Disaster Mental Health Services:

Implementation, Training, and Sustainability

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20.1 Introduction

Disasters and other potentially traumatic events can adversely affect the mental health of those exposed. In order to minimize the negative psychosocial consequences of these events, it is important for certain healthcare organizations[1] and higher learning institutions to operate disaster mental health (DMH) services. This chapter clarifies important considerations related to services implementation; delineates content and processes in the training of managers, supervisors, service practitioners and teams, and identifies strategies for achieving program sustainability. Discussion is organized around two primary phases of disaster response in which teams are likely to be deployed: the immediate hours and days following an event, and weeks and months later when many survivors may benefit from brief crisis counseling.

20.2 Establishment of DMH Services Within an Organization: The Implementation Process

The implementation of DMH services within an organization often begins as a response to legislative mandates, new funding/training resources, executive decisions, or simply the perceived need to participate and contribute help during the immediate phase of disaster. Paraphrasing Andreasen (1995), the "DMH exploration process" requires knowing the needs of those affected by the event and matching interventions and creating services to meet those needs. Typically, as a first step, a disaster mental health steering committee is formed to develop and adopt a policy defining:

- Mission;
- Funding sources, human resources, structural supports;
- Start-up and operational procedures;
- Staffing;
- Training; and
- Program evaluation.

20.2.1 Mission

Whether it is per legislative mandate or another process, the operational definition of the mission (e.g., purpose and scope of services) will shape and define all aspects of the operation, including administrative structure, populations served, structuring of the team, roles and responsibilities of team members, and internal and external operational procedures. Mission statements generally consider addressing scalable response capability, that is, responses ranging from circumscribed incidents to community-wide events.

How does an organization determine its mission? Answers to the following questions will go a long way to helping clarify and define guidance policies and the mission of the DMH service:

- **Who are the populations to be served?** Will services be primarily directed to staff impacted by an event, staff responding to an external event, clients/patients of the host organization who are affected, community members, or all of these groups?
- **What authority might DMH services operate under**? Whether the response team will operate as part of a county, State, or National Incident Management System, or solely its own management system will affect operational planning.

- **What is the scope of services?** What types of resources and services will be made available (e.g., crisis intervention, case management, brief intervention, medication management, other services) given the capacity and structure of the host organization?
- **How long will services be provided?** Is the intention to make DMH services available for two weeks, a period of months, or until no longer needed?
- **Where will services be provided?** Will the program be mobile or be offered within the host facility only?
- **Who will provide the services?** Which helping disciplines will be represented?
- **How will authority be structured?** Who will task the DMH team, who will be in charge? What will be the lines of communication?
- **How will services be funded?** Who pays to launch the services, for potential costs related to salaries, overtime pay, extra hires, travel, lodging, communication equipment, internet fees, materials, safety equipment, and so on? What, if any, mutual aid, will be involved (e.g., organizations' participation in a network made up of many organizations agreeing to offer services outside of each one's catchment area to increase each organization's assets in emergencies)?

20.2.2 Start-up and operational procedures

Initial implementation of a DMH service inescapably affects the organizational environment in which it operates. Such changes may include long employee absences or personnel reassignment, temporary cross-over of authority lines (e.g., a social worker having temporary supervisory responsibility over a psychologist), and realignment of employee counseling services to support the DMH mission. If initiated in the immediate aftermath of a disaster, the start-up program may lead to inter-professional rivalry and unanticipated interpersonal stressors; senior management may experience additional pressures to soothe the fears of staff members and patients who are adapting to changes in practice patterns.

Operational procedures are largely defined by the mission and size of the DMH service. Considerations include the process of tasking declarations, lines of authority, creating a logistical infrastructure, establishing communication protocols involving notification of staff and support of staff in the field, deployment protocols, field operations, return of staff members to normal operations, and documentation and program evaluation. Describing each of these procedures in detail is beyond the scope of this paper. But how the service operates depends to a large degree on the answers to the questions posed. At the point when DMH services become more routine and the service is integrated into the organization, they can be considered to be

fully operational. Ideally, over time, new evidence-based or empirically-defensible practices are regularly integrated and service innovation becomes the norm.

20.2.3 Staffing

There are no evidenced-based findings to guide selection of personnel for disaster mental health services. Generally, it is advisable to include representation of a range of mental health disciplines (psychology, social work, psychiatry, nursing), in addition to chaplaincy, with a reasonable ratio of senior management or supervisors included. Common sense and experience suggests that, to the degree possible, the cultural diversity of the DMH team should be matched reasonably to the population it serve As it is, in racially and ethnically diverse communities, minorities are more likely to be less prepared for disasters and experience prolonged and more challenging recoveries in part due to greater unemployment, low incomes, fewer savings, less insurance, poorer access to information, and bias in search for replacement housing (Department of Health & Human Services, Office of Minority Affairs, 2009). The roles management plays may include weighing in on important developments involving a modification of the mission because of unanticipated post-disaster conditions and serving as the interface between large organizations. When considering size of the team, it is important to take into account that not everyone selected will be available for every deployment and to ensure that back-fill members are included and that there is adequate capacity to support staff rotations. The size of the team should also allow team members to work in pairs or in small sub-groups. Pairing team members and creating sub-groups fosters mutual support between members. Ideally, team composition should allow the pairing of males with females, and of members with different cultural backgrounds or bi-lingual capacities, age differences, and high and low degrees of disaster response experience. Providers' knowledge, skills, and attitudes must also take into consideration the defined scope of DMH services. If long-term agency response is within the scope of services, staffing considerations involve the use of practitioners who are trained to administer evidence-based treatments for PTSD. New brief CBT-oriented models are emerging, e.g., "Skills for Psychological Recovery" however, PTSD evidence-based treatments, e.g., prolonged exposure, cognitive processing therapy are more likely to fall within the service domain of the Employee Assistance Program. Each case, calls for training consideration by agency administrators.

20.3 Training

To date, few empirical studies have investigated outcomes associated with the first respons,the FEMA-funded Crisis Counseling Programs, or other community that survivors commonly receive (Rosen, Young, and Norris 2006; Rosen and Young 2005) and virtually none have established the effectiveness of preparedness training for organizations, stand-alone DMH teams, or individual DMH providers before disaster strikes. Until a stronger research evidence base is developed, we necessarily look to synthesize knowledge used to form the content of and processes of training from four primary sources: existing DMH research; studies of early post-trauma interventions conducted in other trauma survivor populations; practitioner experience reported in the non-scientific anecdotal "gray" literature ; and formal consensus development processes.

20.3.1 Training Content

DMH response team members require knowledge about a range of issues related to their role, including team operations, the larger organizational contexts of their deployments, specific skills for helping related to phase of disaster response, populations served and self-care. What trainees are expected to learn will depend as well on the needs of the trainees, when the training takes place, time allotted for training, and resources available for training. In Box #1, we list the range of core knowledge and skill competencies needed by DMH practitioners to begin working with survivors in the immediate post-disaster phase.

BOX #1. DMH Practitioner Knowledge and Competencies.

- All Hazards systems (e.g. National Incident Command System), plans (National Response Framework), and key concepts;
- Rapid assessment and triage;
- Disaster-related stress reactions: survivors, responders, colleagues, and self;
- Evidence-based disaster mental health risk factors;
- Crisis intervention;
- Psychological first aid;
- Psycho-education;
- Cross-cultural considerations;
- Traumatic grief and loss;
- Management of substance abuse;
- Problem-solving and conflict resolution;
- Information and referral process considerations;
- Advocacy;
- Evidence-based stress-related treatments;
- Working in disaster-mental settings/altered environments (e.g., shelters, relief centers, unconventional intervention settings);
- Concepts of risk communication;
- Field safety considerations; and
- Provider self-care issues.

Training may be offered to the range of helpers commonly represented in disaster response efforts: mental health and medical professionals, clergy, emergency and police personnel, school personnel, and paraprofessionals. Those who lead the mental health response teams should receive training in the management of teams and in methods and strategies of supporting team members.

It is also important to provide training for senior management and supervisors in the organization from which responders are drawn. Managers play key roles in supporting disaster workers. They are well placed to monitor employee job performance and aspects of interpersonal and emotional functioning, problems with which can signal a need for help. They are also important sources of support to the individual worker. Content of managerial training can include an overview of the workplace DMH policy, ways of supporting affected employees, the nature of acute stress responses, indicators when mental health referral may be warranted, the nature of available helping services, self-care for supervisors and staff including monitoring for secondary traumatic stress, sources of consultation, and ways of supporting the deployment mission (e.g., adapting work schedules so that impacted staff can participate; see Box #2).

BOX #2. Senior Management and Supervisory Activities Post-Disaster.

- Briefing workers about the incident (including regular briefings if incident is on-going);
- Informing workers about available mechanisms of support;
- De-stigmatizing seeking social and mental health support;
- Encourage the view that help-seeking is a practical and proactive approach to coping;
- Attending to rumor control;
- Informing disaster mental health services about effectiveness of actions or gaps in services;
- Helping to educate workers about the nature of traumatic stress (e.g., via informal conversations and written handouts);
- Encouraging sharing of information with families; and
- Walking through facility or unit to hold informal conversations and to inquire (in general) how staff are doing;

Ongoing supervisory tasks include:

- Monitoring affected individuals for signs and symptoms of continuing distress as evidenced by changes in job performance, attendance, and interpersonal and emotional functioning;
- Being aware of workers who may be at elevated risk for post-trauma problems (e.g., workers with high levels of exposure or personal loss, workers with a personal history of trauma, workers with pre-existing vulnerabilities);
- Referring employees to DMH services or EAP/other mental health support as appropriate;
- Attending to needs of workers who may be returning to work after the incident (e.g., granting time off as necessary, offering flexibility regarding work schedules, discussing return with employee, preparing co-workers if necessary);
- Paying attention to conflicts that may emerge;
- Defusing turf battles and efforts to cast blame;
- Fostering natural support mechanisms (e.g., social support is key in recovery and the workplace is an important means of this support for a number of workers); and
- Seeking guidance/training as needed from DMH members.

Perhaps most important to training efforts is providing helpers with the specific helping skills needed in their direct work with survivors. Those organizing training programs in immediate response must first decide what skills are to be taught. As research on stress debriefing interventions has demonstrated that they do not prevent development of PTSD (e.g., Roberts, et al. 2009; Bisson, et al. 2009; Rose, Bisson, and Wesseley 2001), emergency outreach guidelines for working in large group settings (Young 2002), and methods of providing Psychological First Aid (PFA) -discussed below- have received more attention (Parker, et al. 2006; Young 2006; NCTSN and NCPTSD 2005) and have increasingly been endorsed via expert consensus processes (National Institute of Mental Health 2002; Hobfoll, et al. 2007) until empirical research yields a stronger base on which to select practices. PFA has been manualized in a *PFA Field Operations Guide* (NCTSN and NCPTSD 2005; **http://www.ncptsd.va.gov/pfa/PFA.html**) and, in this version, it is comprised of eight core helping actions (Box #3) and a wide range of knowledge and skills.

BOX #3. PFA Core Helping Actions.

1. Contact and engagement
2. Providing safety and comfort
3. Helping to achieve stabilization (if necessary)
4. Information gathering
5. Practical assistance
6. Connection with social supports
7. Information on coping and support
8. Linkage to collaborative services

Online training in this model is available **(http://learn.nctsn.org**), but, as noted above, such training must be supplemented by additional training procedures. We recommend that processes of training on PFA (see below for more detail) include formal instruction in the intervention via "hands-on" workshops in which all participants practice key elements of the intervention via role-play and receive individual feedback and coaching related to their performance. Following this, participants are encouraged to receive regular supervision. Research indicates that, to be maximally effective, this supervision should include actual observation of skills participants have been taught to deliver by trainers (Miller, et al. 2004), in this case, either by directly observing trainees conduct PFA with survivors or by listening to recorded tapes of PFA sessions (if formal consent for this activity has been obtained from PFA recipients). This supervision can be provided in weekly or bi-weekly face-to-face meetings, or via scheduled telephone supervision sessions. When organizations conduct disaster exercises, care should be taken to include opportunities to observe providers as they deliver PFA, and to present individualized feedback following the exercise. After training takes place, along with supervision, it is important to establish "communities of practice" that provide opportunities for trained providers to share experiences with the new interventions and problem-solve issues that arise during its implementation.

The interpersonal support, stress-related education, and normalization of acute stress responses that take place under the label of PFA are much needed, but are unlikely to address the full range of survivor needs, especially following events characterized by high-intensity individual exposure to potentially traumatic events. That is, many individuals will require more

than PFA, and many community members will never receive PFA despite experiencing problems.

During the first days, weeks, and months, most of those distressed by their disaster experiences will recover, via personal coping efforts, natural social support, or simply the passage of time. But some persons will continue to experience distress and some may develop post-traumatic stress disorder, other anxiety disorders, depression, or other significant post-disaster problems. Many of these individuals may benefit from relatively brief culturally-appropriate counseling efforts that are offered to natural disaster and terrorism survivors who continue to experience distress in the first months following a disaster. This requires a different skills set than PFA. Typically, services include individual, family, and small-group counseling focused on providing emotional support, education, and referral, as needed, and mental health treatment resources in the community. Such counseling appropriately seeks to be non-stigmatizing by avoiding processes of diagnosis and labels associated with psychopathology.

Research on early interventions to prevent development of trauma-related problems in those exposed to other kinds of traumatic events represents an important source of information that can inform selection of which brief counseling skills will be selected for training. Unfortunately, there is little evidence that simple provision of education and support is effective in preventing PTSD and other mental health problems in trauma survivors. Reviews of early preventive interventions instead indicate that specific brief (4-5 session) cognitive-behavioral interventions can be effective in reducing post-traumatic stress reactions and preventing development of PTSD when they are delivered starting as early as two weeks post-trauma. These interventions have included several helping components, including education, breathing training/relaxation, imaginal and in vivo exposure, and cognitive restructuring. When interventions have been targeted at all trauma survivors, regardless of levels of stress reaction, they have not been found to be effective in reducing and preventing post-traumatic stress symptoms. It is when trauma-focused CBT has been targeted at those with significant symptom levels, especially those meeting criteria for Acute Stress Disorder, that intervention has been effective (Roberts, et al. 2009). Many individuals requesting counseling for post-disaster problems will be experiencing such symptoms.

At present, the cognitive-behavioral interventions that have been tested in other service contexts have some potential limitations in the context of disaster counseling. They have not been researched with disaster survivors, may be inappropriate for some survivors, and have been delivered by well-qualified and trained mental health professionals rather than the

paraprofessionals and non-specialist health care providers who may be called upon to provide post-disaster counseling. Such interventions are now being adapted for disasters (cf., Ruzek, 2006; Ruzek et al. in press). For example, Hamblen and others (2009) developed Cognitive Behavior Therapy for Postdisaster Distress (CBT-PD), a ten-session manualized intervention designed to address a range of cognitive, emotional, and behavioral reactions to disaster. Trained community-based therapists provided CBT-PD for 88 adult survivors of Hurricane Katrina, and participants showed significant improvements on the 12-item Short Post-Traumatic Stress Disorder Rating Interview—Expanded (Sprint-E; Norris et al. 2006), a composite measure of disaster-related PTSD symptoms, depression, stress vulnerability, and functional impairment. Other development efforts are underway. NCPTSD has collaborated with NCTSN and Dr. Richard Bryant to manualize "Skills for Psychological Recovery" (SPR), an evidence-informed counseling approach that is comprised of simplified, brief application of interventions found effective in other service contexts: problem-solving training, positive activity scheduling, skills training in management of trauma reminders and emotional distress, cognitive reframing, and social support. SPR is intended to help survivors identify their most pressing current needs and concerns and teach and support them as they master skills to address those needs. While formal evaluation will be necessary to establish the effectiveness of SPR (and the manual is designed to facilitate evaluation efforts), training in SPR has been extremely well-received by counselors working in the Louisiana Spirit (Katrina) Specialized Crisis Counseling Services; they reported that the skills were highly practical and improved their ability to serve their clients.

Improving services for disaster-impacted minorities is critical. U.S. Census data indicates that minorities represent nearly one-third of the U.S. population. Cultural competency, defined as a set of congruent behaviors, attitudes, and policies enabling a system, agency, or group of professionals to effectively work in cross-cultural situations (Cross, 1989), is one of the primary means to closing the disparities gap in disaster preparedness, intervention, and all of health care. DMH-related training content must incorporate cultural competency principles into preparedness plans and interventions. Training that addresses how to provide culturally sensitive care, how to work with an interpreter, negotiating cultural differences, and implementing culturally and linguistic appropriate services will better serve the increasingly diverse population of the U.S. The Office of Minority Mental Health offers online disaster-related cultural competency training for physicians, nurses, social workers, emergency first responders, and others. In addition, a "Health Care Language Services Implementation Guide" is available online. These training modules can all be found at **www.thinkculturalhealth.org.**

20.3.2 Training Processes

Training in DMH is widespread among helping organizations. But up to the present time there has been little effort to evaluate DMH training programs and dissemination initiatives. To ensure that resources expended on training are well used, and that training results in improved skills among DMH workers, it will be increasingly important that training programs learn from other fields and begin to incorporate principles of effective training and implementation. Although it is not a surprise that passive communication of best practices can be expected to have little impact on the actual behavior of DMH providers, it is unfortunately also true that traditional training workshops often fail to change practices (Jensen-Doss, Cusack, and de Arellano 2008).

Recognition of the limitations of traditional training methods (which form the basis of most current training in the disaster field) is important if the situation is to be reversed. To be effective, workshops must include demonstration of skills and give significant opportunities for behavior rehearsal (Fixsen et al. 2005) and interactive participation via discussion, peer performance feedback, and group planning (Grol and Grimshaw 2003). Such workshop training must then be followed by a period of coaching/supervision. Skills are consolidated via consultation/coaching on the job as workers seek to apply their new abilities (Fixsen et al. 2005). At present, however, few educational activities offered for DMH providers incorporate these crucial elements of active, ongoing practice under supervision.

There is growing evidence that training that includes workshops and continuing supervision can enable practitioners to deliver effective treatment services to those affected by terrorist attacks (Gillespie, et al. 2002; Duffy, Gillespie, and Clark 2007; Levitt, et al. 2007; Brewin, Scragg, et al. 2008; CATS Consortium 2007). For example, in the context of implementation of a centralized public health program to assist survivors of the 2005 terrorist bombing attack on the London transportation system, Brewin, and others (2008) trained clinicians to provide trauma- focused cognitive-behavioral therapy and Eye Movement Desensitization and Reprocessing to individuals needing such services. Clinician trainees received ongoing supervision from experienced clinicians within their individual treatment centers. Preliminary outcome data on 82 individuals meeting criteria for PTSD diagnosis indicated significant reductions in PTSD symptoms, with a large effect size.

The Child and Adolescent Trauma Treatments and Services (CATS) Project (CATS Consortium 2007) similarly trained providers to deliver two evidence- based cognitive-behavioral therapy interventions to children and adolescents who were experiencing problems related to the 9/11 terrorist attacks. Training included direct training workshops, telephone consultation, and on-site

consultation. By the end of the project, 173 clinical staff, primarily social workers and master's-level psychologists, had been trained in one of the two interventions. Seven hundred youth clients participated in the evaluation arm of the project, and 385 received CBT treatment (ranging from 1-36 sessions). Although these research demonstrations were organized well beyond the time period during which most disaster response occurs, they do begin to demonstrate that practitioners can be trained to deliver best practice interventions for disaster survivors.

Interactivity can help keep trainees engaged with the training experience and can be introduced into training activities in a variety of ways (via use of short film clips and live demonstrations of key skills, short lectures and discussions, large-group role plays, group problem-solving exercises, and skill exercises with embedded constructive feedback). We recommend that trainers create exercises that include aspects of the organization's working environment and realistic scenarios specific to settings in which trainees may work. Two such examples of interactive exercises are given at the end of this chapter (Exercise Appendix). The first exercise involves a work-related environment and its staff, while the second exercise concerns community citizens and agencies. An example of an interactive exercise is presented in the Exercise Appendix.

20.4 Sustainability of Services

After DMH services are established and implemented, it will be important to sustain their availability and set up evaluation and training strategies designed to improve operational effectiveness and service efficacy. Program evaluation standards have been articulated by several researchers (Fleischman and Wood 2002; Patton 1978; Rosen, Young and Norris 2006; University of Kansas Work Group 2004). These include utility (how useful?), feasibility (can it be accomplished?), ethics (regard for the right and welfare of all involved), and accuracy (results have integrity). Rosen, Young, and Norris (2006) describe DMH program evaluation strategies to improve processes and outcomes. While a DMH program is operating, monitoring of important aspects of services (e.g., "wait-time") may be used to make program adjustments to improve functioning or outcomes. At the conclusion of services, a post-program evaluation should be used to gather information that may help guide and improve future programs. Other sustainability strategies include implementation of ongoing education, "marketing" activities, and regularly-held training. Education and marketing involve the DMH team presenting on its activities and methods, to the leaders and staff members of the organization in which it is embedded, and to the communities it is designed to serve. This may help maintain leader and

organizational support for the operation, and increase visibility of services. Ongoing training, including exercises (e.g., virtual online, table top, and real-world) is necessary to ensure that the team maintains skills and changes its repertoire as new ideas enter the DMH field.

20.5 Summary

DMH is a relatively young field looking to become more evidence-based. Until there is an empirical knowledge base, extant DMH-related research, evidence-based findings in the successful treatment of other trauma survivors, and the grey literature is best integrated and used to guide implementation, training, and sustainability of an organization's DMH services. This necessarily involves a complex planning effort to meet the array of needs of the populations served. This chapter delineates important considerations in view of the process and elements involved with establishing disaster mental health services, it describes related DMH training content and processes, and lastly, identifies key issues associated with the need for continuous quality improvement and sustainability of services.

20.6 Endnote

1. The term organization includes similar terms, e.g., agency, institution, department.

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EXERCISE APPENDIX

Exercise #1:

Instructions for 1.1 Skill Building Exercise (Brief Supportive Counseling)

ATTEMPTED SHOOTING AT A COMMUNITY HOSPITAL EMERGENCY ROOM

THE EVENT:

Yesterday afternoon, a 49-year-old male Veteran walked up to the reception desk of the community hospital emergency room (ER) stating that he had been sent away by his doctor in the ambulatory care clinic *without* the medications he needed for severe headaches. When the receptionist asked for his name and the name of his doctor, he replied angrily that he was not going to put up with another "run around," and that he wanted to be seen immediately by a doctor to give him his medications. He then pulled out a semi-automatic and began yelling that he might as well shoot everyone.
Alarmed, the receptionist instinctively told him that he could not see a doctor right away. The patient then pointed his gun at her, and screamed for her to get up, find him a doctor or he would kill her and everyone else in the waiting room. The receptionist froze from fright while some other people in the waiting room tried to slip out the door unnoticed. Seeing people attempting to escape, the patient turned and fired his gun in their direction, hitting and shattering a glass door. A hospital security officer, stationed nearby and wearing a holstered pistol, asked the patient to put down his weapon, pleading with him to not shoot anyone. This only further enraged the man and he began to claim that he knew that cops want to kill him. While the patient was distracted, a doctor who came out to the reception desk lunged toward the patient and knocked him down. A nurse appeared and kicked the gun out of the patient's hand. The doctor and nurse then restrained the man as local police arrived and handcuffed him and took him to the county jail. No one was injured.

EXERCISE INSTRUCTIONS:

Form a group of four. Pair off into two dyads. In the first dyad, one person is the emergency mental health team responder, the other is one of the eight hospital staff members listed below. The two people of the second dyad observe the role play. After seven minutes, all four of you discuss role play, for example, what seemed to work well, what did not, how it might be done differently. Then switch roles and repeat process until each member of the group has had a chance to be the mental health responder providing the brief supportive counseling and a staff member receiving the counseling. The person playing the part of a staff member can pick one of the eight roles described below.

ROLES:

- **(1) Hospital emergency mental health responder**
- **(8) Hospital staff**
  - Receptionist
  - Security Officer
  - ER Physician #1
  - ER Physician #2
  - Nurse #1
  - Nurse #2
  - Orderly
  - Psychiatrist

Hospital Emergency Mental Health Responder:

The medical center director is looking to provide support for employees immediately following the incident, and calls upon the emergency mental health response team to meet with the staff who were directly involved. The day following the incident, you are requested by the medical center's emergency mental health team leader to meet with individual employees who were either present during the incident or who had been previously involved with the treatment of the pistol-bearing man. For purposes of the role play, you have seven minutes to conduct an intervention

Receptionist:

You are a new employee who was assigned a week ago to be the ER receptionist while the permanent receptionist is out on medical leave. You were working in a quiet setting as receptionist for the Women's Health Clinic, and you have found the ER setting to be chaotic and stressful. You have a baby and toddler at home, and your spouse is a police officer. Your spouse told you stories about violent patients coming into ERs and warned you that you would not be safe there.

Security Police Officer:

You are a Vietnam Veteran who was deployed from 1968-69 as a warehouse truck loader at a large air base just outside of Saigon. You have been a security officer for 26 years and are planning on retiring later this year. You heard yelling in the ER in the corridor while on your regular rounds, and arrived just as gun shots echoed in the corridor and the glass door shattered. You recognized the patient because you saw him storm out of the ambulatory care clinic earlier and you wondered then if you should do something to calm or restrain him. After you arrived, you tried to reason with the patient, and you told the other people in the area to stay put and not make any sudden moves.

ER Physician #1:

You were suturing a superficial, but bloody arm wound sustained by a psychiatric patient who had punched out a window earlier that day. The patient was sedated, but uncooperative and disoriented, and became more distressed when yelling could be heard from the waiting room. You felt in conflict as to whether you should stay with the patient or go out to assist in the waiting room, but when you asked the nurse to watch the patient after you heard gun shots, she looked confused and terrified. You felt that you could not leave the patient, but felt guilty that you did not go out to protect the people in the waiting room.

ER Physician #2:

You were on break after working 36 hours straight, and tried to ignore the sounds of yelling that you heard out in the waiting room. When you heard gun shots you rushed out to the waiting room, saw the man looking at the door with a pistol in his hand, and lunged to knock him down. You do not remember much until you saw the police rush in and handcuff the man, roughly pulling him out from under you and the nurse who was helping to restrain the gunman.

Nurse #1:

You were in the ER assisting with the suturing of the arm of a patient who was sedated, but uncooperative and disoriented. The patient became more distressed when yelling could be heard from the waiting room. You were feeling very uneasy because you had been assaulted and beaten by a similarly agitated psychiatric patient a year ago. You heard yelling in the waiting room, and the next thing you recall was the physician having told you to watch the patient while he left toward the waiting room. You felt dazed and terrified, and felt unable to move or respond. The physician looked very angry, and brushed you aside saying that you should get yourself back together in case you have to clean up a "real mess" out there.

Nurse #2:

You were the second nurse in the ER assisting with the suturing of the arm of a patient who was sedated, but uncooperative and disoriented. The yelling you heard reminded you of how soldiers erupted when they were over the edge in the casualty staging area you supervised in Vietnam. You knew that the receptionist was new and inexperienced, so you immediately told the other nurse to handle the patient for the physician and went out to the waiting area. When you heard the gunshots you reflexively fell to the floor, and you thought "Oh no!" when you saw a physician rush out toward the man with the gun. You jumped up and went for the gun, kicking it out of the man's hand just as he was about to turn it on the physician who had jumped on him. You tried to apply physical restraint, but kept getting knocked around by the doctor who was trying to restrain the gunman as well.

Orderly:

You were putting supplies away in the storage area at the back of the ER when you heard two sharp loud noises. You wondered if one of the doctors or nurses had knocked over some of the expensive equipment and felt annoyed that you would probably have to clean up You continued to work in the storage area until you were surprised to see a mental health "type" coming back and asking you if you were all right. When the metal health person told you there had been a shooting incident, you felt guilty, but mostly concerned you would be in trouble for not helping.

Psychiatrist:

You have been treating the man with the gun for a bipolar illness for six years, primarily doing medication maintenance on a bi-monthly basis. You recently met with the patient on an unscheduled visit because he came in agitated, demanding Demerol for pain. You tried to convince the patient to attend the pain management program to which you had referred him, and considered hospitalizing him because of what appeared to be an acute increase in mania. However, the patient reported taking his medications and you had seen him regain his composure after similar episodes of agitation. Before you could make a decision, the patient walked out in a huff, so you decided to evaluate further when he returned for his regular appointment next week.

TABLE #1:

Emergency Services Clinic-based 1:1 Brief Supportive Counseling Model

This summarizes the steps of a fifteen minute meeting to offer support, screen for risk, facilitate resilience, and refer if appropriate. Unlike one-off encounters, a setting with DMH services allows for follow-up and more immediate referral resources.

1. Introduction and explanation of rationale (objectives) for meeting
    - Provide staff support
    - Inform staff about common stress reactions
    - Inform staff about potentially useful stress management strategies
    - Inform staff of other resources
    - Review confidentiality
2. Screen for risk factors associated with adverse mental health outcomes
    - "Where were you when it happened?"
    - "What kind of reactions did you have?
    - "What concerns you most about what happened?"
    - "Is there anything in particular you keep thinking about over and over?"
3. Discuss coping and stress management strategies
    - "How have you been coping with what happened?"
    - "What do you ordinarily do to manage stress?"
    - "Is there anyone in particular you turn to for support?"
4. Discuss pertinent risk factors:
    - Degree of exposure;
    - Severe acute stress reactions;
    - Previous traumatization;
    - Pre-existing psychopathology
    - Current life stressors (health, legal, employment, family & relationship, etc.).
5. Discuss Follow-up and or referral

Summarize (in context of survivor's presenting information) common stress reactions, vulnerabilities, warning signs, self-care strategies, when and where to seek additional help.

Exercise #2:

Disaster role play: Mass casualties scenario

TRAINER NOTE #1:	**This scalable role play is for use with 8 or more trainees. It has been used with 110 trainees.**

The role play requires 60-90 minutes, depending on the number of trainees and training assistants. Use assistants to additionally handout role play instructions. The role play may be placed on the training agenda before much DMH-related information or skills training is delivered with the rationale that in doing so, it will help to create added interest in learning new skills. Alternatively, it may be placed toward the end of the agenda to give trainees an opportunity to practice or observe DMH-related skills taught beforehand during the training.

TRAINER NOTE #2:

Fill in "Role Play Assignment Sheet" by dividing the number of trainees by three, selecting number and size of DMH teams to create a maximum of 10 survivors per each DMH provider. For example, if training 50 practitioners, select 15 volunteers (five to each team) to create a ratio of no more than 4 survivors per trainee (in their role as a DMH responder).

ROLE PLAY ASSIGNMENT SHEET

Disaster Mental Health Teams
MH responders Disaster Team 1
MH responders Disaster Team 2
MH responders Disaster Team 3
Other Roles
1 Security Guard:
1 journalist:
Survivors:

TRAINER NOTE #3:

Have blank name tags to distribute to DMH team members. Have name for Security Guard (or child's "Sheriff" badge). Instructions and blank name tags are given to DMH Team members inside the primary training room which for purposes of the role play, serves as a service center for survivors and those who have experienced a loss.

ROLE PLAY INSTRUCTIONS FOR DISASTER MENTAL HEALTH TEAM #1

Background Information:

Yesterday, two commercial planes collided over (use name of a local geographical area), resulting in nearly 70 fatalities including individuals who were inside their homes.
Shortly after the crash, National Transportation Safety Board (NTSB) secured the area. Since then, residents whose homes were red tagged unsafe have been temporarily sheltered at a large nearby hotel. As per 1997 Congressional legislation, American Red Cross and the airlines involved have set up a family service center to begin the process of providing resources and information about long-term replacement housing, rebuilding, refurnishing, etc. This room (training facility room) serves as the service center where those who have losses are gathering. You are members of an ad hoc (Name a local county community mental health agency) disaster mental health response team and have been detailed to the conference room to provide mental health support.

DMH TEAM #1 ROLE:

Put on ID tags. Elect a team leader. Your role playing begins inside the conference room where family members are gathered.

TRAINER NOTE #4:

These instructions are given to the participants volunteering for DMH Team #2 outside of the room serving as the service center. You may opt to have someone assisting with the training hand these instructions out. No ID tags are given.

ROLE PLAY INSTRUCTIONS FOR DISASTER MENTAL HEALTH TEAM #2

BACKGROUND INFORMATION:

Yesterday, two commercial planes collided over a suburban area over _____, resulting in nearly 70 fatalities including individuals who were inside their homes.
Shortly after the crash, NTSB secured the area. Since then, residents whose homes were red tagged unsafe have been temporarily sheltered at a large nearby hotel. A Red Cross/airline service center has been set-up in a hotel conference room to begin the process of providing resources and information about long-term replacement housing, rebuilding, refurnishing, etc. Residents are gathered in the conference room waiting to talk to airline representatives about their losses and the airline's responsibilities.
You are members of the county triage hospital's disaster mental health response team and have been detailed to the hotel to provide mental health support.

DMH TEAM #2 ROLE:

Elect a team leader. Report to the security guard stationed at the door to the entrance of the conference room.

TRAINER NOTE #5:

These instructions are given to the participants volunteering for DMH Team #3 outside of the room serving as the service center. You may opt to have someone assisting with the training hand these instructions out. No ID tags are given.

ROLE PLAY INSTRUCTIONS FOR DISASTER MENTAL HEALTH TEAM #3

BACKGROUND INFORMATION:

Yesterday, two commercial planes collided over a suburban area over _____, resulting in nearly 70 fatalities including individuals who were inside their homes.
Shortly after the crash, NTSB secured the area. Since then, residents whose homes were red tagged unsafe have been temporarily sheltered at a large nearby hotel. A Red Cross/airline service center has been set-up in a hotel conference room to begin the process of providing resources and information about long-term replacement housing, rebuilding, refurnishing, etc. Residents are in the conference room waiting to talk to airline representatives about their losses and the airline's responsibilities. You are members of the local University Medical Center's emergency response team and have been detailed to the conference room to provide mental health support.

DMH TEAM #3 ROLE:

Elect a team leader. Report to the security guard stationed at the door to the entrance of the conference room.

TRAINER NOTE #6:

These instructions are given someone you have selected beforehand as a confederate. The volunteer for this role is best played by an assistant to the training rather than a trainee.

ROLE PLAY INSTRUCTIONS FOR NEWSPAPER REPORTER

BACKGROUND INFORMATION:

Yesterday, two commercial planes collided over a suburban area over resulting in nearly 70 fatalities including individuals who were inside their homes.
Shortly after the crash, NTSB secured the area. Since then, residents whose home were red tagged unsafe have been temporarily sheltered at a large nearby hotel. A Red Cross/airline service center has been set-up in a hotel conference room to begin the process of providing resources and information about long-term replacement housing, rebuilding, refurnishing, etc. Residents are in the conference room waiting to talk to airline representatives about their losses and the airline's responsibilities.

YOUR ROLE:

You are a journalist with a widely distributed newspaper. After having learned that residents of the crash area are housed at a local hotel, you try to get a story. Posing as a mental health professional (having used phony ID to gain entrance to the conference room), you circulate among the survivors and ask intrusive and inflammatory questions, for example,
"How do you feel about the way the airlines are handling the situation?"
"Did you ever think anything like this could happen to you?"
"Was anyone you know injured or killed?"
"Who's to blame here?"

TRAINER NOTE #7:

These instructions are given someone you have selected beforehand as a confederate. The volunteer for this role is best played by an assistant to the training rather than a trainee. He or she is told who the "journalist" is before the role play begins.

ROLE PLAY INSTRUCTIONS FOR HOTEL SECURITY GUARD

BACKGROUND INFORMATION:

Yesterday, two commercial planes collided over a suburban area over _____, resulting in nearly 70 fatalities including individuals who were inside their homes.
Shortly after the crash, NTSB secured the area. Since then, residents whose homes were red tagged unsafe have been temporarily sheltered at a large nearby hotel. A Red Cross/airline service center has been set-up in a hotel conference room to begin the process of providing resources and information about long-term replacement housing, rebuilding, refurnishing, etc. Residents are in the conference room waiting to talk to airline representatives about their losses and the airline's responsibilities.
A hotel conference room has been designated as an emergency Red Cross/airline service center for individuals in need of information about family members residing in the neighborhood where two airlines have crashed earlier in the day.

YOUR ROLE:

You have been assigned to guard the entrance to the conference room and have been instructed not to let anyone in without asking who they are. If people identify themselves as mental health professionals, they must show you ID. For purposes of the role play, some mental health professionals will not have ID. Give them a difficult time and don't let them in at first. After a few minutes, let them in.
If family members arrive late, ask them for ID. Of course, they won't have any. Just let them in. A journalist will pose as a mental health professional. For purposes of the role play, let him or her in immediately.

TRAINER NOTE #8:

These instructions are given to the trainees who have not volunteered for the DMH teams. In short, everyone at the training is involved with the role play. Divide the number of trainees by 5 and use resulting number to determine how many trainees to choose for each of the five scenarios. For example, if you have 20 trainees remaining after trainees have volunteered for one of the DMH teams, you can assign four of the remaining trainees to each role below.
Have some trainees pose as married to each other; have one or two survivors not speak English, have another speak limited English.

FAMILY MEMBERS – INSTRUCTIONS FOR INDIVIDUALS & COUPLES

BACKGROUND INFORMATION:

Yesterday, two commercial planes collided over (name of geographical area), resulting in nearly 70 fatalities including individuals who were inside their homes.
Shortly after the crash, NTSB secured the area. Since then, residents whose homes were red tagged unsafe have been temporarily sheltered at a large nearby hotel. A Red Cross/airline service center has been set-up in a hotel conference room to begin the process of providing resources and information about long-term replacement housing, rebuilding, refurnishing, etc. Residents are in the conference room waiting to talk to airline representatives about their losses and the airline's responsibilities.

YOUR ROLE:

You (or you and your spouse) are in the conference room waiting to speak to an airline representative to discuss your losses and what you can expect from the airlines. Choose one or two of the following scenarios to role play.
1. You weren't home at the time of the crash. You are upset because the fire that destroyed your home destroyed many irreplaceable items (e.g., picture of your grandmother, childhood pictures, family heirlooms).
2. You weren't home at the time of the crash. You are upset because the fire destroyed your new home built to specifications after 18 months of planning, permit seeking, obtaining hard to find building materials, and struggles with the building contractor. You and your spouse just moved in last month.
3. You weren't home at the time of the crash as you were shopping at the _____ Mall. Your neighbor, who was also a good friend was home and was killed along with her two young daughters. You had thought to ask her (and the two girls) to go shopping with you, but didn't because you had been feeling overwhelmed the days just before the crash and wanted some time to yourself. When you exited the mall, you could see the smoke above the mountains.
4. You weren't home at the time of crash. Five years ago, you were in a severe car crash in which you received relatively minor injuries, however, a close friend died in the crash. You find that you keep thinking about the crash and the loss of your friend. Even though you hold common the loss of your home, you feel somewhat distant from the other neighborhood residents/victims.
5. You were home at the time of the crash and heard the unbelievable sounds of the crash racing through the neighborhood. Your home was a block away from the first wave of destruction. You ran to help, but the smoke and debris left you disoriented. You heard people yelling for help, but didn't know exactly where the voices were coming from and didn't know what to do. A policeman saw you and took you to his squad car for safety.
6. When the fire spread, your home was unable to be saved. You have been distraught over the deaths in the neighborhood and unable to sleep more than three hours a night. In addition to the scenarios described above, please choose from any of the following stress reactions to portray:

- Severe anxiety
- Grief
- Anger
- Emotional numbing
- Disbelief

- Guilt
- Impaired concentration
- Impaired decision-making ability

If you are in the role of a couple, find time to verbalize your lack of support toward your spouse's emotional reaction when a mental health professional speaks with you. Do not use anger or rage to the point of disrupting the role play or to the degree that it limits the learning experience of others.

MASS CASUALTIES ROLE: ADDITIONAL TRAINER FACILITATION NOTES

1. After all the trainees have received instructions and are ready to begin, run role play for 20 minutes.
2. If available, use television to cause unnecessary noise.
3. If a trainee asks you questions during the role play, respond that you are with housekeeping and do not know the answers to their questions.
4. Move around to make observations and mental notes.
5. When role play is over, lead discussion.

Beginning with DMH Team #1, ask those who were in the role of responders to share what seemed to work for them and what circumstances they felt challenged or confused by. Ask what goals they had and how they related to the other teams in the room. Ask about any cross-cultural issues they faced and how they tried to resolve them. Proceed to do the same with Teams #2 and #3.

Next, ask the trainees in the role of survivors, what they appreciated most from the responders? Ask if there were any behavioral exchanges that were not helpful, or were confusing or caused discomfort or frustration.

Next, have the individual posing as the journalist share his or her experience. Ask trainees for their impression of the journalist and whether any one guessed that he or she was not a mental health professional.

Ask the assistant in the role of the Security Guard to share his or her experience.

In the course of this discussion, look for opportunities to interject key teach points related to strategies for working in large group settings, mental health service objectives, engagement strategies, PFA core actions, and cross-cultural issues.

Finally, encourage trainees to express appreciation for each other's efforts in the role play.