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

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Module 2: Training for Clinical, Mental Health, and Non-Clinical Staff   2.1

Module 2 of our three part course focuses on how, as mental health (MH) specialists, you can best integrate your skills and knowledge about psychological reactions so that you can support and intervene at your facility. Your MH team may include other clinical staff such as physicians and nurses and non-clinical staff who may be called on to assist with psychological support.

In our discussion, we use the term "mental health specialists" to include psychiatrists, social workers, licensed marriage and family therapists (LMFTs), psychiatric nurses, psychiatric technicians, psychologists, and employee assistance program (EAP) staff.

All of those in these professions have special skills for addressing the psychological needs resulting from terrorism and other public health emergencies. Your MH team may also include other adjunct staff such as chaplains and "Child Life" professionals or child care specialists.

Even though we designed this module with MH specialists in mind, you may decide that all of your staff, regardless of MH training, would benefit from the additional material, particularly if you do not have sufficient MH professionals at your health care facility.

Three Modular Training Components

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

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

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

Module 2: Training for Clinical, Mental Health, and Non-Clinical Staff 2.2

In Module 1, we reviewed the three different modules.

This module is for clinical staff and non-clinical staff who would be tasked with giving psychological support and intervention during a disaster. The module provides specific evidence-informed strategies for providing psychological support and intervention and describes some cultural issues related to integrating mental health staff into the disaster response.

Purpose of This Course

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

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The purpose of this training is to teach MH staff the necessary skills for integrating their specialized functions into the overall emergency response.

We also want to disseminate evidence-informed practices that MH staff can use to support the patients, their family members, and staff who may need psychological support and intervention.

This module has four specific objectives:

- Explain how to integrate your special expertise to improve the overall emergency response.

- Provide more specific education about psychological triggers.

- Explain how to address psychological triggers through evidence-informed strategies and techniques.

- Introduce you to tools that can be used in real time should a large-scale emergency occur.

Study Team

Los Angeles County Department of Health Services
Emergency Medical Services (EMS) Agency
Sandra Shields, LMFT, CTS
Kay Fruhwirth, RN, MSN

Los Angeles County Department of Public Health
Emergency Preparedness and Response Program
Dickson Diamond, MD
Viktoria Vibhakar, LCSW, LMSW

Los Angeles County Department of Mental Health
Halla Alsabagh, MSW
Barbara Cienfuegos, LCSW
Tony Beliz, PhD
Linda Boyd, RN, MSN

RAND Health
A division of the RAND Corporation
Lisa Meredith, PhD
David Eisenman, MD, MSHS
Terri Tanielian, MA
Stephanie Taylor, PhD
Ricardo Basurto, MS

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The course is the result of a collaboration between Los Angeles County and the RAND Corporation.

The effort was funded by Hospital Preparedness Program grant. This grant is part of a multiyear, nationwide effort to enhance the ability of hospitals and clinics to prepare for and respond to bioterrorism and other public health emergencies.

The County of Los Angeles/Department of Health Services Emergency Medical Services (EMS) Agency is the project lead in coordination with the Hospital Preparedness Program, and the County Department of Public and Mental Health (DMH).

Los Angeles County contracted with RAND to perform this work.

Our discussion today has nine parts.

1. We begin by discussing some of the cultural barriers to involving MH specialists in the overall facility disaster response.

2. We describe some of the MH functions within the hospital and clinic context, focusing on identifying psychological hot spots.

3. We provide additional information about psychological reactions to a large-scale disaster.

4. We review the scientific evidence for recommended early intervention strategies and make some suggestions about using them effectively.

5. We focus in particular on Psychological First Aid (PFA).

6. We consider the unique needs of special populations.

7. We suggest ways that health care workers (HCWs) can avoid burnout.

8. We briefly review guidelines for using some of the patient materials provided in this course.

9. We end with some final thoughts.

Unfortunately, in traditional hospital and clinic cultures, your important skills are not always recognized and appreciated.

- Many hospital and clinic staff believe that they can handle all of the problems in their clinic without additional support. After all, they deal with emergency situations in emergency departments every day. But, they may lack the training needed to address psychological problems resulting from terrorism or other large-scale disasters.

- In addition, although staffing varies across facilities, many facilities have only a single EAP representative or social worker tasked with the MH support and intervention role for everyone. In a high-surge situation, one or two specialists could not handle all of the psychological needs.

To enable MH staff to work in collaboration with medical and emergency staff, your facility needs to have a plan for bringing more MH staff into preparedness planning and response. Notice that there are two silos together now.

Strategies for addressing psychological needs should consider emergency department (ED) priorities and include ways to triage and refer those with such needs away from the ED and to a MH specialist. MH staff will also need strategies for demonstrating how they can make the jobs of medical staff easier.

As you know, the emergency room (ER) is a very busy place. ER staff, whose priority is to rapidly assess and treat patients in the ER, might be concerned about adding "extra" staff to the ER (including MH staff) because this could potentially affect patient flow. Therefore, it is important to work with medical care staff in such a way that you do not disrupt patient flow or management.

It is also important to recognize that working in a disaster is different from the day-to-day style with which MH specialists are familiar. Providing MH care in the context of a large-scale disaster is more like field work than office work.

- For example, psychological support is provided in a single-shot format to rapidly assess and treat patients in the ER rather than in a series of sessions over several months.

- In addition, hospital and clinic terminology may differ from that used by MH professionals.

Functions for MH Staff

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

→ • Functions for MH staff: Identifying "psychological hot spots"

- Psychological reactions to large-scale disasters

- Evidence-informed practices for early intervention: Recommendations for use

- Psychological First Aid: How does it work?

- Special populations: Their unique needs

- Principles of self-care for HCWs: Preventing burnout

- Materials for patients: Guidelines for use

- Final thoughts

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Let's turn our attention to the important functions that MH staff will perform, paying particular attention to identify locations vulnerable to psychological reactions.

One way to think about ways that MH staff can address psychological issues during a disaster is to think about the areas in your hospital or clinic that have the greatest potential for triggering psychological needs.

It is also important to think about which MH functions need to be performed by someone with MH training and which could be assigned to someone without training, perhaps under the supervision of an MH-trained staff member.

Areas Likely to Trigger Psychological Reactions

- Where people **enter and exit** the facility

- Where survivors are **treated**

- Where people **congregate**

- Examples:
    - Emergency department
    - Entrance, front desk
    - Waiting room, discharge area
    - Triage areas
    - Television viewing areas
    - Treatment areas

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In the first module of the course, we identified five psychological triggers: limitations or restrictions on movement, limitations in the availability of resources, exposure to trauma, limitations in the availability of information, and perceived personal or family risk.

Other Areas Vulnerable to Triggers

- Decontamination or isolation areas

- All hospital departments/floors

- Pharmacy or other points of distribution

- Public information/public relations briefing areas

- Hospital or clinic incident command post

- Hospital or clinic telephones

- Staff locker rooms, cafeteria, or wherever staff may go to unwind or take breaks

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Here are some other locations where concerned individuals may gather looking for information, reassurance, resources, or a place to be around others. In a crisis, these locations are also potential sources of psychological triggers.

- People who need to be decontaminated or isolated probably are going to be worried about the process, concerned about being separated from their loved ones, or in the case of decontamination, concerned about being disrobed.

- All hospital floors are vulnerable if staff believe there is not enough personal protective equipment (PPE) or that their safety concerns are not being addressed.

- The pharmacy or other points of distribution are vulnerable if people think resources are insufficient or if they think that resource distribution is inequitable.

- Public information/public relations briefing areas are likely trigger points because there may be crowds of people looking for information.

- The hospital or clinic incident command post is a vulnerable location because staff will be working under stressful circumstances.

- In telephone areas, operators may become overwhelmed or burned out.

- Staff locker rooms, the cafeteria, or wherever staff may congregate to unwind or take breaks are also areas needing attention. These are trigger areas because when staff stop working for a moment, they are likely to think about the disaster and may have MH reactions.

Meeting Needs in Vulnerable Locations: Planning for Staff Placement

In advance of a disaster:

- Pre-identify your facility MH disaster response team

- Determine your areas of need for psychological support

- Determine which locations you want your MH staff to respond to and which other staff ("mental health auxiliary team") could respond to

- Formalize relationships with internal non-MH staff to perform MH functions (e.g., administer PFA)

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It is important to have a plan for where you will place MH staff. You need to create this plan *before* an emergency arises. You can do this by:

- Determining where psychological support will be most needed

- Determining which locations will require the presence of MH staff and which locations could be staffed with other individuals (a "mental health auxiliary team")

- Working to formalize relationships with non-MH staff to perform some MH functions—for example, administering PFA.

Issues to Consider in Placing MH Staff

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

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In the first module, we discussed some of the issues to consider when deciding where to place staff.

You will need several types of areas to accommodate the needs and characteristics of different individuals and groups.

You must also think about the surrounding space and avoid locations that will disturb other facility functions or areas that are not appropriate for use by many individuals in many types of weather.

What is it that the MH staff will do in these locations? Some activities were reviewed in module 1.

These activities include:

- Offering assistance to families of survivors, such as grief or bereavement counseling or other supportive services

- MH Team members can "walk the line" by communicating, assessing for reactions, handing out mental health brochures, telling people they can have someone hold their place in line (if they need to leave for the bathroom)

- MH workers from local agencies can help with strategies for dealing with patients who are disrupting others and can help with preventing disruption (see module 3)

- Conducting rapid MH assessments to identify persons with urgent MH needs and provide psychological support

- Assessing who has nonurgent MH needs and provide psychological support

- Providing care that includes evidence-informed early intervention techniques (to be discussed later)

- Providing reassurance to patients and staff.

Other functions that you and other MH staff could perform are shown on the Hospital Incident Command System (HICS) Mental Health Job Action Sheets which we discuss next, and on the Recommended Actions for Preparing Facilities to Address the Psychological Aspects of Large-Scale Emergencies, which we mentioned in module 1.

As seen in this slide, it is important for MH staff to develop a succinct, brief, and focused way to describe their role in a disaster. A simple and brief approach helps hospital and clinic staff to understand the role of MH during a disaster and increases the likelihood that mental health will be included as a regular part of the disaster response. For example, MH staff might describe their role as "to provide psychological support for patients, families, and staff during and following a disaster."

Here is a copy of part of the first page of the HICS Mental Health Job Action Sheet for the HICS MH Unit Leader (for patients and families) of medical facilities. There is another MH Job Action Sheet for an Employee Health and Well-Being Unit Leader. A single person might be responsible for providing leadership in both of these roles. We have included both sheets in your binder, and next, we will show you some examples of functions that the MH unit leader will fill in the event of a large-scale emergency.

Ensure that staff from both MH HICS positions work together to coordinate the overall MH response in your facility.

The HICS MH unit leaders (for patient/family and staff) might take on the following responsibilities:

- Provide MH guidance about potential triggers of psychological effects

- Communicate and coordinate with the "logistics section chief" to determine staff available to provide psychological support

- Request access to the facility's supply of psychotropic medications (especially antipsychotics and antidepressants) for those who don't have their usual medications or who are requesting a new one

- Participate in developing a plan and strategy for communicating about risk and for public information that addresses MH issues

- Observe patients, staff, and volunteers for signs of stress.

Staff available to fill MH functions include not only trained MH professionals but also nurses, chaplains, and experienced volunteers.

Walking around and taking the time to speak with staff casually are valuable activities for MH professionals.

That is, having casual conversations in the halls, break rooms, etc., may provide better MH support during a disaster than providing one-on-one appointments with specialists.

The more successful MH staff use a non-intrusive approach. If more effort is put into trying to "pitch in and be part of the team" then MH will be more likely to intervene effectively.

MH Support Functions for Non-MH Staff

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

- Untrained staff can update the staff information board

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If properly trained, non-MH staff also could perform roles found on the recommended actions sheet, which is in your binder. These include:

- Providing PFA

- Referring staff and patients to MH specialists if they were directly affected by the disaster (lost a loved one, etc.) or are having more than the expected emotional reaction

- Visiting newly admitted patients to assess the need for MH staff

- Passing out MH "coping" brochures

- Staffing the telephone/computer-based support hotline

Even persons not trained in MH issues can help out. One way is by updating a staff information board. This board could include information such as the current disaster situation and hospital activities, including funeral announcements for staff who were lost.

Psychological Reactions to Large-Scale Disasters

- Integrating MH into the response: Addressing cultural barriers and structural obstacles
- Functions for MH staff: Identifying "psychological hot spots"
- Psychological reactions to large-scale disasters
- Evidence-informed practices for early intervention: Recommendations for use
- Psychological First Aid: How does it work?
- Special populations: Their unique needs
- Principles of self-care for HCWs: Preventing burnout
- Materials for patients: Guidelines for use
- Final thoughts

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What kinds of psychological reactions should staff expect to see following a large-scale disaster?

Following any disaster, terrorist incident, or public health emergency, it is normal to expect that individuals exposed to the event or involved in responding to it will experience some psychological reactions. Exposure to such events can affect how people feel, how they behave, and how they think.

Thus, when we refer to psychological reactions we include:

- Emotional distress such as crying

- Behavioral responses such as acting out

- Cognitive effects including difficulty concentrating

- Somatic reactions (physical)

- Psychiatric illnesses such as depression or PTSD.

We will discuss each of these domains and provide some examples of the symptoms or typical reactions you might see.

The information in this section can serve as a reminder of expected psychological reactions following disasters. Some, including initial emotional "numbness," may actually help people cope better with the initial losses due to a disaster. This information can also be used as a part of the mental health team's "educational arsenal" to assist patients, families, and staff with understanding typical reactions following a disaster.

Being a survivor of, witness to, or responder to a traumatic event will affect how people feel. Some typical reactions are listed above. For example, people may feel fear and anxiety, depression, or rage. They might feel guilty or view themselves as helpless or out of control.

In disaster MH, the traditional disease model doesn't fit. Instead, a resiliency model is appropriate where many reactions are normal given the disaster situation.

These are all common emotional reactions to disasters. Typical reactions include numbness, loss and grief, and a feeling of "loss of control" over one's usually predictable life circumstances.

Some of the reactions may be positive. For example, courage, mobilization, social connectedness, and increased energy may result.

Behavioral Responses in Adults

- Agitation

- Aggressiveness

- Social or emotional withdrawal and, in turn, changes in relationships

- Heroic behaviors

- Helplessness versus control

- Risk taking or self-medication
    - Smoking
    - Drinking/recreational drugs

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These emotional responses may also be coupled with changes in behaviors, including:

- Agitation

- Aggressiveness

- Changes in relationships due to social or emotional withdrawal

- Heroic behaviors

- Some may react with helplessness, while others may react by trying to take control of the situation

- Maladaptive behavior, including inappropriate coping such as smoking or drinking

Over a longer period of time, exposure to trauma can also lead to violence—including domestic violence.

All of the above are typical behavioral responses in adults. Experienced disaster mental health responders have suggested that the response of "withdrawal and social isolation" with staff and patients is of particular concern. This withdrawal could indicate the possibility that a person is struggling to cope with the disaster, or that they are lacking a functioning social support system that they can rely on for their recovery.

Behavioral Responses in Children

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

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Exposure to traumatic events may lead to slightly different behaviors in children, including:

- Clingy behaviors (upset about being separated from parents or siblings)

- Aggressive or disruptive behaviors

- Defiance or belligerence

- Withdrawal or avoidance

- Regressive behaviors, such as bed-wetting or setbacks in potty training

- Refusal to attend school or day care

- Relationship changes—difficulty getting along with siblings or parents

- Risk taking, such as using drugs or alcohol (teens)

- Reliving the traumatic events, for example through play

- Self-blame, feeling responsible for a loss.

Some of these responses such as withdrawal may suggest a need for greater support while others such as reenacting events by playing them out with toys can be a sign of normal adjustment.

The above are the typical range of reactions with children. Common reactions include clingy and regressive behaviors, as well as the reliving of events through play. Due to children's developmental stage, they may have the perception that they are somehow "to blame" for something that happened in the disaster. Parents and mental health team staff should take special care to communicate with children about the disaster situation and to reassure them that they had nothing to do with what happened.

Following exposure to a traumatic event, individuals may also experience cognitive effects—changes in how they think or perceive information. These changes may include:

- Difficulty concentrating, remembering, or making decisions

- Repeated thoughts or memories

- Recurring dreams or nightmares

- A sense of vulnerability or, in some cases, a sense of invulnerability

- A distorted sense of reality

- Confusion

- Altruism

- Apathy or loss of interest

- Loss of faith.

All of the cognitive effects listed above are typical and expected responses following disasters. Common reactions can include difficulty concentrating, remembering, or making decisions. Mental Health team members can focus psychological intervention efforts on helping people to set disaster priorities and develop plans on how best to manage the many tasks involved in their recovery. Staff should understand that repeated thoughts, memories, dreams, or nightmares about the disaster are also common and are not a sign of "post-traumatic stress disorder." All of these effects will usually resolve in a short time following the acute phase of a disaster. If, however, the effects seem to linger for a longer time, or if they are interfering with an individual's functioning, then a referral should be made to a licensed mental health practitioner for some (usually) brief counseling. Staff can be referred to the Employee Assistance Program (EAP), if your facility has one. Patients without insurance can be referred to a local 24-hour access hotline. In L.A. County, call the Department of Mental Health 24-hour access hotline at: (800) 854-7771.

Somatic Reactons

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

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Following an event, individuals may experience physical or "body" reactions induced by the psychological stress of the disaster or emergency itself. These reactions, which can resemble those related to exposure to a chemical, radiological, or biological incident, may include:

- Increased heart rate or palpitations
- Sweating
- Nausea or vomiting
- Physical weakness
- Difficulty breathing
- Increased startle reflex
- Stomach irritability
- Fatigue
- Changes in appetite
- Headaches.

In a disaster context, such symptoms are referred to as "disaster somatization reactions" (Diamond, Pastor, and McIntosh, 2004). These responses have been studied in other settings, and you may hear them referred to as "multiple unexplained physical symptoms" or "multiple idiopathic symptoms" (see Engel, 2004, and Diamond, Pastor, and McIntosh, 2004). All of the above are typical somatic (physical) effects following a disaster.

It is not uncommon for individuals to experience physical symptoms following a disaster, especially fatigue, headaches, and stomach irritability. These can be caused by exhaustion as well as anxiety. Facility staff must take care to screen people with physical symptoms to rule out a medical cause. Mental health staff must also proactively refer individuals with physical symptoms for medical evaluation if necessary.

For a small proportion of those involved in a terrorist incident or public health emergency, their psychological reactions may be persistent and clinically significant. Some individuals may meet criteria for one or more DSM-IV-defined psychiatric disorders. Please note that a diagnosis of an acute stress disorder (ASD) is only applicable within the first 30 days of trauma exposure, whereas the diagnosis of post-traumatic stress disorder (PTSD) is only applicable after 30 days. Individuals experiencing severe psychological reactions may also meet criteria for major depressive disorder, panic disorder, generalized anxiety disorder, or an adjustment disorder. These other disorders may have been diagnosed prior to the emergency, become exacerbated by, or develop subsequent to the traumatic experience. Whether or not an individual meets criteria for one of these disorders will inform longer term treatment and follow-up, however, in the short term the principles of early intervention remain the same.

Psychological Reactions: Summary

- Expect a range of emotional, cognitive, and behavioral reactions

- These are typical reactions to abnormal events

- Most reactions will resolve naturally with time

- Care must be taken to evaluate severity and functional impairment before diagnosing a disorder

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In summary, we have provided a very brief review of the types of emotional, cognitive, and behavioral reactions that may be seen after a terrorist incident or public health emergency. These reactions may be experienced by those directly affected, as well as by family members, the responder community, and the public more broadly.

These are common reactions to unusual and abnormal events. Most of these feelings or changes will improve over time naturally. Health care professionals and responders will need to take care when evaluating the severity and impairment associated with these reactions so as to not over-pathologize or over-medicalize them.

Evidence-Informed Practices for Early Intervention

- Integrating MH into the response: Addressing cultural barriers and structural obstacles
- Functions for MH staff: Identifying "psychological hot spots"
- Psychological reactions to large-scale disasters
- Evidence-informed practices for early intervention: Recommendations for use
- Psychological First Aid: How does it work?
- Special populations: Their unique needs
- Principles of self-care for HCWs: Preventing burnout
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- Final thoughts

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

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Now that we have discussed potential reactions that individuals may have following a terrorist incident or public health emergency, we turn our attention to what the scientific evidence suggests in the way of early interventions to address these reactions.

Many studies have been conducted to examine the efficacy of early interventions following mass violence, terrorist incidents, and other disasters. Next, we will review the objectives of early intervention and present recommendations based on the available scientific evidence for choosing and implementing early interventions.

You can obtain more details from the report that followed a National Institute of Mental Health (NIMH) workshop on this topic (National Institute of Mental Health, 2002). You may download this report from http://www.nimh.nih.gov/publicat/massviolence.pdf.

Objectives of Early Interventions

- Provide crisis intervention
    - Provide appropriate triage and psychosocial support

- Reduce emotional and mental distress
    - For example, limit the displaying of video footage of the disaster, particularly in public places

- Improve problem solving and enhance positive coping skills

- Facilitate recovery

- Refer as needed to MH professionals

- Provide advocacy

SOURCE: National Institute of Mental Health, 2002.

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MH interventions immediately after a disaster will have several objectives:

- Provide crisis intervention that includes appropriate triaging of medical and MH needs and support for these needs.

- Minimize emotional distress and mental stress—for example, make sure that patients, families, and staff do not view video footage of the disaster, particularly in public places at the hospital or clinic. However, if patients, families, and staff want to view it, consider offering support to them during and following the viewing.

- Improve problem-solving skills and enhance positive coping skills.

- Facilitate recovery by establishing safety and reducing distress.

- Refer those in need of additional help and treatment to MH professionals for follow-up.

- Provide advocacy for individuals in need.

Many different techniques have been used in a variety of settings to accomplish these goals. We will discuss the evidence-informed principles and key components of early intervention (see National Institute of Mental Health, 2002).

The 2001 NIMH consensus conference referred to earlier reviewed and summarized the available evidence on the effectiveness of early interventions following mass violence and other terrorist incidents. The panel identified several key components of early psychological interventions and came to consensus about the optimal and effective use of early interventions.

The panel concluded, based on the available scientific literature that included rigorously controlled studies of efficacy, that:

- Early brief and focused psychotherapeutic interventions can reduce distress.

- Selected cognitive behavioral approaches may help reduce the incidence, duration, and severity of psychiatric illnesses following mass violence or other traumatic events.

- Early intervention in the form of a single one-on-one recital of events (critical incident stress debriefing) does not consistently reduce the risks for PTSD and other adjustment difficulties. In fact, some evidence suggests that it can increase the risk of adjustment difficulties in some populations that might have recovered naturally.

Key Reminders

- Presuming a clinically significant disorder in the early post-phase is inappropriate, except when there is a preexisting condition

- Those exposed should be offered psychoeducational support

- Debriefings should not be conducted for the primary purpose of preventing or reducing mental disorders

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We know from previous research and prior disasters that, in the immediate phase following an incident, many individuals will experience some symptoms of distress. However, we also know that the majority of these individuals will recover naturally—their symptoms will subside over time.

Therefore, presuming clinically significant disorders in the early phase following an incident is inappropriate, except when there is a preexisting condition. Thus, appropriate triage and possible referral for mental health intervention should include assessing for a history of psychological/ psychiatric conditions.

Individuals exposed to a terrorist incident or public health emergency should be offered psychoeducational support; however, participation in any early intervention sessions should be voluntary.

The NIMH consensus panel noted that debriefings should not be conducted or used for the primary purpose of preventing or reducing mental disorders but for education and reassurance. The panel further recommended that the term "debriefing" should be used only to describe the operational debriefing of a situation to those requiring specific information.

Recognize and Address Hierarchy of Needs

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

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Efforts to conduct early MH assessment and intervention should recognize and be conducted within a hierarchy of needs.

Individuals' needs for survival, safety, security, food, shelter, and health (both physical and mental) must be assured before any assessments are conducted or interventions are delivered.

Individuals should be triaged for emergency and MH care, oriented about immediate and available local services, and provided the opportunity to communicate with their family, friends, and community. Once an individual's basic needs for safety, shelter, and survival are assured, individuals may also benefit from other forms of psychological and social support. To this end, we will discuss the principles of Psychological First Aid (PFA) in a few moments.

Interventions are most likely to be helpful when they are tailored to address individual, community, and cultural needs and characteristics.

Key Steps in Early Intervention

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

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

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Let's consider in more detail how to address these needs.

First, assure acute or immediate basic needs, including survival, safety, security, food, and shelter. Then, once the individual is physically safe and secure, PFA can be used to reduce physiological distress and provide reassurance.

The third step involves a more comprehensive assessment. You can use the Provider Worksheets developed for use with PFA and available in this binder (in "Tools"). You will need to assess the current status and needs (including basic needs, medical care, and emotional coping) of individuals and groups, and determine how these needs will be met. Clinical assessments (using valid and reliable methods) should be conducted to identify high-risk individuals, and appropriate MH referrals should be made for those experiencing significant distress and dysfunction.

Appropriate medical treatment should be provided for those in highest need through referral— this may include hospitalization, psychotherapy, and pharmacotherapy.

Several techniques can be used to foster resilience and recovery, including PFA and bolstering natural social support systems. The recovery environment should also be monitored—e.g., observing and listening to those most affected and monitoring the services that are being provided. Flyers, Web sites, and existing community infrastructures can provide further reassurance and information about finding help and support.

Good practice in early intervention also considers the interests of those who have experienced enduring MH problems, people with disabilities, and other high-risk groups who may be vulnerable and less able to cope.

Contact the country 24-hour hotline for information about assessment and referral (800) 854-7771.

Many survivors experience some symptoms in the immediate aftermath of a traumatic event. Symptoms do not necessarily require long-term follow-up; they may eventually disappear on their own.

However, some individuals and groups are at high risk of developing adjustment difficulties following exposure to a terrorist incident or other disaster. They include:

- Those who have ASD or other clinically significant symptoms stemming from the trauma
- The bereaved
- Those who have a preexisting psychiatric disorder and also experiencing current symptoms
- Those who have required medical or surgical attention
- Those whose exposure to the event is known to have been particularly intense and of long duration.

Not all bereaved people will need counseling. Those with prolonged grief that lasts beyond 1 to 2 years, or interferes with life functioning are likely to need some type of mental health follow-up. Refer the bereaved person to their medical/insurance coverage (if they have it) or Employee Assistance Program (for staff). If the person does not have insurance, then refer them to the county 24-hour hotline.

We mentioned the techniques and principles of PFA previously. We are going to provide more detail about applying and using them. We will include information about how to adapt these techniques to particular populations and situations. We have developed tools for using PFA when talking to distressed individuals, and we have also provided a brochure to give parents to help them talk to their children. These and other materials are included in your binder.

About PFA

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

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PFA is an evidence-informed approach to help all kinds of people (including HCWs, kids, etc.) immediately following a terrorist event or other large-scale disaster. It is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping.

Although PFA has not been formally evaluated, it uses techniques informed by evidence from use in previous disasters. It is by far the most promising approach to supporting those experiencing psychological reactions to terrorist events and other types of public health disasters.

The principles and techniques of PFA are:

- Consistent with research evidence on risk and resilience following trauma

- Applicable and practical in field settings

- Appropriate for development levels across the lifespan

- Culturally informed and delivered in a flexible manner.

PFA does not assume that all survivors will develop severe MH problems or long-term difficulties. Instead, it is based on an understanding that disaster survivors and others affected by such events will experience a broad range of early reactions, including physical, psychological, behavioral, and spiritual reactions. Some reactions will cause enough distress to interfere with adaptive coping, and recovery may be helped by support from compassionate and caring disaster responders.

PFA intervention strategies are intended for use with a wide variety of people, including children, adolescents, parents/caretakers, families, and adults exposed to disaster or terrorism. PFA can also be provided to first responders or other disaster relief workers.

These intervention strategies can be delivered by MH professionals and other disaster response workers and even lay people if properly trained who provide early assistance to affected individuals as part of an organized disaster response effort. Providers may be part of many different response units, including incident command systems, primary and emergency health care, school crisis response teams, faith-based organizations, community emergency response teams, the Medical Reserve Corps, the Citizens Corps, and other disaster relief organizations.

See the NCTSN/NCPTSD web site for information on PFA training: www.ncptsd.va.gov. The PFA Field Guide can be downloaded from the website.

In the context of a public health emergency, PFA has several important strengths:

- It includes basic information-gathering techniques to help providers make rapid assessments of survivors' immediate concerns and needs and implement supportive activities in a flexible manner.

- It relies on field-tested, evidence-informed strategies that can be provided in a variety of disaster settings (including hospitals and clinics).

- It emphasizes developmentally and culturally appropriate interventions for survivors of various ages and backgrounds.

- It includes handouts that provide important information for youth, adults, and families to use over the course of recovery.

While our training has focused on the NCTSN and NCPTSD version of PFA, there are several versions of this approach—including those for use by lay individuals, available through other organizations including the American Red Cross, the Center for the Study of Traumatic Stress, and the Ready.Gov campaign.

PFA provides help during the days or weeks following an event. Providers should be flexible and tailor the amount of time they spend with survivors on each PFA component depending on the specific needs and concerns. The following are the components:

- Contact and engagement: respond to contacts initiated by survivors or initiate contacts in a nonintrusive, compassionate, and helpful manner.

- Safety and comfort: enhance immediate and ongoing safety and provide physical and emotional comfort.

- Stabilization: calm and orient emotionally overwhelmed or disoriented survivors.

- Information gathering: identify immediate needs and concerns, gather additional information, and tailor PFA interventions.

- Practical assistance: offer practical help to survivors in addressing immediate needs and concerns.

- Connection with social support: help establish contacts with primary sources of support, including family members, friends, and community resources.

- Information on coping: provide information about stress reactions and coping to reduce distress and promote functioning.

- Linkage with collaborative services: link survivors with available services.

Let's consider each component in more detail.

Contact with a survivor should be initiated respectfully and compassionately. This contact will enable you to establish an effective helping relationship and increase the person's receptiveness.

Your first priority should be to help those who are seeking help. If many approach you at the same time, make contact with as many as you can. Even a brief look of interest and calm concern can be grounding and helpful to people who are feeling overwhelmed or confused.

Be mindful of different cultural norms and social customs. Some people may be uncomfortable with intense eye contact, closeness, or touch. If you are not sure, then avoid approaching too closely. Identify the "family spokesperson," who is the best person to approach initially.

The example above provides an appropriate approach. Introduce yourself with your name and title and describe what you will be doing to help. Be sure to ask permission and use last names. Then find out what the most pressing problem is and focus on that.

If you speak with a child in distress when no parent or adult caregiver is present, find them as quickly as possible to tell them about your conversation with their child.

Take care to protect the confidentiality of all your interactions. In settings following a disaster, it may be difficult to find a private place to talk, so do your best to talk quietly and abide by the privacy requirements of the Health Insurance Portability and Accountability Act.

2. Safety and Comfort

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

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

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

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To restore survivors' sense of safety and comfort in the immediate aftermath of a disaster:

- Help reorient and comfort survivors by providing information about what to do next, what is being done to assist them, and what is currently known. Reassure people about safety only if you have definite current factual information. If you do not have all of the information, reassure them that every effort is being taken to help them.

- Make sure that the immediate physical environment is organized to make survivors feel safe and comfortable:
  - Ask about physical needs—make sure they have their glasses, hearing aids, medications, etc.—and make sure that special populations are checked often; make sure authorities know of any daily needs that are not being met.
  - Contact relatives, and help survivors who have missing or dead family members.
  - Adjust the temperature, lighting, air quality, and access to furniture and how it is arranged.
  - If there are enough toys for all children, distribute them.

- Facilitate group and social interactions, by connecting individuals with practical and available resources and others who can share similar experiences.

- Protect survivors from additional traumatic experiences and trauma reminders (minimize media viewing):
  - Attend to children who are separated from their parents/caregivers; create a child-friendly space.
  - If a person looks like they may hurt themselves or others, seek immediate support from medical or security staff.
  - If someone shows signs of shock (pale, clammy skin; weak or rapid pulse; dizziness; irregular breathing; dull or glassy eyes; unresponsiveness to communication; lack of bladder or bowel control; restlessness; agitation; or confusion), seek immediate medical support.

3. Stabilization (if needed)

Goal: Calm overwhelmed or distraught survivors

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

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

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Most survivors will not require stabilization. Both strong and muted emotions—such as numbness and confusion—are normal, healthy responses to a disaster. However, extremely high arousal, unresponsiveness, disorientation, or extreme anxiety can interfere with sleeping, eating, decisionmaking, parenting, and other life tasks. Therefore, PFA providers may need to stabilize individuals who are:

- Alone (without family or friends), comfort them in a quiet place (or speak quietly for privacy).
- Re-experiencing the event (e.g., a flashback or panic) and address their primary concern or difficulty rather than simply trying to convince them to "calm down."

For children: If a parent is present, help empower parents to calm their children. Be sure not to undermine their authority or ability to handle the situation. If children are separated from their parents or parents are not coping well, say something like, "Would you like me to sit with you until Mom or Dad gets back?"

Suggest some "grounding" activities to keep survivors busy and calm (e.g., suggest that they sit in a comfortable position; breathe in and out slowly and deeply; and name five soothing objects, sounds, and feelings).

Remember to respect privacy; give time as needed; remain calm, quiet, and present; stand close by as you talk with survivors to keep an eye out for those needing time to calm down; offer support; and give information that helps orient them to their surroundings.

Be aware that trauma exposure could worsen preexisting conditions, and gather information that will help with referrals to a physician, e.g., for medications.

4. Information Gathering

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

• Identify individuals who need immediate referral

• Identify need for additional services

• Identify those who might need a follow-up visit

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

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When you are gathering information on current needs and concerns:

- Be flexible so that you can adapt interventions to particular needs and concerns.

- Gather enough information so that you can tailor and prioritize interventions to meet those needs.

- Although a formal psychological assessment is not appropriate, you may ask about need for immediate referral for MH or other services or offer a follow-up meeting (for those who have witnessed death and destruction, are injured, are contaminated, need decontamination, are separated from family members, have lost loved ones, have lost their houses, have acute ASD).

- If useful, ask some questions to clarify the nature and severity of experiences during the disaster (see the tips for providing PFA, which are included in your binder).

- **Provider Alert:** In clarifying disaster-related traumatic experiences, avoid asking for in-depth descriptions because this may provoke additional distress. Follow the survivor's lead in discussing what happened. Don't press survivors to disclose details of any trauma or loss. However, if they are anxious to talk about their experiences, politely and respectfully tell them that what would be most helpful now is to get some *basic* information so that you can help with their current needs, and plan for future care. Let them know that the opportunity to discuss their experiences in a proper setting can be arranged at a later time.

5. Practical Assistance

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

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

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

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Giving people needed resources can increase their hope and sense of empowerment. Exposure to disasters is often accompanied by loss of hope. Survivors who maintain positive attitudes, such as those listed below, are likely to have more favorable outcomes:

- Optimism or hope for the future
- Confidence that life is predictable
- Belief that things will work out as well as can reasonably be expected
- Belief that outside entities (e.g., government) act benevolently on one's behalf
- Strong faith-based beliefs
- Positive beliefs (e.g., "I believe things will get better")
- Practical provisions, including housing, employment, financial resources.

Follow these principles in offering practical assistance.

6. Connection with Social Support

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

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

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

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Social support facilitates emotional well-being and recovery following disasters. Fostering connections (with family, significant others, friends, and community resources) as soon as possible and helping survivors to develop and maintain social connections will be critical to recovery. If people are disconnected from their social support network, encourage them to make use of available sources and social support (i.e., yourself and other relief workers).

When working with children, bring those of similar age together in shared activities (provide art materials or coloring books, play tic-tac-toe, sing, etc.).

Use strategies to "model" support using reflective and clarifying comments such as "It sounds like you are saying . . ." or "Am I right when you say that you . . . ?"

If survivors are reluctant to seek support, let them know it is ok if they do not feel like talking, but stress how important it is for them to ask for what they need.

**Types of Social Support
You Can Provide**

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

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You can provide or suggest the following types of support:

- Emotional support (listening, showing acceptance, giving hugs, but be sensitive to cultural norms when considering hugging)

- Social connection (encouraging the person to connect and share with others)

- Help person feel needed (communicating importance, value, usefulness to others)

- Reassurance or self-worth (helping people have confidence)

- Reliable support (letting the person know that they can rely on others to help)

- Advice and information (giving advice)

- Physical assistance (helping carry or fix things)

- Material assistance (giving things like food, clothing, etc.).

To help survivors manage their stress and deal more effectively with problems:

- Briefly discuss common distress reactions—avoid "pathologizing" responses; do not use such terms as "symptoms" or "disorder."

- For those with significant exposure to trauma and sustained and significant losses, in addition to providing basic education about common distress reactions, emphasize that reactions are expected but tell survivors that if reactions interfere with functioning for longer than a month, they should consider psychological services.

- When working with *children:*
    - Do not ask them to describe their emotions but instead ask them to tell you about physical sensations—"How do you feel inside? Do you feel something like butterflies in your stomach or tight all over?"
    - If they are not able to talk about their emotions, suggest different feelings and ask them to pick one—"Do you feel sad right now, or scared, or do you feel okay?"
    - Consider drawing the outline of a person (or have the child draw it) and use it to help elicit physical sensations.

- Suggest things that survivors, including families, can do to cope (see the tips brochures included in your binder).

- Identify with developmental milestones. In the aftermath of a disaster, identify whether any of these processes have been interrupted—e.g., toddler toilet training.

- Suggest ways to help manage anger (take time-outs), address highly negative emotions such as guilt or shame, help with sleep problems (relaxation), address alcohol/substance abuse.

8. Linkage with Collaborative Services

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

Provide direct referrals to additional services

• County mental health services or those through private insurance

• Medical services

• Red Cross and FEMA, as appropriate

• For children and adolescents (referrals require parental consent)

• For older adults

– Primary care physician, local senior center, meals, senior housing/assisted living, transportation services

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

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Refer survivors to needed services and reconnect them with agencies that provided services to them before the disaster.

When making a referral:

• Summarize your discussion about his or her needs and concerns.

• Check the accuracy of your summary.

• Describe the referral option, how it may help, and what to expect.

• Ask about the survivor's reaction to the suggested referral.

• Provide written referral information, or make an appointment on the spot.

For *children and adolescents:* Remember that they will need parental consent for services beyond emergency care. Teens may be less likely to self-refer and have difficulty following through with a referral.

• Recommend a brief evaluation of the child or teen to the family.

• Make interactions with youth positive and supportive so they will have a positive attitude toward future providers.

• Because youth have trouble telling and retelling information about traumatic experiences, write down basic information about the event for the referring provider.

For *older adults:* Make sure they have their tangible needs met, such as getting meals, transportation, medications and assisted living.

Addressing the MH Needs of Special Populations

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

- Functions for MH staff: Identifying "psychological hot spots"

- Psychological reactions to large-scale disasters

- Evidence-informed practices for early intervention: Recommendations for use

- Psychological First Aid: How does it work?

- Special populations: Their unique needs

- Principles of self-care for HCWs: Preventing burnout

- Materials for patients: Guidelines for use

- Final thoughts

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Next, we will discuss how to address the MH needs of special populations.

Special Populations

- Children

- The elderly

- People with physical and developmental disabilities

- The severely and persistently mentally ill (SMI)

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Special populations include children, the elderly, persons with physical and developmental disabilities, and the severely and persistently mentally ill (SMI). We'll use this acronym, SMI, in the next several slides. The SMI may include individuals with previously diagnosed bipolar disorder, major depressive disorder, or schizophrenia. These populations may have a more limited capacity for coping with stressful situations and thus warrant special consideration.

In module 1, we described the five types of triggers of psychological response. Remember what these are so that you can see how they affect different groups of people.

We are going to review the needs of each of these groups by using the same framework—the five possible psychological triggers.

Let's first review addressing the needs of people whose movement is restricted, as in the case of isolation or quarantine, for example.

- Children should have access to parents or caretakers while in isolation or quarantine. Minimize separations from parents and adults who they trust.
  - If unaccompanied, they should have access to "Child Life" professionals or child care specialists while in isolation, decontamination, and quarantine areas.
  - Try to provide games, books, or similar items to keep them busy.
- The elderly may need visits to their homes by trained health aids or other professionals, especially if they are sheltered in place and unable to go out for care or basic needs.
- Physically disabled persons will require access to their special equipment while in isolation or quarantine.
  - Your decontamination areas should be wheelchair accessible.
  - If someone is hard of hearing, get an interpreter. If there is no interpreter available, get a pen and paper and ask them if they need assistance and if so, what?
  - If someone is blind, ask them how you can be of assistance. Find out what their needs are.

The SMI should have access to MH staff while in isolation, quarantine, and decontamination areas.

Children, the elderly, and the physically disabled may all need help in evacuations.

Think about what happened during the Katrina evacuation. Clearly, evacuations can be tough situations for all, but imagine how difficult it might be for someone with SMI.

Needs Resulting from Limited Resources: Special Populations

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

- Children and the physically disabled—personal protective equipment may not fit

- The SMI may have reduced ability to cope with disruptions in care

- Children and the SMI may respond more strongly to triggers, so they may require more resources

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Now we turn to addressing the needs of special groups when resources are limited. By limited resources, we mean that access to resources is actually or perceived to be limited or restricted. For example:

- Personal protective equipment may not fit children or persons with disabilities.

- SMI persons may have a reduced capacity for coping with disruptions in care.

- Finally, children and SMI persons may respond more strongly to triggers, and so they may require more resources.

Needs Resulting from Trauma Exposure: Special Populations

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

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

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Now we turn to the needs of special groups who have witnessed or been a survivor of a traumatic event.

- Children may
    - exhibit distress differently from adults
    - be less able to understand *abstract* concepts such as death
    - be less able to communicate about their trauma exposure
    - have fewer positive coping skills.

- Children and SMI persons may respond strongly to the trauma exposure.

- Address this by establishing as much routine as possible and limit exposure to gruesome images and media coverage.

- The elderly may feel ashamed about discussing their reactions to trauma exposure or receiving psychological services. Also, remember that the elderly may have already acquired effective coping skills. Do not underestimate their ability to withstand adversity. Empower them as much as possible.

Needs Resulting from Limited Information: Special Populations

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

- Children—Assign one consistent person to supervise and accompany these children

- The elderly and the SMI—May not understand the standard information provided; staff should be available to explain and supplement it

- The physically disabled—treat the same as anyone else. Accommodate for communication and access to services when needed.

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

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Some groups may have special needs when information is limited. (Limited information means that there is actual or perceived lack of information about risks, potential consequences, and what to do.)

- Staff should be available to talk about the disaster or treatment to children. If possible assign one consistent person to stay with unaccompanied children. Staff also should be available to help unaccompanied children.

- The elderly and SMI persons may not comprehend standard information provided; thus, make staff available for individual attention.

- The physically disabled should be treated the same as anyone else. The only difference is the way you communicate with those who are blind or deaf (e.g., through an interpreter or in writing) and those who are immobile will require assistance with getting around (e.g., help evacuating). This population may be extra vulnerable due to their disability and the lack of information they have. Give them the same information as you would anyone else.

Remember—Handouts for MH staff to use directly or to give to parents to use are available in your binder.

Needs Resulting from Perceived Risk: Special Populations

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

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

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Special groups may have specific needs when they are trying to cope with perceived risk. By perceived risk, we mean that they fear or are concerned about their own safety and well-being or the safety and well-being of their loved ones. For example, children may be more afraid than others and will worry about the safety of their parents. Their parents will be concerned if they are separated from them. The cognitive impairment of SMI individuals could "mask" actual risk and fear.

Culturally Relevant Services

Some cultural minorities may

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

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Finally, we want to talk briefly about the importance of maintaining cultural relevance while responding to psychological needs. For example, some cultural minorities may not want to discuss their trauma with hospital staff because:

- they mistrust health authorities

- they feel ashamed of receiving *psychological* care

Not everyone who wants spiritual counseling will want to speak to a priest or minister. Some may want to speak to a spiritual care giver from their own community. For example, persons from Central or South American countries may want to speak to a curandera, or traditional healer.

Immigrants who have experienced major disasters in their countries of origin respond more strongly to triggers resulting from a current disaster and so may require more resources.

Individuals who do not speak English should have access to translators in isolation, quarantine, and decontamination areas.

If possible, try to find others who may be perceived as more trustworthy and can communicate in ways that are culturally relevant.

Principles of Self-Care

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

- Functions for MH staff: Identifying "psychological hot spots"

- Psychological reactions to large-scale disasters

- Evidence-informed practices for early intervention: Recommendations for use

- Psychological First Aid: How does it work?

- Special populations: Their unique needs

→ • Principles of self-care for HCWs: Preventing burnout

- Materials for patients: Guidelines for use

- Final thoughts

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In the first module of this course, we noted that during the SARS event, HCWs had to function in a greatly changed hospital environment, in which fear, anxiety, isolation, and stigmatization challenged staff and management alike. We remarked that it was no wonder so many HCWs felt depressed and psychologically distressed and that so many reported post-traumatic symptoms, burnout at work, increased use of substances, and missed work days.

In this module, we will devote time to discussing burnout and how staff and management can mitigate and prevent it.

Occupational stress can lead to burnout, severe distress, or psychological problems. Burnout, as we will use the term, is a specific form of psychological distress (not a diagnosis). It has been defined as the "persistent, negative, work-related state of mind in 'normal' individuals that is primarily characterized by exhaustion, which is accompanied by distress, a sense of reduced effectiveness, decreased motivation, and the development of dysfunctional attitudes and behaviors at work. This psychological condition develops gradually and may remain unnoticed for a long time for the individual involved" (Schaufeli and Buunk, 2003, p. 388).

Self-care is the proverbial "ounce of prevention." We will discuss the many practices and behaviors you can use to help prevent, or at least mitigate, burnout.

Managers and administrators have a critical role to play in preventing burnout. If they perform their role effectively, they can mitigate psychological consequences of the disaster among staff.

In some sense, burnout is an imbalance between supply (of job skills; resources; support; perhaps, healthy coping skills) and demand (increasing workload, emotional response to suffering and dying patients, and organizational problems and conflicts).

Burnout occurs when

- Staff are stressed and overburdened at work and outside work (e.g., at home or socially)

- Staff perceive that support and resources at work are inadequate.

After the SARS crisis, rates of distress and burnout of 10–30 percent were reported.

Let's first talk about demand.

Lessons from the SARS crisis help explain the "demand" side of burnout (see Maunder et al., 2003 and 2006; Maunder, 2004). HCWs experienced:

- *Changes in workload and overtime:* For example, managers reported difficulty going home at the end of the day because of a sense of responsibility to their staff; HCWs who normally worked part time at more than one institution were not allowed to do so and faced financial stress as a result.

- *Unfamiliar work:* For example, being assigned to unfamiliar tasks was stressful for some HCWs, such as nonclinical staff who were assigned to screening duties.

- *Greater conflict at work:* For example, in some hospitals, staff had conflicts with administration about whether HCWs could choose not to work in SARS treatment areas and whether providing direct care to SARS patients would merit "hazard pay."

- *Social isolation or stigmatization:* For example, HCWs were instructed to avoid unnecessary contact with each other (to sit several feet apart from each other in the cafeteria), socializing with each other outside of the hospital, or meeting with several people inside the hospital. They felt that people were avoiding them or their families outside of the hospital, including canceling appointments and social events (the SARS epidemic overlapped with the Easter/Passover holidays, which created tensions with families). This was exacerbated because the media made HCWs suspect—reports vilified a nurse for potentially spreading SARS because she rode the subway in the days before being hospitalized with SARS.

How might support and resources at work be provided to reduce burnout?

- *Training in infection control procedures and use of personal protective equipment:* HCWs may have questions when they need to use these procedures and equipment, but they have no one to call and ask at that moment, which is especially problematic for night staff. Uncertainty is exacerbated by the fact that infection control procedures and public health recommendations can change daily, increasing uncertainty.

- *Adequate supplies of PPE:* Knowing that protective gear will be available if needed can reassure HCWs; newspaper headlines blaring "hospital facemasks are in short supply" can be extremely upsetting.

- *Support for worker well-being:* It is important to balance personnel needs with HCW anxiety and fear about working with SARS patients, for example, in cases of conscription of nurses to SARS units. This balance can be met by ensuring that staff feel safe while on duty and making sure that their families are taken care of while they are working.

Self-Care DOs and DON'Ts

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

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Here are a few guidelines for taking care of yourself during and after a public health emergency:

- Recognize that what you are feeling is normal in these circumstances.
- Get enough rest (take a break, take a walk); make sure that you eat.
- Take advantage of those in your social support network.
- Do things that can help you relax—exercise, listen to music, talk, meditate.
- Avoid viewing the event on television.
- Recognize that you are human and can get sick. Seek help if reactions continue or worsen over time.

And here are some of the things that you should try to avoid after an event:

- Using excessive alcohol or drugs
- Neglecting your health
- Isolating yourself from others
- Taking out your stress on coworkers and loved ones
- Thinking you are immune to stress reactions
- Common attitudinal obstacles ("It would be selfish to take time to rest"; "Others are working around the clock, so should I"; "The needs of survivors are more important than the needs of helpers").

Preventing and Reducing Stress: Tips for Supervisors

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

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Good managers and supervisors can be an important part of the MH care response by preventing and reducing stress for MH staff. If workers see that their supervisors are addressing practical concerns, workers will perceive that support and resources at work are adequate, and they will be less anxious. Important guidelines for supervisors:

- Address and revisit procedures for infection control and use of PPE.

- Make sure that workers get sufficient rest and break times. Limit workers' hours; they almost never limit their own hours.

- Do not conscript staff to high-risk situations or prolong their exposure to risk. Give staff a choice, and if they are comfortable with the risk, be sure they are protected.

- Be aware of and address staff conflicts.

- Assess and address the stress that staff may be experiencing because they are concerned for their own or their family's safety.

Managers can create and maintain a supportive environment in a number of ways:

- Provide demonstrable, tangible support for workers who are on duty and in quarantine. For instance, even if social distancing is called for, as it was in the SARS example and would be for pandemic flu, design other ways to communicate and provide support, such as telephone messaging, telephone trees (especially for quarantined HCWs), and "buddying up" of HCWs in high-risk areas.

- Consider staff well-being in decisions. For example, Toronto management found it more useful to negotiate a mutually agreeable system for providing expensive surgical greens, which were deemed unnecessary for infection control, rather than embark on an intensive educational effort about the limited value of "greens" that would risk alienating an important group of workers.

- Visibly, actively manage stress by roaming work areas, providing real-time support.

- Support and enforce self-care principles—urge workers to get proper nutrition, get enough sleep, and find ways to relax.

- Provide a role model by hanging out in the staff lounge. Emphasize accomplishments.

- Provide ready access to supportive MH resources during, after, and on the anniversary of the event and in a casual and non-stigmatizing way.

The Substance Abuse Mental Health Services Administration (SAMHSA) also offers guides and tips for disaster and emergency response workers. These guides can help workers manage their own stress. The guides also present the basic tenets and principles of PFA.

These brochures are available through the Disaster Technical Assistance Center (www.mentalhealth.samhsa.gov/dtac) and a copy is in this binder or on the County Web site.

Materials for Patients and How to Use Them

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

- Functions for MH staff: Identifying "psychological hot spots"

- Psychological reactions to large-scale disasters

- Evidence-informed practices for early intervention: Recommendations for use

- Psychological First Aid: How does it work?

- Special populations: Their unique needs

- Principles of self-care for HCWs: Preventing burnout

- Materials for patients: Guidelines for use

- Final thoughts

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There are many different kinds of materials available for use with patients experiencing psychological consequences of large-scale events. Next, we review these materials and suggest some guidelines for using them.

Psychoeducational Materials

- Distribute to those exposed, treated, or experiencing symptoms of distress

- The materials can serve as a quick reference or self-care guides

- Basic guideline
    - Use culturally appropriate materials
    - Consider translating materials into other languages

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In the immediate aftermath of a terrorist incident or other public health emergency, it is appropriate to give people information about the types of psychological reactions they may experience and suggest what they can do if they need additional help. These materials can serve as a quick reference or self-care guides to help people understand their own feelings and reactions and to point them to additional resources and help when needed. When sharing information and resources, it is important to use culturally appropriate materials and ensure that the information will be accessible in languages other than English.

Online Resources

- SAMHSA
  - http://mentalhealth.samhsa.gov/dtac/

- National Center for Posttraumatic Stress Disorder
  - www.ncptsd.va.gov

- National Child Traumatic Stress Network
  - www.nctsnet.org

- Center for the Study of Traumatic Stress
  - http://www.centerforthestudyoftraumaticstress.org

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There are many resources available online that provide information about the potential psychological effects of disasters, terrorism, and other public health emergencies, as well as material and resources suitable for wide spread dissemination to patients, families, and the community. A few robust sources and sites for further information include:

- The Disaster Technical Assistance Center at the Substance Abuse and Mental Health Services Administration

- The National Center for Posttraumatic Stress Disorder at the U.S. Department of Veterans Affairs

- The National Child Traumatic Stress Network

- The Center for the Study of Traumatic Stress.
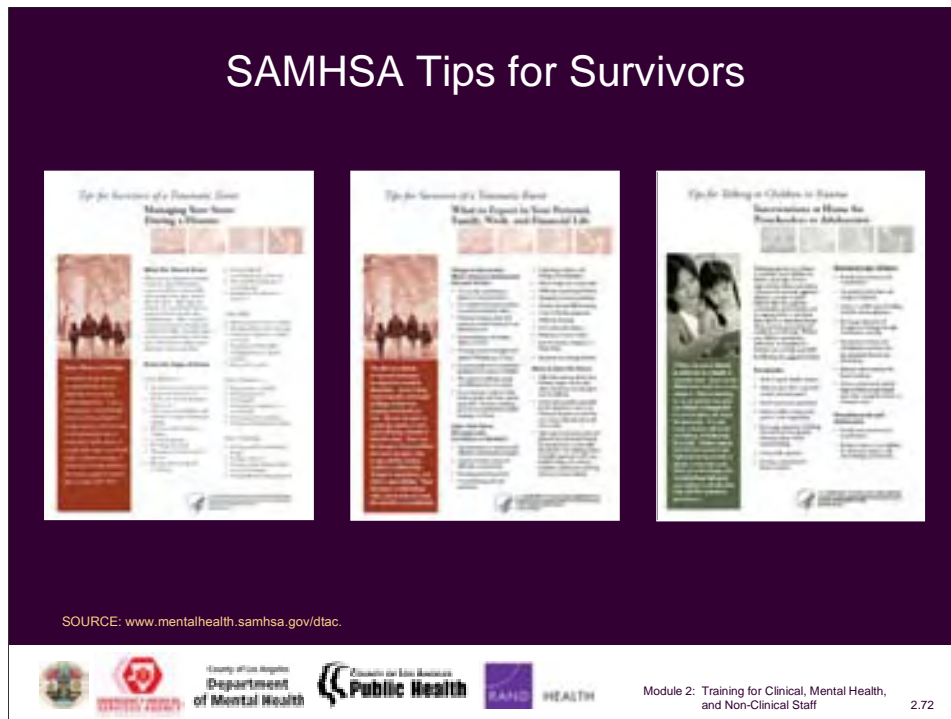
SAMHSA has several patient-oriented brochures for survivors of traumatic events. Their series "Tips for Survivors of a Traumatic Event" includes the following self help guides:

- Managing Your Stress During a Disaster

- What to Expect in Your Personal, Family, Work, and Financial Life

- Talking to Children in Trauma: Interventions at Home for Preschoolers to Adolescents.

These brochures are available through SAMHSA's Disaster Technical Assistance Center at http://www.mentalhealth.samhsa.gov/dtac/ and also in your binder.

Here are the psychological triggers again to help with the examples on the next few slides.

Now let's look at a few case examples:

Let's consider a specific patient encounter during a radiological dispersal device (RDD) incident response.

In this situation, a woman is experiencing physical symptoms (heart palpitations and sweating) but shows no sign of illness. She reports having seen a lot of people die in the explosion. This patient was determined to be ok physically.

So what might you do?

- What might be causing this patient's reactions?

- Based on what we've covered in this course, what are some of the approaches and tools you might use to help her?

Some correct answers to these questions include:

- Her reactions are probably triggered by trauma exposure.

- Provide PFA.

Here is another case example:

The Emergency Department is getting a surge of people who may need urgent medical care, who may be suffering from psychological consequences, or who may be all right.

Some of the people are becoming agitated and aggressive because they want medical attention.

So what might you do? Again, what do you think "triggered" these reactions? What approaches and tools would you use to address the agitated and disruptive people?

Some correct answers are:

- Limited resources, perceived personal or family risk, limited information.
- Identify those in need of urgent medical attention or psychological support.

Now let's consider a specific pandemic flu incident.

In the acute stage, people are being isolated, and there are not enough units, so some are being asked to go home and remain in quarantine. This situation is taxing the capacity of staff who are stretched thin because many staff didn't come to work. They witness their co-workers getting sick and are becoming concerned about themselves.

So what might you do? Again, what factors triggered those psychological reactions?

What strategies and tools would you use and how?

Some correct answers are:

- Restricted movement is the key psychological trigger.

- Principles of burnout are relevant here. Staff need PFA.

How Prepared Is Your Facility?
─Final Thoughts─

- Add one or more mental health professionals to your facility disaster planning team

- Pre-identify one or more mental health staff or clinical staff for the two mental health positions in HICS

- Recruit staff for your facility disaster mental health team

- Include the surge of psychological casualties in your annual exercise program to test your mental health response plans

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As a result of this training today at **minimum** your facility should take the following actions:

- Add one or more mental health professionals to your facility disaster planning team.

- Pre-identify one or more mental health staff or clinical staff to the two mental health positions in HICS.

- Recruit staff for your facility disaster mental health team.

- Include the surge of psychological casualties in your annual exercise program to test your mental health response plans.

Let's end with a summary and some course reminders.

Final Thoughts

Summary

Continuing education credit

Resources

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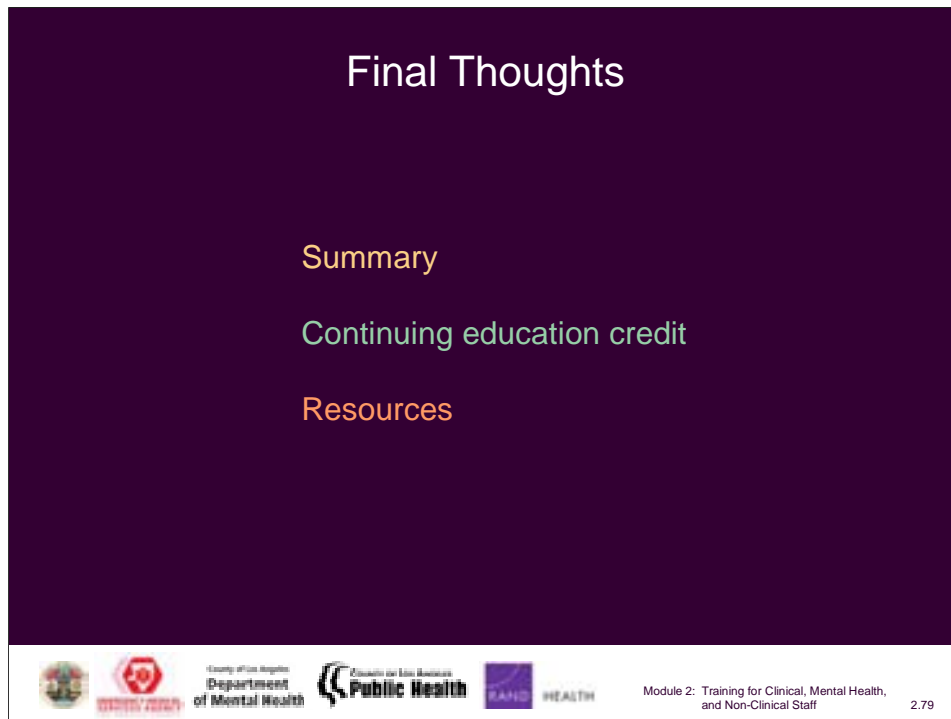
Now I will summarize what we have talked about today. We began with a review of the various cultural barriers and structural obstacles to integrating MH into the structure of hospitals and clinics. We also talked about the functions for MH staff during a disaster and how psychological triggers can cause certain psychological reactions. We provided an overview of early interventions including Psychological First Aid for helping to respond to those reactions. We also talked about dealing with special populations that have specific needs. Finally, we reviewed the tools that were introduced in module 1 so that you will know how to use them if needed.

Remember that we have arranged for you to receive continuing education credits for participating in this course. Please complete your paperwork and return it.

For those of you who will be going back to your facility and training staff locally, we have prepared a separate participant handout for this second module. Again, this manual can be used for training staff and as a self-study guide for those who want to take the course on their own time. You may also download the materials covered today from the county Web site:

http://www.ladhs.org/ems/disaster/trainingIndex.htm.