



# ***Anticipate. Plan. Deter.*** **Building Responder Resilience**

**Los Angeles County EMS Agency  
Disaster Program**

**APD/PsySTART Responder System  
Instructor Guide  
*2019 Revised System Training***

Developed by Merritt Schreiber, Ph.D.

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# Building Responder Resilience:

## *Welcome to Anticipate, Plan and Deter and the PsySTART Responder System 2019 Revised System Training*

Merritt Schreiber, PhD



Welcome to “Anticipate Plan and Deter,” a responder resilience program for disaster medical healthcare workers provided to you by the NETEC and developed by Merritt Schreiber Ph.D. at the David Geffen School of Medicine at UCLA.

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.

## Training Outline

- Understand psychological risk for healthcare workers in mass casualty disasters
- Build personal and health system resilience using the “Anticipate, Plan and Deter” healthcare worker resilience system:
  - Anticipate stress you and your family will face as a health care worker in a disaster
  - Plan in advance how you will handle expectable stress
  - Deter expectable stress during a disaster
  - Learn how to use confidential PsySTART Responder Self Triage



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.

## OBJECTIVES OF ANTICIPATE, PLAN AND DETER RESPONDER RESILIENCE SYSTEM

- Enhance the individual and system level resilience of the LAC EMS Disaster Response System and workforce
  - Hospitals
  - Community Clinics
  - Pre-hospital EMS

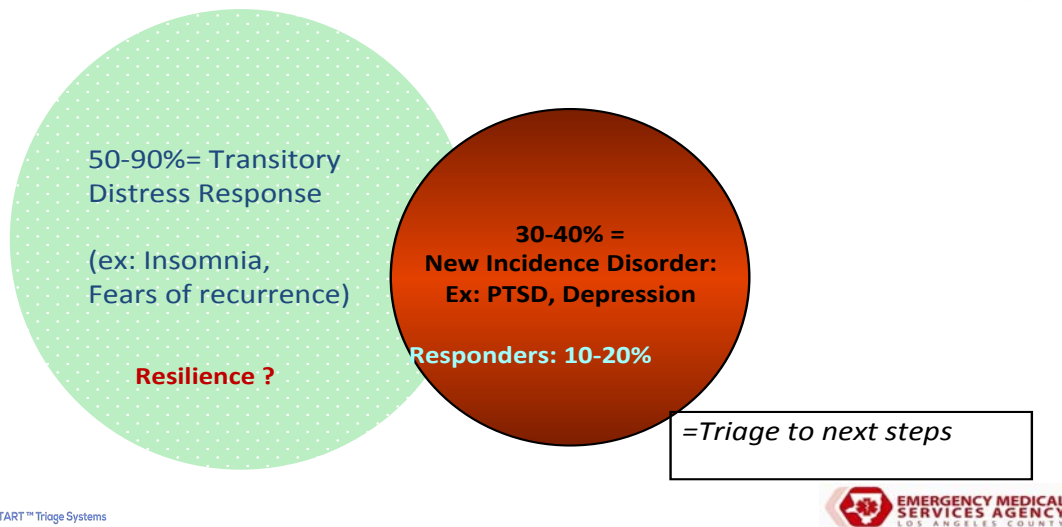
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Here are the goals of this program:

- Read the above bullets and address any questions from the group.
- Key focus on pre-event preparedness, which is the purpose of this training element.

## STATE OF THE ART: MENTAL HEALTH RISK IN DISASTERS: POPULATION LEVEL EFFECTS



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

**This is the key concept of APD and PsySTART: there is a continuum of risk and resilience. Once size does not fit all. Lets not chase tears, lets chase risk**

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 emotionally 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 did not 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.*

## PLAN FOR THE RANGE OF “REAL” EFFECTS ON RESPONDERS



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This slide also depicts the “continuum of risk” idea: One size does not fit all. There are a range of outcomes, most commonly “resilience” which we define in this course as the ability to withstand a potentially traumatic event with some level of distress but with a “rapid return to baseline” status in hours, weeks or days—depending on the magnitude of the stress you encountered and your baseline resilience status. Individuals move up the pyramid from resilience, to concerns/behavior changes, to non-specific distress and defined clinical disorder.

As one develops both symptoms and impairment (which refers to difficulty being able to carry out basic tasks at home and work), one or more clinical disorders can develop such as acute stress disorder, or longer term disorders such as Post Traumatic Stress Disorder (PTSD), Depression, substance abuse and others. Commonly, one or more discrete disorders co-occur, such as PTSD and depression and this entails greater levels of impairment (difficulty functioning) and multiple symptoms.

It is important to note that where one ends up on this scale or in the “distress” vs. disorder circles on the previous slide, depends on many factors, but your disaster or emergency experiences are a major source of risk. This course will help you understand different types of stressful “exposures” on how to determine your own risk based on exposure.

Another key point is that there are now effective interventions for PTSD, depression and the other possible consequences of stressful exposure or loss.



***Further, there is now mounting evidence of “golden month,” where if high risk and distressed individuals are matched to certain, acute evidence based interventions, their risk of full-blown PTSD can be mitigated or even prevented. Therefore, it is important that you understand your risk for disorder based on your self-triage of exposure and your distress level and seek care early to prevent the effects of untreated clinical disorders.***

Traditionally, first responders have not been open to these ideas. However, this is changing coupled with the fact that “one shot” interventions such as debriefing or psychological first aid do not appear to be sufficient for those at increased risk.



This picture is the of the Laguna Beach Wildfire. You will notice this entire community is destroyed except for one home. This is the result of deliberative “resilience” planning based :

The Steps can be compared to APD

1: Anticipate the range of hazards living in this community

2: Plan for those hazards



What were the elements of the plan for this home that enabled it to be “resilient”?  
Allow group to generate a few ideas.

Answers:

- 1) Concrete tile roof
- 2) Fire resistant shrub with increased brush clearance
- 3) The home has no eaves so fire was not able to burn the roof from underneath:
  - a. All of the homes did have concrete tile roofs, but only this one had no eaves

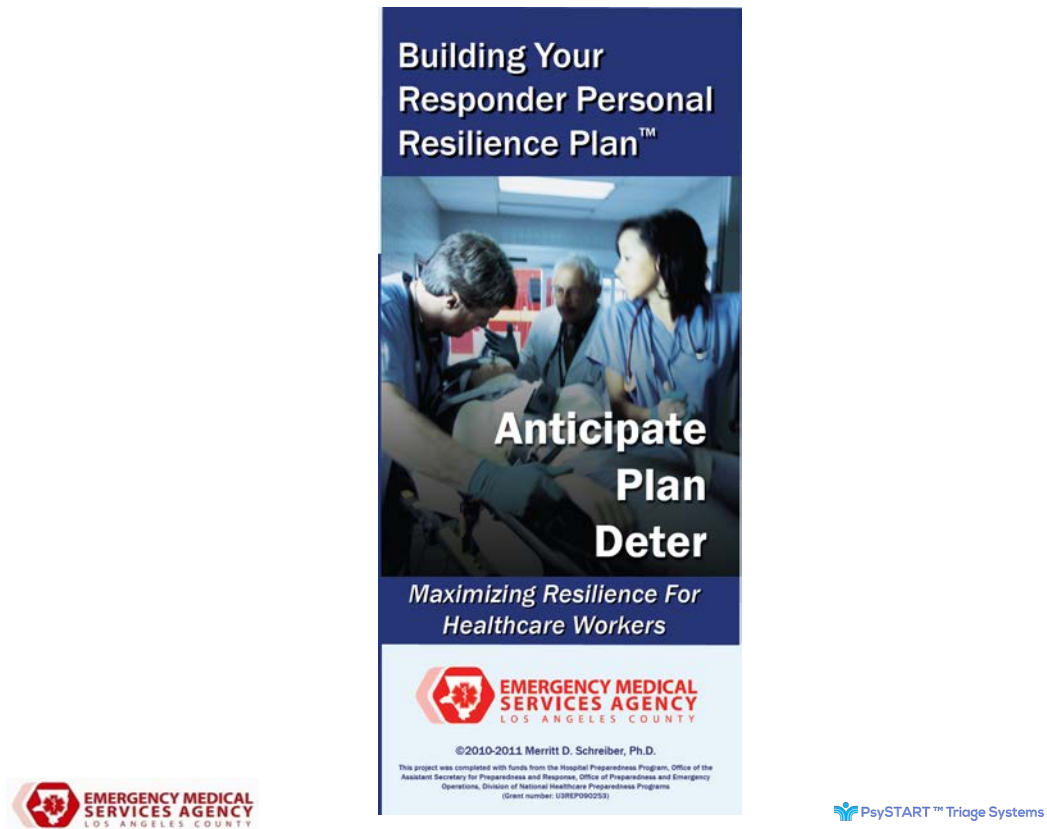
*“Know your enemy (**stress**) and know yourself  
and you can fight a hundred battles without  
disaster.”*

*- Sun Tzu*



This ancient saying is also consistent with the APD model:  
Know the enemy, in our case its knowing stress from being a medical responder in  
everyday and disasters and this can enable you to face stress without succumbing

APD is one approach to knowing and planning for stress in our disaster and  
everyday healthcare provider roles



This is the personal resilience plan that we will focus on in today's training and you will develop your own version to take with you today.

This is the take home for today's training. We strongly encourage you to fill this in as you participate today. If you use the APD Personal Resilience Plan, you are starting to increase your resilience today, one step at a time

## 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 their own stress, coping and resilience



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”.

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.

## FOCUS ON RESPONDER FAMILIES

- First responder children as “at risk” population
- Planning for responders means planning for the families and their school age children in particular



There is also some evidence that the children of EMT medical responders are at increased risk when assessed directly compared to children of law enforcement or non-medical fire personnel.

Although the exact mechanism of this finding is not completely clear, what is clear is that medical responders with school age children have unique concerns about the welfare of their children. In the SARS outbreak in Toronto, medical workers reported that among their most pressing concerns was the risk of infecting their families and children with the SARS virus. Anecdotally, the children of medical providers in Toronto during the height of SARS reported perceptions that others stigmatized their children due to their responder parent's hospital roles. When approaching the impact of potentially stressful experiences on emergency and disaster health care workers, it is critical to take a family perspective and examine impacts on all members.



*“Most stress among humanitarian aid workers is the result of the ongoing, every day pressures of their work (e.g., separation from family, physically difficult living and working conditions, long and irregular hours, repeated exposure to danger, intra-team conflict)....It is the presence of the expectable stressful experiences rather than worker complaints that should trigger agency scrutiny of stress responses in its employees.”*

*Anatares foundation, 2004*



Read slide:

This slide from the Antares foundation presents some interesting ideas. The key idea is that the management of expectable stressors reflecting the potentially traumatic exposures and cumulative stress is manageable. This is the idea we are striving for in “APD”.

**Entertain questions or comments at this point.**

We will now start building out your own “personal resilience plan” and go through each of the three sections sequentially.



# Building Resilience For Healthcare Workers in Disaster

## *“Anticipate, Plan, Deter”*

How to use this tool:

- Pre-event
- Response
- Post-disaster



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We will now go start building your “personal resilience plan” and go through each of the three components...



The first step to our responder resilience model is learning to anticipate expectable stress situations and your 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.

## Step 1 - Anticipate

### Understand Your Stress Reactions

There are two main kinds of responder stressors you can expect. Planning your response to these stressors will maximize your resilience during disasters.

"Traumatic Response Stress" can include exposure and loss factors such as:

- Witnessed severe burns, dismemberment or mutilation
- Witnessed pediatric death(s) or severe injuries
- Witnessed an unusually high number of deaths
- Responsible for expectant triage decisions
- Injury, death or serious illness of coworkers
- At work, you were treated for injury or illness
- Felt as if your life was in danger

These current stressors may also be "Trauma Triggers", activating memories of other past experiences or losses. "Cumulative Response Stress" can include factors such as:

- Exposure to patients screaming in pain/fear
- Forced to abandon patient(s)
- Unable to meet patient needs (such as patient surge, crisis standards of care)
- Direct contact with grieving family members
- Asked to perform duties outside of current skills
- Hazardous working conditions (such as extreme shift length, compromised site/safety or security or lack of PPE)
- 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 agent/toxic exposure (infectious disease, chemical, radiological nuclear, etc.)

These current stressors may also be "Trauma Triggers" that activate memories of past experiences or losses.

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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.

We will consider both potentially severe traumatic experiences or Trauma Response Stress and more common but also potentially stressful experiences in depth.

First we all have to think through what does a "disaster" mean to us and everyone has a different threshold of what this means.



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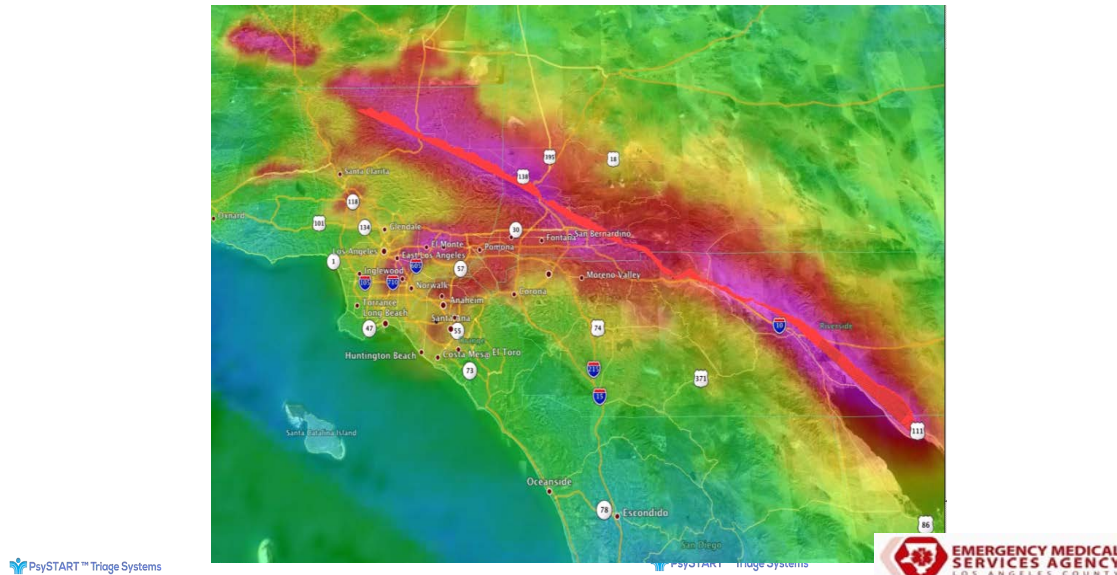
Disasters are all not the same...big and small... disasters are in the eye of the beholder. For some of us, like the developer of the APD model, even a strong wind blowing over lawn furniture could be a big stressor. For others, it is something larger.



Incidents involving biological components such as special pathogens/pathogens of concern such as Ebola **entail unique risks** for the community we serve and our health systems. This can include stigma of patients and healthcare workers, considerable confusion about risk—including confusion among providers and first responders. Consider what was occurred after the nurses in Dallas contracted EVD from the index patient...



## OR IS IT THIS: SOCAL SHAKEOUT SCENARIO



For example, this image reflects a catastrophic or what FEMA calls “Mega Catastrophic” event. This is just a visual example of the ShakeOut Scenario affecting Southern California. It involves a 7.8 Magnitude earthquake that starts near the Salton Sea in the lower right hand corner and then ground movement moves North and West into Riverside, San Bernardino, Orange, Los Angeles and Ventura counties. It is associated with a number of injuries, deaths, home loss, displacement, loss of transportation systems, communications and interruptions in a broad range of public safety services. The first step is trying to decide what your threshold is for when you are in a “disaster.” This will guide you in when to deploy your soon to be developed “personal resilience plan.”



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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 ED.



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Dealing with children who are frightened, scared, severely injured and separated from any caregivers can be quite demanding on healthcare workers and health care settings. How will you cope with many severely injured and upset pediatric patients? In this scene a health worker is attempting to do a radiation screening with a child after the Fukushima reactor meltdown.





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In this scene from the Catastrophic Earthquake in China, workers encountered many grieving parents who lost a child. This can be extremely difficult emotionally for those interacting with these parents.



The next few slides are from Hurricane Harvey and events such as these carry many of the same but also unique risk factors for medical responders.

IF ON TIME:

ASK group: How are events such as hurricanes similar and different from other disasters and day-to-day stressors?



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Is this positive coping with disaster or resilience?  
Sometimes resilience is making the best of challenges in novel ways...

## ANTICIPATE MH HAZARDS: UNDERSTANDING EXPOSURE

Traumatic Response Stress includes exposure and loss factors such as:

Severe burns, dismemberment or mutilation

Witnessed pediatric death (s) or severe injuries

Witnessed an unusually high number of deaths

Responsible for expectant triage decisions

Injury, death or serious illness of coworkers

At work, you were treated for injury or illness

Felt as if your life was in danger

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Traumatic response stress experiences include these:

Review each and get comments

Ask if anyone knows what “expectant triage” is

Ask if anyone has direct experience with expectant triage and wants to disclose optional\*\*

Discuss changes from care as usual to catastrophic care or crisis standards of care idea here



## WHAT PSYSTART RESPONDER MEASURES

What does PsySTART measure?

**NOT Symptoms**

Impact of severe/extreme stressors


“What happened” **not** symptoms, based on objective exposure features):

- **Patient care risk factors**
- **Crisis standards of care**
- **Direct life threat**
- **Family impact**
- **Co-worker impact**
- **Social Support**
- **Outside your head not inside**  
~30days post

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| PsySTART™ Responder System   |  |
|--|--|
| WITNESSED SEVERE BURN, DISMEMBERMENT, OR MUTILATION?   |  |
| EXPOSURE TO PATIENTS SCREAMING IN PAIN/FEAR?   |  |
| WITNESSED PEDIATRIC DEATH(S) OR SEVERE INJURIES?   |  |
| DID YOU WITNESS AN UNUSUALLY HIGH NUMBER OF DEATHS?  |  |
| FORCED TO ABANDON PATIENT(S)?  |  |
| UNABLE TO MEET PATIENT NEEDS?  |  |
| RESPONSIBLE FOR EXPECTANT TRIAGE DECISIONS?  |  |
| DIRECT CONTACT WITH GRIEVING FAMILY MEMBERS?   |  |
| ASKED TO PERFORM DUTIES OUTSIDE OF CURRENT SKILLS?   |  |
| DID YOU EXPERIENCE HAZARDOUS WORKING CONDITIONS (such as extreme shift length, compromised site safety/security, or other issues)? |  |
| INJURY, DEATH, OR SERIOUS ILLNESS OF COWORKERS?  |  |
| UNABLE TO RETURN HOME?   |  |
| WORRIED ABOUT THE SAFETY OF YOUR FAMILY MEMBERS/SIGNIFICANT OTHERS/PETS?   |  |
| UNABLE TO COMMUNICATE WITH FAMILY MEMBERS/SIGNIFICANT OTHERS?  |  |
| HEALTH CONCERNS FOR SELF DUE TO AGENT/TOXIC EXPOSURE (Infectious Disease, Chemical, Radiological, Nuclear, etc.)?                  |  |
| AT WORK, WERE YOU INJURED OR BECAME ILL AND TREATED?   |  |
| DIRECTLY IMPACTED BY INCIDENT AT WORK OR AT HOME? If yes, advise your employee health and well-being unit leader.                  |  |
| FELT AS IF YOUR LIFE WAS IN DANGER?  |  |
| I AM NOT RECEIVING SUFFICIENT SUPPORT FROM OTHERS  |  |
| NO TRIAGE FACTORS IDENTIFIED?  |  |

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LOS ANGELES COUNTY

This is the PsySTART Responder SELF Triage System.

What does PsySTART measure: STRESSFUL EXPERIENCES, NOT SYMPTOMS OF STRESS:

- 1) Instead it measures severe or extreme exposure to risk factors
- 2) The more red or yellow risk factors they higher the risk for developing a new or aggravating prior episode of Post Traumatic Stress Disorder (PTSD)
- 3) Distress is very common in the first 4-6 weeks of an event, so we just don't think risk can be deduced from distress UNLESS very extreme
- 4) So, Instead we look at severe or extreme exposure to risk factors
- 5) Some of these are risk from patient care and the potential of “crisis care” or altered standards of care in high surge events. Also included is being in direct serious life threat in your role, impact on your family or co-workers and if you are receiving sufficient support from others
- 6) Under 30 days, risk is defined by exposure not distress “inside your head”
- 7) PsySTART is OUTSIDE your head risk: what happened, not how you are feeling about it.
- 8) You will be able to create your own confidential PsySTART self-triage account on the PsySTART Responder LAC system today and you can start

using as you see fit today.



## UNDERSTANDING EXPOSURE: Anticipate and Tracking Your Psychological Hazards

Research found that  
*any 6 OR THESE 3*  
*PREDICT PTSD RISK*



|  |   |
|--|---|
| WITNESSED SEVERE BURN, DISMEMBERMENT, OR MUTILATION?   |   |
| EXPOSURE TO PATIENTS SCREAMING IN PAIN/FEAR?   | ✓ |
| WITNESSED PEDIATRIC DEATH(S) OR SEVERE INJURIES?   |   |
| DID YOU WITNESS AN UNUSUALLY HIGH NUMBER OF DEATHS?  |   |
| FORCED TO ABANDON PATIENT(S)?  |   |
| UNABLE TO MEET PATIENT NEEDS?  |   |
| RESPONSIBLE FOR EXPECTANT TRIAGE DECISIONS?  |   |
| DIRECT CONTACT WITH GRIEVING FAMILY MEMBERS?   |   |
| ASKED TO PERFORM DUTIES OUTSIDE OF CURRENT SKILLS?   |   |
| DID YOU EXPERIENCE HAZARDOUS WORKING CONDITIONS (such as extreme shift length, compromised site safety/security, or other issues)? |   |
| INJURY, DEATH, OR SERIOUS ILLNESS OF COWORKERS?  |   |
| UNABLE TO RETURN HOME?   |   |
| WORRIED ABOUT THE SAFETY OF YOUR FAMILY MEMBERS/SIGNIFICANT OTHERS/PETS?   |   |
| UNABLE TO COMMUNICATE WITH FAMILY MEMBERS/SIGNIFICANT OTHERS?  |   |
| HEALTH CONCERNS FOR SELF DUE TO AGENT/TOXIC EXPOSURE (Infectious Disease, Chemical, Radiological, Nuclear, etc.)?                  |   |
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| FELT AS IF YOUR LIFE WAS IN DANGER?  |   |
| I AM NOT RECEIVING SUFFICIENT SUPPORT FROM OTHERS  |   |
| NO TRIAGE FACTORS IDENTIFIED?  |   |

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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), working with patients outside current skills (such as a pediatrician working with adult patients)
- 3) Personal impacts to the provider themselves: Felt as if their own lives 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



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This is video clip from a CNN special on the Ebola response. This clip details some of the PsySTART Responder Self Triage Risk Factors.

Ask the group to identify the PsySTART risk factors they observe

**Key point: Loss of co-worker in their response role**



## CUMULATIVE DEPLOYMENT STRESS: “PROGRESSIVE BURDEN OF EXPOSURE”

### On-going role stressors:

- working outside usual role (comfort zone)
- access to usual equipment, lab and/or support services
- change/conflicting situational information or directives
- working long hours
- temperature extremes
- difficult sleeping
- food arrangements
- Uncertainty (e.g., event, response, role)
- Disease is novel or does not behave according to expectation

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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.

## ANTICIPATE: HOME CONCERNS

### Anticipate your family/home concerns

- Complete basic disaster preparedness at home
- Include a family/significant other communications plan
- Identify other supports for your family (including health needs)
- For those with children, learn how to do **“Listen, Protect and Connect”** Psychological First Aid For Children and adult family members
  - <https://www.fema.gov/media-library/assets/documents/132712>



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](http://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](http://www.ready.gov/sites/default/files/documents/files/LPC_Booklet.pdf)

## ANTICIPATE: mass casualty response roles

Mass casualty events pose unique healthcare worker risk

- Catastrophic events

Crisis standards of care

Higher levels of death and acuity than used to

CBRNE potential

Responder families may also be impacted by the event

Uncommonly gruesome scenes of death and destruction

 PaySTART™ Triage Systems



Another aspect of stress and risk for health care workers are the quantitative and qualitative differences that accrue in mass casualty events

For example in catastrophic events, there may many more people needing certain levels of definitive care than are available. This would trigger so called “crisis standards of care”, where decisions about care are based on meeting as many needs as possible. Triage shifts to population based triage decisions to provide for rational allocation of limited medical resources. Most providers, although they experience death often and removal of life support, have not ever faced decision making in a scarce resource, catastrophic event. Some patients in a non-catastrophic context, would receive many resources and perhaps have good outcomes whereas in a catastrophic context, the same patient may be triaged to palliative care and not receive other interventions.

This would be stressor for the patient, their family and the health care team responsible for that patient.

Some of these issues came to light in Katrina and those wanting more information are encouraged to read the book

5 days at Mercy” which depicts events at one hospital.

Crisis standards of care represent an ethical and rational approach to allocate resources in hospitals and other settings.

Participants are 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 in the responder

Unlike medical risk, just the threat or perception of these materials being present can be enough to trigger long-term post traumatic stress reactions in responders. There is considerable lack of familiarity with these agents, their health effects, PPE and concerns about exposure to self and secondary exposure to family members may add tremendous additional burden to medical workers in these events. Additionally, the larger the scale of the event for a local responder, the more likely their own social network of friends and family will be directly impacted which further impacts medical responders.

## **WARNING: The Following Slides depict graphic mass casualty penetrating trauma and scenes from Ebola Field Response**



Rapidly move through these slides, do not allow extended viewing time, this is a glimpse of exposures

The next series of slides are images of various types of disasters and catastrophic events of the type you might find yourself encountering as a disaster healthcare responder. The purpose of these slides is to expose you to the types of difficult situations you may very well encounter in a disaster response. You can consider these different types of situations as you continue to refine your “personal resilience plan”. The images begin with depictions of various full-scale exercises involving mass casualty disasters and terrorism. They continue with various aspects of these situations such as mass casualty triage, field decontamination, disaster medical field operations venues (such as a Mobile Field hospital, etc.). The images continue on to real world events involving property destruction, including the images of damage to a local hospital from the EF5 Tornado in Joplin Missouri in May of 2011, makeshift medical operations in the Philippines and the Russian Beslan School Massacre in 2004. In this terrorist event, many children, parents and teachers were killed in a fire with gunshot wounds and fragmentation injuries. These are likely to be the most disturbing images in this section.



LA City FD, mass casualty terrorism chemical weapon in a mall (EXERCISE)  
This shows patient transport in full Level 1 Personal Protective Equipment



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Dealing with many grieving family members, in the context of a mass casualty event, perhaps where “crisis standards of care” has been implemented, also poses stressors for medical workers. In this case, it is the parent of a young child. Interacting with grieving family members and particularly grieving parents may be quite challenging for healthcare providers.





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Events involving many or even a single traumatically injured child or those who do not survive are among the most challenging for healthcare and first responders both





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Likewise, dealing with grieving parents or those very worried about their child's survival are challenging.

Question: How does your facility handle "parental presence" during pediatric trauma activations?



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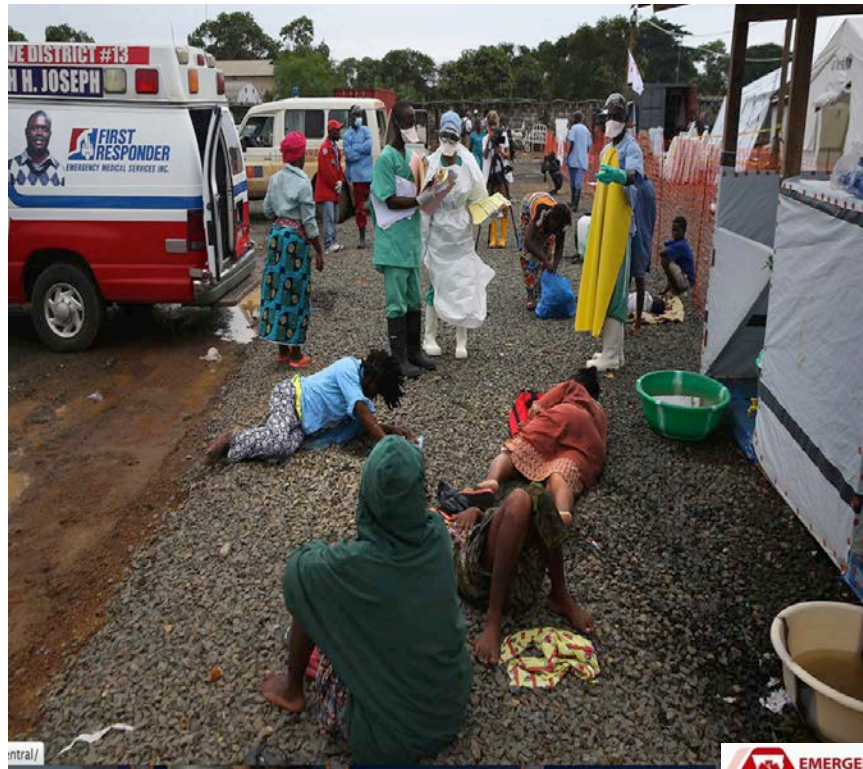
As in the previous slides: mass casualties involving very injured children with catastrophic wounds or those that do not survive despite our best efforts and also interacting with their many traumatized parents who have a lost a child (or children) are extremely difficult for healthcare workers to cope with.



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How have you will cope with this in a mass casualty event?



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SERVICES AGENCY  
LOS ANGELES COUNTY

Consider the next slide scenes from the Ebola response in West Africa. These images were used for the pre-event inoculation for the deployed US Public Health Service Ebola teams using APD/PsySTART Responder





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The next series of images are from the Ebola events inside the United States in Dallas.

IF TIME PERMITS, GROUP DISCUSSION:

What risk factors did these providers experience?

What was different and what was the same from the Ebola stressors facing providers in West Africa?





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Healthcare and first responders involved with the index case being transported to a NETEC bio containment unit for treatment.



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Scene inside the University of Nebraska BCU



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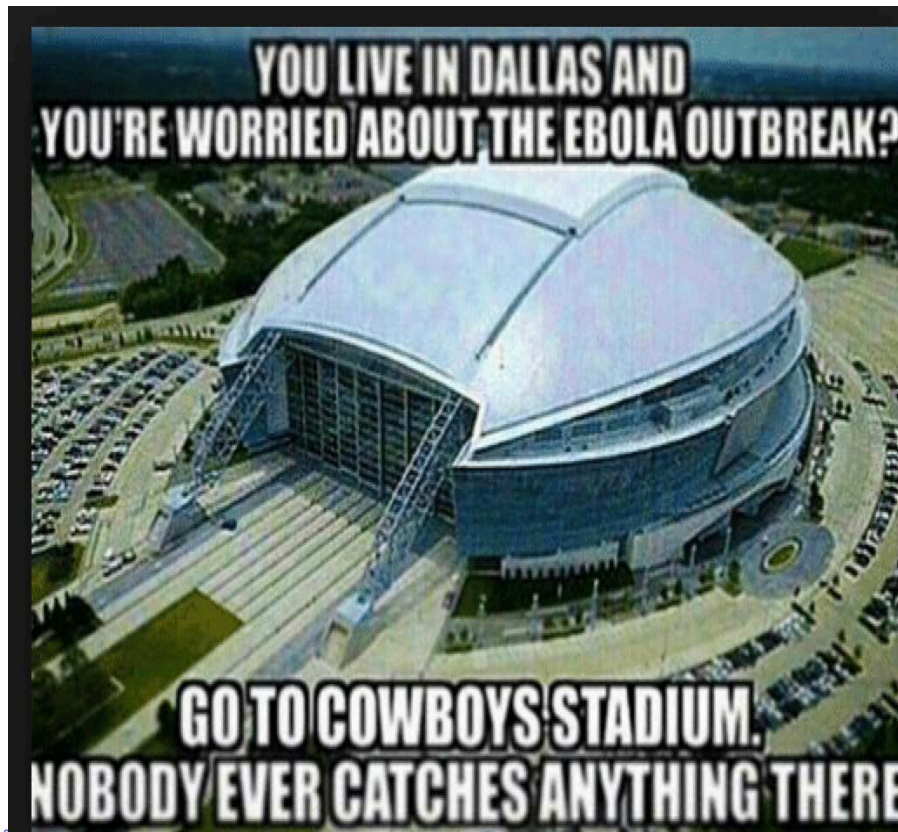


Emerging infectious disease events can trigger significant public reactions that may directly or indirectly impact healthcare workers and their families as was also seen in the SARS event.



This image depicts support for the nurses who contracted Ebola from a patient in Dallas





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This scene from the Philippines Super Typhoon Disaster Haiyan depicts military medical provider operations in an austere, heavily damaged hospital environment. Anticipate that your facility might be damaged and how you might cope with that.





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First Responders and healthcare workers both may experience the injury or death of co-workers.

You may also know many of these responders and co-workers in your job and may also be impacted based on your personal relationships with them.



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Although hospitals are built to different standards than other structures, they too can fall prey in certain large-scale events. (this from a California Earthquake in Los Angeles County)



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Although hospitals are now built differently, they too can fall prey in certain large-scale events. 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!

Less traumatic perhaps but reflecting some of the PsySTART Responder stressors discussed earlier, this image depicts heating and air-conditioning systems support

## ***SO, ANTICIPATE WHAT YOU MIGHT EXPERIENCE.***

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

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Consider two types of medical responder stress:  
Traumatic exposure vs. Cumulative

Ask participants to find “STEP 1” in their personal resilience plan brochure.  
REVIEW each Traumatic Exposure, ask volunteers to discuss any 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 –  
Triggers are:  
Stress expectable, manageable and not necessarily pathological.  
Severity and frequency of stress factors are BOTH important.

The challenge is to *manage stress! Vs. avoidance or sweeping under the rug until you are fully symptomatic and have impairment in daily functioning...*

## Anticipate: Aspects of Mass Casualty Response Role

- Mass casualty events pose unique healthcare worker risk
  - Catastrophic events
- Crisis standards of care
- CBRNE potential
- Families may also be impacted by the event

HEALTH CONCERNS FOR SELF DUE TO AGENT/TOXIC EXPOSURE (Infectious Disease, Chemical, Radiological, Nuclear, etc.)?

WORRIED ABOUT THE SAFETY OF YOUR FAMILY MEMBERS/SIGNIFICANT OTHERS/PETS?

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Another aspect of stress and risk for health care workers are the quantitative and qualitative differences that accrue in mass casualty events. For example in catastrophic events, there may be many more people needing certain levels of definitive care than are resources available. This would trigger so called “crisis standards of care”, where decisions about care are based on meeting as many people as possible with limited resources. For example, patient triage decisions shift from the individual patient to population based triage “the greatest good for the greatest number” given limited medical resources.

Most providers, although they experience death often and removal of life support, have not ever faced decision-making in a scarce resource, catastrophic event. Some patients in a non-catastrophic context, would receive many resources and perhaps have good outcomes whereas in a catastrophic context, the same patient may be triaged to palliative care and not receive other interventions. This would be a stressor for the patient, their family and the health care team responsible for that patient.

Some of these issues came to light following Hurricane Katrina. Those who want more information are encouraged to read the book: “Five Days at Memorial” by Dr. Sheri Fink.

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 post traumatic stress reactions in responders. There is considerable lack of familiarity with these agents, their health effects, PPE and concerns about personal exposure self 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 will also further impact healthcare responders.



## 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 JUST ANOTHER DAY AT THE OFFICE !

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Disasters and MCI events 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”).

**Anticipate :**  
**Possible Reactions to Disaster Stress**

- **Emotional:** irritability, anger, sadness, guilt, worry, fear, apathy, grief
- **Cognitive:** confusion, memory problems, difficulty focusing or attending to details
- **Physical:** sleep difficulties, exhaustion
- **Behavioral:** expressed anger/irritability, substance misuse, withdrawal from others, overwork, abandonment of self care

There are many different ways in which reactions to stress or “distress” manifest. Distress can take the form of emotional reactions: read examples following colon. It can also take the form of Cognitive reactions: read examples after colon. Physical reactions are also quite common, particularly sleep difficulties. Behavioral reactions involve the overt manifestations of some aspects of emotional distress such as overt expressions of anger or irritation and also social isolation or withdrawal from others and the absence of self-care behaviors.

### Anticipate : Possible Reactions to Disaster Stress

- **Emotional:** irritability, anger, sadness, guilt, worry, fear, apathy, grief
- **Cognitive:** confusion, memory problems, difficulty focusing or attending to details
- **Physical:** sleep difficulties, exhaustion
- **Behavioral:** expressed anger/irritability, substance misuse, withdrawal from others, overwork, abandonment of self care

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“Triggers” or “Trauma triggers” refer to features in the current response that remind the individual of other traumatic events in their lives.

- A sight, odor or thoughts can set off a trigger: “Wow the last time I thought that was after...(insert another example of a disaster that has occurred in the past here).”
- Sometimes, these triggers can produce intense distress - especially if the person does not identify the reaction as a “trauma trigger”. When this happens, it seems as if the trigger reaction is “coming out of the blue” and can be very disturbing to the individual.
- Although the reactions to trauma triggers may not be eliminated, it is still helpful to be aware of them and to realize that they are an expectable part of disaster work.
- The individual can use components of their coping plan (that follows) to help manage trauma triggers. The things that work for the individual to manage distress will likely help with trauma triggers as well.
- An example could be treating a gravely injured pediatric patient and being reminded of your own child.

## Review: Anticipate how will I manage my stress?

### ■ Anticipate:

- When you begin to anticipate stressors and then think through a menu of coping responses **you are building personal resilience:**
- Focus of concerns: Friends, Family and self : are they safe, am I safe ?
- Self-care is *primary*, “mission critical” and not secondary
- Traumatic and cumulative response stressors both count

### ■ Triggers

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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.

## STEP 1: Conclusion

- Mass casualty= high risk for healthcare responders
- Special pathogen or other unusual events

=

not another typical day at the office !



Discuss these key points and address any questions or confusion to this point.

- Mass casualty disasters involve both significant qualitative and quantitative stressors including aspects of differences in each of these areas and “Not just another day at the office”:
- Qualitative and Quantitative differences in these areas:
  - Personal impact factors
  - Setting impacts
  - Patient factors
  - On-going climate of threat for responders and their families
  - Family concerns

Consider this carefully:

If we are concerned about the quality and continuity 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 were highly impacted by the event. Medical mission assurance is only as good as the healthcare workers that are the foundation of all medical response. 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.

## Step 2: Create your personal coping plan

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### **NOW LETS BUILD YOUR PERSONAL PLAN:**

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 the “PLAN” part 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. SO, in the APD model, after one considers the potential stress impacts, you develop your OWN plan for how might cope with each of these potential stressors.

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 every day on the job. With APD we are BUILDING ON YOUR RESILIENCE in advance of the next disaster, Public Health Emergency or mass casualty event.

In the APD model, after one faces the potential stress impact, the next step is to build resilience strategy for each “hazard” to your resilience.



## Planning ahead

- What stressors do you anticipate will be the easiest and hardest for you to deal with ?
- These are *your* response “challenges”
- How will you react?
- What are your “resilience” factors ?
- Add it all up: what’s your coping plan?
- **PRACTICE YOUR PLAN**
  - Practice your coping skills NOW

This reviews the first page of their plan and transitions to the resilience and coping sections. “Plan” means develop a range of possible coping tools and strategies to manage the stress impact of those elements you identified as potentially stressful experiences (PSE’s) in the Anticipate section of your personal resilience plan.

- Review each of these, if not already mentioned by group members in the previous slide.
- You can talk about each of these or some of these as time permits and based on group inputs that may have already occurred.

## Creating your resilience plan

- What stressors do you anticipate will be the easiest and hardest for you to deal with ?
- These are *your* response “challenges”
- How will you react?
- What are your “resilience” factors ?
- New short term coping skills package
- Add it all up: what’s your coping plan?
- Then, Practice your plan
  - Practice your coping skills before the “big one” hits



In APD, “PLAN” MEANS DEVELOP A RANGE OF POSSIBLE COPING TOOLS AND STRATEGIES TO MANAGE THE STRESS IMPACT OF THOSE ELEMENTS YOU IDENTIFIED AS POTENTIALLY STRESSFUL EXPERIENCES(PSE’s) IN THE ANTICIPATE SECTION OF YOUR PERSONAL RESILIENCE PLAN

Your Personal Support Plan – We will be asking you to identifying people who help you cope with stress during difficult times. List people who you can talk to following a disaster. Talking with people you trust following a disaster is a key element of your APD “coping plan”.

Your Positive Coping Plan – We will be asking you to identify positive ways they typically manage their stress on a daily basis.

Be prepared for a range of possible stressors now. During a disaster, remember your expected stress reactions, response challenges and coping strategies, as well as the rest of the strategies we will discuss next for APD.

Also remember that building cohesion with your coworkers is a key part of enhancing your social support system.

Develop your OWN plan for how might cope with each of these potential stressors BASED ON YOUR EXISTING COPING STRATEGIES

We will also ask you to consider a few other critical coping skills and free apps to practice and use them should you need them...

## Plan : Building Your Resilience Plan

- Consider what might help you cope in advance
  - Build on your successful coping in everyday life
- How do you typically handle stress ?
  - What works for you ?
- Understand the importance of your response role
- *“Prepare for the possible, focus on the probable”*
- *Short term stress management skills package*
- Understand your disaster role(s)
- Build cohesion with co-workers



In this section we build on other strategies and skills you already use on a daily basis.

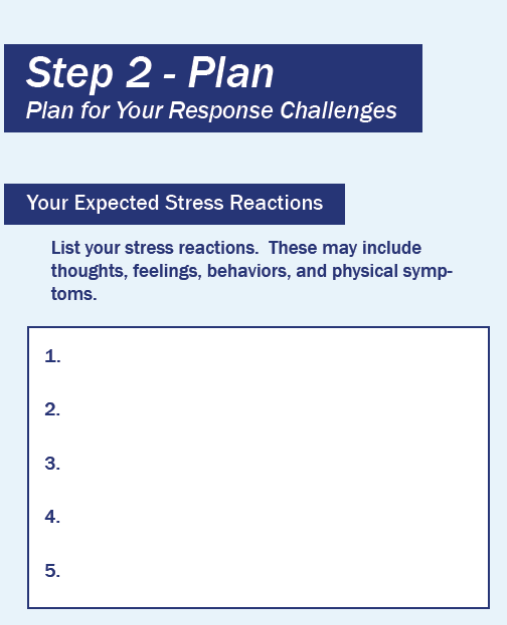
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Also remember that building cohesion with your coworkers is a key part of enhancing your social support system.

## CREATE YOUR COPING PLAN





**Step 2 - Plan**  
*Plan for Your Response Challenges*

**Your Expected Stress Reactions**

List your stress reactions. These may include thoughts, feelings, behaviors, and physical symptoms.

- 1.
- 2.
- 3.
- 4.
- 5.

- What are your expected stress *reactions* following a disaster?
- Please list them now in the box provided

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, please fill in at home. Remember, APD is customized to you based on your anticipated concerns and your own coping styles and resources.

NOW WE ARE GOING TO CONSIDER HOW TO MANAGE THOSE STRESSORS YOU HAVE ANTICIPATED....

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

## CREATE YOUR COPING PLAN

- What are your expected disaster *response* challenges?
- Take a few moments to list the most stressful aspects of a disaster response for you ?

### Your Expected Response Challenges

List what you think the most stressful aspects will be for you during your response. Things like missing your kids or caring for severely injured children may be on your list.

- 1.
- 2.
- 3.
- 4.
- 5.

Next on the same page of your APD Plan Brochure under “Your expected response challenges”:

- Consider and write in the space provided what you now think your biggest response challenges would be?
- The Instructor should remind the group of “potential reactions” discussed earlier in the class and write up to five reactions.
- Ask if anyone is willing to share their response challenges with the group.

Now, we are going to consider how to manage those stressors you have anticipated.

## CREATE YOUR COPING PLAN: BUILDING SOCIAL SUPPORT

Steps to build social support:


- Identify your social support system?
  - Please list them now
- Plan for how to reach them during a disaster
- Plan regular times to access support while at work
- Prepare to provide and receive support
  - Use Listen, Protect and Connect Psychological First Aid available at:

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**Your Social Support Plan**

Who is in your social support system? List people who can support you and who you can provide support to during and after a disaster:

- 1.
- 2.
- 3.
- 4.



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
  - ACTIVE COPING IDEA
- Please list some of these strategies now
  - COPING 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

**Your Social Support Plan**

Who is in your social support system? List people who can support you and who you can provide support to during and after a disaster.

- 1.
- 2.
- 3.
- 4.

**Your Positive Coping Plan**

Everyone has different ways of coping with stress. What positive ways of managing stress work best for you every day? What positive ways of managing stress do you think will work for you following a disaster? Strategies you might consider include limiting your exposure to media reports, focusing beyond the short term, taking frequent short breaks. List your healthy coping plan here:

- 1.
- 2.
- 3.
- 4.

**Your Resilience Factors**

People often find that there are some positive things about working on a disaster. For example, people might feel good about being able to "make a difference" when their community needs them most. Positive resilience factors help you as a healthcare worker to cope better with the stressors associated with responding to a disaster in your facility or community. Below please list positive factors that might give you a sense of mission or purpose following a disaster.

- 1.
- 2.
- 3.
- 4.

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Your Personal Support Plan – Ask participants to take a few moments to list people who help you cope with stress during difficult times. Ask them to list people who you can talk to following a disaster. Talking with people you trust following a disaster is a key element of your 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.

Another strategy that can help you and your co-workers is learning about how to administer Psychological First Aid. We recommend the Listen,Protect,Connect PFA model but others can be substituted.

### BUILDING YOUR POSITIVE COPING PLAN GENERAL AND SPECIFIC STRATEGIES FOR STRESSORS YOU ANTICIPATE

- Its preferable to have a “goto” list of specific and general coping ideas ready when you need them
- Develop possible coping ideas for each of your prioritized stressors
- Think about what might help you if it occurs
- Can be specific things you will do or say to yourself (thought strategies, distraction)
- AND/OR general coping strategies, talking with someone, reading, positive imagery, breathing or any combo

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**Your Social Support Plan**

Who is in your social support system? List people who can support you and who you can provide support to during and after a disaster:

- 1.
- 2.
- 3.
- 4.

**Your Positive Coping Plan**

Everyone has different ways of coping with stress. What positive ways of managing stress works best for you every day? What positive ways of managing stress do you think will work for you following a disaster? Strategies you might consider include limiting your exposure to media reports, focusing beyond the short term, taking frequent short breaks. List your healthy coping plan here:

- 1.
- 2.
- 3.
- 4.

**Your Resilience Factors**

People often find that there are some positive things about working on a disaster. For example, people might feel good about being able to “make a difference” when their community needs them most. Positive resilience factors help you as a healthcare worker to cope better with the stressors associated with responding to a disaster in your facility or community. Below please list positive factors that might give you a sense of mission or purpose following a disaster:

- 1.
- 2.
- 3.
- 4.



The goal here is to develop a list of general coping strategies and also specific strategies tied to the various risk factors the individual has already prioritized in the prior fill in sections of the APD plan

## Listen.Protect.Connect: Psychological First Aid You Can Do

**Listen, Protect and Connect:**  
Family to Family, Neighbor to Neighbor

Psychological First Aid (PFA)  
for The Community Helping Each Other  
Helping Those Around You

**Listen, Protect and Connect**  
Psychological First Aid  
for  
Community Resilience

**Listen, Protect and Connect:**  
Family to Family, Neighbor to Neighbor  
Psychological First Aid for the Community Helping Each Other

**Trainer Notes and Resources**  
For use with Listen, Protect and Connect:  
Family to Family, Neighbor to Neighbor  
Slide presentation  
*2013 Version for use LPC web training components*

Developed for:  
The Los Angeles County Department of Public Health  
Emergency Preparedness and Response Program  
Los Angeles County Community Disaster Resilience Project

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**Listen, Protect, and Connect**

**CONNECT**

**EMERGENCY MEDICAL SERVICES AGENCY**  
LOS ANGELES COUNTY

Another strategy that can help you and your co-workers is learning about how to administer Psychological First Aid using the “Listen, Protect and Connect Family to Family, Neighbor to Neighbor” training program or other programs your facility may already use.

LPC psych first aid is models to both provide support to your colleagues and teammates , patients/victims you encounter and your own family.

Be prepared to provide **and** receive basic psychological first aid builds responder resilience and improves resilience in their patients and family members

For further info on Listen.Protect.Connect Psychological First Aid on the FEMA website

LPC Family to Family, Neighbor to Neighbor Psychological First Aid For Community Members:  
[https://www.ready.gov/sites/default/files/documents/files/LPC\\_Booklet.pdf](https://www.ready.gov/sites/default/files/documents/files/LPC_Booklet.pdf)

or

[www.fema.gov/media-library/assets/documents/132712](http://www.fema.gov/media-library/assets/documents/132712)

## YOUR COPING PLAN: RESILIENCE FACTORS

Identify positive experiences including those that give a sense of mission or purpose:

- “making a difference”
- “being there for those that need us”
- “saving lives, reducing suffering”

**Your Resilience Factors**

People often find that there are some positive things about working on a disaster. For example, people might find great about being able to "make a difference" when their community needs them most. Positive resilience factors help you as a healthcare worker to cope better with the stresses associated with responding to a disaster in your facility or community. Please share the positive factors that might give you a sense of mission or purpose following a disaster.

- 1.
- 2.
- 3.
- 4.

The last section of their plan is the “Your Resilience Factors” section. Here participants are asked to consider other resilience factors they may have like a “life mission” or “personal philosophy” for their work in healthcare and also, their work helping people following a disaster. For some, it is the positive satisfaction from doing hard work to relieve suffering and save lives and a sense of “being there for others that need us.” Use the section provided to list their resiliency factors that will also help them cope and reduce their stress.

Instructors ask for volunteers to share their “resiliency factor” ideas with the group.

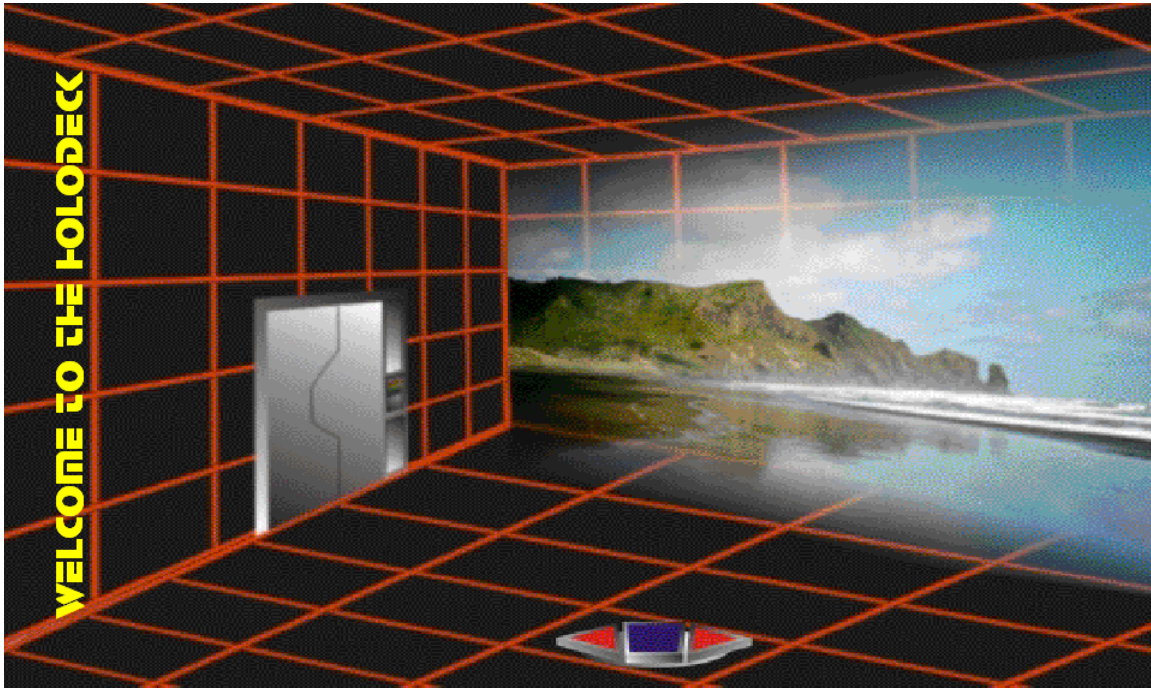
## **“WHAT WORKS FOR YOU?”: HERE’S MY LIST, WHAT’S YOURS?**

- ✓ Create your own “Holodeck”: the combination of :
  - ✓ Mindfulness
  - ✓ Guided imagery/ distraction / relaxation breathing
- Can be added to PsySTART “next steps” tab

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These are examples of a responder personal resilience active coping strategy



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### THE COPING HOLODECK (Guided Imagery/Mindfulness Model)

You might recall the “Holodeck” from the TV Show, Star Trek the Next Generation” Because the missions of the Enterprise were so complex and stressful, they developed the “holodeck” where crew could relax and create their “own little world” for short time to relieve stress

We can all create our own “holodeck” in our minds by focusing on images, thoughts and memories of pleasant times, such as beach or mountain scenes, activities with friends or family or places you have dreamed of visiting. Psychologists call this “guided imagery” or mindfulness

When you create the opportunity for brief respite from the disturbing sights and sounds of disaster response using such

Here are some Coping Holodeck coping options





One strategy the developer of APD uses is a variant of relaxation plus “guided imagery”. This slide shows preselected an image that is enjoyable and relaxing for you. In this case, this is an image of Tuolumne Meadows area in the Sierra Nevada Mountains.

The developer of this course keeps this image on his phone or as a photo in his go kit. When stressed or even at the end of an operational period, he views the image and practices self-relaxation tied to the image.

- Encourage participants to identify similar images they can use for themselves.



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Here is another example from a Ebola medical provider in Africa. This clip indicates one of his resilience cognitive coping strategies...

View clip and ask for comments about the resilience implications this physician described that worked for him...

## PLAN: MORE COPING TOOLS TO CONSIDER FOR YOUR PLAN

- ✓ Paced breathing (app store free)
- ✓ Breathe to Relax (portable stress management tool )
- ✓ Mindfulness Coach
  - ✓ All free at :[www.t2health.dcoe.mil/apps](http://www.t2health.dcoe.mil/apps)
- ✓ PTSD Coach (assist people experiencing symptoms of PTSD): free at:
  - ✓ [www.ptsd.va.gov/apps/ptsdcoachonline/default.htm](http://www.ptsd.va.gov/apps/ptsdcoachonline/default.htm)



Each of these applications supports new coping skills including evidence based tools( PTSD coach).

We urge you to:

- 1) Download these for free to your phone
- 2) Take a look at each one and try them all
- 3) Select the ones you want to your personal resilience plan

**These are also available on the PsySTART responder “next steps” tab**

## STEP 3: APD

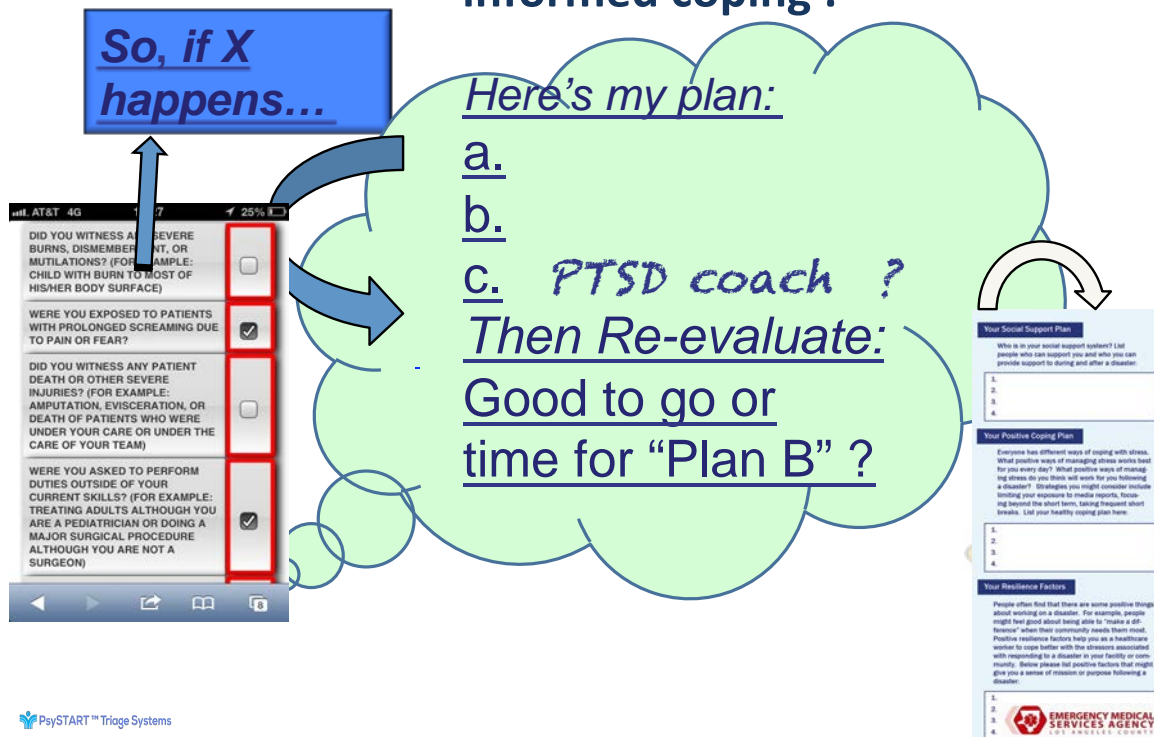
### “DETER”

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#### **Now we move to Step 3 – DETER**

Step 3 is the “Deter” component of APD Responder Resilience System. Here we take all we have learned so far and discuss how to use their APD coping plan during a large event.

## PsySTART Triggers for Triage informed coping :



### Key Points:

1. What's the Activating Event?
2. What is the thought that might happen in response to this Activating Event?  
Discuss possible thoughts. In this example, focus on "It's my fault", "I should have done something different", "I don't deserve to be happy because my buddy was injured/killed".
3. What are the consequences? Discuss possible emotions and reactions. In this example, focus on depression, grief, guilt and reactions of withdrawing from social situations and not doing things that you used to enjoy.



## **“DETER” (STEP 3) ACTIVATE “PERSONAL RESILIENCE PLAN”**

- This means activating your coping plan
  - donning your mental PPE
- Monitor your stress exposure using the PsySTART self triage tag – consider it your confidential stress dosimeter
- Use your personal resilience plan strategies
  - PTSD Coach
- Reach out for support from your social support system
- Engage work based coping resources



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 is “PTSD COACH”, an online, anonymous program that you can to manage post traumatic stress symptoms you may have.(SEE LINK ABOVE)

## PSYSTART STAFF SELF TRIAGE AS YOUR PERSONAL “STRESS” DOSIMETER



=

| PsySTART™ Responder System   |  |
|--|--|
| WITNESSED SEVERE BURN, DISMEMBERMENT, OR MUTILATION?   |  |
| EXPOSURE TO PATIENTS SCREAMING IN PAIN/FEAR?   |  |
| WITNESSED PEDIATRIC DEATH(S) OR SEVERE INJURIES?   |  |
| DID YOU WITNESS AN UNUSUALLY HIGH NUMBER OF DEATHS?  |  |
| FORCED TO ABANDON PATIENT(S)?  |  |
| UNABLE TO MEET PATIENT NEEDS?  |  |
| RESPONSIBLE FOR EXPECTANT TRIAGE DECISIONS?  |  |
| DIRECT CONTACT WITH GRIEVING FAMILY MEMBERS?   |  |
| ASKED TO PERFORM DUTIES OUTSIDE OF CURRENT SKILLS?   |  |
| DID YOU EXPERIENCE HAZARDOUS WORKING CONDITIONS (such as extreme shift length, compromised site safety/security, or other issues)? |  |
| INJURY, DEATH, OR SERIOUS ILLNESS OF COWORKERS?  |  |
| UNABLE TO RETURN HOME?   |  |
| WORRIED ABOUT THE SAFETY OF YOUR FAMILY MEMBERS/SIGNIFICANT OTHERS/PETS?   |  |
| UNABLE TO COMMUNICATE WITH FAMILY MEMBERS/SIGNIFICANT OTHERS?  |  |
| HEALTH CONCERNS FOR SELF DUE TO AGENT/TOXIC EXPOSURE (Infectious Disease, Chemical, Radiological, Nuclear, etc.)?                  |  |
| AT WORK, WERE YOU INJURED OR BECAME ILL AND TREATED?   |  |
| DIRECTLY IMPACTED BY INCIDENT AT WORK OR AT HOME? If yes, advise your employee health and well-being unit leader.                  |  |
| FELT AS IF YOUR LIFE WAS IN DANGER?  |  |
| I AM NOT RECEIVING SUFFICIENT SUPPORT FROM OTHERS  |  |
| NO TRIAGE FACTORS IDENTIFIED?  |  |

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LOS ANGELES COUNTY

PsySTART™ Triage Systems

### Using PsySTART Responder Self Triage System

If you worked in radiation risk environment, you might be issued a personal radiation badge, which is a type of radiation dosimeter. As we discussed previously, PsySTART Responder-Self Triage can be thought of as a method to gauge your stress exposures and risk so you can act to protect yourself early before stress is overwhelming and impacts your response role.

PsySTART is not about “inside your head” it’s about what happened “outside your head” It is not symptoms or a diagnosis. It is a measure of potential risk from events that you experienced as function of “dose” of stressful events you may have encountered.

**Your individual triage encounters are confidential and can only be viewed by you.**

# WHAT PSYSTART RESPONDER MEASURES

What does PsySTART measure?

**NOT Symptoms**

Impact of severe/extreme stressors

“What happened” **not** symptoms, based on objective exposure features):

- Patient care risk factors
- Crisis standards of care
- Direct life threat
- Family impact
- Co-worker impact
- Social Support
- Risk is measured “outside your head not inside (~30days post)

PsySTART™ Triage Systems

| PsySTART™ Responder System   |  |
|--|--|
| WITNESSED SEVERE BURN, DISEMBERMENT, OR MUTILATION?  |  |
| EXPOSURE TO PATIENT'S SCREAMING IN PAIN/FEAR?  |  |
| WITNESSED PEDIATRIC DEATH(S) OR SEVERE INJURIES?   |  |
| DID YOU WITNESS AN UNUSUALLY HIGH NUMBER OF DEATHS?  |  |
| FORCED TO ABANDON PATIENT(S)?  |  |
| UNABLE TO MEET PATIENT NEEDS?  |  |
| RESPONSIBLE FOR EXPECTANT TRIAGE DECISIONS?  |  |
| DIRECT CONTACT WITH GRIEVING FAMILY MEMBERS?   |  |
| ASKED TO PERFORM DUTIES OUTSIDE OF CURRENT SKILLS?   |  |
| DID YOU EXPERIENCE HAZARDOUS WORKING CONDITIONS (such as extreme shift length, compromised site safety/security, or other issues)? |  |
| INJURY, DEATH, OR SERIOUS ILLNESS OF COWORKERS?  |  |
| UNABLE TO RETURN HOME?   |  |
| WORRIED ABOUT THE SAFETY OF YOUR FAMILY MEMBERS/SIGNIFICANT OTHERS/PETS?   |  |
| UNABLE TO COMMUNICATE WITH FAMILY MEMBERS/SIGNIFICANT OTHERS?  |  |
| HEALTH CONCERNS FOR SELF DUE TO AGENT/TOXIC EXPOSURE (Infectious Disease, Chemical, Radiological, Nuclear, etc.)?                  |  |
| AT WORK, WERE YOU INJURED OR BECAME ILL AND TREATED?   |  |
| DIRECTLY IMPACTED BY INCIDENT AT WORK OR AT HOME? If yes, advise your employee health and well-being unit leader.                  |  |
| FELT AS IF YOUR LIFE WAS IN DANGER?  |  |
| I AM NOT RECEIVING SUFFICIENT SUPPORT FORM OTHERS  |  |
| NO TRIAGE FACTORS IDENTIFIED?  |  |



This is a review of the PsySTART Responder Self Triage System risk factors  
This can be used in everyday events to be ready for larger events that are more challenging.

We encourage you to use PsySTART self triage on a regular basis to get your own risk baseline before larger events may happen.



## LAC EMS PsySTART R Responder System

- Go to <https://psystart.net/lares>
- Create an account from laptop/desktop
- Select your site from the dropdown list
- Use 777777 for registration code
  - Do not share this code with others
- Works on any smart phone, tablet or laptop
- Log on via your phone to site
  - Select “save to home screen” to create direct PsySTART app link on your phone
  - Select remember my username”
  - Fast direct self triage encounter without logging on
- Remember: NO INDIVIDUAL INFO VISIBLE -except to you



These are the instructions for the provider to create their own confidential account on the PsySTART Responder System.

Please create your own account in advance so you can assist others in setting theirs up. Do not share registration information outside of authorized LAC EMS Disaster Program end users

To create the proxy smart phone app (direct link), go the site URL on the smartphone or tablet

<https://psystart.net/lares>

log on using user and password

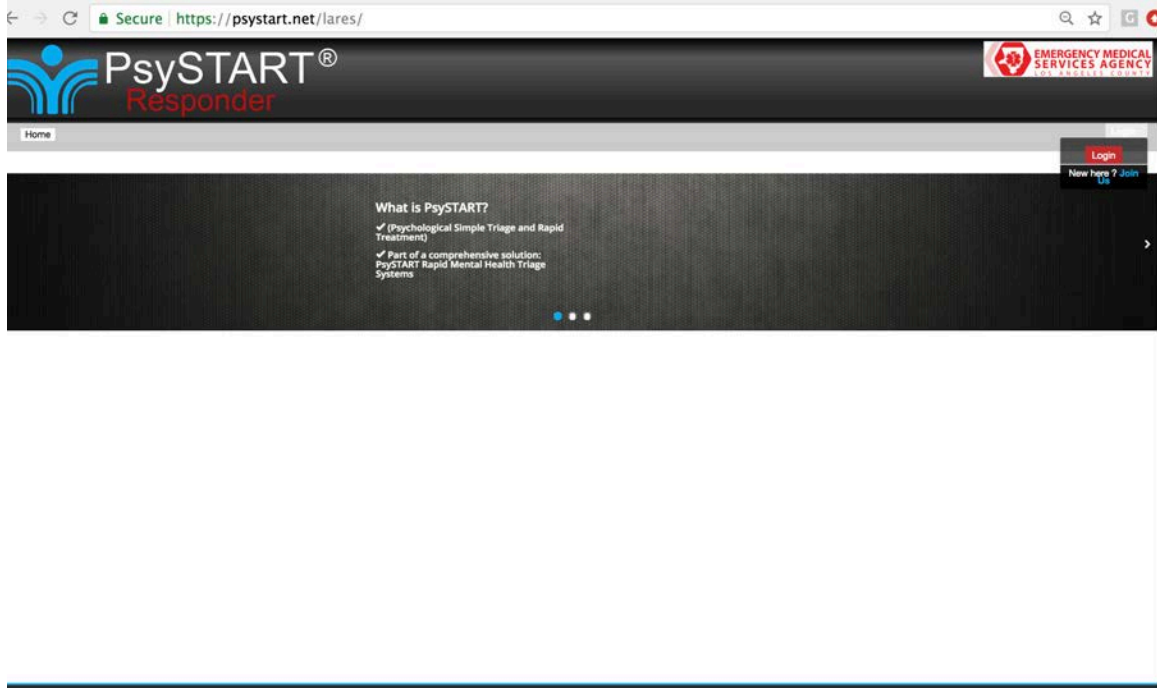
go to the “ add to home screen” feature on iPhone or Android.

This will create a proxy that will allow one touch PsySTART triage from their device and on most devices will allow the password to be saved for rapid self triage option

# Drill down on PsySTART Responder

- Individual triage only available to person that entered
- Incident commander access level can view aggregated, de-identified encounters only
- Incident commander can not view individual encounters ever
- Can use in everyday and emergencies at your discretion
- Frequency is up to you but we recommend every 24 hrs in emergency response and once every 10 days in non emergency mode
- Observe your own trending
- Have your plan ready

## 8 Anticipate Plan Deter: Trainer Guide for LAC EMS



This is your first step to create your confidential PsySTART Self Triage System Account.

This is the create an account landing page.

FIRST, CLICK the RED "LOGIN" BUTTON

THEN click the "blue "JOIN US" button after clicking the LOGIN button.

And follow the registration instructions



Register

Name

E-Mail Address

Gender Male

Date of Birth

Discipline CHAPLAIN/CLERGY

Sponsoring Agency

Primary Location Adventist Health - Glendale

Registration Code

Password

Confirm Password



Enter the information and then push the red submit button  
No personal identifying data is reported.  
De-Identified, aggregated information is restricted to the site level only to authorized users only.  
NO INDIVIDUAL DATA IS AVAILABLE EXCEPT TO THE INDIVIDUAL>>

Secure | <https://psystart.net/lares/login>

**PsySTART® Responder**

Home Login

**Login**

E-Mail Address

Password

☐ Remember Me

Warning: You are accessing a secure information system, which includes this computer, this computer network, and all devices and/or storage media attached to this network or to a computer on this network. This information system is provided solely for official PsySTART, LA-EMS-authorized use only. Federal and State Law prohibit unauthorized use of this portal and unauthorized or improper use of this system may result in disciplinary action, civil and/or criminal penalties and all violations will be reported to the State. By using this information system, you understand and consent to the following: You have no reasonable expectation of privacy regarding any communications transmitted through or data stored on this information system. Registration, log on sessions and all activities are monitored. Any protected health information accessed via this site is subject to existing HIPAA policies. Any communications transmitted through or data stored on this information system may be disclosed or used for any authorized purpose. For further information contact: webmaster@psystartresponder.net

☐ Agree

**Login** [Forgot Your Password?](#)

2019 PsySTART



This is the home screen view of the LAC EMS PsySTART responder self-triage system.

You will be required to enter your password, although the system will remember you username if you wish.

You also need to acknowledge the user agreement each time you log in.

**Although ACCESS to the system is monitored, individual triage information is only available to the individual who creates it.**




PsySTART™ Triage Systems

- 1) You can enter your self triage directly from a laptop or tablet and it will look like this image
- 2) TO ENTER YOUR SELF TRIAGE :
- 3) Select Input My Triage Information
- 4) Follow the instructions and only for those risk factors present, slide the button to the right.
- 5) It will light up either red, yellow or green
- 6) When you have selected all the risk factors you experienced for the date selected, hit the red "submit" button
- 7) If the submit button is blue in color, there are missing elements above.
- 8) When all required information is entered, the button turns red and you can submit your self triage

If the response is "Yes" to any of the statements below, click the button next to it. When the button slides to the right and vibrant color is visible, the statement has been selected.

|   |                          |
|---|--------------------------|
| Did you witness any severe burns, dismemberment, or mutilations? (for example: child with burn to most of his/her body surface)   | <input type="checkbox"/> |
| Were you exposed to patients with prolonged screaming due to pain or fear?  | <input type="checkbox"/> |
| Did you witness any patient death or other severe injuries? (for example: amputation, evisceration, or death of patients who were under your care or under the care of your team)                       | <input type="checkbox"/> |
| Were you asked to perform duties outside of your current skills? (for example: treating adults although you are a pediatrician or doing a major surgical procedure although you are not a surgeon)      | <input type="checkbox"/> |
| Did you experienced any hazardous working conditions? (for example: extreme shift length, compromised site safety/security, or other issues)  | <input type="checkbox"/> |
| Did any serious injury, illness, or death occur among your coworkers?   | <input type="checkbox"/> |
| Were you unable to communicate regularly with your own family or significant others?  | <input type="checkbox"/> |
| Did you feel your life was in danger?   | <input type="checkbox"/> |
| Were you forced to abandon a patient? (for example: leaving a living patient because of unsafe situation or other factors)  | <input type="checkbox"/> |
| Were you directly impacted by the incident at work or at home?  | <input type="checkbox"/> |
| Were you responsible for making expectant triage (triage as black and left to die) decisions? (for example: determining that under existing care/surge circumstances that no emergent care was offered) | <input type="checkbox"/> |
| Were you unable to meet your patients' critical needs at times? (for example: lack of resources such as a drugs, laboratory, imaging, patient surge, or crisis standard of care conditions)             | <input type="checkbox"/> |
| Did you have direct contact with many   | <input type="checkbox"/> |

Once you have created your account, you can log in and enter your PsySTART information a maximum of once a day.

You can also save the PsySTART LAC link to your smart phone and save this link to your home screen. You can then directly enter your self triage

From your smart phone without having to use the laptop or tablet. This is an option for entering your self triage information...

This is the date entry box. You can enter your PsySTART info for up to 4 weeks prior to the current date.

This is a screen shot of a completed self-triage encounter in the last 24-hour period. In this period, two risk factors were present:

- 1) Exposed to patient(s) with **prolonged** screaming due to pain or fear (and unable to mitigate)
- 2) Asked to perform duties outside of your current skills

Note that only is required if the risk factor was present in the current triage period: "No" is not required for each risk factor.

***If no risk factor was experienced, check the "no triage factors" or (green) slider at the very bottom of the input triage page...***

***It is important to indicate that you had no triage factors present because this provides you with your baseline of risk factor exposure and provides de-identified situational awareness for the whole unit on unit resilience and risk that is based on risk factors and resilience factors.***

|   |     |
|---|-----|
| Did you experienced any hazardous working conditions? (for example: extreme shift length, compromised site safety/security, or other issues)  |     |
| Did any serious injury, illness, or death occur among your coworkers?   | Yes |
| Were you unable to communicate regularly with your own family or significant others?  |     |
| Did you feel your life was in danger?   |     |
| Were you forced to abandon a patient? (for example: leaving a living patient because of unsafe situation or other factors)  |     |
| Were you directly impacted by the incident at work or at home?  |     |
| Were you responsible for making expectant triage (triage as black and left to die) decisions? (for example: determining that under existing care/surge circumstances that no emergent care was offered) |     |
| Were you unable to meet your patients' critical needs at times? (for example: lack of resources such as a drugs, laboratory, imaging, patient surge, or crisis standard of care conditions)             |     |
| Did you have direct contact with many grieving family members?  |     |
| Did you have concerns about the safety or well-being of your own family members, significant others, or pets while you were deployed?   |     |
| Did you experience any serious injury or illnesses as a result of your deployment?  | Yes |
| Did you witness pediatric deaths or severe injuries?  |     |
| Did you witness an unusually high number of deaths?   |     |
| Were you unable to return home following your shift?  |     |
| Do(did) you have health concerns for self due to possible agent/toxic exposure(biological, chemical, radiological/nuclear)?   |     |
| I am not receiving sufficient support from others   |     |
| No triage factors   |     |

**EMERGENCY MEDICAL SERVICES AGENCY**  
 LOS ANGELES COUNTY

[Back](#)
[PDF](#)

**PsySTART™ Triage Systems**

This is a screen shot of a completed self triage encounter, which has 2 “yes” risk factors present. These were serious injury, illness or death of co-worker and you experienced injury or illness at work.

“No” is not indicated it is left blank. If the no risk factors at all were experienced, check “ no triage factors identified”(green)

If you wish to make a PDF version of your triage information for your own use or to share with those whoever you choose: Push the red “PDF” button,

This will automatically download a PDF of your triage information to your device.  
**NO ONE ELSE CAN SEE YOUR TRIAGE ENCOUNTER UNLESS YOU SHARE IT WITH THEM...**



**PsySTART® Responder**

**EMERGENCY MEDICAL SERVICES AGENCY**  
LOS ANGELES COUNTY

Incident Name: Default incident

Date: 2019-04-03 Case ID: 825

DOB: 2017-12-31 Gender: male

DID YOU WITNESS ANY SEVERE BURNS, DISMEMBERMENT, OR MUTILATIONS? (FOR EXAMPLE: CHILD WITH BURN TO MOST OF HIS/HER BODY SURFACE)

WERE YOU EXPOSED TO PATIENTS WITH PROLONGED SCREAMING DUE TO PAIN OR FEAR?

DID YOU WITNESS ANY PATIENT DEATH OR OTHER SEVERE INJURIES? (FOR EXAMPLE: AMPUTATION, EVISCERATION, OR DEATH OF PATIENTS WHO WERE UNDER YOUR CARE OR UNDER THE CARE OF YOUR TEAM)

WERE YOU ASKED TO PERFORM DUTIES OUTSIDE OF YOUR CURRENT SKILLS? (FOR EXAMPLE: TREATING ADULTS ALTHOUGH YOU ARE A PEDIATRICIAN OR DOING A MAJOR SURGICAL PROCEDURE ALTHOUGH YOU ARE NOT A SURGEON)

DID YOU EXPERIENCE ANY HAZARDOUS WORKING CONDITIONS? (FOR EXAMPLE: EXTREME SHIFT LENGTH, COMPROMISED SITE SAFETY/SECURITY, OR OTHER ISSUES)

DID ANY SERIOUS INJURY, ILLNESS, OR DEATH OCCUR AMONG YOUR COWORKERS?

WERE YOU UNABLE TO COMMUNICATE REGULARLY WITH YOUR OWN FAMILY OR SIGNIFICANT OTHERS?

DID YOU FEEL YOUR LIFE WAS IN DANGER?

WERE YOU FORCED TO ABANDON A PATIENT? (FOR EXAMPLE: LEAVING A LIVING PATIENT BECAUSE OF UNSAFE SITUATION OR OTHER FACTORS)

WERE YOU DIRECTLY IMPACTED BY THE INCIDENT AT WORK OR AT HOME?

WERE YOU RESPONSIBLE FOR MAKING EXPECTANT TRIAGE (TRIAGE AS BLACK AND LEFT TO DIE) DECISIONS? (FOR EXAMPLE: DETERMINING THAT UNDER EXISTING CARE/SURGE CIRCUMSTANCES THAT NO EMERGENT CARE WAS OFFERED)

WERE YOU UNABLE TO MEET YOUR PATIENTS' CRITICAL NEEDS AT TIMES? (FOR EXAMPLE: LACK OF RESOURCES SUCH AS A DRUGS, LABORATORY, IMAGING, PATIENT SURGE, OR CRISIS STANDARD OF CARE CONDITIONS)

DID YOU HAVE DIRECT CONTACT WITH MANY GRIEVING FAMILY MEMBERS?

DID YOU HAVE CONCERNS ABOUT THE SAFETY OR WELL-BEING OF YOUR OWN FAMILY MEMBERS, SIGNIFICANT OTHERS, OR PETS WHILE YOU WERE DEPLOYED?

DID YOU EXPERIENCE ANY SERIOUS INJURY OR ILLNESSES AS A RESULT OF YOUR DEPLOYMENT?

DID YOU WITNESS PEDIATRIC DEATHS OR SEVERE INJURIES?

DID YOU WITNESS AN UNUSUALLY HIGH NUMBER OF DEATHS?

WERE YOU UNABLE TO RETURN HOME FOLLOWING YOUR SHIFT?

DO(DID) YOU HAVE HEALTH CONCERNS FOR SELF DUE TO POSSIBLE AGENT/TOXIC EXPOSURE(BIOLOGICAL, CHEMICAL, RADIOLOGICAL/NUCLEAR)?

I AM NOT RECEIVING SUFFICIENT SUPPORT FROM OTHERS

NO TRIAGE FACTORS

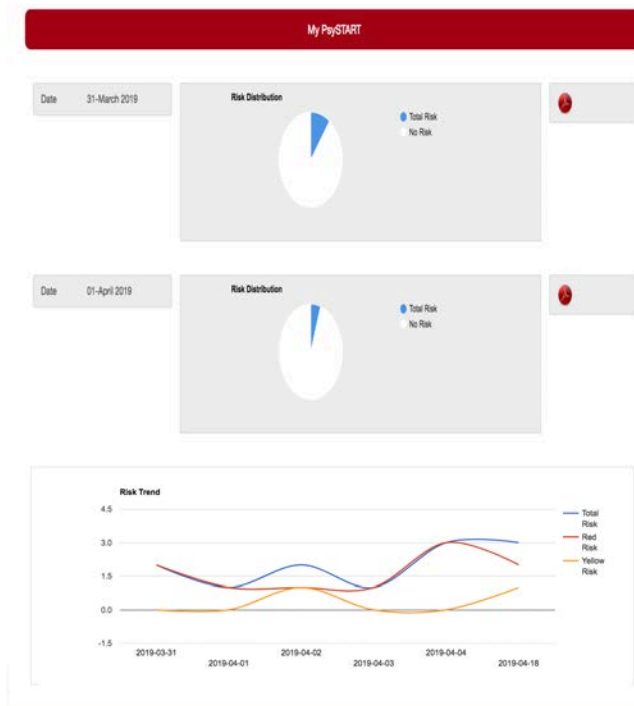
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This is a view of the PDF that you can download. After you enter your self- triage encounter, the system will provide you and ONLY YOU the option to create a pdf of the encounter you just entered only-- on the device you have used to enter it. You can also create the pdf of this encounter late if you wish.

**Note: The individual triage information and the PDF is only available to you**

And unless you decide to share it, no one else can retrieve or see this information at any point.



Using the MyPsySTART Tab:  
This is your cumulative self-triage trending view:

This provides two views: 1) The pie charts your risk for that date. You can also click the pdf button at the far right and create a PDF. 2) The graph at the bottom also shows your risk trending over time: to guide your APD "deter" plan.

\*\*This information and view are only ever available to you

Using the My PsySTART Button function:

By selecting the "My PsySTART" button on your dashboard, you can instantly view and gauge your own stress exposure over time.

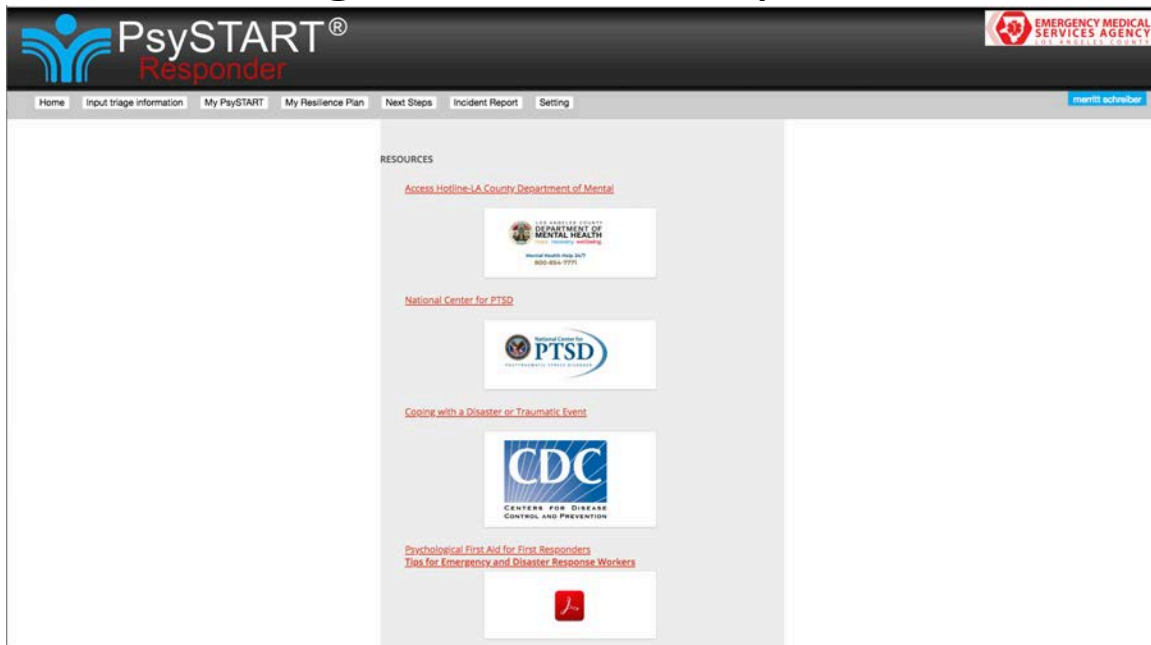
This close up view of a sample triage encounters using the My PsySTART button. It displays a daily "pie" summary of risk factors for each 24 hour period you entered a triage encounter and the bottom shows the trending of red and yellow risk factors over all time points you have used triaged yourself.

On the bottom is a graph. This shows your **triage velocity or the direction of your risk** over time. ACTION STEP:

When the trending is **up and or stable when elevated**, we suggest using your personal resilience plan and consulting with your behavioral health resources to determine any needed "next steps". This does not mean you have a disorder but does mean you may be at risk if you do not act proactively.

By taking steps early on, you can improve your resilience, reduce and perhaps prevent PTSD all together.

## Using the “Next Steps” Tab



If you determine based on you're my PsySTART info or any other concerns you have, you can select "next steps" tab. Several confidential options are available that you can click and be redirected directly to that information and resource.

PLEASE CLICK THROUGH EACH RESOURCE AND DEMONSTRATE THE CONTENT AND POTENTIAL VALUE OF EACH.

THEY ARE VERY DIFFERENT: hot lines vs. internet based interventions.

## How to Use PsySTART R to Monitor Your PTSD Risk:

- Monitor risk factors using the PsySTART R system on a regular basis
- When risk factors occur:
  - Deploy “personal resilience plan” as first line of defense
  - Select positive coping options
  - Use your social support system
  - Consult work setting mental health resources for further problem solving ideas
  - Use PTSD Coach” web intervention
- Expect stress but also resilience and growth over time
- *Try using on a regular basis before disaster occurs at less frequent interval (once every 2 weeks or once a month)*



### Review:

Please MONITOR YOUR DAILY AND CUMULATIVE RISK EXPOSURES ON PSYSTART R.

WHEN YOU DETECT RISK FACTORS, DEPLOY YOUR PERSONAL RESILIENCE PLAN LIKE YOU WOULD DON PPE.

TRY YOUR COPING PLAN IDEAS, SEEK OUT YOUR SOCIAL SUPPORTS AND CONSULT WITH YOUR LOCAL RESOURCES FOR MORE IDEAS OR ASSISTANCE AND USE THE NEXT STEPS TAB FOR OTHER RESOURCES.

TRY THE ONLINE VA PTSD COACH FOR ADDITIONAL IDEAS

YOU CAN HAVE RISK AND STRESS BUT ALSO EXPECT RESILIENCE AND EVEN GROWTH FOR YOUR LIFE SAVING EFFORTS FOR OUR COMMUNITY!

## DETER: WHEN YOU WANT FURTHER ASSISTANCE

- Consider resources in your work setting:
  - Please list those now
- Certain evidence based interventions are recommended when risk factors high and stress does not dissipate
- So what works? :
  - Trauma Focused Interventions
  - Identify concerns and further develop coping tools and strategies
  - PTSD Coach” for distress (not for PTSD) see app resources above)



Know whom to call for additional support such as mental health, spiritual care or Employee Assistance Program resources. In the space below, write the contact information for the person or program in your facility that is responsible for providing mental health support for healthcare workers following disasters:

|    |
|----|
| 1. |
| 2. |
| 3. |
| 4. |

**Listen, Protect, and Connect**

Below are the three steps of “Psychological First Aid” that you can use to provide emotional support to those around you following a disaster. For more information on how to provide Psychological First Aid, download the LPC PFA guide at <http://www.emergencymed.uci.edu/PDF/PFA.pdf>

1. Listen
  - Let those you care about know you are willing to listen and talk about what happened.
  - Make the first move.
  - Take time to talk.
  - Understand silence is OK.
  - Share reactions.
  - Check back often.
2. Protect
  - Help people locate the basics such as shelter, food, community resources.
  - Answer questions about what happened.
  - Support their actions towards recovery.
  - Limit exposure to upsetting sights and noises wherever possible.
  - Encourage healthy behaviors.
  - Develop a safety plan.
3. Connect
  - Providing a sense of support and connection to others is perhaps the most important thing anyone can do after a disaster.
  - Reaching out to family, friends, co-workers and neighbors can help you and those around you “bounce back” from a disaster.
  - Offer to help.

PsychSTART™ Triage Systems



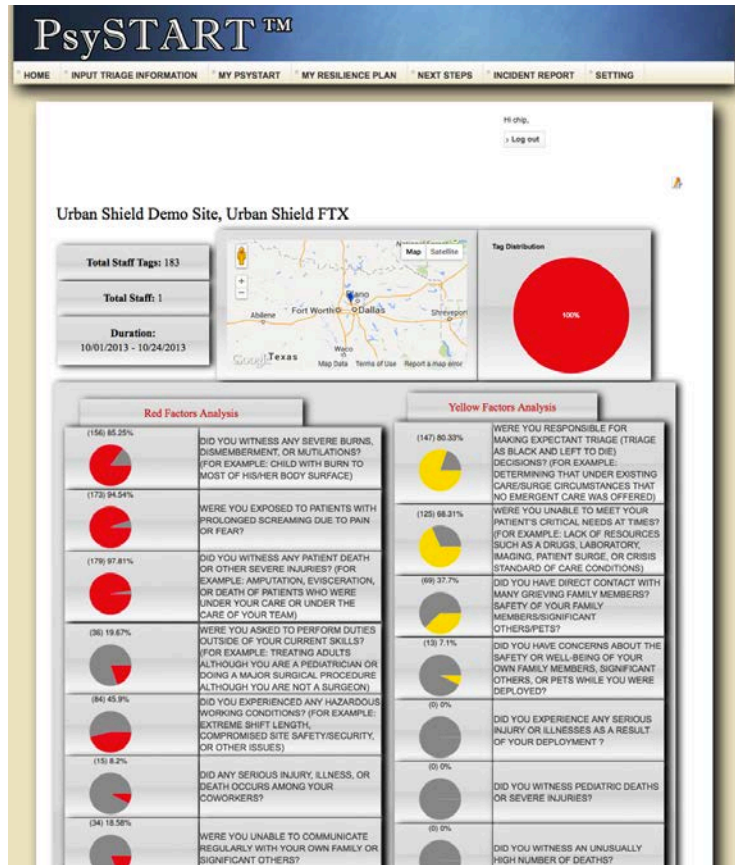
Think now about what resources will be your “goto” resources for next steps  
Sometimes it is useful to identify several different resources ahead of time. Resilient responders tend to have a “Plan B and Plan C” resources already pre-identified..

## BH Team Lead View

SAMPLE Scenario  
from Urban Shield  
2013:  
N=183 EMT,RN

Oakland and Dallas  
Large FTX:  
3 MCI scenario

PsySTART™ Triage Systems



This slide shows the de-identified aggregate view available to LAC EMS and its Operation Center and your own facility. Understanding what the system provides to the PsySTART "Incident Manager":

As we have discussed, the PsySTART Responder System can't share your individual triage encounters with anyone else but it does provide an aggregated report on all triage encounters within a certain date range. It does not provide any name data however at any time.

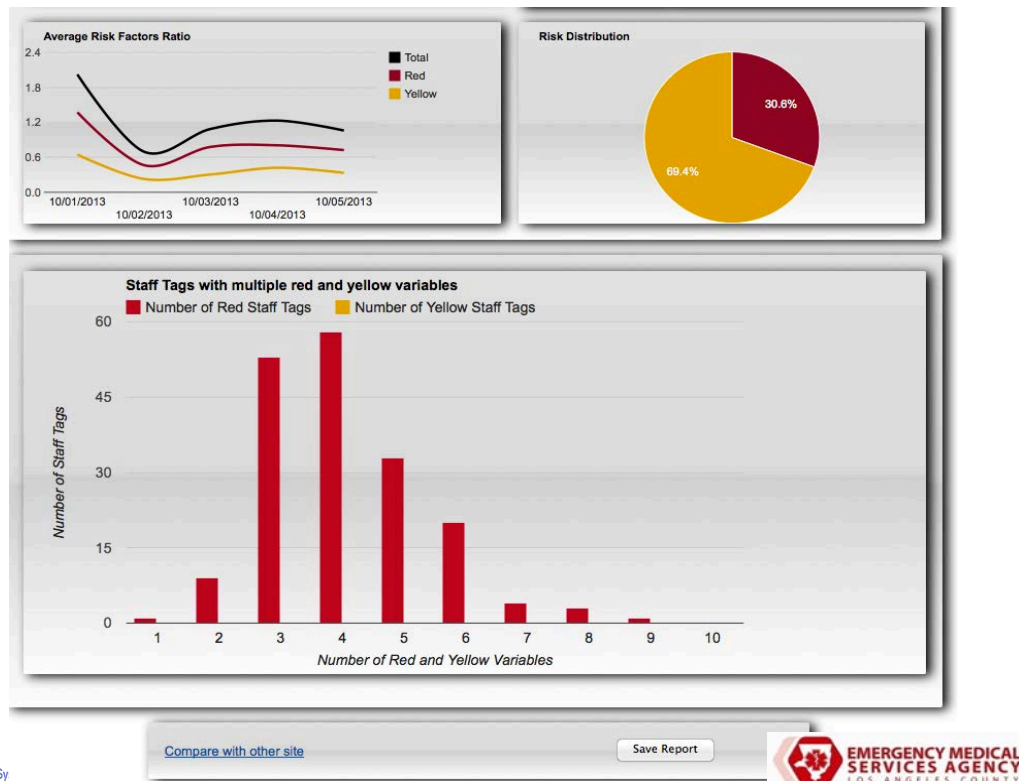
This slide shows exactly what the designated PsySTART Incident Manager can view from their aggregated PsySTART Site Incident Commander View.

Again, no individual self-triage is visible to the incident commander, only the aggregated total view.

This is from a large-scale mass casualty exercise conducted in Alameda County involving three MCI scenarios in the one-day exercise. No personal information is visible or available.



## Health and Wellbeing Unit or Safety View



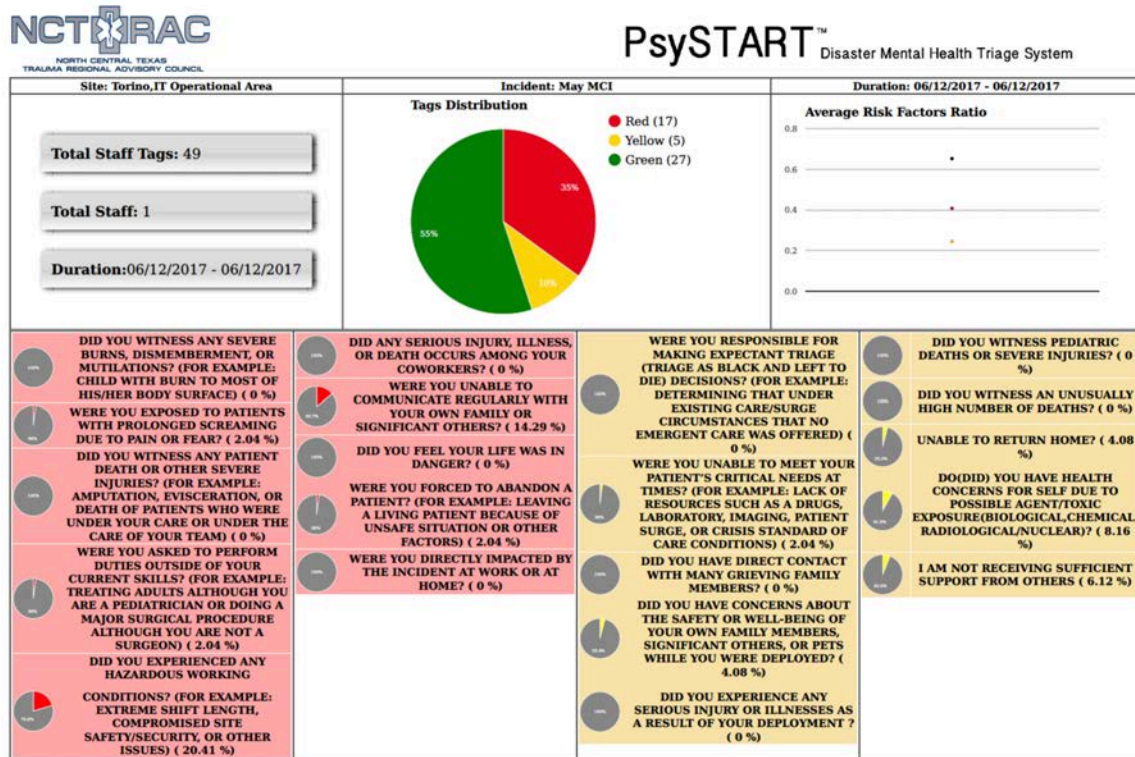
From the same sample incident “Urban Shield”:

This view shows the number of responders with multiple PsySTART risk factors. It **does not** and can not be used to provide information on their identity.

It provides de-identified aggregate information to provide situational awareness to the Incident Commander, Employee Health and Well Being Unit Leader or Employee Health and Safety function as “actionable intelligence” to guide protective actions for the workforce.

This scenario generated moderately high levels of potential responder risk from the combination of three scenarios in a single day.

# 1 Anticipate Plan Deter: Trainer Guide for LAC EMS



This image is from a real world event in Turin Italy that followed a stampede at a large soccer game in Turin. Over 1500 were injured, and one died due to crush injuries. This was triggered by the sound of firecrackers and a false report of an active shooter that was not the case.

One of the larger local hospitals using PsySTART Responder received ~87 patients in the ED in the moments after the event.

The aggregated PsySTART self triage for the entire staff participating at the time of incident is displayed involving 49 staff that completed PsySTART self triage .

What does this aggregated, team level report tell us about the impact of this event on the ED team that day?

DISUCSS:

What risk factors were present?

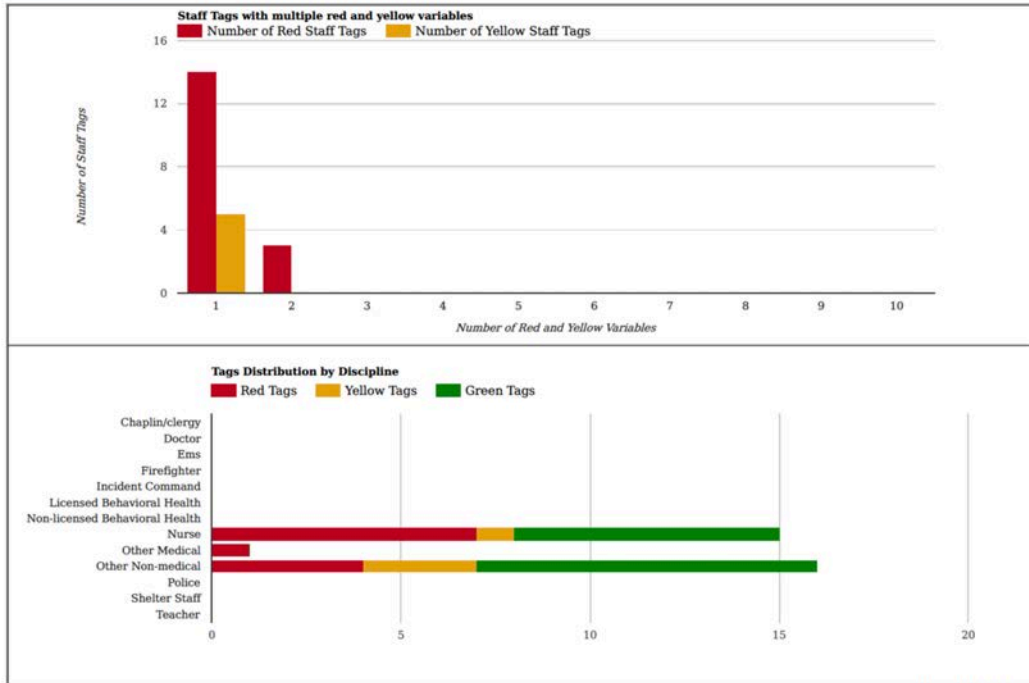
20% of the 49 with “working conditions, extreme shift length, etc.)

14% unable to communicate with their family members

Although the event later turned out to be a “panic” response to loud noises in the sports venue, it was not known if this is was a real active shooter/IED event for an extended period as authorities investigated the scene for sometime before ruling it a false report



## PsySTART™ Disaster Mental Health Triage System



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### Discussion:

What does this report say about the impact on the ED staff at this hospital?

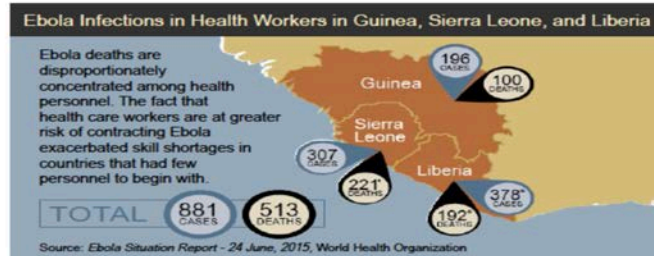
Note that the presumptive cutoff score for PTSD using PsySTART responder is 6 and no single provider in this event had a score greater than 3 well below the presumptive cutoff for PTSD.



This model was used successfully in the US Public Health Service Africa response for Ebola. Information on this is provided as an optional handout...

training, each responder developed an APD personal resilience plan that incorporated the training concepts for a personal strategy, taking into account anticipated stressors and individual coping and resilience resources.

In addition, as part of APD, the officer responders were trained in the PsySTART Responder Self Triage System. PsySTART Responder is a rapid mental health triage tool for disaster or humanitarian missions. PsySTART Responder allowed our officers to triage themselves daily. This empowered the officers to track the presence of their own risk markers and resilience daily and cumulatively across the extended course of the deployment. Over a period of days or weeks of deployment, officers tracked their own trending of risk factors over time. Armed with this information, the officers could elect to employ their "personal resilience plan" developed during our initial training session in Anniston, Alabama, or they could share their daily triage or cumulative triage with the embedded behavioral health providers for additional coping ideas or support. Officers were then empowered by awareness of their own self-triage risk to be proactive and engage their personal resilience plan or seek other support resources in a timely manner. The self-triage information was de-identified of personal information and aggregated automatically using the PsySTART Responder System. Rather than



waiting for risk to become distress and disorder, this approach allowed information to mitigate risk factors trending early, at both the individual and total team levels.

For example, one PsySTART risk factor is "I have a concern about possible chemical, biological, or radiological exposure(s) to myself." Within a 24-hour window, the behavioral health team observed a large spike on this risk factor that had been not present in the team-level (aggregated) daily situational report. The team initially hypothesized a biological exposure, since the officers were working in a high-risk environment with patients who were infected with Ebola. However, further investigation identified that the spike was actually because of concerns over possible chemical exposure from the chlorine used as part of the decontamination process. The behavioral health team shared this information with the command staff and the safety team. As a result, we identified a

health risk to officers that caused concern and stress. We decided to discontinue the use of powder mix, as the concentration levels were inconsistent, and start using a liquid mixing system. We provided health risk information about chlorine exposures and were available for any officers who wanted to talk about their concerns. Within 1 or 2 days, the team-level aggregated PsySTART reports found this risk factor quickly diminished. Using PsySTART for the first time to mitigate real-time risks proved to be effective. Officers could anonymously report a risk factor that could seemingly cause prolonged distress, and the behavioral health team investigated and mitigated the factor. It provided "actionable intelligence" in the form of a concrete risk factor and allowed the behavioral health team to tackle the issue at the "population" level. To our knowledge, the use of the PsySTART Responder System for real-time direct risk factor

The details on the use of APD and PsySTART Responder System with the US Ebola Team is an optional handout in the LACEMS APD materials



# Lets practice PsySTART R





## PsySTART Responder Explosive Device Incident

- In order to better understand how the PsySTART Responder Self-Triage System operates, the following scenario has been developed:
  - The “event” is an explosion in a chemical plant
  - There are numerous injured and dead
  - A number of first responders were injured and killed as well
  - There is concern about release of invisible toxic agents
    - PPE concerns by responders, families and HCF



To further understand how this system operates, a scenario based on a local event in Texas. The scenario is based on real world event in West, Texas involving an explosion with responder stress in clear evidence. The cases are however hypothetical and not related to the actual event..

## Case Vignettes: Case 1

- A single mother brings in her 8 year old, only child, to the ED. He is unresponsive and has severe fragmentation and burn injuries.
  - Due to his condition and the high volume of cases in the ED, it is determined that resuscitation efforts would not be attempted.
  - Despite the mother's anguished pleas, the child is pronounced.

 PsySTART™ Triage Systems

Case 1 is outlined above. After reading through the case, please use the PsySTART Responder Self Triage system to “self triage the risk factors you feel would be indicated for this staff member’s PsySTART Self Triage:

Suggested self triage:

1. **WERE YOU RESPONSIBLE FOR MAKING EXPECTANT TRIAGE (TRIAGE AS BLACK AND LEFT TO DIE) DECISIONS? (FOR EXAMPLE: DETERMINING THAT UNDER EXISTING CARE/SURGE CIRCUMSTANCES THAT NO EMERGENT CARE WAS OFFERED)**
2. **DID YOU WITNESS ANY SEVERE BURNS, DISMEMBERMENT, OR MUTILATIONS? (FOR EXAMPLE: CHILD WITH BURN TO MOST OF HIS/HER BODY SURFACE)**
3. **DID YOU WITNESS PEDIATRIC DEATHS OR SEVERE INJURIES?**
4. **WERE YOU UNABLE TO MEET YOUR PATIENT’S CRITICAL NEEDS AT TIMES? (FOR EXAMPLE: LACK OF RESOURCES SUCH**
5. **AS A DRUGS, LABORATORY, IMAGING, PATIENT SURGE, OR CRISIS STANDARD OF CARE CONDITIONS)**
6. **DID YOU HAVE DIRECT CONTACT WITH MANY GRIEVING FAMILY MEMBERS?**

Suggested Self Triage:

## Case 2

- An 82 year grandmother of 5 is brought in by her family members. She is pale, cool, and diaphoretic and has multiple long bone fractures, an unstable pelvis and multiple abdominal bruises. Her blood pressure is 60 on palpation.
  - Due to her conditions and the high volume of patients in the ED, she is triaged to palliative care only. A staff member informs the accompanying family members of the triage decision.
  - After the administration of minimal pain medication, the patient's blood pressure drops to 50. Despite this, the patient continues to moan in pain loudly.

 PsySTART™ Triage Systems

1. WERE YOU EXPOSED TO PATIENTS WITH PROLONGED SCREAMING DUE TO PAIN OR FEAR?
2. WERE YOU RESPONSIBLE FOR MAKING EXPECTANT TRIAGE (TRIAGE AS BLACK AND LEFT TO DIE) DECISIONS? (FOR EXAMPLE: DETERMINING THAT UNDER EXISTING CARE/SURGE CIRCUMSTANCES THAT NO EMERGENT CARE WAS OFFERED)
3. WERE YOU UNABLE TO MEET YOUR PATIENT'S CRITICAL NEEDS AT TIMES? (FOR EXAMPLE: LACK OF RESOURCES SUCH AS A DRUGS, LABORATORY, IMAGING, PATIENT SURGE, OR CRISIS STANDARD OF CARE CONDITIONS)

## Case 3

- A staff member is at work when the explosion occurs. She learns it is where her significant other
  - There have been no survivors rescued.
  - Fire has broken out in the building and there are not sufficient fire resources to stop it.
  - She is unable to reach sig other by phone or text



### PsySTART Self Triage:

1. **DID YOU HAVE CONCERNS ABOUT THE SAFETY OR WELL-BEING OF YOUR OWN FAMILY MEMBERS, SIGNIFICANT OTHERS, OR PETS WHILE YOU WERE DEPLOYED?**
2. **WERE YOU UNABLE TO COMMUNICATE REGULARLY WITH YOUR OWN FAMILY OR SIGNIFICANT OTHERS?**

## Case 4

- A small community hospital has numerous trauma cases comprised of critically injured and unstable children and adults.
  - As a community hospital, the staff do not have the experience with either the number or severity of pediatric and trauma cases.
  - There are numerous aftershocks and ceiling tiles have fallen, one co-worker is injured.
  - There is a rumor of release of toxic materials from a nearby factory that is “upwind.”



1. WERE YOU ASKED TO PERFORM DUTIES OUTSIDE OF YOUR CURRENT SKILLS? (FOR EXAMPLE: TREATING ADULTS ALTHOUGH YOU ARE A PEDIATRICIAN OR DOING A MAJOR SURGICAL PROCEDURE ALTHOUGH YOU ARE NOT A SURGEON
- 2.

## Implementing PsySTART at your facility

- Determine how MH follow up will be managed at your facility(EAP, MH, Spiritual care, outside referral?)
- Schedule training for line staff and separately for designated psystart incident manager
- Consider integration into daily operations and workflow
- Integrate into exercises



Here are some ideas to move APD and PsySTART can be used at your facility

Review each step with participants and address any questions.  
For questions you are not sure about, contact the PsySTART Coordinator at your facility...



## Thanks for attending today!

- For further information on implementing Anticipate.Plan. Deter with PsySTART Responder contact:

Ami Boonjaluksa 562-378-1643 or  
ABoonjaluksa2@dhs.lacounty.gov

Or Dr. Schreiber at [m.schreiber@ucla.edu](mailto:m.schreiber@ucla.edu)

For PsySTART systems issues, email  
Psystartoperations@gmail.com