



NY DMH Responder

Spring 2017

Volume 22 Issue 2

In this Issue...

Why Infectious Diseases?

Keynote: Just When You Thought It Could Not Get More Complicated!

Behavioral Health and Infectious Disease Outbreaks: Lessons from the Field

Lessons Learned: Treating Ebola In Bellevue Hospital

The DMH Responder is a quarterly production of...

**NYS Office of Mental Health
Office of Emergency
Preparedness and Response**
Steve Moskowitz, Director
518.408.2967
Steven.Moskowitz@omh.ny.gov

**NYS Department of Health
Office of Health Emergency
Preparedness**
Judith LeComb, Manager
Preparedness Training
and Education
518.474.2893
prepedap@health.ny.gov

**Articles contributed by the
Institute for Disaster Mental
Health at SUNY New Paltz**
www.newpaltz.edu/idmh



Subscription to NY DMH Responder


If you would like to be added to the mailing list for this quarterly newsletter please email prepedap@health.ny.gov

Welcome

Welcome to the Spring 2017 issue of the **New York DMH Responder**, our quarterly newsletter for the Disaster Mental Health community. This edition summarizes presentations at the recent Institute for Disaster Mental Health at SUNY New Paltz conference, **“Psychosocial Response to Pandemic Disasters, Infectious Diseases, and Bioterrorism.”** Fueled by both international travel and climate change, the global community has been impacted by several high profile pandemic and infectious disease threats: SARS, Avian Flu, H1N1, Ebola, and most recently the Zika Virus. Even when no citizen is infected the fear of an outbreak and the preparation for a response to these threats impacts everyone and requires a carefully coordinated response. The IDMH conference brought together experts from fields including healthcare, emergency management, mental health, government, and more to discuss their various roles in preparing for and responding to future disease outbreaks.

Thanks to generous sponsorship by the New York State Division of Homeland Security and Emergency Services that fully covered registration fees for staff from DOH, OMH, and other relevant fields, the event was sold out. If you weren't able to attend, this newsletter will describe the key points that were covered with links to available archived presentations.

As always, your feedback and suggestions for topics to cover in future issues are welcome; please email any comments to Judith LeComb at DOH or Steve Moskowitz at OMH.



Having Ebola was almost easier than constantly fearing it.

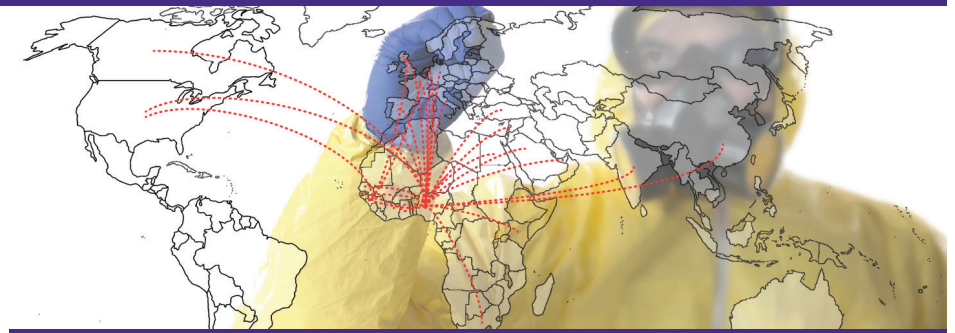
– *Dr. Craig Spencer,
Director of Global Health in
Emergency Medicine, New York
Presbyterian/Columbia University
Medical Center and Ebola survivor*

Keynote:**Just When You Thought It Could Not Get More Complicated!**

The first keynote address was presented by Brian Flynn, Ed.D., Associate Director at the Center for the Study of Traumatic Stress, and Adjunct Professor of Psychiatry, Department of Psychiatry, Uniformed Services University. His goal, he said, was to provide an overview of themes and important conceptual issues in infectious disease outbreaks that would be addressed further in other presentations and workshops.

Dr. Flynn's first point was that the scope of consequences of these events often exceeds those of more traditional disasters. Disease outbreaks cross geopolitical boundaries, impact multiple (potentially all) demographic groups and impact many life domains including personal lives as well as community and social lives and their effect could span generations. Similarly, the magnitude of consequences may be vastly more intense, impacting millions of people, and compromising or destroying systems (health, government, educational, business, economies, etc.). They may cause long-term social disruptions including stigma, ostracizing survivors, and relocation of populations, resulting in disrupted support systems.

A major concern Dr. Flynn raised regarding these points is that we currently lack models of preparedness for national and transnational disasters with behavioral health and health consequences and it's unclear who owns the responsibility for preparedness, response, and



recovery in events that cross multiple borders and involve different systems and legal/civil authorities. This is particularly complex as these public health events will occur in a context of loss, grief, and probably blame.

And the stakes of failing to provide an integrated response are high. Emotionally, it will increase fear, pain, suffering, and loss for those impacted. We will also face the potential for social and economic decline or collapse, as well as continued or accelerated loss of confidence in government. In this climate, behavioral choices based on fear

and anger could kill more people and do more socioeconomic damage than the event itself. In contrast, he outlined these benefits of success:

- Reduced death, loss, suffering
- Reduced socioeconomic adverse impact
- Economic growth
- Stronger individuals and communities
- Restoration in confidence in leadership
- Promotion of pro-social/positively adaptive behavioral choices leading to enhancing the public's health

continued on page 3

Conference Resources

IDMH | **14TH ANNUAL CONFERENCE**
INSTITUTE FOR DISASTER MENTAL HEALTH

PSYCHOSOCIAL RESPONSE TO PANDEMIC DISASTERS, INFECTIOUS DISEASES, AND BIOTERRORISM

APRIL 7, 2017
State University of New York at New Paltz

Presenter biographies, links to presentations, and additional resources can be found at: <https://tinyurl.com/14th-IDMH-Conference>

Keynote: Just When You Thought It Could Not Get More Complicated!, *continued*

Core Challenges

Dr. Flynn then addressed specifically why it's so difficult to develop and deliver good preparedness, response and recovery, listing what he described as seven "cracks in the foundation" in the field:

1. A lack of understanding that the psychosocial factors are the most significant human impact in disasters with a higher cost of adverse psychosocial consequences than other health effects.
2. Lack of understanding of the broad scope of the roles behavioral health can play in addition to direct intervention, such as consultation to leadership, risk and crisis communication, needs assessment, and program evaluation.
3. Leadership makes a tremendous difference but is too often absent, inconsistent, or lacking the big picture. Good leadership requires the ability to integrate and advocate for science, to understand real world response complexity and political realities and to include compassion in a response.
4. Progress, innovation, and integration in the field is often personality-dependent and linked to one individual; when that person leaves these factors tend to suffer.
5. There is almost always a lack of adequate resources; human capacity, funding, and time are all necessary.
6. Our culture seeks easy, cheap, immediate, one-size-fits-all solutions to complex problems,

rather than accepting complexity and the need to value lessons from other countries.

7. Failure to include the public in planning results in inaccurate assumptions about human behavior, and reduces compliance, trust, and confidence.

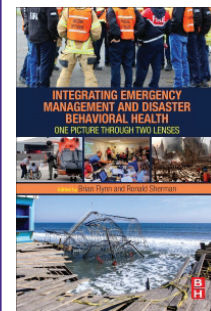
A key question in improving planning is figuring out who "owns" the response legislatively, financially, strategically, socially, and existentially. Dr. Flynn described that last point as perhaps the greatest challenge as it includes how we define success vs. failure and how we will treat members of our communities, or even our families, when they become ill and are suddenly perceived as a threat. We'll reflect on these issues, he said, when the crisis is over and we begin to judge our own performance.

Dr. Flynn then expanded on how infectious disease outbreaks differ from traditional disasters and on the importance of those in the field advocating for the needs of our constituents. We don't have room to describe these important points in detail in this newsletter, but you can watch this part of his very interesting presentation beginning at the hour and 15 minute point here: <https://tinyurl.com/14th-IDMH-Conference-Flynn>

You can also watch Dr. Flynn's afternoon workshop on "Integrating Emergency Management And Disaster Behavioral Health: Overview

and Special Considerations For Pandemics, Infectious Diseases, and Bioterrorism" here: <https://tinyurl.com/IDMH-Flynn-Workshop>

Integrating Emergency Management and Disaster Behavioral Health



Dr. Flynn's new book, edited with Ronald Sherman, identifies the most critical areas of integration

between the profession of emergency management and the specialty of disaster behavioral health, providing perspectives from both of these critical areas and also including very practical advice and examples on how to address key topics.

- ISBN-13: 9780128036389
- Publisher: Elsevier Science
- <https://www.elsevier.com/books/integrating-emergency-management-and-disaster-behavioral-health/flynn/978-0-12-803638-9>

The book includes a chapter by OMH's Steve Moskowitz, with Albert Ashwood, Brian Flynn, and Ronald Sherman, on "Why Is Integrating Disaster Behavior Health Essential to Emergency Management? Challenges and Opportunities."

Why Infectious Diseases?

Following opening remarks by SUNY New Paltz's Gerald Benjamin, Director of the Benjamin Center, and Amy Nitza, Director of the Institute for Disaster Mental Health, Nikhil Natarajan, Deputy Director of the New York State Office of Emergency Management who spoke on behalf of Deputy Commissioner Kevin Wisely. Deputy Natarajan commended the important progress that has been made in recent years in breaking down silos between response partners – government and private sector, public health and health preparedness and mental health and emergency managers working with all parts of their communities. This collaborative approach benefits those individuals who have been through disasters and he emphasized that addressing mental health consequences is essential in events like a pandemic that could result in thousands of fatalities.

That point was then further personalized by the next speaker, Craig Spencer, M.D., M.P.H., Director of Global Health in Emergency Medicine, New York Presbyterian/Columbia University Medical Center, who contracted Ebola while working in Guinea, West Africa with Doctors Without Borders. Dr. Spencer also emphasized the need to understand the psychosocial impact of emerging diseases. He encouraged the audience to recall how immense and omnipresent the fear of Ebola was in 2014: For many in New York so much anxiety surrounded “the idea that this invisible enemy could somehow invade our shores through the body of a healthcare worker like myself, or through someone else with malicious tendencies.” Yet at the time he noted Ebola had killed fewer Americans than falling vending machines, or icicles! But that fear, however misplaced, directly influenced how we responded to Ebola both here and in West Africa – and educated people with an understanding of science were not immune. He noted reports of patients presenting to hospitals in the US who were placed in quarantine because they had recently been to Africa, even if they'd been in South Africa, which is farther from the outbreak region that New York is.

Dr. Spencer acknowledged his own fear at the time including feeling paralyzed about inserting an IV for a patient with Ebola; knowing the consequences if he exposed himself in the process. And that fear compounded the limited resources in the response in



West Africa where many healthcare providers were extremely overworked, lacked adequate personal protective equipment, and were also coping with the deaths of spouses and family members. He also acknowledged the “disastrous and short-sighted” official approach to changing burial traditions that spread the disease that failed to understand the cultural significance of these rituals.

Dr. Spencer concluded his remarks by noting that conference presenters were there to discuss the lessons we've learned from Ebola and other outbreaks – but asked “what if we really haven't” learned those lessons? The international community was slow to respond to the epidemic and then allowed politics and economics to override public health concerns. Once the outbreak was no longer perceived as a risk here, “we patted ourselves on the backs and considered it a case closed and forgot about the fear and hysteria that gripped the country and much of the world in 2014 and 2015.” We failed to apply those lessons about the importance and efficiency of prevention during the early stages of the Zika response when funding for public health measures was delayed – and then was taken from remaining funds allocated for Ebola. Dr. Spencer said that these examples are why this conference must not just be an “academic exercise but a cohesive call to arms for all of the fields and professions that are gathered here today.” We must learn these lessons and remember to apply them, he observed, including addressing the immense and often underappreciated psychosocial impacts of disease outbreaks.

Behavioral Health and Infectious Disease Outbreaks: Lessons from the Field

The second keynote was presented by Captain Michael E. King, M.S.W., Ph.D., a social worker and epidemiologist in the Epidemiology Workforce Branch in the Division of Scientific Education and Professional Development at the U.S. Centers for Disease Control and Prevention. Dr. King focused on three past infectious disease outbreaks that offer specific lessons for the future: SARS, Ebola, and Zika.

First, Dr. King defined “emerging infectious disease” as a disease that is:

1. New in humans; or
2. Appearing among humans in a new population or region; or
3. An old disease, performing in a new manner

To point out how everyone is at risk from these emerging diseases he asked how many in the audience had ever been on an airplane, been bitten by a mosquito, had a cold or the flu, look like they could be from Asia, Africa, or Canada, are a healthcare provider, or don't have two weeks of food and water stockpiled in their home. Of course that encompassed everyone in the audience.

Dr. King then discussed the fear that inevitably accompanies these outbreaks since they contain so much uncertainty. The role of the responder ultimately is to try to break the chain of transmission and contain the outbreak which involves understanding the “human factors” or behaviors involved in transmission, the “agent factors” of the disease itself, and the “environment factors” related to where the outbreak is occurring. While we know some actions that can be taken to break the chain we also have to recognize that just like medications' side effects, any social actions will have both intended and unintended consequences. So, if we attempt to limit transmission by limiting movement, we know that people will lose their freedom, they might lose money if they can't work, they'll be socially isolated just when we know they need social support the most and they'll probably experience some social stigma. To avoid these effect people may not cooperate with efforts to limit their movements with the result that the disease will continue to spread. Instead of relying on mandatory measures to limit movement Dr. King suggested, we need to understand the human factors that influence behavior as in the three outbreaks he then discussed.

SARS, 2003

Severe Acute Respiratory Syndrome first spread through Hong Kong, infecting some 2,000 people. 360 of those infected were healthcare workers who initially didn't understand they were responding to a highly infectious disease. One of them was a WHO physician who treated a patient, realized he was seeing a new disease and reported it to the WHO – and then, sadly, contracted and died of the disease. As the disease spread in Asia the absence of a vaccine meant that public health authorities had to rely on isolation and quarantine to try to contain the spread, including quarantining an entire housing development. Still, the disease spread globally, infecting some 8,000 people worldwide and killing 774.

There were only 8 confirmed cases in the US, yet the media singled out healthcare workers and especially anyone who looked Asian as potential threats, creating a racially based fear that the CDC tried to overturn using a program of community outreach to study and address stigma in social and cultural context. CDC representatives did focus groups with members of Asian-American communities, monitored media coverage, and did outreach to health departments and healthcare workers. A public survey found that Americans were limiting international travel, avoiding people who might have been to Asia and avoiding Asian restaurants. Remarkably, 92% of people said they would be willing to be quarantined if they'd been exposed to SARS and 85% said they would not view quarantine as an infringement on their rights. CDC then focused on information dissemination in multiple languages. Behavioral health had a seat at the table throughout this coordinated, data-driven response.

Ebola, 2014

West Africa experienced the biggest outbreak of Ebola in history with the disease spreading rapidly through numerous communities. Ultimately 28,000 people were infected and 11,000 died before the outbreak was contained by the end of 2015. This was not the first outbreak of Ebola, of course, but the pattern of transmission shifted this time. As a known and highly feared threat, stigma towards

Behavioral Health and Infectious Disease Outbreaks: Lessons from the Field, continued

victims arose immediately and spread far beyond the boundaries of the actual outbreak. When the first infected patient traveled to Dallas and became ill, CDC responded immediately with a 10-person team that was sent to Dallas to trace the patient's contacts and to assist with the response. Disturbingly, two nurses who had treated the patient contracted Ebola despite reporting proper personal protective equipment use. This fueled media coverage and public fear far beyond the already heightened reactions to the initial patient.

CDC begin monitoring 179 contacts of the original patient, including 20 community members and 159 healthcare-related contacts. Among the community members, 8 were children who were kept out of school for the 21-day quarantine period and needed to have laptops and homework provided. One was a homeless man who rode in the ambulance the first patient had been transported in; he needed to be located and then given shelter through the three weeks of quarantine. Local media published the pictures, names, and addresses of two contacts, causing them to experience public stigma. While limiting contact movements is an effective way of preventing transmission, Dr. King pointed out that this was at the cost of marking contacts for public fear and stigma and impeding their ability to continue activities of daily living, making them dependent on the CDC team for all basic needs.

Healthcare workers involved in the response expressed fear about becoming infected and about infecting their families, while struggling with their duty to respond despite their fear. Some were also frustrated at not being able to provide patient care during their observation period. In general, Dr. King noted, everyone who was involved in the response needed to act as a behavioral health provider in some ways so he encouraged the audience to think about how they might incorporate those skills into their role even if they're not mental health professionals.

Zika, Current Outbreak

Zika represents Dr. King's third type of emerging infectious disease, an older disease acting in a new manner. The Zika virus was originally identified in a Rhesus monkey in Uganda in 1947. From the 1950s to '80s it spread by infected mosquitos through

Africa and Southeast Asia in sporadic outbreaks, with a total of just 14 confirmed cases worldwide. It wasn't until 2007 that a major outbreak occurred in Micronesia, when more than 70% of one island's population of 7,000 were found to be infected – though fewer than 20% of them were symptomatic, suggesting there had probably been many more cases of infection in the past that remained unnoticed. By 2013, more than 30,000 cases were reported in French Polynesia and other Pacific islands. Soon after that, a link between Zika and the rare autoimmune disease, Guillain Barre Syndrome was recognized. Next Zika was found in Brazil, where doctors were also recognizing a spike in the number of babies born with microcephaly. Suddenly that meant that any woman who was pregnant or might become pregnant must be seen as a member of an at-risk population, and a disease that had rarely caused much harm was now a serious threat.

In December, 2015, Puerto Rico announced the first case of non-travel-related Zika virus and soon after that the WHO announced that Zika was now an international public health emergency. The very next day Texas announced the first known case of sexually transmitted Zika; soon after that the causal link between the disease in mothers and microcephaly in babies was established. Rates of infection continued to grow in Puerto Rico, and the first case in the continental US was found in July 2016 in Miami, Florida. Containment efforts included spraying entire neighborhoods with an anti-mosquito chemical that is approved in the US but banned in Europe, leading to public protests regarding safety concerns.

All of these shifts demonstrate how rapidly transmission of Zika has shifted. Not only can it be spread via mosquito bite as in the past, now it can also be spread from a pregnant woman to her fetus and it can be spread sexually. Prevention essentially involves not getting bit by a mosquito which can involve using insecticides, larvicides, and barriers like clothing and mosquito netting. Yet it's continuing to spread – in part, perhaps, because most people who become infected are never aware of it. CDC is now focusing on education and prevention efforts aimed at pregnant women, using kits that include informational materials and personal protective supplies like netting, mosquito spray, and condoms.

*Behavioral Health and Infectious Disease Outbreaks: Lessons from the Field, continued***Lessons Learned**

Overall, Dr. King said, we know that there are effective ways to control both infectious disease outbreaks and the related fear but we have to choose to use them to avoid unintended consequences. This can include doing research and using data to determine how to communicate with the population at risk, and to reduce stigma.

Bringing together lessons from these three outbreaks, Dr. King highlighted the following points:

1. We've got to "know before we go" that a plan will be received as intended which requires involving the population at risk in our plans. That means we've got to use data to evaluate our efforts, preferably mixed methods studies that include rich qualitative data like focus groups as well as surveys and other quantitative methods.
2. To fight the fear you've got to communicate the facts. People are bad at assessing risk which means they can't protect themselves and won't cooperate with public health authorities because they're not basing their decisions on accurate understanding of the threat or the solutions.
3. We need to support the public – and our responders – who are dealing with the emotional impact of an outbreak. CDC trains staff and responders in Psychological First Aid which has been effective in maintaining individual and organizational resilience.

In general, Dr. King noted, when people are afraid they're unable to process scientific information. We need to acknowledge that and do what we can to calm their fears in order to build trust and improve cooperation.

See Dr. King's presentation (video only as he was not able to share his slides) at:
<https://tinyurl.com/14th-IDMH-Conference-King>

**Lessons Learned:
Treating Ebola In Bellevue Hospital**

In the final keynote Dr. Craig Spencer returned to the stage, accompanied by Laura Evans, M.D., Associate Chief of Medicine & Chief of Critical Care, NYC Health Hospitals/Bellevue. In 2014 Dr. Evans oversaw Bellevue's care of about 20

CDC Zika Resources

The Centers for Disease Control and Prevention's guide to Zika, including current incidence information, guidance for pregnant women, and the CDC Interim Response Plan, can be found at: <https://www.cdc.gov/zika/index.htm>

patients with suspected Ebola (none of whom did have the disease) as well as the one confirmed case received at the hospital: Dr. Spencer. The two spoke about their experiences treating patients in vastly differently resourced situations and from the perspectives of healthcare provider and patient.

First, Dr. Spencer described his work with Doctors Without Borders in the fight against Ebola in Guinea, in West Africa, which began in September 2014. He was sent to the epicenter of the outbreak, then several months old, where the Ebola Treatment Unit was receiving 70 to 80 cases per week. While there were no new cases in the US at that point some American healthcare workers had been flown back for treatment and there was generally growing awareness of the threat the outbreak could present for the rest of the world beyond the initially impacted countries. After some internal debate and discussions with his family Dr. Spencer decided to join Doctors Without Borders to help treat Ebola patients.

After returning to New York he went to the Doctors Without Borders office to debrief, where he said he received some excellent advice: The Psychosocial Care Unit representative told him that "the likelihood that you're going to get Ebola is extremely, extremely low – but you need to be prepared. I know you've talked about this with your family and your fiancé but don't just talk about how low the risk is. I want you to go home and talk with your family and your partner about what will happen, what will you do, for this extremely unlikely scenario." And he did. They sat down for an hour and made a game plan about what would happen, who they would call, and what they would do if he got sick.

The next few days were difficult for Dr. Spencer as he reflected on having worked 16 hour days, watching people day under horrible circumstances with little

continued on page 8

Behavioral Health and Infectious Disease Outbreaks: Lessons from the Field, continued

resources to help medically. Compounding emotional distress over what he'd experienced there was also the inevitable concern about becoming ill, which he knew was shared by other returning responders. For most, it was a matter of waiting out the 21-day incubation period and then knowing they were fine. But his outcome was different – and his own reaction was surprising: “That morning when I woke up and felt different – I don't say this lightly, but in some way it was almost relieving. That idea of waiting for what I'd built up in my head as the inevitable had finally come and it seemed like dealing with it was almost easier, if only for a brief second, than constantly fearing it.”

At that point he entered the care of Dr. Evans – who initially believed he was presenting as part of an Ebola drill! News broke incredibly quickly: As Dr. Spencer was being transported by ambulance to Bellevue his parents called him and said they'd already been contacted by CNN. At that point he said he believed he might have some other disease like malaria but had to confront the fact that he might have a condition he had just seen young and healthy people die from.

After being tested and waiting a few hours for results Dr. Evans delivered the news that Dr. Spencer had tested positive for Ebola. He said they sat in silence for a few seconds, and then both asked “What are we going to do now?” It affirmed, he said, the standard advice healthcare professionals and others always receive about delivering bad news: Be direct, don't waltz around it or use ambiguous language. He said that Dr. Evans and others were

always direct and that was very helpful for him as a patient to be able to plan what to do next. He also had limited initial exposure to “the full extent of the craziness” going on in New York City and elsewhere as media coverage fanned pre-existing public fears about an epidemic spreading in our communities. While the majority of the mail he received later was supportive and positive, a small percentage attacked him, including one person who sent a clipping of a New York Times article about his activities before getting ill, helpfully annotated with comments like “Inconveniencing all of these people just because you are selfish and thoughtless.”

Dr. Evans then discussed her experiences at Bellevue. She described the glaring gap between the actual magnitude of Ebola's effect in West Africa where it killed thousands and devastated communities, versus the perceived magnitude of effect in New York City where there were extensive resources and only one single confirmed patient. The perceived risk vastly outweighed the actual risk for the community but that did not allay public fears. Dr. Evans also noted the difficulty of countering the flood of “non-fact-based communications” spread by news media and unreliable online sources by disseminating factual information.

Dr. Evans praised the extensive psychosocial support that was provided at the time for Bellevue staff members, including guidance on:

- Addressing the effects of isolation, which Dr. Spencer was in for 19 days;
- Maintaining a provider-patient relationship through the barriers of personal protective equipment (PPE) that obscures all but the helper's face;
- Dealing with the public and media attention which placed the entire response under a magnifying glass; and
- The impacts of fear and stigma.

Fears among staff members were fueled by news of the nurses in Dallas who became infected while caring for an Ebola patient at around that time. That personalized the risk for Bellevue staff, Dr. Evans said, making it no longer an abstract risk but a real one accompanied by rising fear. Nurses and staff members also faced stigma even if they were not

Behavioral Health and Infectious Disease Outbreaks: Lessons from the Field, continued

directly involved in the Ebola response; one local restaurant refused to serve customers wearing Bellevue IDs.

To address staff stress Bellevue administrators provided various forms of support including regular interdisciplinary debriefings, basic needs like food and water and individual and group mental health services provided by hospital social workers, chaplains, and psychologists and psychiatrists. It was essential that all official communications be clear transparent and honest, which included acknowledging uncertainty. People could handle uncertainty, Dr. Evans said, but they couldn't tolerate being told one thing and then something else the next day, though that was sometimes inevitable as official guidance regarding PPE and other precautions kept changing.

Dr. Spencer then discussed the importance of psychosocial support throughout his illness and recovery. Some of that came from professional helpers but he also emphasized the value of being able to stay in touch with his friends and family through technology like video chats, even while he was in isolation physically. He contrasted that access with his patients in Guinea who were often completely cut off from family members who resisted visiting the Ebola treatment unit out of fear of being stigmatized in their communities. To fill that vacuum clinic staff eventually tried connecting patients with each other through any shared relations. Ebola is a very difficult disease mentally as well as physically, he said, so anything responders can do to provide psychosocial resources is important – but in highly under-resourced regions like West Africa, having access to any kind of mental health support is highly unlikely for survivors.

Dr. Spencer then addressed the potential conflict between policies driven by public health vs. politics and how the desire for politicians to appear strong and in charge sometimes led to actions that were contrary to scientific needs and likely to inadvertently undermine future public reactions. In particular, he suggested that the use medically unnecessary mandatory quarantines would increase future resistance to similar requirements in the future. He pointed out that the CDC's recently updated quarantine measures limit citizen's access to

National Ebola Training and Education Center

Funded by ASPR and CDC, this training center's mission is "to increase the capability of United States public health and healthcare systems to safely and effectively manage individuals with suspected and confirmed special pathogens." Among other resources, the center website includes links to educational courses, helpful resources and tools, with an online behavioral health course to be made available soon. Center personnel can also perform site visits and provide technical assistance to facilities regarding infectious disease preparedness.

- Website: www.netec.org
- Email: info@netec.org

due process to resist being placed in quarantine and don't require informed consent for those in quarantine to be examined. It's essential for healthcare providers to be informed about these policies, Dr. Spencer said, in order to be able to inform and protect their patients when the next disease outbreak hits our shores.

Dr. Evans then concluded their presentation by discussing how Ebola and other infectious disease outbreaks are likely to impact healthcare workers. One of the main themes Dr. Evans discussed is the balance between patient care and personal risk. Each individual has their own "set point" for that balance which can lead to friction between colleagues with different levels of threat tolerance. Moving forward in building a patient safety culture in hospitals and healthcare facilities, she emphasized the need for a "blame-free environment" where staff can report errors or near misses without fear of repercussion and where a culture of open communication is honored.

Dr. Spencer and Dr. Evans then took questions from the audience – and received a lengthy standing ovation from the audience honoring the work they do to care for those in need.

View Dr. Evans and Dr. Spencer's presentation here: <https://tinyurl.com/14th-IDMH-Evans-Spencer>