
Quick Start 30 min. version

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Welcome to “Anticipate Plan and Deter,” a responder resilience program for disaster medical healthcare workers in Los Angeles county provided to you by the Los Angeles County Emergency Medical Services Agency and developed by Merritt Schreiber Ph.D. at the UC Irvine Center for Disaster Medical Sciences.

This is a 90-minute interactive training to help you learn about managing your stress. You will leave today with your own personalized plan to manage your coping risk and resilience in disaster, as well as other emergencies that we all face.
Start here:
This training will provide you with the Anticipate Plan Deter Personal Resilience skills to cope with disasters and perhaps every day stress you encounter as an emergency healthcare provider.

The course contains the following elements (Read the above bullets completely).

Anticipate Plan and Deter or “APD” as we call it, is a comprehensive approach to improving the resilience of healthcare workers in Los Angeles County. It involves three key elements: Anticipate, Plan and Deter.

APD is a resilience model that builds on your own considerable resilience resources. We know you are at a resilient group but disasters can challenge anyone. We want to enhance the resilience you already have with some additional tools and resources. We will review practical ideas that you can take home today and use anytime.

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Let’s review and understand risk in disasters to begin.

This slide is an adaptation that Dr. Schreiber created based on a report from the National Academy of Science Institute of Medicine called the “Psychological Consequences of Disasters and Terrorism.” You’ll notice two circles. The green one on the left refers to distress responses that are essentially normative reactions to a disaster experience. Examples include insomnia and a sense of vulnerability. These conditions are normative in that they are common, expectable, typically time limited and resolve without professional intervention of any kind. They don’t necessarily suggest short or long-term impairment, but they are very common in the aftermath of disasters.

Depending on the study, somewhere between fifty and ninety percent of the population will have one or more discrete distress symptoms that are non-syndromal, in that they are not associated with a formal syndromal or syndromic diagnosis or new mental health disorder. These usually resolve in a relatively short period of time without any professional intervention. In an American Red Cross environment, we used to call this “normal reactions to abnormal events.”

Moving down the diagram, the red circle on “new incidence disorders” refers to a portion of the population that would be exposed to the disaster and that would develop a new psychiatric disorder they didn’t have prior. This is not referring to
those individuals that may already have some kind of mental health disorder, or to those having a “severe mental health disorder” or a “severely emotional disturbed child,” both of which are definitions used to indicate individuals that have a psychiatric disorder that is of a more serious nature. The circle encompasses those individuals who may have been sailing along well enough before the event and then after the incident, they develop a new disorder that they didn’t have before, hence “new incidence disorder”.

A classic example of that is Post Traumatic Stress Disorder (PTSD), but it is by no means the only disorder or diagnosis that can occur following a disaster. Major Depression is right behind PTSD in frequency of occurrence after an event. Even more to the point, Post Traumatic Stress Disorder and Major Depressive Disorder are frequently co-morbid, meaning they often go together after a disaster. Those are just two examples, and when we then look to see how many people might develop one of these disorders, we see that among victims directly impacted by the disaster somewhere between 30 – 40 % are going to be at risk for a new psychiatric or mental disorder they didn’t have pre-event.

There’s been a lot of discussion about the impact of disaster on disaster responders. We used to think, as recently as the Oklahoma City bombing, that responders did not really develop new disorders as a function of the disaster. More detailed studies that have occurred after 9/11 and Hurricane Katrina suggest that in fact 10 – 20% of responders are at risk for a new disorder they did not have pre-event. We see that responders are relatively more resilient than direct victims and the vast majority of responders are not going to be at risk for a new disorder. That’s also good news, but there will be a significant minority that might be at risk that we need to attend to.

That’s what we know about the psychological consequences of disaster and terrorism. To summarize, some are going to have normative reactions that are time limited, are not syndromic, resolve on their own and are not associated with any functional impairment. There is a group that is going to be at risk for a new disorder they didn’t have before, most commonly that is either PTSD or depression, although there are a number of other disorders that are possible. Somewhere between 30-40% of the victims directly experiencing the disaster are going to be at risk. Responders are more resilient than direct victims, but even 10 – 20% of responders might be at risk for a new disorder depending on the event. However, it is critical to point out that responders can also be local direct victims and experience risk from both the responder role and their direct victim experiences.
Why Focus on Disaster Medical Responders?

• Disaster health care workers are a known “at risk” group
• In order to preserve patient care, healthcare workers need to manage stress
• Children of EMS providers known risk group
• Feedback from PsySTART advisory group indicated the need for training and tools to enhance healthcare workers resilience in disasters

Why are we focusing on you? Because disaster health care workers are a known “at risk” group but also “hidden” and not frequently provided with resources to reduce the stressful impact of their work. In disasters and other emergencies, one goal is to preserve patient care and the health care system. This is done in many ways such as providing “decontamination” and use of Personal Protective Equipment (PPE). APD is designed to add to these critical efforts and provide “psychological decontamination” and “stress protective equipment”.

Feedback from the LA County PsySTART Advisory Group indicated the need for training and tools to enhance healthcare workers’ resilience in disasters. We want to briefly review some of the current science on disaster medical responders. Indeed, these concerns are borne out by research on the largest longitudinal study on the health effects of disaster workers is the 9/11 WTC health registry study coordinated by the CDC. The most recent findings revealed that 20% of WTC responders developed multiple posttraumatic stress symptoms and about 13% were estimated to have diagnoses of PTSD. Prior to the event, only 3% had used mental health services. This suggests a significant burden created by the WTC response. Over time, their sample of responders evidenced increased risk for acute stress disorder, PTSD and/or depression 7 and 13 months post 9/11. The take home is: effective response depends on your resilience.

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We will now start using your “personal resilience plan” and go through each of the three sections sequentially.
The first step to our responder resilience model is learning to anticipate expectable stress situations and your own particular reactions. Beginning to conceptualize and visualize the “stress threats” you may face is the first step to build your own resilience. Once you know what the threats are, you are better able to develop effective “stress countermeasures” to combat expectable distress and build resilience.
Although many of you are used to emergency scenes and other life and death situations in your daily work, disasters potentially involve much of the same as well as other novel experiences that you may never have encountered before. This is a scene from Super Typhoon Haayan in the Philippines. This is just “not another day” in your busy setting.

The other scene is from the Earthquake, Tsunami and Radiation Disaster In Northern Japan. This involves radiation screening of evacuees including children.
Anticipate…

- Two types of staff stress:
  - Traumatic exposure vs.:
  - Cumulative response stress
- Reactions
- Triggers
- Stress expectable, manageable and not necessarily pathological
- Severity and frequency BOTH important
- Challenge is to manage stress

There are two types of staff stress- Traumatic exposure and cumulative response stress (direct participants to Step 1 in their personal resilience plan brochure).

- Review each Traumatic Exposure; ask participants to discuss thoughts about these items.

- Review each Cumulative stressor and ask them to describe their daily experiences with these. Then ask, how will this be different in a disaster?

- Reactions – We will be discussing this in Step 2.

- Triggers are: expectable, manageable and not necessarily pathological. Severity and frequency of stress factors are both important. The challenge is to manage stress!
The “double whammy”

- In disasters, staff may not be able to get home or stay in contact with family
- Outside factors rival response role stress
- Can have response stress and direct victim stress
- Concerns about family pivotal
- NOT ANOTHER DAY AT THE HOSPITAL!

Disasters are “just not another day in the office” (hospital, ED, clinic, etc.)

How disasters are different:
1) You can’t go home at the end of your shift
2) You can’t reach any of your loved ones and don’t know where or how they are for a protracted period.
3) These “outside factors” rival or can exceed stress as a medical responder.
4) If you are a “local” responder, you can have both stress (and risk) as a responder and also simultaneously be at risk from direct stress in your home/family life.
5) There is considerable evidence that concerns about family, their status and possible risks to them from your work are very powerful. These stresses can be addressed and mitigated but the first step is recognition (“Anticipate”).

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These are a number of potential disaster medical response stressors tied to:

1) Certain types of patient injuries and outcomes (severe burns, traumatic amputations, pediatric deaths or mutilating wounds, higher levels of mortality).

2) Role specific stressors such as having to perform expectant triage decisions that involve the action of not providing definitive care due to surge demand, (see also crisis standards of care idea the previous slide), working with patients outside current skills (such as a pediatrician working with adult patients).

3) Personal impacts to the provider i.e. feeling as if their own lives are in danger, directly impacted by the incident at home or at work (including becoming injured or ill themselves), and also concerns over possible toxic exposure to biological, chemical or radiological materials, etc.
Direct participants to panel 2 of the APD personal resilience plan - Step 1 Anticipate.

These stress experiences may be more common:
   - Patients screaming in pain or fear
   - Direct contact with grieving family members.

Others here may be less commonly encountered:
   - Forced to abandon patients
   - Working outside current skills (adult providers with kids or vice versa)
   - Extreme danger in the work setting or Hazmat in the work setting
   - Unable to meet patient needs because of the disaster response context (i.e. because too many patients to do care as usual or you run out of supplies).

It is important to make sure participants understand what each risk factor is so they can triage themselves later on in the “Deter” cycle of APD.

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Response stress cont’d:

• Unable to return home
• Worried about safety of family members, significant others or pets
• Unable to communicate with family members or significant others
• Health concerns for self due to possible agent/toxic exposure (infectious disease, chemical, radiological nuclear, etc.)

Above slides shows some additional response stressors that are tied to family concerns. Research has shown that when the responders own significant others and family are involved, it is the key element of responder stress.

Read each bullet

• Responders may also be concerned about their family or significant others due to on-going events in their lives.

• Responders need to be aware of these risks in addition to all the others they face in their direct work with patients in disaster contexts.
There are many different ways in which reactions to stress can manifest, emotional, cognitive, physical or behavioral (read all examples above).
As described earlier, "home concerns", (i.e., concerns about significant others, family members and pets) can be a major area of concern and stress for healthcare workers. One way to mitigate that is by home preparedness activities. This includes preparation of a disaster kit, family disaster communications plan, and other sources of support for the family if the responder is not able to return home.

Responders can also provide basic psychological first aid to their own family members, including school age children using the Listen, Protect and Connect Psychological First Aid model (LPC). Instructions on how to learn this are available at: www.cdms.uci.edu/lpc
An all ages LPC Neighbor to Neighbor; family-to-family is available at: http://www.ready.gov/sites/default/files/documents/files/LPC_Booklet.pdf
Resilience begins with staring to anticipate your response role and conditions.

- Consider the different types of stressors you might experience, consider the sights and types of disaster situations you might face and consider how a disaster response is *not another day at the office*.
- Anticipate the focus of your potential concerns: family issues, for local responders weigh heavily on responder stress. When deployed, using APD may markedly reduce your stress.
- If we are concerned about the quality of the medical mission, then self-care of healthcare responders is mission critical and needs to be integrated before, during, and after a response. It is not sufficient to have a single session sharing of “worst moments” (debriefing) following a disaster response and nothing else, particularly for healthcare workers who where highly impacted by the event.
- Working as a healthcare worker is a “marathon, not a sprint”. Healthcare workers are obligated to engage in good personal stress management on a daily basis and during a disaster, healthcare workers must “step up” their stress management plan to meet the emotional demands of the disaster.
Crisis standards of care represent an ethical and rational approach to allocate resources in hospitals and other settings. Participants are also encouraged to read the IOM Crisis Standards of Care report available without cost at: http://www.iom.edu/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx

When the response event involves chemical, biological, radiological or nuclear agents, this adds significant further stress potential for the healthcare responder. Unlike medical risk, just the threat or perception of these materials being present can be enough to trigger long-term posttraumatic stress reactions in responders. There is considerable lack of familiarity with these agents, their health effects, PPE and concerns about personal exposure and secondary exposure to family members. This may add tremendous additional burden to medical workers in these events. Additionally, the larger the scale of disaster, the more likely that the healthcare workers social network of friends and family will be directly impacted.
This picture is of a local hospital that was damaged in the 2011 Tornado in Joplin Missouri. Imagine how stressful it was for healthcare workers to witness the destruction of their hospital and the aftermath of trying to take care of patients and rebuild the hospital?
NOW WE MOVE TO STEP 2.
In step one we considered a range of stressors and explored some possible exposure risks you may face as a healthcare responder. That is the “Anticipate” part of APD. Now it is time for Step 2 OR “Plan” OF APD.

Now that you have “Anticipated” your stress reactions for a disasters/mass casualty event, we will focus on what you can do about it. In APD “what to do” starts in Step 2 – Plan for Your Response Challenges. We will use this next step to help you create your own personalized coping plan. This plan is just for you to use. We hope you consider this as a key part of your personal “go kit” or as a part of your “personal protective equipment” during a disaster.

Based on your existing coping strategies and coping resources, you can facilitate your personal resilience following a disaster. APD is a “strengths based” approach where you will leverage your resilience factors to help you cope better with stressors in disasters and mass casualty events.

APD will offer you some additional choices on how to cope, however, this strategy mainly relies on your already considerable strengths and coping skills that you use daily on the job. With APD we are building on your resilience in advance of the next disaster, public health emergency, or mass casualty event.

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When you leave today, we hope you will have each section of your APD “Personal Resilience Plan” filled out with your own “coping” ideas. If you leave sections blank, then fill in your answers at home. Remember, APD is customized to you based on your anticipated concerns and your own coping styles and resources.

The first step of the plan is to list what your expected reactions might be to a large disaster. (The Instructor should refer participants to the “Step 1 Anticipate” section of their brochure to review the “Traumatic” and “Cumulative” stressors before writing in their responses to this section.)

- Give participants time to fill in this section.
- Ask for volunteers to share examples.
Let’s build on your own current resilience factors. One key coping dimension that has received considerable research support is the link between stress and the effects of social support.

So thinking about your social support system, discuss with them how you might outreach to them during a big event and consider how you want to reach them in a disaster context (talking to them, texting them, video chat, email?) what is your preference? What is most practical in a busy mass casualty event?

How will you use your social media? What is the upside and the downside of using your social media?
Building Your Positive Coping Plan

What works for you?:

• Everyone has different ways in which they cope with stress

• Please list some of these strategies now: your menu

• Consider limiting your exposure to media reports, focusing beyond the short term, taking frequent short breaks whenever possible and practicing “Listen, Protect and Connect”

• Psychological first aid with patients and co-workers

• Identify positive experiences including those that give a sense of mission or purpose:
  - “making a difference”
  - “being there for those that need us”

Here the instructor shares their list of coping strategies and asks group to share theirs briefly.

• Include positive imagery they can use from their own experiences

• Future positive activity planning

• Other strategies they mention that involve active coping

• Your Personal Support Plan – Ask participants to take a few moments to list people who help them cope with stress during difficult times. This should include individuals they can talk to following a disaster. Talking with people they trust following a disaster is a key element of their APD “coping plan”.

• Your Positive Coping Plan – Ask participants to list positive stress management strategies that they could actually use in a disaster. One way to discuss this is to talk about the difference between “positive” and “negative” coping. (If alcohol, food, other substances are mentioned, be prepared to discuss why that may not be the best strategy: i.e. not active coping, blunts feelings but does little to manage the stress or situation per se and reinforces “numbing” but not active coping.) List as many positive strategies as you can. This can be your “coping menu” during a disaster.

• One thing that everyone can include is a plan to manage his or her exposure to media reports. These reports can be informative but also a cumulative stressor when viewed over and over again.

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One thing that everyone can include is a plan to manage his or her exposure to media reports. These reports can be informative but also a cumulative stressor when viewed over and over again. Another strategy that can help you and your co-workers is learning about how to administer Psychological First Aid. If you are interested in learning Psychological First Aid, your facility can contact Sandra Shields, Disaster Program Manager at the LA County EMS Agency to receive training on psychological first aid using the “Listen, Protect and Connect Family to Family, Neighbor to Neighbor” training program.
Now we move to Step 3 – The “Deter” component of APD. Here we take all we have learned so far and discuss how to use their APD coping plan during a large event.
Deter means activating or “donning” your coping plan much as you would “don” your personal protective equipment in a Hazmat. In this context, the hazard is to your health stress and your coping plan is your “mental health PPE”. The first step is monitoring your stress exposures using the PsySTART responder self-triage system. You may consider this your “personal stress dosimeter”. Using these next steps will help you to take proactive steps to reduce or mitigate the stress you are experiencing.

- Remember, you can always use your personal social support system irrespective of your self-triage. Talking with a supportive friend is helpful for most of us.

Another resource that we are piloting is “Bounce Back Now”, an online, anonymous program that you can use to gain more information and coping tools. (Instructors should direct participants to the information on “Bounce Back Now” under the Deter section in their APD brochure.) Again, “Bounce Back Now” is an online, confidential resource that you can use if you feel the need for additional coping tools. It focuses on posttraumatic stress symptoms including depression, anxiety, and substance use.
Goal of the PsySTART Staff Self-Assessment System

- The PsySTART Staff Triage System is designed to quickly help staff members identify their own risk from disaster response.
- Given their triage information, staff members can take proactive steps to manage stress.
- Facilities can use aggregated information to gauge the impact of events on workforce.
- Facilities can use this aggregated information to plan for the needs of their employees, including crisis intervention, psychological first aid, and referral for secondary assessment.

The PsySTART Staff Self-Assessment System is designed to help staff members quickly assess their own risk at a particular point in time and cumulatively across sustained disaster operations. The central idea is that armed with their own self assessment data, staff can take early, small proactive steps to mitigate their own risks. *The PsySTART Self-Assessment tool is not designed to be used as a “stand alone” but as one part of broader individual stress management and facility resilience building efforts.*

- If staff share their own self-assessment data with their facility (even de-identified), facilities can use this “aggregated” staff self-assessment to gauge overall impact on workforce.
- In this way, facilities can use this information to support the HICS employee health and wellness protocol, estimate needs for crisis intervention, psychological first aid and referral for secondary assessment later.

Why are we concerned about early identification of staff at risk? There is increasing evidence that certain interventions applied in the “golden month” to high-risk individuals can reduce or prevent long-term trauma leading mental health consequences. This potentially results in better outcomes for staff and their families and also preserves the essential medical response capability of the county with a more resilient workforce.

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Just to review – This is the single day PsySTART Form. It is also on your APD brochure. We will practice with this shortly.

- The directions for the single day form are to check all boxes that indicate any traumatic or cumulative stress items you experienced during your disaster response that day.
- Please note that it is optional to sign your name and turn in your form to your Department. By the request of the PsySTART Advisory group, it is mandatory for staff to at least enter their Job Role and Department.
- This will help facilities to track trends of staff impact following a disaster. Please note that this form does not specify psychological symptoms. There is no diagnosis of any kind. Tracking exposure is a non-stigmatizing way to track the impact of a (one day in this case) disaster response of staff.
- We encourage healthcare facilities to use this form.
This is the first component of the PsySTART Staff Self-Assessment System. This is the PsySTART Staff Self-Assessment Tag for a MULT-DAY EVENT. The instructions are found on the back of the form.

- The tag lists the same traumatic and cumulative stress items as the single day version.
- Staff can fill out this form at the end of each shift. This form can record up to fourteen days of response work.
- Additional days will be on supplemental pages.

Please note once again that just like the single day form, it is optional to sign your name and turn in your form to your Department. By the request of the PsySTART Advisory group, it is mandatory for staff to at least enter their Job Role and Department. This will help facilities to track trends of staff impact following a disaster. Please note that this form does not specify psychological symptoms. There is no diagnosis of any kind. Tracking exposure is a non-stigmatizing way to track the impact of a multi-day disaster response of staff. We encourage healthcare facilities to use this form. The information is captured at the end of each shift and/or can be collected at the end of the incident. This is performed by health staff to self-monitor stress before stress levels become overwhelming.
The last part of Deter is knowing when to seek out additional help.

Please list some resources available to you in this box now. This could be your Employee Assistance Program at your work or other mental health and even spiritual care resources you might use if you find yourself having a difficult time following a disaster response.