

A Quarterly Technical Assistance Journal on Disaster Behavioral Health
Produced by the SAMHSA Disaster Technical Assistance Center

the Dialogue

2015 | VOLUME 12 | ISSUE 1



Lessons Learned From the Ebola Response

IN THIS ISSUE

- 2 Contributors
- 3 Recent Technical Assistance Requests
- 3 Data Snapshot
- 4 Ebola in Africa: Q&A With Commander Jamie Seligman, LMSW-C, BCD
- 7 A Public Health Approach to Resilience
- 10 Firsthand Experience: U.S. Disaster Behavioral Health Response to Ebola
- 12 Recommended Resources

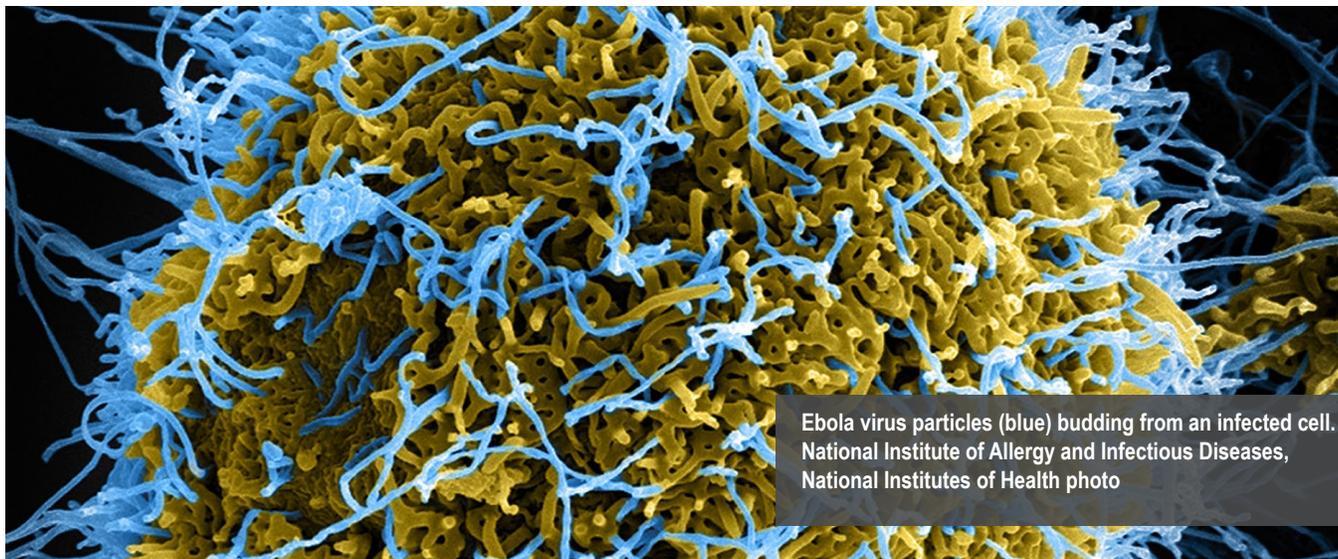
The Dialogue is a quarterly technical assistance journal on disaster behavioral health which is produced by the Substance Abuse and Mental Health Services Administration (SAMHSA) Disaster Technical Assistance Center (DTAC). Through the pages of *The Dialogue*, disaster behavioral health professionals share information and resources while examining the disaster behavioral health preparedness and response issues that are important to the field. *The Dialogue* also provides a comprehensive look at the disaster training and technical assistance services SAMHSA DTAC provides to prepare states, territories, tribes, and local entities so they can deliver an effective behavioral health (mental health and substance misuse) response to disasters. To receive *The Dialogue*, please go to SAMHSA's home page (<http://www.samhsa.gov>), enter your email address in the "Mailing List" box on the right, and mark the checkbox for "SAMHSA's Disaster Technical Assistance newsletter, The Dialogue," which is listed in the Newsletters section.

SAMHSA DTAC provides disaster technical assistance, training, consultation, resources, information exchange, and knowledge brokering to help disaster behavioral health professionals plan for and respond effectively to mental health and substance misuse needs following a disaster.

To learn more, please call 1-800-308-3515, email DTAC@samhsa.hhs.gov, or visit the SAMHSA DTAC website at <http://www.samhsa.gov/dtac>.

The Dialogue is not responsible for the information provided by any web pages, materials, or organizations referenced in this publication. Although *The Dialogue* includes valuable articles and collections of information, SAMHSA does not necessarily endorse any specific products or services provided by public or private organizations unless expressly stated. In addition, SAMHSA does not necessarily endorse the views expressed by such sites or organizations, nor does SAMHSA warrant the validity of any information or its fitness for any particular purpose.

In This Issue



Ebola virus particles (blue) budding from an infected cell. National Institute of Allergy and Infectious Diseases, National Institutes of Health photo

In 2014, people across the world watched as Ebola spread throughout West Africa, especially hitting communities in Liberia, Guinea, and Sierra Leone. Anxieties about infection were high, especially when a confirmed case of Ebola was diagnosed in Dallas, Texas.

This issue of *The Dialogue* provides an inside look into the Ebola response in Monrovia, Liberia, by the U.S. Public Health Service (USPHS). Commissioned officers discuss how the Behavioral Health Branch and a special Behavioral Health Operations Group monitored and addressed the needs of health care workers. In this unique and unprecedented situation, officers implemented programs to support USPHS staff in Liberia as well as their families back home.

Stateside, Ebola affected Dallas in October. A provider on the front lines of that response candidly shares his story of supporting the behavioral health needs of an individual exposed to a person with the virus. He shares lessons learned from his firsthand experience, giving insight into how anxiety over infectious diseases must be managed, even among those whose job it is to help alleviate the anxiety of their patients.

We hope you find the experiences related in this issue insightful. We would love to hear if you have a story to share about how Ebola in the United States or in West Africa affected you or your colleagues. In a new feature, we'll print select reader responses and other requests from the field we receive. To add your voice, or to receive technical assistance for disaster behavioral health needs, email DTAC@samhsa.hhs.gov.

Warmest regards,

CAPT Erik Hierholzer, B.S.N.

Program Management Officer, Emergency Mental Health and Traumatic Stress Services Branch
Erik.hierholzer@samhsa.hhs.gov

Nikki Bellamy, Ph.D.

Public Health Advisor, Emergency Mental Health and Traumatic Stress Services Branch
Nikki.bellamy@samhsa.hhs.gov

Brenda Mannix

SAMHSA DTAC Project Director
DTAC@samhsa.hhs.gov

Contributors

CDR Jamie Seligman, LMSW-C, BCD, is a Program Project Officer in SAMHSA's Center for Mental Health Services (CMHS) and a commissioned officer in the U.S. Public Health Service (USPHS).



CAPT Jeff Coady, Psy.D., ABPP, serves as the SAMHSA Regional Administrator for Region 5, which includes Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin, and is

a commissioned officer in the USPHS. Dr. Coady has deployed in leadership positions in response to numerous public health catastrophes, including the Indian Ocean tsunami in 2004, Hurricanes Katrina and Rita in 2005, Hurricanes Ike and Gustav in 2008, and multiple tribal deployments to address suicide clusters.



CDR Erich Kleinschmidt, M.S.W., LICSW, is a Program Management Officer in SAMHSA's Center for Substance Abuse Treatment for the

Screening, Brief Intervention, and Referral to Treatment program and a commissioned officer in the USPHS. CDR Kleinschmidt has served as team commander for a USPHS disaster case management deployment team since 2011.



CDR Indira Harris, M.S.W., LCSW, is a Public Health Advisor in SAMHSA's CMHS for the National Child Traumatic Stress Initiative and a

commissioned officer in the USPHS. CDR Harris served for 4 years at Fort Bragg Army Installation, Womack Army Medical Center, where she specialized in pre- and post-deployment behavioral health assessment and treatment and led its first embedded Behavioral Health Team/Clinic.



Scott Black, LMSW, is the owner of Transicare, Inc., in Dallas, Texas, which provides a variety of services that support the behavioral health needs of

individuals and communities. He was responsible for responding to the last three hurricanes that affected Texas, during which he provided triage screening, enrollment, medication-assisted treatments, crisis intakes, Psychological First Aid, and nursing support. ■

Recent Technical Assistance Requests

In this section, read about recent questions SAMHSA DTAC staff have answered, technical assistance (TA) requests received, and responses to past articles in *The Dialogue*. Send your questions and comments to DTAC@samhsa.hhs.gov.

Request: SAMHSA DTAC received a TA request asking for information regarding avian influenza resources. The state was dealing with an outbreak affecting the flocks of a number of poultry farms.

Response: SAMHSA DTAC provided the following resources:

- Centers for Disease Control and Prevention: Information on Avian Influenza. This web page contains links to information about avian influenza for different audiences. The language can be changed to Spanish for several of the products by using the dropdown menu on the top right part of the page.
<http://www.cdc.gov/flu/avianflu/>
- U.S. Department of Agriculture: Avian Flu. This web page contains several fact sheets and brochures. A few are in Spanish.
http://www.usda.gov/avian_influenza.html
- American Psychological Association: **Preparing for Bird Flu**. This tip sheet addresses concern about avian

influenza and suggests strategies for coping with related fear and anxiety.

<http://www.apa.org/helpcenter/bird-flu.aspx>

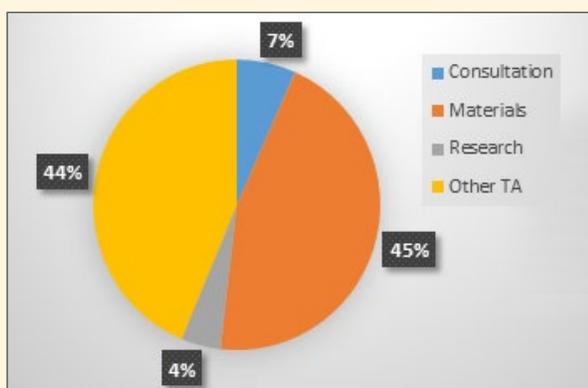
<http://www.apa.org/centrodeapoyo/gripe-aviar.aspx>
(Spanish version)

Request: In recent months, SAMHSA DTAC responded to requests from several states in the Midwest for resources regarding the behavioral health aspects of dealing with the avian influenza outbreak among livestock. A conference call was planned with the state agriculture coordinators from various states, prompting a request to SAMHSA for a brief on the psychological impact of highly pathogenic Asian avian influenza A (H5N1) virus.

Response: SAMHSA DTAC drafted a four-page fact sheet that included background information on H5N1, an update on the current situation, recommendations to prevent infection, common infectious disease behavioral health responses, and financial distress behavioral health considerations as well as links to resources. ■

Data Snapshot

SAMHSA DTAC Technical Assistance to the Field



The TA team at SAMHSA DTAC aims to be your one-stop shop for disaster behavioral health resources. During the past year, we have provided materials, general support, consultation, and research to the nation.

What can we help you with? Call SAMHSA DTAC today with your questions and help us meet your needs.

INTERVIEW

Ebola in Africa:

Q&A With a U.S. Public Health Service Commissioned Corps Officer

Commander Jamie Seligman, LMSW-C, BCD, Program Project Officer in SAMHSA's Center for Mental Health Services, talks about his experience and lessons learned in Liberia, Africa, during the ongoing Ebola crisis.

How did you prepare for this Ebola mission and where did you serve in Africa?

I served on the U.S. Public Health Service (USPHS) Commissioned Corps Ebola Response Mission at the Monrovia Medical Unit (MMU) in Margibi County, Liberia. We received 7 days of Ebola-specific preparation and training in Anniston, Alabama, and deployed to Liberia for 59 days. The MMU was a 25-bed Ebola Treatment Unit focused on providing care to Liberians and international health care workers and responders that may have been infected with Ebola. The MMU was staffed by USPHS officers that included trained clinicians (doctors, physician assistants, nurse practitioners, and nurses), infection control officers, pharmacists, laboratory workers, behavioral health specialists, and administrative management staff.

What was your mission in Liberia?

The USPHS mission in West Africa was to provide hope through care to Liberian and international health care workers and responders who may have the Ebola virus disease and continuing efforts with the

Liberian government and internal partners to build capacity for additional care.

What was your behavioral health team role?

As the Section Chief of the Behavioral Health Branch, I supervised three psychologists, one psychiatrist, and one social worker. Our behavioral health team provided force health protection, spiritual care, direct patient and family care, and collaboration with stakeholders such as the Liberian Ministry of Health and Social Welfare and the Carter Center staff. In our force health protection role, we conducted daily checks with officers who experienced challenges with the intensity of the work and high operation tempo, interpersonal relationship difficulties with colleagues, sleep hygiene problems, and coping with family issues back home. Our behavioral health team provided strategies and interventions that ensured the best possible care for our patients and self-care for each officer. In addition, the Behavioral Health Branch cross-trained in donning, doffing, chlorine mixing, and other collateral duties as needed.

The Behavioral Health Branch provided support with consultation regarding MMU staff retention, personnel conflicts, reintegration issues, and problem-solving strategies. In addition, SAMHSA Region 5 Administrator, Captain Jeff Coody, Psy.D., played a vital role as the lead of the Behavioral Health Operations Group (BHOG) for the entire mission, coordinating behavioral health activities for officers beginning during the pre-deployment process, training, operations, and up through reintegration. The BHOG was instrumental and ensured that vital information was flowing from Washington, DC, to Liberia and vice versa. (For more detail on BHOG's role, see "A Public Health Approach to Resilience.")

How did the Behavioral Health Branch approach responder resilience?

The behavioral health team piloted the use of the "Anticipate, Plan, and Deter" (APD) Responder Resilience System. For the Ebola response teams, APD included a pre-deployment responder stress inoculation training, customized for this deployment. During this

training, each responder developed an APD personal resilience plan that incorporated the training concepts for a personal strategy, taking into account anticipated stressors and individual coping and resilience resources.

In addition, as part of APD, the officer responders were trained in the PsySTART Responder Self Triage System. PsySTART Responder is a rapid mental health triage tool for disaster or humanitarian missions. PsySTART Responder allowed our officers to triage themselves daily. This empowered the officers to track the presence of their own risk markers and resilience daily and cumulatively across the extended course of the deployment. Over a period of days or weeks of deployment, officers tracked their own trending of risk factors over time. Armed with this information, the officers could elect to employ their “personal resilience plan” developed during our initial training session in Anniston, Alabama, or they could share their daily triage or cumulative triage with the embedded behavioral health providers for additional coping ideas or support. Officers were then empowered by awareness of their own self-triage risk to be proactive and engage their personal resilience plan or seek other support resources in a timely manner. The self-triage information was de-identified of personal information and aggregated automatically using the PsySTART Responder System. Rather than

Ebola Infections in Health Workers in Guinea, Sierra Leone, and Liberia

Ebola deaths are disproportionately concentrated among health personnel. The fact that health care workers are at greater risk of contracting Ebola exacerbated skill shortages in countries that had few personnel to begin with.



Source: *Ebola Situation Report - 24 June, 2015*, World Health Organization

waiting for risk to become distress and disorder, this approach allowed information to mitigate risk factors trending early, at both the individual and total team levels.

For example, one PsySTART risk factor is “I have a concern about possible chemical, biological, or radiological exposure(s) to myself.” Within a 24-hour window, the behavioral health team observed a large spike on this risk factor that had been not present in the team-level (aggregated) daily situational report. The team initially hypothesized a biological exposure, since the officers were working in a high-risk environment with patients who were infected with Ebola. However, further investigation identified that the spike was actually because of concerns over possible chemical exposure from the chlorine used as part of the decontamination process. The behavioral health team shared this information with the command staff and the safety team. As a result, we identified a

health risk to officers that caused concern and stress. We decided to discontinue the use of powder mix, as the concentration levels were inconsistent, and start using a liquid mixing system. We provided health risk information about chlorine exposures and were available for any officers who wanted to talk about their concerns. Within 1 or 2 days, the team-level aggregated PsySTART reports found this risk factor quickly diminished. Using PsySTART for the first time to mitigate real-time risks proved to be effective. Officers could anonymously report a risk factor that could seemingly cause prolonged distress, and the behavioral health team investigated and mitigated the factor. It provided “actionable intelligence” in the form of a concrete risk factor and allowed the behavioral health team to tackle the issue at the “population” level. To our knowledge, the use of the PsySTART Responder System for real-time direct risk factor

Health care workers are
21–32 times
more likely to
be infected with
Ebola than the
general public.



Source: World Health Organization

mitigation is a further refinement to this approach pioneered by the behavioral health team in the Ebola response.

What were some of the biggest challenges regarding reintegration back into the community?

The reintegration process was a great challenge and concern for most officers. The behavioral health team spearheaded the effort in gathering pertinent information on officers to help develop their reintegration plans. Many officers' family members were conflicted about their loved ones coming home after being in Liberia for over 2 months. While most families knew they couldn't catch Ebola from their spouse or partner, other people in their lives might be afraid. Because of these concerns, each officer received psycho-educational materials, including information about self-care for family members and even supervisors along with federal and state guidelines—which was a challenging endeavor because each state has different requirements.

The USPHS had a Family Support Network to support and assist (via

one-on-one calls, conference calls, and email) our families while the team was deployed to Liberia. Together, we ensured consistent messaging and provided officers and family members with tools assisting in a safe reintegration to home. To alleviate concerns with reintegration, USPHS leadership provided officers with the option to postpone their return home until their self-monitoring period had ended. With appropriate justification, officers were given the option to complete the required 21-day self-monitoring in alternative housing in Maryland. As an example, I had originally planned to complete my 21-day self-monitoring period away from my family because my wife works for the school system. In the end, I decided to complete the self-monitoring period at home for the 21 days and had no issues. I think it is important to note and respect that officers have their own reintegration plans and no one size fits all.

Ultimately, due to the complexities of reintegration, USPHS leadership created a 3-day debriefing for all officers upon their arrival back in the United States. These 3 days were

intended to assist officers as they decompressed and acclimated to being back home.

How did your family feel when they heard you were being deployed to Liberia?

For the past 8 years, I have worked on disaster grants and have been deployed for disaster response many times. To be honest, my family would have been surprised if I had not been deployed. They are proud of the work that I do on a daily basis and even more proud of my work when I can make a difference during such deployments.

What is the most important thing you learned during your time in Liberia?

I learned that Ebola is a caregiver's disease—the people who are at greatest risk for infection are the caregivers. It's a brother, sister, uncle, aunt, mother, father, or medical staff member who are taking care of the person who are at the greatest risk of contracting the disease. Ebola affects the whole community and not just an individual. ■

About USPHS

The U.S. Public Health Service Commissioned Corps is part of the U.S. Department of Health and Human Services. The Commissioned Corps is an elite uniformed service with more than 6,800 full-time, highly qualified public health professionals, serving the most underserved and vulnerable populations domestically and abroad. To learn more, visit the USPHS's website at <http://www.usphs.gov/>.



This photo was taken during the “decompression period” of the Ebola response, which was a 3-day period when the team from Liberia first returned to the United States to rest and prepare for the Ebola monitoring and general reintegration back to normal life. The officers are (left to right) CDR Antoine Smith, LCDR Aisha Faria, CDR Erich Kleinschmidt, CDR Tarsha Cavanaugh, CDR Aileen Renolayan, and CAPT Tammie Howard. Photo: USPHS/CAPT Cynthia Rubio

A Public Health Approach to Resilience

Contributed by CAPT Jeff Coady, Psy.D., ABPP, SAMHSA Regional Administrator (Region 5); CDR Erich Kleinschmidt, M.S.W., LICSW, Program Management Officer, SAMHSA Center for Substance Abuse Treatment; and CDR Indira Harris, M.S.W., LCSW, Public Health Advisor, SAMHSA Center for Mental Health Services

As part of the whole-government response to addressing the Ebola virus outbreak in West Africa in 2014, U.S. Public Health Service (USPHS) Commissioned Corps officers deployed to stand up and operate an Ebola Treatment Unit in Monrovia, Liberia. While officers and teams have previously deployed for multiple crises and are trained in methods that promote resilience, the Ebola virus deployment presented a unique and unprecedented set of stressors to officers and their families, including longer lengths

of deployment, a novel virus, and austere living conditions.

To more effectively mitigate the stressors for officers and their families, the USPHS Office of Readiness and Deployment Operations Group (RedDOG) implemented a Behavioral Health Operations Group (BHOG), which implemented unique programs across the lifespan of the deployment for both officers and families during pre-deployment, training, operations,

and reintegration. Previous USPHS resilience efforts focused on individuals and the deployed team; but given the novelty of Ebola as an infectious disease and the global fear of an epidemic, it was critical for BHOG to include families, loved ones, and communities.

The programs included the following:

- USPHS officers provided a biweekly speaker series for families and loved ones of deployed personnel on topics including Ebola 101, helping children during deployment, and reintegration, to promote resilience.

- Reintegration specialists assigned to each officer provided peer support, direct active monitoring, and linkages to community-based resources and federal resources. Moreover, BHOG implemented unique programs to

WHAT IS A PUBLIC HEALTH APPROACH?

A public health approach to resilience promotes emotional wellness not only of the individual, but the team as a community. A public health approach includes a focus on data to inform planning, development of structures and systems to support individuals, and engagement with the family and community where the officer resides.

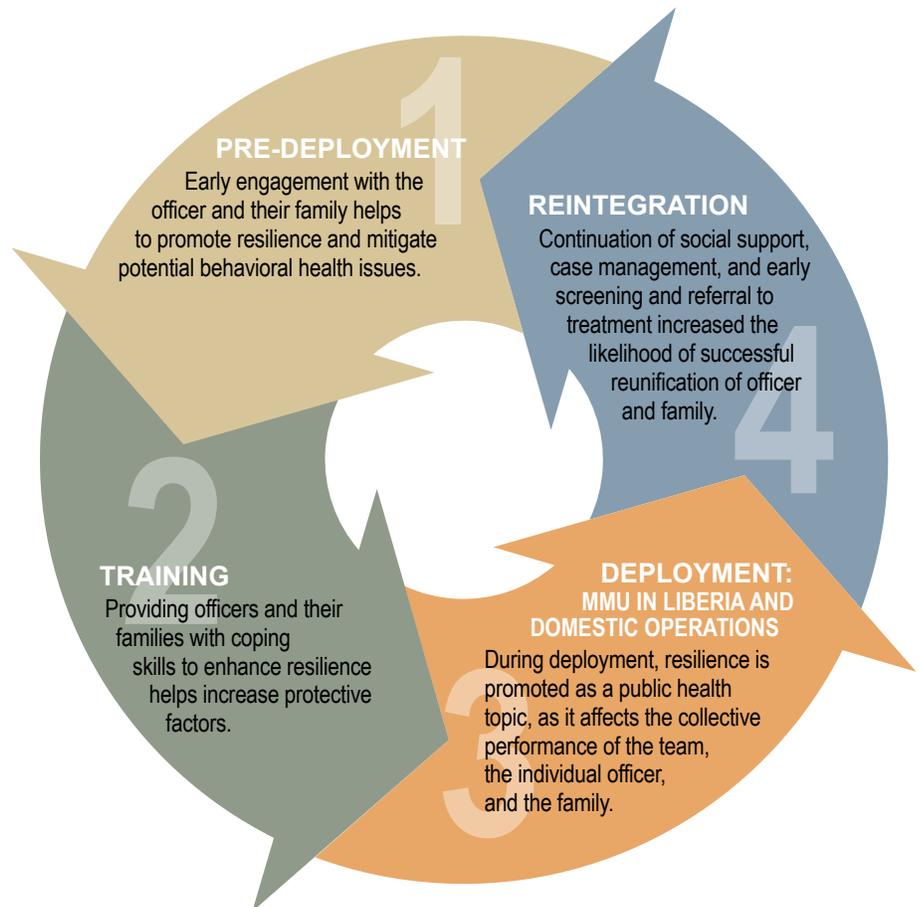
mitigate the stressors for officers and their families.

A comprehensive public health approach to resilience served as the overall strategy for resilience. The public health approach was data informed, integrated, and connected across the lifespan of the deployment as well as post-deployment.

Preparing for Deployment

Before deployment, the Family Support Network (FSN) promoted resilience within the family. The FSN assigned each family a local “sponsor” to provide limited domestic and social support. Sponsors received training on Psychological First Aid as a means to facilitate resilience. FSN operated a 24-hour hotline that families could call to answer any immediate questions or concerns. The officers and their families received SAMHSA tip sheets on preparing for deployment and maintaining resilience to promote early awareness of emotional health and behavioral health literacy.

FSN also developed a weekly speaker series based upon the most typical identified needs of families during the deployment, ranging from preparing for a deployment and supporting children during a deployment to taking an “Ebola 101” course. SAMHSA USPHS officers helped present the speaker series. Most presentations contained links to SAMHSA resources,



including the SAMHSA Behavioral Health Treatment Services Locator (<https://findtreatment.samhsa.gov>) and tips for caregivers, parents, and teachers on how to talk with children during infectious disease outbreaks.

In addition, officers received 6 hours of resilience training in their pre-deployment schedule. The training included a series of self-control techniques: sleep hygiene, deep breathing, relaxation, and visualization. Officers received a stress inoculation as part of a resilience plan during which officers anticipated their greatest stressors during a deployment and devised a personal plan for coping. They completed a short self-triage

instrument daily to monitor their exposure to traumatic stress, which can indicate resilience levels in real time. Just as officers would take their temperature daily, the triage provided a daily emotional barometer for each officer, as well as overall resilience of the entire team.

Deployment: MMU in Liberia and Domestic Operations

During deployment, families received information and resources on Ebola to address social exclusion. During the 2014 outbreak, fears of acquiring Ebola were prevalent and based on misinformation. Many returning health care workers from West Africa and their families experienced prejudice and discrimination in

community settings such as schools and the workplace. If families encountered situations that were particularly challenging, they could use the established hotline and work directly with the RedDOG to mitigate the situation.

Behavioral health officers at the Monrovia Medical Unit (MMU) in Liberia (which included a SAMHSA USPHS officer—see “Ebola in Africa: Q&A With a U.S. Public Health Service Commissioned Corps Officer”) integrated into team operations, from the doffing and donning of personal protective equipment to pre- and post-shift huddles with the various MMU branches. Behavioral health officers provided ongoing consultation to the Chief Medical Officer and Team Commander. They engaged their teammates in a wide variety of settings to extend behavioral health beyond the four walls of a clinic office by proactively engaging the team where officers lived, worked, and socialized.

Anonymous, aggregated data from the officer self-triage provided a snapshot of the resilience and traumatic stress exposure on a daily basis. The aggregated data, coupled with on-the-ground information, helped team leaders be aware of resilience levels and facilitate behavioral health planning and resilience messaging. Besides the stress of being exposed to a novel agent, common stressors included separation from family and concerns for family members

being discriminated against for their connection with someone deployed to a country with Ebola. A newsletter in the MMU provided a key opportunity for public health messaging. Behavioral health officers provided ongoing prevention and treatment services as needed to the team.

Coming Home

The FSN sponsor continued to support the family for 30 days following the officers’ return from Liberia. The FSN sponsors collaborated with other individuals supporting the officer to coordinate and inform support activities.

While at the MMU, officers identified what they most looked forward to in returning home, as well as their possible concerns. Upon return home, a reintegration specialist helped each officer by linking him or her to community-based or federal resources as needed. State and local health departments, through the reintegration specialist, monitored officers twice daily. The establishment of this relationship allowed for dedicated time and ongoing engagement with the returning officers. Officers could discuss pertinent post-deployment reintegration needs such as challenges with returning to work, reconnecting with family, and coping with the separation from officers with whom they deployed in Liberia.

Reintegration specialists also

ensured that officers completed post-deployment behavioral health screenings and referred them to the appropriate providers for follow-up screening, if necessary. They engaged with officers for 60 days post-deployment with decreasing frequency of contact over time.

The unprecedented Ebola virus outbreak required innovative means and methods to ensure resilience for those deployed, their families, and their communities. A public health approach, maintained across the lifespan of the deployment, was necessary to build and maintain resilience. This unique response to the Ebola crisis highlights the importance of partnerships among many agencies when using a public health approach. This model is scalable and sustainable for officer and family support in the U.S. Public Health Service. ■

WHAT IS RESILIENCE?

Resilience is the ability of an individual to adapt to stressful and adverse situations. For a team, resilience is critical in being able to achieve optimal performance.

For an ongoing discussion, listen to the SAMHSA DTAC podcast series, *Resiliency in Disaster Behavioral Health* at <http://www.samhsa.gov/dtac/webinars-podcasts/resiliency-in-disaster-behavioral-health>.



Firsthand Experience: U.S. Disaster Behavioral Health Response to Ebola

Contributed by **Scott Black, LMSW**, Owner, *Transicare, Inc.*

October 4, 2014, in Dallas, Texas, was a typical Saturday of soccer with my daughter until I received a call from a colleague to initiate behavioral health services for a person being involuntarily quarantined following exposure to the bodily fluids of the first U.S. case of Ebola. Gripped by fear, recalling Richard Preston's *The Hot Zone* about Ebola, and considering the potential risk to my family, my first reaction was to say, "I'm sorry. I cannot help you on this one."

Although I agreed to step in the following day, my initial reaction turned out to be a common theme in our collective effort. For me, the most salient lesson learned from this high-stress, unique situation was figuring out how to participate in a system response when I was frequently in fight or flight. In my view, it is critical to acknowledge the climate of fear and uncertainty that framed service implementation, delivery, and exit planning, as all operations were affected by it.

My company, Transicare, was involved in the natural disaster responses to Hurricanes Katrina, Gustav, and Ike, which entailed delivery of services including

transportation, screening, care coordination, pharmacy coordination, psychiatric nursing, Psychological First Aid, and crisis intervention. For Ebola, services were limited to meeting the needs of one individual who was involuntarily quarantined. My business partner, Bonnie Athens, RN, and I made the decision to limit exposure to only the two of us until we could better assess the landscape. In the initial exchange, the client disclosed flu-like symptoms to us that he stated he had not disclosed to the Centers for Disease Control and Prevention (CDC) staff that had cleared him just minutes before. I had read the World Health Organization (WHO) information about transmission, but wrestled with a question I had asked the CDC team lead before I knew the person I would assist: "If a 100-degree fever is our line in the sand, is there not increased transmission risk for people who may not mount a typical febrile response?"

That question was not resolved before my first encounter, and following the client's disclosure of flu-like symptoms, I found myself saddled with managing my own

anxiety. Additionally, upon returning to the office, I became aware that my staff were showing signs of distress. Despite being educated about Ebola and knowing that our involvement was limited to an asymptomatic person, some people would not come near us. The panic and fear spread like a tsunami. Providers refused to assist. Food vendors placed the food outside the door for our client, knocked, and ran away.

The panic and fear followed me to my personal life. After the initial visit with our client, we were called out a second time that afternoon because of reported increased client distress. About the time we had developed a collaborative plan with the client, representatives from the U.S. Department of Homeland Security announced the client would be moved within a few minutes. In the unfolding chaos and crisis management, I ended up handling the client's personal items and clothing to pack them for the transfer. Although I wore gloves, my mind repeatedly turned over the possibility of Patient Zero's bodily fluids being on our client's clothes and now, on me. I then decided I could not live with the possibility of



Despite being educated about Ebola and knowing that our involvement was limited to an asymptomatic person, some people would not come near us. The panic and fear spread like a tsunami.

responses. Behavioral health had not been integrated into initial planning or the incident command structure as in former disasters. Consequently, various agencies would unpredictably become engaged with our client and operate from a different set of priorities, at times causing significant disruption in our crisis stabilization effort. Policy about personal protective equipment (PPE) was evolving as our quarantine period unfolded. Some providers might arrive in complete PPE, while others would only use gloves. Combined with nonstop, often inflamed, media coverage, the overall climate was one in which we repeatedly had to reestablish our equilibrium—not only with our client, but with ourselves as well.

The confluence of these contextual issues provides the foundation for some of the lessons I came away with:

- It was helpful to receive education via television and tip sheets from WHO and Texas Health Presbyterian Hospital, but the information was insufficient for providers once the theoretical situation became real. Too many inconsistencies came out in the media, which served to exacerbate distrust. I had access to an EIS officer who was a subject matter expert and who had been in

West Africa. Personable, authentic, and accessible, he was an invaluable resource. This experience made clear to me that public education about an unknown and fear-inducing threat like Ebola needs to be strategically tailored in terms of content, form, and mode of delivery, commensurate with the overall climate.

- Critical incident stress management is critical and cannot be minimized. The level of support provided by the managed care company's support team, which worked with me and my team, was incomparable. Without the accessibility to processing, debriefing, and normalizing the extraordinary circumstances, I do not believe we would have achieved our successful outcome.

- The breakdown of the command structure translated into lack of clarity about roles, bidirectional communication, and other structural issues, which equated to unnecessary frustration, isolation, and increased stress. The sustained, extraordinary fear and uncertainty characterizing this disaster response was in stark contrast to the last three natural disaster responses in which I have participated. I feel privileged to have had the rare experience of seeing how this affects response implementation and the preparedness needs it highlights. ■

exposing my family to any hint of fluids and decided to stay in a hotel. This significantly distressed my wife, who also had become afraid to be near me.

I felt completely isolated and began to enter the roller coaster world of fight or flight. My focus became finding a subject matter expert whom I could trust. Thankfully, an Epidemiological Intelligence Service (EIS) officer from CDC unknowingly became my de facto support, intermittently helping me to regroup myself and restore a sense of safety and order. Although I had only earlier in that same day—and formerly in prior disasters—filled the role of being the calm and supportive person, I now was the person in desperate need of that form of support.

The involvement of Homeland Security noted above exemplifies an additional theme that differentiated this disaster response from “typical”

RECOMMENDED RESOURCES

Behavioral Health Response to Ebola Webcast

In 2014, four health care providers in Dallas, Texas, responded to the high-stress situation of supporting a quarantined individual who was homeless during the Ebola outbreak. In this webcast, they share their lessons learned and emphasize the importance of coordinating and integrating behavioral health into disaster preparedness and response plans.

View the webcast at <https://www.youtube.com/watch?v=MFLBFEb2dok&feature=youtu.be>

Immediate Disaster Response—Ebola Outbreak in 2014

This installment of SAMHSA’s Disaster Behavioral Health Information Series focuses on the 2014 outbreak of the Ebola virus. Behavioral health professionals can use these resources to help plan and prepare for future infectious disease outbreaks. It also contains links to organizations, agencies, and other resources that address Ebola planning, preparedness, and response.

View the installment at <http://www.samhsa.gov/dbhis-collections/ebola?term=Ebola%20Outbreak-DBHIS>

Taking Care of Your Behavioral Health During an Infectious Disease Outbreak

This tip sheet explains social distancing, quarantine, and isolation in the event of an infectious disease outbreak, such as Ebola. It discusses feelings and thoughts that may arise during this time and suggests ways to cope and support yourself and loved ones during such an experience.

Read and download the tip sheet at <http://store.samhsa.gov/product/SMA14-4894>

Talking With Children During Infectious Disease Outbreaks

This tip sheet equips parents, caregivers, and teachers with tips for helping children manage their stress during an infectious disease outbreak. It explains reactions children—preschool age to adolescence—may have and the support adults can provide to help them.

Read and download the tip sheet at <http://store.samhsa.gov/product/Talking-With-Children-Tips-for-Caregivers-Parents-and-Teachers-During-Infectious-Disease-Outbreaks/SMA14-4886>

Coping With Stress During Infectious Disease Outbreaks

This tip sheet offers practical ways people can cope with stress during an outbreak of an infectious disease. It explains common signs of stress and how to recognize when to get help.

Read and download the tip sheet at <http://store.samhsa.gov/product/Coping-with-Stress-During-Infectious-Disease-Outbreaks/SMA14-4885>. ■



Behavioral Health is Essential To Health Prevention Works Treatment is Effective People Recover

SUBSCRIBE

The Dialogue is a publication for professionals in the disaster behavioral health field to share information, resources, trends, solutions to problems, and accomplishments. To receive *The Dialogue*, please go to SAMHSA's home page (<http://www.samhsa.gov>), enter your email address in the "Mailing List" box on the right, and select the box for "SAMHSA's Disaster Technical Assistance newsletter, *The Dialogue*."

SHARE INFORMATION

Readers are invited to contribute to *The Dialogue*. To author an article for an upcoming issue, please contact SAMHSA DTAC at DTAC@samhsa.hhs.gov.

ACCESS ADDITIONAL SAMHSA DTAC RESOURCES

The *SAMHSA DTAC Bulletin* is a monthly e-communication used to share updates in the field, post upcoming activities, and highlight new resources. To subscribe, please enter your email address in the "SAMHSA DTAC Bulletin" section of the home page of our website at <http://www.samhsa.gov/dtac>.

The SAMHSA Disaster Behavioral Health Information Series contains resource collections and toolkits pertinent to disaster behavioral health. Installments focus on specific populations, specific types of disasters, and other topics related to all-hazards disaster behavioral health preparedness and response. Visit the SAMHSA DTAC website at <http://www.samhsa.gov/dtac/dbhis-collections> to access these materials.

CONTACT US

SAMHSA Disaster Technical
Assistance Center

Toll-Free: 1-800-308-3515

DTAC@samhsa.hhs.gov
<http://www.samhsa.gov/dtac>