Preparedness for Children's Mental Health Needs in a Disaster

Pediatric Patients:
Bridging the Readiness Gaps

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Preparedness for the Expected Psychological Toll of Disasters on Children

Scope of Disaster Impact on Children Worldwide

Although it is difficult to gain exact numbers, aid organizations, governments, NGOs have attempted to quantify the impact of worldwide conflict and disaster upon children.
Some experts and data sources estimate that 40 MILLION children have been impacted over just the last few years

Recent Analysis by Developmental/Behavioral Pediatricians at Case Western and U. of Maryland

Overview of Children and Disasters

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ABSTRACT: Currently, throughout the world, there are nearly 40 million children displaced by natural or man-made disasters. The special needs of children in disasters are often unrecognized, yet children comprise half of disaster victims. The purpose of this review is to provide information on (1) demographics related to children and disasters, both domestic and international; (2) risks for children who experience disasters; (3) programs that help children in disasters; and (4) training programs on the special needs of children in disasters. Children who are displaced by disasters are at risk of acute and long-term medical problems. Disaster experiences can also lead to acute and long-term psychological problems. Ultimately, these have worldwide negative implications for human society, including education, health care, security, and economic and political aspects of daily life. There is a compelling need for more services to help the children who have experienced disasters and for education to train more relief workers about the special needs of children in disasters.

(*J Dev Behav Pediatr* 39:652-662, 2018) **Index terms:** children and disasters, humanitarian emergencies, child trauma.

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Recent Disasters Worldwide Involving Children…Scope

Afghanistan – since 1978 – 5.4 MILLION children impacted

Nepal – April 2015- earthquake – 3.2 MILLION children impacted

Yemen –since 2105 – Conflict- 9.6 MILLION children impacted

Table 2. Estimated Number of Children Affected by Recent Disasters

Country	Date	Event	Affected Children
Afghanistan	Chronic instability since 1978	Complex humanitarian emergency	5.4 million in July 2016[14]
border of the United States)	increase) between 2013 and 2014	emergency	children crossing the southwest US border from October 1, 2013, to September 30, 2014; 59,692 from October 1, 2015, to September 30, 2016[15]
Democratic Republic of Congo	Chronic instability since 1996	Complex humanitarian emergency	4.4 million[16]
Iraq	2014 to present	Complex humanitarian emergency	5.1 million[17]
Myanmar/Bangladesh	Chronic but escalating since August 2017: conflict and instability in neighboring countries, particularly Myanmar (Burma) refugees fleeing to Bangladesh	Complex humanitarian emergency	Numbers changing rapidly—at the time of this publication: 860,000 Rohingya refugees in Cox's Bazar, of whom 646,000 have arrived since August 25, 2017, with more than 336,000 Rohingya
Nepal	April 25, 2015	Natural disaster—earthquake	3.2 million[20]
Pakistan	1980s to present	Conflict in Afghanistan	800,000 birth certificates issued to Afghan refugees[21]
Philippines	November 8, 2013	Natural disaster—Typhoon Haiyan	7.4 million[22]
South Sudan	2013 to present, with renewed conflict since July 2016	Complex humanitarian emergency	4.3 million[23]
Syria	March 2011 to present	Complex humanitarian	6 million in Syria; outside the children[24]
West Africa	December 2013 to March 2016	Biological disaster—Ebola virus epidemic	17,300 children have lost 1 or both parents to Ebola[25]
Yemen	Intensified in 2015; continues to present	Complex humanitarian emergency	9.6 million[26]

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Disaster Psychological Impacts…Are they "Dose Dependent?"

Mass casualty incidents (MCIs) are an increasing component of life in the 21st century. Children (persons under the age of 18 years) represent 25% of the United States total population. Whether children are the specific target, an innocent bystander or simply members of a devastated community, emergency responders must be aware of their unique needs. Healthcare Coalitions and their participating hospitals must be prepared to respond to the special medical, surgical, psychological and social needs of children during a MCI that includes children.

Pediatricians and Other Healthcare Providers are often "First Responders" Supporting Psychological Health

In the aftermath of a critical event that impacts children (especially a large group), there will not be an adequate number of mental health professionals and often others will be called upon to provide support, at least initially

-complaints likely to manifest as **physical ailments** or symptoms
-if **parents** are not coping well, difficult for child to cope
-champions for children should **encourage seeking psychological support,** realizing that some parents might view such referrals as stigmatizing

AMERICAN ACADEMY OF PEDIATRICS

PEDIATRIC DISASTER PREPAREDNESS AND RESPONSE

TOPICAL COLLECTION

CHAPTER 4: MENTAL HEALTH ISSUES

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American Academy of Pediatrics
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Table 4.1: Common Symptoms of Adjustment Reactions in Children after a Disaster or Act of Terrorism
Sleep problems: difficulty falling or staying asleep, frequent night awakenings or difficulty awakening in the morning, nightmares, or other sleep disruptions
increased eating
Sadness or depression: may result in a reluctance to engage in previously enjoyed activities or withdrawal from peers and adults
Anxiety, worries, or fears: children may be concerned about a repetition of the traumatic event (e become afraid during storms after surviving a tornado) or show an increase in unrelated ears (eg, become more fearful of the dark even if the disaster occurred during daylight his may present as se ation anxiety or school avoidance
Difficulties in concentration y to learn and retain new information or to otherwise progress academically
Substance abuse: the or exacerbation of al tobacco, or other substance use may be seen in ch adults after a disaste
Risk-taking b increased sexual beha r reactive risk-taking can occur, especially am er children and adol
Somatization: children with adjustm ies may present instead with physical symptoms suggesting a physical co
Developmental or social regression: children (and adults) may become less patient or tolerant of change or become irritable and disruptive
Post-traumatic reactions and disorders: see Table 2: Symptoms of Post-traumatic Stress Disorder)

Children and Post Traumatic Stress Disorder

- Child may have been a victim of the event or have witnessed
- After a month, if the child is still experiencing
  - Intrusive symptoms (nightmares, flashbacks, dissociation)
  - Avoidance of memories, reminders
  - Alterations of thinking or mood
  - Behavioral issues such as outbursts, exaggerated startle, can't concentrate

Children and Crisis Response

- Unfortunately, there is no perfect process to respond to disaster or crisis for all children
- There is not empirical data to recommend as efficacious Critical Incident Stress Management or Critical Incident Stress Debriefing- IN FACT, some experts feel these are not useful tools and may be detrimental
- Best if mental health early responders have training and ICS awareness

Basic Principles of Intervention

Child Development Principles

Collaborative Relationships with Community Providers

Assessed for Risk Factors and Symptoms

WORK WITH PARENTS

Prevent Social Disruption, Displacement

Who Can Deliver Psychological First Aid?

- Designed for those who would deliver mental health and other disaster response workers as part of ORGANIZED disaster response effort
- May be embedded in response units, ICSs, ED or PCPs, school crisis response, Community Emergency Response Teams (CERT), Medical Reserve Corps, etc.
- Appropriate in immediate aftermath

Strengths of PSA

- Evidence-informed strategies that can be used in several types of settings
- Emphasizes DEVELOPMENTALLY and CULTURALLY appropriate interventions
- Includes the use of materials for later recovery
- Assists in gathering basic information that can assess survivor's immediate concerns and needs

Psychological First Aid PFA

Field Operations Guide
2nd Edition

National Child Traumatic Stress Network

National Center for PTSD

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NCTSN The National Child Traumatic Stress Network

National Center for PTSD

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FOCUS

CONTACT and ENGAGEMENT

SAFETY and COMFORT

STABILIZATION (if needed)

Core Actions

Psychological First Aid Core Actions

1. **Contact and Engagement**
   Goal: To respond to contacts initiated by survivors, or to initiate contacts in a non-intrusive, compassionate, and helpful manner.
2. **Safety and Comfort**
   Goal: To enhance immediate and ongoing safety, and provide physical and emotional comfort.
3. **Stabilization** (if needed)
   Goal: To calm and orient emotionally overwhelmed or disoriented survivors.
4. **Information Gathering: Current Needs and Concerns**
   Goal: To identify immediate needs and concerns, gather additional information, and tailor Psychological First Aid interventions.
5. **Practical Assistance**
   Goal: To offer practical help to survivors in addressing immediate needs and concerns.
6. **Connection with Social Supports**
   Goal: To help establish brief or ongoing contacts with primary support persons and other sources of support, including family members, friends, and community helping resources.
7. **Information on Coping**
   Goal: To provide information about stress reactions and coping to reduce distress and promote adaptive functioning.
8. **Linkage with Collaborative Services**
   Goal: To link survivors with available services needed at the time or in the future.

These core actions of Psychological First Aid constitute the basic objectives of providing early assistance within days or weeks following an event. Providers should be flexible, and base the amount of time they spend on each core action on the survivors' specific needs and concerns.

Preparing to Deliver Psychological First Aid:

- Entering the Setting
- Providing Services
- Group Settings
- Maintain a Calm Presence
- Be Sensitive to Culture and Diversity
- Be Aware of At-Risk Populations

- Children, especially those:
  - Separated from parents/caregivers
  - Whose parents/caregivers, family members, or friends have died
  - Whose parents/caregivers were significantly injured or are missing
  - Involved in the foster care system

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local cultural groups.

Be Aware of At-Risk Populations

Individuals that are at special risk after a disaster include:

- Children, especially those:
  - Separated from parents/caregivers
  - Whose parents/caregivers, family members, or friends have died
  - Whose parents/caregivers were significantly injured or are missing
  - Involved in the foster care system
- Those who have been injured
- Those who have had multiple relocations and displacements
- Medically frail children and adults
- Those with serious mental illness
- Those with physical disability, illness, or sensory deficit
- Adolescents who may be risk-takers
- Adolescents and adults with substance abuse problems
- Pregnant women
- Mothers with babies and small children
- Disaster response personnel
- Those with significant loss of possessions (for example, home, pets, family memorabilia)
- Those exposed first hand to grotesque scenes or extreme life threat

1. Contact and Engagement

<u>Goal</u>: To respond to contacts initiated by survivors, or to initiate contacts in a non-intrusive, compassionate, and helpful manner.

Your first contact with a survivor is important. If managed in a respectful and compassionate way, you can establish an effective helping relationship and increase the person's receptiveness to further help. Your first priority should be to respond to survivors who seek you out. If a number of people approach you simultaneously, make contact with as many individuals as you can. Even a brief look of interest and calm concern can be grounding and helpful to people who are feeling overwhelmed or confused.

Culture Alert: The type of physical or personal contact considered appropriate may vary from person to person and across cultures and social groups, for example, how close to stand to someone, how much eye contact to make or whether or not to touch someone, especially someone of the opposite sex. Unless you are familiar with the culture of the survivor, you should not approach too closely, make prolonged eye contact, or touch. You should look for clues to a survivor's need for "personal space," and seek guidance about cultural norms from community cultural leaders who best understand local customs.
In working with family members, find out who is the spokesperson for the family and initially address this person.

2. Safety and Comfort

Goal: To enhance immediate and ongoing safety, and provide physical and emotional comfort.

Ensure Immediate Physical Safety

Make sure that individuals and families are physically safe to the extent possible. If necessary, reorganize the immediate environment to increase physical and emotional safety. For example:

- Find the appropriate officials who can resolve safety concerns that are beyond your control, such as threats, weapons, etc.
- Remove broken glass, sharp objects, furniture, spilled liquids, and other objects that could cause people to trip and fall.
- Make sure that children have a safe area in which to play and that they are adequately supervised.
- Be aware and ensure the safety of survivors in a particular subgroup that may be targeted for persecution based on their ethnicity, religion, or other affiliations.

Attend to Children Who Are Separated from their Parents/Caregivers

Parents and caregivers play a crucial role in children's sense of safety and security. If children are separated from their caregivers, helping them reconnect quickly is a high priority. If you encounter an unaccompanied child, ask for information (such as their name, parent/caregiver and sibling names, address, and school), and notify the

terms about who will be supervising them and what to expect next. Do not make any promises that you may not be able to keep, such as promising that they will see their caregiver soon. You may also need to support children while their caregivers are being located or during periods when caregivers may be overwhelmed and not emotionally accessible to their children. This support can include setting up a child-friendly space.

Set Up a Child-Friendly Space

- Help to create a designated child-friendly space, such as a corner or a room that is safe, out of high traffic areas, and away from rescue activities.
- Arrange for this space to be staffed by caregivers with experience and skill in working with children of different ages.
- Monitor who comes in and out of the child area to ensure that children do not leave with an unauthorized person.

Stabilization…attempting to manage in the moment

Stabilize Emotionally Overwhelmed Survivors - *continued*

For children or adolescents, consider:

- Is the child or adolescent with his/her parents? If so, briefly make sure that the adult is stable. Focus on empowering the parents in their role of calming their children. Do not take over for the parents, and avoid making any comments that may undermine their authority or ability to handle the situation. Let them know that you are available to assist in any way that they find helpful.
- If emotionally overwhelmed children or adolescents are separated from their parents, or if their parents are not coping well, refer below to the options for stabilizing distressed persons.

4. Information Gathering: Needs and Current Concerns

Goal: To identify immediate needs and concerns, gather additional information, and tailor Psychological First Aid interventions.

Nature and Severity of Experiences during the Disaster - *continued*

Provider Alert: In clarifying disaster-related traumatic experiences, avoid asking for in-depth descriptions that may provoke additional distress. Follow the survivor's lead in discussing what happened. Don't press survivors to disclose details of any trauma

and respectfully tell them that what would be most helpful now is to get some *basic* information so that you can help with their current needs, and plan for future care. Let them know that the opportunity to discuss their experiences in a proper setting can be arranged for the future.

Explaining Death to a Child- Developmental Considerations

The Resource from the American Academy of Pediatrics referenced earlier discusses developmental barriers to children's understanding of death, which will be important when planning for death disclosure

AAP Pediatric Disaster Preparedness and Response Topical Collection
Chapter 4: Mental Health Issues

Table 4.3: Concepts of Death and Implications of Incomplete Understanding for Adjustment to Loss

Concept	Example of Incomplete Understanding	Implication
Irreversibility		
Death is seen as a permanen phenomenon from which there is no recovery or retur	Child expects the deceased to return, as if from a trip.	Failure to comprehend this concept prevents child from taking the first step in the mourning process, that of appreciating the permanence of the loss and the need to
Finality (Nonfunctionali		
Death is seen as a state in which all life functions ce completely.	Child worries about a buried relative being in pain or trying to dig himself or herself out of the grave; child wishes to bury food with the deceased.	Can lead to preoccupation with physical suffering of the deceased and may impair readjustment; serves as the basis for many horror stories and films directed at children and youth (eg, zombies, vampires, and other "living

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Explaining Death to a Child- Developmental Considerations

The manner in which the young child processes the concept of death can lead to maladaptive thoughts and inability to move forward

Inevitability (Universality)		
Death is seen as a natural phenomenon that no living being can escape indefinitely.	Child views significant individuals (ie, self, parents as immortal.	as inevitable, he or she is likely to view death as a punishment (either for actions or thoughts of the child or the deceased).
		shame.
Causality		
A realistic understanding of the causes of death is developed.	Child who relies on magical thinking is apt to assume responsibility for death of a loved one by assuming bad thoughts or unrelated actions were causative	Tends to lead to excessive guilt that is difficult for child to resolve.

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Schools MUST Prepare to Provide Mental Health Support

The school crisis response plan should include generic protocols for the following:

- Notification of team members, school staff, students, and parents of a crisis event
- Delivery of psychoeducational services and brief crisis-oriented counseling, such as through support rooms or short-term support groups
- Memorialization and commemoration
- Follow-up

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School Crisis Planning, continued…

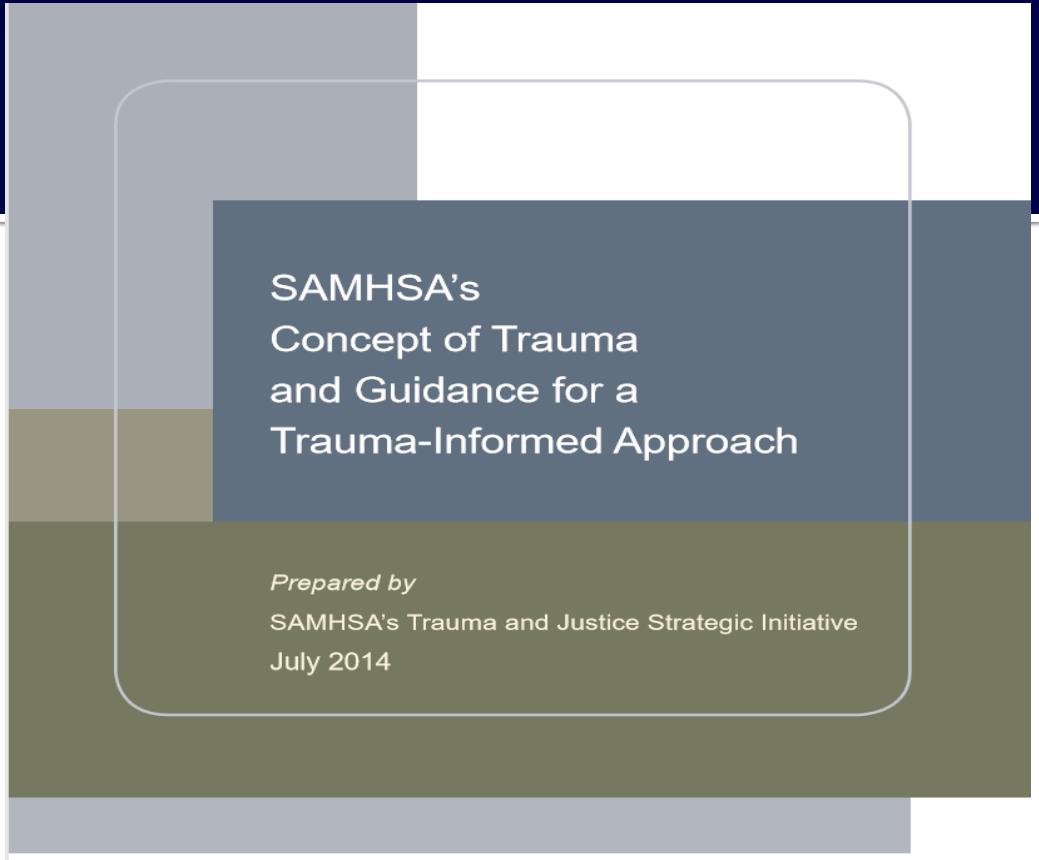
In addition, the crisis response plan should include guidelines on the following:

- Crisis team membership
- Roles of crisis team members
- Protocols for delivery of crisis intervention services
- Specific guidelines for responding to unique situations, such as large-scale natural disasters or a terrorist attack
- Physical safety and security
- Rapid dissemination of accurate and appropriate information
- Attention to the emotional impact of the events and the crisis response; all areas should be addressed concurrently and in a coordinated fashion

Trauma-Informed Care

This is a term you may hear in health care settings

Attempts to provide more carefully crafted care to both patients AND providers (second victims)



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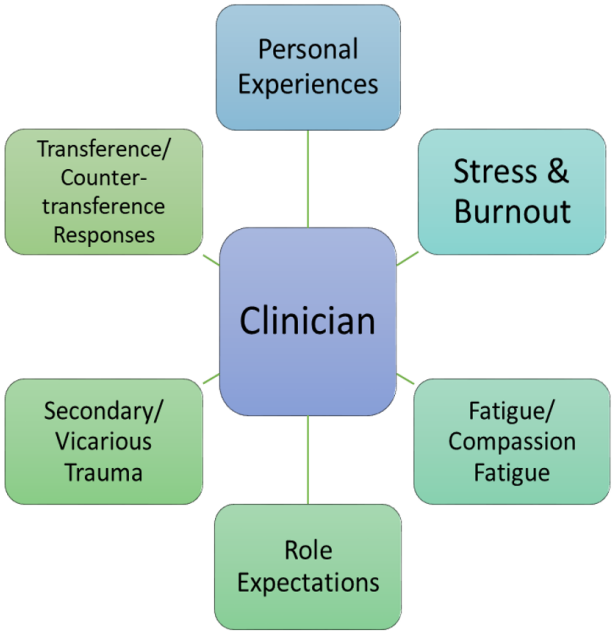
Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Don’t Forget Some Principles of Responder Self Care

Provider/Responder Self Care should be influenced by these principles…

Mature preparedness systems have these principles baked into their planning

Influences on Clinician Responses



ed from Warshaw, C. (2014). Trauma-informed services: Implications for healthcare providers and systems.

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Mature Trauma-Informed Care Systems Prepare and Self-Care

Continuum of Traumatic Stress Responses

Adapted from USMC Combat and Operation Stress Continuum Model

Continuum of Trauma-Informed Interventions

Intervention	Timing	Focus
Resilience Education & Skills-Building	Proactive	Individual, unit
Supervisor Education & Coaching	Proactive	Team-building
"The Pause" Brief Intervention	Responsive	Colleagues, clinical teams
Peer Support	Responsive	Colleagues, teams
On-the-Spot Debriefing	Responsive	Colleagues, immediate treatment team
Moral Distress Consultation	Responsive	Individual, team
Spiritual Care Consultation	Responsive	Individual, team
Emotional Debriefing	Responsive	Team, unit
Coordinated Critical Incident Response	Responsive	Department, organization, community

Thank You So Much for Your Attention

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