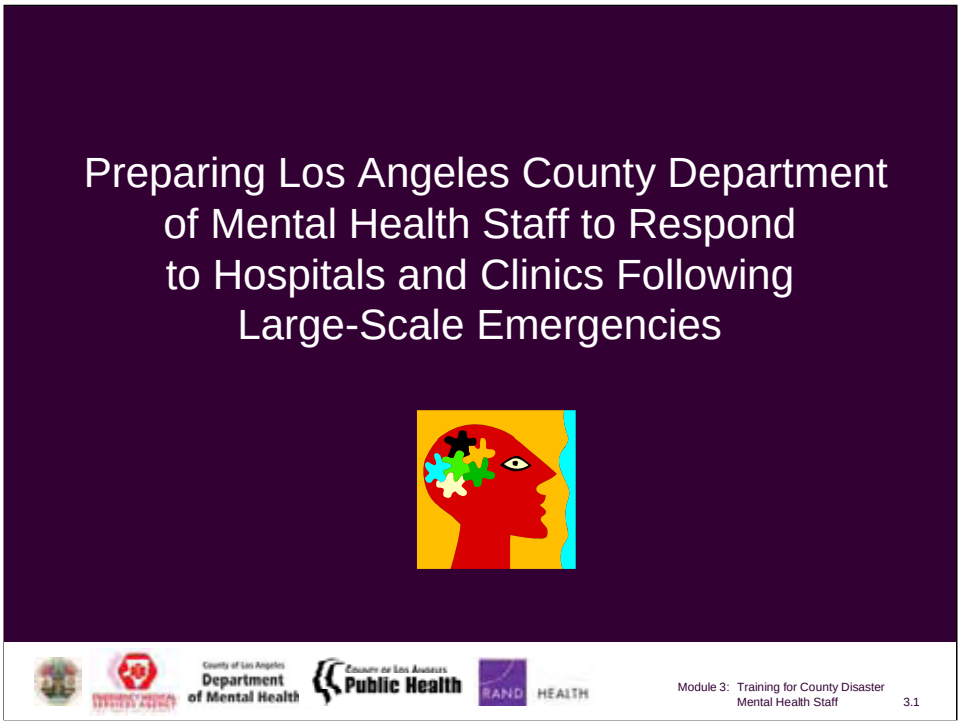
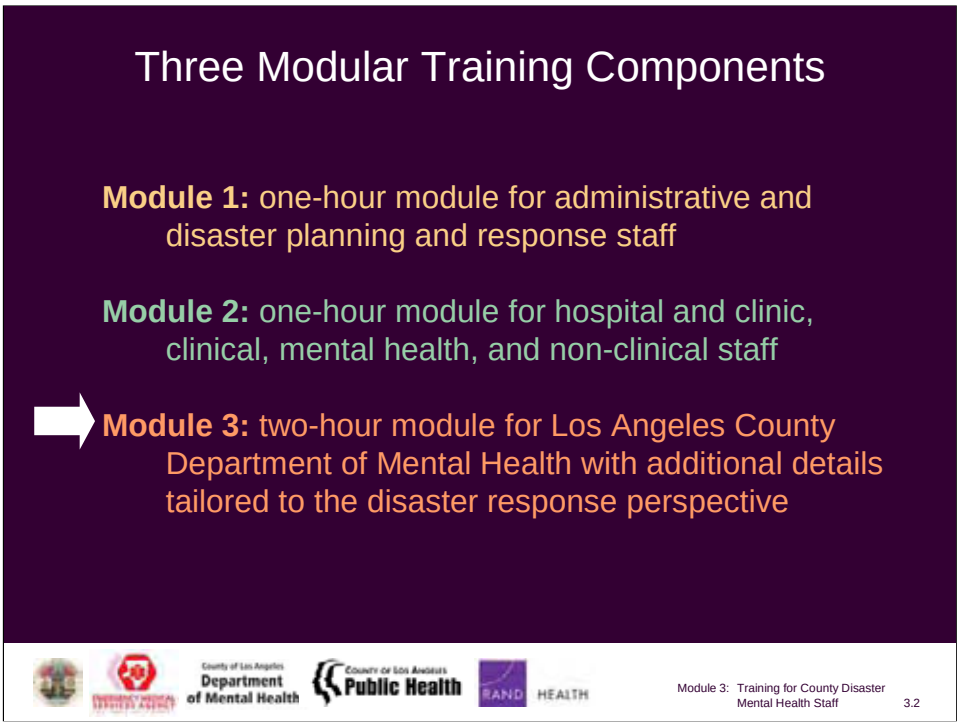


The purpose of this two-hour training module is to prepare Los Angeles County Department of Mental Health (DMH) staff to respond effectively to the demand for mental health (MH) services in hospitals and clinics following large-scale disasters.

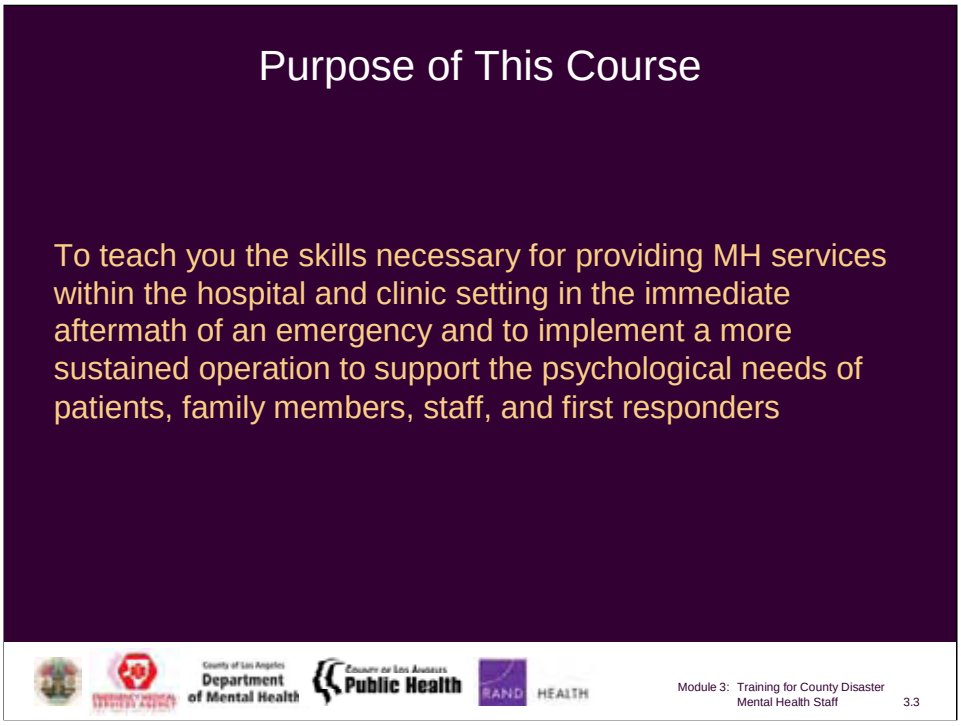


You have already participated in the one-hour general training and the training designed for clinical, MH, and non-clinical staff who work in health care facilities.

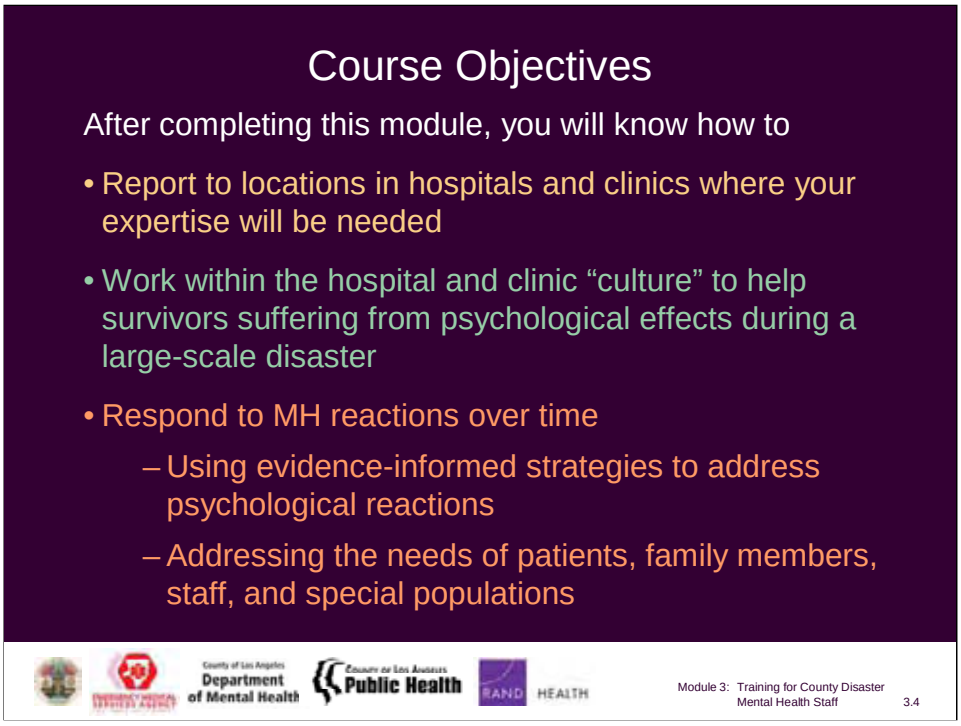
Now you will receive the additional two-hour training designed specifically for the Los Angeles County Department of Mental Health disaster workers.

Participant manuals (and self-study guides for staff who cannot participate in a training course) for all components are available on the county Web site:

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



This course will give you the skills you need to provide MH services in hospitals and clinics after an emergency and to support the psychological needs of patients, family members, staff, and first responders.



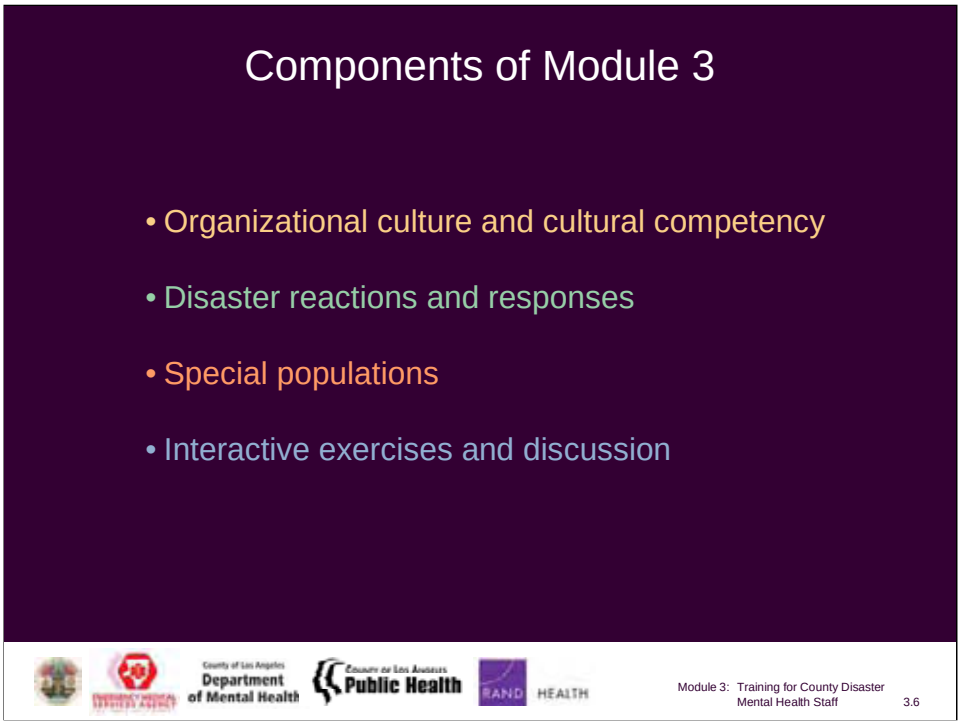
The overall objective of the course is to prepare you to work effectively in the hospital or clinic culture. You will learn where to report within a health care facility during a disaster. You will also learn how to respond to psychological needs in both the short and longer term by using intervention techniques based on the scientific evidence. In addition, you will learn how to help different groups that may be affected, including special populations.

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

The effort was funded by a 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 Departments of Public and Mental Health (DMH).

Los Angeles County contracted with RAND to perform this work.



This training module has four components.

We begin with a discussion of how to work within the hospital and clinic culture, including reporting requirements within the health care setting and the staff with whom you will be working. We also consider where you will be needed once you report to a hospital or clinic.

Next, we consider what to expect in terms of psychological reactions and describe some interventions designed to respond to them.

We will spend some time talking about key populations to address.

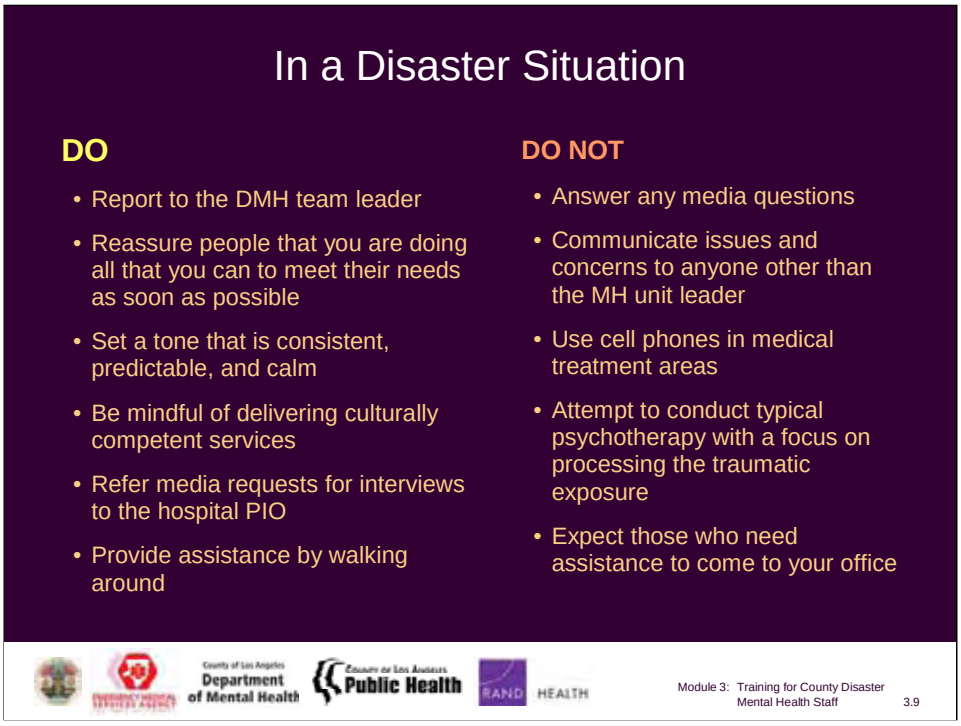
We will end with "break-out" groups in which you will have the opportunity to share your experiences and what you have learned by presenting best practices with respect to the hypothetical scenarios we discussed in the first module.

Regarding organizational culture and cultural competency, we discuss how to work effectively in hospitals and clinics, determining where you are needed most, and the components of providing culturally competent services.

One of the most essential points we want to convey in this course is the uniqueness of providing MH care in the context of a disaster.

Your professional training probably emphasized individualized therapy or possibly some small group therapy or peer-support sessions. However, a terrorist attack or other mass casualty-causing event, such as a pandemic flu or an earthquake, will create a surge of psychological casualties at health care facilities.

In these situations, providing MH care requires a very different approach.



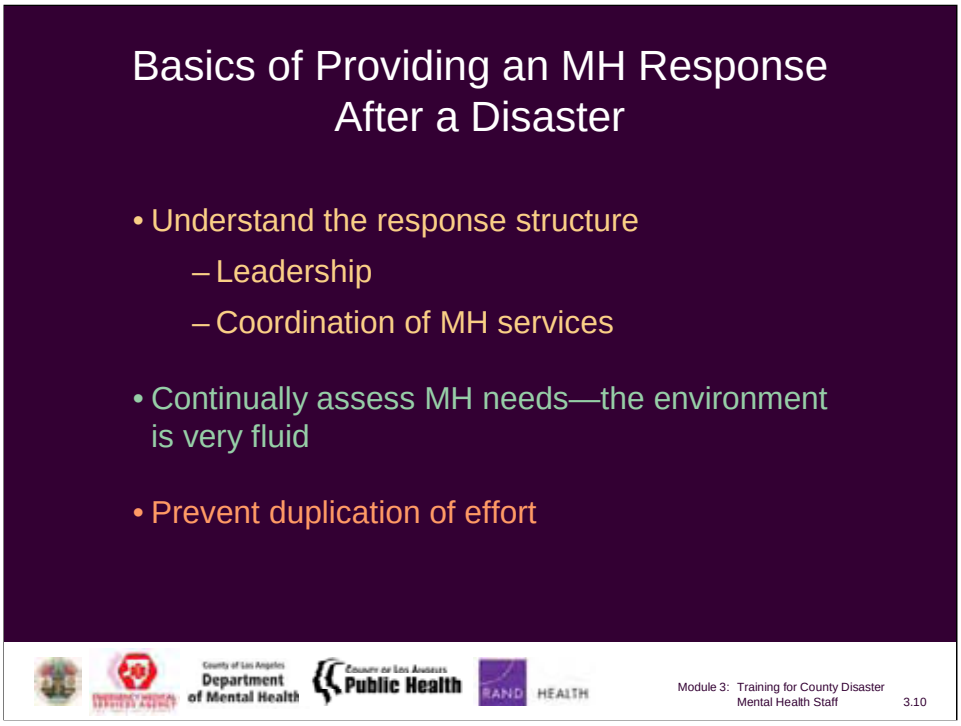
To begin exploring that approach, let's consider this list of things that you should and should not do during a disaster.

The DOs include:

- Initially report to the DMH team leader at the facility. The unit leader will have met with the facility's Hospital Incident Command System (HICS) MH unit leader (for patients and families) and Employee Health and Well-Being Unit Leader (for staff) to decide which of those two people you should report to while you are on scene from then on. You will report either (1) to the county DMH team leader who will, in turn, report to the HICS, or (2) directly to the HICS MH Unit Leader and Employee Health and Well-Being Unit Leader.
- Your first communication with people should focus on letting them know you are doing what you can to help and are trying your best to get accurate information to them just as soon as you receive it yourself.
- Try to set a tone that is calm and consistent.
- Be sensitive to cultural needs.
- Refer media questions to the hospital public information office (PIO).
- And, as mentioned in module 2, provide assistance by walking around.

The DO NOTs include:

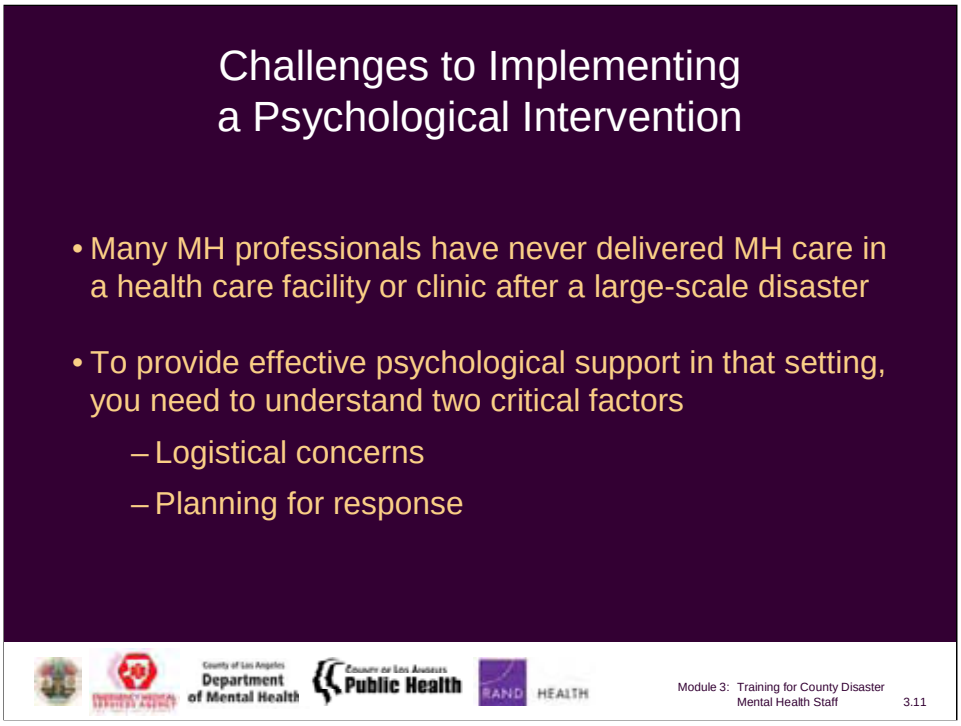
- Interacting with the media. This is reserved for PIO staff. Having a single point of contact will facilitate clear and consistent information and minimize confusion and opportunities for mis-information (including rumors).
- Going outside of the command structure. It is critical that the incident response by tightly coordinated. Deviation from the command structure can hamper the ability for the HICS team to respond efficiently.
- Using cell phones in medical treatment areas. They interfere with patient monitoring devices.
- And remember that typical psychotherapy approaches and settings do not apply in disaster MH.



MH responders should understand the structure of the hospital and clinic response efforts. Knowing how to work within the leadership is critical. Your activities must be coordinated with any other MH programs in the hospital or clinic as well as with outside groups that may report to offer additional MH assistance.

Recognize that disaster situations are continually changing as new information becomes available; so expect survivor needs to change, and be flexible about reassessment.

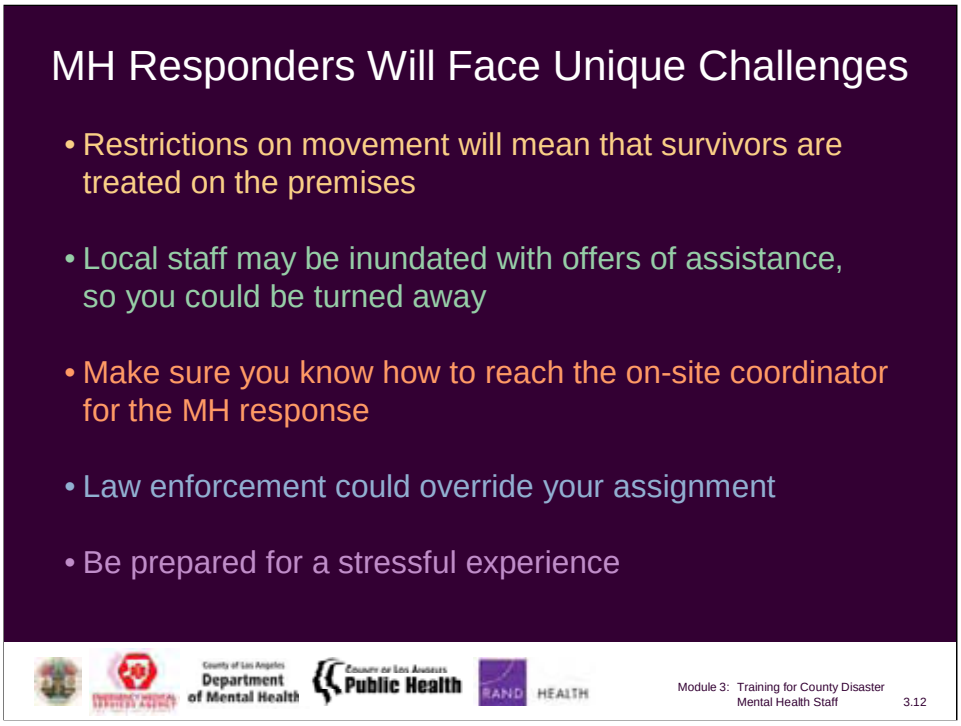
To prevent duplication of effort when trying to meet the needs of survivors, be sure to coordinate your efforts quickly in what will surely be a chaotic environment. An important part of coordination is keeping in touch with the MH unit leader.



Because (fortunately) large-scale disasters are rare, many of you may not have direct experience providing MH care in a hospital or clinic after a large-scale emergency. You may be unfamiliar with the physical environment and associated culture of the facility to which you are assigned.

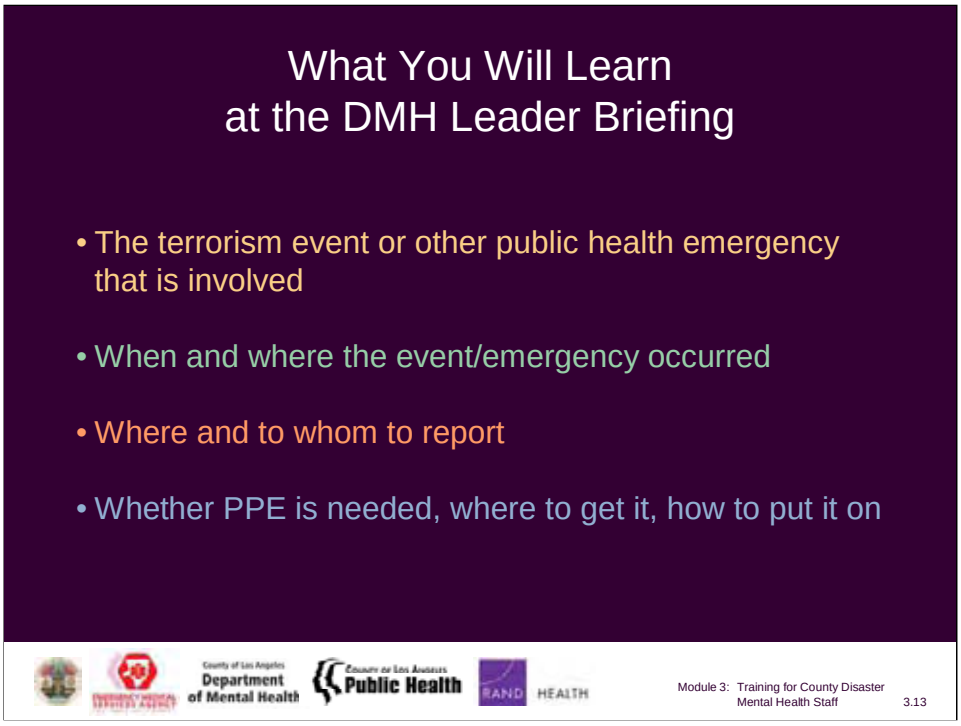
Therefore, it is critical that you understand the logistics (facility layout and floor plan) and know how to plan a response from within the facility. Many health care facilities are large and cover multiple floors. Knowing where to find children who are separated from their parents is an example of why you need to know the location of different departments, wards, and offices. You will also need to know where people congregate, because these are high-surge areas for psychological needs.

Ask for a briefing (or the County DMH team leader should ask for a briefing on behalf of the entire team) on the logistics, facility layout, and planned MH response when you arrive on scene.



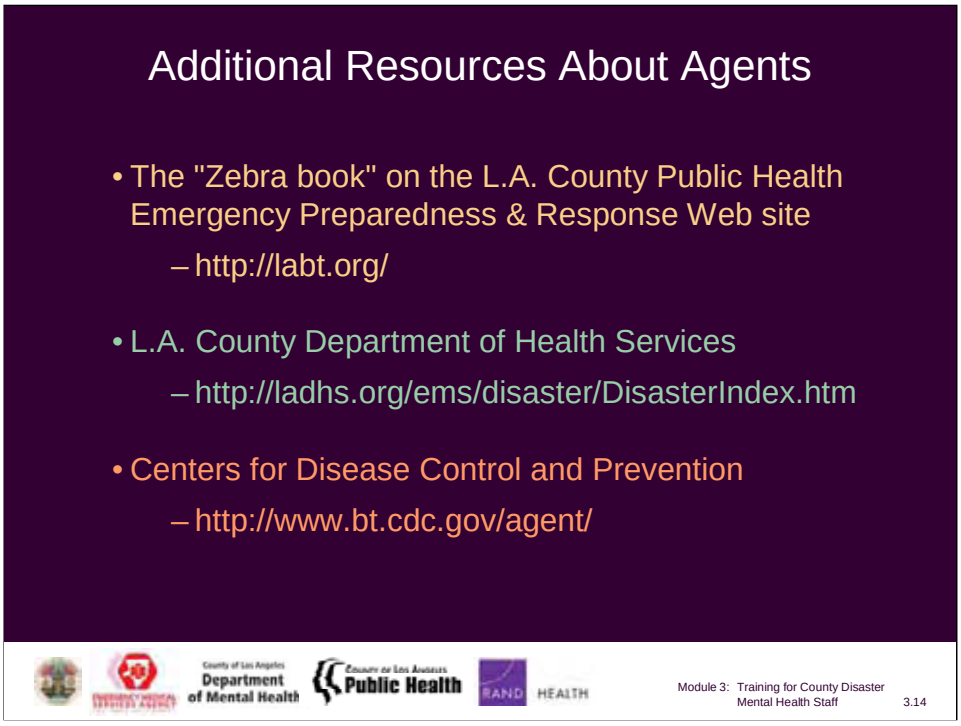
Even if you have had experience with large-scale disasters in the community, there are a number of considerations that are unique to a hospital or clinic:

- If the disaster results in restrictions on movement, such as with isolation or shelter in place, you will be providing services at the facility and cannot move people to other treatment locations.
- The facility staff may not understand your assignment, and because they are overwhelmed, they may turn you away.
- Be sure that you have the proper identification to show facility staff so that they know your assignment is legitimate. While on-site, make sure you understand where to find the coordinator to whom you will be reporting (again, that will be either the county DMH team leader or the facility's HICS MH Unit Leader or Employee Health and Well-Being Unit Leader).
- Law enforcement officials may take the lead in a disaster situation, and they may need to send you elsewhere, overriding your assignment from the HICS unit leaders.
- Be prepared for a stressful situation, and take self-care precautions (as described in module 2).



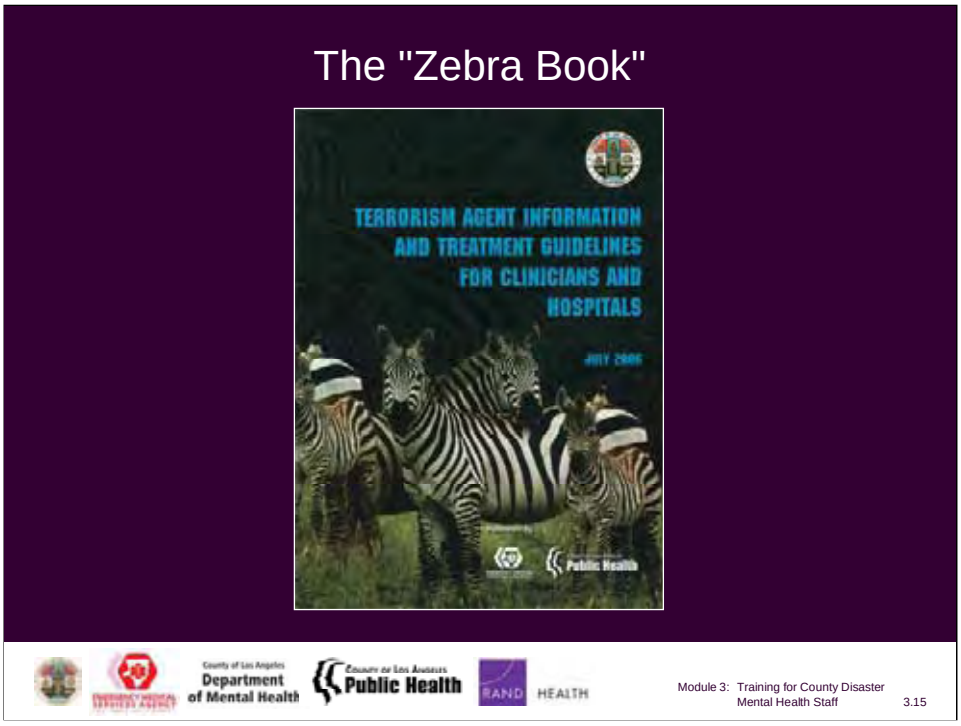
Before you report at a hospital or clinic, the DMH team leader may brief you on key facts about the event. These will include:

- What terrorism event or other public health emergency is involved.
- When and where the event or emergency occurred.
- Where and to whom you should report at the clinic or hospital.
- Whether personal protective equipment (PPE) is needed, and if so, where to get it at the facility and how to put it on. Most likely, you will need only gloves, a mask, and a gown, if anything.
- You should speak to your DMH team leader if you have additional concerns.

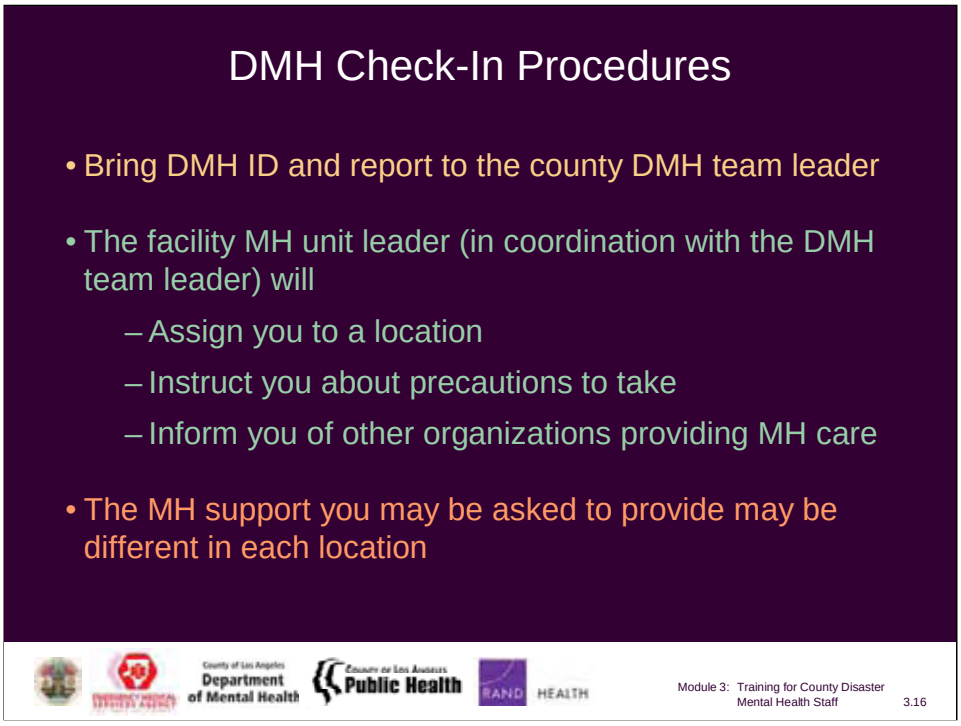


If you are not able to attend a briefing or just want additional information about the agents involved in a disaster, you can use these online resources:

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



Here is the "Zebra book" again. It is available on the Public Health Bioterrorism Website: www.labt.org



Before you report to the facility, be sure to bring your DMH identification, such as your badge or jacket.

When you arrive at the hospital or clinic, report to the county DMH team leader. As we mentioned earlier, you will be told when you arrive at the hospital that you should continue to report to that DMH team leader or that you should report directly to the facility's HICS MH Unit Leader.

One of them will assign you to a location and explain any precautions you should take to ensure your own safety—we will talk more about these issues in a moment. She or he also will inform you about other organizations providing MH care.

Keep in mind that the MH support you may be asked to provide may differ across locations, because each facility has unique response challenges. For example, one facility may have a large MH staff while another may have only one person. In addition, different MH services might be needed, depending on the current disaster situation or other factors such as the population most affected.

Also, you might need to set limits with hospital and clinic staff because they might ask DMH to do inappropriate things like make death notifications. Just say "no." Only the treating provider at the facility has authority to communicate about a death with loves ones.

The hospital incident command system (HICS) MH team leader may tell your DMH leader to send you to a variety of places, including:

- Locations likely to have high demands for psychological needs, such as the ED; the facility entrance; the triage area; and decontamination, quarantine, or isolation areas.
- Waiting rooms, because people may be anxious to get news about their loved ones or information about the potential consequences of the disaster event. Those waiting may be depressed or sad.
- You may also be sent to other places where people congregate, such as the cafeteria, to help staff or patients.

Each location will present unique challenges for providing MH care.

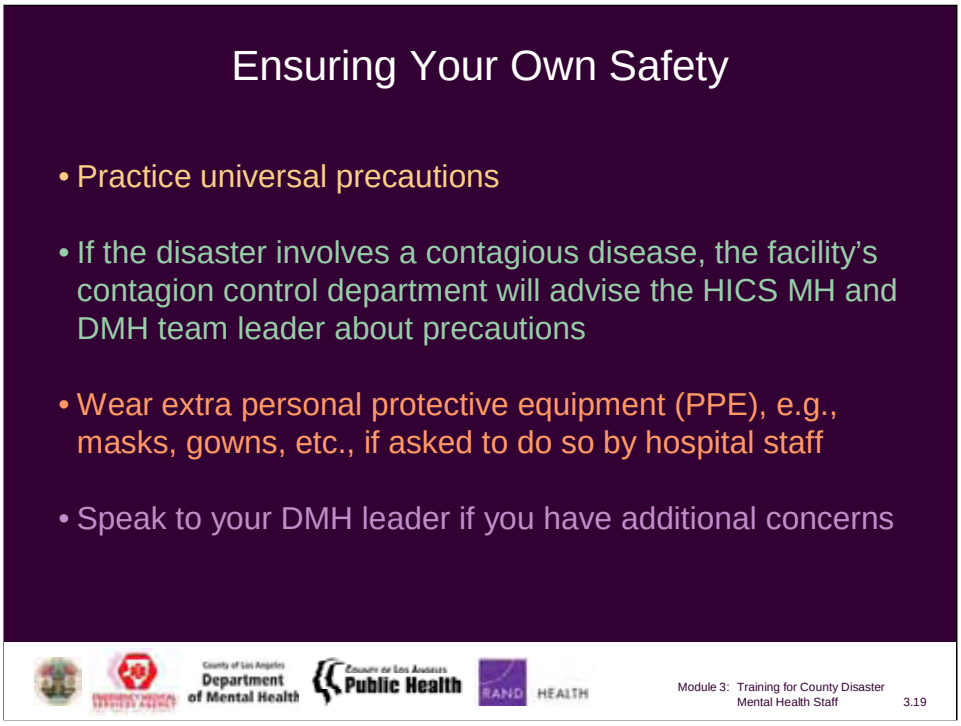
Hospital staff may decide that the main facility cannot be used to provide MH care. For example, if the disaster involves a contagious agent, MH care should be provided away from any contagious persons. In such circumstances, MH staff will have to seek alternative sites to provide care.

These could include:

- Auxiliary hospital buildings
- Clinics
- Parking structures
- Auditoriums.

Each location will present unique challenges. For example, the parking lot might be outdoors, hot, cold, or without bathrooms or a place to sit. The auxiliary hospital may not be located next to the hospital. Families of survivors may not want to stray far from the hospital to receive MH care if they are waiting in the hospital for news about their loved ones.

Privacy in disaster situations is not always possible. Interventions are typically crisis focused and done on the spot. In a disaster situation, the only private space available might be a short distance away from where you are working, out of earshot of others as much as possible.



We want to assure you that every step that can be taken will be taken to ensure your safety while you are at a disaster location.

While delivering MH care, you will need to practice universal precautions, which include wearing gloves, a mask and gown, and washing your hands. However, be aware that hospital staff may be wearing a variety of personal protective equipment (PPE) that may or may not be related to the disaster (e.g., masks, gowns, etc.). You might not be wearing the same PPE as others.

If the disaster involves a contagious disease, the facility's contagion control department will advise the facility MH team leader about precautions you should take to ensure your own health, and the DMH team leader will in turn advise you about what to wear and do.

You should wear additional PPE if asked to do so by hospital staff. However, if you are not specifically assigned such equipment and you walk into an area where others are wearing this additional equipment, leave immediately to reduce your exposure.

If you continue to have concerns about your safety, speak to your DMH team leader.

In addition to the barriers of organizational culture and the unique challenges that you may face when reporting to a hospital or clinic, there are a number of other cultural barriers you may face when trying to help survivors of a large-scale event.

These barriers will range from language and literacy limitations to mistrust of government and other officials.

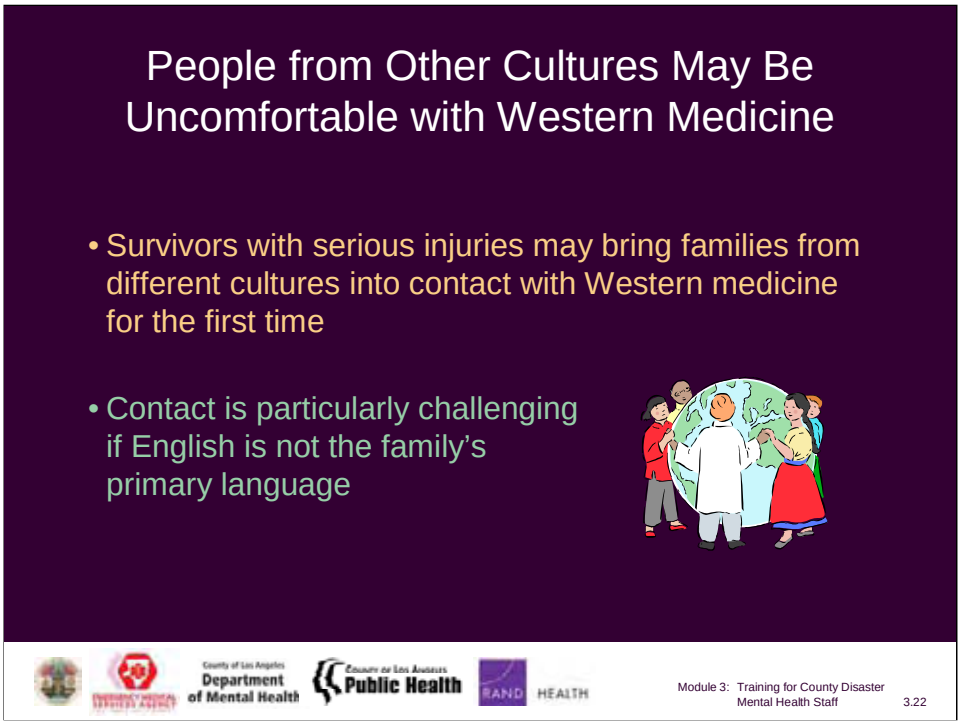
Depending on where you are deployed, you may find that many patients and family members come from divergent racial and ethnic groups; so it will be important to understand in advance of an event where you will be deployed, what groups you will be serving, and the cultural norms or values that need special consideration.

You may also find that some patients and family members do not speak English. Having materials in other languages will help as will finding others who can translate for you.

You will need to use simple lay language to ensure that people understand, because the environment will be strange, chaotic, and distracting.

Many people, especially recent immigrants, may mistrust the government and other officials. Expect some resistance and try to convey that you want to help them and not put them at risk.

Hospital and clinic politics as well as broader political issues could hamper your objective of providing MH support. Working closely with other community leaders and facility staff will advance your mutual goal of helping survivors. Have these linkages worked out ahead of a disaster so that you are better prepared.



Also, regarding cultural sensitivity, bear in mind that the Western model of medicine is not the only model and is not universally accepted. Many groups may be uncomfortable with some of the clinical practices. Thus, it is very important to clearly explain what you are hoping to do and why. It may take time for these survivors to feel comfortable with your style of providing care.

It is important to address different cultural, ethnic, and racial differences when treating individuals from different backgrounds.

Cultural practices and values are interwoven with aspects of a disaster:

- For example, in some cultures, the death of a loved one will bring many extended family members to the facility, compared with cultures that are more nuclear-family oriented.
- The response may also be a function of their prior experiences. For example, those coming from war-torn countries may be more traumatized by a disaster and may be anxious about the presence of uniformed personnel.

Rituals surrounding death vary by culture. Notifying family members about a death, releasing the body, and the timing of the burial are handled in a variety of ways. MH workers could be called upon to deal directly with such issues:

- For example, in Buddhist culture, the funeral is usually held within one week of the death; one should not communicate with the bereaved until after the funeral; and the body is washed, bathed, and properly dressed before the ceremony. Cremation is the norm.
- In contrast, in Greek Orthodox culture, the funeral occurs within two to three days of death, and visitation and prayer service are conducted the evening of the funeral. Cremation is not permitted under any circumstances.

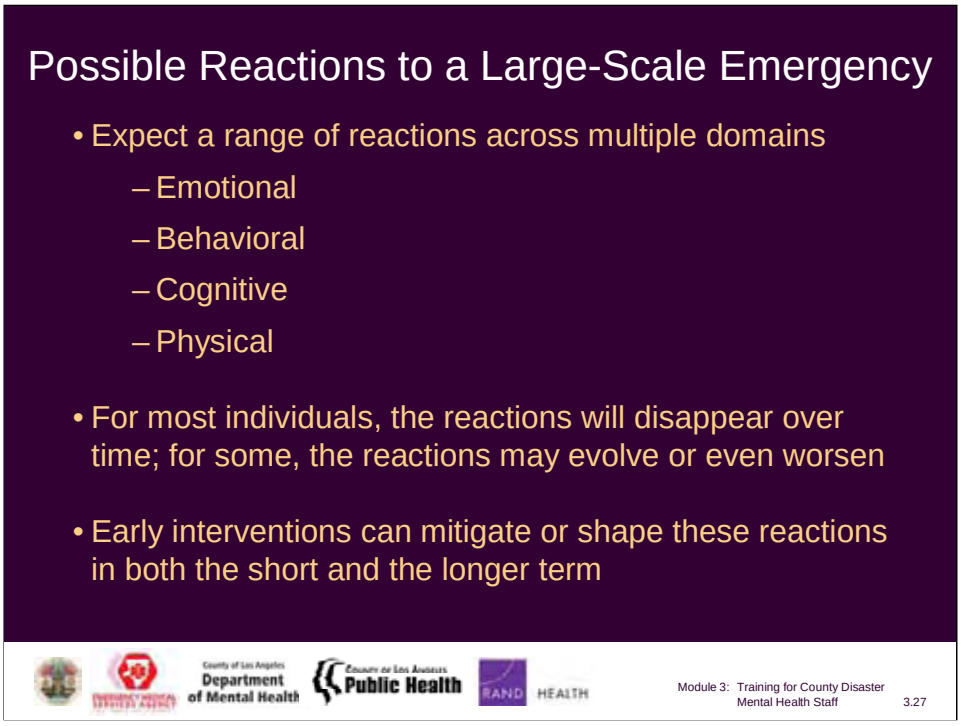
There are many ways to demonstrate your cultural sensitivity. Be courteous, be clear about your role, and be mindful of the cultural issues we have discussed. It may take more time for some people to be comfortable with you, so be patient. Tailor your contact and any intervention to the particular group. Your facility should become familiar with the cultural groups in your local area, in advance, because these are likely to be the people who show up in large groups following a disaster.

These Web sites can provide additional information about cultural competency.

Now, let's turn our attention to how survivors might react to a large-scale disaster and how you might respond to provide support.

First, we discuss the range of common reactions to a disaster. Then, we consider MH interventions that are informed by scientific evidence that can address psychological reactions in both the short and the long term.

We conclude this subsection by discussing how to work with the family.



As we discussed in module 2 of this course, you should expect a range of reactions following a terrorist incident or public health emergency. Reactions can be either adaptive, helping individuals to cope and recover, or maladaptive, leading to negative consequences for health and recovery.

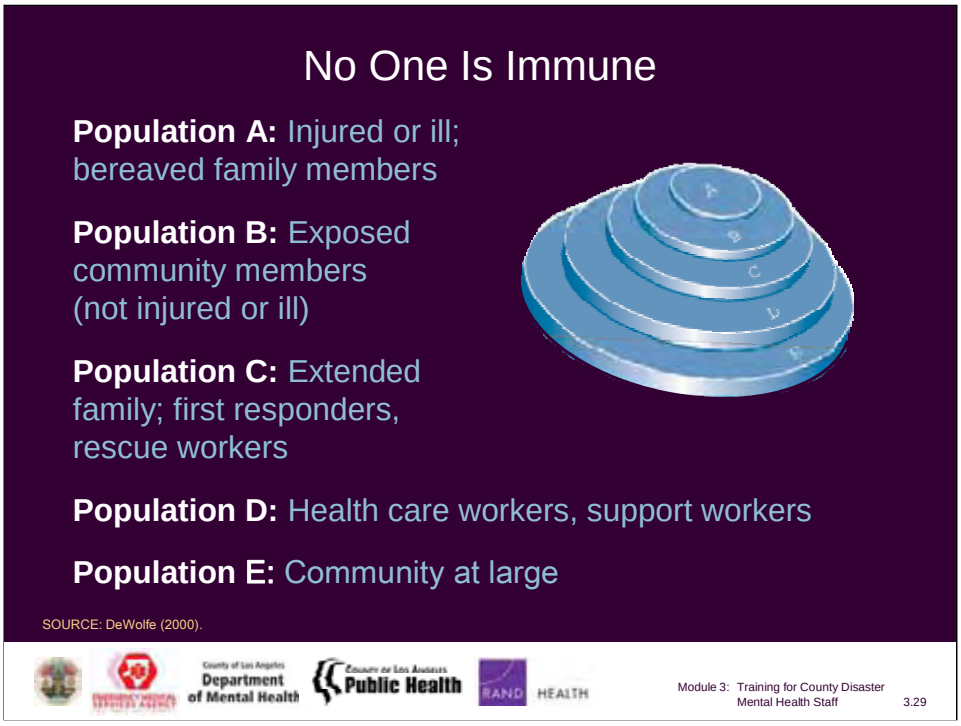
These reactions can be categorized by domain: emotional, behavioral, cognitive, or physical. Over time, the reactions of most individuals will resolve naturally without intervention; however, for some, the reactions may evolve and potentially worsen.

We know from prior research and experience that early interventions and responses can mitigate or shape these psychological reactions, both immediately and in the long term. As MH professionals, we have an opportunity to help individuals cope with the immediate incident or emergency as well as to mitigate or prevent longer-term consequences.

Here are some examples of reactions in each of the domains we just mentioned:

- Physical reactions may include agitation, hyperarousal, appetite changes, nausea, sweating, or gastrointestinal distress.
- Behavioral reactions may include sleep changes, hypervigilance, avoidance, isolation, withdrawal, or violence.
- Emotional reactions may include shock, disbelief, grief, sadness, irritability, anxiety, hopelessness, or guilt.
- Cognitive reactions might include confusion, intrusive thoughts, or difficulties making decisions or concentrating.

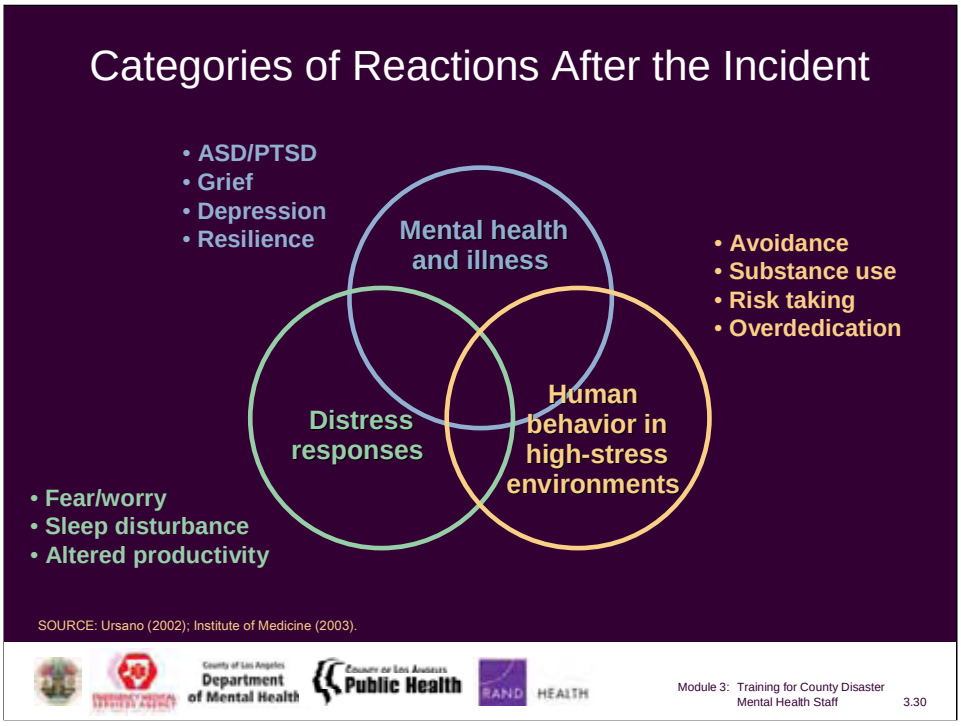
Some of these reactions may be positive, such as becoming more alert and energetic.



It is important to remember that following a disaster, terrorist incident, or other public health emergency, no one is immune to experiencing some type of reaction.

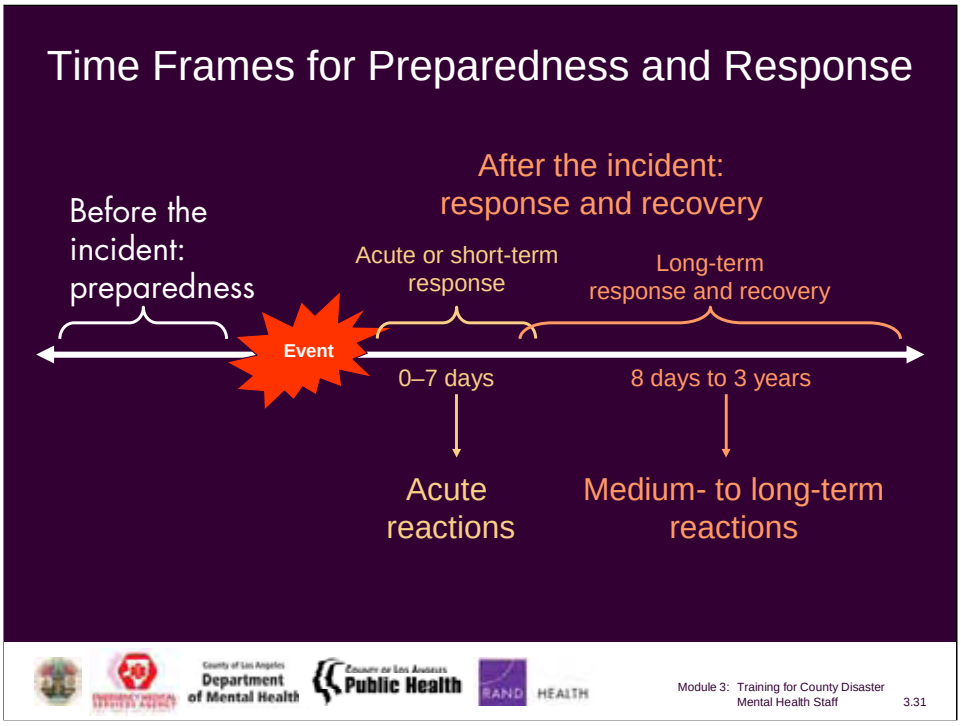
DeWolfe (2000) uses the population exposure model to describe the "levels" or "layers" of populations that may experience some degree of psychological, emotional, or behavioral reaction after the event.

Experience and research suggest that those closest to the incident are at greater risk of more severe reactions, but as depicted in this model, multiple populations are exposed. Those directly affected (either through injury, illness, or death of a loved one) are at greatest risk, followed by those in their immediate surroundings. First responders and health care workers are part of populations believed to have slightly less exposure; however, in some cases (for example, a smallpox outbreak or influenza pandemic), they may be at greater risk of exposure to injury or illness because of their responder role, thus placing them in one of the higher-risk categories.



The Institute of Medicine (2003) used this figure to highlight three primary categories of reactions following a terrorist incident or disaster: distress reactions, such as fear or worry; behaviors common in high-stress environments, such as overdedication or avoidance; and MH and illness-related reactions, such as acute stress disorder (ASD), traumatic grief, depression, and post-traumatic stress disorder (PTSD).

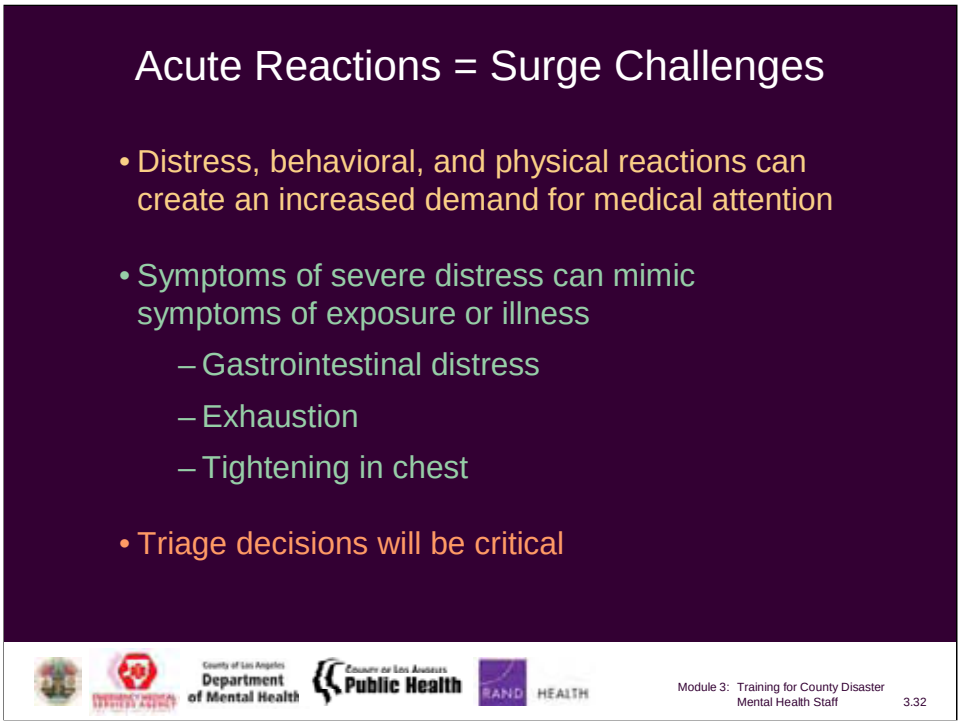
Individuals may have reactions in only one of these areas, in two, or in all three.



As we noted in module 1, there are three phases for preparedness and response activities. Accordingly, reactions will be specific to the response phase after the particular incident.

Initially, during the first week following the incident, acute distress reactions, both physical and psychological, will result in a surge to the facility, creating high need for care and staff to provide care.

Over the longer term, one to three years following the event, you will see such reactions as traumatic bereavement; unsafe behaviors, such as substance abuse and violence; and the development of psychiatric disorders, including PTSD. Finally, those exposed to a traumatic event may experience relationship and lifestyle changes—e.g., moves and divorce.

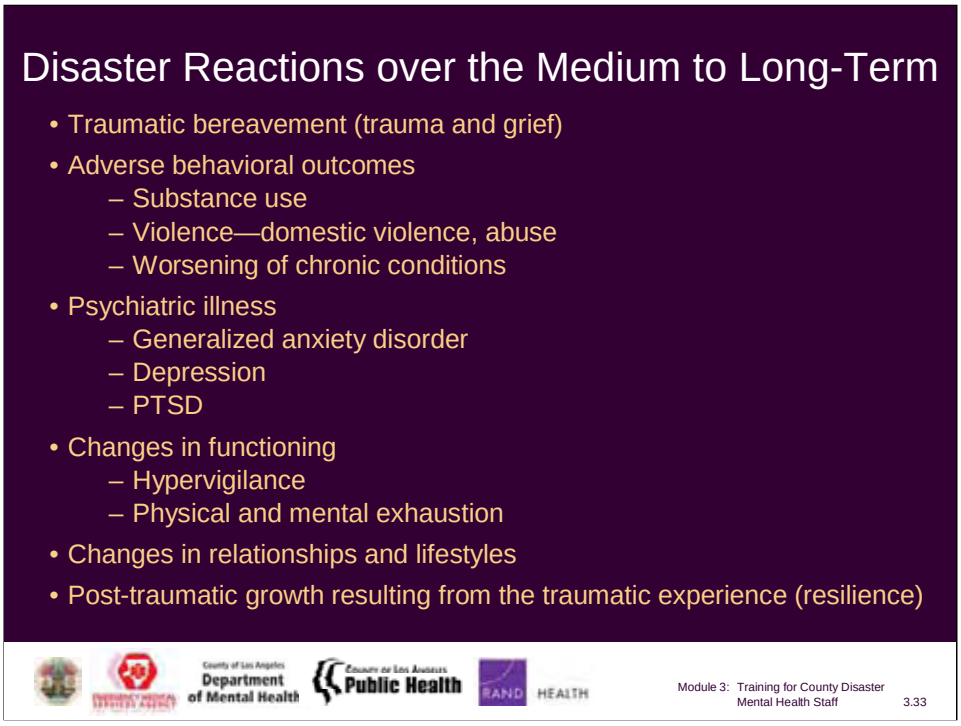


Immediately after the incident or the acute response phase, how individuals respond may create surge challenges. In module 1, we shared with you the real-life ratios of physical casualties to psychological casualties from previous events, such as the sarin attack in Tokyo (88 percent of the emergency room visits were for persons who were not exposed to the chemical but had symptoms that they feared were from exposure to sarin).

Acute distress may stimulate behavior that will warrant or demand medical attention. Thus, acute distress reactions may create a surge of demand on the medical system.

Distinguishing stress reactions from physical reactions will be particularly challenging since some severe distress reactions produce symptoms that mimic a medical illness or exposure to a chemical agent.

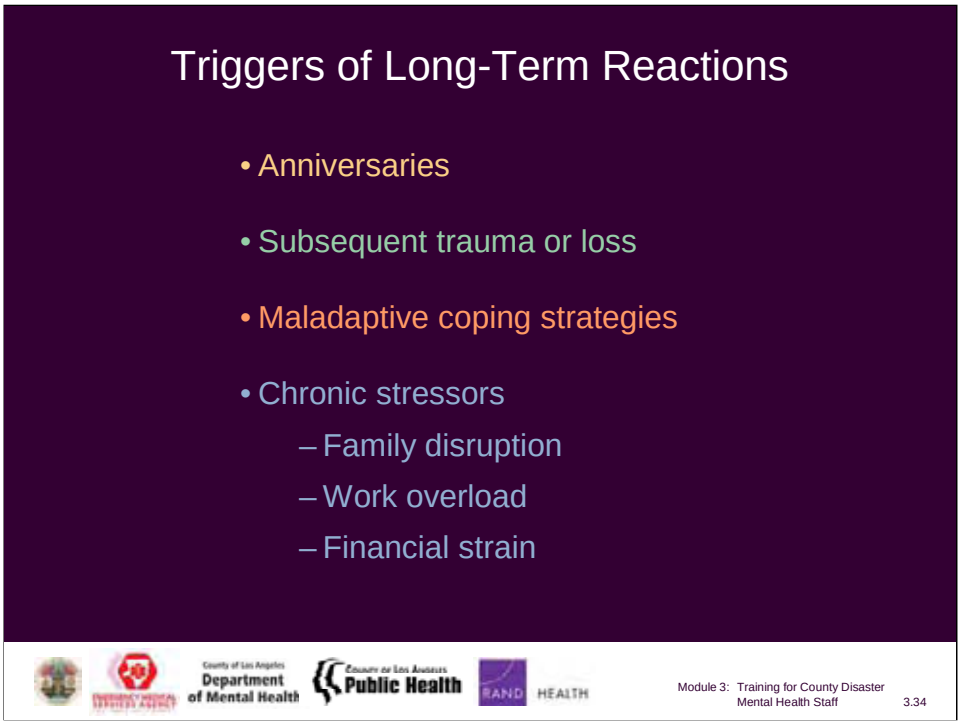
Handling triage decisions in a manner that does not minimize these physical reactions will be important on two levels: first, some physical symptoms may truly warrant medical attention (e.g., cardiac complaints) and ethically must not be turned away; second, how individuals are triaged or responded to has the potential to mitigate reactions or to exacerbate them.



Prior experience has also demonstrated that exposure to terrorist incidents, disasters, and public health emergencies can also have consequences over the medium to long term. These reactions develop after the acute response phase but may eventually require intervention. They include:

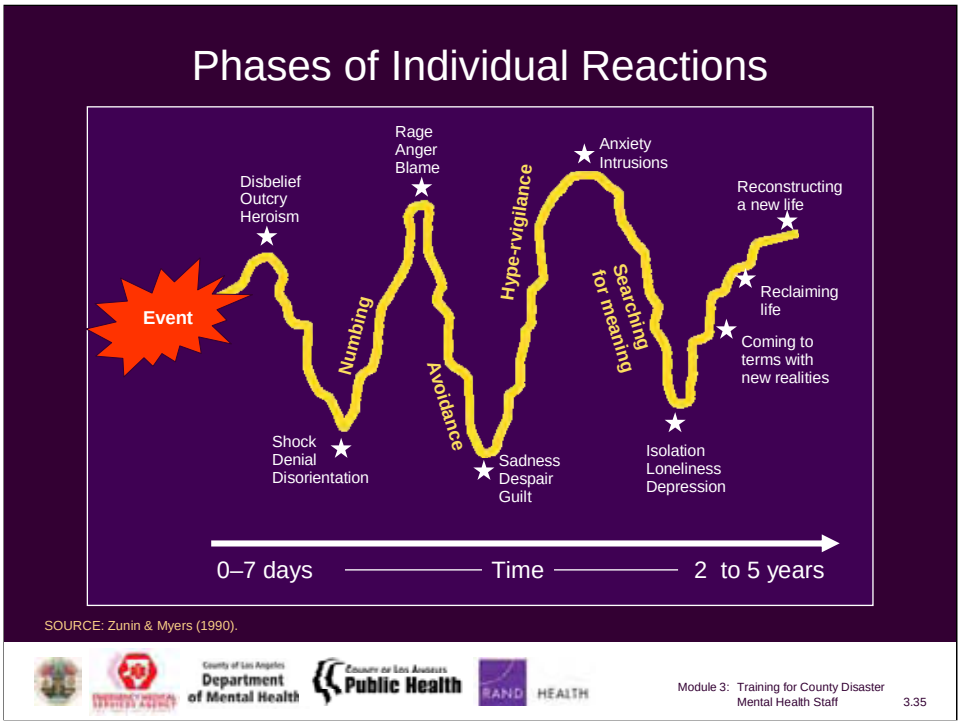
- Traumatic bereavement—when grieving over the loss of a loved one is complicated by a traumatic cause of death
- Adverse behavioral outcomes, including substance abuse; violence, including domestic violence or child abuse; and worsening of chronic health conditions
- Psychiatric illnesses, such as generalized anxiety disorder, depression, and PTSD
- Changes in functioning, which might include being overvigilant or perhaps exhausted.

After the disaster, we also see changes in relationships and lifestyles (e.g., divorce), but some individuals may emerge from the experience as stronger people. For example, the traumatic experience may make people more resilient and confident in their ability to face adversity.

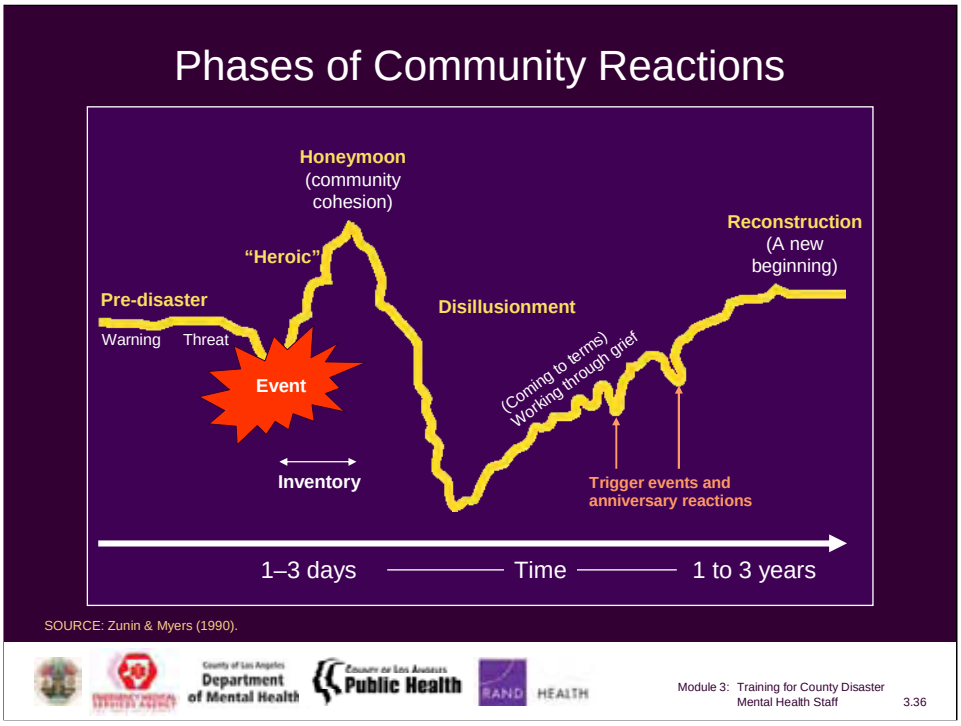


Long-term psychological consequences of disasters may be triggered by one or more events following the incident, including:

- Anniversaries of the event, which serve as a reminder of the loss and trauma associated with the original event and can generate emotional distress
- Subsequent loss or trauma (death, job loss, etc.) following the incident
- Maladaptive coping strategies (denial, self-medication, etc.)
- Presence of other chronic stressors, including family disruption, work overload, or financial hardship.

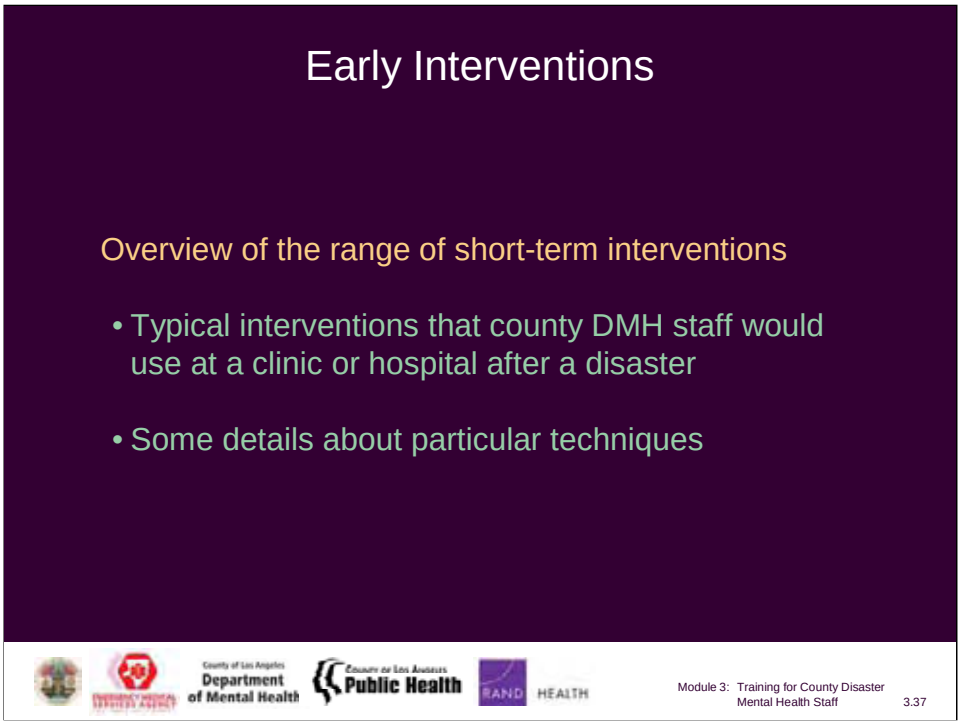


The U.S. Department of Health and Human Services (2004) outlined several phases of an individual's reactions to trauma and bereavement. As the graphic depicts, an individual's reaction may vary over time, with several peaks and valleys.



Zunin and Myers (1990) outlined five phases that a community goes through following a disaster. The phases include acute as well as medium- to long-term reactions to a disaster. This community-level phasing is an influential context for an individual's response and reaction.

This graphic displays the phases of community reactions. When the disaster occurs, there is an immediate decline in community functioning. Then as a community rallies, there is a heroic phase culminating in a "honeymoon" phase, characterized by community cohesion. As resources and attention shift or diminish, or efforts become more complex, a community may become disillusioned, and its functioning may decline to a level below where it was when the disaster occurred. Over time, however, as the community comes to terms with the disaster or incident, works through grief, and creates a road to recovery, functioning gradually increases. That trend may be offset by events that trigger emotional challenges—for example, anniversaries or other community-level traumas. However, in one to three years, the community is on a path of reconstruction.



Now, let's turn our attention to the kinds of interventions that county DMH staff might use to address the psychological reactions that we have just considered.

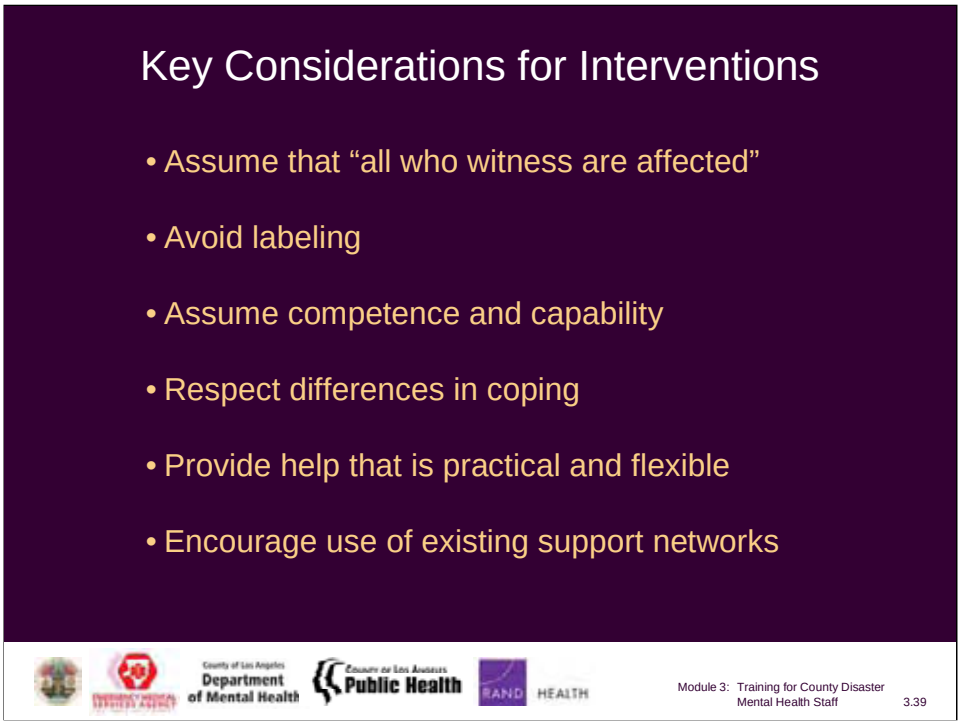
We describe some typical interventions that DMH staff might use on scene at a clinic or hospital following a disaster.

We provide some details about each technique but not complete training.

MH interventions immediately after an emergency have the following goals:

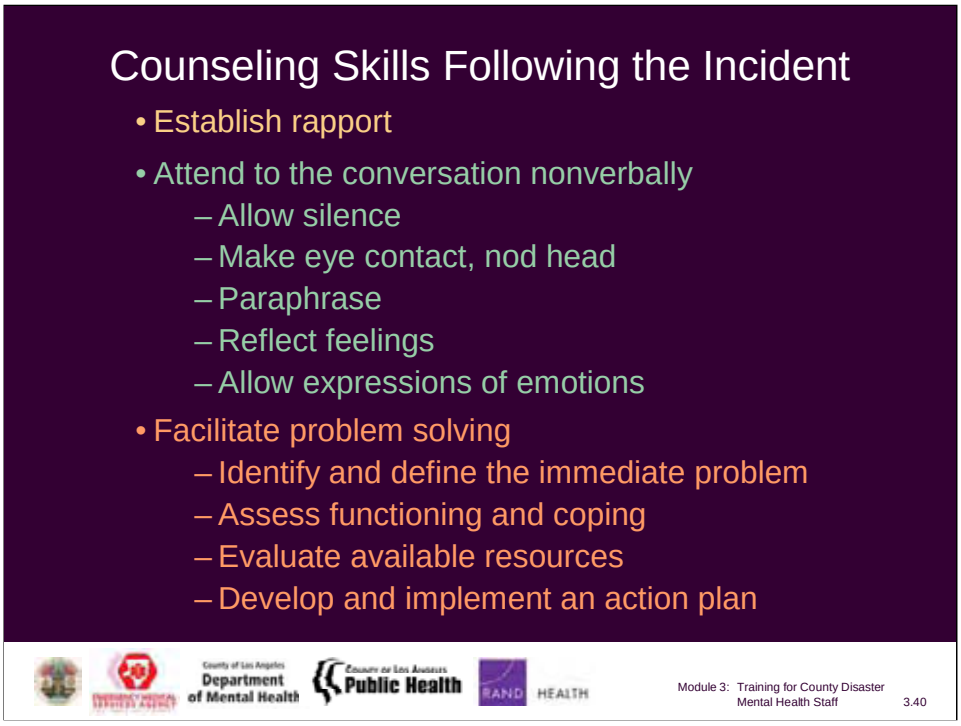
- Provide crisis intervention that includes appropriate triaging of medical and MH needs and provides reassurance.
- Reduce emotional distress and mental stress.
- Improve problem solving skills and enhance positive coping skills.
- Facilitate recovery.
- Refer those in need of additional help and treatment to MH professionals for follow-up.
- Provide advocacy for individuals in need.

Many different techniques have been used to accomplish these goals. Next, we consider the evidence-informed principles and key components of early intervention.



We know from research and prior disasters that many individuals will experience some symptoms of distress immediately after an emergency. We also know that the majority of them will recover normally—their symptoms will diminish over time. It is inappropriate to assume that people with symptoms of distress after an emergency have clinically significant disorders, except when there is a preexisting MH condition. In this situation, appropriate triage by the MH clinician on scene must include an assessment of the history of psychological/psychiatric symptoms, current MH treatment, as well as any current psychiatric medications being taken. When necessary, you should ensure that the patient is connected to his or her current psychological services. If a patient is not currently receiving psychological services but would benefit from immediate and/or continued psychological treatment, you should facilitate a referral.

Individuals exposed to a terrorist incident or public health emergency should be offered psychoeducational support; however, participation in early intervention sessions should be voluntary. The timing and implementation of early interventions should reflect survivors' needs, be acceptable to them and their families, and reflect best available practice. Careful screening and needs assessments can facilitate effective early interventions. Specific screening techniques can be used for individuals or groups at high risk for serious MH outcomes. Screening should be safe and effective. Follow-up should be offered to those at high risk for long-term difficulties.

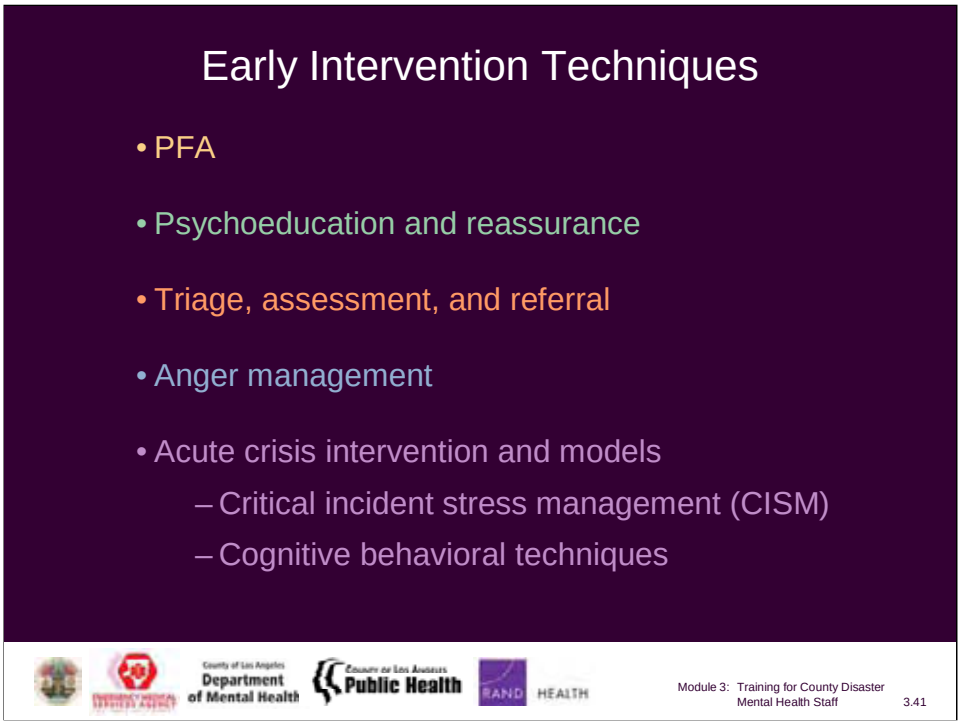


Counseling skills following the incident resemble standard therapeutic skills; however, the time to establish a connection with the client is short and the interaction may include only one brief encounter. You will need to draw on your counseling skills to quickly establish a rapport with the survivor or survivors.

Listen actively so that you can understand the person's needs and concerns—it is okay to allow silence. Remember to attend nonverbally. You should allow expressions of emotions and be sure to reflect the person's feelings.

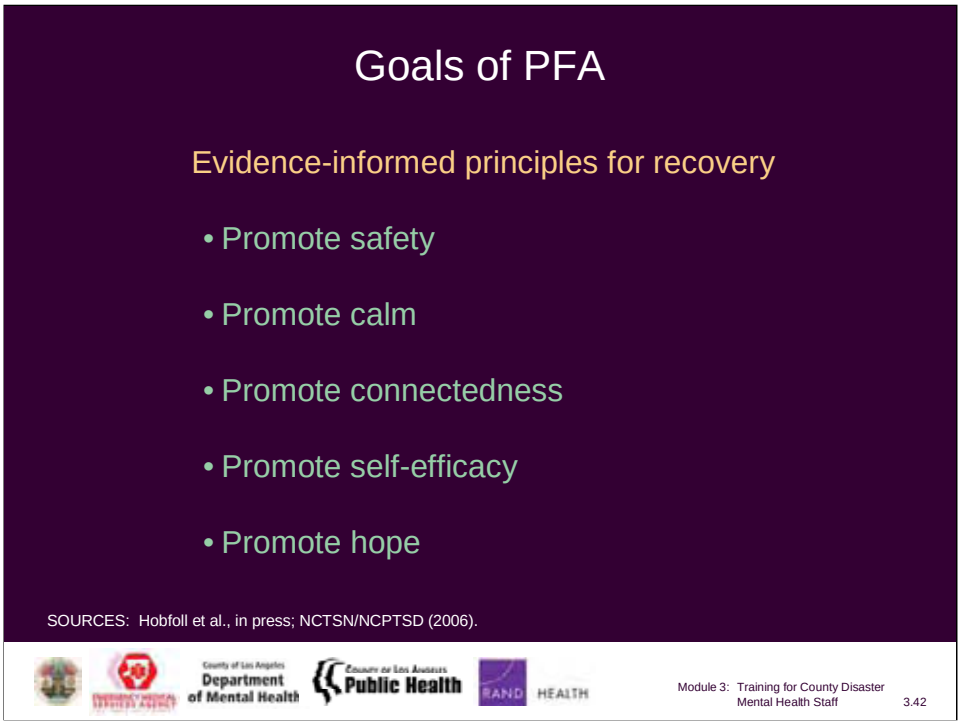
Your goal will be to quickly facilitate problem solving. The first step is to help the person identify and define the immediate problem. Attempt to assess the person's functioning and coping skills, ask about available resources, and work with the individual to develop and implement an action plan for dealing with that immediate problem.

Let's consider some specific techniques for accomplishing this goal.



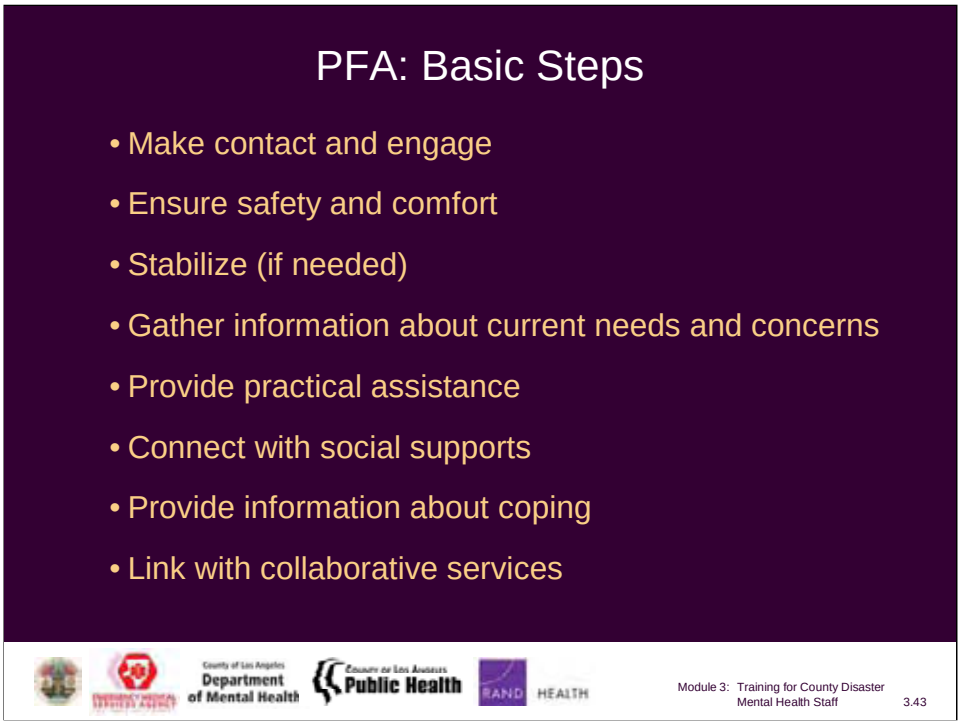
Several early intervention techniques have been developed and used to respond to the psychological consequences of a major disaster. We briefly discuss the following techniques:

- Psychological First Aid (PFA)
- Psychoeducation
- Triage and assessment
- Anger management
- Acute crisis intervention and models, including critical incident stress management (CISM), which was developed to address stress resulting from a disaster.



PFA is an evidence-informed approach to help all kinds of people (including health care workers, children, etc.) immediately following a terrorist event or other large disaster. It is designed to reduce the immediate distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping. Its five principles of recovery are:

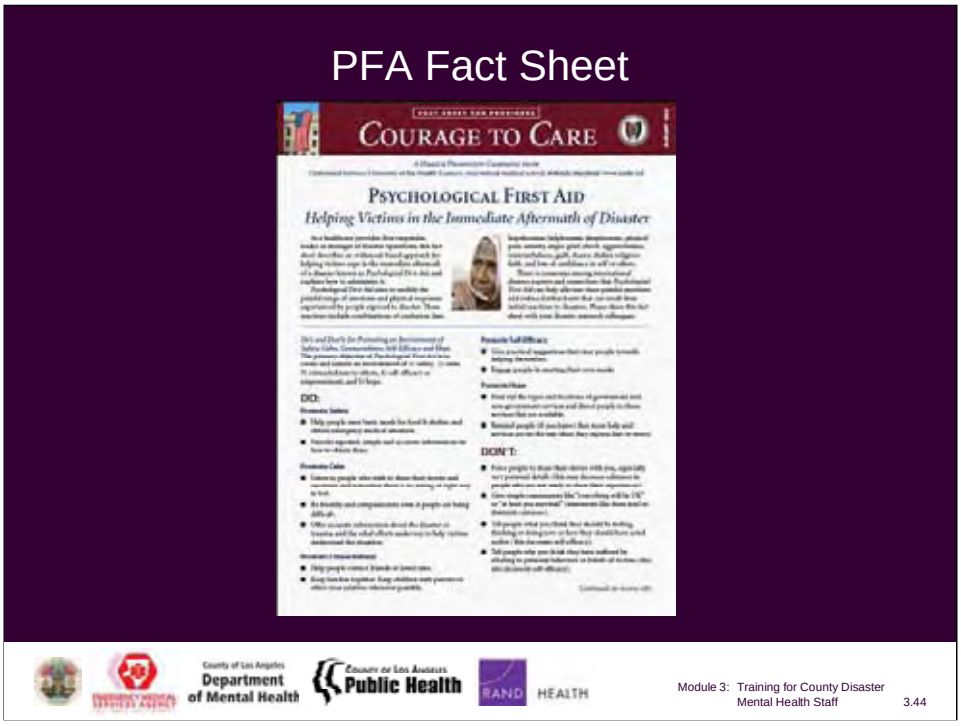
- Safety
- Calmness
- Connectedness
- Self-efficacy
- Hope.



These basic steps in PFA are the core objectives of providing early assistance within days or weeks following an event. Providers should be flexible and base the amount of time they spend on each step on survivors' specific needs and concerns (see the tips for providing PFA in the Tools section and the PFA tip sheet in the Resources section of your binder).

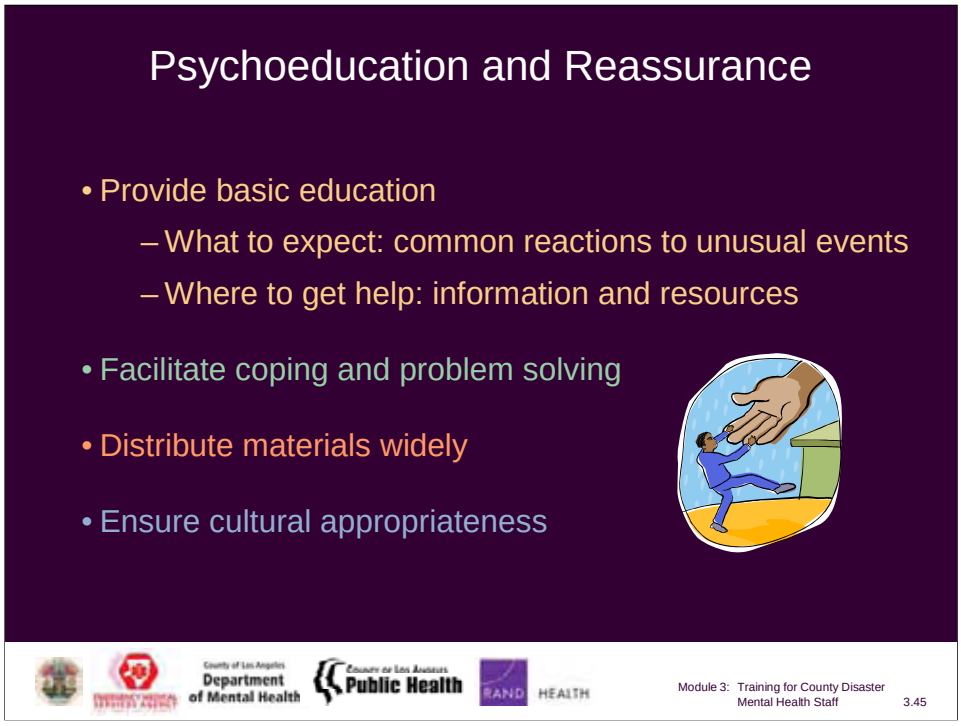
The following are the goals of the basic steps:

- Contact and engagement: respond to contacts initiated by survivors, or initiate contacts in a nonintrusive, compassionate, and helpful manner.
- Safety and support: 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: help survivors address immediate needs and concerns.
- Connection with social supports: help establish contact with support persons, such as crisis or grief counselors, or other sources of support.
- Providing information about coping: help individuals understand how to deal with stress reactions and to reduce distress and promote adaptive functioning.
- Linkage with collaborative services: connect survivors with available services.



This brief fact sheet contains some simple DOs and DON'Ts of PFA. While it is written for a lay audience, it may serve as a helpful reminder of the basic components of PFA, with guidance on what to and what not to do. The fact sheet is available online through the Courage to Care campaign of the Center for the Study of Traumatic Stress:

http://www.centerforthestudyoftraumaticstress.org/education.courage.shtml



The second early intervention technique we discuss is psychoeducation and reassurance. Psychoeducation can provide a critical opportunity to reassure and inform the population.

Materials that provide basic education about what to expect and where to get help can greatly facilitate understanding, coping, and problem solving among survivors.

These materials should be developed in advance of an incident. They can be widely distributed following an emergency, thus lessening the potential burden on the response system. Materials should be culturally appropriate and tailored to specific populations at risk—including children and responders.

The third type of intervention is triage and assessment. Optimally, efforts to conduct early MH assessment and interventions should recognize and be conducted within a hierarchy of needs.

First, ensure that anyone who urgently needs medical or MH care is referred immediately.

As you triage individuals, keep in mind and ask questions about their needs for basic survival: food, shelter, security. Assess their psychological and social support needs and available resources, and be thinking about the appropriateness of further interventions.

Specific referrals to a psychiatrist or other physician for psychotropic medication may also be warranted—for example, for survivors or loved ones who need access to existing psychotropic medications (if they are unable to access their normal supply) or for those who are experiencing severe distress reactions or have difficulty sleeping or concentrating.

A psychiatrist or physician can assess whether medications will be useful in mitigating these symptoms and improving functioning during recovery.

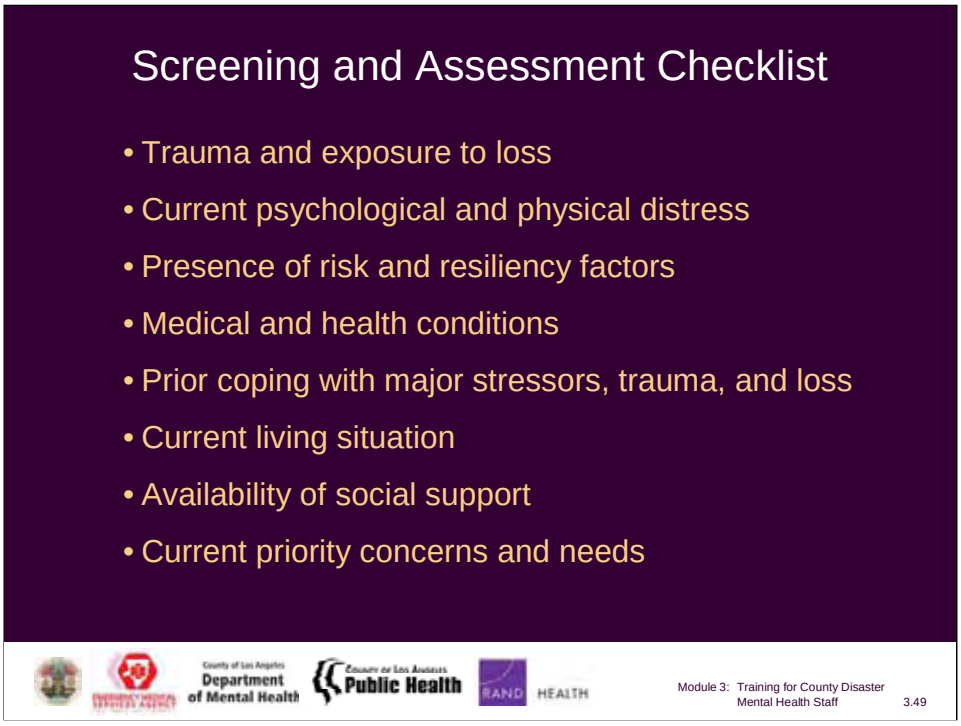
As you triage individuals, keep in mind that they may have multiple concerns and needs—including concerns for basic survival. They may be experiencing grief over loved ones or the loss of possessions, so they may be distraught and unable to fully communicate.

Attend to their fear and anxiety about safety and recognize their need to be part of a community—connectedness is a critical aspect of recovery.

Also, remember that psychological reactions can result from problems in living and changes in normal routines after the disaster—they result not just from exposure to the event, but also in trying to cope and live after the event.

Individuals and groups at high risk of developing adjustment difficulties following exposure to a terrorist incident or other public health emergency should be referred for MH follow-up. You should also refer individuals as appropriate (not all will need a referral):

- Who are disoriented—cannot recall events over the past 24 hours
- Who have clinically significant symptoms stemming from the trauma such as numbing, dissociation, detachment, pervasive recollections, etc., that cause impairment in social, occupational, or other areas of functionality
- Who are bereaved
- Who have a preexisting psychiatric disorder
- Who have required medical or surgical attention
- Who may be unable to care for themselves
- Who exhibit homicidal or suicidal thoughts or plans
- Who have problems with alcohol or drugs
- Who exhibit violent behaviors toward others
- Whose exposure to the event is known to have been particularly intense and of long duration
- Who are isolated and lack social support.



Here is a simple summary checklist for screening and assessment:

- An individual's 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 (if in need of urgent care, including medication provision, referral to an MH specialist or physician, and hospitalization). They should also be directed to immediate and available local services and provided the opportunity to communicate with their family, friends, and community.
- Interventions are most likely to be helpful when they are tailored to address individual, community, and cultural needs and characteristics.

When an individual's sense of security and well-being has been shaken, anger and frustration may result. During the early intervention period, you may need techniques to deal with this reaction from an individual or a group. Anger and frustration can lead to maladaptive behaviors and will require attention and response. Your actions can help to reduce an individual's anger and shape more adaptive behaviors:

- Patience is vital as you interact with angry survivors, or loved ones.
- Remaining calm, composed, and respectful is critical.
- Acknowledge and validate the person's feelings.
- Identifying the specific sources of the anger will be key to mitigating it.
- Although it may be difficult in the face of angry behavior, remain focused on the problem and its resolution—do not become distracted by tangential issues.
- Always remain respectful of the person's feelings—both in your actions and in your word.
- Remember to follow-up and keep any promises that you have made.

We have described four early intervention techniques that have been used effectively in the immediate aftermath of a public health emergency or other disaster: PFA, education and reassurance, triage and assessment, and anger management. Now let's turn our attention to crisis intervention.

This technique is used immediately after an incident, disaster, or emergency. It is often used with survivors who have had their lives severely disrupted and with individuals who are having difficulty coping or are experiencing some level of impairment.

As we talk about this technique, it is important to remember that crisis intervention is not psychotherapy. Crisis intervention is a way to mitigate or prevent more severe consequences. It is not intended nor should it be considered a technique for "curing" an individual's trauma symptoms.

Crisis intervention techniques are designed to provide immediate support and to facilitate coping and recovery. We will consider two of them in some detail: CISM (which is intended for use with staff and other homogeneous groups) and cognitive behavioral therapy (CBT which is not indicated in the first week post-trauma because of the drain on time and energy required by the survivor).

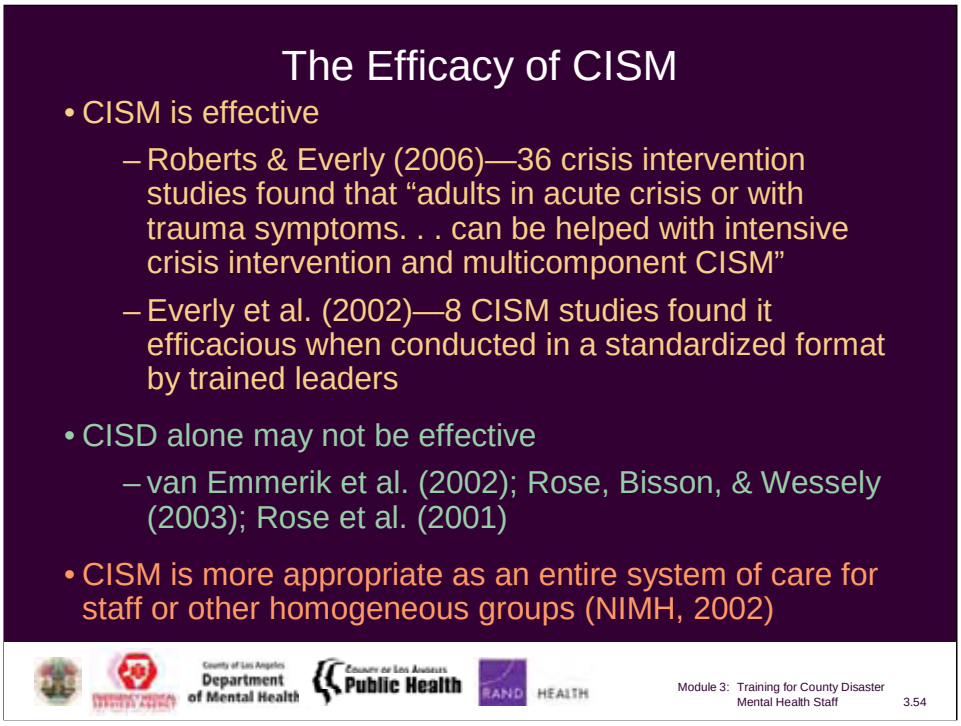
CISM is a collection of evidence-informed interventions designed to prevent and/or mitigate adverse psychological reactions accompanying a disaster.

Most of the evidence for the success of CISM comes from studies of its use with individuals to prevent PTSD. However, the scientific evidence is unclear. The approach may increase sense of support and improve immediate functionality but it is unclear whether it can prevent PTSD.

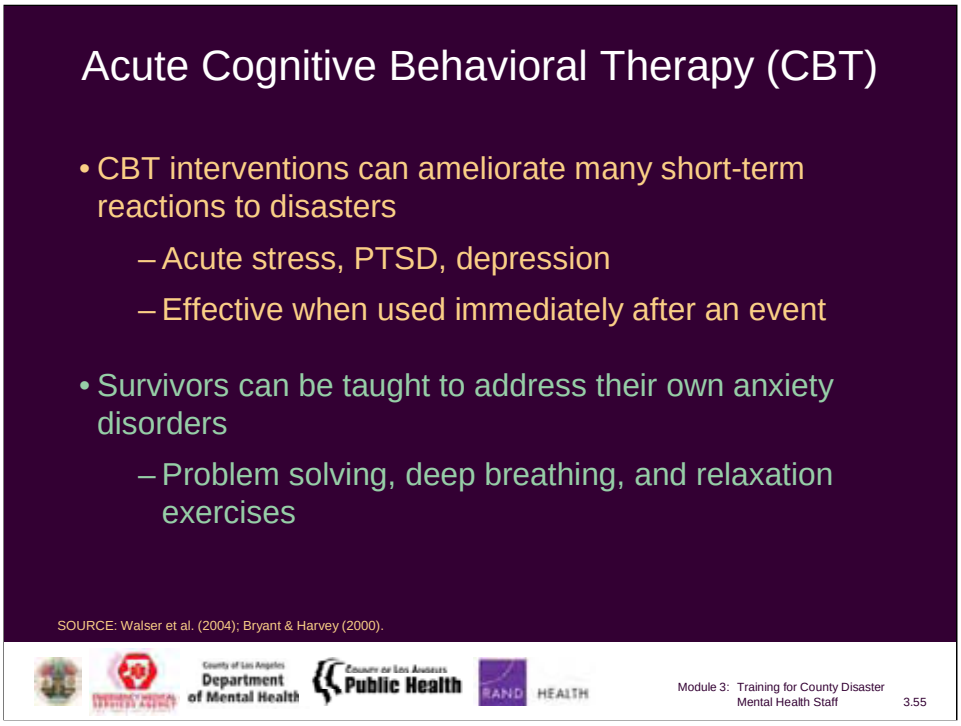
You can find more information about CISM on the International Critical Incident Stress Foundation Web site: http://www.icisf.org/

Licensed MH professional staff, nurses, and other staff who have been specially selected and trained can work together to deliver the components of CISM. The components can be tailored to the particular setting (e.g., emergency services versus hospitals and clinics). Components include:

- Precrisis preparation and education
- Individual crisis intervention support during an event
- Group meetings include:
  - Diffusing for small groups immediately after a traumatic event
  - Crisis management briefings such as critical incident stress debriefing (CISD) for the community
- Support services provided to larger groups, such as "demobilization" for emergency services personnel
- Family support services
- Referrals for those who may need more help
- Follow-up services.

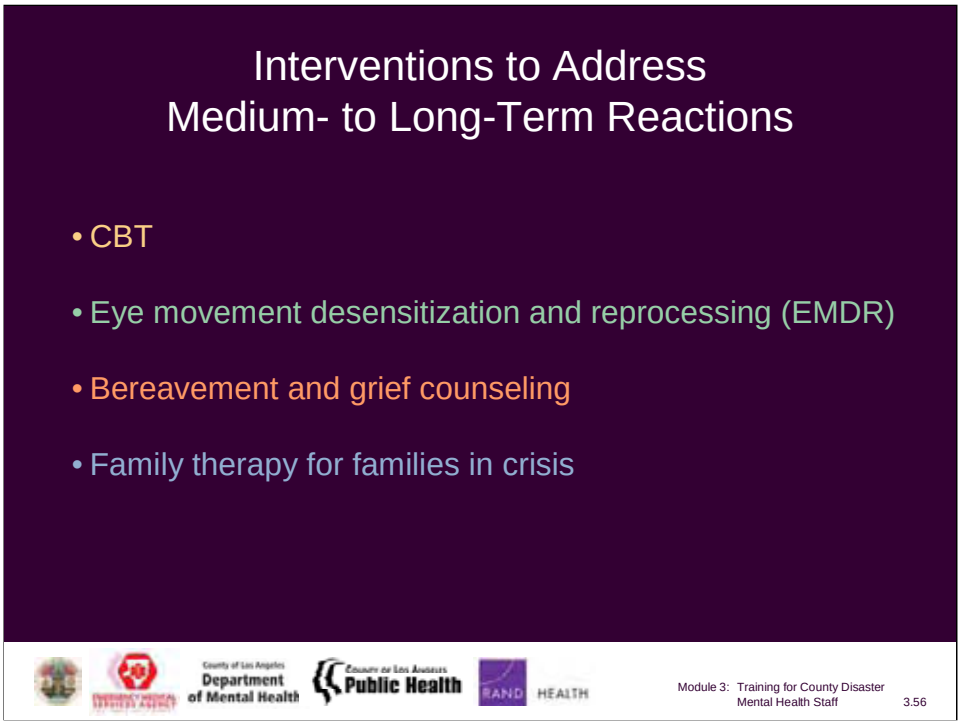


A number of studies have been undertaken to determine the efficacy of CISM. In general CISM, when implemented properly by trained professionals, is an effective crisis intervention model. We have listed a few of the meta-analysis studies that have examined the efficacy. It is important to note that CISD alone may not be effective and in some cases may cause harm if not used by properly trained individuals and in the right context (with first responders such as fire and police) Therefore, CISM is more appropriate as an entire system of care for staff or other homogeneous groups (NIMH, 2002).



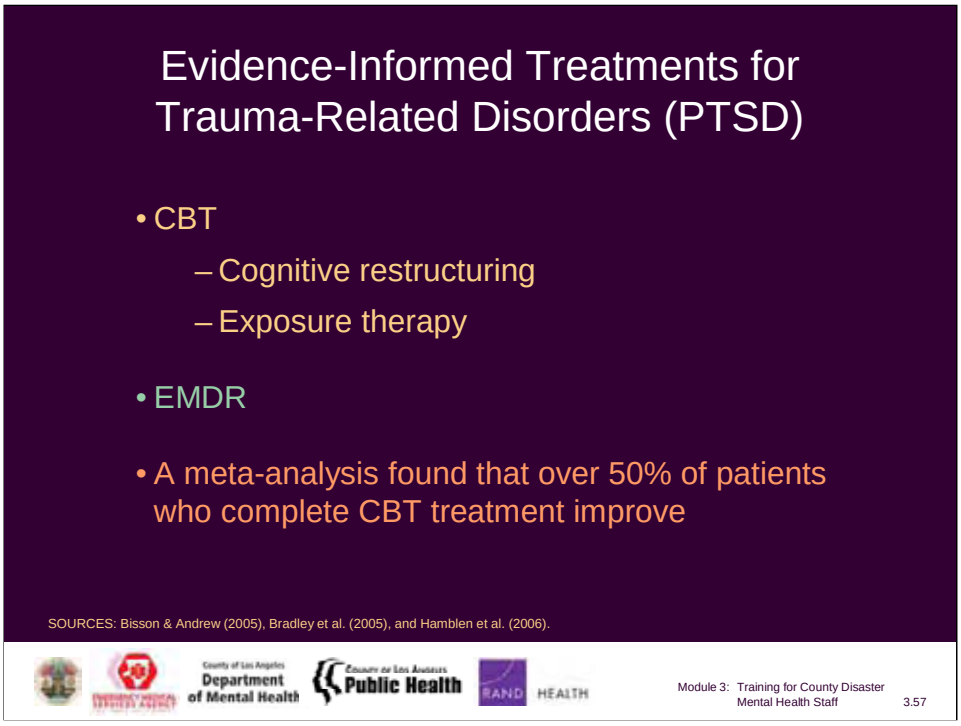
Another acute crisis intervention technique shown to be effective when used after a disaster is cognitive behavioral therapy (CBT). It is usually offered after the immediate week of the disaster.

CBT can reduce and treat many short-term problems following trauma. Examples include acute stress, PTSD, depression, and other psychological problems such as panic disorder and generalized anxiety disorder. CBT emphasizes pragmatic steps to help survivors cope with the situation. In the CBT framework, such problems as increased alcohol use are viewed as "maladaptive behaviors" rather than as signs of mental illness. Teaching survivors to analyze their problem in terms of a challenging situation is another core component of acute CBT. Techniques typically used for anxiety management are also important.



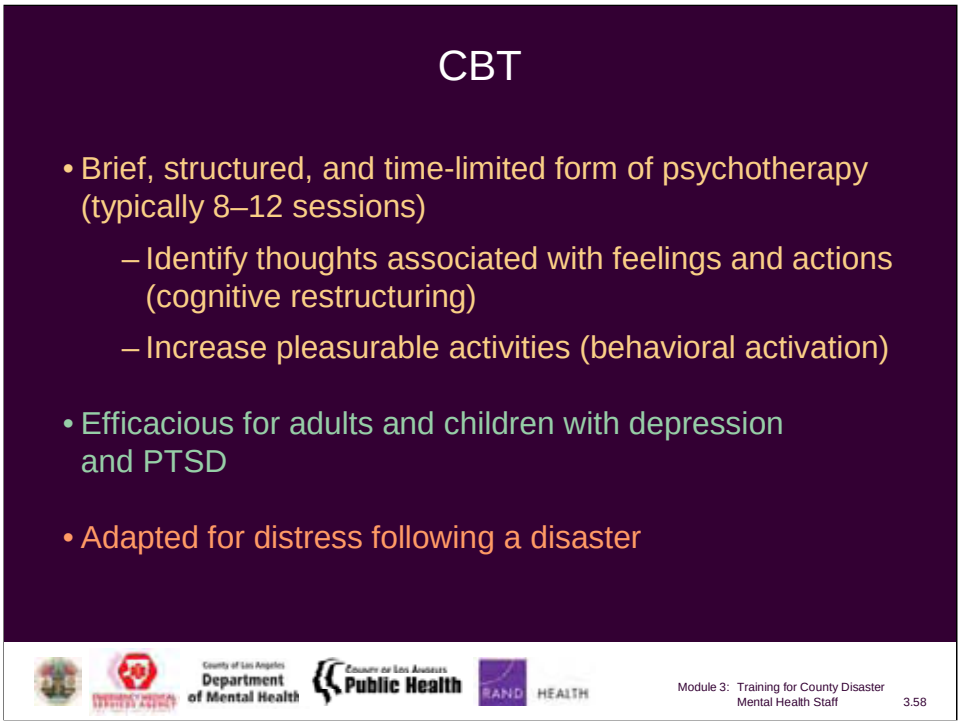
We have been discussing evidence-informed techniques for early intervention. We will now turn our attention to interventions intended to address longer-term reactions to a large-scale emergency. Here are some of these interventions:

- Some forms of psychotherapy, such as CBT
- A form of exposure therapy, eye movement desensitization and reprocessing (EMDR)
- Counseling specifically developed for addressing bereavement and grief
- Forms of family therapy.



Let's begin by noting the types of treatment for which there is scientific evidence of effectiveness:

- CBT, which is based primarily on cognitive restructuring and exposure therapy techniques, has been found to be effective in half of the patients who complete it.
- EMDR also has some evidence for reducing PTSD symptoms. Here we list it as a unique treatment although it is also considered to be another form of CBT.



CBT is a brief, structured, and time-limited approach to psychotherapy that can range from 8–12 sessions.

- A major objective of CBT is to identify thoughts that trigger feelings and actions. Identifying such thoughts is referred to as cognitive restructuring.
- An important characteristic of CBT is its emphasis on finding ways for recipients to increase activities that they normally find pleasurable—e.g., being with friends and family, listening to music, going to the park.

CBT has been found to be effective in both children and adults suffering from depression and PTSD. It has also been adapted as a strategy for helping survivors of disasters.

This adapted form of CBT, funded through Project Liberty (a federally funded crisis counseling program used following the 9/11 terrorist attacks and the Florida hurricanes in 2004), was developed to provide support to survivors of 9/11. Candidates who might benefit from this approach are those who have more than transient stress following a disaster. The therapy serves as an intermediate step between crisis counseling and longer-term psychotherapy. The ideal timing for this intervention is 60 days after the disaster.

CBT for disaster survivors is designed to follow a protocol and to cover 8–12 sessions addressing those problems that persist following exposure to a disaster.

The approach takes into account various techniques that have been shown to be effective in the literature for a wide range of symptoms, including anxiety, depression, substance abuse, grief, and anger.

The intervention has three parts:

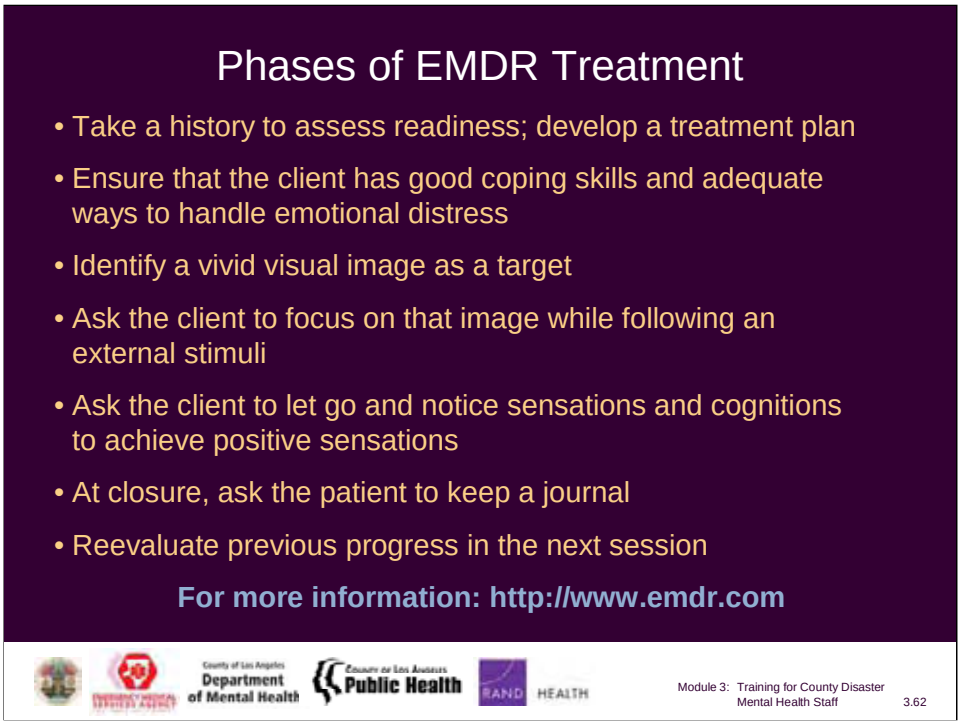
- Psychoeducation
- Coping skills
- Cognitive restructuring.

It is important to note that this intervention is not designed to treat a specific MH diagnosis.

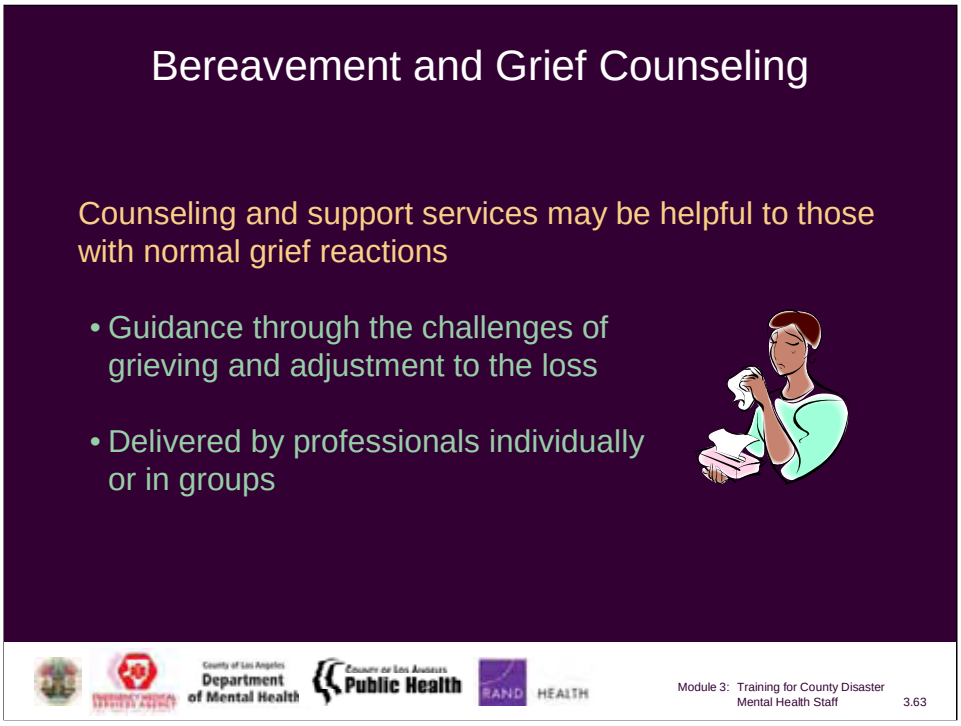
Another evidence-informed technique for addressing long-term reactions to a disaster is EMDR. This approach involves some exposure therapy and processing of the traumatic event.

It is effective in substantially reducing PTSD and depression over a sustained period. Studies have shown that it is more effective than psychotropic medications and is especially effective for adult-onset trauma survivors.

The Veterans Administration has given this form of therapy the highest level of recommendation for treating trauma.



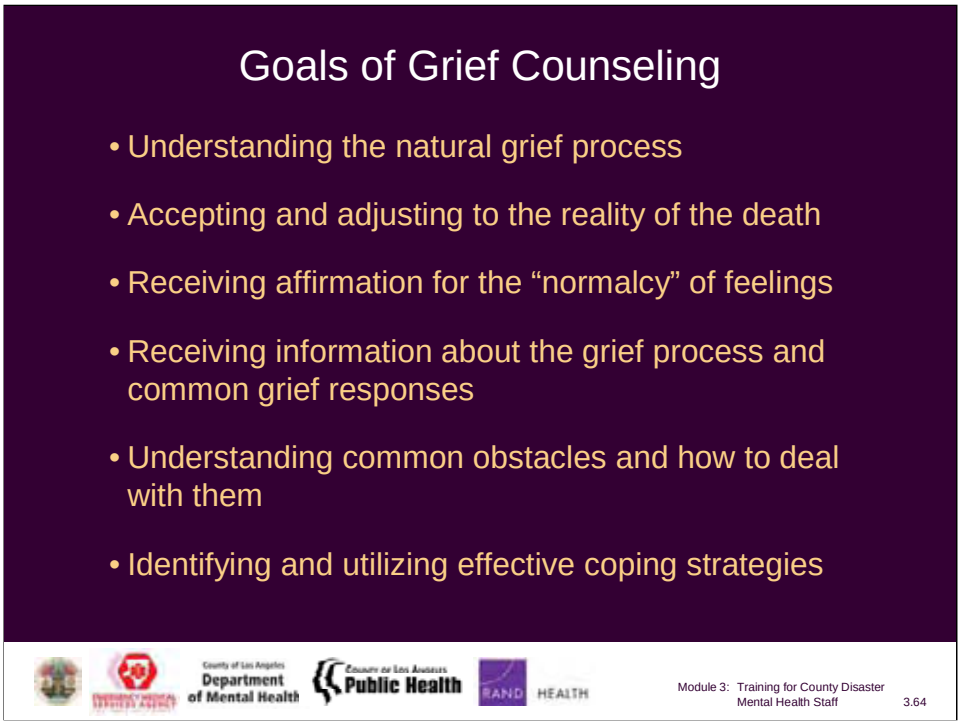
EMDR has eight basic phases. The first phase is a history-taking session. The therapist assesses readiness for EMDR and develops a treatment plan. The second phase involves ensuring that the client has adequate ways to handle emotional distress and has coping skills. In the third stage, a target image is identified. The fourth through sixth phases involve processing the target image or memory that is most salient (i.e., bodily feeling) to generate positive beliefs and emotions. In the subsequent phases, the client focuses on the image while simultaneously using eye movements (or sounds or touch) to let the mind go and continue to process the distress until it is completely diminished. In the seventh phase, the therapist attempts to obtain closure and asks the client to keep a journal to document instances that remind the client of the event. Follow-up sessions begin at phase eight, when progress is evaluated. You can go to the EMDR Institute Web site for more information.



A third type of intervention for addressing longer-term reactions is bereavement and grief counseling. This approach can help people adjust to the loss of a loved one. It is delivered by professionals in either individual or group format.

Disasters involve a variety of losses with which people may have difficulty coping. Helping people understand and deal with their grief is an important part of the disaster recovery process, and grief counseling is one of the most commonly used longer-term interventions:

- Counseling may focus on a variety of losses, including family members, pets, belongings, community, and peace of mind and security.
- People injured in a disaster might also experience the loss associated with diminished functioning and a loss of independence.
- People without a network of family and community support may need more assistance.
- People who have already experienced many losses, children, and other vulnerable groups might also have an especially difficult time coping.



The goals of grief counseling include:

- Helping the patient understand the natural process involved in grieving, which will vary by culture
- Affirming the normalcy of the patient's feelings
- Providing information on what to expect
- Understanding the challenges and what to do to overcome them
- Helping the bereaved cope effectively by helping him or her emphasize the positive qualities of the deceased person or identify sources of support (through peer groups) to help share feelings.

There are different approaches to grief counseling for different situations.

Grief therapy (interpersonal therapy/IPT or complicated grief therapy/CGT) can help with complicated forms of grief and help resolve conflicts that arise from separation, inability to experience normal grief, and resurgence of grief reactions:

- Complicated grief is unresolved grief that is characterized by prolonged mourning and being overwhelmed by emotions.
- When grief begins to interfere with other healthy relationships, a job or school work, more serious help is needed.
- Complicated grief is distinguished from a natural phase of grief mostly by its duration (grief symptoms persisting for at least six months following loss of a loved one).

Bereavement groups can help people put their feelings in perspective relative to others with similar experiences. Groups can also help people feel less isolated.

Counseling can be tailored for specific groups, such as widows, parents who have lost a child, and those grieving the suicide of a family member.

The last kind of intervention for longer-term reactions that we will discuss is family therapy. Trauma experienced by individuals who are exposed to an agent, experience terrorism, or survive other disasters usually affects the entire family.

Disaster situations often lead to dysfunctional family behaviors.

- For example, six months after Hurricane Andrew, the incidence of child and spousal abuse had increased dramatically from levels before the disaster.

The main goal of family therapy is to restore healthy family functioning. The first step is to understand exactly how the crisis affects the family. Not all families will react in the same way to the same crisis. Every post-disaster family has a pre-disaster history. Family problems that existed before the disaster are very likely to be there after the disaster and become exacerbated. To address these issues, use problem-solving strategies and teach coping skills.

Ultimately, therapy should bring family interactions back into balance by reestablishing the role of the family members and rebuilding lines of communication.

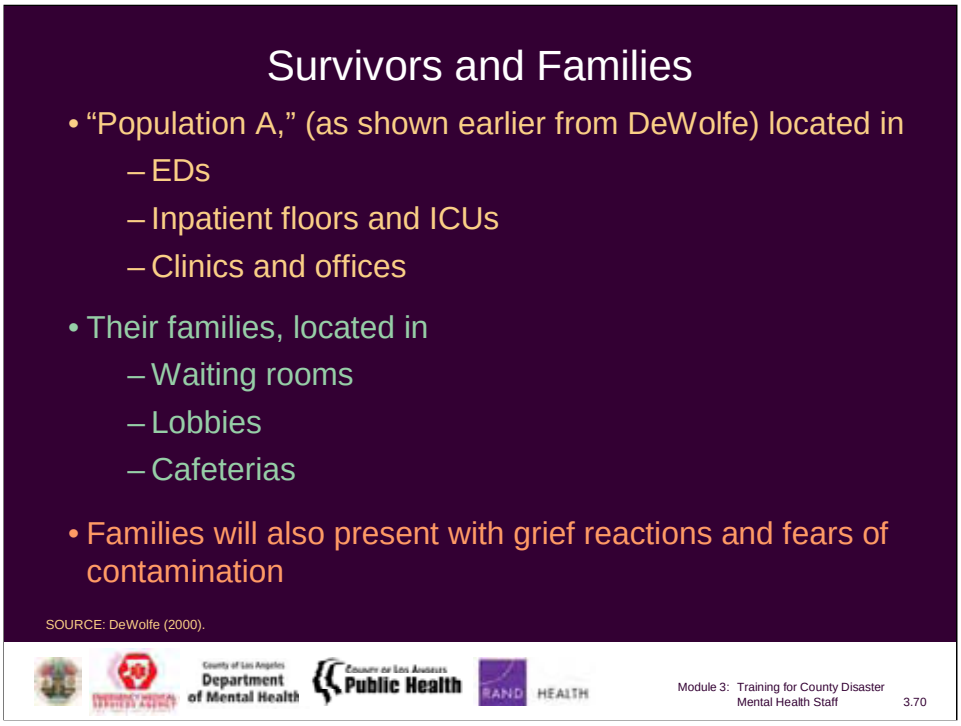
Let's now turn our attention to special populations. Why are they special? How can we interact with them in ways that meet their needs?

We are concerned with those with whom hospitals, clinics, and health care staff will be dealing. These include:

- Survivors and their families, including persons exposed but not necessarily seriously injured, and families of victims who have died
- Individuals who were not exposed, but who may have symptoms that they feel are due to the event
- Current hospital patients
- Hospital staff
- Disruptive patients in the ER insisting on receiving care ahead of others.

In addition to those groups above, we are also concerned with the following special populations:

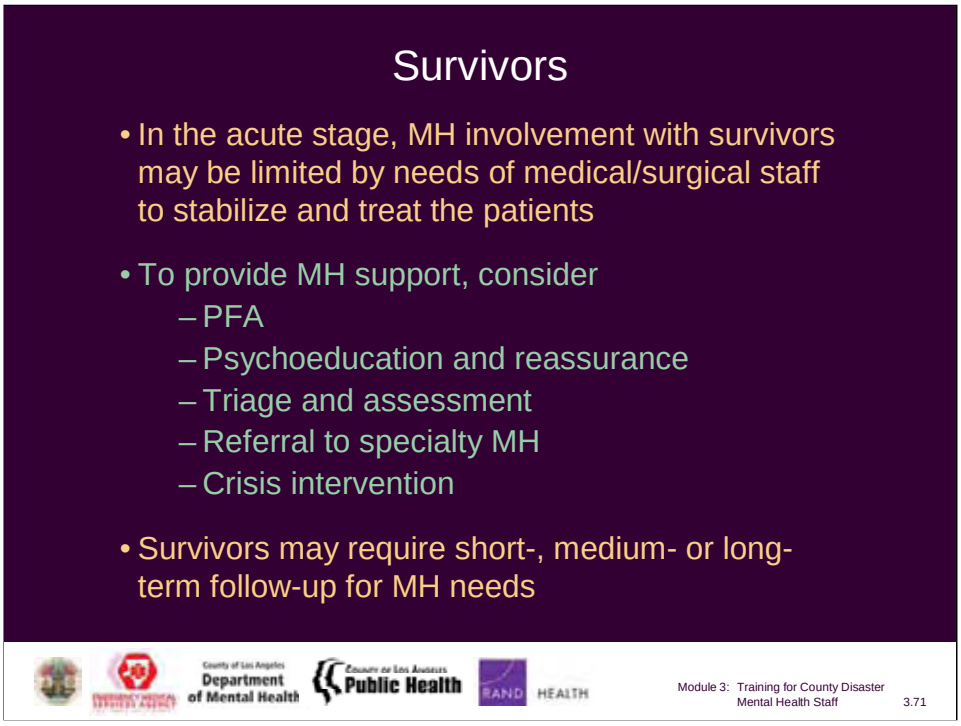
- Individuals or families that may require special assistance—e.g., persons with physical or developmental disabilities, sensory impairments, or chronic diseases such as HIV/AIDS; those who are nonambulatory; the elderly; and children
- The chronically mentally ill.



Clearly one of the main populations we are concerned about are those who were injured or made ill by the event and the families of these survivors. This is "Population A" from the population exposure model.

These patients will be located in the EDs, inpatient floors, and intensive care units (ICUs), as well as in clinics and offices. Their families will be in all these places and elsewhere—waiting rooms, lobbies, and cafeterias for instance. Families will also present with grief reactions and fears of contamination.

Let's discuss these groups in more detail.

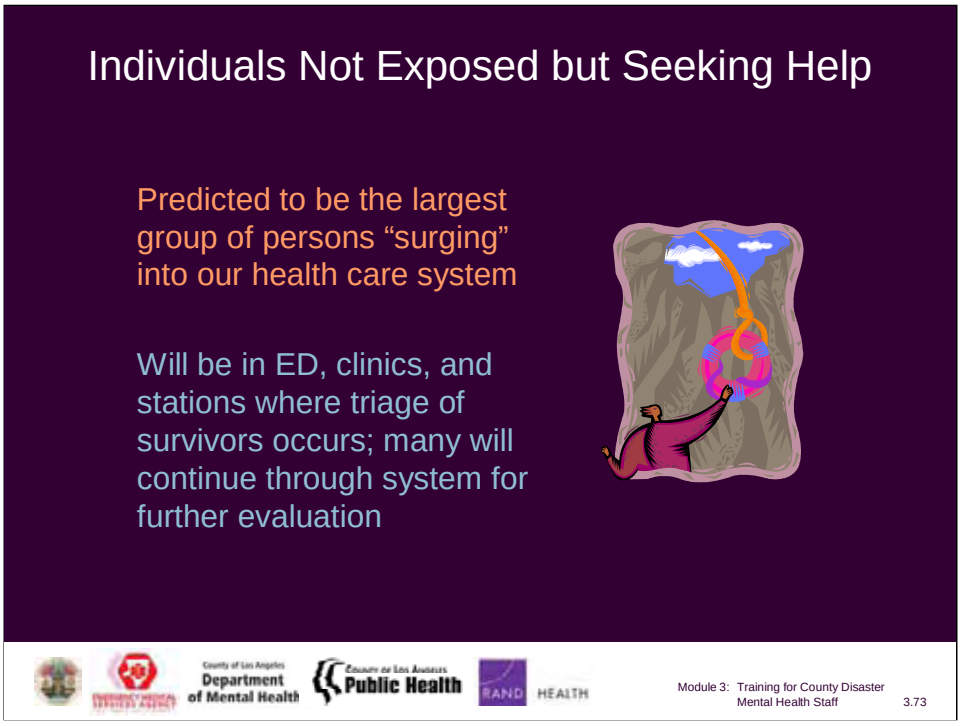


In the acute stage of disaster your ability to provide MH care may be limited by the needs of medical/surgical staff who need to first stabilize and treat these patients. Recalling some of the interventions we just discussed, you may want to consider using PFA, psychoeducation and reassurance, and triage and assessment. Acute crisis intervention techniques and referrals to specialty MH staff may also be appropriate.

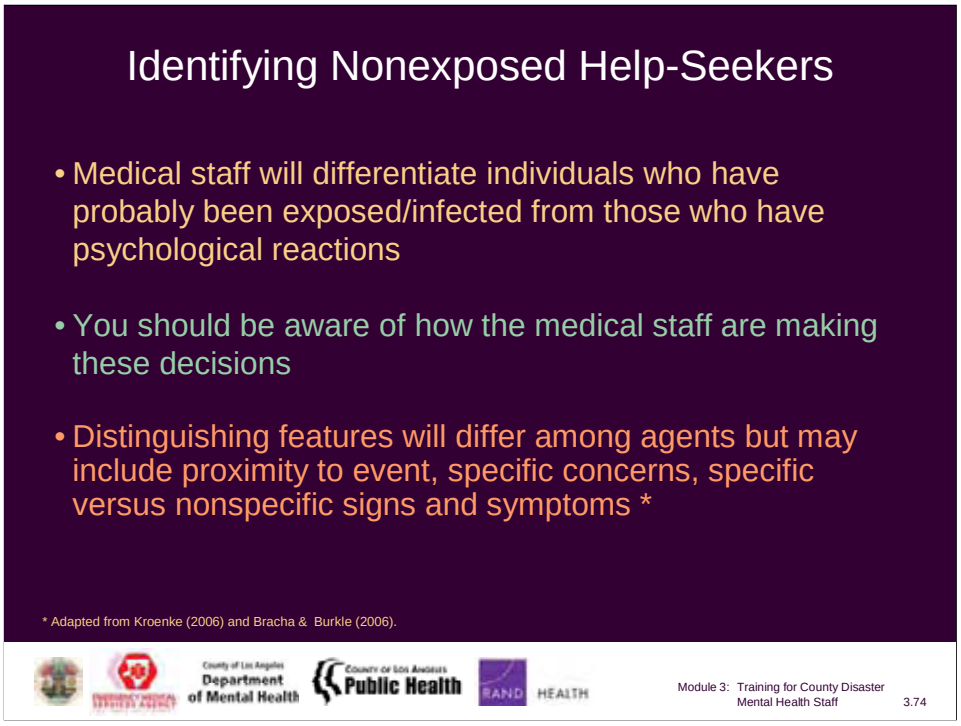
These survivors will require short- to long-term follow-up for their MH needs.

Triage decisions will dictate how urgently families of victims should be seen relative to the survivors with acute medical needs. Early intervention techniques may be especially useful for family members. Anger management and grief counseling may be particularly appropriate.

Family members may also need medication because they do not have their prescription medications with them or because they need a new prescription for anxiety and sleeplessness. Follow-up arrangements should be considered to evaluate family members for medium- to long-term MH concerns.



People who had no direct exposure to the event but have event-related concerns are predicted to be the largest group of persons who will be "surging" into our health care system. They will turn up in the ED, clinics, and stations where triage of survivors occurs. Many of them will continue through the system for further evaluation.



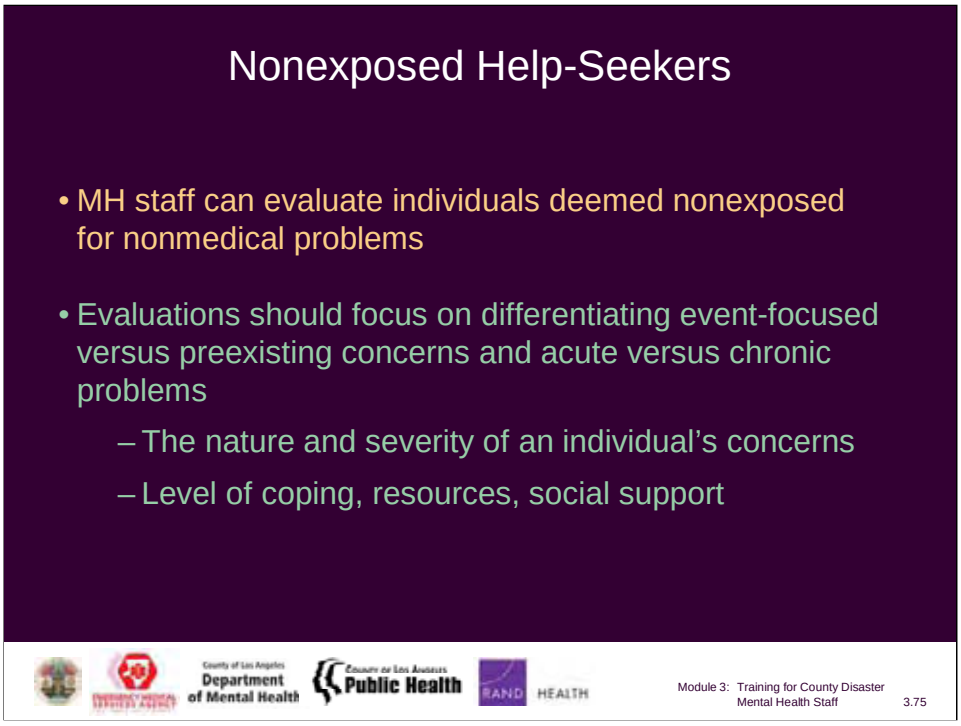
It will be the responsibility of the medical staff to differentiate individuals who have probably been exposed/infected from those who are having psychological reactions.

Knowing how medical staff are making these decisions may help you choose which interventions you will use first, such as PFA, anger management, and patient advocacy.

It will be difficult to distinguish those who were probably exposed from the nonexposed help-seekers. Distinguishing features differ among agents, assuming we even know what the causative agent is at the time. For this reason alone, no single "one size fits all" screening instrument is likely to be available early in a crisis. Key information that will distinguish these groups will probably include:*

- Proximity to the event: Is the individual in a geographic area at high risk?
- Are symptoms present? If yes:
  - Are symptoms *nonspecific* (e.g., fatigue, headache, dizziness)?
  - Are symptoms more *discriminating*, i.e., ones that are less common in psychosomatic-related distress (e.g., fever, vomiting, diarrhea, skin changes, blurred vision)?

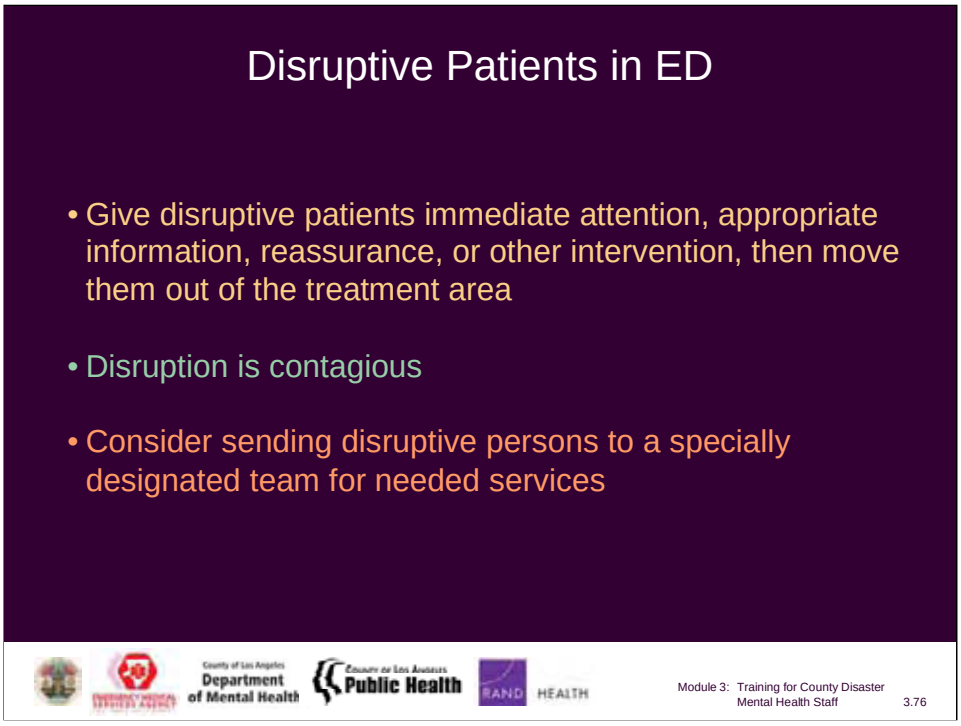
* Adapted from Kroenke (2006) and Bracha & Burkle (2006).



Once the medical staff have determined that an individual is probably not infected or exposed and that the event-triggered symptoms or concerns are nonmedical, a staff member with MH training may be asked to evaluate the person for the type of nonmedical (potentially psychological) problem and to determine the resources best suited to manage the problem. This face-to-face encounter should occur in an infection/exposure-free zone. The goal is to provide high-quality care while balancing needs to "bring them in and move them out."

The evaluation should focus on differentiating event-focused versus preexisting concerns and acute versus chronic problems. Areas of evaluation should include:

- The nature and severity of an individual's specific concerns. What is the person's level of distress? Is it consistent with an expected grief reaction or beyond that expected (e.g., extreme physical reactions)?
- Level of coping, resources, social support (for the frail elderly, for children, and for those who are socially isolated).



Some individuals in the ED may disrupt the staff's ability to provide care by becoming combative, confrontational, or offensive. Give them attention immediately, provide appropriate information and assurance, then move them out of the treatment area.

Because disruption is contagious, you may be able to prevent it with videos, by "walking the line," communicating, handing out water, telling people they can use "line holders" i.e., if a person needs to go to the bathroom, etc.

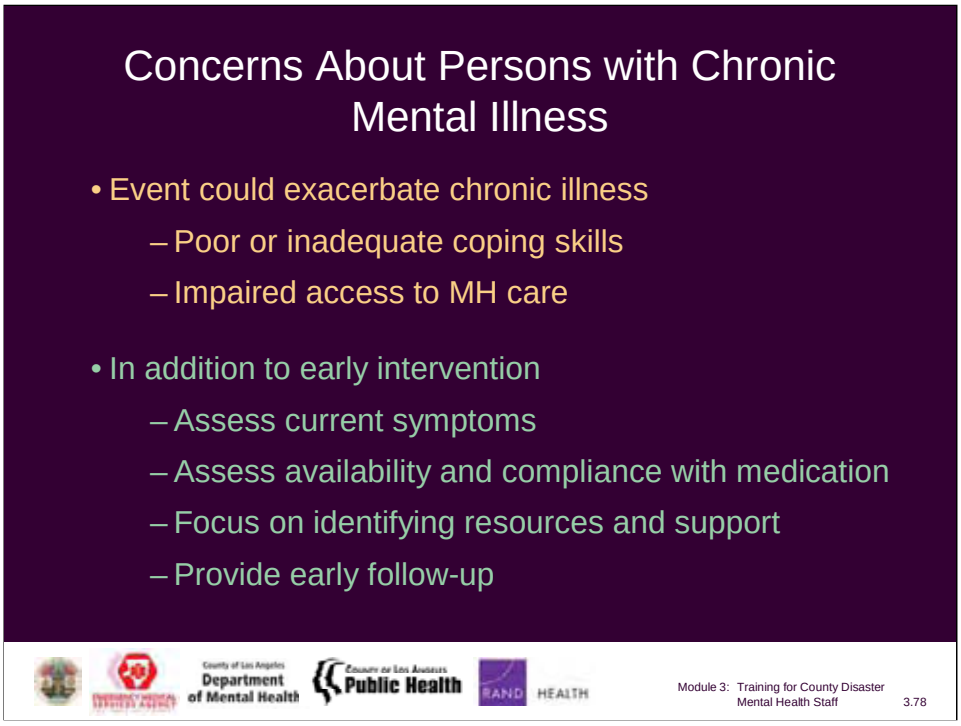
Consider sending disruptive persons to a specifically designated team to ensure that they get whatever services they need as quickly as possible and to make certain that they are not asked by staff to leave the ED or physically removed by security. The name of such a team need not be "special needs"—it could be "crisis team" or "fast track," etc.

Individuals requiring special assistance include anyone whose needs are not fully addressed by traditional health care services or who may be less able to access and use standard health care resources. Therefore, they include but are not limited to those who are physically and mentally disabled; medically or chemically dependent individuals; the homeless; the frail elderly; and children (adapted from U.S. Department of Health and Human Services, 2006).

Individuals who are hearing or vision impaired may also need special assistance—you may need an interpreter to work with them.

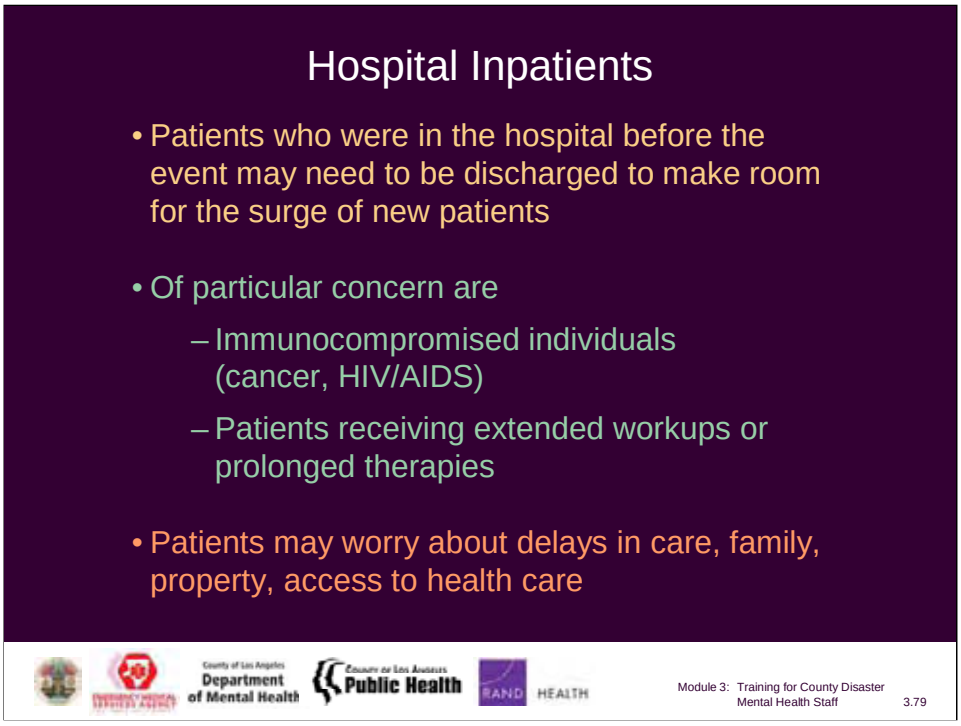
All of these groups are at increased risk of harm because they are less able to detect and respond to changes in their environment and because they have fewer physical or cognitive resources for recovery.

Their MH problems may present in atypical ways—for example, children may regress to earlier patterns of behaviors or exhibit excessive fear of losing their parents; the frail elderly may experience decreased cognitive capacity (such as forgetting) as a symptom of a primary psychiatric disorder. For the elderly, you may need to work with caregivers and neighbors who will have information about them and the ability to help them.



One population whose needs are unique are persons with chronic mental illness, such as schizophrenia. A disaster may exacerbate their chronic illness because such individuals typically have poor coping skills and impaired access to MH care because they do not know how to find or ask for it.

Early interventions are appropriate for this group. In addition, you need to assess their current symptoms and determine whether they have their needed medications and are complying with their medication regimen. Your focus should be to identify tangible resources and social support and to provide early follow-up.



Los Angeles hospitals are filled with patients of all ages, receiving health care services of all kinds. Such patients will be in the hospital immediately before and immediately after an event, at least until they can be discharged to make room for the surge of new admissions.

These patients and their families will have reasonable concerns about how the emergency will affect the patients' health and health care. For instance, all patients, especially immunocompromised patients (with HIV/AIDS or cancer or on immunosuppressive therapies), may fear becoming ill from newly admitted, contaminated patients.

Patients undergoing prolonged diagnostic workups or therapies will be concerned about delays in care, cancellations of procedures, and hastened discharges.

All patients, shut off as they are from the outside world, may fear for their families' lives, their property, etc. and be without the resources or ability to find out how they fared.

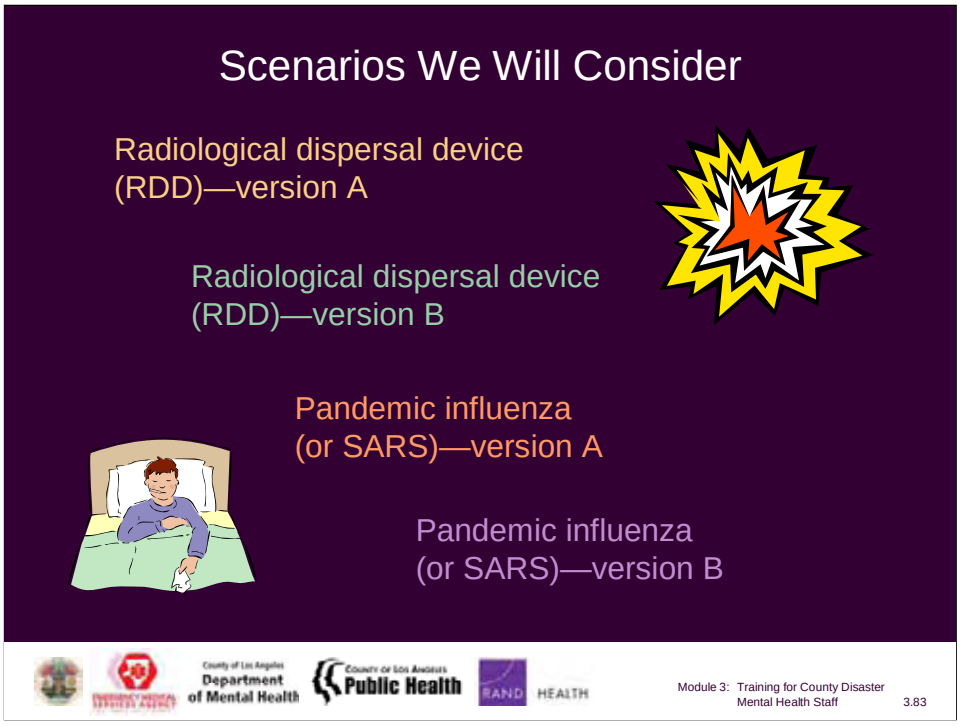
We probably know the least about this group of people because they have not been discussed in the literature regarding SARS or other events. This apparent shortcoming may be because this issue was not significant or because no one has documented it and the lessons learned.

Triage decisions will dictate how urgently these cases should be seen relative to the survivors with acute MH needs and their families. That said, we suggest that some of the principles of early intervention may be useful here, especially providing crisis intervention by reducing emotional distress and mental stress, facilitating problem-solving skills, and advocating for them by helping the entire health care team understand and address the specific needs of patients who are being pushed to discharge.

Finally, we consider how MH staff can help support hospital and clinic staff:

- Provide simple support and advice, e.g., encourage self-care as we discussed in module 2 regarding burnout. Support includes the simple tasks of normalizing staff reactions to the events ("all who witness are affected"); helping them see their competency, strengths, and different ways of coping; encouraging certain behaviors (relaxation time, use of social supports) while discouraging others (drinking); and so on.
- MH staff seeing patients should be encouraged to chat with hospital and clinic staff. It is important to just walk around, be seen, and be part of the team.
- Staff break areas also offer opportunities to provide MH support.

Now it is time for group discussion.



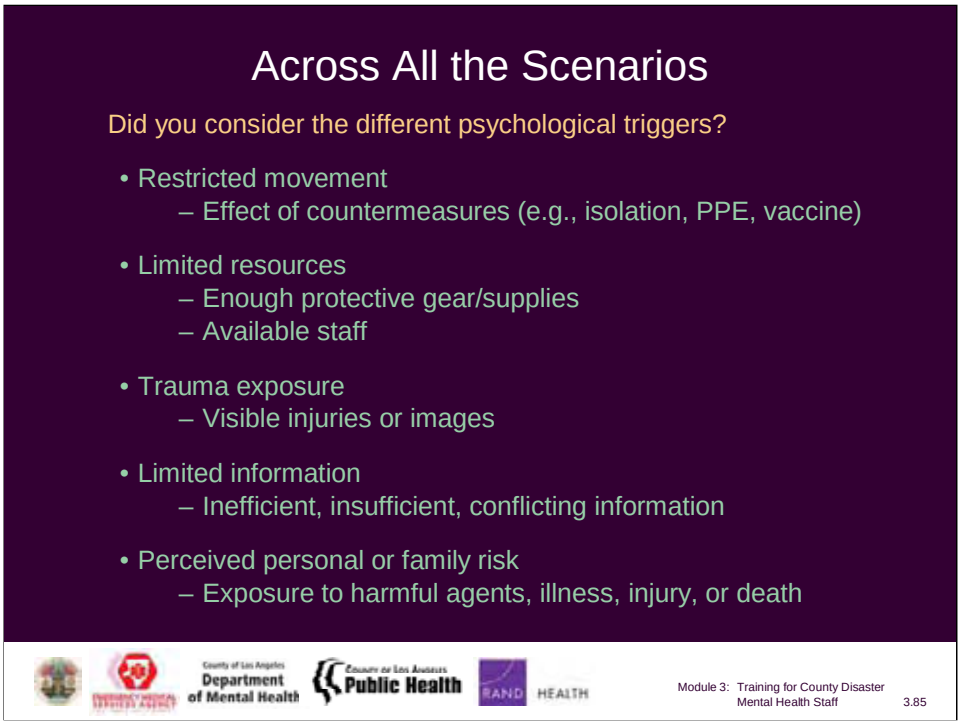
Now we are going to divide you into four groups. Each group will be given one of four scenarios that we have been using throughout this course. You will need to select a note taker as well as someone to report back to the group.

Self-study participants: If you are reading this manual as a self-study guide, see the scenarios for "break-out" sessions included in your binder. You should read each in turn and then look at the answers on the subsequent pages.

Please follow this group process: Imagine that you are called to provide MH assistance, you receive an incident briefing, and then you are assigned to a health care facility.

- This is your opportunity to tell us what you have learned from this module.
- Please assign someone to lead your group and a note taker.
- Spend about 15 minutes answering the different questions at the end of your briefing description.
- Then, summarize your response to the broader group.

If you are reading this manual for self-study, be sure not to peek at the answers on the next slide until you have answered the questions in the scenarios included in your binder.



We hope you were able to identify the different psychological triggers in each of the scenarios.

Here is a review of the different categories that we have covered throughout this training.

The RDD scenario emphasized all five of the key triggers of psychological reactions that we covered in modules 1 and 2 including:

- Resource limitations
- Traumatic exposure
- Limited information
- Restricted movement
- Perceived personal or family risk.

These are the different aspects that you should have considered in responding to this RDD situation. For example, you should have checked with the MH team leader upon arrival at the hospital or clinic to clarify your role. Also, you should have assessed the availability of protective equipment and taken safety precautions for yourself. If there is a large surge of people who do not need medical attention but are worried about contamination, then you would need to identify these individuals and provide PFA and consider what other interventions are appropriate. You will also want to consider any specific cultural needs of the people present, such as a translator if there are non-English speakers needing help.

Here are some of the variables you should have considered in responding to a pandemic flu (pan-flu) situation.

Besides the responses we covered for RDD, many of which also apply for pan-flu, you should have considered:

- How to protect yourself and others from exposure to a contagious disease
- Self-care needs of staff and how to help them.

Also, when you are relieved of your shift or duties, be sure to brief your replacement, which is applicable for all types of disasters.

We have arranged for you to receive continuing education credit for participation in this training. Please remember to complete your paperwork and return it.

We hope that in this module you have learned more about how county MH staff can assist hospital and clinic staff with the psychological aspects of a large-scale emergency.

Thank you for participating in this training module.