


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




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

Three Modular Training Components

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

➔ **Module 2:** one-hour module for health center 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



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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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Course Objectives

After completing this module, you will:

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

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Integrating MH into the Disaster Response

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

MH Is a Lonely Silo

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



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



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MH and Medical Care Should Complement Each Other

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



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



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Functions for MH Staff

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

Where are the areas of greatest MH need?

What functions should be performed by MH staff?

What functions could be performed by other staff?



Areas Likely to Trigger Psychological Reactions

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



Other Areas Vulnerable to Triggers

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



Meeting Needs in Vulnerable Locations: Planning for Staff Placement

In advance of a disaster:

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



Issues to Consider in Placing MH Staff

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



What Will MH Staff Do?

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



MH Support Functions for Non-MH Staff

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

Psychological Reactions to Large-Scale Disasters

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

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

Emotional Reactions

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








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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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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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Cognitive Effects

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

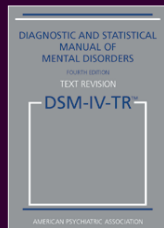


Somatic Reactions

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

Diagnosable Psychiatric Illness

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



Psychological Reactions: Summary

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

Evidence-Informed Practices for Early Intervention

- Integrating MH into the response: Addressing cultural barriers and structural obstacles
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SOURCES: Hobfoll, Watson, Bell et al., in press, NIMH (2002).

Objectives of Early Interventions

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

SOURCE: National Institute of Mental Health, 2002.

What Evidence Suggests About Early Interventions

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

Key Reminders

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

Recognize and Address Hierarchy of Needs

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




Key Steps in Early Intervention

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


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Follow-up Should Be Offered to Some Individuals

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


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Psychological First Aid

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About PFA

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



PFA—for Whom? By Whom?

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

SOURCE: NCTSN/NCTSD (2006).



Strengths of PFA

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



Eight Core Components of PFA

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






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



1. Contact and Engagement

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

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



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






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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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3. Stabilization (if needed)

Goal: Calm overwhelmed or distraught survivors

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

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



4. Information Gathering

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

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

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



5. Practical Assistance

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

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

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



6. Connection with Social Support

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

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

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

Types of Social Support You Can Provide

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

7. Information on Coping

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

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



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

8. Linkage with Collaborative Services

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

Provide direct referrals to additional services

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

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



Addressing the MH Needs of Special Populations

- Integrating MH into the response: Addressing cultural barriers and structural obstacles
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- ➔ **Special populations: Their unique needs**
- Principles of self-care for HCWs: Preventing burnout
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Special Populations

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

Needs Resulting from Trauma Exposure: Special Populations

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

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

Needs Resulting from Limited Information: Special Populations

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

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

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

Needs Resulting from Perceived Risk: Special Populations

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

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

Culturally Relevant Services

Some cultural minorities may

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

Principles of Self-Care

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- ➔ **Principles of self-care for HCWs: Preventing burnout**
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What Is Burnout?

A form of psychological distress (not a diagnosis)

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



* Schaufeli and Buunk, 2003, p. 388.



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Department of Public Health

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Burnout Is an Imbalance Between Supply and Demand

Stressed and overburdened at work and outside work

Perception that support and resources at work are inadequate

Prevalence rates during SARS 10%–30%



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What Generates Demand?

Changes in workload and overtime

Unfamiliar work

Greater conflict at work

Social isolation or stigmatization

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



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What Might Increase Supply?

- Training and education in infection control procedures and use of PPE
- Adequate supplies of PPE
- Support for worker well-being ensuring safety at the workplace


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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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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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How Supervisors Can Maintain a Supportive Environment

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

SAMHSA Tips for Workers



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

Materials for Patients and How to Use Them

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Psychoeducational Materials

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

Online Resources

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

SAMHSA Tips for Survivors



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

Example 3: Pandemic Flu

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

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

What do you do?

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

How Prepared Is Your Facility? —Final Thoughts—

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

Final Thoughts

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Final Thoughts

Summary

Continuing education credit

Resources
