# MODULE 1: Preparing Hospitals and Clinics for the Psychological Consequences of a Terrorist Incident or Other Public Health Emergency

## Participant Handout

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*In collaboration with County of Los Angeles partners:*
*Department of Health Services, Emergency Medical Services Agency*
*Department of Mental Health*
*Department of Public Health Emergency Preparedness and Response Program*

County of Los Angeles
**Department of Mental Health**

# Preparing Hospitals and Clinics for the Psychological Consequences of a Terrorist Incident or Other Public Health Emergency



## What D0 We Mean by Psychological Consequences?

- Emotional
- Behavioral
- Cognitive

Reactions that affect hospital and clinic staff, patients, family members, and concerned community members in the face of a disaster

Institute of Medicine (2003).

## Purpose of This Course

To give you protocols, templates, manuals, and tools so that you can train staff at your health care facility to address the psychological consequences of terrorism or other public health events



## Course Objectives

- Recognize the triggers of psychological distress
- Raise awareness of the types of psychological effects to expect
- Provide principles and tools to bring back to your facility to augment your response plan and strengthen resources
- Help train staff at your facility:
  - Increase their knowledge and ability to plan and respond to the psychological consequences of large-scale emergencies

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## Three Modular Training Components

**Module 1:** one-hour module for administrative and disaster planning and response staff

**Module 2:** one-hour module for hospital and clinic, clinical, mental health, and non-clinical staff

**Module 3:** two-hour module for Los Angeles County Department of Mental Health with additional details tailored to the disaster response perspective

## Health Facility Needs Vary

| Type of Facility | Components to Emphasize |
|---|---|
| Hospital with no on-site MH staff | Module 1: Staff assignments |
| Hospital with on-site MH staff | Module 2: All sections |
| Children's hospital | Module 2: Special populations |
| Community clinic | All sections of modules 1 and 2 are relevant |



## Overview of Module 1

- **Need:** The psychological consequences of large-scale emergencies
- **Context:** Characteristics of emergencies that are likely to trigger psychological effects
- **Planning for MH Need**: Preparing staff and facilities to best serve needs
- **Response**: Using tools and resources to address psychological effects
- **Discussion**: Summary and wrap-up

- **Need:** The psychological consequences of large-scale emergencies
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# Sarin Gas Attack

Tokyo, March 20, 1995

Details are based on Okumura et al., 1998.

# Public Health Emergencies Produce Medical Surges

(At Least Four Times As Many with MH Effects)

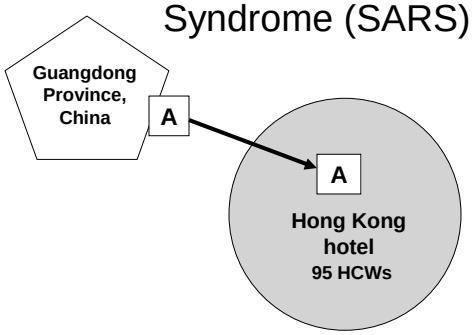
Tokyo, 1995, *sarin*: 88% of visits were for persons who were not exposed

Brazil, 1987, *radioactive cesium isotope*: 125 exposed, 125,000 sought screening, 5,000 had symptoms without exposure

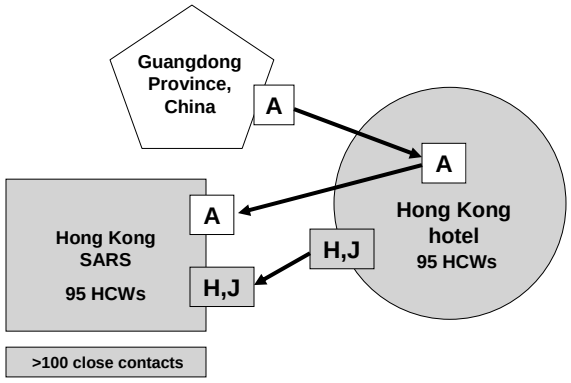
Washington DC, 2001, *anthrax*: 22 cases, 35,000 received prophylactic antibiotics



# Roadmap of an Emergency: Severe Acute Respiratory Syndrome (SARS)



# Roadmap of an Emergency: SARS



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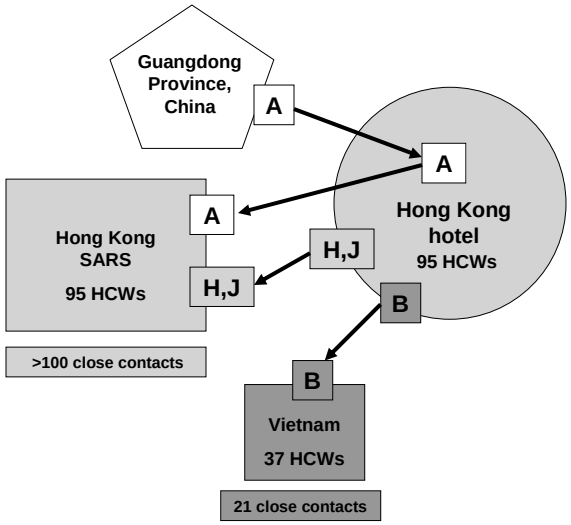

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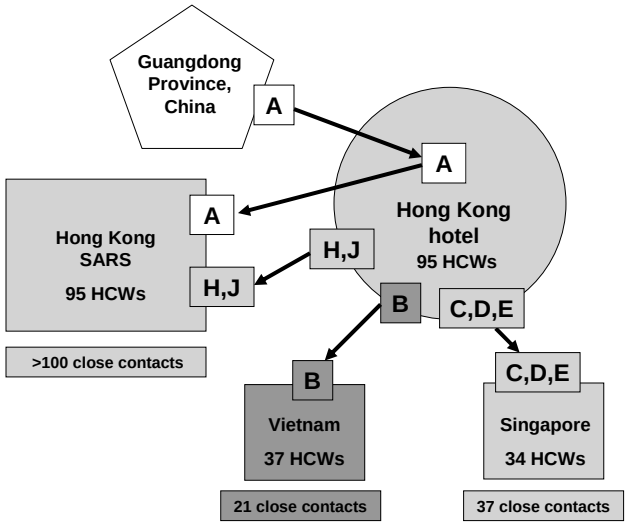




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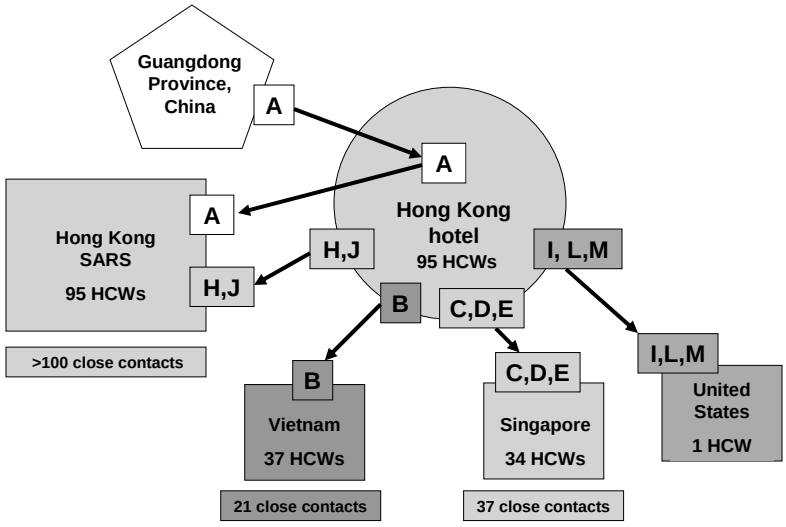

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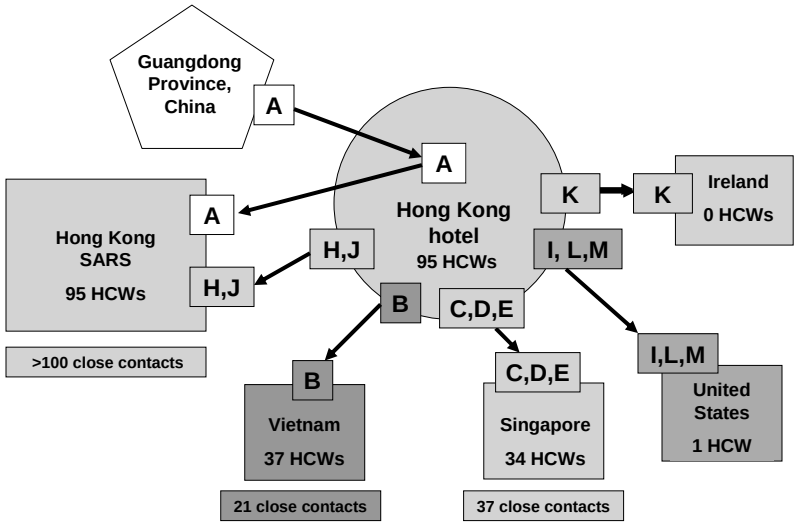




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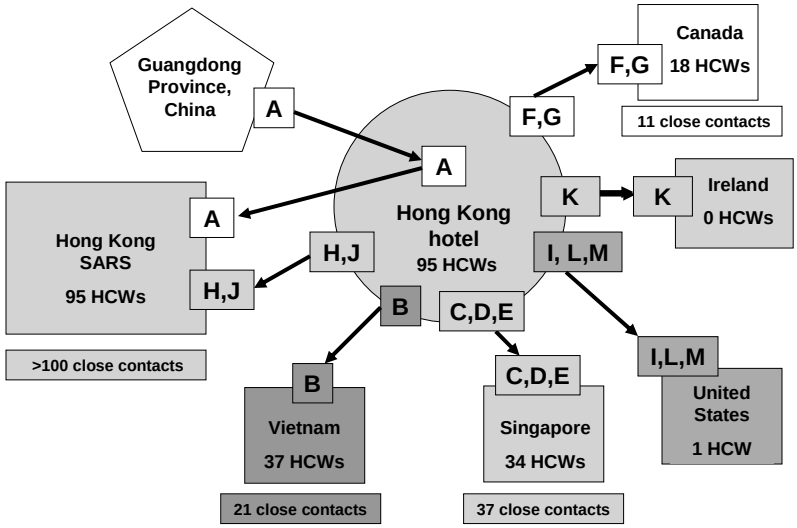


## SARS: Effects on HCWs

- In the first month in Toronto, more than half of the quarantined patients in one hospital were HCWs
- Fears and infection control procedures led to isolation and stigmatization of HCWs
- Rates of psychological distress were high
  - 10–30% of quarantined persons developed psychological distress, including symptoms of depression or PTSD
  - 30% of HCWs reported job burnout one year later

SOURCE: Maunder et al., 2006.



## Mental Health Needs Can Have Cascading Effects

Persons directly exposed and ill

Persons not directly exposed and with non-specific signs of illness

Persons directly exposed but no signs of illness

## Mental Health Needs Can Have Cascading Effects

Persons directly exposed and ill

Survivors in isolation developing stress reactions

Persons not directly exposed and with non-specific signs of illness

Persons directly exposed but no signs of illness

Survivors developing stress reactions after decontamination



## Mental Health Needs Can Have Cascading Effects

Parents of exposed children

Families seeking loved ones who are missing

Persons directly exposed and ill

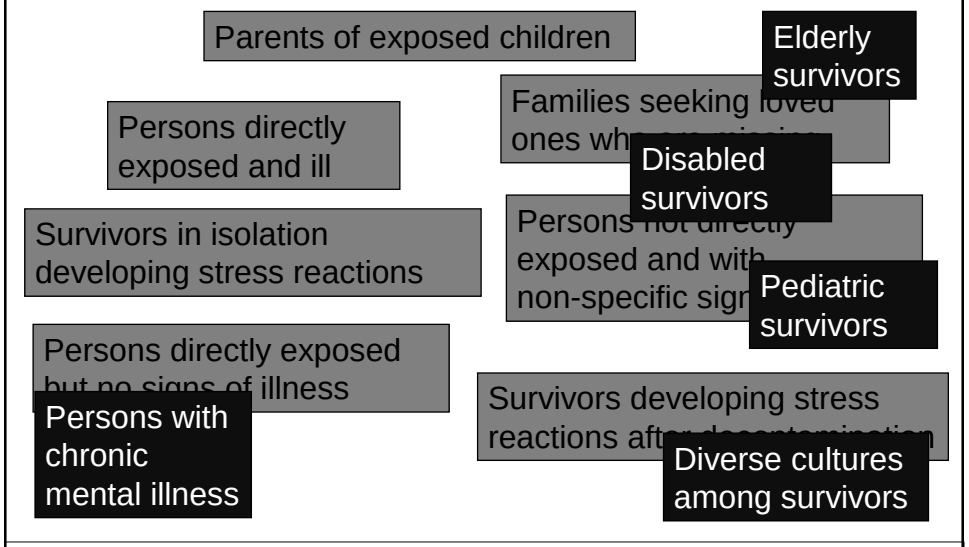
Survivors in isolation developing stress reactions

Persons not directly exposed and with non-specific signs of illness

Persons directly exposed but no signs of illness

Survivors developing stress reactions after decontamination

## Mental Health Needs Can Have Cascading Effects



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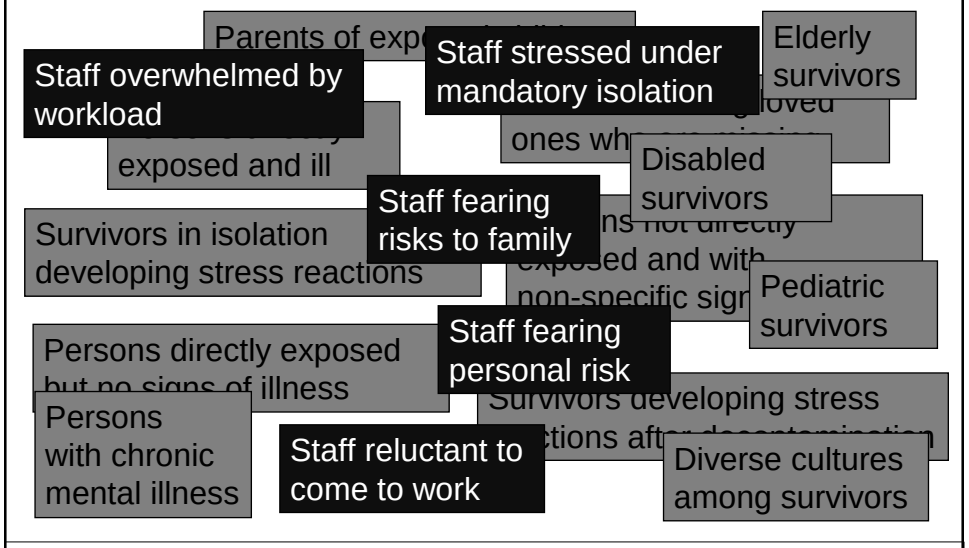

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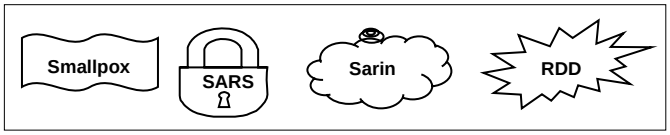
*Terrorist incident or public health emergency*




*Triggers of psychological effects*

- **Restricted movement**
- **Limited resources**
- **Trauma exposure**
- **Limited information**
- **Perceived personal or family risk**

*Short-term and longer-term effects*

- **Emotional**
- **Behavioral**
- **Cognitive**

# Restricted Movement

- **Definition:** Limitations on movement or interactions with others
  - Isolation
  - Shelter in place
  - Decontamination
  - Quarantine
  - Increased social distance
  - Evacuation

- **Potential reactions**
  - Loneliness
  - Anger and fear
  - Maladaptive behavior
- **Example:** A woman hospitalized with a severe respiratory problem is placed in isolation. She has no contact with her two young children or spouse and little access to social stimulation or personal relationships. Her family is quarantined at home, isolating them as well. Becoming agitated, she insists on leaving isolation to be with her family.



# Limited Resources

- **Definition**: Access to resources is, or can be perceived as, restricted
  - Clinics closed and supplies limited
  - Resource distribution is seen as inequitable

- **Potential reactions**
  - Anger
  - Feelings of being stigmatized
  - Agitation and hostility
- **Example:** Hospital staff are potentially contaminated while responding to an RDD event because there isn't enough personal protective equipment. Staff become anxious about working with exposed patients; some refuse to work in the decontamination zones. Some staff try to steal protective equipment to use as a precaution when they travel home.

# Trauma Exposure

- **Definition:** Witnessing or being the survivor of a traumatic event
  - Gruesome images of the injured or ill, especially children
  - Severe injury or death

- **Potential reactions:**
  - Grief
  - Anger
  - Worry
  - Burnout (psychological distress from adverse work conditions)

- **Example:** During the response to an RDD, the hospital emergency department receives multiple survivors, including many school children from the explosion site. Patients, their loved ones, and staff are exposed to gruesome images of burn/blast survivors.



# Limited Information

- **Definition**: Actual or perceived lack of appropriate information about risks, symptoms, and recommended actions
  - Communication is inefficient or insufficient
  - Information is conflicting or lacking

- **Potential reactions**:
  - Fear
  - Anxiety
  - Frustration
  - Anger/hostility

- **Example:** During a chemical attack, people lack information about what to do. They begin calling the hospital for additional guidance; some go to the ED demanding to be evaluated. Officials and the media give the public differing information about risk zones, increasing the confusion

# Perceived Personal or Family Risk

- **Definition:** Concern about personal or family safety
  - Exposure to harmful agents
  - Illness, injury, death

- **Potential reactions:**
  - Fear
  - Inappropriate precautions
  - Demand for medical care
- **Example:** During a pandemic influenza emergency, half of the hospital nursing staff are unable or unwilling to work because they either have no child care arrangements (schools and day-care centers are closed) or they are worried that they will be exposed to the disease and in turn expose their families



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## Areas Likely to Trigger Psychological Reactions

- Where people **enter and exit** the facility
- Where survivors are **treated**
- Where people **congregate**
- Examples:
  - Emergency department
  - Entrance, front desk
  - Waiting room, discharge area
  - Triage areas
  - Television viewing areas
  - Treatment areas



## Where Do I Locate Everyone?

In advance of a disaster, determine where to locate:

- Psychological support
  - Fire and police may want their own MH team to administer care in a separate area
  - If necessary, use the parking lot or ancillary hospital/clinic building
- Waiting families and friends
  - Try to not mix families of the deceased with other families
- The bereaved
- Disruptive persons and assist people who become violent

## What to Consider in Selecting Waiting Areas and Locations for MH Care

- Don't use the emergency department or intensive care unit halls
- Consider parking lots, auditoriums, cafeterias, and adjacent hospital buildings
- Choose
  - Spaces with easy access to bathrooms
  - Outdoor spaces that are viable in bad weather



## Planning for Your Hospital MH Response Team

- Plan to be on your own for at least three days
- You will be limited to existing hospital/clinic staff
  - If available, MH clinical staff
  - Nonmental health clinical staff
  - Nonclinical staff (e.g., administrators and security staff)
- Pre-identify staff for your disaster MH team (and put them on your disaster planning committee)
- Identify the HICS MH Unit Leader and/or Employee Health and Well-Being Unit Leader

## Plan for Additional Sources for MH Staff

- **Make pre-disaster agreements for mutual aid**
- **Disaster Resource Center including umbrella hospitals and clinics (pre-disaster)**
- **County Department of Health Services (post-disaster)**
  - DHS can access other county resources such as the Department of Mental Health, Public Health, etc.
  - DHS Emergency Medical Services Agency can contact the County Emergency Operations Center to access state and federal resources for postdisaster support
- **Establish partners (pre-disaster agreements)**
  - Volunteer organizations (social services)
  - Religious organizations (Chaplains)
  - Businesses (help with translation)
- **Volunteers**
  - Familiarize yourself with hospital/clinic plan for using volunteers
  - Develop list of approved groups



## Suggestions for Using Mutual Aid Staff During Disasters

Reduce chaos and problems by determining:

- How staff from mutual aid partners including volunteers will be processed upon arrival at your facility
- Who/where they will report to:
  - HICS MH Unit Leader
  - Employee Health and Well-Being Unit Leader
  - Staging area or staff registration area
- How to identify and badge outside staff working in your facility during disasters

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## Time Frames for Preparedness and Response

Before the incident: planning and training

During the incident: acute/short-term response

After the Incident: recovery

# Tools to Use Before, During, and After a Disaster

| Tool Name | Purpose | When to Use |
|---|---|---|
| Definitions | To explain selected medical concepts and countermeasures | Before and during |
| HICS MH Job Action Sheets | To improve the disaster response by including MH content and integrating MH functions | Before and during |
| Recommended Actions | To guide hospital/clinic staff in specific responses needed | Before and during |
| An Algorithm for Triaging MH Needs | To help staff decide who may need urgent psychological assessment from those who need nonurgent assessment | Before and during |
| REPEAT | To help hospitals/clinics assess their levels of preparedness | Before and after |
| Providing PFA: Tips for Talking with Adults and Children, Reference card and NCPTSD Handouts | To outline the 8 principles of early intervention in a disaster | Before and during |
| Tips for Workers and Survivors | To help prevent or mitigate burnout | Before, during, and after |
| Facility Poster | To promote preparedness among hospital/clinic staff | Before, during, and after |



# Getting Additional Resources

L.A. County DMH is the lead agency for all disaster-related psychological services provided to the public

- Your hospital incident commander (or other disaster coordinator) can request DMH services through the County DHS EMS Agency Emergency Operations Center by contacting:
  - Medical Alert Center (***MAC***): (323) 722-8073
  - Disaster Operations Center (***DOC***): (323) 890-7601
  - Hospital Emergency Administrative Radio (***HEAR***)
  - Web-based hospital messaging system: ***ReddiNet***
- To access L.A. County DMH crisis counseling and long-term MH care resources, call:

24-Hour Hotline: (800) 854-7771

# Radiological Dispersal Device (RDD)

A dirty bomb containing cesium is detonated in downtown Los Angeles

- 180 deaths; ~270 injured; widespread contamination
- Hospitals inundated with ~50,000 people who believe they have been affected
- Patients, loved ones, and staff are exposed to gruesome images of burn/blast survivors
- Hospital and clinic staff may be contaminated because they lack protective gear
- Staff do not understand risks and are anxious and hesitant in their work
- Dozens of staff do not come to work
- ~ 20,000 individuals will probably be contaminated
  - Injured will require decontamination and treatment
  - Thousands more will probably need decontamination and medical follow-up



*Terrorist incident or public health emergency*

*Triggers of psychological effects*

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- **Perceived personal or family risk**

*Short-term and longer-term effects*

- **Emotional**
- **Behavioral**
- **Cognitive**

# Radiological Dispersal

| | |
|---|---|
| "Hospital staff may be contaminated because they lack protective gear." | Limited resources |
| "Patients, their loved ones, and staff are exposed to gruesome images of burn/blast survivors as they enter the ER." | Traumatic exposure |
| "Staff don't understand risks of cesium exposure, making them anxious and hesitant in their work." | Limited information |
| "The injured will require some decontamination while being treated and, if possible, before hospital admission." | Restricted movement |
| "In the hours and days following the attack, dozens of staff don't come to work." | Perceived personal or family risk |



# Pandemic Influenza

25 cases of a new, highly contagious strain of flu appears in a small village in south China. Over the next 4 months, outbreaks appear in Hong Kong, Singapore, South Korea, Japan, Los Angeles, and three other major U.S. cities. The CDC announces plans for allocating the limited supply of vaccine and provides guidelines for using scarce resources.

Health care providers are overwhelmed. Media attention highlights shortages of medical supplies, equipment, hospital beds, and HCWs. Those HCWs at work are worried about contaminating their families. In underserved areas, up to 25% of the nursing staff cannot come to work: They have no child care arrangements because schools and day care facilities are closed.

Hospital and clinic staff are torn between their roles as health care providers and parents. Some HCWs, especially those placed in home quarantine, become depressed; others, traumatized by working in hospital isolation units, develop PTSD.

## Pandemic Influenza

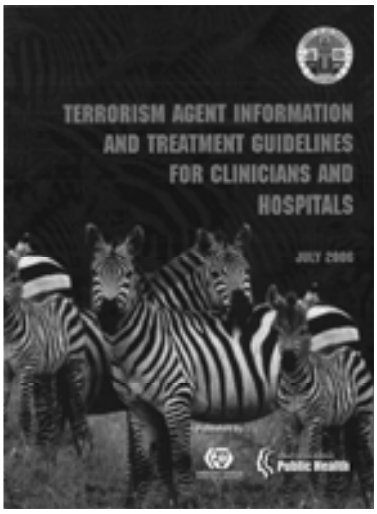
| | |
|---|---|
| "The CDC announces plans for allocating the limited supply of vaccine and provides guidelines for using scarce resources." | Limited resources |
| **"**In underserved areas, up to 25% of the nursing staff cannot come to work: They have no child care arrangements because schools and day care facilities are closed**."** | Limited resources |
| "Some HCWs, especially those placed in home quarantine, become depressed; others, traumatized by working in hospital isolation units, develop PTSD." | Traumatic exposure and restricted movement |
| "HCWs are worried about contaminating their families." | Perceived personal or family risk |



## Using the Tools in an RDD or Other Disaster

- Contact Hospital Incident Command for staffing help
- Consult the "Zebra book" to look up agent information and treatment guidelines
  - www.labt.org
- Look up countermeasures in Recommended Actions
- Use the Algorithm for Triaging Mental Health Need
- After the event, complete the REPEAT assessment tool
- Distribute tips brochures
- Use PFA immediately after the disaster
- Display the poster and distribute the reference card
- Follow HICS Mental Health Job Action Sheet

# The "Zebra Book"






# Using the Recommended Actions Tool to Address RDD

**Contents**


| Psychological Trigger | Agent | Page Number |
|---|---|---|
| Restricted Movement | | 5 |
| • Isolation | Biological, Chemical | |
| • Shelter in place | Contagious, Chemical, RDD | |
| • Decontamination | Chemical, RDD | |
| • Quarantine | Contagious | |
| Limited Resources | | 8 |
| • Staffing shortages under surge | Any | |
| • Space limitations for providing psychological care | Any | |
| • Availability of personal protective equipment (PPE) | Biological, Chemical, RDD | |

# Using the Recommended Actions Tool to Address RDD

## Decontamination

During the planning stage

- Train non-MH staff to help keep people calm and possibly also to identify MH trauma
- Prepare decontamination instruction signs in languages appropriate for residents of surrounding communities
- Think through privacy or modesty issues that may be cultural and plan to address them

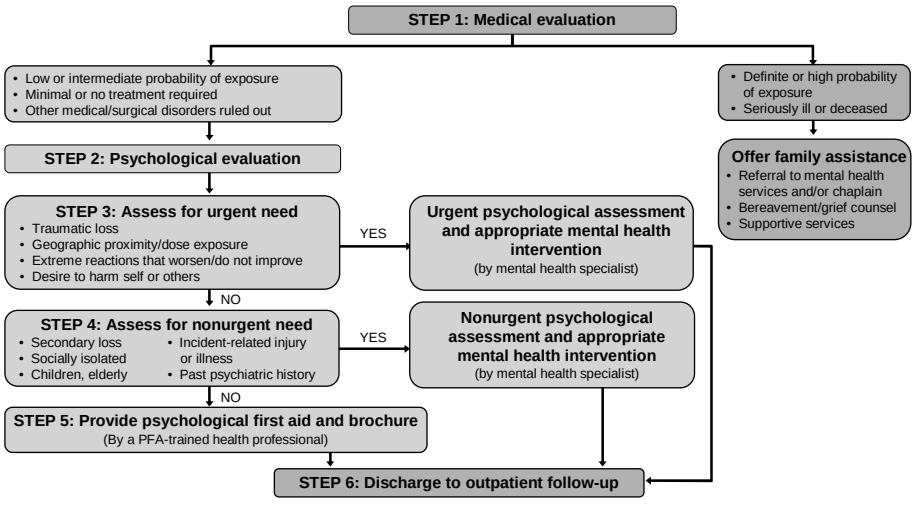
During the decontamination process

- After individuals have been triaged and identified as exposed or not exposed, conduct MH assessments among both groups to identify those who need supportive care or MH intervention
- Try not to separate parents and children during the decontamination process
- Place MH staff in the "clean" zone to assess for trauma



# Identifying Urgency of Mental Health Needs

## Patients with Exposure-Related Concern or Illness



# Identifying Urgency of Mental Health Need

Patients with Exposure-Related Concern or Illness

**STEP 1: Medical evaluation**

- Low or intermediate probability of exposure
- Minimal or no treatment required
- Other medical/surgical disorders ruled out

**STEP 2: Psychological evaluation**

NEXT SLIDE

- Definite or high probability of exposure
- Seriously ill or deceased

**Offer family assistance**

- Referral to mental health services and/or chaplain
- Bereavement/grief counsel
- Supportive services



# Assessment for Urgent Need

**STEP 3: Assess for urgent need**

- Traumatic loss
- Geographic proximity/dose exposure
- Extreme reactions that worsen/do not improve
- Desire to harm self or others

YES

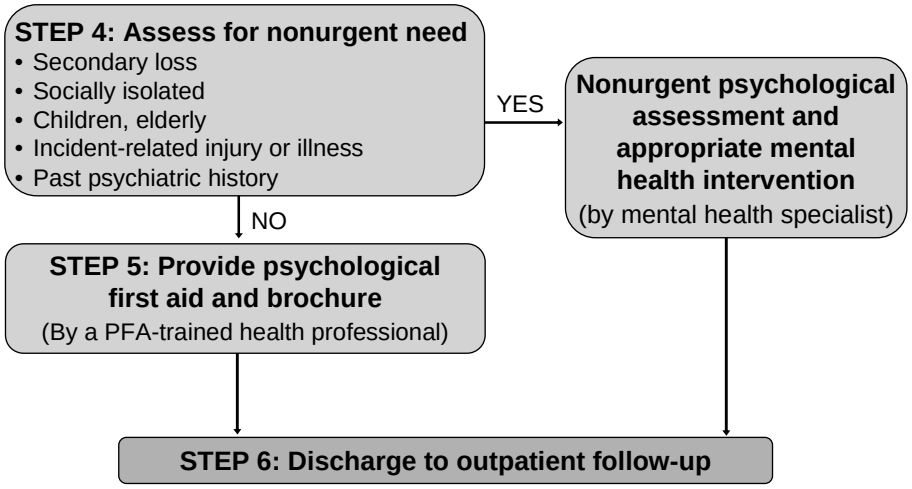
**Urgent psychological assessment and appropriate mental health intervention** (by mental health specialist)

NO

NEXT SLIDE

**STEP 6: Discharge to outpatient follow-up**

# Assessment for Nonurgent Need






# Structures and Processes for Health Care Facility Readiness

| Structure | | Process | | Outcomes |
|---|---|---|---|---|
| • Internal organizational structure and chain of command<br>• Resources and infrastructure<br>• Knowledge and skills | + | • Coordinating with external organizations<br>• Risk assessment and monitoring<br>• Psychological support and intervention<br>• Communication and information sharing | = | *Appropriate MH disaster response* |

SOURCE: Donabedian (1966).

## How Prepared Is Your Facility?

- Assess your level of preparedness to respond to a terrorist incident or other public health emergency
  - Set a baseline score
  - Identify areas for improvement
- Reassess preparedness
  - Gauge amount of improvement
  - Identify areas still needing attention



## How Prepared Is Your Facility?
## –Final Thoughts–

- Add one or more mental health professionals to your facility disaster planning team
- Pre-identify one or more mental health staff or clinical staff for the two mental health positions in HICS
- Recruit staff for your facility disaster mental health team
- Include the surge of psychological casualties in your annual exercise program to test your mental health response plans

# REPEAT for Health Care Facilities

**Disaster Preparedness Self-Assessment Tool**

| Psychological Element* | Full Implementation (Score = 2) | Some Implementation (Score = 1) | No Implementation (Score = 0) | Your Score and Areas to Improve |
|---|---|---|---|---|
| **Structure** | | | | |
| Internal Organizational Structure and Chain of Command | • Leadership recognizes the need to address psychological consequences<br>• Disaster plan includes MH in the incident command structure/ job action sheets<br>• Clear roles are identified for direct MH service to survivors and family; and staff | Some of these structures are in place to address psychological consequences | There is no infrastructure to address psychological consequences | 2 1 0 |
| Resources and Infrastructure | • Plan has been reviewed to ensure adequate resources and supplies will be available<br>• Resource list is available with information on who to contact (county DMH)<br>• Have capacity to handle a MH surge up to 50 times the number of physical casualties | Some but not all resources that would be needed are available | Resources available are inadequate should a disaster occur | 2 1 0 |
| Knowledge and skills | • MH staff are trained for roles in command structure and familiar with job action sheets<br>• MH staff are trained in MH assessment and early psychological intervention<br>• Staff receive hands-on training through exercises and drills to test plans | Some staff have received some training activities on MH reactions and response | Staff have not received training on MH reactions and response | 2 1 0 |
| | | | Subtotal Disaster Preparedness Self-Assessment Score (***Structure:*** possible range = 0–6) | |



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# Discussion

Summary

Continuing education credit

Resources

# MODULE 2: Training Hospital and Clinic Facility Clinical, Mental Health, and Non-Clinincal Staff to Address the Psychological Consequences of Large-Scale Emergencies

## Participant Handout

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# Training Hospital and Clinic Facility Clinical, Mental Health, and Non-Clinical Staff to Address the Psychological Consequences of Large-Scale Emergencies



## Three Modular Training Components

**Module 1:** one-hour module for administrative and disaster planning and response staff

**Module 2:** one-hour module for hospital and clinic, clinical, mental health, and non-clinical staff

**Module 3:** two-hour module for Los Angeles County Department of Mental Health with additional details tailored to the disaster response perspective

## Purpose of This Course

To teach you the skills necessary to integrate MH functions into the overall emergency response, to review evidence-informed practices for early intervention, and to provide specific tools and techniques to support the psychological needs of patients, family members, staff, and first responders



## Course Objectives

After completing this module, you will:

- Know how to integrate your MH response team expertise and functions into the overall disaster response
- Understand key triggers of psychological consequences of public health emergencies
- Know how to deliver evidence-informed techniques to support and intervene with individuals suffering from psychological consequences
- Know how to use just-in-time tools to address potential psychological reactions

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## Integrating MH into the Disaster Response

- Integrating MH into the response: Addressing cultural barriers and structural obstacles
- Functions for MH staff: Identifying "psychological hot spots"
- Psychological reactions to large-scale disasters
- Evidence-informed practices for early intervention: Recommendations for use
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- Final thoughts

## MH Is a Lonely Silo

- MH expertise is often underutilized
- Clinical staff believe they can handle patient MH problems on their own
- Many facilities have limited MH staff and cannot handle a "surge" situation

Clinical staff may lack the training needed to address the psychological consequences of terrorism or other large-scale emergencies



## MH and Medical Care Should Complement Each Other

- Have a plan for bringing more MH staff to the situation
- Consider emergency department priorities
- The model for a large-scale disaster is different from the usual style used to counsel MH problems

Having MH staff appropriately trained to address psychological reactions can make the jobs of medical staff easier

# Functions for MH Staff

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# Functions for MH Staff

Where are the areas of greatest MH need?

What functions should be performed by MH staff?

What functions could be performed by other staff?

## Areas Likely to Trigger Psychological Reactions

- Where people **enter and exit** the facility
- Where survivors are **treated**
- Where people **congregate**
- Examples:
  - Emergency department
  - Entrance, front desk
  - Waiting room, discharge area
  - Triage areas
  - Television viewing areas
  - Treatment areas



## Other Areas Vulnerable to Triggers

- Decontamination or isolation areas
- All hospital departments/floors
- Pharmacy or other points of distribution
- Public information/public relations briefing areas
- Hospital or clinic incident command post
- Hospital or clinic telephones
- Staff locker rooms, cafeteria, or wherever staff may go to unwind or take breaks

## Meeting Needs in Vulnerable Locations: Planning for Staff Placement

In advance of a disaster:

- Pre-identify your facility MH disaster response team
- Determine your areas of need for psychological support
- Determine which locations you want your MH staff to respond to and which other staff ("mental health auxiliary team") could respond to
- Formalize relationships with internal non-MH staff to perform MH functions (e.g., administer PFA)



## Issues to Consider in Placing MH Staff

- Where to provide MH care
  - Firefighters/police may prefer care in a separate area
  - Use parking lots or ancillary buildings
- Where to place
  - Waiting family and friends
  - The bereaved
  - Disruptive persons
- Avoid areas near the ER or intensive care unit
- Choose spaces with easy access to bathrooms and protection from weather

## What Will MH Staff Do?

- Offer family assistance
- "Walk the line"
- Identify potential disrupters
- Conduct rapid MH assessments to identify urgent MH needs and provide psychological support
- Assess those identified as having nonurgent MH need and provide psychological support
- Provide care that includes early intervention techniques (to be discussed later)
- Perform other functions: See Hospital Incident Command System (HICS) functions and Recommended Actions tool



## HICS Functions for HICS MH Unit Leader

Job Action Sheet

OPERATIONS SECTION
Medical Care Branch

**MENTAL HEALTH UNIT LEADER**

**Mission:** Address issues related to mental health emergency response, manage the mental health care area, and coordinate mental health response activities.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____

**Position Reports to: Medical Care Branch Director** Signature: _____

Hospital Command Center (HCC) Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

| Immediate (Operational Period 0-2 Hours) | Time | Initial |
|---|---|---|
| Receive appointment, briefing, and appropriate forms and materials from the Medical Care Branch Director. | | |
| Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification. | | |
| Notify your usual supervisor of your HICS assignment. | | |
| Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis. | | |
| Appoint Mental Health team members and complete the Branch Assignment List (HICS Form 204). | | |
| Brief Unit team members on current situation, incident objectives and strategy; outline Unit action plan and designate time for next briefing. | | |
| Meet with the Command staff and Employee Health & Well-Being Unit Leader to plan, project, and coordinate mental health care needs of patients, their family, and staff. The plan should include addressing the mental health needs of people who arrive at the hospital with concerns that they are or may be victims of the disaster. | | |
| Participate in briefings and meetings, as requested. | | |

## HICS Job Actions for HICS MH Unit Leaders

- Provide MH guidance and PFA on potential triggers of psychological effects
- Communicate and coordinate with "logistics section chief" to determine available staff to provide psychological support
- Access the supply of psychotropic medications in the facility
- Participate in developing a plan for communicating about risk and about addressing MH issues
- Observe patients, staff, and volunteers for signs of stress



## Walk, Talk, Work

Practice mental health by walking around

Provide informal staff support and reassurance

Be present throughout the incident

SOURCE: Maunder et al., 2003.

## MH Support Functions for Non-MH Staff

- If trained, non-MH staff can:
  - Provide PFA
  - Refer staff and patients for MH follow-up, if needed, by assessing those directly affected by the disaster
  - Visit newly admitted patients to assess the need for MH staff
  - Pass out brochures outlining potential coping strategies
  - Staff support phone/computer hotline
- Untrained staff can update the staff information board



## Psychological Reactions to Large-Scale Disasters

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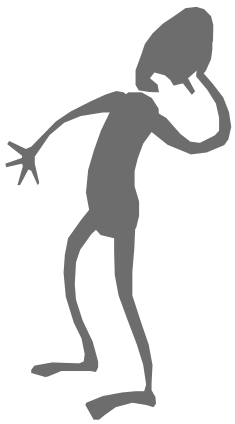
## Psychological Reactions

- Emotional distress
- Behavioral responses
- Cognitive effects
- Somatic reactions
- Diagnosable psychiatric illness



## Emotional Reactions

- Fear, anxiety, “terror”
- Grief
- Sadness, depression
- Disbelief, numbness
- Anger, rage, resentment
- Hopelessness, despair
- Guilt
- Helplessness, loss of control



## Behavioral Responses in Adults

- Agitation
- Aggressiveness
- Social or emotional withdrawal and, in turn, changes in relationships
- Heroic behaviors
- Helplessness versus control
- Risk taking or self-medication
  - Smoking
  - Drinking/recreational drugs



## Behavioral Responses in Children

- Clingy behaviors
- Aggression or disruption
- Defiance or belligerence
- Hyperactivity (as a presentation of anxiety)
- Withdrawal or avoidance
- Regressive behaviors
- Refusal to attend school or day care
- Relationship changes—difficulty getting along with siblings or parents
- Risk taking (drugs or alcohol—teens)
- Reenacting events (through play)
- Self-blame

## Cognitive Effects

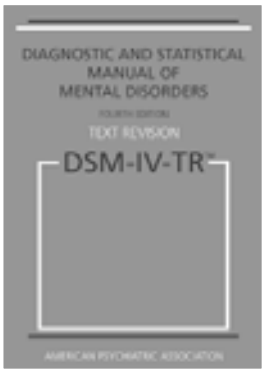
- Difficulty concentrating, remembering, or making decisions
- Repeated thoughts or memories
- Recurring dreams or nightmares
- A sense of vulnerability—or invulnerability
- A distorted sense of reality
- Confusion
- Altruism
- Apathy or loss of interest
- Loss of faith

## Somatic Reactons

- Increased heart rate or palpitations
- Sweating
- Nausea or vomiting
- Physical weakness
- Difficulty breathing
- Increased startle reflex
- Stomach irritability
- Fatigue
- Changes in appetite
- Headaches
  - Responses involving these reactions are often referred to as
    - Multiple unexplained physical symptoms (Diamond, Pastor, and McIntosh, 2004)
    - Disaster somatization reactions (Engel, 2004)
  - Emotional reactions of distress can be misinterpreted as symptoms of exposure to WMD

## Diagnosable Psychiatric Illness

- Acute stress disorder (ASD)
  - Within 30 days of trauma
- Post-traumatic stress disorder (PTSD)
  - After 30 days post trauma
- Major depressive disorder
- Panic disorder
- Generalized anxiety disorder
- Adjustment disorder (especially with children)






## Psychological Reactions: Summary

- Expect a range of emotional, cognitive, and behavioral reactions
- These are typical reactions to abnormal events
- Most reactions will resolve naturally with time
- Care must be taken to evaluate severity and functional impairment before diagnosing a disorder

## Evidence-Informed Practices for Early Intervention

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SOURCES: Hobfoll, Watson, Bell et al., in press; NIMH (2002).



## Objectives of Early Interventions

- Provide crisis intervention
  - Provide appropriate triage and psychosocial support
- Reduce emotional and mental distress
  - For example, limit the displaying of video footage of the disaster, particularly in public places
- Improve problem solving and enhance positive coping skills
- Facilitate recovery
- Refer as needed to MH professionals
- Provide advocacy

SOURCE: National Institute of Mental Health, 2002.

## What Evidence Suggests About Early Interventions

- Early, brief, and focused psychotherapeutic intervention can reduce distress
- Selected cognitive behavioral approaches may help reduce incidence, duration, and severity of ASD, PTSD, and depression
- Early interventions that focus on the recital of events DO NOT consistently reduce risks of PTSD or related adjustment difficulties



## Key Reminders

- Presuming a clinically significant disorder in the early post-phase is inappropriate, except when there is a preexisting condition
- Those exposed should be offered psychoeducational support
- Debriefings should not be conducted for the primary purpose of preventing or reducing mental disorders

## Recognize and Address Hierarchy of Needs

1. Survival
2. Safety
3. Security
4. Food
5. Shelter
6. Health (physical and mental)
7. Triage
8. Orientation
9. Communication with family, friends, and community
10. Other forms of psychological support



## Key Steps in Early Intervention

- Assure basic needs
- Provide PFA
- Conduct needs assessment
- Triage individuals
- Provide treatment
- Foster resilience, coping, and recovery
- Monitor recovery environment
- Conduct outreach and disseminate information
- Pay attention to needs of special populations

Call the 24-hour hotline for assistance: (800) 854-7771

## Follow-up Should Be Offered to Some Individuals

- Who have ASD or other clinically significant symptoms
- With complicated bereavement
- With preexisting psychiatric disorders with current symptoms
- Who require medical or surgical attention
- Who experienced particularly intense or particularly long exposure



## Psychological First Aid

- Integrating MH into the response: Addressing cultural barriers and structural obstacles
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## About PFA

- **Definition:** Evidence-informed modular approach to assist children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism
- **Principal actions:**
  - Establish safety and security
  - Connect to restorative resources
  - Reduce stress-related reactions
  - Foster adaptive short-and long-term coping
  - Enhance natural resilience rather than preventing long-term pathology



## PFA—for Whom? By Whom?

- For whom is PFA intended?
  - Children, adolescents, parents/caretakers, families, and adults exposed to disaster or terrorism
  - First responders and other disaster relief workers
- Who delivers PFA?
  - MH and other disaster response workers who provide early assistance to affected groups as part of an organized disaster response effort
  - Responders working in primary and emergency health care (i.e., hospitals and clinics)

SOURCE: NCTSN/NCPTSD (2006).

## Strengths of PFA

- Includes basic information-gathering techniques to aid rapid assessments
- Relies on field-tested, evidence-informed strategies
- Emphasizes developmentally and culturally appropriate interventions for different ages and backgrounds
- Includes handouts providing information for different groups to use in recovery



## Eight Core Components of PFA

1. Contact and engagement
2. Safety and comfort
3. Stabilization (if needed)
4. Information gathering: Current needs and concerns
5. Practical assistance
6. Connection with social support
7. Information on coping
8. Linkage with collaborative services

## 1. Contact and Engagement

**Goal:** Establish a human connection in a nonintrusive, compassionate manner

- Introduce yourself
- Ask for permission to talk
- Explain the objective

**PFA provider:** *"My name is _____. I am a mental health or _____ staff member here. I'm checking with people to see how they are feeling. Can we talk for a few minutes? May I ask your name?* "



## 2. Safety and Comfort

**Goal:** Enhance immediate and ongoing safety and provide physical and emotional comfort

- Provide information about disaster response activities/services at your facility
- Offer physical comforts
- Offer social comforts/links with other survivors
- Protect from additional trauma (including media viewing)

**PFA provider:** *"Do you need anything to drink or eat? Is your family here with you? Do you have a place to stay? We are providing _____ services. Do you have any questions I can answer now?"*

## 3. Stabilization (if needed)

**Goal:** Calm overwhelmed or distraught survivors

- Watch for signs of disorientation or overwhelming emotion
- Take steps to stabilize a distressed individual
  - Remain calm and provide opportunities to talk
  - Help people focus on tasks they need to complete right now
  - Suggest that the person take a few moments "time out" before deciding what to do next
  - Teach deep breathing
  - Focus on soothing things

**PFA provider:** *"You have been through a lot. It might help to take a few deep breaths right now. It is normal during a disaster to feel like you don't know what to do. Can I help you with deciding what to do next?"*



## 4. Information Gathering

**Goal:** Identify immediate needs and concerns, gather information, and tailor PFA interventions

- Identify individuals who need immediate referral
- Identify need for additional services
- Identify those who might need a follow-up visit

**PFA provider:** *"Can you tell me where you were during the disaster? Were you injured? Do you have a place to live right now? Is your family safe? How are you (and your children) coping with what is happening? Is there anything else you'd like to talk about?"*

## 5. Practical Assistance

**Goal:** Offer survivors practical help to address immediate needs and concerns

- Identify the most immediate need(s)
- Discuss ways to respond
- Act to address the need

> **PFA provider:** *"It seems like what you are most worried about right now is _____. Can I help you figure out how to deal with this?"*



## 6. Connection with Social Support

**Goal:** Help establish brief or ongoing contacts with primary support persons or with other sources of support such as friends and community resources

- Enhance access to primary support persons
- Encourage use of other support persons who are immediately available
- Optional: Discuss elements of support seeking
- Address extreme social isolation or withdrawal

> **PFA provider:** *"Are there family members or friends who you can call right now who can help? Is there a community group (such as a church, etc.) that could help you? Have you contacted any of these sources of support to let them know what has happened?"*

## Types of Social Support You Can Provide

- Emotional support
- Social connection
- Encouragement of value to others
- Reassurance of self-worth
- Reliable support
- Advice and information
- Physical assistance
- Material assistance



## 7. Information on Coping

**Goal:** Provide information about stress reactions and coping to reduce distress and promote adaptive functioning

- Provide basic information about common stress reactions
- Be sure to include common reactions for children and adolescents
- Provide information on ways of coping
- Include information on when to seek further MH services

**PFA provider:** *"After an experience like this, it's understandable for you (and your kids) to feel (confused, afraid). You will probably start to feel better soon. But if you don't, there are places to get help. There are people available 24 hours every day at 800-854-7771. That is the number for mental health services for L.A. County. Staff there are understanding and can help you work your way through this difficult time."*

## 8. Linkage with Collaborative Services

**Goal:** Link survivors with services available to them before the disaster

Provide direct referrals to additional services

- County mental health services or those through private insurance
- Medical services
- Red Cross and FEMA, as appropriate
- For children and adolescents (referrals require parental consent)
- For older adults
  - Primary care physician, local senior center, meals, senior housing/assisted living, transportation services

For more information and detail on PFA: http://www.ncptsd.va.gov



## Addressing the MH Needs of Special Populations

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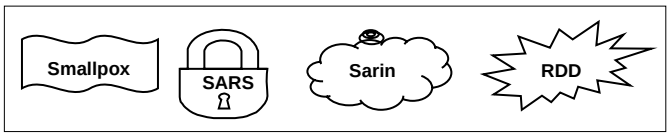
# Special Populations

- Children
- The elderly
- People with physical and developmental disabilities
- The severely and persistently mentally ill (SMI)



*Terrorist incident or public health emergency*




*Triggers of psychological effects*

- **Restricted movement**
- **Limited resources**
- **Trauma exposure**
- **Limited information**
- **Perceived personal or family risk**

*Short-term and longer-term effects*

- **Emotional**
- **Behavioral**
- **Cognitive**

## Needs Resulting from Restricted Movement: Special Populations

- Children in isolation/quarantine should have access to
  - Parents or "Child Life" professionals or child care specialists
  - Games, books, etc.
- The elderly may need home visits for shelter-in-place situations
- The physically disabled
  - They will require access to their special equipment while in isolation or quarantine
  - Decontamination areas should accommodate wheelchairs
  - Use interpreters for the hard of hearing
  - Ask how you can be of assistance, e.g., for the blind



## Needs Resulting from Restricted Movement Among Special Populations

- The SMI should have access to
  - MH staff while in isolation, decontamination, and quarantine
- Children, the elderly, and the physically disabled may require help during evacuations

## Needs Resulting from Limited Resources: Special Populations

**Limited resources:** Access to resources is actually or perceived to be limited or restricted

- Children and the physically disabled—personal protective equipment may not fit
- The SMI may have reduced ability to cope with disruptions in care
- Children and the SMI may respond more strongly to triggers, so they may require more resources



## Needs Resulting from Trauma Exposure: Special Populations

**Trauma exposure:** Witnessing or being the survivor of a traumatic event

- Children may:
  - Exhibit distress differently from adults
  - Be less able to understand concepts like death
  - Be less able to communicate about their trauma exposure
  - Have fewer positive coping skills
- Children and the SMI may respond strongly to triggers
- The elderly may:
  - Feel ashamed about discussing emotional reactions or receiving psychological services

## Needs Resulting from Limited Information: Special Populations

**Limited Information:** Actual or perceived lack of information about risks, potential consequences, and what to do

- Children—Assign one consistent person to supervise and accompany these children
- The elderly and the SMI—May not understand the standard information provided; staff should be available to explain and supplement it
- The physically disabled–treat the same as anyone else. Accommodate for communication and access to services when needed.

Remember—Handouts for MH staff and for parents are available in this training binder



## Needs Resulting from Perceived Risk: Special Populations

**Perceived personal or family risk:** Fear or concern about the safety and well-being of yourself or loved ones

- Children:
  - Children may be more fearful than others
  - Their parents will be concerned if they are separated from their children
- The SMI—their cognitive impairment could "mask" actual risk and fear

## Culturally Relevant Services

Some cultural minorities may

- Not want to discuss their trauma with MH staff because they
  - Mistrust health authorities
  - Are ashamed of getting psychological care
- Want spiritual counseling particular to their culture
- Need more MH resources if they had prior experiences with major disasters in their country of origin
- Require translators in isolation, quarantine, and decontamination areas



## Principles of Self-Care

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## What Is Burnout?

A form of psychological distress (not a diagnosis)

- The "persistent, negative, work-related state of mind . . . characterized by exhaustion, . . . accompanied by distress, a sense of reduced effectiveness, decreased motivation, and the development of dysfunctional attitudes and behaviors at work"*
- Develops gradually and may remain unnoticed for a long time

* Schaufeli and Buunk, 2003, p. 388.



## Burnout Is an Imbalance Between Supply and Demand

Stressed and overburdened at work and outside work

Perception that support and resources at work are inadequate

Prevalence rates during SARS 10%–30%

## What Generates Demand?

Changes in workload and overtime

Unfamiliar work

Greater conflict at work

Social isolation or stigmatization

SOURCE: Maunder et al., 2003 and 2006; Maunder, 2004.



## What Might Increase Supply?

Training and education in infection control procedures and use of PPE

Adequate supplies of PPE

Support for worker well-being ensuring safety at the workplace

## Self-Care DOs and DON'Ts

- Recognize that disasters are extraordinary events, and that your emotional reactions are normal, universal, and expected
- Get adequate sleep, rest (take a break, take a walk), nutrition
- Use your social support network
- Exercise, listen to music, talk, meditate
- Limit viewing of events on television
- Seek help if reactions continue or worsen over time



## Preventing and Reducing Stress: Tips for Supervisors

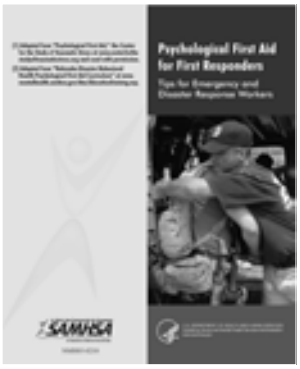
- Always **address practical concerns**:
  - Codify and revisit disaster procedures (infection control and PPE use)
  - Manage work-rest schedules
  - Avoid conscripting workers to high-risk situations against their wishes and without proper training and protection
  - Manage conflicts between staff
  - Assess and address staff perceptions of personal and family risk

## How Supervisors Can Maintain a Supportive Environment

- Provide tangible support for workers on duty and in quarantine
- Consider staff well-being in decisions
- Visibly, actively manage stress by roaming work areas
- Support and enforce principles of self-care: nutrition, sleep, exercise/activities, talking, music
- Provide a role model: hang out in the staff lounge
- Provide ready access to supportive MH resources during and after the event



## SAMHSA Tips for Workers




SOURCE: www.mentalhealth.samhsa.gov/dtac.

## Materials for Patients and How to Use Them

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## Psychoeducational Materials

- Distribute to those exposed, treated, or experiencing symptoms of distress
- The materials can serve as a quick reference or self-care guides
- Basic guideline
  - Use culturally appropriate materials
  - Consider translating materials into other languages

# Online Resources

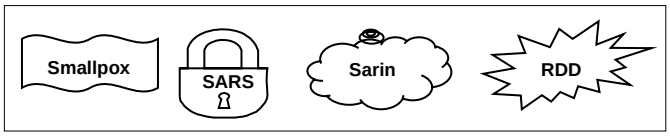
- SAMHSA
  - http://mentalhealth.samhsa.gov/dtac/
- National Center for Posttraumatic Stress Disorder
  - www.ncptsd.va.gov
- National Child Traumatic Stress Network
  - www.nctsnet.org
- Center for the Study of Traumatic Stress
  - http://www.centerforthestudyoftraumaticstress.org



# SAMHSA Tips for Survivors

SOURCE: www.mentalhealth.samhsa.gov/dtac.

*Terrorist incident or public health emergency*

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# Example 1: RDD

After completing triage, a young woman begins complaining of heart palpitations. She is visibly sweating and reports that she is going to vomit. She reports having witnessed lots of people die from the explosion.

The provider assesses the patient and rules out any acute medical needs.

**What do you do?**

- What are some potential triggers of a psychological reaction?
- What intervention(s) might you use?

## Example 2: RDD

The Emergency Department waiting room is at capacity as the staff try to triage individuals for medical treatment.

Several individuals become very agitated and verbally aggressive toward staff because they are concerned that they are exposed.

**What do you do?**

- What are some potential triggers of a psychological reaction?
- What intervention(s) might you use?



## Example 3: Pandemic Flu

During the height of the first wave, the isolation units are filled, and many personnel have been instructed to follow home quarantine restrictions.

Staff are being stretched thin and face enormous challenges as they see some of their colleagues becoming very ill.

**What do you do?**

- What are some potential triggers of a psychological reaction?
- What intervention(s) might you use?

## How Prepared Is Your Facility?
## —Final Thoughts—

- Add one or more mental health professionals to your facility disaster planning team
- Pre-identify one or more mental health staff or clinical staff for the two mental health positions in HICS
- Recruit staff for your facility disaster mental health team
- Include the surge of psychological casualties in your annual exercise program to test your mental health response plans



## Final Thoughts

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# Final Thoughts

Summary

Continuing education credit

Resources

# MODULE 3: Preparing Los Angeles County Department of Mental Health Staff to Respond to Hospitals and Clinics Following Large-Scale Emergencies

## Participant Handout

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*RAND Health*
*In collaboration with County of Los Angeles partners:*
*Department of Health Services, Emergency Medical Services Agency*
*Department of Mental Health*
*Department of Public Health Emergency Preparedness and Response Program*

County of Los Angeles
**Department of Mental Health**

# Preparing Los Angeles County Department of Mental Health Staff to Respond to Hospitals and Clinics Following Large-Scale Emergencies

## Three Modular Training Components

**Module 1:** one-hour module for administrative and disaster planning and response staff

**Module 2:** one-hour module for hospital and clinic, clinical, mental health, and non-clinical staff

**Module 3:** two-hour module for Los Angeles County Department of Mental Health with additional details tailored to the disaster response perspective

## Purpose of This Course

To teach you the skills necessary for providing MH services within the hospital and clinic setting in the immediate aftermath of an emergency and to implement a more sustained operation to support the psychological needs of patients, family members, staff, and first responders



## Course Objectives

After completing this module, you will know how to

- Report to locations in hospitals and clinics where your expertise will be needed
- Work within the hospital and clinic "culture" to help survivors suffering from psychological effects during a large-scale disaster
- Respond to MH reactions over time
  - Using evidence-informed strategies to address psychological reactions
  - Addressing the needs of patients, family members, staff, and special populations

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## Components of Module 3

- Organizational culture and cultural competency
- Disaster reactions and responses
- Special populations
- Interactive exercises and discussion

## Organizational Culture and Cultural Competency

- Organizational culture and cultural competency
  - Working effectively in hospitals and clinics
  - Going where you are needed most
  - Providing culturally competent services
- Disaster reactions and responses
- Special populations
- Interactive exercises and discussion



## MH Care Is Different in a Disaster Situation

Traditional MH care

Disaster situation

## In a Disaster Situation

**DO**

- Report to the DMH team leader
- Reassure people that you are doing all that you can to meet their needs as soon as possible
- Set a tone that is consistent, predictable, and calm
- Be mindful of delivering culturally competent services
- Refer media requests for interviews to the hospital PIO
- Provide assistance by walking around

**DO NOT**

- Answer any media questions
- Communicate issues and concerns to anyone other than the MH unit leader
- Use cell phones in medical treatment areas
- Attempt to conduct typical psychotherapy with a focus on processing the traumatic exposure
- Expect those who need assistance to come to your office



## Basics of Providing an MH Response After a Disaster

- Understand the response structure
  - Leadership
  - Coordination of MH services
- Continually assess MH needs—the environment is very fluid
- Prevent duplication of effort

## Challenges to Implementing a Psychological Intervention

- Many MH professionals have never delivered MH care in a health care facility or clinic after a large-scale disaster
- To provide effective psychological support in that setting, you need to understand two critical factors
  - Logistical concerns
  - Planning for response

SOURCE: Morrow (2001).



## MH Responders Will Face Unique Challenges

- Restrictions on movement will mean that survivors are treated on the premises
- Local staff may be inundated with offers of assistance, so you could be turned away
- Make sure you know how to reach the on-site coordinator for the MH response
- Law enforcement could override your assignment
- Be prepared for a stressful experience

## What You Will Learn at the DMH Leader Briefing

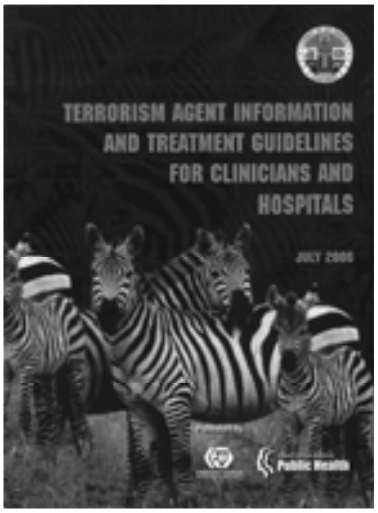
- The terrorism event or other public health emergency that is involved
- When and where the event/emergency occurred
- Where and to whom to report
- Whether PPE is needed, where to get it, how to put it on



## Additional Resources About Agents

- The "Zebra book" on the L.A. County Public Health Emergency Preparedness & Response Web site
  - http://labt.org/
- L.A. County Department of Health Services
  - http://ladhs.org/ems/disaster/DisasterIndex.htm
- Centers for Disease Control and Prevention
  - http://www.bt.cdc.gov/agent/

## The "Zebra Book"






## DMH Check-In Procedures

- Bring DMH ID and report to the county DMH team leader
- The facility MH unit leader (in coordination with the DMH team leader) will
  - Assign you to a location
  - Instruct you about precautions to take
  - Inform you of other organizations providing MH care
- The MH support you may be asked to provide may be different in each location

## Where Might You Be Needed?

- The facility MH unit leader may send you to
  - Locations likely to have high levels of psychological need—e.g., ED, entrance, triage, decontamination/quarantine/isolation
  - Waiting rooms
  - The cafeteria (staff and patients)
- Each location will present unique response challenges



## Using Alternative Sites for MH Care

- Sites could include
  - Auxiliary hospital buildings
  - Clinics
  - Parking structures
  - Auditoriums
- MH staff should look for areas to provide MH care privately

## Ensuring Your Own Safety

- Practice universal precautions
- If the disaster involves a contagious disease, the facility's contagion control department will advise the HICS MH and DMH team leader about precautions
- Wear extra personal protective equipment (PPE), e.g., masks, gowns, etc., if asked to do so by hospital staff
- Speak to your DMH leader if you have additional concerns



## Some Cultural Barriers to MH Intervention

- Language
- Immigration status
- Literacy/education level
- Mistrust of government and law enforcement
- Varied perception of medical professionals
- Political climate

## Tailor Support and Intervention to the Cultural Needs of Specific Groups

- Be culturally sensitive
- Provide information and services in the appropriate language
- Collaborate and consult with trusted organizations and community leaders to serve the needs of the hospital or clinic community (in advance of a disaster)

SOURCE: U.S. Department of Health and Human Services (2005).



## People from Other Cultures May Be Uncomfortable with Western Medicine

- Survivors with serious injuries may bring families from different cultures into contact with Western medicine for the first time
- Contact is particularly challenging if English is not the family's primary language

## Respond Sensitively and Specifically

- Many aspects of a disaster have cultural overlays
  - Death of a loved one
  - Community trauma
  - Mass victimization
- Rituals surrounding death are deeply rooted in culture and religion
  - Appropriate handling of physical remains
  - Funerals and burials
  - Memorials and belief in an afterlife



## Try to Communicate Cultural Sensitivity

- Use culturally accepted courteous behavior
  - Greetings, physical space, knowing who is considered "family"
- Describe your role in culturally relevant terms
- Take time to establish rapport
- Ask about cultural practices when uncertain
- Value diversity and respect differences
- Develop and adapt approaches and services to meet the needs of specific groups likely to seek care in your location

## Information About Cultural Competency

- Substance Abuse and Mental Health Services Administration (SAMHSA)
  - http://mentalhealth.samhsa.gov/
- California Institute for Mental Health (CIMH)
  - http://www.cimh.org/home/index.cfm
- U.S. Department of Health & Human Services, Office of Minority Health
  - http://www.omhrc.gov/



## Disaster Reactions and Responses

- Organizational culture and cultural competency
- Disaster reactions and responses
  - Common responses to a disaster
  - Evidence-informed interventions for the short term
  - Interventions to address long term reactions
  - Work with families
- Special populations
- Interactive exercises and discussion

## Possible Reactions to a Large-Scale Emergency

- Expect a range of reactions across multiple domains
  - Emotional
  - Behavioral
  - Cognitive
  - Physical
- For most individuals, the reactions will disappear over time; for some, the reactions may evolve or even worsen
- Early interventions can mitigate or shape these reactions in both the short and the longer term



## Reactions: Some Examples

- **Physical:** agitation, hyperarousal, fatigue, gastrointestinal distress, appetite changes, alertness
- **Behavioral:** sleep changes, hypervigilance, avoidance, isolation, withdrawal
- **Emotional:** shock, disbelief, sadness, grief, irritability, anxiety, despair, guilt, feeling involved
- **Cognitive:** confusion, intrusive thoughts, recurring dreams, difficulty concentrating or making decisions, courage

# No One Is Immune

**Population A:** Injured or ill; bereaved family members

**Population B:** Exposed community members (not injured or ill)

**Population C:** Extended family; first responders, rescue workers

Population exposure model

**Population D:** Health care workers, support workers

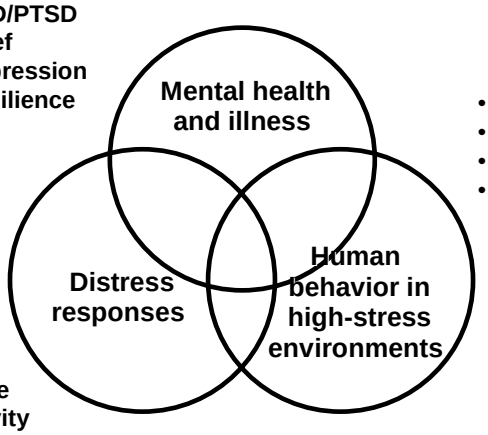
**Population E:** Community at large

SOURCE: DeWolfe (2000).



# Categories of Reactions After the Incident

- **ASD/PTSD**
- **Grief**
- **Depression**
- **Resilience**

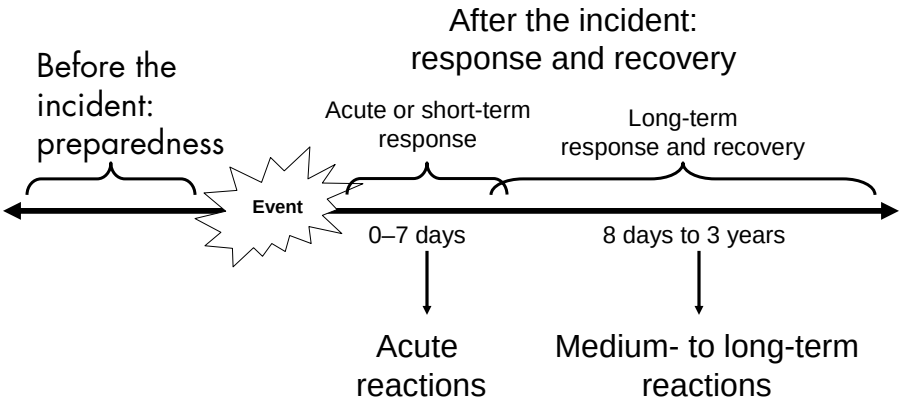



- **Avoidance**
- **Substance use**
- **Risk taking**
- **Overdedication**

- **Fear/worry**
- **Sleep disturbance**
- **Altered productivity**

SOURCE: Ursano (2002); Institute of Medicine (2003).

## Time Frames for Preparedness and Response






## Acute Reactions = Surge Challenges

- Distress, behavioral, and physical reactions can create an increased demand for medical attention
- Symptoms of severe distress can mimic symptoms of exposure or illness
  - Gastrointestinal distress
  - Exhaustion
  - Tightening in chest
- Triage decisions will be critical

## Disaster Reactions over the Medium to Long-Term

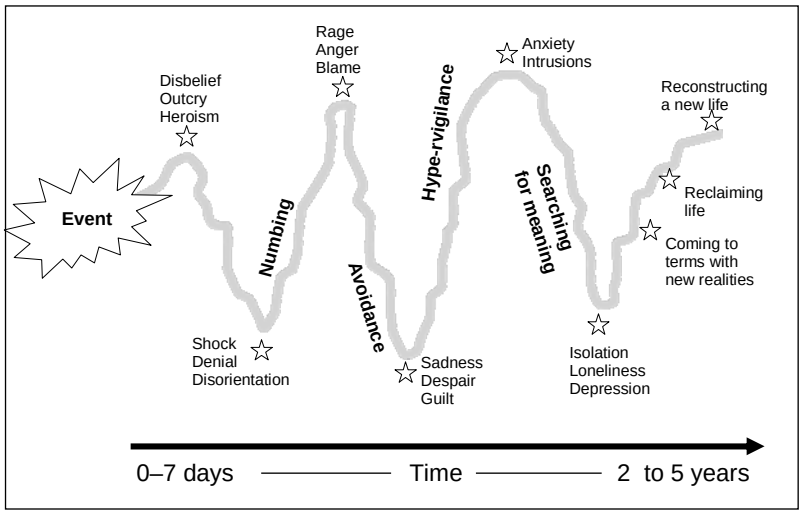
- Traumatic bereavement (trauma and grief)
- Adverse behavioral outcomes
  - Substance use
  - Violence—domestic violence, abuse
  - Worsening of chronic conditions
- Psychiatric illness
  - Generalized anxiety disorder
  - Depression
  - PTSD
- Changes in functioning
  - Hypervigilance
  - Physical and mental exhaustion
- Changes in relationships and lifestyles
- Post-traumatic growth resulting from the traumatic experience (resilience)



## Triggers of Long-Term Reactions

- Anniversaries
- Subsequent trauma or loss
- Maladaptive coping strategies
- Chronic stressors
  - Family disruption
  - Work overload
  - Financial strain

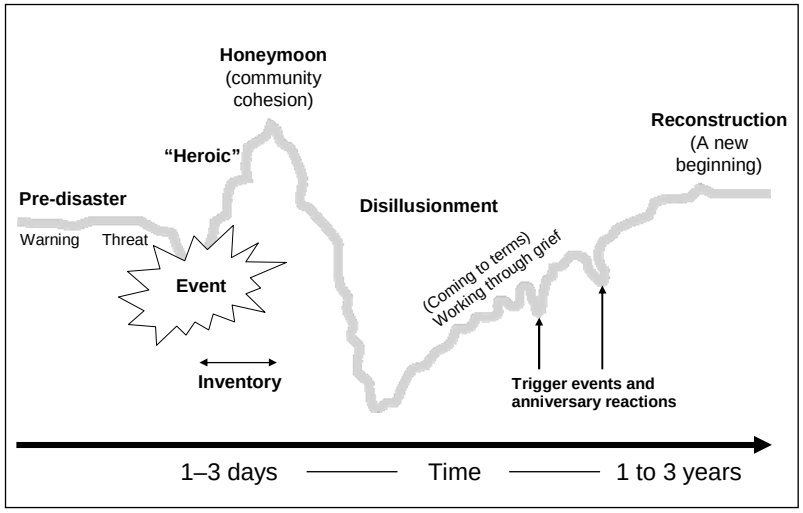
# Phases of Individual Reactions




SOURCE: Zunin & Myers (1990).



# Phases of Community Reactions




SOURCE: Zunin & Myers (1990).

## Early Interventions

Overview of the range of short-term interventions

- Typical interventions that county DMH staff would use at a clinic or hospital after a disaster
- Some details about particular techniques



## Objectives of Early Intervention

- Provide appropriate triage and psychosocial support
- Reduce emotional distress and mental stress
- Improve problem solving and enhance positive coping skills
- Facilitate recovery
- Refer, as needed, to MH professionals
- Provide advocacy

## Key Considerations for Interventions

- Assume that “all who witness are affected”
- Avoid labeling
- Assume competence and capability
- Respect differences in coping
- Provide help that is practical and flexible
- Encourage use of existing support networks



## Counseling Skills Following the Incident

- Establish rapport
- Attend to the conversation nonverbally
  - Allow silence
  - Make eye contact, nod head
  - Paraphrase
  - Reflect feelings
  - Allow expressions of emotions
- Facilitate problem solving
  - Identify and define the immediate problem
  - Assess functioning and coping
  - Evaluate available resources
  - Develop and implement an action plan

## Early Intervention Techniques

- PFA
- Psychoeducation and reassurance
- Triage, assessment, and referral
- Anger management
- Acute crisis intervention and models
  - Critical incident stress management (CISM)
  - Cognitive behavioral techniques



## Goals of PFA

Evidence-informed principles for recovery

- Promote safety
- Promote calm
- Promote connectedness
- Promote self-efficacy
- Promote hope

SOURCES: Hobfoll et al., in press; NCTSN/NCPTSD (2006).

# PFA: Basic Steps

- Make contact and engage
- Ensure safety and comfort
- Stabilize (if needed)
- Gather information about current needs and concerns
- Provide practical assistance
- Connect with social supports
- Provide information about coping
- Link with collaborative services



# PFA Fact Sheet

COURAGE TO CARE

PSYCHOLOGICAL FIRST AID

*Helping Victims in the Immediate Aftermath of Disaster*

DO:

DON'T:

## Psychoeducation and Reassurance

- Provide basic education
  - What to expect: common reactions to unusual events
  - Where to get help: information and resources
- Facilitate coping and problem solving
- Distribute materials widely
- Ensure cultural appropriateness

## Triage and Assessment

- Identify individuals who urgently need medical and MH care
  - Refer for follow-up as appropriate
- Conduct needs assessments
  - Safety, security, survival
  - Psychological and social support and available resources
  - Further interventions (depending on impairment)

## Attend to Needs During Triage

- Concern for basic survival
- Grief over loss of loved ones or loss of possessions
- Fear and anxiety about safety
- A need to feel part of the community and recovery efforts
- Problems in living and changes in normal routines



## MH Referrals

Make MH referrals for follow-up as appropriate

- Disoriented: unable to recall past 24 hours, etc.
- Clinically significant symptoms that impair functioning
- Bereaved
- Preexisting psychiatric disorder
- Required medical or surgical attention
- Inability to care for self
- Homicidal or suicidal thoughts or plans
- Problematic use of alcohol or drugs
- Violent behavior (child, elder, or spousal abuse)
- Particularly intense and long exposure
- Isolated and lack social support

## Screening and Assessment Checklist

- Trauma and exposure to loss
- Current psychological and physical distress
- Presence of risk and resiliency factors
- Medical and health conditions
- Prior coping with major stressors, trauma, and loss
- Current living situation
- Availability of social support
- Current priority concerns and needs



## Anger Management

- Stay calm
- Listen seriously and attentively
- Acknowledge and validate feelings
- Identify specific sources of anger
- Focus on problem and its resolution
- Remain respectful
- Follow-up and keep your promises

## Acute Crisis Intervention

- When should you use crisis intervention?
  - When life has been disrupted
  - When coping mechanisms fail
  - When there is evidence of impairment
- Remember: crisis intervention is support, not psychotherapy
- This technique is crisis focused, and prevention and education oriented, not cure oriented



## CISM

- CISM is an integrated "system" of interventions designed to prevent and/or mitigate adverse psychological reactions that often accompany disasters
- It has been used principally to prevent PTSD although the science is not clear

**For more information:**
**http://www.icisf.org/**

## Components of CISM

- Education
- Individual support
- Group meetings
- Support services for operations personnel and management
- Family support
- Referral
- Follow-up



## The Efficacy of CISM

- CISM is effective
  - Roberts & Everly (2006)—36 crisis intervention studies found that "adults in acute crisis or with trauma symptoms. . . can be helped with intensive crisis intervention and multicomponent CISM"
  - Everly et al. (2002)—8 CISM studies found it efficacious when conducted in a standardized format by trained leaders
- CISD alone may not be effective
  - van Emmerik et al. (2002); Rose, Bisson, & Wessely (2003); Rose et al. (2001)
- CISM is more appropriate as an entire system of care for staff or other homogeneous groups (NIMH, 2002)

## Acute Cognitive Behavioral Therapy (CBT)

- CBT interventions can ameliorate many short-term reactions to disasters
  - Acute stress, PTSD, depression
  - Effective when used immediately after an event
- Survivors can be taught to address their own anxiety disorders
  - Problem solving, deep breathing, and relaxation exercises

SOURCE: Walser et al. (2004); Bryant & Harvey (2000).



## Interventions to Address Medium- to Long-Term Reactions

- CBT
- Eye movement desensitization and reprocessing (EMDR)
- Bereavement and grief counseling
- Family therapy for families in crisis

## Evidence-Informed Treatments for Trauma-Related Disorders (PTSD)

- CBT
  - Cognitive restructuring
  - Exposure therapy
- EMDR
- A meta-analysis found that over 50% of patients who complete CBT treatment improve

SOURCES: Bisson & Andrew (2005), Bradley et al. (2005), and Hamblen et al. (2006).



## CBT

- Brief, structured, and time-limited form of psychotherapy (typically 8–12 sessions)
  - Identify thoughts associated with feelings and actions (cognitive restructuring)
  - Increase pleasurable activities (behavioral activation)
- Efficacious for adults and children with depression and PTSD
- Adapted for distress following a disaster

## CBT for Post-Disaster Distress (1)

- Developed by Project Liberty (a federally funded crisis counseling program used in 9/11 and Florida hurricanes)
- Intended for those who show more than normal transient stress after a disaster
- Functions as an intermediate step between traditional crisis counseling and longer-term MH treatments
- Designed to be implemented no sooner than 60 days following the disaster

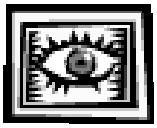
SOURCE: Hamblen et al. (2006).



## CBT for Post-Disaster Distress (2)

- Manualized 8–12 session treatment for problems that persist after exposure to disaster
- Incorporates techniques shown to be effective with a range of symptoms commonly seen in disaster survivors
  - Anxiety, depression, fear, phobias, substance abuse, grief, anger
- Three main sections:
  - Psychoeducation
  - Coping skills
  - Cognitive restructuring
- Not intended to treat a specific psychiatric disorder

# EMDR



- Psychotherapeutic approach involving some form of exposure and "trauma processing"
- Effective in reducing substantial and sustained PTSD and depression
  - More successful than pharmacotherapy
  - Primarily for adult-onset trauma survivors
- Given highest-level recommendation by the Veterans Administration for trauma treatment

SOURCE: van der Kolk et al. (2007).



# Phases of EMDR Treatment

- Take a history to assess readiness; develop a treatment plan
- Ensure that the client has good coping skills and adequate ways to handle emotional distress
- Identify a vivid visual image as a target
- Ask the client to focus on that image while following an external stimuli
- Ask the client to let go and notice sensations and cognitions to achieve positive sensations
- At closure, ask the patient to keep a journal
- Reevaluate previous progress in the next session

**For more information: http://www.emdr.com**

## Bereavement and Grief Counseling

Counseling and support services may be helpful to those with normal grief reactions

- Guidance through the challenges of grieving and adjustment to the loss
- Delivered by professionals individually or in groups

## Goals of Grief Counseling

- Understanding the natural grief process
- Accepting and adjusting to the reality of the death
- Receiving affirmation for the “normalcy” of feelings
- Receiving information about the grief process and common grief responses
- Understanding common obstacles and how to deal with them
- Identifying and utilizing effective coping strategies

## Approaches to Grief Counseling

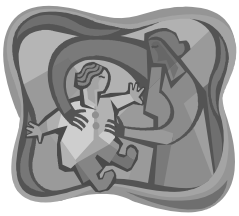
- Grief therapy
  - Indicated for complicated grief
  - Identifying and resolving the conflicts of separation that interfere with the normal mourning process; "anniversary" reaction grief
- Bereavement groups
  - Help individuals recognize feelings and put them in perspective
  - Alleviate loneliness; enhance social network
- Specialized groups
  - Widows, parents who have lost a child, family members of suicide survivors

SOURCE: Shear et al. (2005).



## Therapy for Families in Crisis

Crisis strains the fabric of the strongest, most functional families



Dysfunctional family behaviors can develop when circumstances that accompany a disaster unbalance the equilibrium of the family structure and functioning

SOURCE: Wells (2006); Laudisio (1993).

## Goals of Family Therapy

- Restore healthy family functioning
- Convey how the crisis affects the family
- Identify any sources of stress that existed before the disaster
- Teach the use of problem-solving strategies
- Teach coping skills
- Create equilibrium by restoring communication and reestablishing roles



## Special Populations

- Organizational culture and cultural competency
- Disaster reactions and responses
- Special populations
  - Identifying these populations
  - Interacting with them appropriately
- Interactive exercises and discussion

## Special Populations in the Hospital and Clinic Setting

- Among the main groups potentially affected
  - Survivors and their families
  - Nonexposed individuals seeking help
  - Disruptive patients in the ED
  - Hospital inpatients
  - Hospital and clinic staff
- There are also the needs of special populations to consider
  - Persons requiring special assistance
  - Persons with chronic mental illness



## Survivors and Families

- "Population A," (as shown earlier from DeWolfe) located in
  - EDs
  - Inpatient floors and ICUs
  - Clinics and offices
- Their families, located in
  - Waiting rooms
  - Lobbies
  - Cafeterias
- Families will also present with grief reactions and fears of contamination

SOURCE: DeWolfe (2000).

## Survivors

- In the acute stage, MH involvement with survivors may be limited by needs of medical/surgical staff to stabilize and treat the patients
- To provide MH support, consider
  - PFA
  - Psychoeducation and reassurance
  - Triage and assessment
  - Referral to specialty MH
  - Crisis intervention
- Survivors may require short-, medium- or long-term follow-up for MH needs



## Families of Victims

- In the acute stage, MH involvement with families will be dictated by triage decisions
- Potential early intervention techniques:
  - PFA
  - Psychoeducation and reassurance
- Triage and assessment
  - Referral to specialty MH
- Crisis intervention
  - Anger management
  - Grief counseling
- Follow-up for medium- to long-term MH needs

## Individuals Not Exposed but Seeking Help

Predicted to be the largest group of persons "surging" into our health care system

Will be in ED, clinics, and stations where triage of survivors occurs; many will continue through system for further evaluation

## Identifying Nonexposed Help-Seekers

- Medical staff will differentiate individuals who have probably been exposed/infected from those who have psychological reactions
- You should be aware of how the medical staff are making these decisions
- Distinguishing features will differ among agents but may include proximity to event, specific concerns, specific versus nonspecific signs and symptoms *

* Adapted from Kroenke (2006) and Bracha & Burkle (2006).

## Nonexposed Help-Seekers

- MH staff can evaluate individuals deemed nonexposed for nonmedical problems
- Evaluations should focus on differentiating event-focused versus preexisting concerns and acute versus chronic problems
  - The nature and severity of an individual's concerns
  - Level of coping, resources, social support



## Disruptive Patients in ED

- Give disruptive patients immediate attention, appropriate information, reassurance, or other intervention, then move them out of the treatment area
- Disruption is contagious
- Consider sending disruptive persons to a specially designated team for needed services

## Individuals Requiring Special Assistance

- Individuals include those with physical or developmental disabilities, sensory impairments, the frail elderly, children, etc.

- They are at increased risk of harm from the event
  - Less able to respond to the environment; fewer physical or cognitive resources for recovery
- MH issues may present in atypical ways
  - Consider what materials and experience you have to help traumatized children. Work through trusted caregivers/neighbors for the very old



## Concerns About Persons with Chronic Mental Illness

- Event could exacerbate chronic illness
  - Poor or inadequate coping skills
  - Impaired access to MH care
- In addition to early intervention
  - Assess current symptoms
  - Assess availability and compliance with medication
  - Focus on identifying resources and support
  - Provide early follow-up

## Hospital Inpatients

- Patients who were in the hospital before the event may need to be discharged to make room for the surge of new patients
- Of particular concern are
  - Immunocompromised individuals (cancer, HIV/AIDS)
  - Patients receiving extended workups or prolonged therapies
- Patients may worry about delays in care, family, property, access to health care



## Addressing the Needs of Hospital Inpatients

- The literature says little about dealing with this group following a disaster
- Triage decisions will dictate how urgently these cases should be seen
- Crisis intervention may be useful
  - Reducing emotional distress and mental stress
  - Facilitating problem-solving skills
  - Advocating for patients with the health care staff

## Supporting Hospital/Clinic Staff

- During a disaster, MH care for hospital and clinical staff emphasizes immediate and practical needs
- MH staff seeing patients should be encouraged to linger to chat with staff; provide simple support and advice, e.g., about self-care
- Staff break areas also offer opportunities to provide MH support

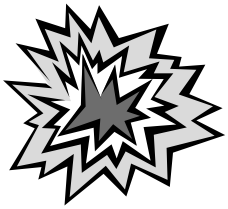


## Group Discussion

- Organizational culture and cultural competency
- Disaster reactions and responses
- Special populations
- Interactive exercises and discussion
  - "Break-out" groups
  - Sharing best practices
  - Discussion

## Scenarios We Will Consider

Radiological dispersal device (RDD)—version A



Radiological dispersal device (RDD)—version B

Pandemic influenza (or SARS)—version A

Pandemic influenza (or SARS)—version B



## Group Process

- You are called to respond to a large-scale disaster, hear a briefing, and are assigned to a hospital or clinic
  - What are you going to do?
  - What are the best practices?
  - Is there any part of the response that you have questions about?
- Select a group leader and a note taker
- Take 15 minutes to answer questions
- Report back to the group

## Across All the Scenarios

Did you consider the different psychological triggers?

- Restricted movement
  - Effect of countermeasures (e.g., isolation, PPE, vaccine)
- Limited resources
  - Enough protective gear/supplies
  - Available staff
- Trauma exposure
  - Visible injuries or images
- Limited information
  - Inefficient, insufficient, conflicting information
- Perceived personal or family risk
  - Exposure to harmful agents, illness, injury, or death



## RDD Scenarios

Did you consider

- Reporting to the facility MH team leader
- Concerns about contamination; no protective gear
- People exposed to gruesome images
- Insufficient information about the risk of cesium exposure
- Alternative staffing to offset staff not reporting to work
- Identifying alternative locations for care
- Providing PFA and other early interventions
- Practicing cultural competency

## Pan-Flu Scenarios

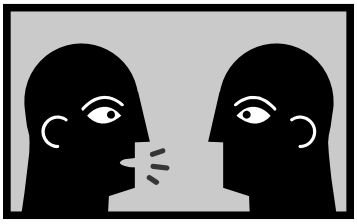
Did you consider

- Reporting to the facility MH team leader
- The implications of isolating those exposed
- MH consequences of limited medical supplies
- Shortage of staff
- How to protect yourself from contagion
- Self-care needs of staff
- Identifying a more quiet area where crisis counseling/MH care can be provided
- Providing PFA and other early interventions
- Practicing cultural competency



## Discussion

Continuing education credit

Resources

Wrap-up