BIOTERRORISM: A NEW ROLE FOR SOCIAL WORKERS

By

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Presented by CEUSchool
Brief Bio

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Years of Experience: 20+ as a Social Worker; 5 as a Bioterrorism Grant Manager

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- Post- Graduate Certification in Gerontology
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Writers Comments:

Too often, when emergency preparedness is being discussed, Social Workers are not included in the planning stages. As every Social Worker knows, during a crisis it is the Social Worker who keeps the situation under control when emotions are out of control. Emergency responders cannot effectively do their jobs if they are distracted by distraught individuals. All Social Workers should know their facility’s emergency plans. They should also become part of the emergency interdisciplinary planning team at their agency/facility, if they are not part of it, so their input can be incorporated into the plans.
**Brief Course Description:**

Terrorism, especially bioterrorism, has become a world-wide threat. Social Workers in all types of settings will be involved in a response to any terrorist crisis. This program will provide information necessary for a Social Worker if a terrorist attack, particularly a bioterrorist one, should occur and will cover the following topics:

- An overview of Bioterrorism
- Emergency Management Planning
- Psychological Responses to a Public Emergency
- A Social Worker’s Role in a Public Emergency

**Course Objectives:**

After completing this offering, the participant will be able to:

- Define Bioterrorism
- List at least 3 reasons a country is vulnerable to a bioterrorism attack
- Identify at least 4 bioterrorism agents
- Explain the difference between quarantine and isolation
- Define an Emergency Management Plan
- List the 4 major components of an Emergency Management Plan
- List 3 early intervention goals for psychosocial management during a public emergency
- List at least 4 techniques of self-care a Social Worker should utilize in a public emergency
- List at least 8 categories of items needed in emergency preparedness kits
- Name at least 5 reasons a more severe response to an emergency can be triggered in individuals
SECTION I: BACKGROUND

A bomb placed in a large arena went off during a sold-out sporting event without causing obvious damage. The police initially thought the bomb, assumed to be placed by a terrorist, failed to explode properly. Within 4 days, news broadcasters begin reporting that doctors, outpatient clinics and hospitals within a 75 mile radius of the explosion are seeing large numbers of people with fever, headache, fatigue, difficulty breathing, and chest pain. These respiratory problems quickly progress to pneumonia. It is expected that all social and medical agencies and/or practices will be inundated with people seeking help and support. Soon affected individuals begin dying and the government urges anyone with signs and symptoms of upper respiratory illness who were in the area of the sporting arena on the day of the explosion or who have been exposed to individuals who became ill to seek treatment with antibiotics. Panic takes over. The disease is diagnosed as Pneumonic Plague and in 2 weeks the death toll has risen to tens of thousands.

Bioterrorism is defined as the intentional release of a virus, bacteria, or toxin upon a population for the purpose of causing illness or death. Many people may think that the possibility and/or probability of a bioterrorism attack, such as the one described above, is a scare tactic invented by the media. Unfortunately, a bioterrorism attack is a very real risk in today’s world. Some of the reasons for this are:

- Small amounts of the biological agents can cause devastating effects.
- The agents can be cultivated without excessive cost or the need for extravagant equipment (such as is needed for nuclear or radiological terrorism).
The delayed onset of symptoms allows terrorists time to get away before detection and allows the spread of the agent.

Most civilian populations are currently unprotected

Panic from a biological outbreak would result not only in the spread of the disease but in a disruption of the health care system and social upheaval, impacting all aspects of everyday life.

Initial detection and reporting will, in all likelihood, be made by health care providers identifying unusual clusters of an illness which differ from what would be expected. Surveillance and tracking of these reports by Public Health Officials is extremely important.

Other weapons of mass destruction can also be potential terrorist methods. Chemical and radiological agents can cause devastating effects through respiratory failure such as Sarin caused in Japan’s subway in 1995. Other chemical agents can cause blistering and skin damage, such as Mustard Gas caused during World War I. Dirty bombs can cause immediate death from the blast itself, but they can also cause long-range effects from nuclear and/or radiological contamination. Increases in cancer, such as happened after the Chernobyl nuclear disaster in 1986, could occur as well as environmental pollution which would affect animals, food and water. These affected areas would be unlivable for many, many years, if not centuries. However, it is much more difficult to get the material for chemical, nuclear or radiological material and they are more readily detectable by our current surveillance techniques. Since the goal of terrorism is to create “terror” - the intense, overpowering fear to cause psychological, social, and economic disruption,
not simply to hurt or kill those near the attack - a biological attack on an unsuspecting population is a more likely terrorist choice.

From a historical perspective, bioterrorism is not something new. Biological weapons have been used to wage war and promote terror throughout history. The first recorded use of biological agents was by the Romans, using dead animals to foul the water supply of their enemies. It is believed that the bubonic plague epidemic that swept across medieval Europe, killing 25 million people, was caused by the Tartars catapulting bodies infected with Bubonic Plague over the walls of the city of Kaffa. On several occasions, Smallpox was used as a biological weapon. The explorer Pizarro reportedly gave Smallpox virus-contaminated clothing to South American natives in the 15th century. During the French-Indian War, the British gave blankets used by Smallpox victims to the Native Americans, causing an epidemic which resulted in wide-spread death. During World War II, the Japanese used biological agents against the Chinese and prisoner’s of war. The list could go on and on. Even though the Biological and Toxin Weapons Convention of 1972 banned the development, production, and stockpiling of biological weapons not required for peaceful intentions, many authorities feel that the threat of their use still exists today.
SECTION II: BIOLOGICAL AGENTS

Certain agents have been identified as more likely to be used as biological weapons. They are classified alphabetically, going from the most likely ones to be used to the less likely ones. The Category A Critical Agents are thought to be the ones most likely to be used based on previous use, ease of spreading the agents, the ability to cause significant mortality or illness, and how infectious they are.

The Biological Agents of Highest Concern

- Anthrax
- Pneumonic Plague
- Tularemia
- Botulism
- Viral Hemorrhagic Fevers
- Smallpox

Except for Smallpox, most of these agents can be found in nature. Anthrax is found in the soil, usually through feces from animals. Plague can be contracted by the bite of an infected flea. Tularemia can be found in desert areas from animals. Botulism can be gotten through food contaminated by inappropriate canning. Viral Hemorrhagic Fevers are believed to be spread through the bites of animals. These naturally occurring illnesses usually occur in isolated instances and can be traced to the source of the infection. Any incidence of Smallpox would be
considered an act of bioterrorism, however, as it has been eliminated as a result of a world-wide vaccination program.

Even though most of these agents are found naturally, agents used by terrorists will, in all likelihood, be converted into an aerosol version which can be spread widely. It will be colorless, odorless and be initially undetectable. The agents could be spread to humans directly through the air or they could be used to infect the food supply or environment, such as an area’s water supply. This would enable the agents to be spread to a broader number of people.

**Symptoms of Anthrax:**

These symptoms can occur within 7 days of infection. It is not contagious person to person. The disease is usually 75% fatal, even with appropriate and prompt medical attention.

- Fever (temperature greater than 100 degrees F); the fever may be accompanied by chills or night sweats
- Flu-like symptoms
- Cough, usually a non-productive cough, chest discomfort, shortness of breath, fatigue, muscle aches
- Sore throat, followed by difficulty swallowing, enlarged lymph nodes, headache, nausea, loss of appetite, abdominal distress, vomiting, or diarrhea
- A sore, especially on the face, arms or hands, that starts as a raised bump and develops into a painless ulcer with a black area in the center
Symptoms of Pneumonic Plague:

These symptoms appear suddenly, typically 2-3 days after exposure. It is contagious person to person. If medical treatment is not started within 24 hours after disease symptoms occur, death may be unavoidable.

- Fever, chills, headache, cough, rapid breathing
- Difficulty breathing
- Rapidly progressing pneumonia
- Blood in sputum

Symptoms of Tularemia (also known as Rabbit Fever):

These symptoms usually appear 3-5 days after exposure. It is not contagious person to person. It can be fatal if untreated.

- Sudden fever, chills, headache
- Diarrhea
- Muscle aches, joint pain
- Dry cough, bloody sputum
- Progressive weakness
- Pneumonia, chest pain, difficultly breathing
Symptoms of Botulism:

These symptoms can appear within 3-4 days of exposure. It is not contagious person to person. It is rarely fatal if appropriate and timely treatment is provided. However, individuals may need ventilators (breathing machines) to assist in their breathing and there may not be enough of them if a wide-spread bioterrorism attack were to occur.

- Blurred vision, double vision
- Dry mouth, dizziness, slurred speech
- Difficulty swallowing
- Muscle weakness progressing to paralysis
- Respiratory failure

Symptoms of Viral Hemorrhagic Fevers (VHF) - Ebola, Lassa, Marburg, Crimean-Congo:

Specific signs and symptoms vary by the type of VHF. It is contagious person to person. The incubation period depends on the type of virus exposure. Recovery depends on the care received.

- Fever, fatigue, dizziness
- Muscle aches, loss of strength, and exhaustion
- Bleeding under the skin, in internal organs, or from the mouth, eyes, or ears
- Shock, nervous system malfunction, coma, delirium, seizures
- Renal (kidney) failure
Symptoms of Smallpox:

These symptoms appear within 7-17 days after exposure. It is contagious person to person.
Recovery depends on the care received.

- Fever
- Body aches, headache
- Vomiting
- Rash
- Open sores

It is not necessary to remember each and every thing about a specific biological agent. If an epidemic broke out, everyone will be inundated with information about it. What everyone should be aware of is that most of these critical agents produce initial non-specific or “flu-like” symptoms after an incubation period. Most of them become contagious before people start showing symptoms. But since these symptoms mimic common illnesses, bioterrorism may be overlooked as a cause at first. A cough, pneumonia, headache and confusion are common symptoms of many non-terrorism illnesses. It is easy for a population to be oblivious to the start of a bioterrorism attack and therefore have an epidemic of enormous proportions.
Types of Illnesses These Agents Can Cause

- “Flu-like” illness (fever, sweats, nausea)
- Cough and/or pneumonia
- Headache, confusion
- Skin ulcers (Anthrax, Tularemia, Pneumonic Plague)
- Rashes (Smallpox, Viral Hemorrhagic Fevers)
- Paralysis (Botulism)
SECTION III: TREATMENT

Treatments are available and recovery is possible if treatment is begun in a timely manner. Prophylaxis (the use of treatments to prevent the development of an illness) of exposed persons with antibiotics, antitoxin, or immunization might prevent the development of the disease. However, it is not recommended that the general population take antibiotics as a preventative measure because overuse of antibiotics can cause a person to become allergic to it or for the germ to mutate and make the antibiotic ineffective.

Agents That May Require Antibiotics, Antitoxin, or Immunization

- Antibiotics are used with Anthrax, Pneumonic Plague, Tularemia
- Antitoxin (an agent that neutralizes the poison/toxin that the illness causes) is used with Botulism
- A vaccine for immunization is available for treating Smallpox, Anthrax, and some Viral Hemorrhagic Fevers

As workers in the field, Social Workers should be concerned about their own safety as well as those of the patients. Medical personnel will attend to the health care needs of people. Social Workers will need to take care of non-medical needs of the patients and their families. While performing their functions, Social Workers must be equipped with safety measure to protect themselves. Extensive decontamination after exposure to a critical agent is usually not necessary. Soap and water is adequate in most instances, but Social Workers should be familiar with their facility’s guidelines for decontamination.
General Decontamination Protocols for Category A Critical Agents are:

- Exposed persons – showering/washing thoroughly with soap & water adequate for most; bleach not necessary
- Facility & equipment – may not be necessary if contaminated with agents of short survival time; others may need bleach, sporacidal chemicals, incineration and/or sterilization in an autoclave

Social Workers should also be familiar with a facility’s infection control program. If a Social Worker is not affiliated with a specific facility or agency, recommendations have been developed. According to the US Center for Disease Control (CDC), if the agent is known and a person is not an emergency worker or environmental sampler who is entering a suspected or confirmed site of release or dissemination of an agent, general infection control precautions should be followed. Even though Social Workers may not have hands-on interactions with patients, they may be involved in interviews and assessments with them, so they have to be aware of how to protect themselves. Personal Protective Equipment (PPE) is used for interviewing and information-gathering purposes with potentially exposed or sick individuals. PPE consists of such things as disposable gloves, face masks, and anything else that a person needs to prevent becoming infected with an illness. Various infection control measures and the necessary PPE are used for different agents, depending on how the illnesses caused by them are spread.
Infection Control: Category A Critical Agents

- Standard precautions – all cases
- Airborne & contact precautions - Smallpox, Viral Hemorrhagic Fevers
- Droplet precautions – Pneumonic Plague

Standard precautions should be used in all cases. For standard precautions, a person needs to wear disposable gloves and other disposable personal protective equipment, such as a disposable face-shield and gown, if splashing is anticipated. The protective gear needs to be changed between patients and hands must be washed before putting the disposable gloves on and after removing them.

Standard Precautions – Infection Control

- Disposable, non-sterile gloves
- Hand-washing before and after glove removal
- Disposable gown/apron, face-shield if splashing anticipated
- Change protective gear between cases

Airborne and contact precautions should be used for Smallpox and Viral Hemorrhagic Fevers. Contact precautions need to be used if the disease can be spread through contact with body fluids or open sores. Use standard precautions and only use objects that can stay in the room. For instance, if a book or writing materials are brought in, they should not be removed from the room. Otherwise the infection may inadvertently be spread. Airborne precautions add the use of respiratory equipment with HEPA filters and having the patient in a negative air pressure room.
These would be necessary if the illness can be spread through the air by the patient’s breath. Social Workers must make sure, if they are going into a room that has airborne precautions, that they have been instructed in how to wear the respiratory equipment and that it fits properly or else it will be worthless as protection.

**Infection Control - Contact Precautions**

- Standard precautions plus
- Change gloves & gown after contact with infectious material even if not leaving the room
- Dedicate non-critical patient care items to single patient or disinfect between patients

**Infection Control - Airborne Precautions**

- Standard Precautions plus
- Patient in negative air pressure room
- Wear respiratory protection (HEPA filter mask)

Droplet infections add the use of a face mask whenever anyone gets within 6 feet of a patient if the disease can be spread through coughing. Droplet precautions should be used with Pneumonic Plague.

**Infection Control - Droplet Precautions**

- Standard precautions plus
- Wear mask when within 6 feet of patient
To control the spread of illness, besides using the infection control measures just mentioned, it may be necessary to isolate or quarantine people who have been exposed to a biological agent.

**Definitions: Isolation vs. Quarantine**

- Isolation is the separation of a *contagious* person or group from other people to prevent the spread of infection.
- Quarantine is the restriction of activities or limitations of freedom of movement of people who are *presumed* to have been exposed to a contagious disease, but have no symptoms of the disease, to prevent contact with those who have not been exposed.

Isolation is easier to do and is more readily accepted by others because these people are already sick or are known to be contagious. Quarantine, on the other hand, is harder to do and more negatively received because these people may not actually be contagious. They may feel stigmatized or fear getting an illness from other people who are quarantined with them who may be contagious when they are not. They may feel vulnerable and sense a loss of control.

Quarantine doesn’t necessarily mean putting people away somewhere or locking them in their homes. Population-wide quarantines may also be implemented. These quarantines include such things as suspension of large public gatherings, closure of public places, and the restriction of travel like the restrictions during the SARS epidemic in China and Canada in 2003.

The major reason for isolation and/or quarantine is that the *identified disease can be transmitted person-to-person*. Quarantine may be necessary if exposed individuals can
transmit the disease person-to-person before a diagnosis can be made, thereby inadvertently spreading the disease. Other issues to consider are: how contagious is the disease, the extent of the outbreak, the amount of contact and closeness required to spread the illness, the susceptibility of the population, and how many people are already immune to it. For instance, airborne transmission can affect more people without their knowing it than a disease spread by direct contact. Isolation and quarantine are never necessary if the disease is not transmitted person-to-person.

**Medical Reasons for Isolation or Quarantine**

- **Isolation** – Disease transmitted person-to-person (Pneumonic Plague, Smallpox, Viral Hemorrhagic Fevers)
- **Quarantine** – Disease may be transmitted by exposed persons before a diagnosis is made

In the event of a biological attack, panic and increased stress levels will be common. Real illness, psychosomatic (displaying symptoms of the disease without actually having it) manifestations, as well as concern over sick/dying or exposed loved ones will trigger the increase in these stress levels. Social Workers should be aware that isolation and/or quarantine can dramatically increase the stress that people are under during a bioterrorism event and they may respond in a negative way. Social Workers will be called upon to help deal with these responses. That is why it is important that all Social Workers learn their agency’s Emergency Management plans, their community’s Emergency Management plans and that they and their families develop and practice their own Emergency Management plans.
SECTION IV: EMERGENCY MANAGEMENT

Emergency Management (or Disaster Management) deals with preparing for a disaster before it occurs, responding to a disaster while it is happening, and recovering after a disaster has occurred. Emergency Management is described by various terms throughout the world. For example, Crisis Management is used within the European Union (EU) and the United States developed the National Incident Management System (NIMS). Whatever the terminology, all Emergency Management programs provide a consistent, country-wide template to enable all government, private-sector and non-governmental organizations to work together during a crisis.

The type of Emergency Management plans used depend on local economic and social conditions, as well as the specific type of emergency. However, they all share commonalities. The process of Emergency Management involves four phases: Preparedness, Response, Mitigation and Recovery.

**Preparedness** – This involves evaluating the risks that could occur, the probability of them occurring, the extent of the damages that would occur, and how to handle the situation if the risk occurs. For example, certain areas of a country may be at risk of flooding and have a high probability of it happening. People living in those areas should be prepared for them to occur. Some disasters could happen, but the probability of them occurring is low. For example, a desert area with no population could have an earthquake, but the probability and impact would be low compared to a country like Japan that frequently has them. Preparedness involves not only identifying what the risks are and the probability of them occurring, but also prioritizing the risk
response based on the likelihood of them occurring. In this way resources can be utilized in the most effective and efficient manner. Another aspect of preparedness is casualty prediction - the study of how many deaths or injuries to expect for a given kind of emergency. This gives planners an idea of what resources need to be in place to respond to a particular kind of crisis. This type of evaluation is known as an all-hazards risk analysis. Once an all-hazards risk analysis has been done, an Emergency Plan of Action is developed for each identified risk. Common preparedness measures include:

- Development of communication plans with non-technical, understandable terminology and a Communications Officer to centralize the disbursement of information
- Development and practice of multi-agency coordination (Mutual Aid) and incident command with an Incident Commander (Unified Command) responsible for the overall handling of the emergency
- Proper maintenance and training of emergency services, including community emergency response teams
- Development and exercise of emergency population warning methods combined with emergency shelters and evacuation plans
- Development and maintenance of disaster supplies and equipment in centralized locations
- Development of organizations of trained volunteers among civilian populations to assist professional emergency workers who may be overwhelmed in mass emergencies
**Response** – This involves how the risks that have been identified are dealt with when they occur. The response phase includes the mobilization of the necessary emergency services and first responders into the disaster area. For example, if a bioterrorism attack were to occur, where would information about it be obtained? Where would the closest medical facility to treat someone who was exposed be located? Would quarantine be established for specific individuals or area? What impact would the emergency have on people, property, and business? The response to any significant disaster - natural or terrorist – will be based on the emergency plans developed and the existing emergency management organizational systems and processes established.

**Mitigation** – This means to reduce the effects or prevent a reoccurrence of a disaster. No one will ever be able to plan for every single emergency that can occur. However, by good planning, and knowing what resources are available and which people to contact for a specific type of emergency, the impact of the event can be lessened. Mitigation efforts attempt to prevent hazards from developing into disasters altogether, or to reduce the effects of disasters when they occur. For example, earthquake-prone areas could implement building codes for the reinforcement of buildings to better withstand the effects of the earthquake. Also, areas with known risks, such as being flood-prone, can have flood levees built to mitigate future flooding. Lessons learned can also be used to mitigate future emergencies. This is why fire drills are routinely held in public institutions, for example. It can show what is being done wrong and allows corrections to be made to improve the response. Mitigating the results of the emergency can help the recovery process.
**Recovery** – This means to restore the affected area to its previous state as quickly as possible; what would be needed to restore unmet needs and how can this be done. This may be done on a local, national, or international level. A Social Worker’s assessment skills will ascertain what unmet needs people may have as the result of an incident. These may be concrete things such as food & clothing or reassurance and information to meet their psychosocial needs. By having good preparation and knowing the local resources, recovery will be easier to attain.

**Emergency Management – 4 Components**

- Preparedness – evaluate risks/probabilities
- Response – how to deal with risks/probabilities
- Mitigation – how to minimize the effects or prevent reoccurrence of disaster
- Recovery – What would be needed to restore unmet needs/how to do this

On a personal level, two simple measures can help prepare everyone for sitting out the disaster at home (sheltering in place) or evacuating as necessary. During the disaster, normal functioning of society may be impeded. Supplies such as food and gasoline may not be available because of transportation restrictions. Public facilities such as banks, schools, and stores may be closed. Any public gatherings may be prohibited, closing many businesses. Also, emergency resources may not be available for several days after the start of an emergency. Therefore, each family must take responsibility for their own emergency preparedness.
First, an emergency preparedness kit should be prepared by every family and include the following:

- Water – 1 gallon/person/day X 3 days
- Food – 3 days
- Battery operated radio/television/telephone – extra batteries
- Portable Lighting (flashlight) – extra batteries
- First Aid Kit
- Sanitation/Hygiene Supplies – hand sanitizer lotion
- Kitchen/Cooking Supplies – ready to eat, non-perishable food; non-electric can opener
- Documentation/Personal Records (picture ID, insurance & health records)
- Financial/Money – ATMs may not be working
- Special Needs Items - Adult & Child (favorite toy, hearing aid, medicines, gas for car)
- Clothing/Bedding/Shelter
- Tools – hammer, screwdriver, saw

Secondly, individuals should have their own emergency preparedness plans. Social Workers should know and participate in Emergency Management plans designed for their agencies and communities as well as for their own families. No matter how young a family member is, all members should practice or be part of disaster drills in their home. A communication plan should be in place to contact members who may not be at home if/when an emergency begins. Parents of school-age children should be aware of the Emergency Management plans in their children’s schools. If a family member is in a critical position that would have to respond to an emergency,
the family should know what to do if that member is unavailable to assist them. Practical matters should also be attended to. For example, people should always have at least one-half tank of gasoline in their automobiles to ensure evacuation is possible if it is mandated. Available money should also be on hand because banks may be closed. Enough medication/supplies for chronic illnesses such as asthma or diabetes should be on hand to last until additional supplies can be obtained. People should register family members who need special therapies, such as renal dialysis, in the communities that have this type of registration. Copies of important documentation (i.e. insurance papers, picture identifications, medical records, birth certificates, etc.), should be readily available if they are needed for medical treatment or applying for government assistance. In this manner, individuals will be better prepared for the emergency and reduce their own levels of stress.
SECTION V: PSYCHOSOCIAL MANAGEMENT

Social Workers need to understand their role in any type of emergency response. The basic responses to all emergencies are similar. Besides medical care, people will need other types of assistance during the emergency. The type of assistance they require will be based on their needs. To adequately assess the situation, Social Workers should be aware that people will be affected by the emergency differently. The severity of their response will depend on various things:

- **Proximity to the event:** If people are injured/get sick or they lost a loved one, they will be more affected than those that didn’t.

- **People who are intensely exposed**, such as first responders, will also be more affected by the event.

- **People who are displaced from their homes or are unable to get to work** will have lost a sense of normalcy and be more strongly affected.

- **Loss of property:** People who have lost homes have not only lost their shelter, but have lost personal items that have tremendous emotional value to them (i.e. family pictures, heirlooms, etc.).

- **Some age groups** will be more affected than others, such as the elderly and the young. Children are not little adults. They need to have things explained to them on their developmental level. The elderly are more resistant to change, may not want to leave their home, usually have some medical issues to deal with (need prescriptions, supplies, etc.) and/or may be cognitively impaired (dementia) and not able to understand the situation.
• **Special needs populations** are another group that will be affected strongly by an emergency. For example, they may need assistance with Activities of Daily Living (ADLs) because they have sensory deficits (blindness, deafness, paralysis, etc.) and/or they may be incompetent to fully understand the situation and cooperate with instructions (cognitively impaired, autistic, etc). Others may need continuous medical care (renal dialysis, IV medication, etc.).

• **Culture** may also influence how people respond. Some cultures are very community oriented and will have a good support system in times of crisis. Other cultures may be very emotional and demonstrative and create a sense of panic in people by their behaviors.

• **Having a history of previous trauma, mental illness, substance abuse and chronic illness** will also impact the response people will have to the emergency. These people have had stressors affecting them and their coping skills may not be as effective as those of other people. They may need more psychosocial support to help them deal with the situation.

**Severity of Response Dependent Upon**

• Proximity to event (injured/bereaved)

• Intensely exposed (first responders)

• Displaced from home/work

• Loss of property

• Age (child/elderly)

• Special Needs (developmentally disabled/blind/cognitively impaired/etc)
Culture

History of: previous trauma, mental illness, substance abuse, chronic illness

During an emergency, a Social Worker’s usual role is changed. In-depth needs and psychosocial assessments are not appropriate at this time. Instead, the Social Worker will have certain main goals to attain to stabilize the status of the individuals affected. The goals for immediate assistance to individuals during an emergency can be summarized in 3 early intervention goals:

- Safety
- Function
- Action

The first goal is to provide for people’s safety. Protect them from further physical harm by removing them from the traumatic scene. Also, basic needs such as food, shelter, clothing, sanitation, sleep and medical care should be provided. Information about what is happening, even if it is not good news, will help to alleviate fear of the unknown and reduce needless stress.

Once safety issues are handled, the next goal can be dealt with.

**Early Intervention Goal #1 - Safety:**

- Protect from further physical harm (remove from traumatic scene)
- See to basic needs (food, shelter, clothing, sanitation, sleep, medical care)
- Information dissemination
The second goal is to return the people to as normal a function as possible. By linking them to critical resources, reuniting families and keeping them together, and reducing reminders of the incident by not constantly watching TV, listening to the news, etc., some of the stress will be relieved. Educating them about the body’s responses to stressful or traumatic events can also help alleviate stress. For example, let them know that forgetting words or not sleeping well for a while is perfectly normal. Getting back into as normal a routine as possible will help people recover from the effects of the emergency.

**Early Intervention Goal #2 - Function:**
- Support to return to normal function (reduce stressors/reminders)
- Link to critical resources
- Reunite and keep families together
- Educate about responses to stressful or traumatic events

The third goal is to help people get back to productive activity. Either get them back to their normal routine, or if that is not possible, redirect them to some constructive activities or helping tasks. For example, perhaps an elderly person could read to children in a shelter if they are housed there temporarily or a developmentally delayed individual could be allowed to perform ability-appropriate chores. These activities will provide positive action and make them feel more in control of the situation.
Early Intervention Goal #3 - Action:

- Support to return to productive activity
- Redirect to constructive/helping tasks

If any individuals are identified as having the need for more in-depth mental health services, the Social Worker should refer them to the mental health specialist assigned to that specific task in the Emergency Management plan. By referring them, the individuals are removed from the general population. This decreases their stress by going into a calmer environment. It also lessens the stress of surrounding people by removing disturbances the individuals may be causing.

In the event of a biological attack, additional information Social Workers need to know before they can help others is:

- Is the group or area the Social Workers are helping considered to be in danger of exposure to the disease by authorities?
- What are the signs and symptoms of the disease?
- Are medications or vaccines being distributed?
- Where? Who should get them?
- Where should people go to seek emergency medical care if they become sick?

One other aspect of emergency response should be noted. Social Workers should only respond if they are needed at that time, are part of the Emergency Management plan, and know their role in that Emergency Management plan. Untrained volunteers or people not needed at the scene of the emergency can cause a disruption and breakdown in the Emergency Management plan.
SECTION VI: COMMUNICATION

Throughout all interactions with persons affected by an emergency, nothing is as important as the way Social Workers communicate. Some simple guidelines that should be followed are:

- Be aware of non-verbal communication. The tone of voice or body language will either help to reassure an individual or increase his/her anxiety much more than what is actually being said. Speak slowly in a calm manner without raising the voice level.

- Tell the truth as it is known, when it is known. Fear of the unknown will only increase stress. Also, trust is built when people feel someone is being honest with them. Once trust is established, it is easier to achieve the early intervention goals.

- Explain what is being done to deal with the situation.

- Avoid withholding bad or disturbing information. If people find out something is being withheld, a Social Worker will have lost their trust. This will increase stress and possibly negative behaviors.

- Be forthright about what is not known. Admit what is not known, but reassure them that they will be told as soon it is known. Also, let them know that the information they want to know about will be sought.

- Provide practical guidance. This relates to helping meet the intervention goals. Don’t generalize. For example: Tell them where they can get help for their specific needs (food, clothes, etc.). Inform them of what to expect as far as common reactions to stress and trauma. Help them to fill out necessary forms.

- Make messages simple and straightforward. People under stress tend to be easily distracted and their attention may wander. They can’t focus. They may also have
difficulty processing complex explanations. Written information to supplement what is being said is always helpful.

- If language is a barrier, get an interpreter to relay any information or use pictographs (visual representations of objects/actions) to illustrate what is trying to be communicated.

**Communication - General Guidelines:**

- Tell the truth as it is known, when it is known
- Explain what is being done to deal with the situation
- Avoid withholding bad news or disturbing information
- Be forthright about what is not known
- Provide practical guidance
- Messages should be clear, simple & straightforward
SECTION VII: SELF CARE

Helping and assisting others during and after a public emergency are what Social Workers do. One thing Social Workers and all care providers have to keep in mind is that in order for them to help others, they first have to take care of themselves. The initial thing they must do is decide if they want to assist and can do so without having their own personal concerns interfere. If Social Workers are distracted by personal issues, they will hinder more than help the situation.

Once a decision is made that they will provide assistance, they must remember that a healthy lifestyle is important. They have to make sure they get enough rest and food and that their basic needs are met during this time. They need to self-regulate themselves. They shouldn’t try to overdo things. They need to take breaks and hand off the work to their peers. They need to practice stress management techniques such as deep breathing exercises, walks in the woods, listening to music, or yoga. Another way to increase their comfort level about a public emergency is through additional education about emergency preparedness. The training they receive and the practice they do will help them develop positive coping skills for the emergency. This will help them to deal with the situation better and therefore help others more. In short, self-care involves:

- Healthy lifestyle
- Self-regulation
- Stress management
- Education and Practice of Emergency Preparedness
- Positive coping skills (resilience)
SECTION VIII: SUMMARY

This course described bioterrorism and discussed the potential biological agents that could be used during a bioterrorism attack, their symptoms, and the treatment needed to combat the effects of the illness caused by the biological agents. It described Emergency Management and a Social Worker’s role during the emergency to stabilize the psychosocial effects of the emergency on individuals. It also briefly discussed Social Workers’ self-care to enable them to be as effective as possible for others and for themselves.

Summary of the Key Points:

- Most biological agents produce initial non-specific or “flu-like” illnesses.
- Standard precautions should be used with all clients/patients following a bioterrorism incident.
- Quarantine or isolation is never used unless the disease can be spread person-to-person.
- All emergency responses are based on Emergency Management plans.
- The Incident Commander is in charge of the emergency response.
- Emergency Management consists of four phases: Preparedness, Response, Mitigation, and Recovery.
- Reactions to a disaster will differ from person-to-person based on their life experiences.
- Effective communication is vital.
- The three early intervention goals for a Social Worker in an emergency are: Safety, Function, and Action.
- Care providers need to practice self-care during an emergency response.
- Everyone needs to train for emergency preparedness to be most effective.
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