Chair: Harold I. Schwartz, M.D.

**EDUCATIONAL OBJECTIVE:** At the conclusion of the session, the participant should be able to: 1) identify the elements of the state agency response which coordinated multiple resources providing crisis support to school children, school staff, family members, responders and the community; 2) participants should be able to recognize the role which the Connecticut Psychiatric Society played in organizing its members for the crisis response, identifying the challenges and lessons learned; 3) participants should be able to identify the transition from crisis response to short and long term recovery goals, recognizing progress made and the challenges remaining for the Newtown community; 4) participants should be able to recognize issues raised by resulting statutes on gun control, school safety and mental health and identify the elements of the national dialogue on mental health.

**SUMMARY:** On the morning of December 14, 2012, a young man with an assault rifle killed 20 school children and six adults at the Sandy Hook Elementary School in Newtown, Connecticut setting off a disaster response at the local, state and national levels. The Connecticut Department of Mental Health and Addiction Services coordinated the crisis response which included clinical support to surviving family members, school children and personnel, support to town and school officials and strategic planning for longer term recovery. The Connecticut Psychiatric Society (CPS), many of whose members had the month before undergone disaster response training, organized a volunteer contingent which joined in the relief effort. Members of the CPS provided counseling to hundreds of men, women and children in the aftermath of this tragedy.

The National Child Traumatic Stress Network created the Newtown Recovery Program which included a needs assessment, the selection of developmentally appropriate interventions and services for students, school staff, parents and families; the facilitation of partnerships with community, state and federal resources; organizing and delivering training and education and addressing ongoing secondary adversities. Mourning and maladaptive grief, as well as the unique needs of school and community leadership, are factors that must be considered in establishing any recovery program.

The Sandy Hook disaster reverberated throughout the nation. Several states passed stringent gun control laws as well as statutes addressing school safety and mental health. In at least two cases, these new laws create problematic requirements to report patients considered to be “dangerous” or who have been hospitalized. The Sandy Hook Advisory Commission was established to report out far reaching recommendations regarding gun control school safety and mental health. At the national level, the administration has initiated a “national dialogue on mental health” as part of a national action plan that addresses gun safety, school safety and mental health issues with a special focus on prevention, early intervention and access to care for adolescents and young adults.

This symposium will review the lessons learned regarding disaster response in a mass shooting event including the immediate crisis response and the short and longer term recovery strategies. The impact of Sandy Hook has been felt far beyond the confines of the Newtown community and the lessons learned extend beyond the community to the impact of state statutes passed by legislatures in the rush to “do something” before the impetus fades and to federal initiatives to address gun and school safety and access to mental health services.

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**NO. 1: PROMOTING RESILIENCE AND RECOVERY IN NEWTOWN**

Speaker: Patricia Rehmer, M.S.N., R.N.

**SUMMARY:** CT Department of Mental Health and Addiction Services (DMHAS) is designated as lead agency for behavioral health in Connecticut. In the wake of the Sandy Hook tragedy DMHAS coordinated a multi-tiered mental health response which included local, state and national resource coordination, clinical support to surviving family members, school children and personnel, community assistance and administrative support to town and school officials, as well as planning and referrals for long term recovery.

This session will explore the scope of the behavioral health response to this mass casualty event within the school and the community. The session will focus on strategies, interventions and resources used by DMHAS and behavioral health responders to promote resiliency and achieve response goals. The discussion will include a range of “lessons learned” at both the individual responder level and the state response level.
NO. 2: THE MENTAL HEALTH DISASTER RESPONSE TO THE NEWTOWN MASSACRE: LESSONS LEARNED, LESSONS NEVER TO FORGET

Speaker: Carolyn Drazinic, M.D., Ph.D.

SUMMARY: On the morning of Friday, December 14, 2012, a young adult male with an assault rifle killed 20 school children and 6 adults. This tragedy occurred in a small town in CT, but it could have happened anywhere. The entire community was traumatized. A mental health disaster response was clearly needed, but how does one create it and, in particular, what role can a state psychiatric society play? There was no precedent for this type of response at such a large scale, even for the Connecticut Red Cross, which was accustomed to managing natural disasters like hurricanes and freak ice storms the previous year.

This presentation will explain how mental health providers and the Connecticut Psychiatric Society rose up to meet this challenge, counseling hundreds of men, women, and children, for days, weeks, and months after this terrible tragedy. There were many lessons learned from this moving and humbling experience, from both organizational and emotional perspectives. It was a unique moment in history: people of all ages, including first responders, sought counseling in the open, without fear of being publicly seen getting help from psychiatrists. Some mental health volunteers also experienced vicarious traumatization, even as they sought to help the Newtown community.

There were many lessons learned, and many lessons never to forget, for the future development of mental health disaster responses, and an open discussion will be encouraged.

NO. 3: A MODERN APPROACH TO BEHAVIORAL HEALTH AND ACADEMIC RECOVERY: CREATING THE PATH TO RECOVERY IN NEWTOWN

Speaker: Robert Pynoos, M.D.

SUMMARY: This presenter will discuss how to move from the initial response to creating and implementing a long-term school-based behavioral health and academic recovery program for schools, such as Sandy Hook Elementary School, impacted by catastrophic violence. Dr. Pynoos will outline the strategies for how the National Child Traumatic Stress Network created the Newtown Recovery Program, including: 1) conducting an initial needs assessment to determine the "signature" of the school violence and identification of differentially affected populations; 2) selecting appropriate developmentally-appropriate interventions and services for students, school staff, parents, and families; 3) facilitating partnerships with community, state, and Federal partners; 4) organizing and delivering training and education; and 5) addressing ongoing secondary adversities. This presentation will also highlight how mourning and maladaptive grief needs to be taken into account while creating a recovery program, as well as addressing the unique needs of school and community leadership. Finally, this presentation will highlight findings from previous school catastrophic events and lessons learned that should be considered to meet the longer-term needs for schools impacted by school violence.

NO. 4: POLICY RESPONSE AT THE STATE AND FEDERAL LEVEL: STATUTES, COMMISSIONS AND THE NATIONAL DIALOGUE ON MENTAL HEALTH

Speaker: Harold I. Schwartz, M.D.

SUMMARY: The wake of the Sandy Hook disaster reverberated throughout the nation. The Connecticut legislature, along with legislatures in New York and Colorado, rapidly enacted new laws on gun control, school safety and mental health, including some of the most stringent gun control regulations in the nation. The Connecticut and New York statutes include controversial patient reporting requirements opposed by most in the psychiatric community. Connecticut's Governor Daniel Malloy established the Sandy Hook Advisory Commission which was charged with reporting out far reaching recommendations for the future of mental health services, gun control and school safety. At the national level, President Obama called for a "national dialogue on mental health" as part of a national action plan which emphasizes the closure of gun background check loopholes, banning military style assault weapons and magazines, making schools safer and increasing access to mental health services. Interventions are targeted on the young (16-25) and focus on early detection and intervention through programs such a Mental Health First Aid.
EDUCATIONAL OBJECTIVE: At the conclusion of the session, the participant should be able to: 1) Understand the development of “measures” and their importance in quality improvement initiatives; 2) Identify 5 of the measures in the Physician Consortium on Performance Improvement “Major Depressive Disorder Measure Set”; 3) Recognize the major elements in the Fukushima Nuclear Disaster Stress Relief Project; 4) Understand core features of quality improvement initiatives in low resource countries; 5) Recognize general principles in the reduction of mental health care disparities.

SUMMARY: This symposium is a joint submission by WPA Section on Quality Assurance and APA Workgroup on International Psychiatrists.

Over the past decade there have been major initiatives in many countries focusing on improving the quality of medical care. A major stimulus for these efforts was the 2001 Institute of Medicine landmark study “Crossing the Chasm: A New Health System for the 21st Century”. This symposium will include presentations on recent Quality Improvement initiatives in three high resource countries (Germany, Japan and the United States.) The presentation on initiatives in Germany will discuss the efforts to establish a national common framework of standardized quality measures that address both processes and outcomes of mental health care. The presentation from Japan focuses on the impact of a nuclear disaster and what can be done to decrease the mental health outcomes on a population. Learning from the experiences in the Chernobyl disaster, the Fukushima Nuclear Disaster Stress Relief Project has been developed. The presentation will describe the four pronged project and preliminary results of the project. The presentation from the United States focuses on the AMA convened Physician Consortium on Performance Improvement (PCPI), a leading developer of measures to advance quality improvement efforts. The work of PCPI generally and one of PCPI’s recent measurement sets – on Major Depressive Disorder will be discussed. In addition there will be two additional presentations, one on Quality Improvement efforts in Low and Lower Middle Income Countries and the final presentation on initiatives to provide culturally and linguistically competent mental health care and decrease health care disparities.

NO. 1: GUIDELINES, QUALITY INDICATORS, QUALITY MANAGEMENT: REGULATIONS AND RESULTS FROM GERMANY

Speaker: Wolfgang Gaebel, M.D., Ph.D.

SUMMARY: The German mental healthcare system is currently undergoing discussions regarding the assessment of mental healthcare quality and the identification of potentials for improvement. Internal and external quality management procedures and quality assurance initiatives play an important role in the optimization of mental healthcare in Germany. In numerous national and regional initiatives, evidence-based quality instruments and measures are being developed, including clinical practice guidelines, quality indicators and instruments for measuring patient satisfaction. One of the main challenges is the implementation and evaluation of quality measures as well as the establishment of a common framework of standardized quality measures that address both processes and outcomes of mental healthcare. This presentation will describe current initiatives and initial results of quality indicator evaluations in mental healthcare in Germany.

NO. 2: FUKUSHIMA PROJECT: NUCLEAR DISASTER STRESS RELIEF

Speaker: Tsuyoshi Akiyama, M.D., Ph.D.

SUMMARY: Evelyn Bromet reported that mental health is a leading cause of disability, physical morbidity and mortality as consequence of Chernobyl disaster. In order to prevent the health damage in Fukushima, we are planning to carry out Fukushima Project Nuclear Disaster Stress Relief Project as follows;

1. Parent child play and peer discussion
   - Young mothers play with their children and exchange peer discussion with other mothers. The purpose is to reactivate the contacts between mothers and children and to enhance peer support and self-affirmation among the mothers.

2. Focus group with public health nurse
   - The purpose is to gather information on the experience of the public health nurse in providing care to the residents and to formulate it into a useful material.

3. Outside of the Wire care
The purpose is to enhance peer emotional support among the public health nurse and young mothers, utilizing Outside of the Wire method. This method comprises dramatic theater reading and following discussion and has been used for various mental health support purposes in the States.

4. Lecture and discussion with residents
   A combination of lecture on general health topics and small group discussion after the lecture will be provided. The purpose of small group discussion is to assist the residents to assimilate the lecture contents.

The project team is composed of experts in Fukushima, Tokyo and New York.

NO. 3: PHYSICIAN CONSORTIUM ON PERFORMANCE IMPROVEMENT (PCPI) AND MAJOR DEPRESSIVE DISORDER MEASURE SET

Speaker: John S. McIntyre, M.D.

SUMMARY: The American Psychiatric Association has been a leader in the development of practice guidelines for the treatment of mental illnesses. A major challenge for all developers of guidelines is the implementation stage—assisting physicians and systems of care in actually using the guidelines in daily practice. A major step in the implementation phase is the development of measures from the guidelines. The Physician Consortium on Performance Improvement (PCPI) is a national physician-led initiative in the U.S. dedicated to improving patient health and safety. The PCPI develops, tests, implements, and disseminates measures that reflect best practices in medicine. This presentation will highlight some of the work and products of PCPI which has been functioning for over a decade. In particular one of the measurement sets on Major Depressive Disorder (MDD) will be reviewed. This set, approved in February 2013, contains 10 measures with an aim to improve outcomes for patients with MDD. These measures include screening, evaluation, suicide risk assessment, appraisal for alcohol or drug abuse, antidepressant medication management, patient education, follow up care and coordination of care of patients with co-morbid conditions. The measures, their use and the impact of their use will be reviewed.

NO. 4: QUALITY IMPROVEMENT IN LOW AND LOWER MIDDLE INCOME COUNTRIES

Speaker: Jagannathan Srinivasaraghavan, M.D.

SUMMARY: World Bank defines countries by their Gross National Income per capita level. In the Low income countries it is less than $1005 and in Lower Middle income countries it ranges $1006 to $3975. These countries share common problems such as low health care budget, even lower mental health care budget, lack of infrastructure and trained mental health professionals. Further in many of these countries, many traditional healers practice other forms of medicine. With that background, this paper articulates a vision to improve the quality of care in a stepwise fashion by defining core features to deliver initially. The role of psychiatrists has to be expanded in training new generation of mental health practitioners including nurses, graduate students, community workers and teachers, emphasizing teaching methods in specialty training in research methods and community program development, supervision of mental health workers and advocating for mental health and stigma reduction. The World Psychiatric Association can encourage the teaching of a mandatory course on mental health in undergraduate medical education and with the help of high income countries make it possible for tele-psychiatry consultations from tertiary care centers.

NO. 5: PATIENT-CENTERED AND EQUITABLE HEALTH CARE AS QUALITY INDICATORS: APPLICATIONS FOR MENTAL HEALTH

Speaker: Francis Lu, M.D.

SUMMARY: In the 2001 Institute of Medicine landmark study “Crossing the Quality Chasm: A New Health System for the 21st Century,” patient-centered and equitable health care were defined as two of the six principles of quality health care. This presentation will first review how these fundamental concepts have evolved toward synergism and have been applied to healthcare organizations both at the system and clinical levels. Specifically, this presentation will review the 2013 US Dept of Health and Human Services Office of Minority Health “National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care” (the “National CLAS Standards”), which is intended to advance health equity by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Also, this presentation will review the Joint Commission’s 2010 “Advancing Effective Communication, Cultural Competence, and Patient-and Family-Centered Care” monograph. Secondly, the presentation will show how these quality principles have been applied in mental health with the focus on reducing mental health disparities and providing culturally and linguistically competent mental health care. The DSM-5 Outline for Cultural Formulation and the DSM-5 Cultural Formulation Interview will be reviewed as specific clinical tools. Finally, the presentation will discuss some possible new directions for further development in this area.
SYMPOSIA 53 | BUILDING A COMMUNITY MENTAL HEALTH RESPONSE TO TRAGEDY: LESSONS FROM NEWTOWN

Chair: John Woodall, M.D.

EDUCATIONAL OBJECTIVE: At the conclusion of the session, the participant should be able to: 1) Recognize the scope and complexity of the major personal, familial, community and institutional psychological pressures that are released in the complex phenomena of a communal tragedy; 2) Appreciate the complex issues involved in prioritizing the key clinical and administrative tasks required to mount a sustainable community response to a communal tragedy; 3) Contrast the distinguishing features between a traditional mental health community trauma response and a resilience-building response to crisis.

SUMMARY: A tragedy like that which occurred in Newtown, CT poses extreme challenges to an already burdened mental health system. Identifying the key psychological needs and coordinating a meaningful response through the immediate crisis, the stabilization phase and long term are daunting tasks in the extreme. This symposium looks at the challenging psychological issues involved in personal, familial and community grief and trauma, as well as the complex issues involved in coordinating helpers with different theoretical assumptions and training and from various individual, local, state, federal and not-for-profit initiatives. Achieving mental health goals through non-clinical means by mobilizing established community resources becomes an important part of a sustainable resilient response over time. Lessons learned from Newtown will be shared by clinicians most directly involved with providing services to the community since the tragic shooting.

NO. 1: CHAIRMAN, DEPARTMENT OF PSYCHIATRY, DANBURY HOSPITAL

Speaker: Charles Herrick, M.D.

SUMMARY: Coordinating an immediate and long term response is fraught with many obstacles from an organizational standpoint. Sandy Hook prompted a response simultaneously from multiple local, state and national agencies making coordination of services challenging. These agencies included not only mental health agencies but also local and state private providers, organizations such as the Connecticut Psychiatric Society, the APA, and other professional organizations, as well as national mental health experts from major academic and federal institutions such as Harvard, Yale, the FBI and Homeland Security. Additionally, providing immediate psychological first aid required the location of an adequate venue, as well as the linking up with city and school district officials. Finally, building capacity to meet the long-term community needs is an ongoing task. Coordinating these agencies into an organized and coherent structure was the primary goal and community hospitals are in the best position from the standpoint of their central location, ED services and access to communications and linkage with local and State providers.

NO. 2: ACHIEVING MENTAL HEALTH GOALS THROUGH NON-CLINICAL MEANS: BUILDING A COMMUNITY-WIDE RESILIENT RESPONSE TO THE NEWTOWN TRAGEDY

Speaker: John Woodall, M.D.

SUMMARY: The mental health model and the system that supports it are neither theoretically nor institutionally suited to deal with the aftermath of severe and widespread community trauma. While proper training, referral to and coordination of mental health resources are essential parts of a response to a communal tragedy, they are nowhere near sufficient to meet the flood of human needs after a severe communal crisis given the paucity of resources and slowness of the system in dealing with even current loads. To meet this wide-spread need, a different model of approach is needed to augment and complement the essential clinical interventions. To achieve mental health goals a resiliency theoretical approach focuses on reducing risk and strengthening personal, familial and community assets instead of a symptom reduction model. Innovative examples of how this is being approached in Newtown will be shared to inform future tragic situations.

NO. 3: THE CLINICAL COMMUNITY’S IMMEDIATE RESPONSE TO THE NEWTOWN TRAGEDY

Speaker: Irvin Jennings, M.Med.

SUMMARY: In the hours following the morning of December 14, 2012, clinicians in all parts of Connecticut as well as from states near and far sought a way to help. Three local mental health agencies were able with the cooperation of the Newtown school administration to establish a walk-in clinic for any person needing counseling in a local, easily accessible location by early Friday evening. Less than 24 hours after the shooting, scores of clinicians arrived at the Reed Intermediate School to help large numbers of Newtown citizens seeing help. This is to share the experiences of all those impacted by this effort over the following four months.

Compiled by the APA Committee on Psychiatric Dimensions of Disaster
NO. 4: CREATING A SCHOOL-BASED RECOVERY PROGRAM AFTER CATASTROPHIC VIOLENCE

Speaker: Melissa Brymer, Ph.D., Psy.D.

SUMMARY: This presentation will highlight the steps taken in Newtown public schools to create a long-term school-based recovery program after the catastrophic shooting in December 12, 2012. Dr. Brymer will discuss the initial assessment that informed the key elements of the recovery program including: establishing a district-wide program to address the overall impact on this small community; identifying developmentally-appropriate trauma and grief evidence-based interventions and services; creating structures to handle the outpouring of assistance from outside individuals and families; and coordinating with community, state, and federal partners. She will mention the key accomplishments of the program, highlight the role social media played in the recovery, and how they addressed the numerous secondary adversities that impacted this community. Finally, lessons learned will be noted with an emphasis on what psychiatrists need to consider when working in communities after mass violence.

NO. 5: RESPONDING TO NEWTOWN: CHALLENGES TO PROVIDING EVIDENCE-BASED EARLY INTERVENTION AND LONGER TERM TRAUMA CARE

Speaker: Steven Marans, M.S.W., Ph.D.

SUMMARY: In the wake of the tragedy in Newtown, there was an outpouring of support from local, regional and national mental health providers. However, too few of these providers had experience or training in evidence-based trauma-focused treatment and too few were to remain available to the community over the long haul. The response of the Yale Trauma and Recovery Program was to provide support, consultation and training to local mental health and primary health care providers as well as direct clinical care and engagement in the Sandy Hook elementary school. This presentation will review those activities and review principles that informed Yale Trauma and Recovery Program efforts to enhance local capacity and to help develop continuity of care at the local level from acute to peri-traumatic to long-term phases of post-event reactions.

SYMPOSIA 94 | PSYCHIATRISTS WORKING ON THE GLOBAL STAGE

Chair: Vivian B. Pender, M.D.
Discussant: Pedro Ruiz, M.D.

EDUCATIONAL OBJECTIVE: At the conclusion of the session, the participant should be able to: 1) Diagnose and treat psychiatric disorders when working in a field experience outside of the ordinary practice setting; 2) Identify caveats and personal motivations for working temporarily as a psychiatrist in another country; 3) Advise and teach medical students who seek to create clinics that provide psychiatric evaluations for torture survivors who are seeking asylum in the United States; 4) Learn how to get involved with the non-governmental organizations that advocate for psychiatry at the United Nations; 5) Treat individuals and families traumatized by political violence and disasters.

SUMMARY: This Symposium will explore international working experiences for psychiatrists. Three psychiatrists will present lessons learned from practicing in Haiti, Burundi and Tanzania. Haiti had a catastrophic earthquake in 2010 resulting in severe loss of life and disruption of the country’s resources. Burundi underwent years of political violence and conflict, seriously traumatizing their population. Tanzania has been a stable country but without adequate health care. The country accepts U.S. medical students and residents who spend a month in their hospitals and clinics. One psychiatrist has worked in a non-governmental capacity at the United Nations and will share her experience. One psychiatrist advises a medical student clinic that evaluates and treats torture survivors. Efforts of these psychiatrists to diagnose, treat, and advocate for psychiatric patients will be presented.

NO. 1: “DO ONE AND TEACH ONE”: USING INNOVATIVE PROGRAM DESIGN TO CREATE A HUMAN RIGHTS CLINIC FOR ASYLUM SEEKERS

Speaker: Joanne Ahola, M.D.

SUMMARY: Joanne Ahola, M.D., will discuss multiplying your effectiveness in providing pro bono psychiatric evaluations for torture survivors seeking political asylum in the U.S. by creating medical student clinics where attending clinicians can simultaneously provide evaluations and teach medical students to do this critically important work. Such a clinic can be started at no financial cost, using trained
volunteer students and faculty, borrowed space, technology and partnerships with non-profit organizations. Weill Cornell Medical College has the first such clinic, but several other medical schools have begun sister clinics, and all provide exciting and rewarding clinical experiences: global health at home.

NO. 2: INTERNATIONAL PSYCHIATRY: LESSONS FROM TANZANIA

Speaker: John W. Barnhill, M.D.

SUMMARY: Increasing numbers of medical students, psychiatry residents, and psychiatric faculty are working internationally for relatively brief amounts of time. These experiences can be transformative for the participant and very helpful to the host community. This paper will focus on ways in which the visiting clinician can be effective and also the ways in which the experience can prove to be suboptimal for all concerned.

NO. 3: EXPERIENCE OF PRACTICING PSYCHIATRY IN A HAITIAN TRAUMA HOSPITAL

Speaker: Joseph Carmody, M.D.

SUMMARY: This talk will focus on the description of experiences and lessons learned in the practice of psychiatry in a Haitian Trauma Hospital. Topics will include a discussion of the cultural, ethical, and clinical questions that I encountered as the first psychiatrist to work as such a clinic.

NO. 4: CHAIRING THE NGO COMMITTEE ON THE STATUS OF WOMEN AT THE UNITED NATIONS

Speaker: Vivian B. Pender, M.D.

SUMMARY: The NGO Committee on the Status of Women was established in 1972 and today has members representing over 80 international and national NGOs in Consultative Status with the United Nations. The mandate is to foster dialogues between NGOs and Member States concerning issues that are being discussed that impact the rights and well-being of women and girls. As Chair of the NGO CSW, Vivian Pender was able to advocate for the mental health of women and girls with Member states of the UN Commission on the Status of Women.

NO. 5: COLLECTIVE TRAUMA

Speaker: Jack Saul, Ph.D.

SUMMARY: Political violence and disasters confer significant mental health vulnerability to individuals, families and communities. Mental health and health professionals working in response to large scale political violence or natural disaster are starting to play a larger role on the global stage in various ways. During this symposium, the speakers will discuss specific case studies on how to address mental health issues from a community and systems perspective.

Jack Saul PhD will present narratives from his book ‘Collective Trauma, Collective Healing: Promoting Community Resilience in the Aftermath of Disaster’ and discuss the idea of a collective approach to trauma with a specific focus on resilience and coping within families and communities at large.

NO. 6: COMMUNITY RESPONSES TO MENTAL HEALTH IN BURUNDI AND BEYOND: A COLLECTIVE APPROACH TO TRAUMA

Speaker: Sonali Sharma, M.D.

SUMMARY: Political violence and disasters confer significant mental health vulnerability to individuals, families and communities. Mental health and health professionals working in response to large scale political violence or natural disaster are starting to play a larger role on
the global stage in various ways. During this symposium, the speakers will discuss specific case studies on how to address mental health issues from a community and systems perspective.

Sonali Sharma MD MSc will present a framework for strengthening mental health care in post-conflict settings focused on the integration of mental health into primary care and a qualitative research component which formed a basis for operational work.

**SYMPOSIAS 97 | VICARIOUS TRAUMA IN CATASTROPHIC EVENTS: FROM THE PERSPECTIVE OF MENTAL HEALTH PROVIDERS AT VARIOUS PHASES OF A DISASTER**

Chair: Gertie Quitangon, M.D.
Discussant: Charles Figley, Ph.D.

**EDUCATIONAL OBJECTIVE:** At the conclusion of the session, the participant should be able to: 1) Increase understanding of Vicarious Trauma and related concepts in the setting of large scale disasters; 2) Recognize disaster stage-specific strategies and interventions to prevent Vicarious Trauma and promote resilience in mental health clinicians on an individual and organizational level; 3) Identify opportunities for further empirical validation of Vicarious Trauma in the context of massive disasters to inform best practices and shape policy and programs in disaster planning.

**SUMMARY:** Floods, hurricanes, tornadoes, acts of terrorism and other large-scale catastrophic events have increased in the last decade and emergency preparedness and disaster resilience have become a national imperative. Mental health professionals play many important roles in helping communities prepare and respond to disasters. What happens when mental health providers share the trauma and vulnerability from the toll taken by a disaster with the victims they care for? How can clinicians increase resilience during various phases of a disaster and provide mental health services effectively?

**NO. 1: HURRICANE KATRINA: A PHYSICIAN’S WHIRLWIND COURSE IN DISASTER PSYCHIATRY**

**Speaker:** Shane S. Spicer, M.D.

**SUMMARY:** This article chronicles one mental health provider’s experiences during Hurricane Katrina and the immediate aftermath. The author talks about surviving the storm; opening a make-shift clinic in a hotel restaurant to help people with mental disorders and anxiety, as well as physical symptoms; and dealing with the chaos and the decline of social order.

**NO. 2: THE AFTERMATH OF 9/11 VIEWED THROUGH THE LENS OF A PSYCHIATRIST IN TRAINING AT ST. VINCENT’S HOSPITAL**

**Speaker:** Jeremy Winell, M.D.

**SUMMARY:** A psychiatrist will transport the audience back to a dark time and draw insight from the vantage point of a PGY3 resident in a teaching hospital most proximal to the towers that fell on 9/11. From staffing the Family Crisis Center to running group psychotherapy for New York City firefighters, evaluating children and teens schooled near Ground Zero, and witnessing the awestruck response of friends, colleagues, teachers, and mentors in the mental health community. What happens during an unprecedented act of terror where the clinicians themselves are traumatized?

**NO. 3: WITNESSING THE IMPACT OF PROVIDING DISASTER BEHAVIORAL HEALTH SERVICES IN THE COMMUNITY**

**Speaker:** April J. Naturale, Ph.D.

**SUMMARY:** Disaster Behavioral Health is an emerging discipline that is being informed rapidly with the increase in both natural events and incidents of mass violence over the past decade in the US as well as globally. Mental health providers, substance counselors, faith-based workers and other community volunteers are being called for multiple and longer term disaster mental health deployments than ever before even though they are disaster survivors themselves. While mental health and public health professionals comprise the largest percentage of this group, many students and community workers become immediately involved. The presenter will illustrate the impact of providing disaster behavior health services during large scale disasters including the terrorist attacks of 9/11, the Newtown school shooting, the Boston Marathon bombing alongside natural disasters, including Hurricane Katrina, the Joplin tornado and the huge spate of additional tornados that tore through the Southern section of the US in 2011.
NO. 4: VICARIOUS TRAUMA AND DISASTER RESPONSE TO SANDY: THE NYU WORLD TRADE CENTER HEALTH PROGRAM RESPONSE

Speaker: Mark Evces, Ph.D.

SUMMARY: A psychologist will discuss his experience of being dislocated from the NYU World Trade Center Mental Health Clinic for several months following Hurricane Sandy. Clinic offices became inaccessible due to flooding, and mental health staff were relocated to a temporary office. Patients were reachable by phone only as no clinic space was available until clinic facilities at Bellevue Hospital could be repaired. The presenter will discuss effects of being unexpectedly prevented from seeing patients face to face, and the experience of providing support to 9/11 first responders during Sandy, many of whom experienced retraumatization during and following the storm. The presenter will discuss the interaction between feeling impacted by the storm and supporting patients who were also impacted. These experiences will be described using the construct of vicarious trauma: shifts in emotions, thoughts and behaviors resulting from indirect exposure to trauma via empathic engagement with patients’ traumatic material.

WORKSHOP 33 | SURVIVING SANDY: A PERSPECTIVE OF HURRICANE SANDY FROM THE VIEWPOINT OF PSYCHIATRY RESIDENTS AT METROPOLITAN HOSPITAL CENTER, NEW YORK CITY

Chairs: Joshua R. Ackerman, M.A., M.D., Cliff S. Hamilton, M.D.
Speaker: Peter Kakatsos, M.D.

EDUCATIONAL OBJECTIVE: At the conclusion of the session, the participant should be able to: 1) Discuss the general impact of Hurricane Sandy on Metropolitan Hospital Center (ability to provide care, facilities, personnel); 2) Describe the acute requirements of psychiatric chief residents as a result of the storm in terms of staffing, safety, and service; 3) Discuss the unique circumstances caused by the closures of NYU/Bellevue Hospitals and the impact this had on Psychiatric residents at Metropolitan Hospital (patient volume, new staff); 4) Analyze what was learned and how this experience impacted the psychiatric residents.

SUMMARY: As a result of Hurricane Sandy in Oct 2012, the NYC healthcare system was stretched to its limits. As major hospitals (NYU/Bellevue) suffered catastrophic facility failures, Metropolitan Hospital in Spanish Harlem remained open during the storm. In the days, weeks, and months following the hurricane, Metropolitan Hospital provided ongoing care for the displaced psychiatric patients as well as physicians/ support staff. This required a massive coordination between HHC hospitals, administration, and individual staff members. Specifically, our workshop will focus upon the challenges faced by the residents of the Department of Psychiatry at Metropolitan Hospital Center. Every aspect of the mental services provided by this group was affected; outpatient, inpatient, and psychiatric ER. The immediate increase in volume of patients in need of care seemed to be an insurmountable task. Add to this the absorption of psychiatrists, psychiatric residents, and support staff from the closed hospitals and the full spectrum of the challenge can be appreciated. Also included during the workshop will be photographic documentation recorded by residents at Metropolitan Hospital illustrating the storm as well as its aftermath.

Participating in this workshop will be the Director of The Department of Psychiatry, the Director of the Psychiatry Residency Program, and the 4 Chief Residents on duty during the storm. They will provide a detailed description as well as a focused discussion of the unique requirements faced by the psychiatry residents.

WORKSHOP 56 | PTSD OPEN FORUMWORKSHOPS

Chairs: Gary H. Wynn, M.D., David M. Benedek, M.D.

EDUCATIONAL OBJECTIVE: At the conclusion of the session, the participant should be able to: 1) Discuss the basic aspects of PTSD both within the military and veteran context as well as among other populations (e.g. natural disaster survivors) who suffer from PTSD; 2) Discuss the ways in which PTSD impacts various groups and the possible ways that management of PTSD may vary within these groups; 3) Understand those practices discussed within the session that have relevance to a provider’s clinical practice and develop a means of implement such practices.

SUMMARY: This session is based on the text “Clinical Manual for Management of PTSD” from American Psychiatric Publishing, Inc. and is intended to give participants the opportunity to hear a brief discussion from the editors (Drs. Benedek and Wynn) about PTSD as well as their experience putting together the text. The majority of the session will be dedicated to taking questions and facilitating discussion of topics of interest to the audience, including but not limited to pharmacology, psychotherapy, CAM treatments, and interacting with PTSD patients. Please come prepared with questions and ready to participate in the discussion regarding this timely topic.
WORKSHOP 72 | SPECIAL PSYCHIATRIC RAPID INTERVENTION TEAM (SPRINT) AND THE ART OF DISASTER PSYCHIATRY IN THE NAVY

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Jeffrey Millegan, M.D., M.P.H.
Speakers: Jeffrey Millegan, M.D., M.P.H., William Sauve, M.D.

EDUCATIONAL OBJECTIVE: At the conclusion of the session, the participant should be able to: 1) Understand Psychological First Aid as a framework for a disaster mental health response; 2) Understand the challenge of adapting the mental health response to the unique aspects of a particular disaster; 3) Be familiar with practical lessons learned in the field to increase the effectiveness of the response.

SUMMARY: The special psychiatric rapid intervention team (sprint) is a rapid response multidisciplinary team of mental health professionals and chaplains in the navy who provide short-term mental health and emotional support prior to and immediately after a disaster with the goal of preventing long-term medical psychiatric dysfunction or disability. The response provided is based on the Hippocratic principle of “first, do no harm” and has its foundation in the principles of psychological first aid. The team has the ability to mobilize in response to a disaster anywhere in the world within eight hours of being requested. The principle challenges for the team are to, first, quickly tailor a response to the particular trauma and people affected, and second, to find a way to rapidly gain rapport and the trust of the affected community. Gaining the confidence of leaders and local support personnel is critical. Given the short duration of a sprint mission, every effort should be made to empower the community to aid in its own recovery. By keeping communications open with the community after the immediate mission, sprint is able to continue to support the recovery into the future. The sprint model of mental health disaster response is illustrated in a real world case study.

WORKSHOP 154 | LESSONS LEARNED: THE IMPACT OF HURRICANE SANDY ON THE ORGANIZATIONAL DYNAMICS OF A RESIDENCY TRAINING PROGRAM AND A MULTI-HOSPITAL SYSTEM

Chairs: Jennifer L. Goldman, M.D., Carol A. Bernstein, M.D.
Speakers: Kerry J. Sulkowicz, M.D., Elizabeth S. Albertini, M.D., Meredith Bergman, M.D., Megan Borkon, M.D.

EDUCATIONAL OBJECTIVE: At the conclusion of the session, the participant should be able to: 1) Discuss the ramifications a natural disaster like Hurricane Sandy had on the psychiatric care of patients in private, state and federal health care centers; 2) Discuss the impact of Hurricane Sandy on a residency training program as well as the effect on residency and hospital leadership; 3) Share recommendations with other hospitals, residency programs and clinics on how best to prepare or respond to such a crisis; 4) Create an opportunity for an open dialogue amongst other psychiatric and medical institutions, programs or clinics that were faced with natural disasters or other overwhelming crises.

SUMMARY: Hurricane Sandy touched down October 29th, 2013 and not only took lives but also devastated NYC infrastructure for weeks and months to follow. This included the closure of several New York City hospitals and outpatient clinics which supply care to thousands of patients.

As especially vulnerable members of society, psychiatric patients were greatly affected by the storm as both their personal lives were interrupted and as they were unable to obtain mental health services in lower Manhattan. Care was funneled to other city hospitals, most of who were overwhelmed by the demand, and patients were left stranded without resources or information on how to access treatment.

The NYU psychiatry residency program supplies most of major mental health services in lower Manhattan, encompassing Bellevue Hospital, NYU Langone Medical Center, the Manhattan VA and outpatient offices in midtown. This is a vast infrastructure of public, private and military mental health treatment.

This workshop will provide a summary of how the leadership of the NYU residency program dealt with this crisis, and the experience of the residents who were personally and professionally affected. Additionally, we will share the steps that were taken to allow residents to continue to provide excellent psychiatric care to a traumatized community.

As this is an interactive platform for sharing, we welcome stories and feedback from APA members regarding crises that their organizations have suffered.

Through this, we hope to provide ideas and suggestions for residency programs on how to survive future organizational traumas. This workshop will also highlight areas of improvement on how mental health care might be better served in times of crisis.
WORKSHOP 156 | PLANNING BEYOND SURVIVAL: RESTORING PSYCHIATRIC SERVICES IN LONG ISLAND AFTER A DISASTER (ONE-YEAR UPDATE FOLLOWING HURRICANE SANDY)

Chairs: Damir Huremovic, M.D., M.P.P., Nyapati R. Rao, M.D., M.S.
Speakers: Lisa Jacobson, M.S.W., Rajvee Vora, M.D., M.S., Ronke L Babalola, M.D.

EDUCATIONAL OBJECTIVE: At the conclusion of the session, the participant should be able to: 1) Identify the challenges mental health agencies faced during preparation and in the aftermath of a major hurricane-force storm in NY; 2) Understand how to identify and utilize the local and federal resources available to health providers following a major disaster; 3) Understand the need for coordinated response planning to ensure adequate mental health care services after a disaster; 4) Develop strategies for a coordinated mental health care response and for sustained recovery strategy planning in a disaster affected area.

SUMMARY: Unlike some natural disasters (e.g. earthquakes), hurricane-force storms have a unique feature of being forecast, giving the communities in their path limited, but crucial time to prepare. During this little lead time, that often barely allows only for evacuation, mental health care agencies and providers must make difficult professional and personal choices about how to weather the storm and how to continue to operate and provide services in its aftermath.

Contingency plans for such events mostly deal with preserving assets for continued and uninterrupted provision of services. Most of such plans also contain provisions for addressing a spike in disaster-related emotional distress in the population. What is often overlooked when preparing for such events, however, is that storms of such magnitude change the landscape of the mental health services as much as they change the physical landscape of the affected area. If such catastrophic magnitude storms tend to repeat at more or less regular intervals, then learning lessons from the experience of others becomes a worthwhile endeavor for mental health professionals from certain regions.

Having survived the storm, mental health agencies and providers find themselves multitasking at different levels: providing for own inpatients while caring for patients evacuated from other facilities, reconnecting with own outpatients while attending to never-before-seen patients who now cannot reach their own providers, coordinating assistance with local, state, and federal disaster management agencies while personnel’s own homes are in dark, flooded, or completely destroyed.

A remarkable part of recovery after a major disaster is the task of re-mapping and reestablishing the fabric of community mental health services, a challenge that cannot be addressed by a single agency or provider. A portion of precious time communities have to prepare for an impact of a major storm that is spent on coordinating care can be leveraged enormously in the aftermath of the disaster.

This workshop reviews the challenges and adversities that a pivotal Long Island mental health facility – Nassau University Medical Center, faced during Sandy, a hurricane-force storm affecting the metro NYC area in the Fall of 2012. Leadership of the Department of Psychiatry provides a personal account of own experiences as well as analysis of what was done well through preparations and in the aftermath and what could have been done better. A special consideration will be given to the aspect of coordinating response with and relying on assistance from local, state, and federal agencies (e.g. FEMA, PHS, and Disaster Area Management Teams). Also underscored and charted is the progress in sustained recovery at one-year mark following the storm.

Ample time will be allowed for questions and answers and for interaction with participants.