BEHAVIORAL HEALTH STAFF PLANNING and RESPONSE

STRATEGIES FOR SCARCE RESOURCE SITUATIONS

NORTHWEST HEALTHCARE Response Network.

Conventional Capacity – The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.	**Contingency Capacity** – The spaces, staff, and supplies used are not consistent with daily practices, but provide care to a standard that is functionally equivalent to usual patient care practices. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources)	**Crisis Capacity** – Adaptive spaces, staff, and supplies are not consistent with usual standards of care but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant and adjustment to standards of care (Hick et al, 2009).

RECOMMENDATIONS	***Strategy***	***Conventional***	***Contingency***	***Crisis***
GENERAL (For all clinical settings: inpatient, outpatient, group homes, specialty care facilities, ACF)				
1. Include Staff mental/behavioral health guidance/resources in all response plans and continue to maintain, test, and update mental health surge plans.				
2. Include Mental Health surge issues in trainings and exercises including De-escalation Training, Management of the aggressive patient and Staff Safety.[1,2]	*Prepare*			
PLANNING for PATIENT Mental Health Surge				
3. Identify all staff with mental health/behavioral health training and appoint key individuals to lead and organize disaster mental health preparedness and response				
3a. Recommend specific disaster mental health training for Behavioral Health providers currently embedded in general medical settings. These individuals will be key in providing Just-in-Time (JIT) training to others in times of mental health patient surge.				
3. Store resources and JIT disaster mental health training materials. (e.g. Health Support Team Curriculum, or Skills for Psychological Recovery National Child Traumatic Stress Network). See references below for specific material recommendations.[3,4,5]	*Prepare*			
PLANNING for STAFF Mental Health needs:				
4. Encourage psychological first aid training to all medical staff especially for key clinical leaders and administrators.[5,6]				
5. Identify and train willing behavioral health and non-behavioral health providers with more comprehensive curricula than PFA, to act as monitors and evaluators for their colleagues. Utilize evidence-based questionnaires as needed to determine current staff functioning. For example, ProQOL is one quick evaluation tool (https://proqol.org)				
6. Provide psychoeducation for staff on caregiver fatigue, including symptoms, and coping/support tools[4,5,7,8]	*Prepare*			
7. Teach appropriate debrief strategies recognizing[9,10,11] ○ Group debriefing may not be appropriate for all. Prepare and plan to do 1 on 1 debriefing ○ The pace of the debrief session should be responder driven not agenda driven ○ Individuals process traumatic situations at their own pace. Forcing graphic or stressful debriefing can cause increased trauma.				
PLANNING FOR IN-PATIENT PSYCHIATRIC FACILITIES:				
8. Encourage inpatient psychiatric facilities to develop connections with other inpatient psychiatric facilities to develop planning for potential patient transfers, evacuations and staffing.				
9. All inpatient psychiatric facilities should develop general disaster planning to include basic care for patients e.g. adequate food/water/shelter, staffing shortfalls, medications, transport of patients, methods of transport, and management of patients who may represent a danger to themselves or others.	*Prepare*			

RESPONSE **Patient Surge** 10. Notify pre-trained providers to prepare for surge. Implement JIT training of other staff to help with patient surge. 11. Ensure Alternate Care Facilities have written educational materials to assist with patients, and access to mental health consultation as needed. 12. In preparation for possible loss of electronic medical records, have printed patient information to include diagnosis, allergies, and current medications/dosages. 13. Modify individual treatment to shorter, symptom focused appointments. 14. Utilize psycho-educational, and brief evidence-based interventions. 15. Use Telehealth mental health providers as off-site resource.	*Substitute/ Adapt*			
16. Shift treatment to emphasize coping strategies, interventions to manage symptoms, and identifying and accessing personal resources. 17. Deploy multi-disciplinary response teams as needed to provide Just in Time training for healthcare providers/organizations, and to provide consultation on Behavioral Health interventions including medications and crisis management. 18. Shift from individual therapy to group intervention.	*Substitute/ Adapt*			
Staff Self Care 19. Consider "deliberate Coping and Calming" strategies or "Personal Reflective Debrief" techniques over mandated and prescribed CISD for staff during and after traumatic events.[9,10] 20. Encourage and support staff self-care. When possible maintain schedules, routines and shifts. 21. During an event encourage personal "pauses" for reflection and self-evaluation. 22. Encourage utilization of organizational support systems, (e.g. employee assistance program, wellness programs, etc.). 23. Maintain consistent scheduled communication between administrators and providers during and after acute event. (e.g. huddles, check-ins, sign-outs, etc)	*Substitute/ Adapt*			
MEDICATIONS RECOMMENDATIONS: 24. Psychiatric medications may not be available due to supply chain disruptions during a major event. Encourage all facilities who care for mental health patients (outpatient, in-patient medical, long term care, group homes, or specialty care facilities) to develop psychiatric medication supply strategies. Consider increasing par levels, developing stockpiles, and/or planning with local retail pharmacies as potential psychiatric medication supply strategies.	*Prepare*			

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[1]*https://handlewithcare.com/wp-content/uploads/2010/08/hwc-mentalhealth.pdf*

[2]*https://www.crisisprevention.com*

[3]*https://learn.nctsn.org/course/index.php?categoryid=11*

[4]*Contact Health Support Team directly at http://healthsupportteam.org for curriculum.*

[5]*https://www.nctsn.org/resources/skills-psychological-recovery-spr-online. Requires free registration for materials.*

[6]*https://learn.nctsn.org/course/index.php?categoryid=11*

[7]*Killian, K. Helping Till It Hurts? A Multimethod Study of Compassion Fatigue, Burnout, and Self-Care in Clinicians Working with Trauma Survivors. Traumatology. 2008, Vol 14(2) June 32-44*

[8]*Mendenhall, T., Trauma-Response Teams: Inherent Challenges and Practical Strategies in Interdisciplinary Fieldwork. Families Systems, & Health, 2006, 24(3):357-362.*

[9]*Cicognani, E., Pietrantoni, L., Palestini, L., & Prati, G. (2009). Emergency workers quality of life: The protective role of sense of community, efficacy beliefs and coping strategies. Social Indicators Research, 94(3):449*

[10]*http://www.massey.ac.nz/~trauma/issues/2003-1/orner.htm*

[11]*Joint Commission: https://www.jointcommissionjournal.com/article/S1553-7250(08)34066-5/fulltext*