society sent boxes of material that the social worker then prepared as packets for every patient and family. (*Edwards, 2001a; Edwards, 2001b*) The social worker was on duty that Saturday and then was off on Sunday. She went to the grocery store and recalled feeling disconnected from the rest of the world, likening it to the experience of veterans returning from the Vietnam War. She felt removed from family

and friends, unable to explain what it was like to do the work, see what she saw or hear what she heard. She felt she wanted the world to acknowledge what had happened, but sensed the world had no way of truly knowing what they would be acknowledging. It was as if staffs were all in a "bubble" of relative degrees, experiencing the sights and sounds within the TICU, within the social work department, within the hospital, then within the circle of friends and relatives in the community. Intellectually knew she was making a difference, but she felt very insignificant because there was so much pain and suffering. While she felt physically and emotionally drained- as if she were "a sponge soaking up all of the pain"- this did gradually fade over time.

As noted, a number of cases involved children. Most of the time families and grandparents stepped in to assume responsibilities. Most wanted to protect the children and did not want them to enter hospital rooms. One nine year old was visiting the hospital because her mother was burned in the fire. She was with her stepfather, and began asking to see her mother with whom she was very close. The social worker spent significant time with the child, explaining what was happening with her case and her mother's treatment. She and a nurse prepared the little girl for what to expect both in terms of her mother's scars and swelling and the ICU environment. The social worker helped her dress in the necessary protective gown and brought her to the door, explaining that she did not have to go in the first time. The child did go in the room, approached the bed and touched her mother's leg because her arms were severely injured and bandaged. She spoke briefly to her mother and was calm enough to leave after a few minutes. All of the children were viewed as "little troupers" by staff. They wanted to go in the room and none were so frightened that they ran off. The social worker worked with them in the aftermath (*Edwards, 2001a; Edwards, 2001b*).

In another instance, the father of three small children was severely burned and was unaware that his wife had died. Upon gaining consciousness, he began asking about her. The social worker spent time with his parents discussing how and what to tell him about his wife's death. She reinforced that they needed to tell him clearly that she had died and not use euphemisms. She had his parents practice in preparation for the conversation and finally they went in to tell him before he inadvertently heard about it from another patient or family member. The social worker and the doctor accompanied the parents, helped in the explanation and then did grief work with him. The social worker brought the children in to visit him, already knowing that their mother had died. Notwithstanding their age, many grandparents stepped up to the plate to assume care of the children.

One patient thought he had pushed his girlfriend out a window. He had previously thought he would never meet the "right" woman or marry, but along with her children, they were planning their wedding. As the love of his life, he had taken her to see the band for her birthday present because she liked the band so much. The social worker repeated the process of helping his parents inform him of her death and then dealt with his grief and guilt about what could have been and what was not to be.

The losses from this event were countless, of lives, dreams…things that could have been. At the same time, however, the social worker perceived it was "divine intervention" that she was there to help these patients and families. She thanked God for having the opportunity to be an instrument of God in their lives. She held what many other hospital staff perceived, that it was a "privilege" to be there with the patients and their families.

NON-TRADITIONAL ROLES

Virtually as soon as the patients had been admitted or transferred, and families had learned of the fate of their loved ones, many activities transpired in support of the clinical work being performed. Although the fire occurred late in the evening on a Thursday and the trauma center was the center of activity throughout the night, by mid-Friday morning the emergency mobilization plan (HEICS) was declared over and it became business as usual in the emergency department. On the inpatient units by contrast, the work had just begun.

Rhode Island Hospital had never experienced a disaster of such scope and magnitude. While disaster drills and disaster planning had historically been performed as part of regional disaster drills, the events of September 11th made these drills take on added significance. The simulated disasters included fictitious victims of plane crashes and toxic gas exposure. Following each drill, the response was critiqued for response time, accuracy and efficiency, and areas of improvement were identified. Changes made to the disaster plan as a result of these re-evaluation sessions subsequently proved invaluable in responding to the nightclub disaster.

One aspect of the post-disaster scenario that had not been anticipated, planned or practiced was the reality that many hospital departments continued to function as if the emergency plan was still in effect. Families of forty-three patients needed ongoing support and assistance and staffing had to be increased to accommodate the demand. Food had to be provided for the families and also for the three shifts of personnel that were continuously providing patient care. Volunteers needed to be mobilized to assist professional staff in manning a family support center. Donations of food, gifts, cards and other material began to appear and needed to be managed and distributed. Staff external to those of the hospital such as burn nurses, psychiatrists and clinical social workers had to be processed for privileges and assigned. Rehabilitation services and respiratory care services had to be increased. Coordination of services and support with the community and State agencies required continuous monitoring and documentation. Communication between the hospital administration and families needed to be established in an effective, ongoing manner unlike any previous experiences.

Although the formal emergency situation was declared "over" at one point and the emergency command center closed, it became evident post emergency work was continuing at a high level. The decision was made to establish an "ad hoc" emergency command center in the central offices of the clinical social work department and use it to

coordinate post-disaster services. This command center functioned for two weeks. One of the first tasks accomplished was scheduling families to meet with the Hospital President and Chief of Surgery in the hospital auditorium on the Saturday evening after the fire. In addition, several educational sessions were arranged to support families. Staff from a "sister" hospital specializing in child and adolescent psychiatric illness provided two sessions on how to prepare children for traumatic injury, potential death, and death.

The presence of media created additional and unique challenges. Social work played a critical role in media relations. A principal issue that emerged was how to deal with the volume and demand for access to patients and families, while protecting privacy and confidentiality. Rhode Island Hospital had never experienced an event with the scope of this fire and the level of media exposure was intense. Practical concerns had to be addressed including where to locate media representatives and provision parking and regular communication. The more significant challenge, however, was determining the balance between patient/family privacy with the media's legitimate need for information. Media relations staff had the responsibility of establishing that balance while recognizing the hospital's bottom line responsibility to protect patients' rights. The assistance of the social work staff was sought as they were viewed as capable of providing guidance about media response while maintaining sensitivity to patients and families.

EPILOGUE

To date, only the two club owners and the band's manager have been indicted for the tragic consequences of the fire. The manager was subsequently found guilty and sentenced to fifteen years, with four to serve and eleven years suspended. One owner was also sentenced to serve fifteen years in prison, with four to serve and eleven years suspended. The other owner received a ten year suspended sentence, three years probation and five hundred hours of community service. The event prompted months of investigation and led to legislation that has transformed Rhode Island law into the most stringent fire code in the country. It also generated close examination of local, state and regional disaster preparedness regarding communication and collaboration between first responders, state resources and local hospitals.

The tragic Rhode Island nightclub fire continues to influence and affect the healthcare community, mental health community and Rhode Island community at large. Fire victims continue to receive services at the hospital. Emergency preparedness planning and drills are conducted and critiqued in the context of this life altering event. Some of the "lessons learned" have been incorporated into new procedures and prompted ongoing training. Educating professionals about the experiences and lessons learned from the Station Nightclub Fire is an important mission. The entire hospital community rose to the occasion, providing exemplary service based upon the foundations of training and compassion. Perhaps the most significant lesson learned is that we can never be truly prepared for an event of this magnitude, but we can rely on our continued efforts to strive to be prepared and establish the framework within which staff can accomplish their work and be supported.

REFERENCES

_____. (2004). Helping children after a disaster. AACAP Facts for Families. *American Academy of Child & Adolescent Psychiatry*, 36 (July), pp. 1-2.

Badger, J. (2001). Understanding Secondary Trauma & Stress. *American Journal of Nursing*, (Vol. 101, Issue 7, pp. 24-33.

California Emergency Medical Services Authority, S. Skivington, Project Administrator. (2006). *Hospital Incident Command System Guidebook*. Sacramento, CA.: author.

Dziegielewski, S. (2003). *The Changing Face of Health Care Social Work*. New York, NY: Springer Publishing Company.

Edwards, K. (2001a). Burn Survivor and Family Learn Lessons of Endurance. *The Phoenix Society Burn Support News, Issue 3 (Fall)*, pp. 6-9.

Edwards, K. (2001b). Preparing Children to Visit the Burn Unit. *The Phoenix Society Burn Support News, Issue 4 (Winter), pp 6-8.*

Everly, G. (2000). Five Principles of Crisis Intervention: Reducing the Risk of Premature Crisis Intervention. *International Journal of Emergency Mental Health*, 2(1), 1-4.

Everly, G. and Mitchell, J. (1999). *Critical Incident Stress Management: A new Era and Standard of Care in Crisis Intervention*. Ellicot City, MD: Chevron.

Figley, C.R. (Ed.) (1995). *Compassion Fatigue: Secondary Traumatic Stress Disorders from Treating the Traumatized*. New York: Brunner/Mazel.

Flannery, R. (2000). Crisis Intervention: A Review. *International Journal of Emergency Mental Health, 2(2), pp. 119-125.*

Flynn, B. (2004). *Moving from Response to Recovery: Mental Health Implications Following the West Warwick Rhode Island Fire*. [author PowerPoint presentation]

Gabriel, M. (2001). *Surviving Listening and Witnessing: Vicarious Traumatization in Social Workers Practitioners*. Retrieved March 12, 2003 from www.naswnyc.org/p30.html

Ginaitt, P. (2007). *Personal communication to the author, May16, 2007*)

Goode, Erica. (2001). Therapists Hear Survivors' Refrain: 'If Only'. *The New York Times*. September 25, 2001.

Harrington, DT, Biffl, WL. and Ciolffi, W. (2005). The Station Nightclub Fire. *Journal of Burn Care & Rehabilitation*, 26(2), 141-143.

Lahad, M. (2000). Darkness over the abyss; Supervising crisis intervention teams following disaster. *Community Stress Prevention (Vol. 4).* Washington, DC: NASW Press.

Lahad, M. (2001) Darkness over the abyss: Supervising crisis intervention teams following disaster. *Traumatology*, 6(1-4), 273-294.

Lindemann, E. (1944). Symptomatology and Management of Acute Grief. *American Journal of Psychiatry*, *101*, 141-148.

Parsons, E. (2002). *Victims of Disasters:Helping People Recover-From Acute Distress to Healing and Integration*. Retrieved June 13, 2007 from http://giftfromwithin.org/html/victims.

Parker, Paul E. (2003). The Station Nightclub Disaster - 412 people inside club on night of Station fire. *The Providence Journal*. September 21, 2003, p.1.

Robbins, M. (2003). *Personal communication to the author, October 7, 2003*)

National Association of Social Workers. (2006). Policy Statements: Disasters. *Social Work Speaks, (7th Ed.), pp 88-93.* Washington, DC.

United States Department of Homeland Security, Office of Domestic Preparedness. (2003). *State of Rhode Island, After Action Report on the Station Fire*. Washington, DC.

William J. Kirkpatrick, LICSW is Director, Clinical Social Work, Lifespan Academic Medical Center (Bradley Hospital, Rhode Island Hospital, the Miriam Hospital), 593 Eddy St., Providence, RI, 02903. He may be reached at wkirkpat@lifespan.org