


Disaster Behavioral Health 101

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Agenda



- Differences between clinical and "every day" MH/BH treatment, disaster response considerations and understanding mental health surge
- Risk and Resilience factors in the context of disasters (individual and population level) over time (phases of recovery)
- Specific Populations: Kids, Healthcare Providers and other Responders; School Personnel
- Personal preparedness at work and home

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Basic Principles of Disaster Behavioral Health

- There are different mental and behavioral health needs at different times throughout the disaster response and recovery cycle.
- Need and demand often (almost always) outpace available resources and supply, particularly after the initial shock of the event has worn off.
- Models and Interventions must be scalable to communities and population levels be effective.
- Traditional interventions and modalities are often inappropriate and need to be adapted for the disaster or crisis situation.
- Mental health must be integrated into the broader disaster response effort for both to be ultimately successful.

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<h3 style="text-align: center;">Graceful Degredation</h3> <ul style="list-style-type: none"> ◦ Part of a system continues operating properly in the event of failure of some of its parts ◦ If operating quality decreases at all, the decrease is proportional to the severity of the failure ◦ Particularly sought after in high-availability or life-critical systems <p>Example: electrical utilities use the concept of graceful degradation in planning ahead for "brown-outs," in order to avoid "black-outs."</p>	<h3 style="text-align: center;">Catastrophic Degredation</h3> <ul style="list-style-type: none"> ◦ Rapid reduction of the ability of a system, subsystem, component, equipment, or software to perform its intended function ◦ Even a small failure can cause total breakdown ◦ Usually results in total failure to perform any function
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WHAT THIS MEANS IN A LARGE-SCALE DISASTER

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The first severely injured patient from a mass casualty incident will be greeted in a shock room of the regional trauma center by the trauma team on call.

The eighth critical patient will be treated in an improvised resuscitation bay by a reinforcement team that may not even include a surgeon with trauma experience.

The twentieth severe casualty will be lucky to end up on a regular emergency department gurney with a physician who is Advanced Trauma Life Support program certified.

Even the most creative disaster plan in the best trauma center will not prevent this decline in the quality of trauma care during a multi-casualty incident.

Hirschberg, Holcomb, Mathox. *Annals of Emergency Medicine*, (37) June, 2001

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THEORETICAL BASES AND CURRENT RESEARCH SUPPORTING DBH STAGES FRAMEWORK

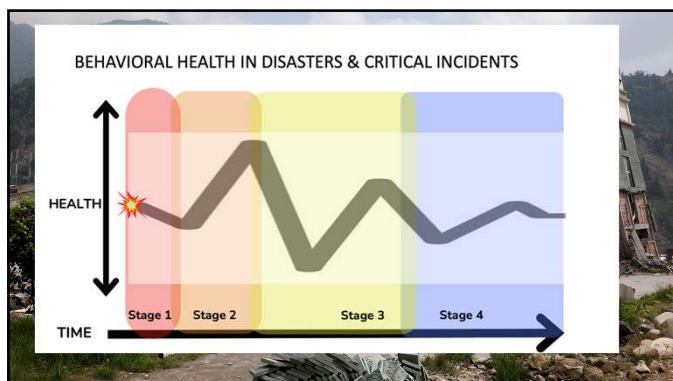
Research supporting this stage model was garnered from international and national (U.S.) sources in an attempt to find common themes and timelines across incidents.

The framework of stages was made to broadly provide structure for what we recognize are considerable local, individual and incident specific variability of experience.

Areas of research literature that were included in the process of developing in this stage model include:

- Emergency Management
- Trauma recovery
- Grief & Loss
- Resilience
- Clinical Psychology
- Disaster / Risk Science
- Public Health

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Stage 1:
Impact / Rescue
(hours to weeks post-impact)

Clinical / Tactical GOALS: Adjust to safety and primary needs, Triage, Initial impact assessment, resource allocation relative to basic needs (food, shelter, water, etc)

Clinical / Tactical ISSUES: Shock, Fear, Panic, Uncertainty, Direct loss and exposures, "Medically Unexplained Physical Symptoms" (MUPS)- headaches and stomachaches

Clinical / Tactical FOCUS: Triage, Psychological First Aid, Safety, Assessment of ongoing or potential threat

Emergency Management Considerations: Initial mission and scope, initial impact assessment, understand trends and characteristics of disaster mental health to prepare, get foot into the formal response efforts NOW!

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Stage 2:
Heroic / Cohesion
(weeks to months post-impact)

Clinical / Tactical GOALS: Establish BH supports & strategies; use energy and attention to prepare for challenges. Leverage professional and community supports.


Clinical / Tactical ISSUES: Denial of impact, Unrealistic perception of recovery, high bonding & external support, lack of resource to need matching (too much 'help' in the wrong places). At-risk communities or groups may be particularly vulnerable during this time.

Clinical / Tactical FOCUS: Planning, Training, Prep for mental health surge, Communicate typical reactions / Reassure and provide education about what is "normal" in an "abnormal" event.

Emergency Management Considerations: Establish update tempo for data/input & revised strategies, prepare for the surge NOW despite likely low pressure, ensure response integration (internal/external), establish strategy to engage offers for support (individual/agency) later when needed.

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Stage 3:
Adversity / Surge
(months post-impact)



Clinical / Tactical GOALS: Behavioral health support at higher acuity levels and for more people (MH surge), screening & assessment as needed and referral sources available to provided evidenced-based interventions with efficacy. Nuanced, tailored and culturally appropriate supports for at risk and special groups / populations (rural communities, children / youth, etc)

Clinical / Tactical ISSUES: Grief, Loss, Hopelessness, Depression, Suicide, Exhaustion, Disaster cascade effects (economics & limits of assistance) which are more common than most realize.

Clinical / Tactical FOCUS: Tiered and appropriate levels of support, Garnering vetted referral sources, Plan for long-term recovery

Emergency Management Considerations: Continue cycle of updated situational awareness, new strategies, manage the surge coming now, prepare for long-term recovery

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Stage 4:
Rebuilding / Resilience
(months to years post-impact)



Clinical / Tactical GOALS: Assisting with adjustment, Reconnection to community and supports, Care provision for higher-risk groups with nuanced and culturally appropriate resources, Development of purpose, hope moving forward.

Clinical / Tactical ISSUES: Grief, Loss, Disaster cascade effects, Exhaustion, "new" focus and apathy towards change and adaptation (disaster fatigue).

Clinical / Tactical FOCUS: Community Connections and Collaboration between groups with varying resources (e.g. schools and hospitals), Training, ongoing educational support around disaster recovery expectations, Lessons Learned / Readiness


Emergency Management Considerations: Manage long-term recovery efforts + connect, strengthen partnerships gained, leverage lessons learned into meaningful readiness

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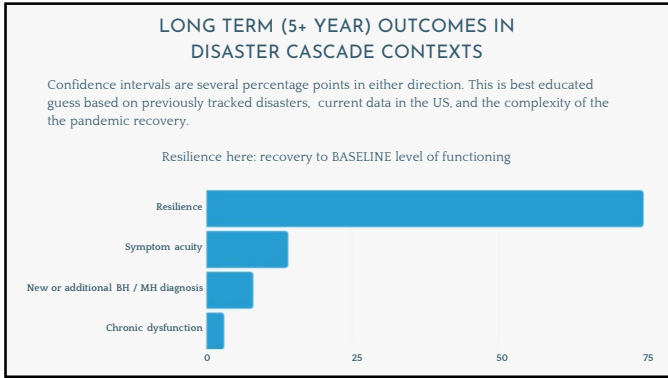
Disaster cascades:

Defined as : more than one large-scale impact that occurs during the recovery window (approx.18-24 months) from the original impact.

- Tax already depleted mental, emotional and physical resources
- Re-start the disaster recovery cycle, but at a lower baseline
- Extend the recovery cycle
- Increase acuity of symptoms



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Situations that may result in trauma may include but not be limited to:

- A natural disaster (earthquakes, floods, fires)
- "Every day trauma" e.g. automobile accident, etc.
- War
- A kidnapping or being held hostage OR witnessing any of these situations
- An attack (such as assault, physical abuse, rape, or sexual assault)
- Community violence
- Traumatic loss of family, friends

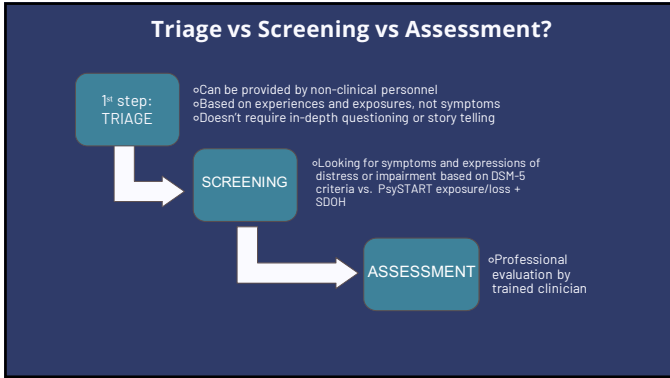
we will talk later about the ways in which trauma and stress are related (and not)

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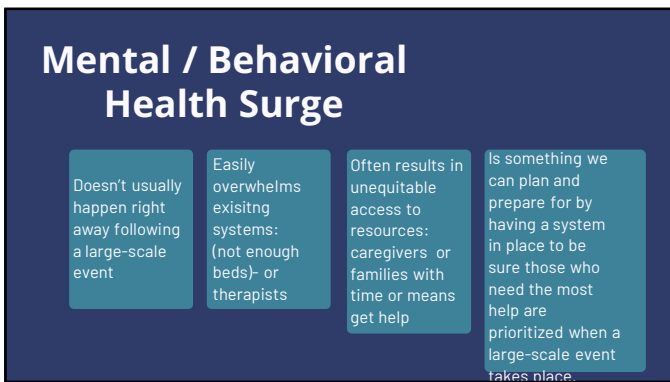
Challenge

- Following any disaster or other high impact event, mental health needs will vastly exceed the mental health resources
- And, there is a continuum of risk and resilience
- How do we **rationaly and equitably** provide resources to individuals and the community?
 - Individual decision support
 - And a *Population level* focus
 - "the most good for the most kids"
- Trauma Informed response to suicide
 - Understanding the context

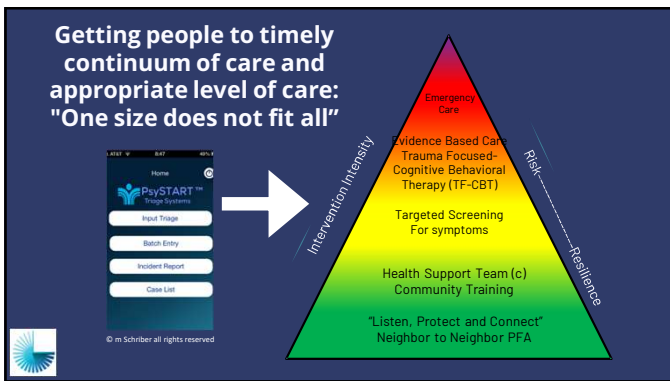
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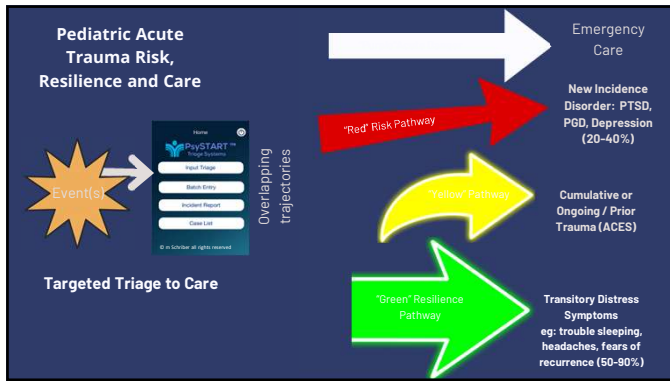
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- PsySTART is not a symptom-based screener. It identifies acute trauma exposure and loss, which are associated with increased risk for new psychological disorders.
- It identifies severe/extreme stressors, loss, injury and not initial symptoms upset/distress
- "Outside your head, not in" – does not require identifying or sharing feelings
- Validation on acutely traumatized children (and adults) and predicts clinical PTSD and Depression (JAMA. 2006 Aug 2;298(5):549-59)

Distress or PTSD?

Numb or "chill" ?

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Early Symptoms vs. Risk

Unaccompanied child

Home not livable

Thought I was going to die

Death of loved ones

Scenes of death

Symptoms & appearance are unreliable within first 30 days after event.
Instead, we use objective experiences which are precursors of risk

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We Start Here

Identify trauma exposure

- EXPRESSED THOUGHT OR INTENT TO HARM SELF/OTHER?
- FELT OR EXPRESSED EXTREME FEAR?
- 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?
- CHILD CURRENTLY SEPARATED FROM ALL CAREGIVERS?
- FAMILY MEMBERS WHO ARE CURRENTLY SEPARATED OR MISSING?
- HEALTH CONCERN DUE TO EXPOSURE OR CONTAMINATION AND EXPERIENCED MEDICAL TREATMENT OR DECONTAMINATION DUE TO EXPOSURE?
- PRIOR HISTORY OF EITHER MENTAL HEALTH CARE, DRUG OR ALCOHOL USE FOR SELF OR FAMILY MEMBER?
- BELIEF NOT RECEIVING SUFFICIENT SUPPORT FROM OTHERS (SUCH AS SOMEONE TO TALK TO)?
- VERY OFTEN DO NOT HAVE ENOUGH TO EAT, CLEAN CLOTHES TO WEAR OR A SAFE PLACE TO GO?
- CANNOT GET HELP NEEDED WHEN SICK?
- EXPOSURE TO DOMESTIC VIOLENCE, EMOTIONAL, PHYSICAL OR SEXUAL ABUSE?

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Assumption:

If you don't count it: It won't count.

- High mental health impacts from day to day emergencies and disasters (**20-40% risk rates**)
- Strong need for mental health services and support, but not all high risk (triage)
- Early intervention and support is key
- Triage is critical for early intervention **and** to make best use of limited resources:
 - Exposure vs symptoms
 - Most impact for youth most in need

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PsySTART®

Sonoma County SCOE Aggregated Pediatric MH Situational Awareness Report 14 Jan 2021

Unit: SCOE All Sites Support | Incident: Combined 2019 H1N1 Infl. COVID-19 | Period: 10 September 2020 to 24 January 2021

42% High Risk, 42% Moderate Risk, 16% Low Risk

Number of events with sample sizes

Average Patient Risk Factor Heat

High Risk Factors (40% of sample):

- EXPRESSED THOUGHT OR INTENT TO HARM SELF/OTHER? (1.28%)
- CHILD CURRENTLY SEPARATED FROM ALL CAREGIVERS? (1.28%)
- FAMILY MEMBERS WHO ARE CURRENTLY SEPARATED OR MISSING? (1.83%)
- HEALTH CONCERN DUE TO EXPOSURE OR CONTAMINATION AND EXPERIENCED MEDICAL TREATMENT OR DECONTAMINATION DUE TO EXPOSURE? (1.28%)

Moderate Risk Factors (42% of sample):

- PRIOR HISTORY OF EITHER MENTAL HEALTH CARE, DRUG OR ALCOHOL USE FOR SELF OR FAMILY MEMBER? (1.83%)
- BELIEF NOT RECEIVING SUFFICIENT SUPPORT FROM OTHERS (SUCH AS SOMEONE TO TALK TO)? (1.28%)
- VERY OFTEN DO NOT HAVE ENOUGH TO EAT, CLEAN CLOTHES TO WEAR OR A SAFE PLACE TO GO? (1.28%)
- CANNOT GET HELP NEEDED WHEN SICK? (1.28%)
- EXPOSURE TO DOMESTIC VIOLENCE, EMOTIONAL, PHYSICAL OR SEXUAL ABUSE? (1.28%)

Low Risk Factors (16% of sample):

- NO TRIAGE FACTORS IDENTIFIED? (16.41%)

You can access a summary report that helps identify who to prioritize for care or additional follow up / referral



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**DISASTER BEHAVIORAL HEALTH
IS NOT CLINICAL
PSYCHOLOGY**

and this distinction is critical for anyone with
a healthcare license (of any kind) to
understand before an even occurs

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Comparison

 <p>Clinical Psychology</p> <ul style="list-style-type: none"> • Control of physical conditions • HIPAA • 55 minute hour • Therapeutic Relationship • Multiple meetings with the same client or clients • Treatment plan or goals 	<p>VS</p>	 <p>Disaster Behavioral Health</p> <ul style="list-style-type: none"> • Challenging environmental conditions • Ambiguous circumstances • Sometimes not a lot of privacy • No EHR, Insurance etc- sometimes no if any record keeping • Training in skills and Symptom Reduction • Triage and Screening
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Trauma & Stress

- All trauma is stressful, but all stress isn't necessarily traumatic
 - Stress can build up over time

- The ability to function effectively CAN be compromised by either one.
- Long term moderate to severe stress affects the brain in ways similar to traumatic events

- Resilience can be developed intentionally, or can come about as a result of adverse experiences

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The relationship between trauma and stress:

- All trauma is stressful (all ducks are birds)
- NOT all stress is traumatic (but not all birds are ducks)

STRESS (BIRDS)

X

TRAUMA (DUCKS)

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Specifics

- Stress: gradual or event based
- Tragedy: usually event based
- Trauma: event based, can build up over time too, can also be generational and genetically influences
 - PTSD – combining trauma and stress or, extreme stress as a result of a traumatic experience



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Factors that influence the resilience and reconstruction process

OR may result in the experience of a “disaster cascade” depending on the nature of the secondary impact

- Social marginalization
- Discrimination
- Economic status
- Access to resources and healthcare
- Generational trauma
- ACES (Adverse Childhood experiences)
- Previous experiences in disasters or critical incidents
- Sociopolitical climate
- Additional incidents or smaller scale disasters that are a ripple effect of the first



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Neurophysiology

The human brain and body respond in known and predictable ways to stress and trauma. There are often similar responses to exposure in single incidents or over longer periods of time. The limbic system is activated when we perceive a threat, and additional processes are engaged in an effort to keep us **alive and safe**.



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Structures of Note:

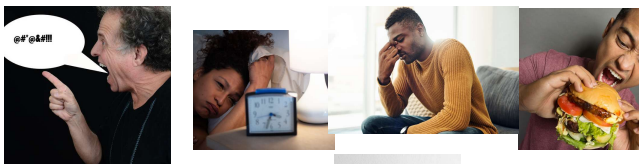
Prefrontal cortex:
higher-level functioning, planning, organization, details, filtering.

Limbic system:
emotion, impulse, pleasure and safety, memory, defense, protection (fight, flight or freeze).
Includes the Amygdala & Hippocampus

There is plenty of evidence that many of us are more activated than usual in the Limbic system, resulting in miscommunication, aggression and impulsivity.



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Common Experiences And Challenges



Cognitive,
Physical,
Behavioral,
Social,
Emotional,
Spiritual



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Mental and Behavioral Health supports NEED to be culturally and locally appropriate.
 It's always better to be prepared from within a community than to have folks come in from the outside.

Both LPC / PFA and the Health Support Team (HST) trainings are meant to be flexible and adapted to what is happening on the ground.

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Resilience Development

- Purpose**
What motivates you? What is important to you? What are you striving for, or what helps you move forward?
- Adaptability**
How can you make adjustments that are needed, to time, space, fun, expectations, etc? How can you respond with curiosity?
- Hope**
What are the realistic opportunities you have, new options, or new ideas for how to approach an issue or address a problem?
- Connection**
To whom or what are you connected? Connection can be anything that prevents isolation.

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Special Populations / Groups

Children	Medical providers and other First Responders	Schools / Districts
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Special Considerations: Youth in Disaster and Crisis Events

- Children are at increased risk for psychological consequences during, and after "all hazards" disaster and other acute traumatic events
- When disorders do develop, they are often trans-diagnostic involving more than one clinical syndrome
- Everyone is affected by a disaster in some way including providers who care for children.



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Challenge:

There are Not Enough Mental Health Providers to Address Youth Needs In Baseline Situations –Crisis Events and Disasters Make this Even Worse

- Disproportionate impact on children and youth of color and lower SES
- Lack of access due to location (e.g.rural) or time required (e.g.parents unable to take time off of work) to engage in in-person services
- Cost of care and limitation of care in both state and private insurance creates barriers

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COMMON SYMPTOMS AND EXPERIENCES

PHYSICAL*	EMOTIONAL	COGNITIVE / THINKING	BEHAVIORAL
Nausea	Fear	Trouble Concentrating	Withdrawal
Dizziness / Fainting	Guilt	Trouble Remembering	Outbursts of Anger
Chest Pain	Anxiety	Re-occurring thoughts	Increased Alcohol Use
Fatigue	Irritability	Reoccurring images	Increased Drug Use
Rapid Heart Rate	Anger	Suspiciousness	Changes in Appetite
Trouble Breathing	Depression / Sadness	Nightmares	Changes in Activities
Headaches	Grief	Constant Alertness	Restlessness
Stomach Pain	Panic	Feeling Overwhelmed	Constant Movements
Chills	Denial		Yelling / Crying

*Please consult with a medical professional to address physical symptoms.

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How do violent incidents impact children?

4-5 months after incident:

69% of survivors perceived their academic performance to be impaired

44% to be unchanged
16% to be improved

14-15 months after incident:

143 (61%) survivors reported academic performance to be impaired

26% unchanged
12% improved

(Stene et al., 2019)

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What do Children, Youth and Teens need?

TRUST
honest answers and explanations

SAFETY, ROUTINE, STABILITY
consistency, plans and predictable patterns

CONTROL AND A SENSE OF FUTURE
Forward thinking

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RESPONDER SPECIFIC CONCERNS

CULTURAL AND COPING NORMS

Traditional coping patterns, stigma around mental health and behaviors that are "acceptable" - such as alcohol use.

LACK OF SOCIAL AND / OR COMMUNITY SUPPORT

Cultural and political shifts that influence the bond, relationship or interaction with members of the public.


INCREASING SUICIDE RATES

Rates have increased dramatically in recent decades.

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PTSD: BY THE NUMBERS


More than 80% of first responders experience traumatic events on the job.



- According to one study (3), PTSD is present in approximately:
 - 15% of emergency personnel (paramedics)
 - 13% of rescue teams
 - 7% of firefighters
 - 5% of police officers
- In absolute numbers, an estimated 400,000 first responders in America have at least some symptoms of PTSD.

1. <https://www.scribd.com/document/100000000/PTSD-in-First-Responders>
 2. <https://www.scribd.com/document/100000000/PTSD-in-First-Responders>
 3. <https://journal.sagepub.com/doi/10.1177/1043986207303408>

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MORE DATA

Almost **37 percent of EMS personnel and firefighters in the US have contemplated suicide at some point in their lives.** This is nearly 10 times the rate in average Americans.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), **roughly 1 in 3 first responders develop PTSD.** In comparison, the incidence of PTSD in the general population is about 1 in 5 people.

[HTTPS://WWW.SAMHSA.GOV/SITES/DEFAULT/FILES/DTAC/SUPPLEMENTALRESEARCHBULLETIN-FIRSTRESPONDERS-MAY2018.PDF](https://www.samhsa.gov/sites/default/files/dtac/supplementalresearchbulletin-firstresponders-may2018.pdf)

[HTTPS://INSTITUTESOFHEALTH.ORG/PTSD-IN-FIRST-RESPONDERS/](https://institutesofhealth.org/ptsd-in-first-responders/)



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How do we get in front of this?

- Any responder needs a personal coping plan BEFORE an incident occurs
- Developing and practicing a plan is a helpful form of stress inoculation and a deterrent for PTSD
- Self triage (PsySTART Responder) is also a good option
- Support development of behavioral health culture change from within

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3 Schools and Districts

N HIGH SCHOOL

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When responding to school or district incident: ACT with intention



Assess

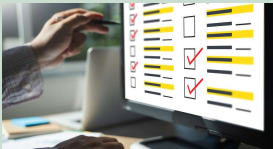

Communicate

Tailor

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ASSESS

- Assess scale of impact, priorities, available and needed resources.
- Who, specifically, are the parties in each role. How current is your response plan? Update it regularly (prior to) and immediately (in event of) an incident.

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To specific groups: Staff, Students, Parents, Community, Media

COMMUNICATE

The comms plan needs to be separate for each group, AND consistent with itself.

Understanding best practices for de-escalation and effective at-work (and at home) communication

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Key features of effective response communication include:

WHO is responsible for what communication role (eg. who is coordinating volunteers, who is coordinating professional crisis services). Names, emails and phone numbers.



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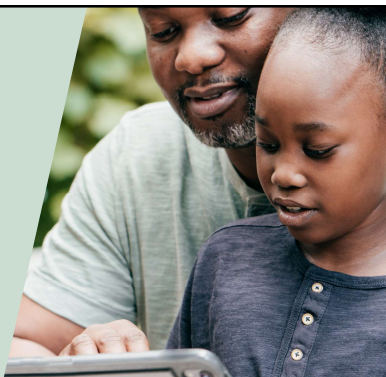


- **WHAT** the resources are that are available for each specific audience or group in need.
- **WHAT** resources are still needed
- **WHAT** the asks are of the community, district or other officials.
- **WHAT** is still unknown or undecided: it is ok to communicate what you don't yet know.
- **WHAT** is available in the languages needed in your community and what needs to be translated to increase access!

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WHERE each specific group (caregivers, staff, community) can go to find what is needed for them (online, in person, etc)

WHEN the resources are available or for how long



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TAILOR

Tailor your response with key concepts in mind for behavioral health:

- Not one size (or one intervention) fits all.
- There need to be options for different groups, in different places, over different time frames.
- No requirements to participate in debriefing (CISM) or other processing groups. (1,2,3)
- Nuance can be hard but is very important.



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Plan for HOW your actions in the first two weeks post-impact are aligned with the longer term recovery goals.


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- **acknowledge challenges, length and breadth of recovery**
- **acknowledge BH triage and support is so essential in early response**
- **acknowledge culturally informed coping options and supports**



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Examples of Collaboration and Communication



Sandy Hook Elementary School Shooting (2012)

What Worked:

- Inclusion of all state responders and key governmental organizations
- Additional attention to communication among adult, child, school system and law enforcement services.


Take-aways:

- Better understanding of ethnic and cultural preferences and norms regarding mental health care and care seeking
- Having staff pre-trained to do triage

(DiLeo et. al., 2018)

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Examples of Collaboration and Communication



Marjory Stoneman Douglas High School Shooting (2012)

- Communication must be maintained between first responders and supported stakeholders
- Coordinate messages with media and public

Why?

- Helps maintain situational awareness
- Helps maintain operational coordination
- Provides timely and accurate information to media and public
- Inconsistent communication provides uncertainty and fear in community
- Establishing a clear comms leader is vital for communication and unity within the community

More information here: <https://www.policinginstitute.org/wp-content/uploads/2019/08/Broward-Final.pdf>

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Other take-aways

 <p>Plan and Prepare based on impact, not probability</p>	 <p>Clearly defined roles and back up roles are game changers</p>	 <p>Don't underestimate the power of leadership modeling</p>	 <p>Behavioral health is a critical component of response, not an addendum</p>
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Why Do We Prepare?

- We live in an area at high risk for natural disasters
- When large scale disasters strike, resources are quickly overwhelmed
- If we want to be helpful for both our families and our community, we need to plan so that we are not a drain on limited resources
- We can only comfortably deploy if our own families are safe

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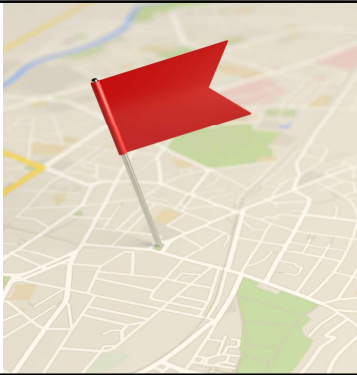
Personal Preparation at Home

- Assume that help won't be coming any time soon
 - What can you eat?
 - How can you cook?
 - How can you stay warm and sheltered?
 - How do you manage injuries?
 - What do you do for water?
 - How can you cope with boredom?

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Developing a Neighborhood Team

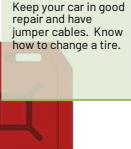
- Map Your Neighborhood
- Learn about neighborhood needs and resources
- Share information
- Develop a neighborhood plan

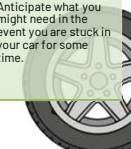



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Cars

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Good practice is to "drive on the top of your tank" e.g. try not to let your gas tank go below half before filling up.
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Keep your car in good repair and have jumper cables. Know how to change a tire.
- 

Anticipate what you might need in the event you are stuck in your car for some time.
- 

Put together your "get home bag" and keep it in the car at all times

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Keeping it Safe at Work

What is the evacuation plan should you have to leave the building?

What supplies do you need for minor injuries?

How would you manage without electrical power?

What is the plan if you have to "shelter in place" due to an event preventing evacuation?

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Critical Take-Away Points for High-Level Planning

- Mental health **response and recovery strategy must be adapted based on the gap between mental health impacts (and thus demands) and mental health resources.**
- The bigger the gap: the more highly specialized services must be **focused on those of the greatest risk (triage), the more the response model must use population-level approaches**, the more the response model must include scalable/replicable/modular features, the more useful train-the-trainer approaches become.



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Critical Take-Away Points for High Level Planning

Mental health response must connect and integrate with the primary touch-points for services, support, and community in order to meet the needs / demand at scale.

- Systems of care: healthcare, mental health
- Response: shelters, casework/recovery centers, long-term recovery organizations
- Community: schools, religious centers, cultural centers




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Best Practices in Disaster Recovery

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In general:



- 1 Don't self-deploy- be invited or have a local "host"
- 2 Be prepared at home - walk the talk
- 3 Have a family communication plan
- 4 Include your workplace in your planning
- 5 Educate yourself about local resources - CERT, MRC, Trainings, etc

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In a response / activation / deployment:

<p>Be willing to do anything that needs doing within your skill set and competence</p>	<p>Let go of traditional ways of providing services or reaching goals while remaining ethical</p>	<p>Learn as much as you can about the history and culture of a place (including norms) as you can</p>	<p>Be willing to connect - with your colleagues / coworkers / team members and with survivors</p>
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BOTTOM LINE:

- Prepare yourself, your family and your business at home.
 - Start by 'walking the preparednesstalk'
 - If you are interested in doing disaster relief, get training, get certified.
 - CPR, CERT, MRC, FEMA etc
- Establish communication networks and regular huddles with key partners to establish protocols
- Do some personal inventory about your level of comfort with ambiguity, difficult physical conditions, roles, and tasks.
- Educate yourself or get training in disaster response behavioral health support:
 - Learn more about Psychological First Aid(PFA)
 - Health Support Team(HST)and other programs that specifically are aimed at providing direct service or training to those affected by disasters and critical incidents.
 - PsySTART training coming soon!!

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