Medicine, and the National Center for Post Traumatic Stress Disorder.

> *In the past decade, there has been a growing movement in the world to develop a concept similar to physical first aid for coping with stressful an traumatic events in life. This strategy has been known by a number of names but is commonly referred to as psychological first aid (PFA).*—Institute of Medicine, 2003.

Psychological First Aid is an approach for providing assistance to victims, family members, and first responders in the immediate aftermath of disaster. It has been designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning.

The basic objectives of PFA are to: (1) establish a human connection in a non-intrusive manner; (2) enhance safety and provide comfort; (3) calm and orient emotionally distraught survivors; (4) offer practical assistance and information to help survivors address their immediate needs; (5) connect survivors as soon as possible to social support networks; (6) support positive coping efforts; (7) empower survivors to take an active role in their recovery; and (8) provide information that may help survivors to cope effectively with the psychological impact of disasters.

Psychological First Aid can be provided by a variety of disciplines including: (1) mental health specialists; (2) first responders; (3) emergency medical providers; (4) school personnel; and (5) faith-based providers.

This presentation is designed to give Congress attendees a basic overview of PFA.

Keywords: disaster; mental health; Psychological First Aid; psychology
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Beliefs and Attitudes to Family-Witnessed Resuscitation among Doctors, Nurses, and Paramedics in Emergency Departments

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Background: The tragedy of the sudden or unexplained death of a patient in the Emergency Department (ED) can leave the surviving loved ones with many unanswered questions. Giving the family the option to be present during resuscitation offers a more compassionate and family-centred approach to this crisis.
Objective: To provide an insight into the attitudes and beliefs of UK-ED staff about family witnessed resuscitation (FWR).
Methods: A survey was conducted among the doctors, nurses, and paramedics who work in two UK EDs. Experience, life support training, years in practice, consent issues, as well as ethical factors and concerns regarding medico-legal implications were sought. A 5-point Likert Scale was used and mean scores were analyzed.
Results: Of the 129 staff members surveyed, 34% of doctors, 29% of nurses, and 35% of paramedics believed in the concept of trauma FWR. In cardiac arrest patients, 55% of staff members were in favour of FWR, 28% opposed, and 17% were undecided. In addition, 62% of respondents believed that litigation was possible with FWR (mean 1.9; SD 0.8), and 83% thought that critical incident debriefing would be of benefit to assist staff dealing with stress (mean 1.5; SD 0.4). Fewer doctors believed in FWR in cardiac arrest patients compared to nurses (p =0.004) and paramedics (p =0.006). In trauma, these differences were non-significant.
Conclusions: Healthcare professionals caring for families in the EDs must recognize the need for compassionate, family-centred care using a well-trained and motivated team, equipped with effective, well thought-out guidelines.

Keywords: attitude; belief; emergency department; family; psychosocial; resuscitation
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Effective Disaster Mental Health Policy is Integral to Preparedness

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Studies show that the impact of the terrorist attacks of 11 September 2001 was widespread and long-lasting. A study of children in grades 4–12 found that 28.6% of the children showed symptoms of depression and/or anxiety six months after the attacks. Data from a 2003 survey show that two years after the attack, 30% of city adults continued to feel depressed, and 26% continued to show multiple emotional reactions to 11 September 2001. For children, 24% showed signs of anxiety, depression (12%), sleep disturbances (11%), and 16% complained of somatic problems. That same year, crisis counseling services ("Project Liberty") lost their funding despite documented need. The crisis counseling model was and still remains limited in the degree to which it diagnoses and treats mental health problems. While crisis counseling focuses on services provided during a disaster, data show that one year after 11 September 2001, only 13% of New York children who were affected by the attacks received professional services. More than (US)$150 million in federal funds were allocated for crisis counseling. However, Project Liberty was cancelled so abruptly that funds were returned while people in need went unserved. Currently, similar problems now are occurring in the aftermath of Hurricane Katrina. Providers in New Orleans are expected to screen children for mental health needs and refer them for services, but there is a grossly inadequate supply of places to which referrals can be made. Evidence on which effective disaster mental health policy may be based with reference to baseline service capacity, applicable law (the Stafford Act), and regulations will be presented.

Keywords: disaster; emotional reactions; mental health; preparedness; symptoms
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