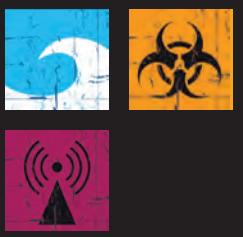

Chapter 14

Family Reunification in Mass Casualty Incidents

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Preface

> "Hospitals are sensitive to the medical care demands that can result from disasters and mass casualty situations, and by and large they prepare themselves to meet these demands. There is a tendency, however, for hospitals to be less sensitive, in their planning and operations, to the emotional and social components related to such emergencies. Yet, psychosocial components are present to some degree in all casualty-producing situations, and in a surprising number of instances the demands they place upon a hospital's non-medical resources are greater than those placed upon its medical and surgical facilities."[1]

The question of whether hospitals should be expected to address psychosocial needs when they prepare their major mass casualty incident (MCI) response plans has been asked since the 1970s, and probably much earlier than that. Part of the challenge in answering the question comes from a lack of direct research and writing on the topic, despite the general acknowledgment of such a need, and the existence of much anecdotal comments. One exception where the question has been answered with action is Israel, where, unfortunately, experience demands a hospital's emergency planning always include a response to psychosocial needs of the family and the patient in the aftermath of an MCI.[2–5]

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The Basics of a Hospital Psychosocial Response

Psychosocial Surges

First Surge

In most mass casualty incidents (MCIs), the first surge at a hospital will begin with the arrival of injured who do not need ambulance assistance[6–8] and will be upward of 80%[9] of the incident's overall patient load. Sometimes known as the "walking wounded," these survivors may be only minimally injured and will be coming in from the incident on their own or helped by passersby. They may arrive en masse, depending on a particular hospital's vicinity to the incident. Many will be emotionally distressed, in some cases severely, suffering from acute stress due to what they have just experienced, including exposure to myriad sensory disaster stimuli—death, loss, separation, and terror.

These first arrivals can overwhelm an emergency department[10] and, in their emotional state, make irrational, insistent demands and requests as they seek information, assistance, and safety.[6] In the midst of this chaos, additional patients will begin arriving—those too injured to bring themselves to hospital, but with the ability to flag down cars and gain assistance. They will be followed by the more severely injured, who arrive by ambulance.

When looking at the overall surge of survivors in a hospital, it has been observed that the ratio of psychological casualties can outnumber the primarily medical patients by 4/1 or greater.[4,9] The greater psychological casualty numbers come from incidents in which people are unsure of whether or not they have been physically compromised, such as gas or radiation attacks.

Second Surge

The second psychosocial surge to be experienced by a hospital involves families and friends who have heard through a variety of sources, including traditional and, more recently, social media, that survivors have been brought to the hospital and sometimes to a specific hospital. For various reasons, these families believe that their loved ones may have been caught in the incident.[3] They may have tried to make contact, but have been unsuccessful. Hearing where the survivors have been taken is a chance at hope, and they will take it. In September 2006, after the shooting at Dawson College, an estimated 300 family members[8] surged to the closest Montreal hospital to Dawson College, McGill University Health Centre. The hospital was "inundated."[8] When they did not find who they were searching for at the first hospital, some of these same families moved on to other area hospitals in a roving surge. The authors of a study on the effects of Dawson now recommend the need for hospitals to have psychosocial intervention plan including a space for families.[11]

It is a known phenomenon that families make it a priority in crisis to reconnect and reunify.[3,5,9,10,12–15] The fear of potential loss drives these situations. It is neither irrational nor panic—although it may resemble it from outside—but a primal need to find the family and bring them to safety. Social support has been identified as an individual's most important resource in crisis. Many other needs

in these situations become secondary. In "Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention," the authors list these primary needs as: promotion of safety, calming, self and group efficacy, connectedness, and hope.[12] The importance of connection or reconnection with family is a basic need. Connection is also listed as a major factor in *Psychological First Aid*, the newest standard of psychosocial response.[13] Keeping families together is a primary goal.

The drive of social supports to reunify is inexhaustible; anecdotal examples of searching families can be found after every major incident, whether it is family members putting themselves at risk digging through rubble after an earthquake or attaching countless missing persons posters displaying personal information to every surface possible in New York City in the days after 9/11. It is also not unusual for families to move from one hospital to the next while they are searching,[8,10] and this can go on for days or weeks. In these cases, families may at first try to contact a hospital by phone, but at these times, the phone lines are often overloaded or the operators staffing the phones just don't have the information needed to answer all the questions. The UK system of setting up a "Casualty Bureau"[16] in major incidents allows access to a single number that is broadcast via the media and avoids jamming hospital switchboards. Israeli hospitals broadcast specific phone numbers for the purpose to avoid jamming the regular hospital phone lines. Despite these plans, a certain amount of families still go to the hospitals.

Families in these situations would rather be at the hospital in person, "just in case." If they believe that their missing family member or friend is in a specific hospital, they will not be redirected. Locking them out may only lead to negative relationships with the family down the line when you may need them involved.

Preplanning combined with a family's advance knowledge of community resources and/or of an alternate hospital family support site in an emergency may be the only way to mitigate the second psychosocial surge on a hospital as in the UK plan. This would likely require a change in the current Canadian system and require community-wide planning initiatives, education, and a comprehensive crisis communications strategy.

Guiding Principle of an Effective Psychosocial Response

Family Focus

The most important guiding principle in a hospital psychosocial response is taking a family-focused approach. Over the years, many hospitals have moved to a patient-focused model of care, in which the patient is included as an active partner in the decision-making process and care planning. In this decision-making process, families may often feel left out, as patient focused does not always interpret as family focused, although they have a large role to play in a patient's recovery, discharge, and supply vital information on a patient's medical history. In a disaster scenario, this family role is magnified. The patient is not just a singular person, a survivor existing in vacuum, but the family as a whole. The patient him/herself may be the injured party, but the family is psychologically

wounded along with the patient, and this is especially the case if the person the family is looking for cannot be found. Taking the family-focused approach means working for the good of the patient and the family simultaneously.

Components and Tasks of an Effective Psychosocial Response

"The primary objective of a psychosocial response is to provide an immediate, short-term service that will help disaster, or trauma survivors to restore their feeling of safety, confidence, competence, and trust."[17]

There are 3 primary components of a hospital psychosocial response:

- The development and implementation of a Family Information and Support Centre (FISC), in response to a surge of searching families.
- Coordination of emergency department FISC support.
- A planned response to deal with psychological casualties.

There is also a secondary component, although not a less important one, addressing the unique needs of patients (and their family members) already in the hospital before a major incident taking place.

FISC

The hub of a hospital's psychosocial response is what can be called a Family Information and Support Centre, or FISC. The concept is simple; a FISC is a temporary team made up of hospital staff and deployed in a Code Orange/MCI event to address the needs of searching families. Its first and primary responsibility is the reunification of searching families with the missing individuals. In addition, it provides families with information, referral to outside resources, and emotional support in a difficult time, while at the same preventing these same families from draining emergency department resources at the affected hospital and others.

How to Establish a FISC Plan

The following is a basic practical guide to establish a FISC plan. It is based on the plan that continues to evolve at Sunnybrook Health Sciences Centre in Toronto, Ontario, Canada, since before 2001. In addition, the general plan has been used to educate other Toronto hospitals to develop their own FISC plans for 2010 G20 Summit preparations. Coincidentally, this plan is very similar to a FISC plan developed for New York City hospitals after 9/11.[18] For the purpose of this chapter, the approach will be generic, as individual FISC plans should be created to fit individual hospital needs and resources.

Location

A well-thought-out location is of great importance to FISC planning to prevent and deter families from surging into the emergency department along with the

patients from the incident. Containment and security issues are keys. If possible, a hospital will want to make sure that the FISC has a separate outside entrance. The hospital will want the ability to easily direct searching families into the FISC or back out without their need to travel through the general areas of the hospital. A FISC must at the same time have a relatively direct route to the emergency department in the event that a specific family member is required there. Ideally, the FISC should not be directly beside the emergency department itself, thereby removing the temptation of families going to look for loved ones on their own. Other considerations are practical—having washrooms close by, in addition to enough phone and data links to meet equipment needs. The size of the space can be flexible, but an auditorium, cafeteria, or large classroom would be the first place to start as they have the furniture already. Having access to smaller rooms for use in counseling or private discussions, such as death notification, would be helpful.

Services Provided

As previously mentioned, the primary service of a FISC is to reconnect families. This will require registration and gathering of information, not just for the missing person but for the searchers as well. Information gathered should include physical identifiers, in case the patient is unable to provide specific personal identification such as name and date of birth.

You will want to make sure that you have up-to-date information about the incident and the resources, both in the community and from the hospital, available to families, as some may now be evacuated or be without other resources, including money or communications. Remember to provide the information on the reunification process regularly and accurately. Continue to have regular announcements even if you have nothing substantial to report. In addition, there may be circumstances in which the FISC crisis support staff may be called on to assist with death notification or in extreme circumstances perform this task on their own. It is important to remember some victims will not be found, or whose bodies cannot be removed from the event site, so families may be there for a while. Having access to translation services is essential.

Involve a member of the hospital's communications department in developing a comprehensive crisis communications strategy.

Equipment Needs

These are minimal and should not require a lot of extra expenditure as some of the equipment can be reallocated from other areas of the hospital in time of need. The setup is essentially a waiting room: chairs and tables, a place for registration, and access to washrooms. What is different is that the room will also have computers and phones, ideally for the use of both staff and families, providing ways that family can communicate outside of the hospital is essential for speeding up the reunification process, as it eliminates the searching families whose missing members are actually safe, but have been unable to find each other due to overloaded communication devices or access.

The other supplies for the FISC are basic refreshments such as cookies, juice, coffee, and water. Some families may be waiting a long while to find out whether their loved ones are in the hospital, providing them with refreshments means

they will be in a better state of mind if decisions need to be made. Resources on acute stress would be helpful, as would supplies such as magazines, newspapers, and games for the children. Some FISCs have a corner where children of searching families, for short periods of time, can be cared for.

Registration

FISC documentation is a hospital version of a missing persons report. This is the essential step for reunification. *Who do you as a family member want the hospital searching for?* The information will include both patient identification such as name, date of birth, and address, and also patient identifiers such as hair and eye color, height, weight, identifying marks, scars, and tattoos. Have families complete paper forms with this information? It may be useful for the information to be in duplicate so that copies of the forms can be sent to the emergency department psychosocial team collecting survivor information to compare. (Ideally, this information would be compared online with any electronic admission or patient records but this would require further preplanning and expense for a system that may not be used.) The alternative is a paper version in the emergency department as well, listing the same type of identification as the families have listed, for easier correlation.

Once registered, families could be given visible ID (badge, bracelet, etc.) to identify them as registered. This will enable the staff in the room to better control the situation and know who should be there from who should not or who has not been registered yet.

Staffing

Resource the FISC with staff typically used to assist families in crisis; within hospital, this would be social workers and chaplaincy. Also useful are psychologists, psychiatric RNs, and other mental health staff, although they do not typically work in the acute care areas or with the families of patients in these areas. What is important is having allocated individuals who could be from clinical areas closed down due to the crisis, or other Allied Health staff, that is, physio, occupational therapist, speech, patient relations, and so on. Hospital volunteers are also a useful staff resource for the FISC for roles of runners, clerical, and reception. The development of a call-out procedure will be necessary, as not all the staff needed for the FISC will be immediately available or even on-site if the incident happens at night.

Roles

The roles needed for the FISC are not fixed. The FISC coordinator needs to have at least an intermediate knowledge of the hospital's IMS structure, code orange plan and process, and the FISC connection to it. It is more important to have someone knowledgeable about the issues rather than someone already in management. There should be someone to act as the logistics person for the group to make sure that the equipment and supplies are available and setup. In addition to the coordination, basic task areas include door screening, registration, emotional support/counseling, and runners/escorts.

Communication

As part of the overall hospital code orange plan, the FISC needs to be able to receive detailed updates from the hospital emergency operations center (including any details that would make it easier to plan for specific populations and groups that may be impacted by the incident) and supply hospital decision makers with information on the family surge and any ongoing or anticipated needs. In addition, the FISC by its nature would need to be in contact with all of the units with specific code orange psychosocial connections, such as the emergency department or code orange established discharge center. Remembering the primary purpose of family reunification, a well-established means of communication should be setup in advance so that activation of such a system is seamless. Lastly, the FISC should be connected and familiar with the community's greater psychosocial response in advance of any major incident. This community response may be in the form of community public health, Red Cross, or emergency social services reception or evacuation center. Referrals to this outside resource may be necessary.

Security

It is necessary to keep the FISC space safe for the families to legitimately search for their missing loved ones. Security is there to keep the peace and to remove any individuals who become overly belligerent or abusive or who are in the FISC for insincere reasons such as a media reporting on the incident. Security staff should be given training in the psychosocial issues of trauma and basic psychological first aid.

It is important to be vigilant in looking out for press and/or instigators masquerading as relatives who wish to gather information or access to the hospital.

Reunification

If a match between a searching family member and patient/survivor is confirmed, reunification should not take place in the FISC if reasonably possible. One family member should be escorted to see their family member wherever they are in the hospital for at least a short visit. Circumstances that involve a dying patient, child, or need for a substitute decision maker to be present may require a family member to remain in the emergency department unescorted or if a survivor is now on another hospital unit, regular hospital visiting rules may then come into effect. Release of patients with minor injuries can be done through a neutral "discharge area" rather than interfering with the processes of either the FISC or the emergency department.

FISC Preparedness

It is expected that a FISC may be setup for a maximum of 72 hours but this is an estimate; it could be more or less depending on the incident. The forms, handouts, and procedures should be prepared and practiced in advance and stored for a possible code orange event where a FISC coordinator and leadership team have quick and easy access for start-up at a moment's notice. Regular

training and exercising of the staff you would expect to be available for the FISC are essential.

Emergency Department Psychosocial Tasks and FISC Support

Although FISC being a central part of a hospital psychosocial response plan, it cannot function on its own. It requires consistent access to information and support from the hospital emergency operations center, and it requires the emergency department to have a psychosocial response of its own. The psychosocial tasks of an emergency department are essentially 2-fold: first, the gathering patient identification information, and second, the triage and support for the psychological casualties. Neither of these should be considered more significant than the other and may in the end require different staff and skill sets for the tasks involved.

Gathering Survivor Information in the Emergency Department

The gathering of identifying information for the survivors of a large-scale incident has traditionally not been considered necessary or a priority when dealing with a major, critical patient emergency department surge.[3,10] Frequently, this information is excluded from the standard MCI triage. The development of a strategy for gathering patient identification information early in a patient's emergency department triage will enable a hospital to reconnect families quickly. The information gathered will provide crucial medical history and, in some cases, when dealing with patients with only minor physical injuries or psychological symptoms, it may help to expedite discharge from the hospital. Conscious and capable patients should be encouraged to contact their family straight from the emergency department, resulting in a mitigation of family anxiety, a minimizing of hospital surge, and the discharge of patients who can be picked up soon after their families have been informed. This process may benefit from having a separate but temporary discharge unit, if space is available. A place where the actual reunification of patient and family would take place and where additional information can be given to family, including information on acute traumatic stress symptoms and healthy coping, follow-up appointments and homecare can be arranged.

All the identification information gathered from the survivors would then be sent to the FISC to look for possible matches for family waiting there. If a patient has already been discharged, searching family members can be informed about this.

There may occasionally be problems with parent/child separation if children are taken to different hospitals or areas within that hospital.

Responding to Psychological Casualties

Psychological casualties are those survivors who come into hospital in the midst of an MCI without any apparent major injuries, but with moderate-to-severe

psychological reactions to the incident they have just been involved in. Some hospital staff may be tempted to view only physically harmed patients as legitimate casualties, but psychologically impacted individuals are equally incident victims. Their psychological injuries come from exposure to traumatic material (such as being trapped for a period of time or witnessing the death or serious injury of others) and sensory information (such as smells and sounds). In addition, they may have had a traumatic perception that they were going to die.[4,12] A hospital response to this population, once individuals are identified, would likely, if possible, involve moving them to an area separate but close to the emergency department. Psychological casualties will need to be triaged, a psychological Triage or PsyTriage, of which PsySTART is one example,[19] to determine those individuals with the most serious acute stress responses, traumatic exposure, and behavioral issues, from those who only need a safe environment for a few hours, in addition to the information and possible referrals to community mental health supports. For those with higher acute stress and risk, longer monitoring may be needed, including in-patient treatment. Left unidentified, denied, or ignored acute stress can manifest as PTSD, depression, and a host of social issues including domestic abuse and violence, substance abuse, and isolation.[4,6,9,13]

Already Existing Patients

Lastly, we must not forget those patients, and their families, who were already in the hospital before the MCI. They were listed near the beginning of the chapter as a secondary priority of the psychosocial response and although they are not a priority to the response itself *per se*, they are an equally important hospital population overall. An MCI causes them fear, disruption, and sometimes displacement. They may feel that they do not have a voice. They are affected quite profoundly through suddenly restricted visiting hours and sudden moves to other units, or to whole new facilities or possibly home much earlier than expected. The key response to this group is providing them with information on how they will be directly affected. Provide it regularly, timely, and accurately.

A Community-Wide Reunification Plan: An Example from the City of Toronto

Large-scale displacement and separation of families were clearly seen in the news reports after 9/11 and Hurricane Katrina as families ended up separately and in different evacuation centers or desperately posting homemade missing person posters on every wall surface imaginable. But an effective reunification plan cannot be created during an incident. Multihospital efforts for the reunification of families require advanced planning, as issues of privacy protection and procedures need to be worked out. One such case of preplanning took place in Toronto for the G20, 2010. For this major event, a unique hospital family reunification safety net was created for the City of Toronto. The project was supported by the Local Health Integration Network (LHIN), a lead agency for Toronto G20 Emergency Medical planning.

Ten participating Toronto area hospitals were asked to prepare FISC plans as a baseline reunification plan. Toronto Public Health was also involved in the planning. Some of the hospitals already had FISC plans established, but for most, this was their first venture into FISC planning and they were supplied with instructions and ideas on how this could be done. Then through a long process of negotiation with the hospitals and their privacy officers, an agreement was struck in which a central, secure online database was created. To this database, if activated by an MCI, would be uploaded code orange patient identification information (i.e., name, address, date of birth, hospital file number) and/or identifying features (i.e., gender, hair/eye color, weight/height, scars, tattoos, etc.). Uploaded information would include the hospital where the patient was located and whether individual patients were identified or unidentified. One of the hospitals was asked and agreed to provide the physical server space to host this database and portal.

Although this shared database is simple in concept, existing privacy laws and general privacy considerations made its execution a complex undertaking. There was a considerable discussion to determine how much personal information could be collected and shared. The ultimate determination was that all conscious and capable patients would be asked for consent to upload their information. Unconscious and incapable patients would not need to give consent as it is considered as a standard and accepted practice to make reasonable efforts to find their substitute decision makers for unconscious or incapable patients.

If activated, the plan would have enabled a family searching for a loved one after a major incident to identify themselves and register at any of the 10 hospital FISCs. Each could provide information on the missing person, if they'd have been admitted to any of the participating hospitals. If a potential victim was not found in the standard hospital registration system, the staff of that hospital's FISC would then be able to cross-reference the family provided identification information with that in the portal database and make a probable match, and then provide this location information to the searching family. The overall aim of the plan was to reduce the anxiety of possible searching families, as well as the need for roving family search surges moving from one hospital to another. Further, Toronto Public Health would also have had access to this database, what was referred to as the Family Reunification Portal. Toronto Public Health nurses are part of the emergency shelter/evacuation center plan for Toronto and could have accessed the database from these locations if needed. Only the Public Health Staff in the reception centers could access the patient identification information as they are covered under the provinces exiting patient privacy laws. The plan was active for a 2-week period surrounding the G20.

Although not required during the G20, it was agreed upon by many that this reunification plan would benefit Toronto if in place permanently. Steps are currently underway to look into this possibility.

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