COCA Call: Review of Health Advisories and Clinical Care Guidance for Survivors of the Haiti Earthquake

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February 24, 2010

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Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode. During the question and answer session, please press star 1 on you touchtone phone. Now I'll turn the meeting over to Ms. LeShaundra Cordier. Ma'am you may begin.

LeShaundra Cordier: Good afternoon. My name is LeShaundra Cordier and I'm representing the Clinician Outreach and Communication Activity, COCA with the Emergency Communications System at the Centers for Disease Control and Prevention.

Welcome to today's conference call, Review of Health Advisories and Clinical Care Guidance for Survivors of the Haiti Earthquake. We are very excited today to have Captain Marc Safran with the Centers for Disease Control and Prevention, CDC and Dr. Phyllis Kozarsky, an expert consultant for the Division of Global Migration and Quarantine with CDC's Traveler's Health.

We are using a PowerPoint presentation for this call that you should be able to access from our Web site. If you have not already downloaded the presentation, please go to www.emergency.cdc.gov/coca . Click on conference call information summaries and slide sets and the PowerPoint can be found under the call in number and pass code.

The objectives for today's call are the participants will be able to identify cultural and situational issues that may influence how Haitian earthquake survivors communicate with clinicians about their mental health following an earthquake, discuss potential approaches for addressing mental health and culturally sensitive, supportive in non-stigmatizing ways, give examples of challenges that may be encountered in the clinical evaluation of Haiti earthquake survivors in the United States, identify questions to ask when first seeing patients returning from Haiti and understand common medical issues and problems concerning those returning from Haiti.

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Our first presenter is Marc Safran, MD and MPA and Captain with the U.S. Public Health Service. Dr. Safran has been a psychiatrist with CDC since 1993 and led successful efforts to gain acceptance for mental health as part of CDC's commission as a mainstream part of public health. A distinguished Fellow of the American Psychiatric Association, a Fellow of the American College of Preventative Medicine, a long term Chair of the CDC Mental Health Workgroup and a graduate of CDC's Epidemic Intelligence Service (EIS) Training Program. Captain Safran has worked to combat chronic and infectious disease and has served in the emergency response. He is currently the mental health lead for the Haiti earthquake response. And I would like you to welcome Dr. Safran.

Marc Safran: Thank you very much and thank you all for taking out time today to try to focus on what we can do to try to help those who survived this terrible earthquake.

I realize that you have to move your slides yourself or you might be looking at them on a piece of paper but so I'll try to help you along to see where I am. At this point, if you look at the picture of the destruction, that slide, the third slide or fourth slide. I want you to think about that picture for a minute and think about how that picture is going to mean very different things to each survivor that you might see as one of your patients. Think of what that picture might mean to a child whose home that might have been or to an older person who maybe might have had trouble with mobility. And again, that might have been someone's home. Think about what that scene would mean to responders who were there first on the scene pulling bodies out of the wreckage. And just think about every other permutation and possibility what that could mean to someone and you'll realize that when we speak about how to address the mental aspects of this crisis with your patients, it's going to be very different for each person. If you superimpose on that the fact that we're dealing with a culture that's very varied, very different from our own in the United States but which - and even within Haitian culture is very different among different people depending on their religions, their families, their backgrounds. Each person is going to have a very different experience.

In Haiti Voodoo is a very common religion there. And even for people who are Christian, it's something that people often mix with their other religions. So someone could be protestant or Catholic and quite developed but also may have aspects of beliefs that relate to Voodoo.

And so one of the things that you want to think about also is that for each person, they're not only going to be thinking about the meaning of what's

happened in the context of themself and their immediate family but they're also going to be thinking about extended family. They're going to be thinking about their connection with people who are no longer alive, their ancestors. And many of these ancestors have been buried in mass burials or may not be accounted for. And so this is - it's going to mean something different for each person.

So with that said, we're going to move on now. The next slide gives some examples of stressors that some survivors may have experienced during this earthquake. There's certainly direct and indirect exposure to the earthquake and its impact. Loss of loved ones or friends. Exposure to prior trauma. And it's very important because what someone has lived previously in their life and experienced is going to influence how they respond to this.

There's also - there's preexisting mental illness in some cases, which may or may not have been diagnosed because in Haiti the mental health system is not as extensive as it is here. And like here, there's a lot of stigma around mental illness in Haiti even more so there. So it's very likely that there could be mental illness that is undiagnosed that might be impacting. And also people think about mental illness differently. But we'll go into that later.

The social isolation that occurred during and after the earthquake will be impacting people. Multiple relocations and displacements, loss of home and possessions current or subsequent life stressors and just the fatigue and the weather exposure and the hunger and the sleep deprivation; even when I speak to our emergency responders on the ground in Haiti and when I talk to others in any emergency response, the issue is that even for the responders it's hard to maintain the type of diet and sleep that one needs to function regularly. So the extreme fatigue isn't just limited to the people who survived the

earthquake but to those who come to help too. And from what I understand right now, there's still - well I will move on to that later.

So look at the next slide and the aftermath of a disaster. So many survivors will show reactions to stress. Reactions to stress, we want to stress that those are expected and that the reactions to stress can be confusing or frightening to people.

Now some examples of acute reactions to stress are listed in the next slide. There are physical, cognitive, emotion and interpersonal reactions. And you see some of the common symptoms that are listed. What happens is its very complex because all of these symptoms can potentially also be symptoms of general medical illnesses that are not psychiatric and they could be symptoms of distress itself. They could be indications of some other psychiatric illness that's going on. I mean it could be normal reactions to stress that will go away or they could be something that's going to be turned into something that's more serious.

So it makes it very hard for the person who's experiencing these and it also makes it very hard for you as the clinician when you're seeing someone and you don't know whether these are something that's a sign of general medical, psychiatric, or other problem or whether it's just a reaction to stress that's going to resolve. And regardless of what it is, for that person it's frightening and it's of great concern.

So we go on to the next slide and we see we're talking about grief here, which again like acute stress reactions, grief is a normal response. However, sometimes the grief can become so severe and persistent as to interfere with daily function to a degree that will warrant clinical attention. So, you know, we have definitions and you've all seen we have definitions of normal

grieving trying to differentiate it from something that requires immediate attention. The problem is though that people are people. Every person is different. And so sometimes someone may fit in a certain place according to the textbook or the diagnostic and statistical manual, DSM-IV. But they may still need help.

So for example, if someone is suicidal or if someone wants to hurt another person, that's going to get attention regardless of whether there's a diagnosis. And if someone needs help, you want to be helpful. The problem is in Haiti the system is so overwhelmed right now that my understanding is that even many people with severe psychiatric illnesses like schizophrenia aren't getting the care that they need. There just aren't enough mental health professionals to go around. And so in Haiti right now, there are people who basically are not able to get psychiatric care or psychological care that would get it in - if they were here. So that's something to keep in mind too because the norms are a little different. We have more resources in our country. So we can afford to see people that wouldn't get seen there. So that's something also.

So the next slide is that of the brain. And it's just to remind you of how complex the brain is and what an important organ the brain is. It's also to remind you that we forget that in a severe earthquake like this, many people will have suffered brain injuries that mean - and in the whole chaos of everything that was going on, these may not have come to clinical attention.

I mean remember; this is a country that was severely devastated with the worst earthquake in 200 years. And the public health resources and the medical resources were just overwhelmed. So many people are just glad to be alive and to have survived. And so you - when you see people - 30,000 people who are earthquake survivors have come to the United States. And when you see them whether it's now or eve a year from now, there may be injuries that

they have that have never been diagnosed. So that's something to keep in mind. So when we go back to that acute reactions to stress slide and you see some of those symptoms, that slide, realize that some of these could be signs of an undiagnosed medical disorder. So it makes it very hard because you're trying to calm the quote "*worried well*" but you're also trying to make sure you're not missing something that requires treatment and possibly even that jeopardizes someone's life.

So, all right. Let's move on. The definition of mental disorders; I put that there. That's from the Surgeon General's report that's just - there are lots of definitions of what makes a mental disorder and what doesn't. But some key elements are basically health conditions that are characterized by alternations and thinking, mood or behavior and associated with distress and/or impaired functioning. And you can see where that's very difficult to apply here because what person has experienced an earthquake wouldn't be having some alterations in their thinking, mood and behavior immediately following the earthquake? And who wouldn't have experienced the stress and impaired functioning? So very difficult. What happens is the criteria for many of the disorders require that a certain amount of time be allowed before one would diagnose someone with a mental disorder following a major disaster. And just normally the criteria for major depression would require two weeks of symptoms and that meet the DSM-IV criteria and the PTSD would require a month.

But what becomes really complicated is you're dealing with a situation where people are still sleeping out on the street there because there are still tremors. I mean yesterday there were tremors, the day before there were tremors. And people don't know each set of tremors and they could be pretty strong tremors. You know, earthquakes actually same. I mean very small. To a person who's on the street, the ground is shaking. Just because it stops in a little while, when

it starts shaking, they don't know whether the ground is going to stop shaking or whether this is going to be the next big earthquake. There are people that have been sleeping out on the street since this earthquake because they are afraid to go back into their houses even if they've not been destroyed. And people are just - people are frightened.

And people - I'm told actually, one colleague of mine was basically describing highly respected scientists who are absent-minded acting out or a ghost of themselves. And even physicians who will not get help because of fear, concern or anger or sadness over their - basically they have fear, concern, anger, sadness and but they're just embarrassed to express it.

So it's - we're dealing with something that is just hard for people to face in any culture. And talking about emotions or about mental health is very stigmatized in Haitian culture. And for women, they might be able to talk about their emotions more but for men to be able to talk about emotion, it's very difficult. Men are supposed to be strong and not talk about such things in many - and there are actually - when they make statements like this, those are general statements. For any culture, people are different. And there are some people anywhere that may be educated about Western ideas, about mental illness and may welcome it. And there are some people who are well educated and more affluent and more steeped in Western ways perhaps or for whatever reason that actually will seek out mental healthcare and will talk about it. But it varies.

So when you see your patients, you have to just remember each person is an individual. You see the next slide has examples of PTSD symptoms. And it does include dissociation and Intrusive re-experiencing, avoidance of reminders of the disaster, emotional numbing, hyper arousal, severe anxiety, severe depression are other kinds of symptoms to look for too. The anxiety

and depression I put there to actually not for the PTSD. I think really that's there - the anxiety and depression are there to remind me to mention that those are disorders to look at too. Everyone thinks that PTSD and those first symptoms are PTSD symptoms. But what happens is that anxiety disorders, major depression are also problems that can be common after a major disaster.

So we want to - I've mentioned - the next slide has the cross cultural issues noted and I've - I mean I've been talking about some of them already. What you want to realize is that every person's culture is different. So you might read a book and there are articles - certainly I hope you'll look on our website and on the World's Health Organization website too and others and you'll get a sense that - you'll get a - you can read about the culture but every person is different. So just because you've read about Haitian culture doesn't mean that's exactly your patient. Your patient will be - even if they practice Voodoo, there are different kinds of Voodoo.

So cross cultural issues I wanted to remind you the stigma. There's the belief and the sense among - of the interconnectedness of ancestors more so than, you know, and others that are living now. And that connection is stronger than in some other cultures. There are issues with support structures. In some cases there may be more of an extended family. There may - and the communication issues really to recognize first just the language itself, French and Creole, they are different dialects of them. We've even in translating documents that different people from different places will have different interpretations as what the French and Creole translation means.

And there are nuances in how to express emotion. Some people may feel more comfortable talking about physical symptoms and they may come to you and be talking about, you know, a stomachache or anything and/or fever and maybe they really do have that and you just have to look more closely. But

they may not be talking about that at all. The person - and this could be in any culture, A person may be talking about their pain and their emotions and expressing it through physical symptoms.

So the next slide is a picture of a health alert notice that we use. This was designed shortly after the earthquake to be given to every person entering the United States from Haiti. And you see the way it's designed. Originally, we were going to be putting together a mental health alert notice. And we quickly realized that in Haitian culture, probably in a lot of cultures, but it would have - that would have just not flown. People would have been offended by receiving it. It would have made them feel uncomfortable because there's a stigma to mental illness.

We also realized that there was so many general medical health conditions that we needed to alert people to that were important at that point that we couldn't even get them on a page. But so what we did was we framed mental health as a small part of an overall public health notice. And you see the language that we used there is very sensitive, very different than from what we might use somewhere else.

We basically used language that did not use mental health - we tried to avoid stigmatized language. We tried to avoid labeling people so that if someone wanted to talk with their doctor - doctors are very respected in Haiti. If someone want to talk with their doctor about - or their - or religious leader, those also very respected in Haiti. If someone wanted to talk to someone like that about how they felt.

Okay. So maybe that's a mental health issue but if we call it that, no one's going to go. So maybe if someone talks to their doctor about how they felt or their religious leaders if the religious leaders could be educated to help in this

way or may already know to help in this way. Regardless, if we could get people to basically reach out. And then if the doctors or religious leaders or others would then - if people need a professional mental health referral, make those referrals. And oftentimes in our country a lot of the mental health care is given by a primary care physicians so that would be, you know, basically an entree. Some people might be willing to see a primary care physician but not a mental health specialist.

So you see some of the considerations that basically - we have to take into account in designing our health alert notice. So a lot of that will be relevant to you when you see the next slide. Patients - I want to stress, patients may be reluctant to acknowledge psychiatric distress.

You don't want to necessarily have to label them with that. If you are making referral, it's really important to do that in a way that the person can still retain their dignity and this is a medical issue and you don't even have to have the diagnosis clear at that point.

If someone needs a mental health referral that's part of their medical care or if that's something you're going to address as part of that care. But the next slide is there to remind of children and how basically you need to remember or we all need to remember that children are different. Each child has their own developmental level, their own unique qualities. And children are not necessarily going to understand everything that just happened.

And it may be that they terribly misperceive something that happened in this crisis and may even blame themselves. And so we want to keep that in mind and we need to look at whether the children have had changes from where they were developmentally, where they are now. And we need to ask them how they felt and what their perceptions are.

And finally, I go to that next slide about potential for misattribution of symptoms. I've talked about that already. We just need to remember always that sometimes in symptoms that appear to be psychiatric may actually have a general medical cause.

Some signs and symptoms that initially appear to be non-psychiatric could actually have a psychiatric cause and medications and abrupt interruption of medications can sometimes cause psychiatric or general medical type symptoms that could easily be misperceived as psychiatric or general medical illness. And keep in mind that some of the very medicines that we're prescribing even malaria prophylaxis could cause psychiatric symptoms. So just always be alert these people who have survived an earthquake, they deserve to get the good thorough medical care that anyone else would get in our country and more so because they've been through so much and there are just so many things that could be mixed up right now if we don't look really carefully. Very hard job.

So you see there are some resources on the next slide. There's a link to the Website of the Substance Abuse and Mental Health Services Administration; also SAMHSA hot line. Unfortunately - and you'll see other Web resources. We have a link - the next slide, a link to our CDC mental health - earthquake mental health page. You see the link there. And then there's a link to the Mental Health Advisory for Health Professionals who are providing care for the survivors of the 2010 Haiti earthquake. And that's what I've been alluding to a lot in this presentation. And we want you to please consider all of those points that we're making there.

And also one of the limitations that we're also going to face is that a lot - there are very few clinicians in our country that speak French and/or Haitian and are

also aware of Haitian culture and are used to treating people who've come from major disasters. So that means that not everyone who has come here and survived the earthquake will be able to have the fortune of being able to be treated with someone like that.

So it means - where we can we need to get people to - people with that kind of experience and where we can't, we need to all do the best that we can to try to educate ourselves and to try to see that there are translation resources available and just do everything we can to get good care for this very traumatized population. Keep in mind, most people are very resilient. Most people do recover from disasters over, you know, over time. Some won't. Some develop serious psychiatric illness. And, you know, you'll read and hear all these experts making all these pronouncements about what will happen and what percent of people will or won't develop this or that.

You've got to keep in mind that each population in each disaster is a little different. So in some ways, I mean while we know a lot based on past disasters, there's a lot that we don't know. And so it's even more important that as health professionals we pay very careful attention to our patients and to our populations. And so I've basically said enough right now. I'm going to turn this over to the next presenter but please if you have any questions or suggestions or experiences you'd like to share, we definitely want to hear about that during the discussion part of this call.

So thank you very much for your time. And I now yield to my colleague.

LeShaundra Cordier: Thank you Dr. Safran. Our next presenter is Dr. Phyllis Kozarsky with the CDC's Division of Global Migration and Quarantine. A 15 year veteran of CDC, she's a co-editor of *Health Information For International Travel* and the co-head of Tropical Medicine at Emory University in Atlanta, Georgia.

Dr. Kozarsky has been practicing in infectious disease, clinical tropical medicine and in traveler's health for about 20 years and currently helps manage the Emory University pre and post travel clinics. Please welcome Dr. Kozarsky.

Phyllis Kozarsky: Thank you very much and welcome everyone. We're going to spend the next few minutes talking about the medical evaluation of individuals arriving from Haiti. And what we're going to be focusing on is really the first visit, when you see somebody following travel that is either having been in Haiti for a short period of time in the disaster response and coming back home or else Haitians who have come here. And we'll try to go back and forth a little bit and give you a taste of what you might be seeing as well as the approach to the patient.

In the first slide at the overview, the presentation is based on our interim guidance of the medical and psychological evaluation of individuals arriving from Haiti that was developed by the CDC Division of Global Migration and Quarantine and the Traveler's Health Branch. The presentation will cover the history or key points in the history to note, the physical examination, a differential diagnosis, recommendations for laboratory testing, follow-up and resources.

The next slide is our background. And we're well aware of that today following the January 12 earthquake, thousands of relief workers from the United States responded to the disaster and are continuing to do so in a number of ways. As well, at the time there were an estimated 45,000 Americans in Haiti at the time of the earthquake. However, in evaluating everyone who you might see, please be aware that - you know, I remember in my training, somebody always said to me don't always look for zebras in the Bronx. Common things happen commonly.

And when people often come back from a place like Haiti, particularly when they've been exposed to raw sewage, contaminated food, water, and the kinds of things that they're being exposed to over there, look at simple-thing problems such as gastrointestinal illness, skin problems, rashes, respiratory infections and then fever.

The next slide is looking at the history. And you're all familiar with how to craft, if you will, a history appropriate for the patients you're seeing. You want a detailed history of chronic conditions and medications. As Dr. Safran said, that many people who have chronic problems have not been able to have care for those. So there are many, many diabetics who very much out of control right now. People with hypertension, heart disease who have not had access to any medications since early January.

You want to know the immunizations status of the person. Now many Haitians have never had even primary immunizations and one actually assumes that that's the case when seeing somebody who was born and lived in Haiti. For those returning to this country, you want to know about their pre-travel vaccinations. Had they had their Hepatitis A vaccination? Were they up to date with certain of their childhood immunizations?

Number 3, you want to know if the traveler took malaria chemoprophylaxis and whether they were compliant. That's a huge thing. They'll always say yes. Somebody called a prescription in or gave me a prescription. Then the question is did they finish taking it. And oftentimes, as you know, they took it while they were there and then stopped. So that's a key point. Haiti's specific history is also important. The length of time they were there, whether they were living there or ongoing. (Were there an ex-pat) or a traveler who had just been there for a few days or a few weeks. Their living conditions. Whether

they had air conditioning, screening, mosquito nets. What they were doing in Haiti. Were they handling patients? Were they working on this disaster? What their food and water sources were; exposure to insects or even animal bites; acute traumatic injuries and any other unusual symptoms that they had during and following travel.

The next slide shows the focus on illnesses common both in travelers and returnees from Haiti. In other words, what we want to do is do a focused physical examination on the first encounter. Because particularly if these people are going to be under your care for quite a while, oftentimes you can't approach the patient on the first visit and spend hours with them. So you need to do a focused physical exam as well as the history.

Number 1, whether or not somebody has fever is critical. Because as you may know, malaria illness is common all over Haiti and that can kill within 24 to 48 hours. So if somebody has a fever that needs to be addressed. Number 2, infectious diarrhea as mentioned before or dysentery is probably one of the most common things that people will present to you with after - particularly after return from Haitian travel given the issue with contaminated food and water sources.

Typhoid fever is a common illness. As we've mentioned before, because people have not had their primary immunizations, their illnesses such as childhood illnesses, measles, may be a bigger problem there than elsewhere. Dengue there have been a number of people already who have come back to the United States with Dengue as a result of Haitian travel recently. Tuberculosis is a huge issue in Haiti and even Leptospirosis. Rash illnesses, measles, entroviruses and typhoid fever can present with a rash. Respiratory illnesses. The most common thing would be the common cold, sinusitis, influenza or pneumonia. Lymphadenopathymay reflect somebody who has a

virus, a mono like syndrome, if you will. Or acute HIV or chronically, tuberculosis. Hepatomegaly or right upper quadrant tenderness may be a sign of hepatitis. So all of these things should be looked at, particularly again, fever.

The next slide and the one thereafter talks about some additional considerations to always keep in the back of your mind here. The first one has been talked about - spoken about by Dr. Safran, not as symptoms expressed may be superimposed on emotional trauma or typically are, you know, superimposed on emotional trauma, stress and fatigue. Whether it's someone who was there during the earthquake or even these travelers who go in for several days or several weeks in consultation or working with patients or any kind of relief organization, oftentimes they're fairly well traumatized.

And people may come to you having a diagnosis of apepsia. They called in for the appointment because they have a cold, because they have diarrhea. But once you get them into the room and the door closes, all of a sudden they break down crying. And you realize the tremendous burden of emotional trauma that's taken place.

Number 2, malnutrition contributes tremendously to morbidity and mortality from acute illness in Haiti, even such as diarrhea and measles can be life-threatening diseases especially for children. So people from Haiti coming into this country who are malnourished may be much, much sicker than the short-term traveler from the United States. Something about children, Number 3. Although routine medical screening includes testing for anemia and lead poisoning, consider these chronic problems in any ill child.

Next slide. Mentioned already, vaccine preventable diseases. The immunization rates in Haiti are estimated to be very low. Thus persons

originating from Haiti may not have had routine childhood immunizations. And as a matter of fact, we assume that they haven't and therefore are at greater risk for these infectious diseases.

And returning ex-patriots or residents of Haiti entering the U.S. at some point will need comprehensive history and physical exams, as well as, more extensive lab testing such as stool examinations for ova and parasites to just give you one example because of the tremendous burden of helminthic diseases.

Next slide. Something that is crucial in seeing any person after travel is calculating an approximate incubation period. It's amazingly useful in ruling out or ruling in possible etiologies. For example, if fever began three weeks or longer after departure from Haiti, the possibility of Dengue as a cause of the fever is not there anymore. On the other side of the coin, if the patient who spent a few days there consulting in Haiti came back and immediately presents to you with a fever does not have malaria because the incubation period is too short. They've only been away for five days. So it's very, very valuable in seeing anybody who's returning from travel to have a feel for when the symptoms began because that immediately can help put a patient into a category of diseases.

Next slide, the laboratory testing. Not all returnees will require laboratory testing on the first evaluation. Even those people who are ill. Many people come in because they're concerned. There are, as we call in parenthesis, worried well. There are people who have a mild diarrheal disease, have an upper respiratory infection and really don't need chest x-rays, complete chemistries, things like that. And just like in any patient you're seeing, use your clinical judgment. You could always tell somebody if they don't feel better to call you back and come in again and you can retrace steps. Patients

may benefit from routine complete blood count or chemistries. But you can make that call depending on the signs, symptoms and how sick they are.

The next slide is on laboratory testing. It's very important. People with fever need to be treated differently because of the problems of malaria all over Haiti. Plasmodium falciparum is endemic all over Haiti and certainly one worries about whether or not somebody has malaria, if they are either a returning traveler or if they are a resident of Haiti. If your first blood smear is negative and you still don't have a cause for the fever and it could be malaria, please do repeat it. Blood cultures are important to rule out other causes of infection like typhoid fever. Or ones related to maybe injury. They may have a staff infection or a strep infection.

Chest radiography is important obviously if respiratory symptoms are present whether if you hear something in the physical exam or the respiratory symptoms are continuing despite the fact that the - despite the fact that you've given them time to improve.

Next slide on laboratory testing. A tuberculin skin test or the interferon-gamma release assay is recommended 8 - 10 weeks after return if somebody has fever, if somebody has respiratory illness that's ongoing, if somebody has sputum that is - might be suggestive of ongoing infection. Basically tuberculosis is a major health problem in Haiti, much more so than here and should be put in the back of your mind at all times when seeing somebody from there. Serologic testing may be appropriate for many infectious diseases to document measles, Dengue or, things like hepatitis, HIV. So consider those as well.

Follow ups on the next slide. The CDC's Division of Global Migration and Quarantine requests notification for infectious diseases that have potential

public health importance or clusters that you might see in infectious diseases identified in persons who recently arrived fro Haiti. Reports may be made by calling the CDC quarantine station with jurisdiction over the state where the patient is currently residing.

The next slide shows some - an additional resource. And this will be very, very helpful if you're seeing people after - when they return or after travel from Haiti. And that is at www.cdc.gov/travel . There is on the front page a lead in to specific guidelines and recommendations for the evaluation of patients coming in from Haiti. And that will be very, very helpful for you.

Next slide gives you a list of the kinds of recommendations that have been written for clinicians regarding the medical and psychological evaluation, guides for healthcare providers assisting travelers who are going out to Haiti, which is still incredibly important with regard to the malaria chemoprophylaxis and immunizations particularly that are recommended. The health alert notice that Dr. Safran shared with you and interim recommendations for the initial domestic medical screening of the incoming children. That may be very helpful as well.

Next slide are additional resources and let me add one to that because you'll have this slide available to you later as well; is www.aftnh.org . And that's the Website of the American Society of Tropical Medicine and Hygiene that has a clinic listing in the United States for people who are clinical tropical medicine specialists, who may be people who can be resources for you or as well you may refer patients to if you are uncomfortable seeing somebody who might have a complicated problem after coming in from Haiti. Thank you very much. I think we'll stop here now and take questions.

LeShaundra Cordier: Thank you so much for that presentation. We'll now open up the lines for the question and answer session.

Coordinator: If you would like to ask a question, please press star 1. You'll be prompted to record your first and last name. To withdraw your request, please press star 2. As a reminder, today's conference is being recorded.

Marc Safran: So while we're waiting for the first person to ask a question, let me also say if someone has any comments or observations they'd like to share. We welcome that as well.

Coordinator: Our first question comes from (Deanna). Your line is open.

(Deanna): Hello. It's more of an affirmation of what's already been said as far as response workers. The importance of TB testing upon return after the appropriate amount of time. I became infected with latent TB infection after a response to the island of Nias after the earthquake there in 2005. And the reason I really got tested is because I was an occupational health director at the time and TB was my life.

And to my surprise, I was - had latent infection and was able to undergo the appropriate chemoprophylaxis. But I did something that I don't think that is stressed enough in response workers and especially when you have a lot of spontaneous volunteers going over there that don't have the training that maybe DMAT workers have or other response workers. This is I can see could be a silent growing problem if it's not stressed enough. But I just want to thank the presenters for all the information they've given. It's been just a good presentation. Thank you.

Phyllis Kozarsky: Thank you for the comment. I will say you're absolutely correct because people tend to not come into the medical system following such relief efforts

unless they're sick. And so TB will remain at the - TB and TB conversion will often remain silent and is not picked up.

Marc Safran: And if I could add that things like that may happen and that's why we have to be very sensitive to our patients and not just immediately assume that they're worried well. And if someone's telling you that something is different, we need to respect that. And while there might not have been any signs or symptoms initially of the conversion, there could have been some mal signs someone might have noticed some symptoms and if we're just too quick to brush people off, we may not respect the fact that people often are the ones that know their own body best.

And the challenge here is that on the one hand we're trying to reassure people and have them not worry about acute stress symptoms that we want to just resolve and go away. But then on the other hand, we know that they were just exposed to this terribly awful situation that potentially exposed them to head injuries and infections and parasites of not just infectious diseases that we might think of as TB but basically any kind of infection, any nutritional problems, anything.

Maybe heart disease because this could have been so traumatic for them. Or maybe diabetes. They haven't been taking their medicine. So there are so many things. So it's really hard. And as clinicians, we need to stay calm and not let it overwhelm us because this is a really hard job to be the clinician who is seeing someone who has come back from this earthquake. And they're going to look to us for our calm and for our confidence but yet this is a really hard job.

(Deanna): I agree. And I also believe we need to do more in debriefing our response workers in coming back because of what you go through. Just personally what

I have noticed in myself coming back from austere care environments and just the conflicting feelings in coming back into a society that has so much.

And, you know, the stressors, you know, people that you left behind. And we're expected to be tough and everybody thinks, you know, we're the caregivers. So I'm just concerned about there needs to be more done in formally debriefing response workers and providing the assets making it accessible for them to get the - especially the mental health support so they can continue with this type of work. So I thank you for addressing this issues and especially the mental health issues also in the first presentation.

Marc Safran: Thank you and thank you for emphasizing mental health as well. And one of the things - let me just share with everyone. Dr. Kozarsky did mention debriefing and let me just - different people mean different things by that. And so just so that you know, on the mental health side of things there is a lot of controversy now as to - in certain procedures exactly which ones are more helpful than others. While a lot is know, about what is helpful, there's still a lot that remains to be learned. And the issue of debriefing, that is such an interesting topic. We could give a whole two-hour lecture on that.

One of the - one of the issues is that there are certain things that have been done in the past that - under the name of debriefing that were designed for certain types of coherent responders, certain types of units of people that were cohesive and worked together and that after the incident they would basically debrief in a certain way that was supposed to help them. And then that was expanded to other groups.

And so what happened though was that subsequent research indicated, and depending on which side you're on, you'll say different things. But subsequent research has indicated that for some people it actually may harm them more

than help them. And so it depends on what you - I mean it depends on what's being done. So it's important that when we get mental health interventions for people and that when we do things that we remember the do no harm.

(Deanna): Right.

Marc Safran: And this is also - this is a - it's a really hard job. So - and just to simplify without going into the three hour talk that we could all do, it's basically - if you think back to that first slide, that traumatic scene could mean so many different things to so many different people and it could just be so traumatic. And what would be done sometimes in the debriefing would be that it would actually - but sometimes people they're not ready to experience the level of intensity of what they just went through. And there, you know, there are normal defenses that kick in and sometimes people aren't ready.

And so what would happen sometimes in the debriefings that were done if - you know, sometimes people might have been too aggressive or for whatever reason it just may have re-traumatized the people so that actually for some people may have hurt them more than help them. And some other people may have benefited from them.

And it's - I'm over simplifying a very complex field. But so my point is that we have to be attentive to our patients and recognize that what works for one person won't necessarily work for another. What worked for one - again, we may read in the literature about something that worked really well in a previous disaster or a previous different population or whatever. But we can't just assume that all of our interventions are going to work when they've not been tested in the population we're using them on. And when, you know, we just have to consider risks and benefits and...

Phyllis Kozarsky: I agree. I just - I think maybe the word debriefing sounds a little militaristic but...

Marc Safran: Oh, you probably didn't mean the kind of - I'm sure you didn't mean the kind of debriefing I'm thinking of. But...

Phyllis Kozarsky: Actually what I mean is access - well, at least access to resources to where they have an area where they can discuss their unique experiences with a group of people that - because a lot of these clinicians are going back into austere care where someone else may not have had any experience with austere care, disaster relief.

And just so that they have access free from penalty let's say for dealing with the emotions that come up after responding to something like this. Not a forced debriefing but just ensuring that we - somehow as we build these different resilient systems and response systems to make sure that's in there for the response workers.

Marc Safran: Oh yeah. And to make it that's it's not stigmatized. Basically...

Phyllis Kozarsky: Correct.

Marc Safran: ...it's expected that if a - it's a professional thing. And you're right. I mean the big problem is that oftentimes people are concerned, you know, especially if you're in a uniformed service or if you're - or any kind of professional service where you've been a responder. And, you know, people are concerned it's going to impact on their reputation and on whether they'll get future assignments.

Phyllis Kozarsky: Correct.

Marc Safran: Or whether people will think that they're made of the right stuff. And so we need to break that down and make it the norm that people get help when they need it. And the issue is - and I've seen all different ways that that's been operationalized and yeah, and so I mean the Red Cross has - I mean when I was - I remember one time being out with the Red Cross on a emergency response to some hurricanes.

And everyone that finished the mission at the end, they basically they had to touch base with mental health team before they left. And it wasn't - there was nothing that they had to do or anything. They just - it was that was the station you had to go by and had to check in with mental health.

So that way if someone needed help, they could ask for it. And there was no stigma because it was just everyone had to stop by mental health. And if, you know, if they didn't or, you know, didn't want to talk about anything, then they just - we checked that box and they went on to the next station.

Phyllis Kozarsky: The addition of the mental health teams to the - to being deployed with the DMAT teams I think has been particularly helpful for dealing with things right there in the field and giving a place, I say place, for responders to go and to deal as, you know, in real time. And it's - I've just - I've seen the growth of that and seen it's been a great asset.

Marc Safran: Oh definitely. And there are all different procedures that have been developed. I mean I was over simplifying the Red Cross' procedure. I mean actually it's a little more complicated that that. But basically it, you know, there are ways of having people do things following their admission that they're not going to be harmful and that should be helpful.

And so we just need to think through all of those things. And also after the fact. Remember some - oftentimes these psychological problems won't manifest themselves right away necessarily. Oftentimes...

Phyllis Kozarsky: Correct.

Marc Safran: ...or if they do, they might not be recognized right away. So we have to recognize as clinicians that our patients may come to us, you know, days, weeks, years later even and we need to be attentive and open to that.

Phyllis Kozarsky: Correct.

LeShaundra Cordier: Do we have any additional questions from the phone?

Coordinator: We do have another question. Our next question comes from (Meg Coleman). Your line is open.

(Meg Coleman): Hello.

Coordinator: (Meg Coleman), your line is open.

Marc Safran: Do you have a question for us?

Coordinator: Our next question comes from (Jane Bishop). Your line is open.

Marc Safran: Hi (Jane), are you there?

Coordinator: Please check your mute button.

Marc Safran: (Jane), do you have a question? Hello.

Coordinator: (Jane Bishop), your line is open.

Our next question comes from (Rosie). Your line is open.

(Rosie): Hi. This is (Rosie). Can you hear me?

Marc Safran: Yes.

(Rosie): Okay. My question is are we offering medical interviews at the quarantine stations at the port of entries for people that are coming back from Haiti either refugees or workers? Are we offering routine screening if people want it? Or are we eyeballing people as they get off the plane and talk to them a little bit?

Phyllis Kozarsky: I think that considering the numbers of people coming in from all over the world as well as Haiti there is no way to interview everybody coming in certainly. What goes on are routine ways of handling people. And that is if people are identified as being ill on board an aircraft or on leaving an aircraft, it is up to the Captain of the aircraft to report that to the quarantine station ahead of time. And then somebody will meet that aircraft and take care of that particular individual.

(Rosie): Okay. Yeah, I was oriented to the search staff for Chicago. And that was part of our training was, you know, that that was how they did it. So has there been an increase in numbers of people that are being identified as being - having fevers or coughs or...

Phyllis Kozarsky: You know, I'm not aware - I'm not aware of it. I can't say yes or no. And perhaps that's a question that we can take offline and find out the answer to for you.

(Rosie): Okay. Thank you.

Coordinator: Our next question comes from (Rachel Caw). Your line is open.

(Rachel Caw): Hi. Thanks for taking my question. And actually this is specifically for Marc. I wanted to make one comment to piggyback on a comment about the returning responders because I work at HHS and what we've been doing is actually making sure that every responder comes back and has some sort of a briefing.

And what that is is a medical as well as mental health information providing sessions. So, you know, I think we've been trying to sort of go with the lowest level of intervention in terms of if people want to talk to each other, that's fine. There's mental health professionals there if they want to check in.

But really I think what that caller was talking about was the need to formally address the mental health stressor issues. And I know we're certainly trying to do that. But it isn't operationalized everywhere and it really needs to be.

But after that comment, actually my real question was for Dr. Safran and I'm just wondering do you have any actual operations going on, mental health mission of any description that's being, you know, done by CDC at this point?

Marc Safran: At this point, as you know Rachel, we are - our role is not primarily a mental health one. The mental health that we're involved in is in terms of trying to monitor epidemiology...

(Rachel Caw): Right.

Marc Safran: ...trying to basically catch up on what's going on. Our partners - and as you know, HHS doesn't have a very big role in the mental health part of this at all. And - I mean we have some but not a lot as an agency. And so basically most of the mental health work that's being done in Haiti is being done by people on the ground who are either with other agencies - the WHO has a presence on the ground. They're trying - they're starting to do some mental health work.

There are other agencies that are basically working together to get mental health work done. Within Haiti itself, the mental heal infrastructure before the earthquake was very limited. And so, you know, as I indicated, my understanding is that for people even with severe mental illness after the earthquake, the existing mental healthcare there was very limited.

There's a mental health workgroup that formed among organizations and people that are over there doing mental healthcare. And one of the things that the chair of that mental health workgroup communicated to me when I asked if there's any particular message that she would want me to pass on to people, you know, clinicians here.

One was that if people do come to help there, you know, they were thinking that if people come and in there affiliated with an organization that's working there that, you know, that has a presence there that that's more helpful. If someone comes as an individual, then the problem with that is that there's no - there's no follow up. That person just pops in there, they may even create needs because they start someone on a certain treatment and then there's no - it's just the country doesn't have the resources for follow up.

Also the issue of mental healthcare needs to be something that is - that has - that's long term. And so when people want to come as mental healthcare

providers to just - practitioners to just come and go for a couple of days and help out or a week or something, that's not - you know, they need people who are going to stay longer.

And so that was one concern that they had that they need a lot of help. But they need people to do it within the context of existing organizations and to have follow-up. Not to generate needs without the follow through. And the - and so that's one of the issues that I wanted to mention to you.

(Rachel Caw): And I appreciate that because that's something I keep trying to pass on to folks when they ask me about volunteering is, you know, if you're affiliated, that's great. But actually sometimes going to help, you become part of the problem and complexity of things. So thank you.

Marc Safran: Exactly. And can I just mention thanks to (Rachel Caw) and her office in HHS, the ASPR office which has been basically working to try to coordinate HHS different agencies here in the U.S. that are, and over there, that are working on assisting with the Haiti earthquake and basically just helping us to keep in touch with each other on what's been going on.

So thank you Rachel for that. And thanks for giving me the cue to that. I mean we didn't rehearse this in advance. But thanks for giving me that cue.

(Rachel Caw): You know, I just wanted to say that I sincerely meant my question and that things change so often and sometimes even as much as we try to stay in touch, who's doing what is a daily question.

Marc Safran: Yes. But no, no, no, that's very helpful. And actually that's a good example of one of the things. And we encourage you as you're working with the survivors that are back in your states to just keep in touch with each other just like

Rachel and I and others in other agencies have to work really hard everyday. Because we're, you know, we're so busy trying to keep abreast of this that it's easy to forget to tell someone something key that you're doing.

And so we encourage you to get in touch with and get to know the people in your state and your town that are working on this issue or nearby. And there are agencies that can help you out. I put on my slides a link to SAMHSA and they have state disaster mental health coordinators and they may be able to help you.

We also have a link on our website to the - to mental health resources in each state. You know, on the Haiti earthquake mental health site we have a link to the mental health resources in each state that's actually something that's put together by SAMHSA where they - that's the Substance Abuse and Mental Health Services Administration where actually each state there's a page. And you can go there and find out what are the mental health advocacy organizations in that state.

What are, you know, what are some of the places someone with a mental health problem may go to for help? Now unfortunately most of those do not speak Creole or French and, you know most of those are probably not necessarily geared to this. But the disaster and mental coordinators in those agencies certainly could help to find people who were or help in whatever way they could.

And so that's something that clinicians locally or local health departments can get in touch with those people and hopefully get some help in trying to piece together ways of helping these survivors who are not just located in the major centers where there are large Haitian populations, but also some may be

located in some very widespread places where there aren't or where there isn't that community.

LeShaundra Cordier: All right. We've got time for one more question.

Coordinator: Question comes from (Meg Coleman). Your line is open.

(Meg Coleman): Hi. I was in Haiti shortly after the earthquake and I think that the respect for doctors and clergy is an important thing for us to recognize here when Haitian folks come for treatment. But I have a question about other - are there other kinds of specific cues that you can, you know, cultural pieces of information that you are aware of that would be helpful to us?

Let me tell you why I ask the question. We had a man come to our medical tent with his newborn and the child had red yarn for example on her wrist and her ankle which we were informed was to keep her mom's spirit from coming to her to take her.

Those kinds of things are big for us to know. And I don't know if we can gather some of that information so that we have it when we work with families.

Marc Safran: There is one - and basically there are several documents that are about on the Internet and the literature about Haitian culture. One thing that I'll mention is that the World Health Organization actually commissioned a literature review that was done by Jewish General Hospital in Montreal, the Cultural Communication Service there, their Department of Psychiatry.

And it was commissioned by the World Health Organization. And that - it is available on the Internet. It's not on the WHO site yet. I'm not sure why. We

had been sent drafts of this. But there is - there are Web sites on the Web that have this document there. And if you search - if you do a literature search for this document, you'll find it on the web. It's called Mental Health in Haiti a Literature Review.

(Meg Coleman): Oh great.

Marc Safran: And it was - again it was - we didn't - I can't take credit for this. This was not done by us. It was done by the World Health Organization. And, you know, and they basically did this literature view and it - the idea being that all of us were tripping over ourselves to try to basically answer just that same question that you did.

(Meg Coleman): Okay.

Marc Safran: And so you'll find that.

(Meg Coleman): Great. Thank you.

Marc Safran: Thank you.

LeShaundra Cordier: I want to thank our presenters for providing our listeners with this information. And I'd also like to thank our participants for joining us today. If you have any additional questions for any of our speakers, please email the Clinician Outreach Communication Activity at coca@cdc.gov . Please indicate the speaker's name in the subject line of your email. We will ensure that they are forwarded to the appropriate person for a response.

Again, that email address is C-O-C-A at C-D-C dot G-O-V. The recording of this call and the transcript will be posted to the COCA website at www.emergency.cdc.gov/coca within the next week.

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Thank you again for participating and have a great day.

Phyllis Kozarsky: Thank you.

Coordinator: This will conclude today's conference call. You may now disconnect.

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