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Ardis Hanson

University of South Florida, hanson@usf.edu

Claudia J. Dold

University of South Florida, cdold@usf.edu

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Disaster Mental Health: Building a Research Level Collection

Paper by Ardis Hanson & Claudia J. Dold at USF-Tampa
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Disaster Mental Health: What it Covers

Disasters are not uncommon events, and take many forms. Disasters, in whatever form they take, rob us of our sense of well-being, our security, our community, our loved ones, and our homes. Disasters forever change 'life as we know it' and seriously impact our ability to function. The psychosocial effects of a natural or manmade disaster can be long lasting, and the resulting trauma can reverberate even with those not directly affected by the disaster. Mental, neurological, and behavioral disorders are common sequelae to natural and manmade disasters. People with these disorders endure social isolation, poor quality of life, and increased mortality. Further, these disorders are the cause of staggering economic and social costs. With the increase in natural and manmade disasters, the incidence of mental illnesses has grown exponentially, creating large at-risk and vulnerable populations.¹

For those of us who work in behavioral health services research and policy, we recognize that advance preparation, early intervention, and post-disaster interventions, assist those whose lives are touched by disaster.

Disaster Mental Health: An Operational Framework

In 2009, there were 245 international natural disasters, of which 224 were weather related. 55 million people were affected by natural disasters; 3 million were affected by manmade disasters.² Between January and November 2009, 48 million people were affected by weather-related events (91.4%), which remain the highest risk with the largest numbers of affected people. In 2009, the U.S. Federal Emergency Management Agency declared 107 emergency and disaster declara-

tions in the United States, of the 52 were major disaster declarations. In addition to natural and technological disasters, manmade disasters, such as genocide, ethnic cleansing, and war continue to take their toll. The Global Internal Displacement Profile Project estimates that 25 million people were forced from their homes due to severe political, religious, ethnic, or social persecution.^{3, 4,5} Between the massive international and national dislocations due to natural and manmade disasters, huge numbers of vulnerable populations require health and mental health services.⁶⁻⁹

Although health services first come to mind as disaster relief, mental health care is just as important for disaster survivors. The World Health Organization (WHO) defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.” Conversely, disasters are psychologically distressing events outside the range of normal human experience which involves actual or threatened death or serious physical injury to an individual or others and intense fear, helplessness, and horror.¹⁰

Research estimates that 14% of the global disease burden is due to mental disorders.¹¹⁻¹³ Further, the WHO estimates that about half of mental disorders begin before the age of 14,¹⁴ from which approximately 20% of the world's children and adolescents suffer, with similar types of disorders being reported across cultures.¹⁴ Further, mental illnesses also increase the risk for developing many physical illnesses and are major risk factors for communicable and non-communicable diseases and unintentional and intentional injury.¹⁵ At the same time, many health conditions, including those brought about by sanitation and malnutrition to disasters, increase the risk for mental disorder, and complicate diagnosis and treatment.¹⁵

From a public mental health perspective, the consequences of disasters are horrifying. There are increases in mental illnesses and substance abuse. Disruptions in food supply, immunizations, medications, and health services affect people's health for months, and perhaps years following the cessation of genocidal actions. Consequences of infectious diseases borne from deprivation, abuse, and unsanitary living conditions, organ system failure due to torture and deprivation, neurological injuries, and increase in severe psychiatric disorders all create an increased

burden of disease for adults and children across generations into the future.¹⁶⁻²² Mortality rates due to disasters far exceed mortality from HIV/AIDS or war. Intergenerational transmission of mental health sequelae is widely documented. Children of holocaust survivors report higher rates of current and lifetime post-traumatic stress disorder symptoms than control subjects, despite similar self-reported rates of traumatic experiences in both groups.²³⁻²⁶ In one study of 3,030 surviving Rwandan children (ages 8–18), a majority of the children suffered from symptoms of post-traumatic stress disorder.²⁷ Further, populations have increased at-risk factors to perpetuate genocidal behaviors due to desensitization to catastrophic violence on a population-wide scale.²⁸⁻³¹

From a longitudinal perspective, data available from military and civilian disasters has shown a fairly predictable ratio of acute and severe emotional trauma associated with mass casualty events.³² The prevalence of PTSD in directly affected populations varies between 12% and 16%. The reported prevalence of all types of psychopathology following disasters varies from 7% to 70%. The risk for developing post-disaster PTSD varies by age, with an increase during school age, followed by a second more prominent increase during middle age. There is a 40% higher prevalence PTSD among predominantly female populations. Marriage and parenthood are also associated with increased risk due to increased caring responsibilities and lack of resources. For men, a major post-disaster behavioral outcome is alcohol abuse.

Thus, an extended burden of disease maybe conferred on communities already coping with a multiplicity of disaster-related health consequences.^{33,34} When these communities seek health care, health professionals require the knowledge, training, skill or personal assurance to deal with the effects of such massive and lasting trauma.³⁵⁻³⁷ Increased awareness of and sensitivity to disaster survivors can lessen their anxieties and, potentially, improve treatment outcome.³⁸⁻⁴⁰ This is particularly important as refugee populations age out of childhood into adulthood into elder status.⁴¹

Disaster Mental Health: Details of the Plan

The University of South Florida Library System (USF), under the direction of Dean Bill Garrison, supports collection development for the FMHI Research Library Disaster Mental Health Collection. This initiative is one of several initiatives to build additional collections of distinction at

USF. Working with Dean Junius Gonzales, the Dean of the Florida Mental Health Institute, the FMHI Research Library became part of a work group comprised of several FMHI researchers working in disaster research.

Part of our work was to create definitions and build a conceptual framework for the collection and its subsequent development. To do so, we closely examined how federal agencies, who have oversight on the delivery of mental public health services and/or emergency services, have constructed disaster models for response. In addition, we investigated the intersection of federal and global disaster health perspectives for response, planning, and preparedness. The following more fully explain our framework and offer a rubric for CD.

1. Disaster should be viewed within the “all-hazards” model of emergency preparedness. Nationally, this model is promoted by FEMA and endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA), in the Department of Health & Human Services. The U.S. Centers for Disease Control and Prevention similarly situates the concept of “Disaster Mental Health” within its category of “All-Hazard Emergency Preparedness and Response.” Globally, the mental health dimension of the “all-hazards” model fits within the World Health Organization’s concept of “global public health security,” which focuses both on prevention and response.

2. In the all-hazards model, the term “disaster” is broadly defined to include “any event, real and/or perceived, which threatens the well-being of citizens.” This includes natural and man-made events. In addition to natural events such as hurricanes, floods, tsunamis, earthquakes, and tornados, the rubric of disaster includes (but is not limited to) war, genocide, intrastate conflicts, terrorism, torture, and systemic human rights violations. Consistent with USF’s strategic goals, the populations of interest should be global in scope and diversely inclusive of different ethnic, cultural, racial, and religious groups.

3. The scope of this collection should properly include titles pertaining to the nature, causes, prevention, mitigation of, and response to, different types of disaster threats (with a particular focus

on their psychosocial aspects), and to the nature, causes (including perpetrators), prevention, mitigation of and response to mental, emotional, health-related and behavioral conditions that are associated with or arise from disaster events and their affected populations (e.g., first-responders, refugee, migration, and diaspora, among others. The scope address must also research, measurement and analytic methods for studying them. The integrated emphasis on behavioral health among vulnerable and at-risk populations coheres with the priorities of the United Nations and the World Health Organization. Titles are chosen based on the following rubric.

ets	Fac-	F1: Nature/ Causes	F2: Prevention	F3: Mitigation/ Response	F4: Vulnerable, At-Risk & Trau- matized Populations
Domains					
D1: Disas- ter/Hazard/Threat					
D2: Associated Behavioral Health Conditions					
D3: Measurement, Analy- sis and Research Methods					

4. The proper reach of a collection focused on these issues should include/draw content broadly from the social/behavioral and medical sciences to address such areas as services delivery, law & policy, population, health status, epidemiology (prevalence and incidence data), structural factors, and security. This suggests that criteria for discovery and inclusion of relevant titles must extend beyond those that include the specific phrase “disaster mental health.” Titles that include that designation should at least be considered for the collection, but confining the collection to only those titles would substantially reduce its depth, breadth and value to the scholarly community. Assuring proper breadth requires a range of materials on the relevant topic, from introduction and survey level to expert analysis, supported by raw data; providing historical information to trace the development of theory, policy, and practice including foreign material for the benefit of different points of view; viewing disaster mental health from the many different perspectives situated within the interests of the Institute/College/USF, including departmental perspectives, audi-

ences (practitioners, first responders, participants, perpetrators, victims/survivors, etc.), levels of response for delivery of services (individual to system), and policy at every government level.

5. The proposed collection represents a significant investment of USF resources and should be designed not only to support USF researchers, but also to appeal to scholars who might travel to FMHI/USF to work in our library or request items through inter-library loan to substantiate their own understanding of the topic. FMHI Research Librarians have systematically reviewed disaster mental health-related collections at other nationally recognized, academic centers, providing a gap analysis that affords us an opportunity to make a unique contribution to this global field of study. The collection can build depth in certain areas or specific geographic areas where no systematic aggregation of resources has yet occurred.

We believe this approach to collection development allows us to quickly target and develop collections in response to the changing nature of disaster services, particularly within a public health/mental health perspective. It also allows us to code older materials in our collection to capture the scope and depth of our collection.

Call Number Analysis (a portion of the total list)

The matrix below lists LC class numbers and LC subject headings, which are mapped to Dewey class numbers as well as to the National Library of Medicine classification schedule and the MeSH (Medical Subject Headings). This matrix offers the CD librarian a broad view of subject headings and the associated call numbers, useful in analyzing the strengths and weaknesses of a targeted collection.

DISASTER MH CLASS/SUBJECT MATRIX

Class Schedule	Subject headings	DEWEY	NLM	MESH
BF176-176.5 Conspetus 3	Disasters--Psychological aspects-- Testing	150.287 150.87 153.93 152.8	BF 176	Disasters Psychological tests See also names of specific tests

BF723.D5 Conspectus 4	Disasters--Psychological aspects Disasters – Reactions to	155.4+ 136.722752 370.1523	WA 295	Disasters--Psychological aspects Survivors -- Psychological aspects Disaster Planning Mass Casualty Incidents War
BF789.D5 Conspectus 4	Disasters--Psychological aspects September 11 Terrorist Attacks, 2001-- Psychological aspects. Terrorism victims' families -- Psychology. Terrorism -- Psychological aspects. Disaster victims x Mental health ser- vices x Planning Disaster victims x Services for x Plan- ning Emergency medical services x Planning Emergency management Disaster relief	155 303.625	WA 295 WM 170 HV 6430-33	Terrorism -- Psychological aspects. Disasters— “ Survivors – “ September 11 Terrorist Attacks Mental health services x Planning Emergency medical ser- vices x Planning Disaster Planning Mass Casualty Incidents War
<i>BL65.T47</i>	<i>Violence x Religious aspects. Terrorism x Religious aspects</i>	201.763+	WA 295 WM 170 HV 6430-33	<i>War crimes Violence --Religious Beliefs Terrorism -- Religious Be- liefs September 11 Terrorist Attacks [Incident Name Terrorist Attacks]</i>
<i>BJ1475 Conspectus 2</i>	Humanitarian assistance x Standards.	361.74	BJ 1474	Special topics, by subject
<i>BL80.3</i>	<i>Radicalism x Religious aspects Terrorism x Religious aspects</i>	322.1	WA295	<i>Violence --Religious Beliefs Terrorism -- Religious Be- liefs Terrorism x prevention & control</i>
<u>BP64.A32</u>	<i>Qaida (Organization) Islam and politics -- Africa, East. Jihad. Terrorism -- Africa, East. Terrorism -- Government policy -- United States. Africa, East -- Politics and government -- 21st century. Africa, East -- Ethnic relations.</i>	320.55709676	WA 295 WM 170 HV 6430-33	Terrorism

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