

Emergency mental health lessons learned from Continental Flight 3407 disaster

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When a disaster's physical evidence is gone -- debris removed, shooter arrested, ashes cold -- the psychological effects of the disaster on emergency responders and civilians involved still may burn.

Emergency mental health, a field often overlooked in the chaos, is a vital component of any disaster response, but may not be well represented in [emergency preparedness](#) planning.

Trained mental health responders to the Continental Flight 3407 disaster outside Buffalo in 2009 share their lessons learned on mental health preparedness in an article that appears in the current issue of Disaster Medicine and Public Health Preparedness.

Gregory G. Homish, PhD, assistant professor of community health and [health behavior](#) at the University at Buffalo School of Public Health and Health Professions and a specialist in emergency preparedness, is first author.

"We hope our lessons learned will be useful to others to help them prepare for future disasters," he said.

"Although it is a gross understatement, the crash of Flight 3407 was a tremendous loss for the families and friends of those on the aircraft, on the ground and for the community at large," Homish continues. "However, pre-disaster planning, training and evaluations of previous responses help to ensure a coordinated approach to providing [mental health services](#) to all of the individuals in need."

The assessment found several key successes. Perhaps the most important was that authority and relationships among responders were clearly identified in advance.

"Each emergency mental health team was assigned to a specific population, and leadership from all three teams communicated regularly by

telephone or in person to ensure adequate coverage and no duplication of services," says Homish.

"Many first responders are members of multiple teams in which they play different roles. For Flight 3407, responders chose a single team and had to stay with that team for the duration. This requirement was a lesson learned from a previous disaster, when it wasn't clear which team the individual was representing. This creates communication and coordination problems."

Other positive results were: Responders covered all persons who might be affected by the crisis, including responders and community members as well as victims and families.

Mental health referrals were long lasting and included nontraditional mental health approaches, such as canine therapy and massage therapists.

Also, preparedness includes ongoing recruiting of new members and providing frequent low-cost or free training, which keeps all responders up to date and familiar with other team members. Homish points out that these interactions provide essential skills training and increase efficiency during a deployment.

The report also discusses some areas in need of improvement. It points out that during a crisis one person may need to be assigned to focus entirely on administrative services, such as scheduling and coordinating the emergency mental health functions, to increase efficiency.

An additional recommendation noted the importance of integrating emergency mental health personnel into the overall command structure from the beginning.

"The emergency mental health function was not represented initially during command briefings,"

says Homish.

"For the first 24 hours, command staff made decisions about mental health needs of the community without having an expert available to provide consultation and direction. This resulted in a slight delay in the delivery of a comprehensive response to those affected by the disaster."

A final recommendation emphasizes that employers of volunteer responders need to be prepared to release emergency team members quickly from their jobs.

"It's also important to note that traditional mental health services such as therapists, and complimentary approaches, such as canine therapy teams, are available to everyone, families as well as responders," Homish adds.

Provided by University at Buffalo

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