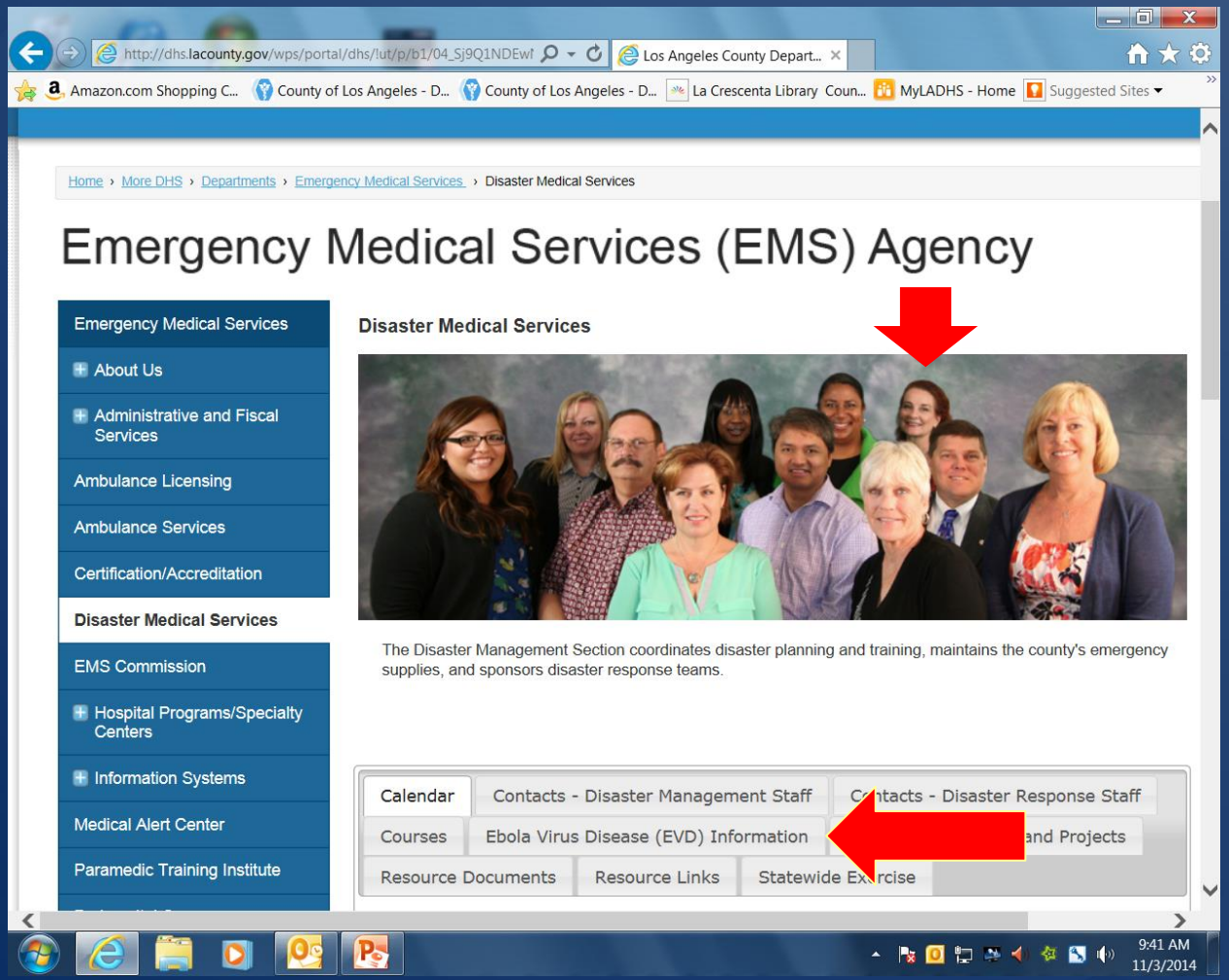
Preparing Hospitals and Clinics for the Psychological Consequences of a Terrorist Incident or Other Public Health Emergency

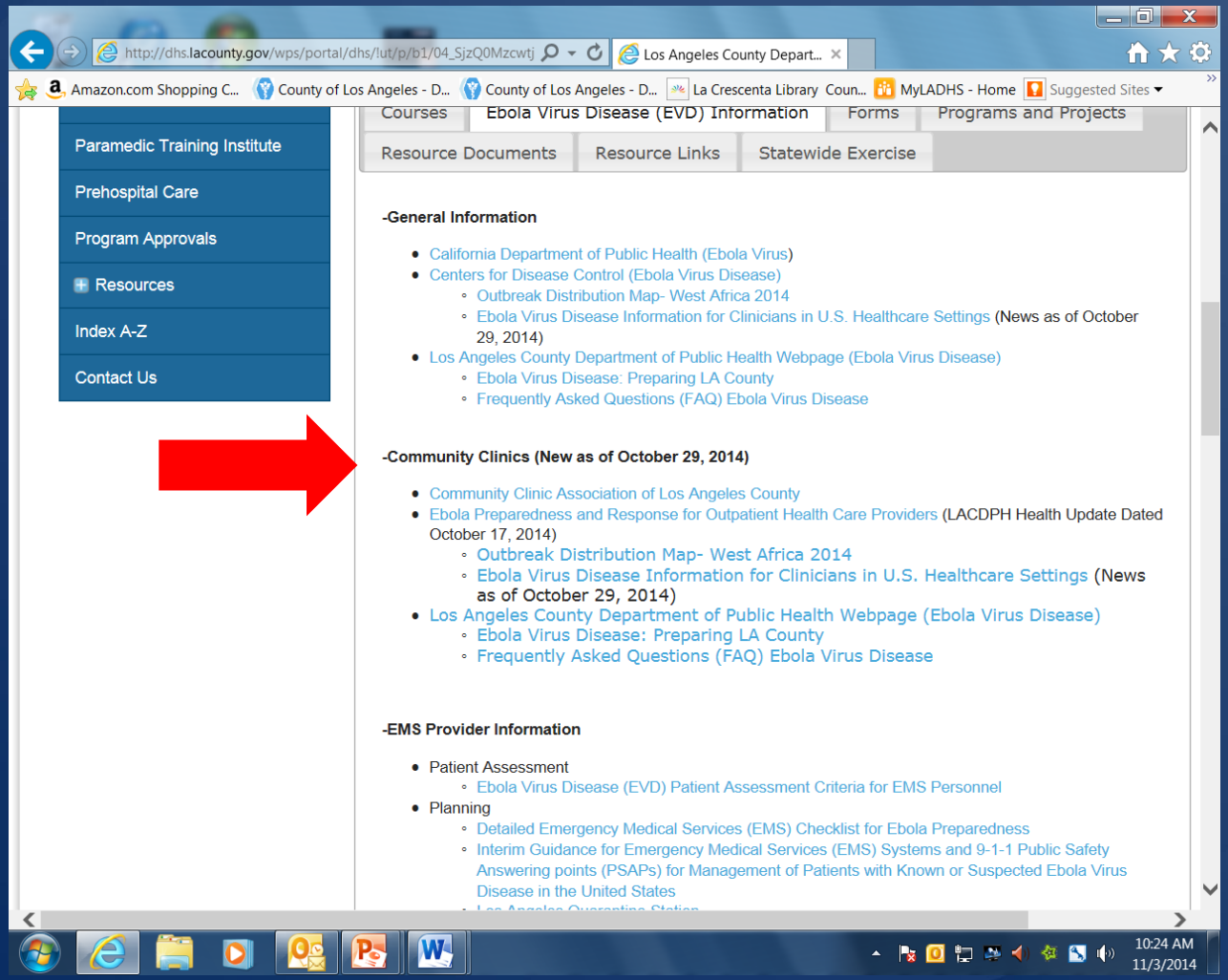
NCHPH Webinar
November 4, 2014

LA County EMS Agency Website



EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

LA County EMS Agency Website Ebola Guidance for Clinics



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LA County EMS Agency Website #2

- EMS Agency Website address, click on Disaster Medical Services http://dhs.lacounty.gov/wps/portal/dhs/ems/

- Instructor materials for this training today:

http://ems2.dhs.lacounty.gov/Disaster/DisasterTrainingIndex.htm

You may use the instructor materials. If you add anything, please change the slide background to indicate this is your material.

Other Projects

- Mass Fatality Management Guide for Healthcare Entities

http://ems.dhs.lacounty.gov/Disaster/MassFatality.htm

- Los Angeles County Family Information Center Planning Guide for Healthcare Entities

http://www.calhospitalprepare.org/FIC

- CHA Mental/Behavioral Health Resources

http://www.calhospitalprepare.org/mental-behavioral-health

Broader Coalition Building

- State of California Mental/Behavioral Health Disaster Framework-December 17, 2012

http://www.cmhda.org/go/portals/0/cmhda%20files/breaking%20news/1212_dec/ca_mental-behavioral_health_disaster_framework_(12-20-12).pdf

- Contains “recommended actions” for coalitions for the disaster cycle: Mitigation and Preparedness, Response, Recovery, Concept of Operations, Training, etc

Los Angeles County EMS Agency: Psychological Preparedness Activities for HPP Hospitals and Clinics 2003-Present

- In context of the HPP program
- Hired a full time mental health professional
- “Planning for Psychological Consequences” training for Hospitals and Clinics
- Operational rapid mental health triage and incident management system (PsySTART)
- Staff triage and Staff resilience system
- ConOPS, Exercise Guide, Sustainability Plan

PsySTART for LA County

PsySTART

(Psychological Simple Triage and Rapid Treatment)

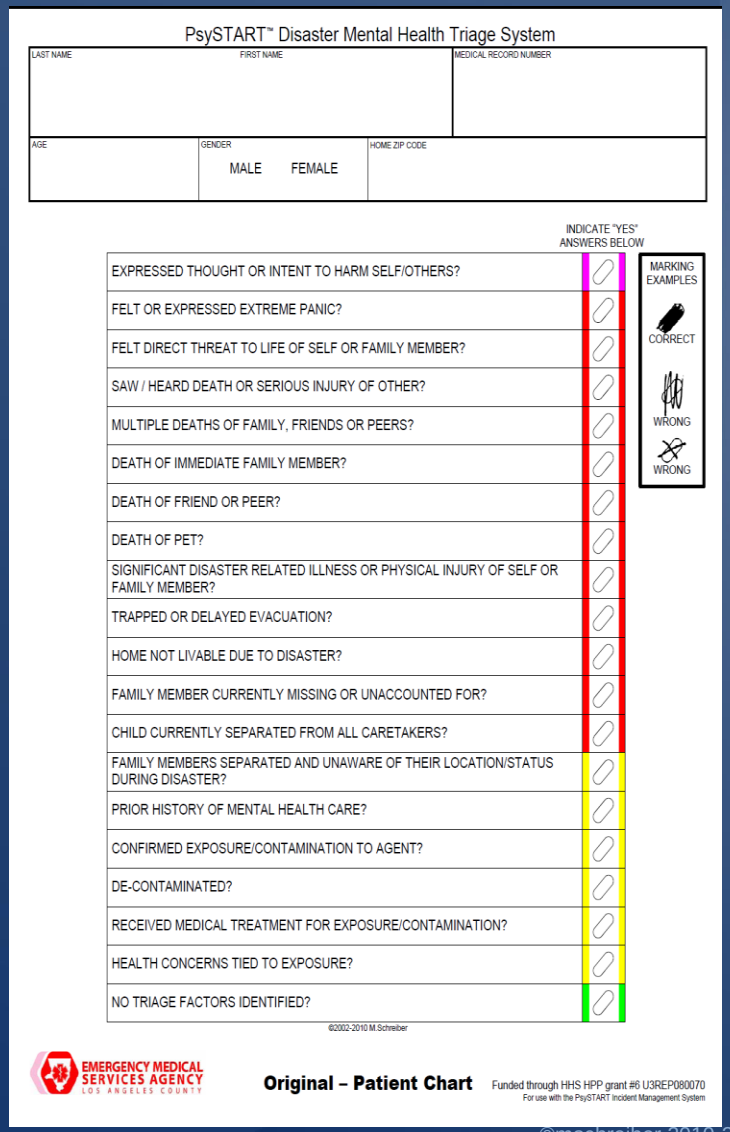
LA County works with Dr. Merritt "Chip" Schreiber (UCI) to adapt PsySTART for use by hospitals and clinics.

- Year 1 – Developed a pilot system for DRC hospitals and clinics and prototype tag
- Year 2 – Extended project to non-DRC hospitals and clinics, developed "Staff" and "Leader Tags", Exercise
- Year 3 – Building a "staff resiliency system".
- Year 4 – Building CONOPS for PsySTART "Patient" and "Staff" Systems, Exercise 2
- Year 5- On line and T-T-T for Anticipate, Plan and Deter ; and Listen, Protect and Connect, Implementation Assistance, MWeb – Sustainability Plan

What does PsySTART measure?

- NOT Symptoms
- Impact of severe/extreme stressors

- "What happened" ***not*** symptoms, based on objective exposure features):
  - **Severe/extreme exposures**
  - **Traumatic Loss (inc. missing family members)**
  - **Ongoing or persistent stressors**
  - **Injury/illness**
  - **Peritraumatic severe panic**



PsySTART™ Disaster Mental Health Triage System

LAST NAME	FIRST NAME	MEDICAL RECORD NUMBER

AGE	GENDER	HOME ZIP CODE
	MALE FEMALE	

	INDICATE "YES" ANSWERS BELOW
EXPRESSED THOUGHT OR INTENT TO HARM SELF/OTHERS?	
FELT OR EXPRESSED EXTREME PANIC?	
FELT DIRECT THREAT TO LIFE OF SELF OR FAMILY MEMBER?	
SAW / HEARD DEATH OR SERIOUS INJURY OF OTHER?	
MULTIPLE DEATHS OF FAMILY, FRIENDS OR PEERS?	
DEATH OF IMMEDIATE FAMILY MEMBER?	
DEATH OF FRIEND OR PEER?	
DEATH OF PET?	
SIGNIFICANT DISASTER RELATED ILLNESS OR PHYSICAL INJURY OF SELF OR FAMILY MEMBER?	
TRAPPED OR DELAYED EVACUATION?	
HOME NOT LIVABLE DUE TO DISASTER?	
FAMILY MEMBER CURRENTLY MISSING OR UNACCOUNTED FOR?	
CHILD CURRENTLY SEPARATED FROM ALL CARETAKERS?	
FAMILY MEMBERS SEPARATED AND UNAWARE OF THEIR LOCATION/STATUS DURING DISASTER?	
PRIOR HISTORY OF MENTAL HEALTH CARE?	
CONFIRMED EXPOSURE/CONTAMINATION TO AGENT?	
DE-CONTAMINATED?	
RECEIVED MEDICAL TREATMENT FOR EXPOSURE/CONTAMINATION?	
HEALTH CONCERNS TIED TO EXPOSURE?	
NO TRIAGE FACTORS IDENTIFIED?	

MARKING EXAMPLES: CORRECT; WRONG; WRONG

©2002-2010 M.Schreiber

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Original – Patient Chart

Funded through HHS HPP grant #6 U3REP080070
For use with the PsySTART Incident Management System

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2012 FTX

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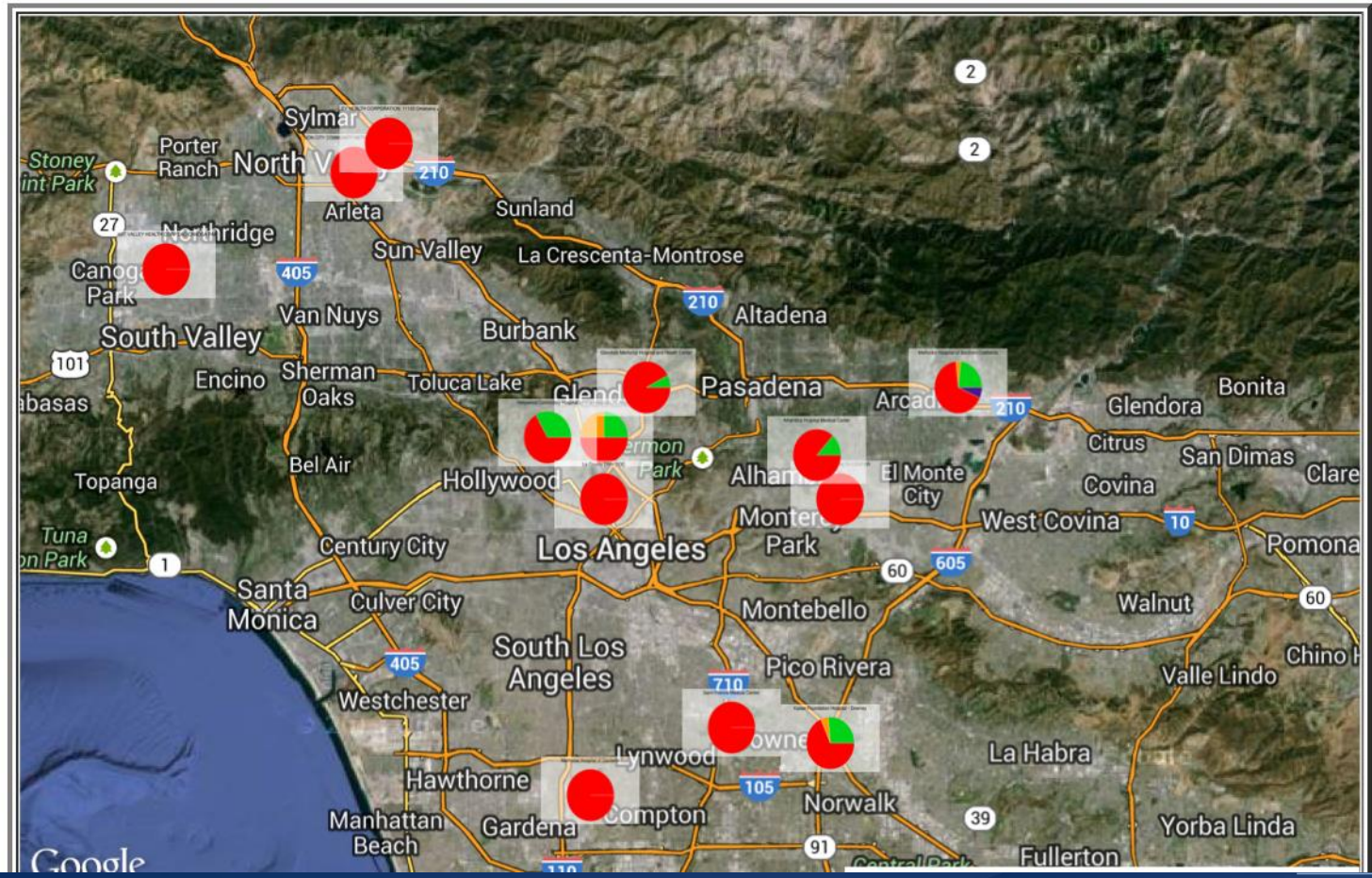
PsySTART™ Disaster Mental Health Triage System

Print this Page

Los Angeles County Operational Area



What Do We Mean by Psychological Consequences?

- Emotional
- Behavioral
- Cognitive

Reactions that affect hospital and clinic staff, patients, family members, and concerned community members in the face of a disaster

Institute of Medicine (2003).

Purpose of This Course

To give you protocols, templates, manuals, and tools so that you can train staff at your health care facility to address the psychological consequences of terrorism or other public health events

Course Objectives

- Recognize the triggers of psychological distress
- Raise awareness of the types of psychological effects to expect
- Provide principles and tools to bring back to your facility to augment your response plan and strengthen resources
- Help train staff at your facility:
  - Increase their knowledge and ability to plan and respond to the psychological consequences of large-scale emergencies

Study Team

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A division of the RAND Corporation
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Three Modular Training Components

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

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

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

Health Facility Needs Vary

Type of Facility	Components to Emphasize
Hospital with no on-site MH staff	Module 1: Staff assignments
Hospital with on-site MH staff	Module 2: All sections
Children's hospital	Module 2: Special populations
Community clinic	All sections of modules 1 and 2 are relevant

Overview of Module 1

- **Need:** The psychological consequences of large-scale emergencies
- **Context:** Characteristics of emergencies that are likely to trigger psychological effects
- **Planning for MH Need**: Preparing staff and facilities to best serve needs
- **Response**: Using tools and resources to address psychological effects
- **Discussion**: Summary and wrap-up

- **Need:** The psychological consequences of large-scale emergencies
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Sarin Gas Attack

Tokyo, March 20, 1995

Details are based on Okumura et al., 1998.

Public Health Emergencies Produce Medical Surges

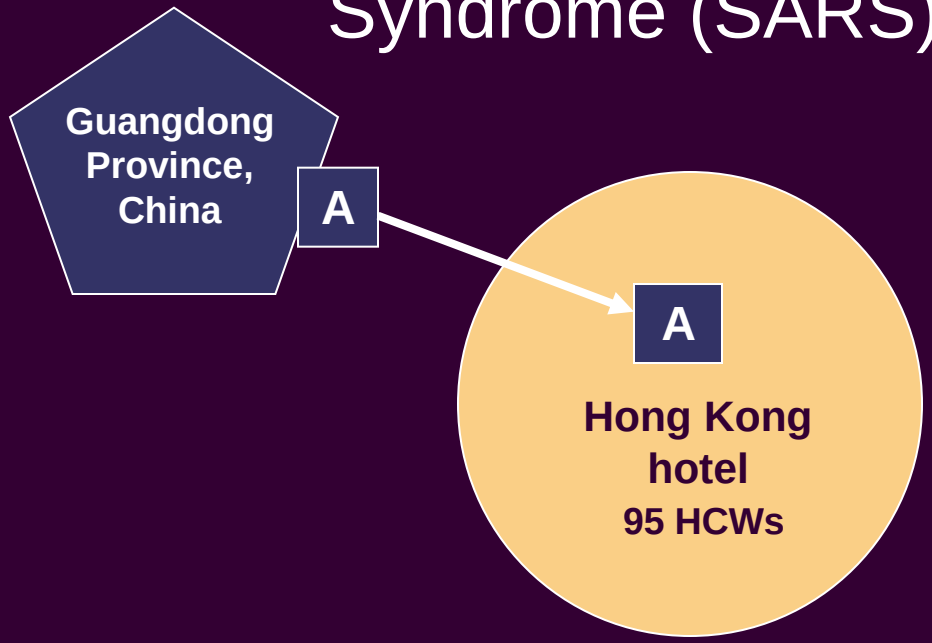
(At Least Four Times As Many with MH Effects)

Tokyo, 1995, *sarin*: 88% of visits were for persons who were not exposed

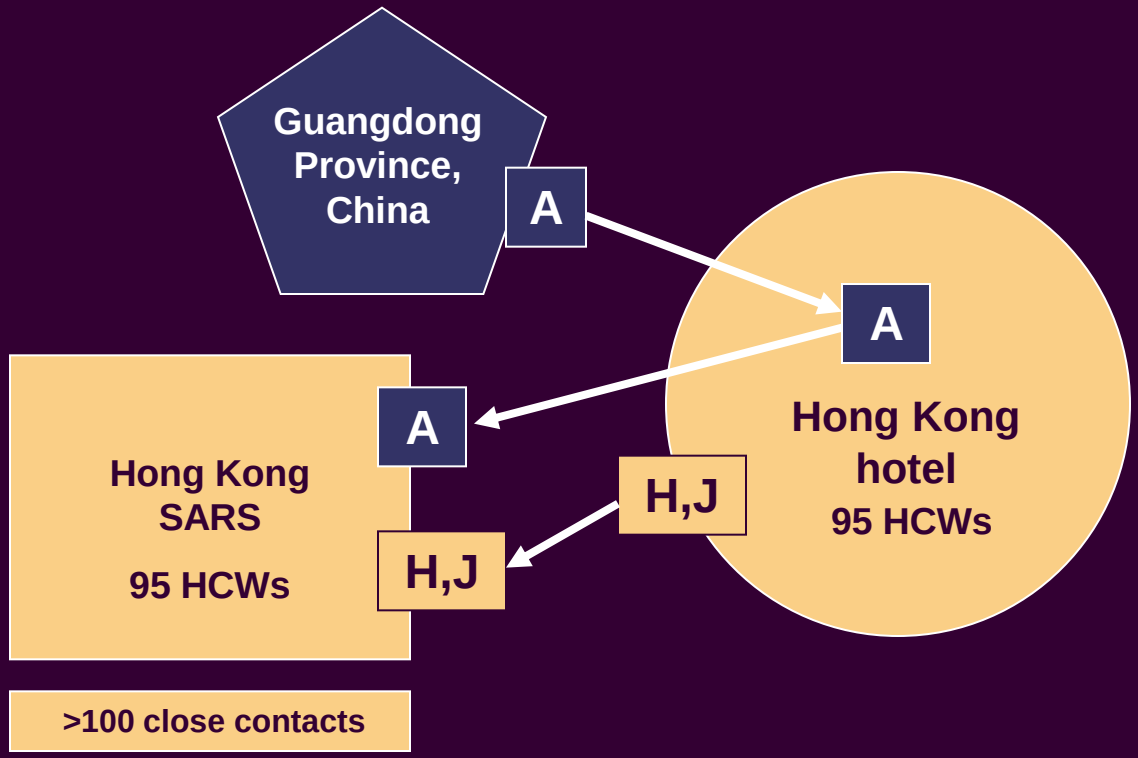
Brazil, 1987, *radioactive cesium isotope*: 125 exposed, 125,000 sought screening, 5,000 had symptoms without exposure

Washington DC, 2001, *anthrax*: 22 cases, 35,000 received prophylactic antibiotics

Roadmap of an Emergency: Severe Acute Respiratory Syndrome (SARS)



Roadmap of an Emergency: SARS



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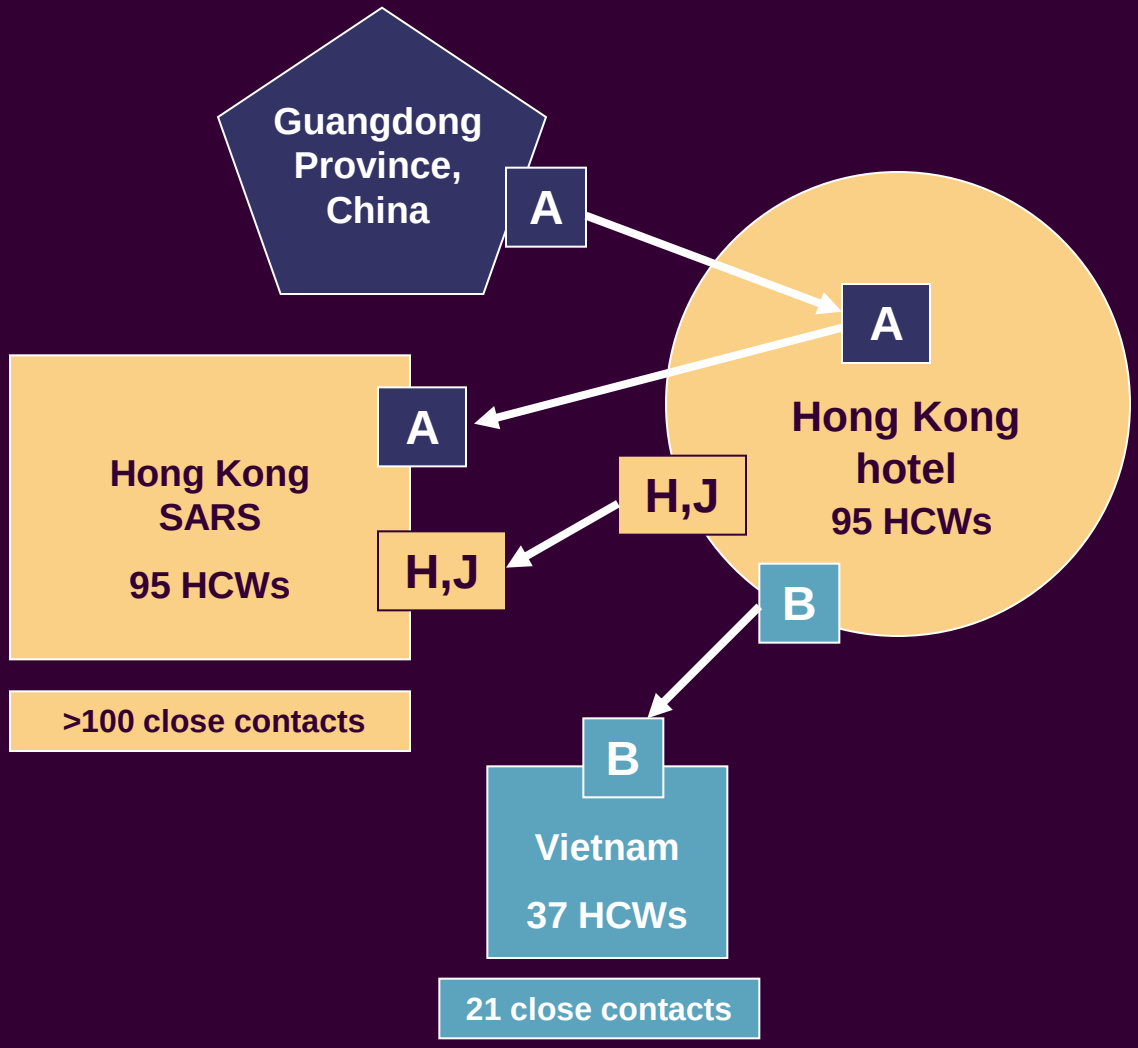

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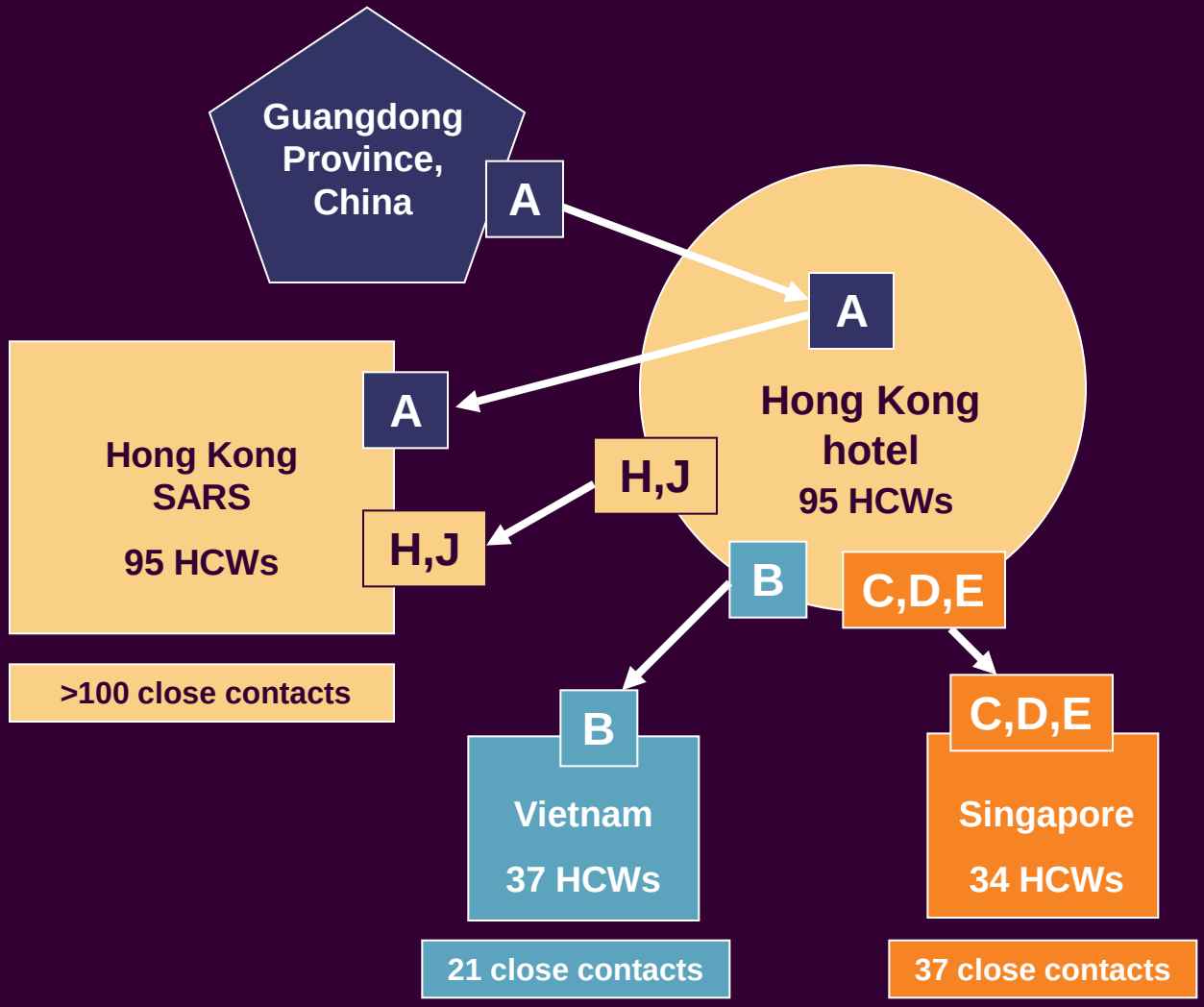

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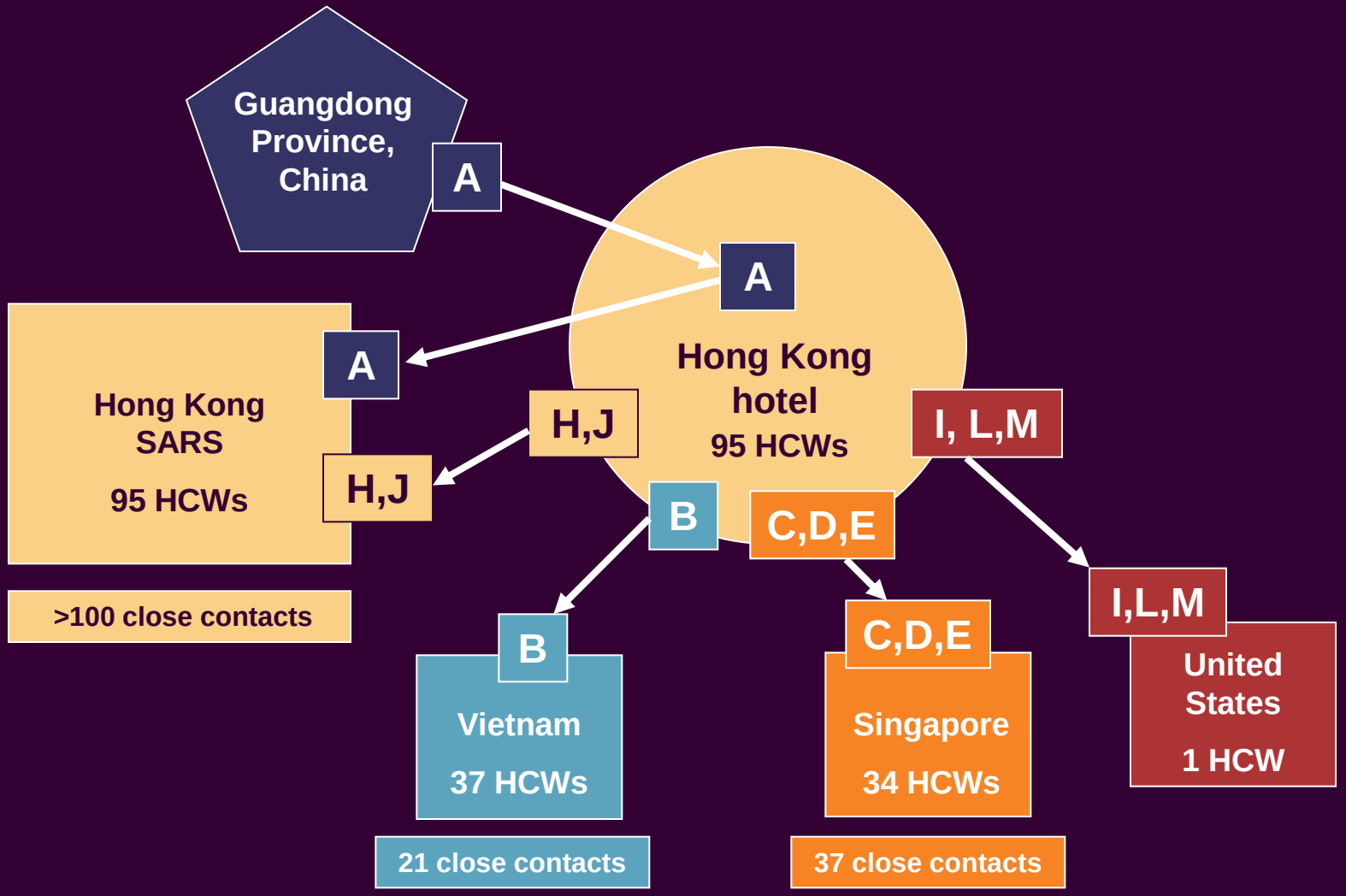

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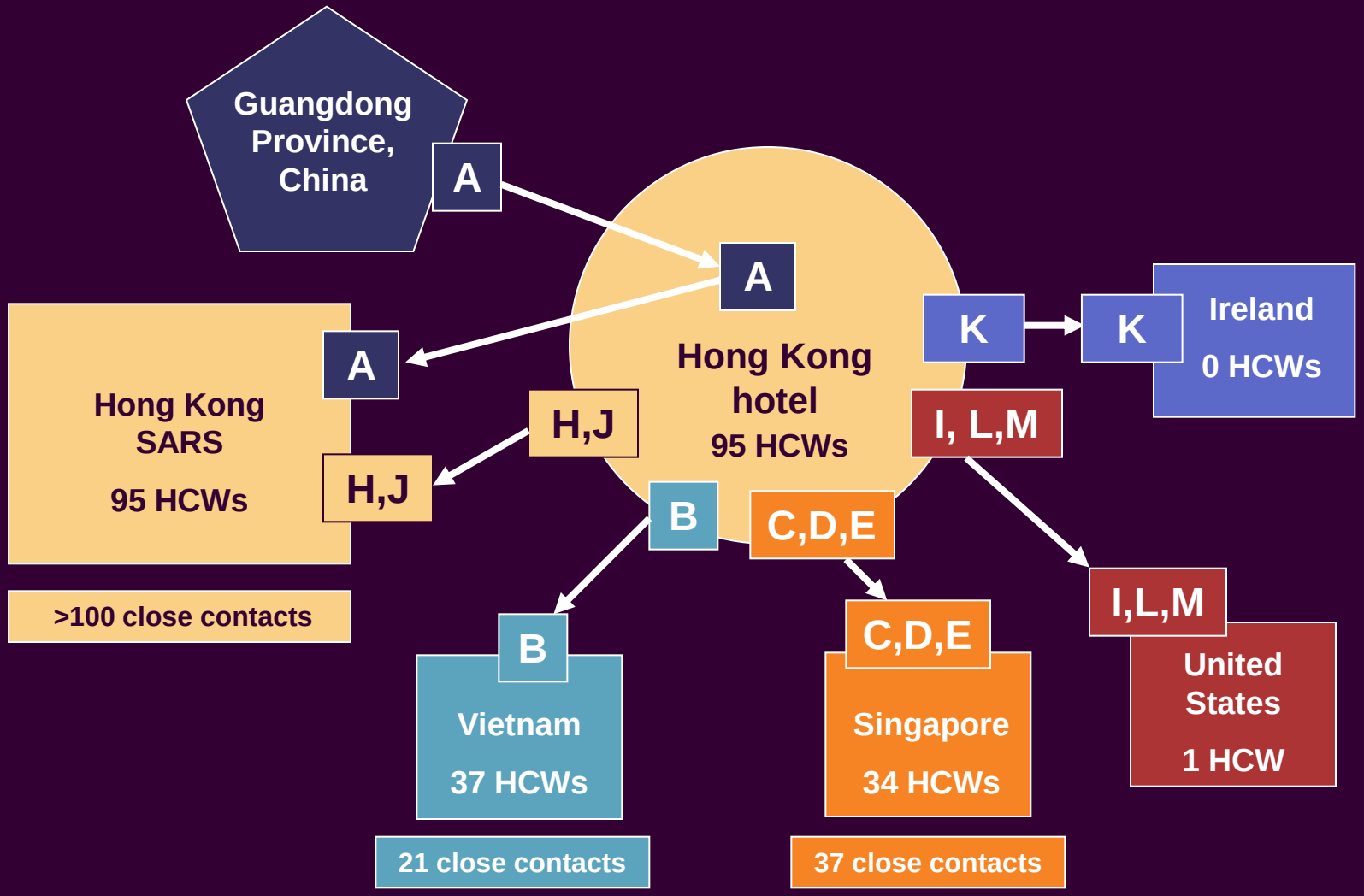

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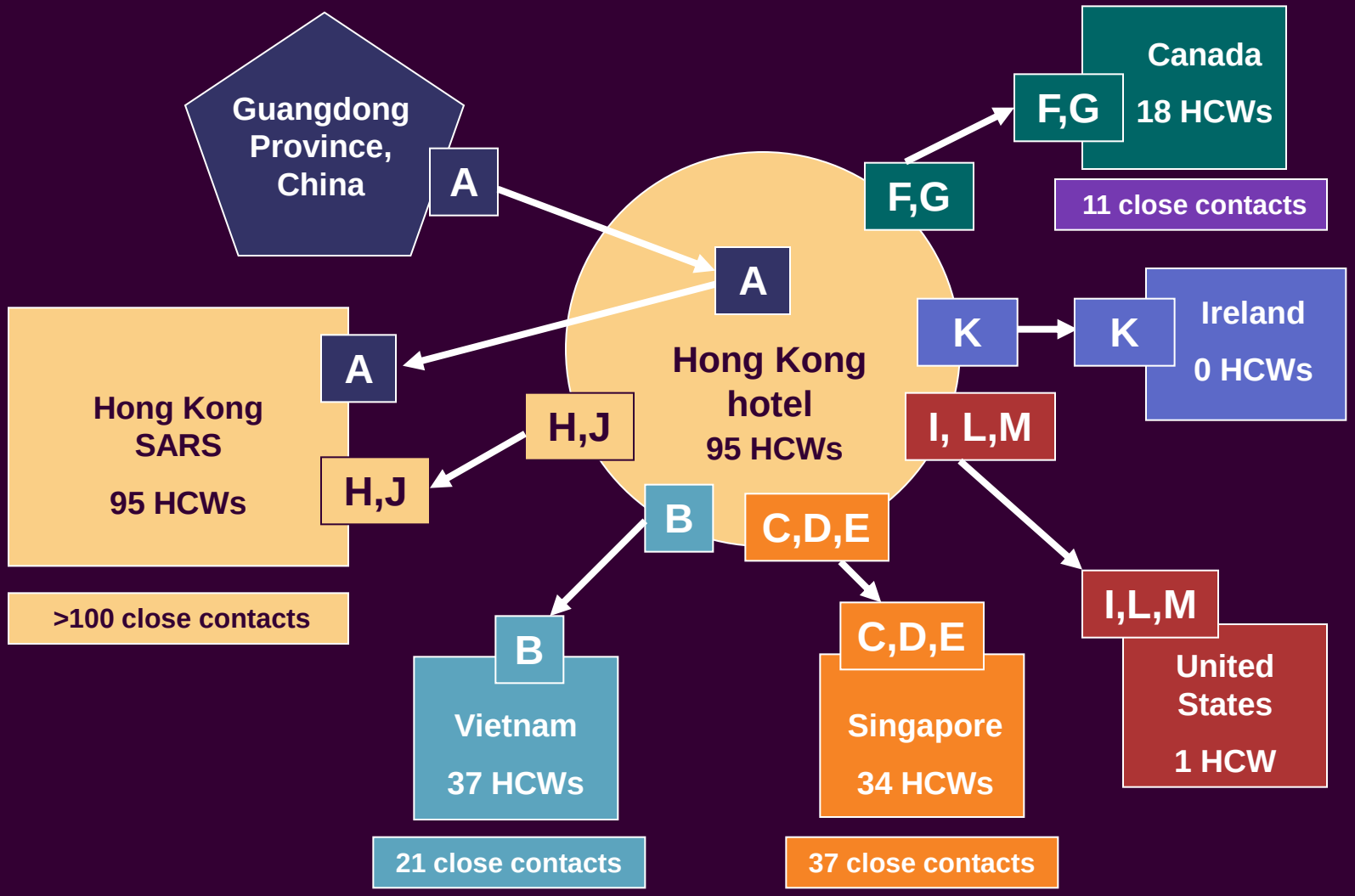

SARS: Effects on HCWs

- In the first month in Toronto, more than half of the quarantined patients in one hospital were HCWs
- Fears and infection control procedures led to isolation and stigmatization of HCWs
- Rates of psychological distress were high
  - 10–30% of quarantined persons developed psychological distress, including symptoms of depression or PTSD
  - 30% of HCWs reported job burnout one year later

SOURCE: Maunder et al., 2006.

Mental Health Needs Can Have Cascading Effects

Persons directly exposed and ill

Persons not directly exposed and with non-specific signs of illness

Persons directly exposed but no signs of illness

Mental Health Needs Can Have Cascading Effects

Persons directly exposed and ill

Survivors in isolation developing stress reactions

Persons not directly exposed and with non-specific signs of illness

Persons directly exposed but no signs of illness

Survivors developing stress reactions after decontamination

Mental Health Needs Can Have Cascading Effects

Parents of exposed children

Families seeking loved ones who are missing

Persons directly exposed and ill

Survivors in isolation developing stress reactions

Persons not directly exposed and with non-specific signs of illness

Persons directly exposed but no signs of illness

Survivors developing stress reactions after decontamination

Mental Health Needs Can Have Cascading Effects

Parents of exposed children

Elderly survivors

Families seeking loved ones who are missing

Persons directly exposed and ill

Disabled survivors

Persons not directly exposed and with non-specific signs

Survivors in isolation developing stress reactions

Pediatric survivors

Persons directly exposed but no signs of illness

Survivors developing stress reactions after decontamination

Persons with chronic mental illness

Diverse cultures among survivors

Mental Health Needs Can Have Cascading Effects

Staff overwhelmed by workload

Staff stressed under mandatory isolation

Elderly survivors

Disabled survivors

Staff fearing risks to family

Survivors in isolation developing stress reactions

Pediatric survivors

Staff fearing personal risk

Persons with chronic mental illness

Staff reluctant to come to work

Diverse cultures among survivors

- **Need:** The psychological consequences of large-scale emergencies
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Terrorist incident or public health emergency

Triggers of psychological effects

- **Restricted movement**
- **Limited resources**
- **Trauma exposure**
- **Limited information**
- **Perceived personal or family risk**

Short-term and longer-term effects

- **Emotional**
- **Behavioral**
- **Cognitive**

Restricted Movement

- **Definition:** Limitations on movement or interactions with others
  - Isolation
  - Shelter in place
  - Decontamination
  - Quarantine
  - Increased social distance
  - Evacuation

- **Potential reactions**
  - Loneliness
  - Anger and fear
  - Maladaptive behavior

- **Example:** A woman hospitalized with a severe respiratory problem is placed in isolation. She has no contact with her two young children or spouse and little access to social stimulation or personal relationships. Her family is quarantined at home, isolating them as well. Becoming agitated, she insists on leaving isolation to be with her family.

Limited Resources

- **Definition**: Access to resources is, or can be perceived as, restricted
  - Clinics closed and supplies limited
  - Resource distribution is seen as inequitable

- **Potential reactions**
  - Anger
  - Feelings of being stigmatized
  - Agitation and hostility

- **Example:** Hospital staff are potentially contaminated while responding to an RDD event because there isn't enough personal protective equipment. Staff become anxious about working with exposed patients; some refuse to work in the decontamination zones. Some staff try to steal protective equipment to use as a precaution when they travel home.

Trauma Exposure

- **Definition:** Witnessing or being the survivor of a traumatic event
  - Gruesome images of the injured or ill, especially children
  - Severe injury or death

- **Potential reactions:**
  - Grief
  - Anger
  - Worry
  - Burnout (psychological distress from adverse work conditions)

- **Example:** During the response to an RDD, the hospital emergency department receives multiple survivors, including many school children from the explosion site. Patients, their loved ones, and staff are exposed to gruesome images of burn/blast survivors.

Limited Information

- **Definition**: Actual or perceived lack of appropriate information about risks, symptoms, and recommended actions
  - Communication is inefficient or insufficient
  - Information is conflicting or lacking

- **Potential reactions**:
  - Fear
  - Anxiety
  - Frustration
  - Anger/hostility

- **Example:** During a chemical attack, people lack information about what to do. They begin calling the hospital for additional guidance; some go to the ED demanding to be evaluated. Officials and the media give the public differing information about risk zones, increasing the confusion

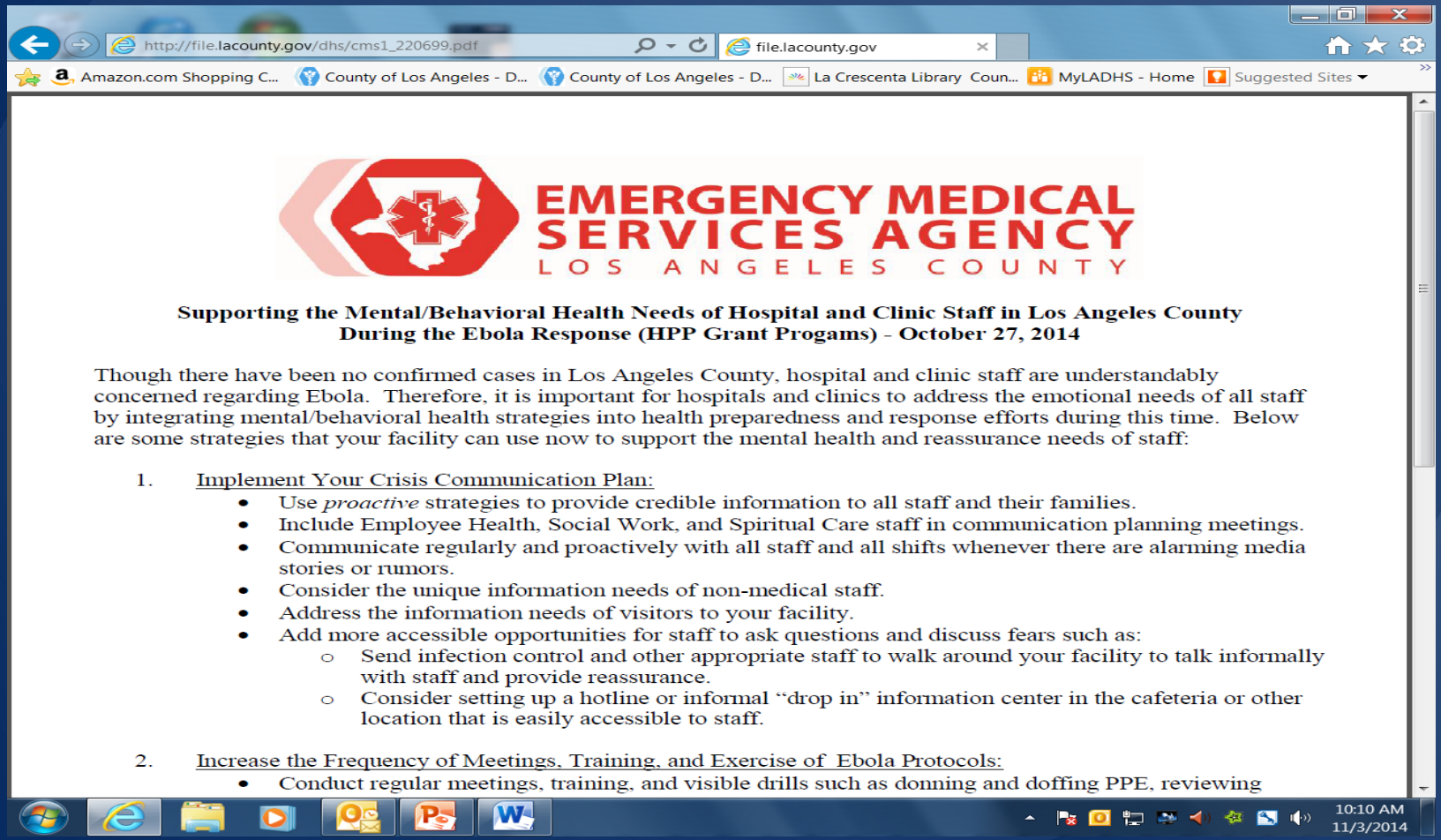
Perceived Personal or Family Risk

- **Definition:** Concern about personal or family safety
  - Exposure to harmful agents
  - Illness, injury, death

- **Potential reactions:**
  - Fear
  - Inappropriate precautions
  - Demand for medical care

- **Example:** During a pandemic influenza emergency, half of the hospital nursing staff are unable or unwilling to work because they either have no child care arrangements (schools and day-care centers are closed) or they are worried that they will be exposed to the disease and in turn expose their families

Ebola Example from LA County



http://file.lacounty.gov/dhs/cms1_220699.pdf

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EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Supporting the Mental/Behavioral Health Needs of Hospital and Clinic Staff in Los Angeles County During the Ebola Response (HPP Grant Progams) - October 27, 2014

Though there have been no confirmed cases in Los Angeles County, hospital and clinic staff are understandably concerned regarding Ebola. Therefore, it is important for hospitals and clinics to address the emotional needs of all staff by integrating mental/behavioral health strategies into health preparedness and response efforts during this time. Below are some strategies that your facility can use now to support the mental health and reassurance needs of staff:

1. Implement Your Crisis Communication Plan:
   - Use *proactive* strategies to provide credible information to all staff and their families.
   - Include Employee Health, Social Work, and Spiritual Care staff in communication planning meetings.
   - Communicate regularly and proactively with all staff and all shifts whenever there are alarming media stories or rumors.
   - Consider the unique information needs of non-medical staff.
   - Address the information needs of visitors to your facility.
   - Add more accessible opportunities for staff to ask questions and discuss fears such as:
     - Send infection control and other appropriate staff to walk around your facility to talk informally with staff and provide reassurance.
     - Consider setting up a hotline or informal "drop in" information center in the cafeteria or other location that is easily accessible to staff.

2. Increase the Frequency of Meetings, Training, and Exercise of Ebola Protocols:
   - Conduct regular meetings, training, and visible drills such as donning and doffing PPE, reviewing

10:10 AM
11/3/2014

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Areas Likely to Trigger Psychological Reactions

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

Where Do I Locate Everyone?

In advance of a disaster, determine where to locate:

- Psychological support
  - Fire and police may want their own MH team to administer care in a separate area
  - If necessary, use the parking lot or ancillary hospital/clinic building
- Waiting families and friends
  - Try to not mix families of the deceased with other families
- The bereaved
- Disruptive persons and assist people who become violent

What to Consider in Selecting Waiting Areas and Locations for MH Care

- Don't use the emergency department or intensive care unit halls
- Consider parking lots, auditoriums, cafeterias, and adjacent hospital buildings
- Choose
  - Spaces with easy access to bathrooms
  - Outdoor spaces that are viable in bad weather

Planning for Your Hospital MH Response Team

- Plan to be on your own for at least three days
- You will be limited to existing hospital/clinic staff
  - If available, MH clinical staff
  - Nonmental health clinical staff
  - Nonclinical staff (e.g., administrators and security staff)
- Pre-identify staff for your disaster MH team (and put them on your disaster planning committee)
- Identify the HICS BH Unit Leader and/or Employee Health and Well-Being Unit Leader

Plan for Additional Sources for MH Staff

- **Make pre-disaster agreements for mutual aid**
- **Disaster Resource Center including umbrella hospitals and clinics (pre-disaster)**
- **County Department of Health Services (post-disaster)**
  - DHS can access other county resources such as the Department of Mental Health, Public Health, etc.
  - DHS Emergency Medical Services Agency can contact the County Emergency Operations Center to access state and federal resources for postdisaster support
- **Establish partners (pre-disaster agreements)**
  - Volunteer organizations (social services)
  - Religious organizations (Chaplains)
  - Businesses (help with translation)
- **Volunteers**
  - Familiarize yourself with hospital/clinic plan for using volunteers
  - Develop list of approved groups

Suggestions for Using Mutual Aid Staff During Disasters

Reduce chaos and problems by determining:

- How staff from mutual aid partners including volunteers will be processed upon arrival at your facility
- Who/where they will report to:
  - HICS MH Unit Leader
  - Employee Health and Well-Being Unit Leader
  - Staging area or staff registration area
- How to identify and badge outside staff working in your facility during disasters

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Time Frames for Preparedness and Response

Before the incident: planning and training

During the incident: acute/short-term response

After the Incident: recovery

Tools to Use Before, During, and After a Disaster

Tool Name	Purpose	When to Use
Definitions	To explain selected medical concepts and countermeasures	Before and during
HICS MH Job Action Sheets	To improve the disaster response by including MH content and integrating MH functions	Before and during
Recommended Actions	To guide hospital/clinic staff in specific responses needed	Before and during
An Algorithm for Triaging MH Needs	To help staff decide who may need urgent psychological assessment from those who need nonurgent assessment	Before and during
REPEAT	To help hospitals/clinics assess their levels of preparedness	Before and after
Providing PFA: Tips for Talking with Adults and Children, Reference card and NCPTSD Handouts	To outline the 8 principles of early intervention in a disaster	Before and during
Tips for Workers and Survivors	To help prevent or mitigate burnout	Before, during, and after
Facility Poster	To promote preparedness among hospital/clinic staff	Before, during, and after

Getting Additional Resources

L.A. County DMH is the lead agency for all disaster-related psychological services provided to the public

- Your hospital incident commander (or other disaster coordinator) can request DMH services through the County DHS EMS Agency Emergency Operations Center by contacting:
  - Medical Alert Center (***MAC***): (323) 722-8073
  - Disaster Operations Center (***DOC***): (323) 890-7601
  - Hospital Emergency Administrative Radio (***HEAR***)
  - Web-based hospital messaging system: ***ReddiNet***
- To access L.A. County DMH crisis counseling and long-term MH care resources, call:

24-Hour Hotline: (800) 854-7771

Radiological Dispersal Device (RDD)

A dirty bomb containing cesium is detonated in downtown Los Angeles

- 180 deaths; ~270 injured; widespread contamination
- Hospitals inundated with ~50,000 people who believe they have been affected
- Patients, loved ones, and staff are exposed to gruesome images of burn/blast survivors
- Hospital and clinic staff may be contaminated because they lack protective gear
- Staff do not understand risks and are anxious and hesitant in their work
- Dozens of staff do not come to work
- ~ 20,000 individuals will probably be contaminated
  - Injured will require decontamination and treatment
  - Thousands more will probably need decontamination and medical follow-up

Terrorist incident or public health emergency

Triggers of psychological effects

- **Restricted movement**
- **Limited resources**
- **Trauma exposure**
- **Limited information**
- **Perceived personal or family risk**

Short-term and longer-term effects

- **Emotional**
- **Behavioral**
- **Cognitive**

Radiological Dispersal

"Hospital staff may be contaminated because they lack protective gear."	Limited resources
"Patients, their loved ones, and staff are exposed to gruesome images of burn/blast survivors as they enter the ER."	Traumatic exposure
"Staff don't understand risks of cesium exposure, making them anxious and hesitant in their work."	Limited information
"The injured will require some decontamination while being treated and, if possible, before hospital admission."	Restricted movement
"In the hours and days following the attack, dozens of staff don't come to work."	Perceived personal or family risk

Pandemic Influenza

25 cases of a new, highly contagious strain of flu appears in a small village in south China. Over the next 4 months, outbreaks appear in Hong Kong, Singapore, South Korea, Japan, Los Angeles, and three other major U.S. cities. The CDC announces plans for allocating the limited supply of vaccine and provides guidelines for using scarce resources.

Health care providers are overwhelmed. Media attention highlights shortages of medical supplies, equipment, hospital beds, and HCWs. Those HCWs at work are worried about contaminating their families. In underserved areas, up to 25% of the nursing staff cannot come to work: They have no child care arrangements because schools and day care facilities are closed.

Hospital and clinic staff are torn between their roles as health care providers and parents. Some HCWs, especially those placed in home quarantine, become depressed; others, traumatized by working in hospital isolation units, develop PTSD.

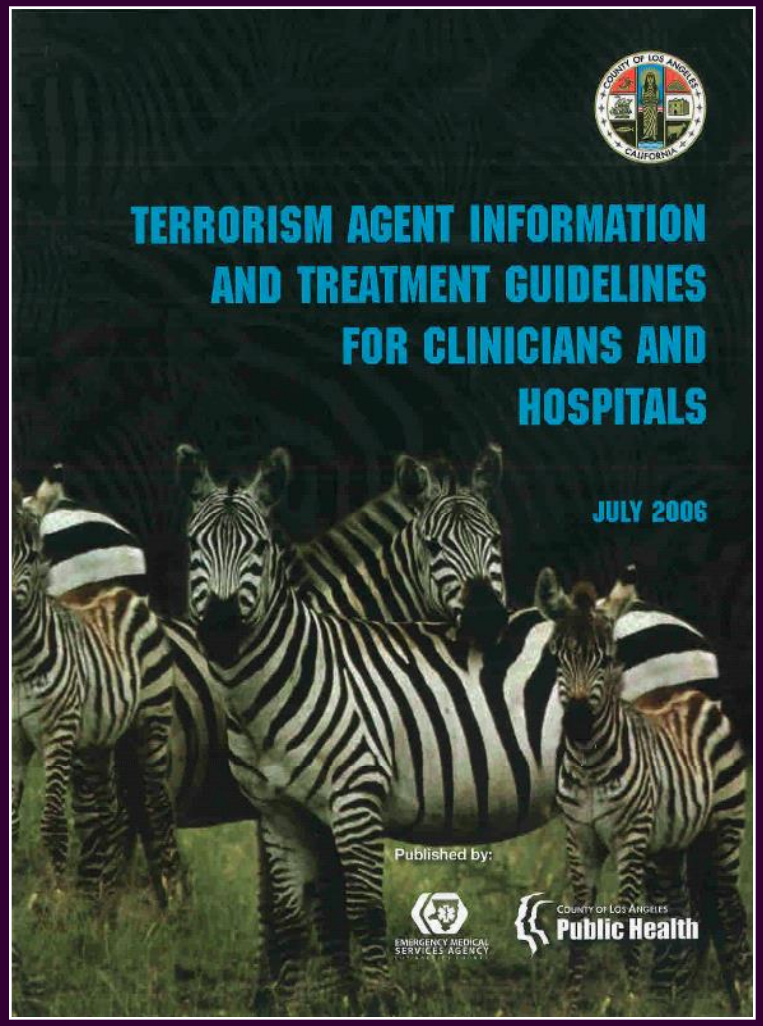
Pandemic Influenza

"The CDC announces plans for allocating the limited supply of vaccine and provides guidelines for using scarce resources."	Limited resources
"In underserved areas, up to 25% of the nursing staff cannot come to work: They have no child care arrangements because schools and day care facilities are closed**."**	Limited resources
"Some HCWs, especially those placed in home quarantine, become depressed; others, traumatized by working in hospital isolation units, develop PTSD."	Traumatic exposure and restricted movement
"HCWs are worried about contaminating their families."	Perceived personal or family risk

Using the Tools in an RDD or Other Disaster

- Contact Hospital Incident Command for staffing help
- Consult the "Zebra book" to look up agent information and treatment guidelines
  - www.labt.org
- Look up countermeasures in Recommended Actions
- Use the Algorithm for Triaging Mental Health Need
- After the event, complete the REPEAT assessment tool
- Distribute tips brochures
- Use PFA immediately after the disaster
- Display the poster and distribute the reference card
- Follow HICS Mental Health Job Action Sheet

The "Zebra Book"



Using the Recommended Actions Tool to Address RDD

Contents

Psychological Trigger	Agent	Page Number
Restricted Movement		5
• Isolation	Biological, Chemical	
• Shelter in place	Contagious, Chemical, RDD	
• Decontamination	Chemical, RDD	
• Quarantine	Contagious	
Limited Resources		8
• Staffing shortages under surge	Any	
• Space limitations for providing psychological care	Any	
• Availability of personal protective equipment (PPE)	Biological, Chemical, RDD	

Using the Recommended Actions Tool to Address RDD

Decontamination

During the planning stage

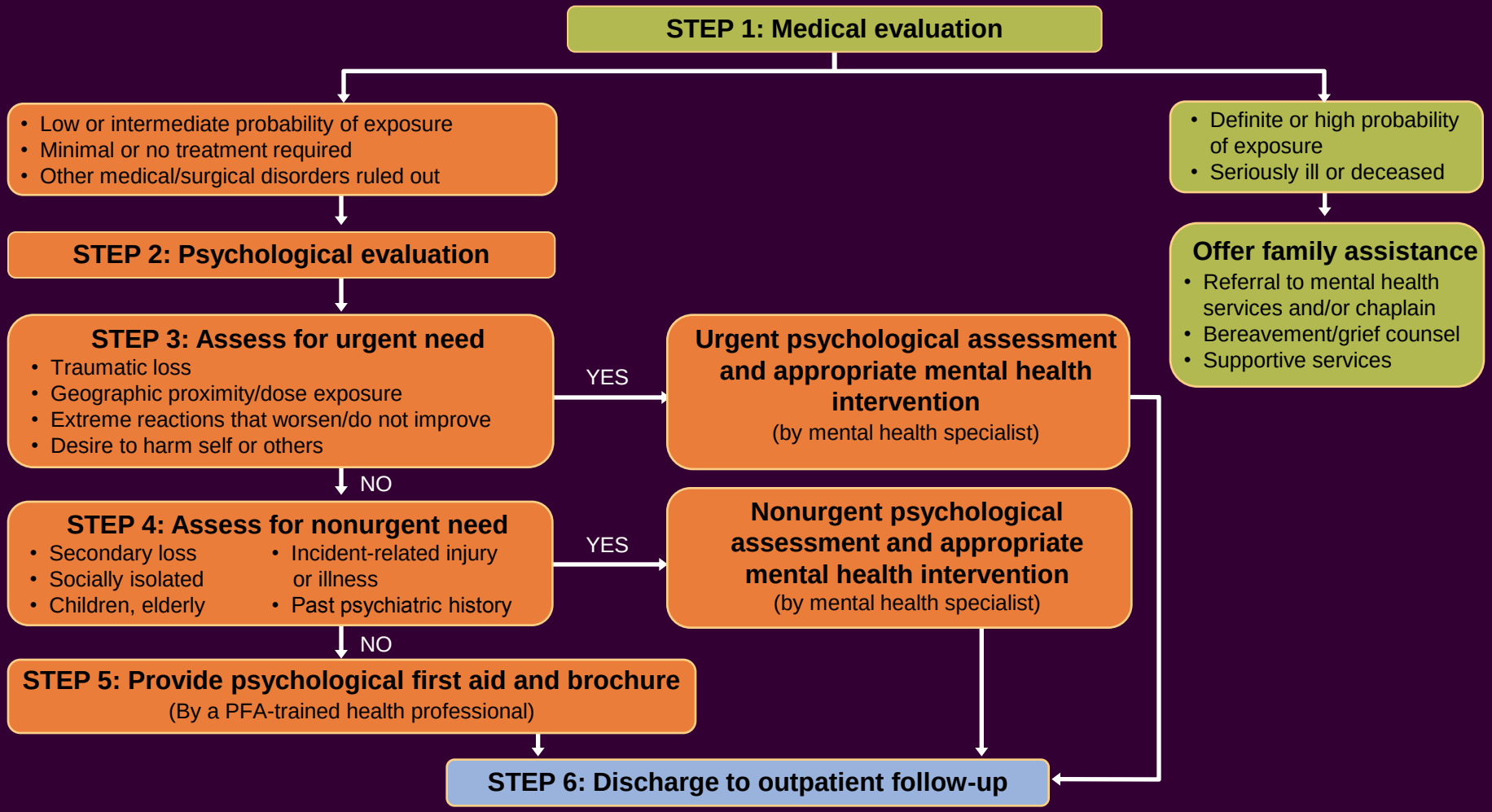
- Train non-MH staff to help keep people calm and possibly also to identify MH trauma
- Prepare decontamination instruction signs in languages appropriate for residents of surrounding communities
- Think through privacy or modesty issues that may be cultural and plan to address them

During the decontamination process

- After individuals have been triaged and identified as exposed or not exposed, conduct MH assessments among both groups to identify those who need supportive care or MH intervention
- Try not to separate parents and children during the decontamination process
- Place MH staff in the “clean” zone to assess for trauma

Identifying Urgency of Mental Health Needs

Patients with Exposure-Related Concern or Illness



Identifying Urgency of Mental Health Need

Patients with Exposure-Related Concern or Illness

STEP 1: Medical evaluation

- Low or intermediate probability of exposure
- Minimal or no treatment required
- Other medical/surgical disorders ruled out

STEP 2: Psychological evaluation

NEXT SLIDE

- Definite or high probability of exposure
- Seriously ill or deceased

Offer family assistance

- Referral to mental health services and/or chaplain
- Bereavement/grief counsel
- Supportive services

Assessment for Urgent Need

STEP 3: Assess for urgent need

- Traumatic loss
- Geographic proximity/dose exposure
- Extreme reactions that worsen/do not improve
- Desire to harm self or others

YES → **Urgent psychological assessment and appropriate mental health intervention** (by mental health specialist)

NO → NEXT SLIDE

STEP 6: Discharge to outpatient follow-up

Assessment for Nonurgent Need

STEP 4: Assess for nonurgent need

- Secondary loss
- Socially isolated
- Children, elderly
- Incident-related injury or illness
- Past psychiatric history

YES → **Nonurgent psychological assessment and appropriate mental health intervention** (by mental health specialist)

NO → **STEP 5: Provide psychological first aid and brochure** (By a PFA-trained health professional)

STEP 6: Discharge to outpatient follow-up

Structures and Processes for Health Care Facility Readiness

Structure		Process		Outcomes
• Internal organizational structure and chain of command • Resources and infrastructure • Knowledge and skills	+	• Coordinating with external organizations • Risk assessment and monitoring • Psychological support and intervention • Communication and information sharing	=	*Appropriate MH disaster response*

SOURCE: Donabedian (1966).

How Prepared Is Your Facility?

- Assess your level of preparedness to respond to a terrorist incident or other public health emergency
  - Set a baseline score
  - Identify areas for improvement
- Reassess preparedness
  - Gauge amount of improvement
  - Identify areas still needing attention

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

REPEAT for Health Care Facilities

Disaster Preparedness Self-Assessment Tool

Psychological Element*	Full Implementation (Score = 2)	Some Implementation (Score = 1)	No Implementation (Score = 0)	Your Score and Areas to Improve
Structure				
Internal Organizational Structure and Chain of Command	• Leadership recognizes the need to address psychological consequences • Disaster plan includes MH in the incident command structure/ job action sheets • Clear roles are identified for direct MH service to survivors and family; and staff	Some of these structures are in place to address psychological consequences	There is no infrastructure to address psychological consequences	2 1 0
Resources and Infrastructure	• Plan has been reviewed to ensure adequate resources and supplies will be available • Resource list is available with information on who to contact (county DMH) • Have capacity to handle a MH surge up to 50 times the number of physical casualties	Some but not all resources that would be needed are available	Resources available are inadequate should a disaster occur	2 1 0
Knowledge and skills	• MH staff are trained for roles in command structure and familiar with job action sheets • MH staff are trained in MH assessment and early psychological intervention • Staff receive hands-on training through exercises and drills to test plans	Some staff have received some training activities on MH reactions and response	Staff have not received training on MH reactions and response	2 1 0
			Subtotal Disaster Preparedness Self-Assessment Score (***Structure:*** possible range = 0–6)	

- **Need:** The psychological consequences of large-scale emergencies
- **Context:** Characteristics of emergencies that are likely to trigger psychological effects
- **Planning for MH Need**: Preparing staff and facilities to best serve needs
- **Response**: Using tools and resources to address psychological effects
- **Discussion**: Summary and wrap-up

Discussion

Summary

Continuing education credit

Resources

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