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The DMH Responder is a quarterly production of...

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Introduction

Welcome to the Fall 2018 issue of the **New York DMH Responder**, our quarterly newsletter for the Disaster Mental Health community. This edition will kick off a year-long focus on Psychological First Aid (PFA), the universal early intervention that can be learned by anyone and used to support anyone going through a stressful or traumatic experience. We’ll highlight the long-in-the-works training collaboration among the New York State Department of Health, Office of Mental Health, and Institute for Disaster Mental Health at SUNY New Paltz that is now being rolled out statewide. This initiative’s goal is to train as many personnel as possible to incorporate PFA principles into their response work, as a kind of force multiplier for the smaller group of mental health professionals trained to provide more advanced Disaster Mental Health. We hope you’ll enjoy this focus, and will encourage your facility’s administration to train all staff in this important intervention.

As always, your feedback and suggestions for topics to cover in future issues are welcome; please email any comments to Tom Henery at DOH or Steve Moskowitz at OMH.

“The greatness of
a community is
most accurately
measured by the
compassionate
actions of its
members.”

– Coretta Scott King



The Psychological First Aid – New York Training Initiative

Providing training in Psychological First Aid is not new in New York State, as a PFA curriculum was first developed and delivered on the topic beginning in 2007 as part of the post-9/11 wave of disaster preparedness programs. While that training was thorough and comprehensive, it took a full day to deliver, which was simply impossible for many facilities to accommodate, and a decade into its use there were some newer

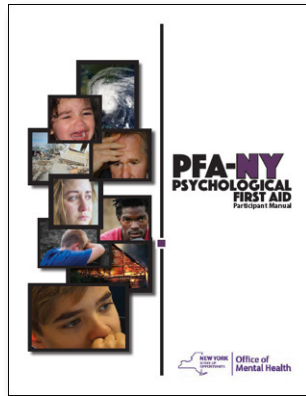
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developments in the field that were not reflected in the content. So, a few years ago, the partners at OMH, DOH, and IDMH began discussions about what a revised curriculum might look like.

Funding was pieced together between the two state agencies to collaboratively support the new program, and we began talking to representatives from both agencies and from around the state to see what would really help their staff members. This process involved many debates about the exact PFA content to include in the materials, as well as more practical factors like how long staff could realistically devote to a training session, the likely experience level of the on-site training coordinator or other person who would lead the session, and how to incorporate adult learning principles to make the training engaging for participants from a range of professional backgrounds and experience levels. We're grateful to everyone who contributed to those discussions.

The end result is the new Psychological First Aid-New York curriculum, a three-hour long training targeted to a general audience that includes modules



on reactions to disasters, PFA elements, and productive self-care practices. It also includes video examples of PFA interactions, and an interactive exercise where participants practice their new PFA skills by alternating acting as a helper, survivor, and observer in a variety of scenarios. (You can see how you'd react to one of these scenarios on page 5 of this newsletter.) In addition to presentation slides and a participant manual, materials include a trainer manual with guidance on how to deliver the curriculum. In summer 2018, this guide was used by the IDMH Deputy Director, Karla Vermeulen, Ph.D., to prepare 255 representatives from OMH and DOH facilities in Train-the-Trainer sessions in seven counties statewide – literally from Long Island to Buffalo. Each of those trainers is expected to present the participant training at least once in their home facility, and we hope they will keep repeating the training until every employee and every volunteer in every OMH and DOH facility has learned these important skills.

Another round of PFA-NY Train-the-Trainer sessions will be delivered in summer 2019, so in the spring please watch this newsletter and the Aware Prepare Update for announcements about dates and locations. Many thanks to everyone who took the training – we would love to hear about your experiences teaching PFA-NY in your facilities!

Why Train in PFA?

Excerpted from the PFA-NY Participant Manual:

It's an unfortunate but unavoidable fact that disasters are more common and often more intense than ever before, and New York State has certainly experienced its share of these events. Between seasonal weather disasters like hurricanes, floods, and ice storms; acts of intentional violence like terrorism and mass shootings; and transportation disasters involving planes, trains, and buses, experience teaches us that we must all be prepared to help out when it's our own community that is impacted.

We also recognize that the harm these events cause isn't limited to physical damage – they also can create stress and trauma in all who are impacted. That includes not only the people who directly

experienced the disaster, but also their friends and families, their community members, and everyone who tries to help them. While the NYS Office of Mental Health and Department of Health train mental health professionals to respond to more intense or long-lasting traumatic responses using Disaster Mental Health interventions, we also believe that everyone affiliated with these organizations can benefit from learning how to support survivors' and responders' immediate reactions. Even if people are responding to a disaster as a healthcare provider, supervisor, security guard, or in any other professional role, they will encounter survivors' emotional reactions, which may be influencing their behavior and decision-making.

Why Train in PFA, *continued*

Fortunately, experience also has taught us that providing survivors with immediate support through the provision of Psychological First Aid (PFA) can often help prevent these early and expected stress reactions from turning into more serious emotional issues, like Posttraumatic Stress Disorder or depression. PFA can be used with everyone – children, adolescents, adults, and the elderly; families and individuals; disaster survivors and professional responders. It can be used anywhere and at any point in the response and recovery cycle. Really, it's less a specific intervention than a supportive attitude based on warmth, empathy, and caring that can underlie all of your interactions with any person in distress, or under more routine forms of stress.

Just as PFA is universal in who it can benefit, it's equally universal in terms of who can practice it. Providing PFA doesn't require any formal mental health background.

Think of it like physical first aid: Everyone in a community can and should be trained in basic first aid skills, and by using those skills in an emergency they can do a great deal to help others in need. For example, if a neighbor falls off her bicycle and scrapes her knee, anyone can learn to disinfect and bandage that small wound and hopefully prevent it

from getting infected and turning into a more serious problem. But if infection does set in – or if she didn't just scrape her leg, but broke it – she's going to need help from a trained healthcare professional. Similarly, everyone in a community, hospital, agency, etc. can learn to practice PFA, and in many cases that will be enough to calm disaster survivors and activate their natural recovery processes so they don't need any further formal intervention. But for some people that won't be sufficient; they'll need help from a mental health professional with specialized training in the specific needs of disaster survivors. Therefore, people who become trained in PFA need to recognize their limits. Being trained in PFA certainly won't qualify people to provide counseling, but it can help them notice when a referral to a mental health professional may be a good idea.

PFA also isn't meant to fix every problem in a person's life, only to address needs generated by the disaster or traumatic experience. It's entirely focused on the here and now. A PFA intervention could consist of giving a survivor a blanket or a bottle of water if their most pressing need is being cold or thirsty, or it could mean treating an angry and frustrated survivor with kindness and patience while helping them fill out paperwork. In general, PFA involves focusing on survivors' immediate needs, both physical and emotional, in order to help them return as quickly as possible to their level of pre-disaster functioning.

Participants in the PFA-NY trainings learn how to respond to a disaster in a way that supports survivors' emotional needs as a part of their main professional response role. We expect they'll find that understanding why people react the ways they often do in times of stress will increase their ability to cope with strong emotions that might otherwise feel troubling, frustrating, or challenging. Overall, we believe that learning PFA skills will make all personnel feel better equipped to respond to any intense event that may strike their community, so it's an important way of building workforce resilience as well as strengthening individuals' competence and confidence.

In the World of Psychological Support, What's in a Name?

Steve Moskowitz, MSW

Disaster Mental Health, Mental Health First Aid, Psychological First Aid... all good programs, providing meaningful, and often, critical support to individuals in need. But is there really enough that separates them from one another to make a difference for most people? And if there are differences, how much does it matter and why might it matter at all?

Ultimately, this is one of those “good” problems. The only reason this becomes a topic for consideration is that these three different, but related, areas of assistance for individuals facing psychological challenges have been proven to be successful in reaching broad numbers of people and practitioners across numerous disciplines, from emergency response to public health to education to your local PTA. With the growing public and professional awareness of these models of practice however, comes a degree of confusion over just which practice does what and for whom?

The easiest and most prevalent misunderstanding among individuals, both in the mental health community and the broader public, is confusing Psychological First Aid (PFA) with Mental Health First Aid (MHFA). Given the mutual use of First Aid in their names it's easy to see why but the programs, while sharing some similarities, have very different objectives and goals. Most readers of this newsletter are already familiar with the goals of PFA as an approach to help children,



adolescents, adults, and families in the immediate aftermath of disaster and terrorism to reduce the initial distress and to foster short- and long-term adaptive functioning and coping. This last decade's increase in the number of traumatic events, both those caused by nature as well as humans, has led to a corresponding increase in the value of PFA as an easily accessible and effective set of tools to assist those adversely affected by those events.

Mental Health First Aid, as described by the National Council on Behavioral Health, is a public education program that introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and overviews common treatments. According to the National Child Traumatic Stress Network, the goals of MHFA are to demystify mental illness and give participants the capacity to obtain, process, and understand the health information and services

needed to make appropriate decisions and seek care.

What the PFA and MHFA programs share is that each is designed to teach skills relating to psychological challenges to large numbers of individuals across numerous social and professional settings. However, while PFA seeks to assist individuals and families who have recently been impacted by a traumatic event, MHFA's focus is on providing education about the signs and symptoms of specific mental illnesses like anxiety, depression, schizophrenia, bipolar disorder, eating disorders, and addictions. Both are valuable and worthy endeavors, but not at all interchangeable. You can learn more about MHFA at <https://www.mentalhealthfirstaid.org/>.

The challenges of differentiation relating to Disaster Mental Health (DMH) are both more and less apparent. First, there's obviously less of a chance of confusion based on name alone. And, while there's still a chance of assuming

In the World of Psychological Support, What's in a Name?, *continued*

likenesses between DMH and MHFA, it's really understanding the differences between DMH and PFA which can be more challenging. DMH practice, after all, is based on the fundamental understandings and techniques defined in PFA – embracing PFA's core actions like providing comfort care, recognizing basic needs, and validating survivors' thoughts and feelings.

Some of that challenge can be traced to the very success PFA training has found in reaching beyond the confines of the traditional mental health audience which first embraced PFA training. As our recently developed PFA-NY curriculum emphasizes, the potential communities of both beneficiaries and practitioners of PFA are universal. The empowerment created by acquiring skills to provide psychological assistance is, however, accompanied with a

corresponding need for caution as non-mental health trained PFA helpers must be aware of the limitations of their abilities as well.

Disaster Mental Health training is designed specifically for mental health professionals who will be deployed to respond to disasters locations where survivors have been exposed to trauma on a large scale. To be adequately prepared to assist in these settings, DMH responder

training not only provides a firm grounding in how to apply the skills of PFA to assist survivors, but also a fuller awareness of the psychological dynamics of the disaster environment and how to bring effective support under difficult circumstances. This includes insight into the etiology of traumatic stress and how to provide rapid triage, crisis intervention, and other related supportive services in diverse and often difficult settings.

Elements of Psychological First Aid

Providing comfort care

Recognizing basic needs and helping to solve problems

Validating survivors' feelings and thoughts

Connecting people with their support systems

Providing accurate and timely information

Providing education about stress reactions

Reinforcing strengths and positive coping strategies

PFA Practice: What Would YOU Do?

When people hear about the elements involved in Psychological First Aid, their first response is often something like “well, of course I would do all of those things to help someone in distress!” It's true that the PFA elements often seem like common sense – but as we like to remind people, in times of disaster or crisis, common sense isn't always common. That's why we emphasize the need to practice skills in the PFA-NY training, so participants get a sense of what it's like to try to support someone experiencing intense emotions or dealing with a great deal of

uncertainty. We do this through an exercise where training participants rotate through acting as helper, survivor, and observer in different disaster scenarios.

Now it's your turn: Read through this scenario from the training and imagine yourself on the scene. First, how you would feel if you were the survivor in this situation? What would you need and what would you find helpful or unhelpful? Then shift mental gears and imagine being the PFA provider: How would you start a conversation, and what might you be able to do to address the

survivor's immediate needs using the PFA elements provided?

Scenario Description:

The survivor is a young woman who has come to the hospital seeking information about her husband, who was working in a local factory when a major explosion occurred. Amid the confusion generated by the incident, first responders at the scene have been directing family members to the hospital for news about workers and bystanders injured in the accident, and rumors are starting to spread among those gathered.

Research Brief

PFA is Evidence-Informed, Not Evidence-Based

Usually in this section of the *DMH Responder* newsletter, we highlight new or innovative research on some aspect of disaster mental health interventions so readers can be sure you're using techniques whose usefulness has been demonstrated by rigorous empirical testing. Alas, that is not the case when it comes to establishing Psychological First Aid's effectiveness. So why are we emphasizing the use of a practice that does not have the kind of data-driven support we usually like to see? Quite simply, the nature of PFA makes it resistant to conducting methodologically sound research on its efficacy, and it's important to understand why.

Some of the methodological problems are shared with other types of disaster mental health interventions. First, there's the issue of random assignment to different conditions. In a randomly controlled trial, the so-called "gold standard" of testing interventions (whether that's a medication, a kind of therapy, or anything else intended to cause change in participants), researchers take people who don't differ from each other in significant ways and randomly assign them to, say, receive or not receive a particular standardized treatment, or to receive the same standardized treatment but at varied doses from each other. If members of the otherwise similar treatment groups experience different results, we can be reasonably confident that those results can be attributed to the intervention being tested. It's the equivalent of taking two identical slices of dry toast, buttering one, and comparing how they taste. If one is now notably more delicious, we can safely argue that the butter caused the increase in deliciousness.

Now think about how this applies to disasters: Even if we could identify a group of community members without significant differences from each other, we can't randomly assign some to experience a disaster, nor can we ethically withhold support from half of them afterward just to see how they recover compared to a group that receives DMH care. There are some ways around this, like comparing two different types of interventions or putting some people on a waitlist so they receive treatment at a later point, but these approaches each create their own ethical challenges and limit validity of the results.

And now consider the characteristics of PFA: It's ideally delivered in the immediate aftermath of a

traumatic experience so there is no way to use the waitlist approach. The emphasis is on providing support, not collecting data – and actively distressed people may not even be able to provide appropriate informed consent to participate in research immediately after a disaster. Above all, by design the delivery of PFA is anything but standardized. We emphasize when training people to practice PFA that it should be completely tailored to the individual survivor's needs at that particular point in time. That flexibility and customized approach is the core strength of PFA, but it makes it virtually impossible to conduct research that meets our usual standards to claim an intervention is "evidence-based."

Instead we usually describe PFA as "evidence-informed," based partly on its consistency with a highly regarded article (Hobfoll et al., 2007) that was written by a group of 20 international mass trauma experts based on a combination of empirical research and their experience in the field. Their goal was to identify the core elements of effective early treatments for survivors of disaster or mass trauma, focusing more on the goals of treatment than the actual practices. The five essential elements for early interventions they recommend are:

- Safety
- Calming
- Efficacy
- Connectedness
- Hope

PFA essentially puts these goals into action, so those in the disaster response field feel comfortable that we are providing the best form of early intervention for survivors when we incorporate PFA elements into our work. Of course we would like to be able to say something like "providing three PFA-based contacts in the first four days post-disaster reduces survivor distress by 62%," but that's simply not the nature of the intervention. However, given how much anecdotal support there is for the practice of PFA, the lack of empirical evidence shouldn't undermine our confidence in its value.

Source:

Hobfoll, S.E., Watson, P., Bell, C.C., Bryant, R.A., Brymer, M.J., Friedman, M.J. et al. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry: Interpersonal and Biological Processes*, 70, 283-315.