Disaster Behavioral Health Ethics: Building on Practitioner Knowledge and Community Resiliency

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Outline

- Introductions
- Disaster Behavioral Health (DBH) vs. Crisis & Trauma Work
- Foundational Ethical Principles
- Unique ethical challenges
- Cultural Competence & Personal Values
- DBH Ethics Resources

Disaster Behavioral Health includes…

Psychosocial support to survivors and first responders of a disaster event, primarily in community settings

Addressing immediate needs, providing physical and emotional comfort, offering practical assistance, emphasizing resilience, assisting with coping with reactions as normal responses to event

Interventions: linking to resources, providing outreach, psycho-education, psych first aid, information & referral

(Dailey & LaFauci Schutt, 2018)

Definitions and Distinctions

Crisis response focuses on work with an individual coping with large stressor or life-changing event; crisis is a state

Traditional *counseling* usually involves ongoing professional relationship, (may) focus on diagnosis and "treatment", encourages insight, seeks to change an individual's functioning and/or work toward goals

Trauma counseling focuses on helping individuals cope with ongoing symptomology following exposure [e.g., "actual or threatened death, serious injury, or sexual violence", (APA, 2013, p. 271)]

DBH vs. Traditional Mental Health

There are important differences between your day-to-day work as a mental health professional and the delivery of disaster behavioral/mental health services:

- Worksite
- Teamwork
- Initiation
- Relationship
- Duration
- Methodology
- Nature of Interventions
- Scheduling
- Accessibility
- Responsibility

Role of a DBH Worker

Outreach and crisis counseling are central to DBH

- Work hand-in-hand with paraprofessionals, volunteers, community leaders, and survivors in ways that may differ from formal clinical training
- Actively involve and empower; promote "neighbor-helping-neighbor"
- Modalities may include:
  - ✓ Psychological First Aid
  - ✓ Spiritual Care
  - ✓ Substance Abuse Services
  - ✓ Other crisis intervention/disaster specific support (response organization dependent)

Foundational Ethical Principles

Autonomy

Freedom of thought and choice

Non-maleficence

Do no harm, avoid actions that risk harming others

Beneficence

Do good, improve and enhance the welfare of others

Justice

Equal treatment, presumes reciprocity & impartiality

Fidelity

Keep promises, maintain respect and civility

(Kitchener, 1985)

Ethical Decision-Making

1. Identify the problem
2. Apply ethical code(s)/relevant laws
3. Determine nature & dimensions of dilemma (e.g., foundational principles)
4. Generate potential courses of action
5. Consider potential consequences of options & determine course of action
6. Evaluate selected course of action (e.g., justice, publicity, universality)
7. Implement course of action

(Forester-Miller & Davis, 1996)

Ethical Guidance

- Professional Code of Ethics (e.g., ACA, APA, NASW)
- Ethical Principles & Ethical Decision-Making Models
- American Red Cross (2012) Disaster Services Ethical Directives
- Code of Conduct for the International Red Cross & Red Crescent Movement and Non-Gov. Organisations in Disaster Relief
- APA New Haven Trauma Competencies (2014) - Trauma-informed professionalism

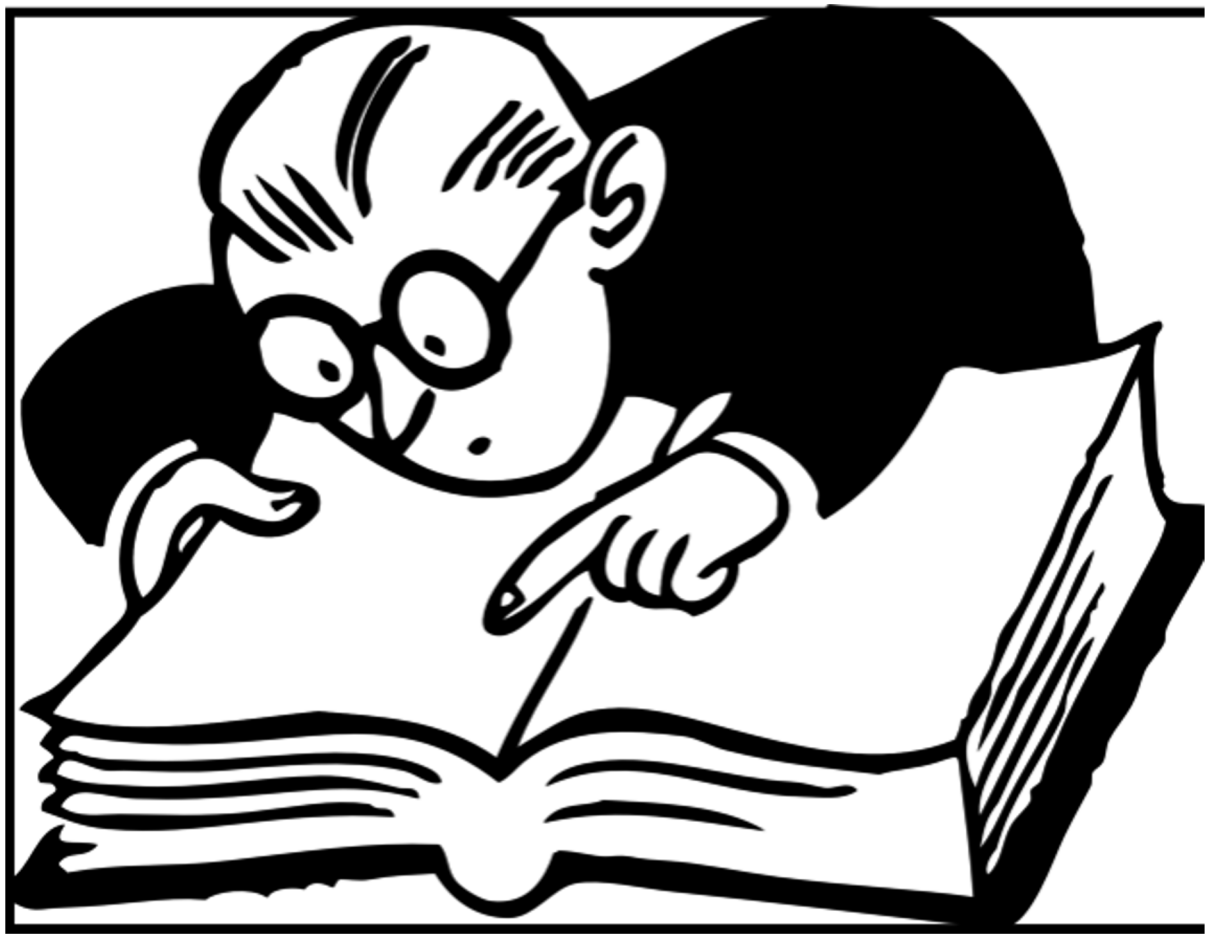
Common Ethical Questions

- What training do I need?
- Do I need to be licensed?
- What about informed consent?
- Is it true DBH workers have immunity under "Good Samaritan" laws?
- What if I *know* someone clearly has a mental health diagnosis?
- I am not trained to work with children. What if a child needs help but no other DBH workers are available?

Common Ethical Challenges

- Primary Responsibility
- Professional Competence
- Informed Consent
- Records and Documentation
- Confidentiality
- Duty to warn
- Cultural & Developmental Considerations
- Personal Values
- Boundaries & Advocacy
- Termination and Referral
- Responder Impairment and Self-care

(Dailey & LaFauci Schutt, 2018; Hunt et al., 2018; Tarvydas, Lopez Levers, & Teahen, 2017)



Primary Responsibility

- Responsibility to the client: survivor of event and their families, trauma responders
- Respect welfare of client
- Do no harm

(Tarvydas et al., 2017)

Professional Competence

- Practice w/in your competency areas/license and standard of care
- Complete all required training in DBH prior to deployment - often specific to deploying organization (e.g., ARC)
- Provide only services deemed necessary
- Seek supervision during response to gain expertise
- Legal requirement of state license for *most* organizations

(Dailey & LaFauci Schutt, 2018; Hunt et al., 2018)

Informed Consent

- Usually verbal – always identify yourself & your role
- Additional consent to share information or advocate on behalf of individuals
- Challenges of obtaining consent for separated minors or those with pre-existing conditions that may affect ability to consent

(Dailey & LaFauci Schutt, 2018; Hunt et al., 2018)

Records & Documentation

- Unique to responding organization
  - ARC: forms for documenting client case information and needs; triage; release of confidential information
  - SAMHSA/FEMA: forms for documenting services (e.g., crisis counseling, event reactions) and weekly tallies
- Similar to traditional practice; ethical/legal mandate to keep information confidential
- Usually less detailed than clinical notes/medical records
  - Aggregate data: number of individuals impacted, major events, needs assessment
  - Individual: risk consultation, needed resources

(Dailey & LaFauci Schutt, 2018)

Confidentiality

- Ethical mandate remains
- Challenging due to response setting
- Important to remind survivors of risks to confidentiality (e.g., location, media)
- Know when may need to break confidentiality (e.g., reporting suspected abuse)

(Dailey & LaFauci Schutt, 2018; Hunt et al., 2018)

Duty to Warn

Mandate to keep information confidential does not apply in cases of serious and foreseeable harm OR when laws require release

Know protocols of deploying organization & laws of jurisdiction

Attend to immediate needs, consult and help survivor access additional services

Potential situations include individuals at risk for suicide, homicide and other self-harming behaviors

(Dailey & LaFauci Schutt, 2018)

Cultural Considerations

- Vulnerable populations are disproportionately affected; decreased resources + increased stressors; discrimination & oppression
- Consider age, development, race, ethnicity, gender, language, religion/spirituality, disability, marital & family status, and other cultural factors
- Seek consultation/supervision; avoid value-based referrals
- Involve cultural groups most affected by event as DBH responders when possible; collaborate with local services

(Dailey & LaFauci Schutt, 2018; Hunt et al., 2018; Tarvydas et al., 2017; West-Olatunji & Yoon, 2013)

Cultural Considerations

- Views of behavioral health
- Expression of disaster stress responses
- Referrals/resources (MDs, traditional healers, etc.)
  - Views medication and treatment
- Role of family & cultural values (communal, elders, gender)
- Religious/spiritual beliefs
- Social support systems
- Communication: language, dialect, literal vs. metaphors, body language, relational styles
- Past traumas/historical context of culture; attitudes towards disaster event/cause
- Diversity within cultural groups and acculturation

(Marsella et al., 2008)

Personal Values

Heightened emotions, strong statements concerning alleged perpetrator(s), government, religion/faith are common.

- Questioning God's existence after one's home was destroyed
- Survivor of active shooter incident asking your views on gun control

Define and reflect on your personal values. Avoid imposing your beliefs onto others.

- Be cognizant of your own values and beliefs.
- Access supervision or local resources to assist

(Dailey & LaFauci Schutt, 2018)

Boundaries & Advocacy

- Boundary extensions (e.g., services in private homes) may occur
- Challenges of working within your own community
- Potential need for both *personal* and *systems* advocacy to assist survivors in accessing resources and/or improve equity of process
- Advocacy competency

(Dailey & LaFauci Schutt, 2018; Tarvydas et al., 2017)

Termination & Referral

- Disaster behavioral health work is usually *short-term*
- Management of short-term relationship and termination process is essential
- Referral to another worker, additional services, or longer-term care may be needed
- Know protocols of deploying organization and how to access community resources

(Dailey & LaFauci Schutt, 2018)

Responder Impairment/ Self Care

Burnout, compassion fatigue, vicarious trauma

Monitor self and peers for signs of impairment

Obtain supervision and consultation when needed

Develop self-care plan to use during deployment

(Tarvydas et al., 2017)

Disaster Behavioral Health Ethics Resources

- NE Behavioral Health All-Hazards Disaster Response and Recovery Plan: https://www.disastermh.nebraska.edu/resources/state-plan/
- Responding organization (e.g., ARC, FEMA, State DMH) & professional associations
- SAMHSA Disaster Technical Assistance Center: www.samhsa.gov/dtac
- Humanitarian Health Ethics Analysis Tool: www.humanitarianhealthethics.net
- Disaster mental/behavioral health literature (e.g., DeWolfe, 2000; Flynn & Speier, 2014; Webber & Mascari, 2018)

Conclusion

Questions?

Sharing of resources and ideas

THANK YOU!

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