TEAM KENTUCKY

Promoting Workforce Resilience in Long-Term Care Facilities during COVID- 19

Supervisor Resources

Prepared by

Kentucky Cabinet for Health and Family Services
Department for Behavioral Health, Developmental and Intellectual Disabilities

Kentucky Community Crisis Response Board

April, 2020

CHFS
KENTUCKY
Cabinet for Health and Family Services

KCCRB
Kentucky Community Crisis Response Board

Overview & How to Use this Guide:

This packet provides long-term care facilities with tools and information to support and build a resilient workforce in the face of challenging and difficult circumstances resulting from COVID-19. Recognizing and proactively addressing the psychological effects of pandemic on the workforce is critical in sustaining a healthy, competent, willing and able workforce to provide essential services to residents through a pandemic crisis. Facilities should have a COVID-19 Crisis Response Team, and within that team designate a specific person to oversee workforce resilience activities. The strategies are tools to prevent and mitigate the negative psychosocial effects related to pandemic response; they may be utilized independently of one another, and may be introduced gradually over time. A step-by-step guide is offered as an example of how to implement these practices, and adaptations to fit unique contexts should be made as indicated. Facility leadership should think about when staff will be able to utilize and respond to these resources, and recognize that during the initial crisis phase, staff may be focused on survival and not ready for these types of supports. These strategies may also be used in response to and in conjunction with other responses to non-pandemic traumas (deaths from other causes, natural disasters, etc.) that occur during the COVID-19 response period.

The ABC's of maintaining a resilient workforce during COVID-19:

A	Acknowledge the stress the pandemic is creating for staff, professionally and personally
B	Build resilience by supporting staff to take care of their own minds and bodies, as well as taking care of their patients
C	Care for all staff, from the top to the bottom of the organization, before, during and after the pandemic crisis

Step by Step Guide to Supporting Workforce Resilience during COVID-19

Step 1: Form a COVID-19 Crisis Response Team

- Include representation from all areas of the workforce
- Designate one Team Member to serve as the Workforce Resilience Lead and oversee this process
- Team ensures all staff remain current on public health guidelines for disease prevention and containment

Step 2: Connect with External Supports

- Crisis Response Team & Workforce Resilience Lead meet (virtually as needed) with Kentucky Department for Behavioral Health, Development and Intellectual Disabilities (DBHDID) and Kentucky Community Crisis Response Board (KCCRB) to discuss response strategy.
- Workforce Resilience Lead identify and reach out to community partners who may be able to provide structural supports (food, resources), behavioral health or grief support services (counseling, support, debriefing, crisis triage and response), employee supports (employee assistance programs).

Step 3: Create a Peri-Pandemic Workforce Resilience Plan to Address Needs During & After the Pandemic Period

- Acknowledge psychological stress
- Build resilience with activities, supports, resources
- Care for staff through connecting, monitoring, soliciting input and check-in regularly

Step 4: Implement & Adapt Resilience Plan

- Include monitoring and evaluation components
- Assess and adapt in real time to meet needs

Step 5: Evaluate Post-Pandemic

- Assess lessons learned
- Recognize the “new normal”
- Create pandemic plan for workforce resilience to use next time

Supervisor Strategies to Support Workforce Resilience

These strategies may be used individually or collectively, in any order after Strategies #1 and #2 are completed.

Strategy #1: Acknowledge and thank staff for their dedication, commitment and hard work. Do this early on in the crisis, and continue to do it throughout the pandemic response period. Convey this appreciation through:

1. Email appreciation
2. Intercom announcements
3. Virtual or in-person meetings
4. Video message posted to webpage
5. Thank you notes
6. Certificates of appreciation

Strategy #2: Inform all staff of current best practice guidelines for COVID-19 prevention, containment, treatment and recovery pertaining to resident care and their own health and well-being. Develop routine communication channels to disseminate current information and resources to all staff using email, text or telephone announcements, intercom announcements, and written brochures, posters and flyers. Ensure staff have accurate information about the following:

1. Personal protective measures including social distancing and hygiene guidelines; availability and proper use of personal protective equipment in the workplace and beyond
2. Facility rules and limitations regarding visitation and outside service provision
3. Resident assessment and referral for medical evaluation and/or testing
4. Measures to support resident quarantine or isolation
5. Signs and symptoms of COVID-19, when to stay home, when and how to quarantine or isolate
6. Staff testing protocols and responses including COVID-19 leave provisions
7. Return-to-work protocols following positive test and/or quarantine following exposure
8. Public Health Department contact information and overview of public health response including contact tracing following suspected exposure or positive testing

See April 15, 2020 letter from Commissioner Morris in the Appendix.

Strategy #3: Create spaces to proactively acknowledge and normalize the emotional toll on staff **by checking in with your staff** during group meetings and individual contact. Ask, "How's everyone doing?" or "What do you need?" You can use these prompts at these times:

1. Start of work day/ shift
2. End of work day/ shift
3. Start or end of meetings (in person or virtual)
4. Individual supervision or meetings: make checking in on staff mental health and well-being a routine part of supervisory meetings

Strategy #4: Help staff **process feelings** to minimize the build-up of negative emotion and discharge strong emotions before going home to family. This is best done by having a daily **5-minute check-in at end of work shift** to allow staff to de-brief their feelings and thoughts. This is also a way of checking in to see if anyone is in need of additional support. Supervisors can open the conversation by:

1. Thanking staff for their dedication and commitment
2. Acknowledging what went well during the shift
3. Recognizing challenges during the shift and acknowledging feelings of frustration, powerlessness, anxiety, sadness, grief, anger, fear, etc.
4. Asking staff if anyone wants to share anything about how they are feeling or what they are thinking; steer the conversation towards what staff are feeling and thinking rather than a description of details of what was traumatizing or difficult; teach staff to use Low-Impact De-Briefing *(description attached)*
5. Thank staff for sharing; affirm the legitimacy of these difficult feelings and thoughts
6. Send staff out with a positive thought or suggestion to get through the time until they return to work, e.g. "We will get through this. We will get through this together. We are #TeamKentucky and #TeamWesternStateHospital."

Strategy #5: Build **regular breaks** into the work schedule to prevent physical and emotional exhaustion and chronic elevation of cortisol and other stress hormones. Breaks can occur through:

1. Daily breaks during shifts for walks, talks, mindfulness, phone calls, checking facebook, checking in with family, etc.
2. Regular time off for staff to sleep and re-charge
3. Try to maintain a regular work schedule for staff (e.g. same shift)
4. Avoid multiple shifts in a row when possible to give staff time to re-charge
5. Model "time off" e.g. don't communicate at all hours of the night
6. If possible, rotate staff between areas of high and low exposure to trauma

Strategy #6: Provide **healthy snacks** for staff at work: connect with facility food services or community partners to provide healthy snacks to staff to promote physical and psychological well-being. Make snacks available as close to the work locations as safely possible. Community partners who may seize this opportunity to show appreciation to your staff include:

1. Local grocery stores, farmers or restaurants
2. Faith-based organizations or houses of worship
3. Civic groups, business associations and Chambers of Commerce
4. Youth organizations and clubs

Strategy #7: Check in with staff who are sick or in quarantine – check in about their mental health and well-being as well as their medical status.

1. Reach out to staff to check on them and let you know they care
2. Ask about their emotional status before asking when they think they will return to work
3. Be honest about any challenges, stresses, deaths or illness among other staff or patients, but don't lead with that information
4. As they are preparing to return to work, check in with them about anxieties around re-exposure, stigma, or trauma reminders; identify ways and resources to **support re-entry** back to the workplace
5. For hourly or contract workers who may not be getting paid, make sure they know about other sources of support through state government and local social service organizations

Strategy #8: Push out information and resources to staff about the psychological effects of working during pandemic and ways to manage that stress. This should include information about the signs & symptoms of anxiety, depression & traumatic stress; ways to monitor these signs and symptoms in themselves and co-workers; effective coping strategies; and when to seek professional help. *See attached resources for examples of information.* Information should be pushed out via:

1. Email messages to staff
2. Posters hung in high traffic areas in the workplace (e.g. above handwashing stations, in bathrooms, breakrooms, kitchens, near time clocks)
3. Brochures available throughout the workplace
4. Employee pages of website

Strategy #9: Assist staff in the moment if they become overwhelmed or distressed while on duty. Provide support to help them discharge strong emotions, and be able to regain control in order to resume work duties or be able to go home and recharge before their next work shift. Try using Hot Walk and Talk strategy *(attached)*.

Strategy #10: Provide staff with **information and resources about local support services** available to them during this pandemic response.

1. Human Resources Director:
2. Kentucky Community Crisis Response Board (KCCRB) 888-522-7228
3. Local Hospice Grief Support:
4. Local Community Mental Health Center Crisis Helpline:
5. National Suicide Lifeline (connects to Kentucky): 1-800-273-8255 or 1-800-784-2433
6. National Domestic Violence Hotline (connects to Kentucky): 1-800-799-SAFE
7. National Sexual Assault Helpline (connects to Kentucky): 1-800-656-HOPE
8. Kentucky Child/ Adult Abuse Hotline: 1-877-597-2331

Strategy #11: Provide supervisors and staff with tools to **monitor secondary trauma, compassion fatigue, burnout, anxiety and depression**, including tools attached:

1. Professional Quality of Life (Pro-QOL 5) for compassion fatigue, burnout, compassion satisfaction, attached and available at: https://proqol.org/uploads/ProQOL_5_English_Self-Score.pdf
2. Secondary Traumatic Stress Scale (STSS): attached
3. Generalized Anxiety Disorder (GAD-7) attached and available at: https://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf
4. Patient Health Questionnaire (PHQ-9) for depression, attached and available at: https://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf
5. Columbia Suicide Severity Rating Scale (CSSRS), attached and available at: https://www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf

Strategy #12: Provide opportunities for **staff input and voice** via physical and virtual suggestion boxes. Assign someone to monitor both suggestion boxes, convey suggestions to leadership and inform staff of responses.

Strategy #13: Celebrate successes and recognize staff accomplishments even during pandemic response and times of high stress. Create special recognition categories, announce staff recipients, provide public recognition and affirmation. Include categories that cover all levels of staffing including support staff. Examples include:

- Staffperson of the Month/ Week
- Frontline Heroes
- Super Star Staff
- Generous Givers
- Above & Beyond Awards

Strategy #14: Ensure all levels of staff, including **executive staff and top leadership, receive support for resilience-building strategies** during pandemic response. Leadership must "put on their own oxygen masks" in order to ensure that the rest of the staff will be able to utilize their masks appropriately.

Strategy #15: Prepare for post-pandemic crisis recovery, or "post-habilitation" and return to more regular work conditions. Recognize that this will be a "new normal" which will likely incorporate new ways of caring for residents, and protecting staff. Planning should include support groups to assist staff in processing and metabolizing the accumulated and intense emotions and thoughts associated with pandemic crisis response. Attention to delayed grief responses will also be important, including creating opportunities to memorialize residents and colleagues who have died. *See attached suggestions, Planning for After the Covid-19 Crisis.*

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Appendices

Prepared by

Kentucky Cabinet for Health and Family Services
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April, 2020

CABINET FOR HEALTH AND FAMILY SERVICES
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Eric C. Friedlander
Acting Secretary

Wendy T. Morris
Commissioner

April 15, 2020

Dear SCL Waiver Providers,

We appreciate the hard work and dedication the Supports for Community Living (SCL) and Michelle P. waiver community has shown over the past several weeks in response to the COVID-19 state of emergency.

You have been creative and resourceful as you have pulled together to find the best ways to serve some of the most vulnerable people in our Commonwealth.

Social distancing, limiting contacts, and handwashing remain the best ways to avoid COVID-19 infection. Around the globe, personal protective equipment (PPE) is increasingly difficult to obtain and is not currently recommended for everyday use by those who are not caring for people who have the virus. However, facemasks (e.g., cloth facemasks) are currently recommended to help reduce the spread of the virus. Guidance on cloth masks from the Kentucky Department for Public Health can be found at kycovid19.ky.gov.

In the event you do have a participant test positive for the virus, it will be important to contact your local health department for guidance. They can help you determine what type of PPE you need to safely provide care, as well as where you may obtain those items in your specific community.

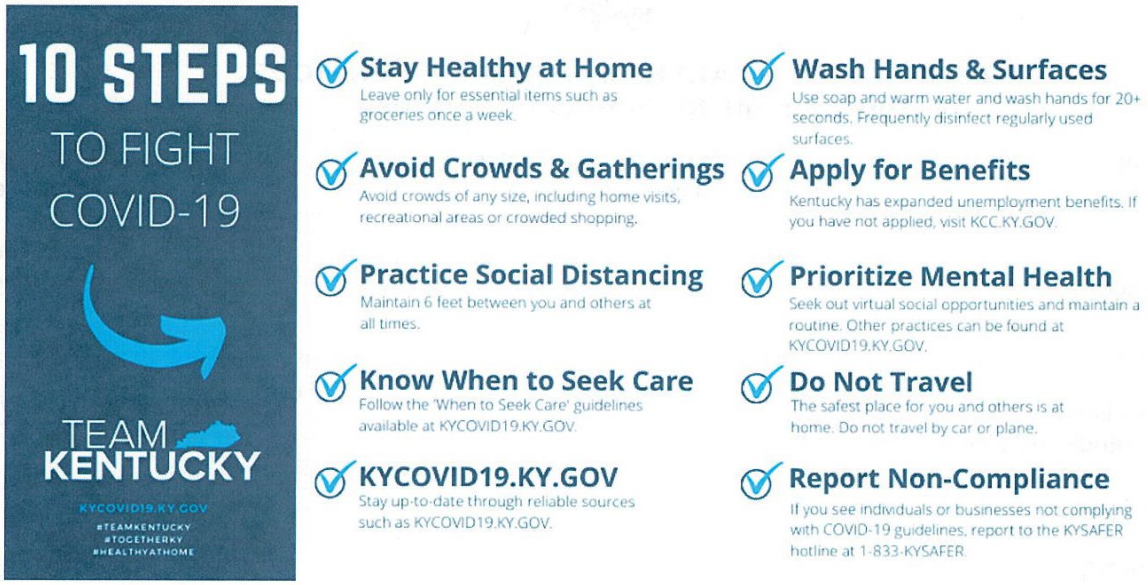
Here are some additional steps providers can take to reduce risk of exposure during this state of emergency:

- Residential providers should continue to work toward having consistent staff at each location and not scheduling staff to work at multiple homes.
- Providers should educate and support direct support professionals (DSPs) about how to limit exposure for themselves when they are away from work.
- Continue to reinforce the importance of handwashing to both participants and staff.
- Implement a COVID-19 screening for both participants and staff that includes daily temperature checks and observation of symptoms.
- Educate staff about the proper use of PPE when it is available and necessary.
- Continue to follow the Governor's "10 Steps to Fight COVID-19"

- Eliminate all in-person family and/or guardian visits. Providers should work with family members on alternative ways to stay connected with loved ones.
- Participants should not join in any gatherings in their neighborhood, regardless of size or "social distancing."
- Develop a plan for grocery shopping, picking-up medications, and other essential errands that does not involve participants being exposed in the community.
- Providers can contact their quality administrator (QA) for information about any BHDID virtual meetings.
- Providers can access additional resources shared by BHDID each week through the DDID listserv. To be added to the listserv please contact: DDIDCertification@ky.gov

Your BHDID quality administrator and DDID team continue to be an excellent resource to talk through concerns, assist with brainstorming solutions, and to help seek out any available resources.

We appreciate you and the work you are doing to not only keep people safe, but to help people continue to have meaningful and engaging days while being #HealthyAtHome. We will get through this, together.



Sincerely,

Wendy Morris, Commissioner

LOW IMPACT DEBRIEFING:

Four steps to protect you from being slimed, and to help ensure you don't traumatize your colleagues friends and family.

How do you debrief when you have heard or seen hard things?

Do you grab your closest colleague and tell them all the gory details?

Do your colleagues share graphic details with you over lunch or during meetings?

Helping Professionals often hear and see extremely difficult things in the course of their work. After a hard day, a normal reaction is to want to debrief with someone, to alleviate some of the burden of carrying what they have experienced. Debriefing is a natural and important process. The problem is that if debriefing isn't done properly it becomes "sliming" and can have negative consequences.

WHAT IS "SLIMING"?

At TEND we use the term sliming to describe the kind of debriefing that happens without warning or permission, and generally leaves the person receiving the information feeling as though they now carry the weight of this unnecessarily graphic or traumatic information. Sliming is contagious.

CONTAGION

Without realizing it, Helping Professionals can unwittingly spread traumatic stories vicariously among their colleagues, family and friends. It is common for Helpers to feel desensitized and often admit that they don't think of the secondary trauma that they pass along to the recipients of their debriefing. Some Helpers say that sharing the "gory" details is a normal part of their work. An important part of Low Impact Debriefing is to stop the contagion effect by not adding unnecessary details and thus not adding to the cumulative exposure to traumatic information.

TYPES OF DEBRIEFING

1. THE INFORMAL DEBRIEF

These happen in casual way, in a colleague's office at the end of a long day, in the staff lunchroom, the police cruiser, during the drive home or with family and friends.

Warning: Informal debriefs can evolve in a way where the listener doesn't have a choice in receiving this information. The result of these types of debriefs can be that the listener feels that they are being slimed rather than taking part in a debriefing process.

Solution: Use the 4 steps of Low Impact Debriefing

2. THE FORMAL DEBRIEF

A scheduled meeting, sometimes referred to as peer consultation, supervision or critical incident stress debriefing.

Warning: The challenge of formal debriefing is the lack of immediacy and limited or poor supervision. When a Helper has heard something disturbing during a clinical day, they usually need to debrief right away. Crisis work is so live and immediate that Helping Professionals rely on informal debriefing instead – grabbing the closest trusted colleague to unload on.

"Helpers who bear witness to many stories of abuse and violence notice that their own beliefs about the world are altered and possibly damaged by being repeatedly exposed to traumatic material."

Karen Saakvitne and
Laurie Ann Pearlman,
Trauma and the Therapist (1995).

What is a "Helping Professional"?

At TEND we say that a Helping Professional is someone whose job it is to care for others, physically, psychologically, intellectually, emotionally or spiritually. These professions include (but are not limited to) medicine, nursing, psychotherapy, counseling, social work, education, life coaching, law, criminal justice, first response, ministry.

LOW IMPACT DEBRIEFING: THE STEPS

1. SELF AWARENESS

Have you ever shocked or horrified friends or family with a work story that you thought was benign or even funny? Helping Professionals can become desensitized to the trauma and loss that they are exposed to daily. Be aware of the stories you tell and the level of detail you provide when telling a story. Are all the details really necessary? Can you give a "Coles notes" or abbreviated version?

2. FAIR WARNING

If you had to call your sister to tell her that your grandfather has passed away, you would likely start the phone call with "I have some bad news" or "You better sit down". This allows the listener to brace themselves to hear the story. Allow your listener to prepare and brace themselves by starting with "I would like to debrief a difficult situation with you and the story involves traumatic content."

3. CONSENT

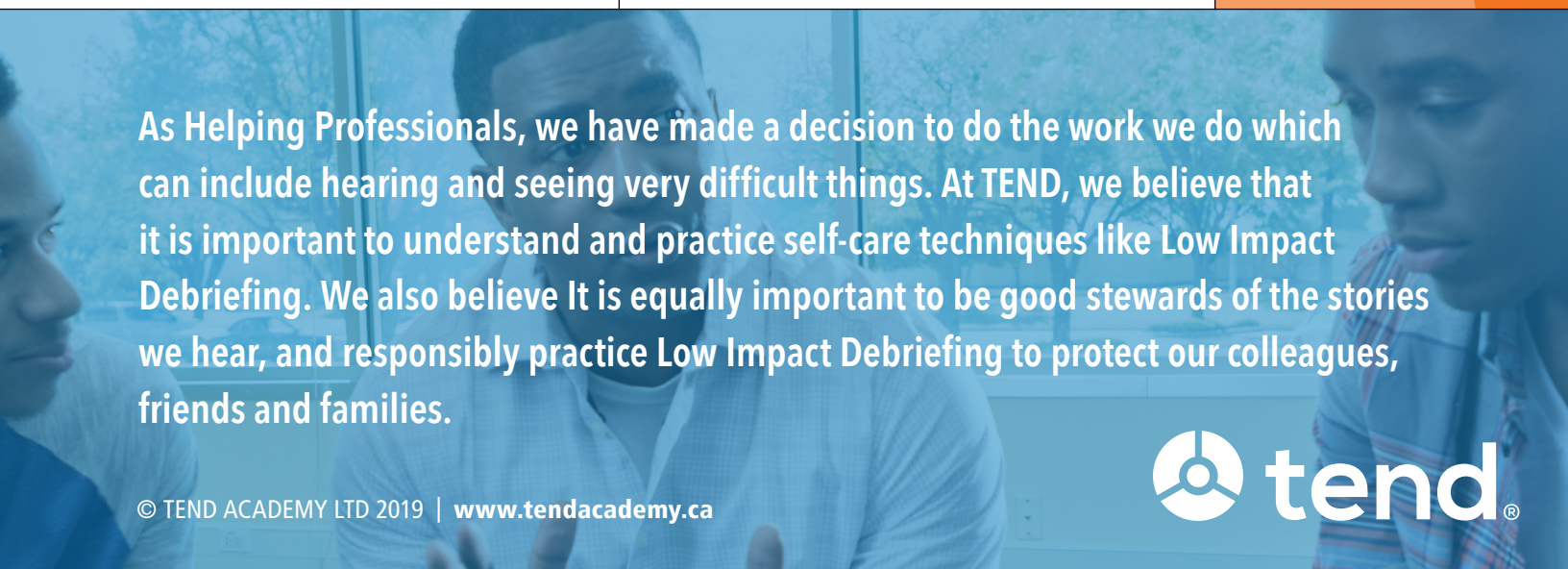
Once you have warned the listener, then ask for consent. This can be as simple as something like: "I would like to debrief something with you, is this a good time?" or "I heard something really hard today, could I talk to you about it?"
The listener then has a chance to decline, or to qualify what they are able/ready to hear.

4. LIMITED DISCLOSURE

Once you have received consent from your colleague, decide how much to share, starting with the least traumatic information, and gradually progressing as needed. You may end up not needing to share the most graphic details.

"When Helping Professionals hear and see difficult things, a normal reaction is to want to debrief with someone, the problem is that we are often debriefing ourselves all over each other..."

Françoise Mathieu,
M.Ed., CCC., RP,
Co-Executive Director,
TEND



As Helping Professionals, we have made a decision to do the work we do which can include hearing and seeing very difficult things. At TEND, we believe that it is important to understand and practice self-care techniques like Low Impact Debriefing. We also believe It is equally important to be good stewards of the stories we hear, and responsibly practice Low Impact Debriefing to protect our colleagues, friends and families.

tend®

(613) 547-3247

Hot Walk and Talk Protocol

November 22, 2018 / By Tasha Van Vlack / In Uncategorised / 2 Comments

Protocol for the Hot Walk and Talk

This protocol applies when there has been no physical injury and the person is stable enough in the aftermath to proceed. In the event that the individual has been physically injured or is in shock you would need to follow emergency procedures and get the appropriate immediate medical resources.

This protocol is designed to provide helpful first aid immediately after a team member experiences a particularly distressing or disturbing incident and is undergoing a completely normal stress reaction. This is something either supervisors or peers can offer each other and you will consider what would work best for you in your particular circumstances.

Remember that when we are experiencing a high stress response our body is in the flight, fight or freeze state and we are flooding with stress hormones and all the physical, emotional and cognitive responses that go with that. So, our first response introduces safety and containment for the person.

The following steps in the process are typically helpful:

1. Go to the individual, ensure that they are physically out of danger, and ask them to come walk with you.

2. Walk away from the area where the incident occurred and toward a neutral or safe area (if you can get outside that can be even more grounding).
3. Walk beside them and set a pace that is brisk enough to engage the individual and help them discharge some of the distress… as the walk proceeds you may find that they naturally slow the pace – let them progressively have more control over the pace as the debriefing proceeds.
4. Bring a bottle of water and have them drink the water as you walk
5. Let them know that they are safe now and you are here to support them as they move through this absolutely normal response to high stress.
6. Ask them to tell you what happened in their own words, if they seem stuck in the incident, prompt them to move on with the narrative by asking “and then what happened”. You want to help them move through the whole narrative from beginning to the end – until they get to the present where they are walking with you in safety and are no longer at risk.
7. After you have gone through this initial debrief you may work in an environment where you are required to complete an incident report. If this is the case, go with the individual and ask them how you can help in completing the report. They may want you to type in the information as they dictate it, or they may simply appreciate your presence while they complete the report.
8. Remember to remind them to focus on their breathing and open posture to help them deescalate from the stress response – especially after you have stopped walking and may be standing or sitting.
9. After the initial debrief and report (if required), ask the person what they would find helpful now? Do they want to phone a family member, get a sandwich, take a break, go back to work? They need to have control over their choices while attending to their needs.
10. Let the individual know that you will remain available to them and encourage them to access addition supports that may be available if they would find them helpful (e.g.,

Employee Assistance Programs, counselling, other community resources)

Following, and sometimes parallel to, this immediate first aid response, there may be additional steps needed from an institutional perspective. These may include:

- The debriefer stays with the affected person, and asks a colleague to notify the supervisor about the incident. The debriefer can provide updates to the supervisor as needed.
- The supervisor speaks with the affected person(s) and assesses whether the person should remain at work following the incident. The debriefer or supervisor assists with making travel arrangements if the affected person is not in a condition to drive home. If the affected person goes home early, the supervisor phones the affected person to ensure that they arrived home safely.
- The debriefer emails a summary of the incident to the supervisor, based on the information gathered from the affected person. The supervisor may also be responsible for submitting paperwork.
- The supervisor updates other staff in the office about the incident, as needed.
- The supervisor works with the affected person(s) to discuss any case management or other relevant

  decisions in relation to the incident.

- The supervisor will check-in periodically with the affected person and continue to offer support in the weeks that follow.

2 Responses to *Hot Walk and Talk Protocol*

January 3, 2019 at 1:30 pm

Tasha Van Vlack

Good Afternoon Dr.Steele — I have passed along your message to Dr. Fisher! Expect to hear from her soon, thank you for your interest in using TEND materials and we love that you believe it will be supportive in your work.

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 23, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job. (Alpha scale reliability 0.88)

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

If your score is below 23, this probably reflects positive feelings about your ability to be effective in your work. If you score above 41, you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern. (Alpha scale reliability 0.75)

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

If your score is above 41, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional. (Alpha scale reliability 0.81)

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. _____
6. _____
12. _____
16. _____
18. _____
20. _____
22. _____
24. _____
27. _____
30. _____

Total: _____

The sum of my Compassion Satisfaction questions is	And my Compassion Satisfaction level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

*1. _____ = _____
*4. _____ = _____
8. _____
10. _____
*15. _____ = _____
*17. _____ = _____
19. _____
21. _____
26. _____
*29. _____ = _____

Total: _____

The sum of my Burnout Questions is	And my Burnout level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. _____
5. _____
7. _____
9. _____
11. _____
13. _____
14. _____
23. _____
25. _____
28. _____

Total: _____

The sum of my Secondary Trauma questions is	And my Secondary Traumatic Stress level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

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SECONDARY TRAUMATIC STRESS SCALE – DSM 5

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past **seven (7) days** by circling the corresponding number next to the statement.

NOTE: *"Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.*

	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb…….…..	1	2	3	4	5
2. My heart started pounding when I thought about my work with clients…….….	1	2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my client(s)……....	1	2	3	4	5
4. I had trouble sleeping……....	1	2	3	4	5
5. I felt discouraged about the future…….…..	1	2	3	4	5
6. Reminders of my work with clients upset me……..	1	2	3	4	5
7. I had little interest in being around others…….…..	1	2	3	4	5
8. I felt jumpy…….….	1	2	3	4	5
9. I was less active than usual…….….	1	2	3	4	5
10. I thought about my work with clients when I didn't intend to…….	1	2	3	4	5
11. I had trouble concentrating……..	1	2	3	4	5
12. I avoided people, places, or things that reminded me of my work with clients…….	1	2	3	4	5
13. I had disturbing dreams about my work with clients……...	1	2	3	4	5
14. I wanted to avoid working with some clients……..	1	2	3	4	5
15. I was easily annoyed……....	1	2	3	4	5
16. I expected something bad to happen……....	1	2	3	4	5
17. I noticed gaps in my memory about client sessions……..…	1	2	3	4	5
18. I experienced negative emotions……...	1	2	3	4	5
19. I engaged in reckless or self-destructive behavior……	1	2	3	4	5
20. I unrealistically blamed others for the cause or consequences of the trauma(s) experienced by my client(s)……..	1	2	3	4	5
21. I had negative expectations about myself, others, or the world…….	1	2	3	4	5

Citation: Bride, B.E. (2013). The Secondary Traumatic Stress Scale, DSM 5 Revision. Unpublished Manuscript.

OLD Scoring Instructions for DSM -IV-TR:

Intrusion Subscale (add items 2, 3, 6, 10, 13)	Intrusion Score	_____
Avoidance Subscale (add items 1, 5, 7, 9, 12, 14, 17)	Avoidance Score	_____
Arousal Subscale (add items 4, 8, 11, 15, 16)	Arousal Score	_____
TOTAL (add Subscale Scores)	**Total Score**	**_____**

NEW Scoring Instructions for DSM - V:

Intrusion Subscale (add items 2, 3, 6, 10, 13)	Intrusion Score	_____
Avoidance Subscale (add items 12, 14,)	Avoidance Score	_____
Negative Cognitions & Mood (add items 1, 7, 9, 17, 18, 20, 21)	Negative Cog/Mood	_____
Arousal Subscale (add items 4, 8, 11, 15, 16, 19)	Arousal Score	_____
TOTAL (add Subscale Scores)	**Total Score**	**_____**

NOTE: Item #5 "I felt discouraged about the future" does not align the DSM-5 symptom criteria for PTSD. As such, it is not included in the calculation of scores for the revised version of the STSS. However, it is retained in the instrument to allow calculation of DSM-IV congruent scores for comparison with prior studies.

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005

Primary Care PTSD Screen (PC-PTSD)

Description

The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Scale

Instructions:

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?

   YES / NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

   YES / NO

3. Were constantly on guard, watchful, or easily startled?

   YES / NO

4. Felt numb or detached from others, activities, or your surroundings?

   YES / NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

Prins, Ouimette, & Kimerling, 2003

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COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and <u>underlined</u>.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***<u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***<u>Have you actually had any thoughts of killing yourself?</u>***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***<u>Have you been thinking about how you might kill yourself?</u>***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u>, as opposed to "*I have the thoughts but I definitely will not do anything about them*." ***<u>Have you had these thoughts and had some intention of acting on them?</u>***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***<u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>***		
6) Suicide Behavior Question: ***<u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u>*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *<u>How long ago did you do any of these?</u>*** · Over a year ago? · Between three months and a year ago? · Within the last three months?		

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Since Last Visit**	
Ask questions that are bold and <u>underlined</u>	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***<u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing myself"* without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***<u>Have you actually had any thoughts of killing yourself?</u>***		
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Planning for After the COVID-19 Crisis

Once the initial crisis has passed, staff and clients are likely to feel relieved, but this may also be a time of strong emotion. Workers may experience a flood of emotions, or they may allow themselves to feel their emotions for the first time since they aren't so focused on working and providing care through the emergency. This can cause increased anxiety, depression, hopelessness and feelings of being overwhelmed. Initially this seems illogical, since now there is ostensibly less to be afraid of, and more control over the situation. However, it makes sense when we remember that in the midst of a crisis we are in survival mode, and not really thinking about or noticing our feelings. Once the crisis has passed, staff may also experience a flood of accumulated grief that there was no time to express or process; this may be necessary to achieve a sense of closure regarding those losses.

Facilities should plan to offer the following to staff in the period after the pandemic emergency:

1. **Push out regular messaging** to all staff clearly outlining the **current protocols and expectations**. This may be through announcements in meetings, e-mail messages, messages posted on the employee webpage, and printed brochures, flyers and notices.

2. Clearly disseminate **information to all staff recognizing** that even though the pandemic crisis is over, **they may continue to experience feelings of stress, anxiety, depression, sadness, grief or being overwhelmed**. Remind them that this is not unusual, and provide resources (see below) and supports. Push this information out through the same channels as above (announcements, emails, webpage messages, printed information).

3. Schedule regular times for **group support meetings and/or de-briefings** led by crisis response providers (e.g. Kentucky Community Crisis Response Team) or behavioral health professionals about the psychological impact of COVID-19. Meetings for support or de-briefing should be conducted at a department level, and be scheduled as part of regular work hours. This should be available to staff across all departments in the organization, including administration, and physical plant. **Psychological First Aid** (PFA) is an evidence-informed approach that has been adapted for use with healthcare providers. See the attached brochure, and learn more about PFA in general here: https://www.nctsn.org/treatments-and-practices/psychological-first-aid-and-skills-for-psychological-recovery/about-pfa

4. Make crisis response providers and behavioral health professionals available to staff for **individual support, crisis counseling, and screening and referral**. Make sure these services are confidential, and free. Services may be provided through the Kentucky Community Crisis Response Team, Employee Assistance Programs, and local community provides. You may wish to provide **drop-in hours**, as well as **written information, emails and web-page postings** about how to reach providers.

5. Continue to provide **resilience-building supports and activities for staff** including:
    - Healthy snacks
    - Regular breaks
    - Routine check-in on their mental health and well-being
    - Celebration of successes, positive outcomes and creative solutions
    - Acknowledgement of dedication, commitment and effort

6. Continue to **provide information resources for healthy coping**, including:
    - Maintaining a regular routine
    - Taking care of body through healthy food, regular exercise, adequate sleep
    - Taking care of mind through calming strategies, mindfulness practice, talking about feelings
    - Staying connected to others professionally and personally
    - Maintaining hope and optimism for the future

7. Create ways to **memorialize those lost during the pandemic**. This can be a way to acknowledge the contributions of those staff and residents, to provide a sense of closure and saying good-bye, to allow for sharing of memories and stories, and to acknowledge the depth of shared loss. Memorialization can occur through:
    - Planting a tress or garden
    - Dedicating a bench, sculpture or piece of art
    - Creating a wall of plaques or photos
    - Creating a wall of memories, cards, sayings, mementoes
    - Holding a memorial service; this can include family members and friends of staff or residents who passed away
    - Creating a memorial fund to support designated activities

For more information and resources visit **Kentucky's COVID 19 webpage** at:
https://govstatus.egov.com/kycovid19

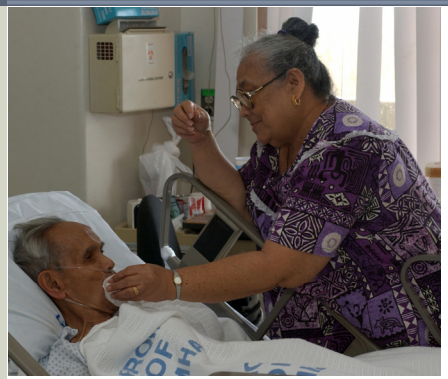
CHFS
KENTUCKY
Cabinet *for* Health *and* Family Services

- Encourage individuals to engage in physical activities and to combine these activities with useful tasks.

Take care of yourself

- Get enough rest and eat healthy foods.
- Pay attention to your own stress responses.
- Seek out family and friends for support.
- Try exercising or other physical activity to relieve stress.
- Engage in helpful, productive activities that are satisfying and useful in the situation.
- Follow the advice you would give others.
- Manage your own reaction when faced with emotional outbursts from others by:
  - Remaining quiet and calm.
  - Avoiding the temptation to engage in a shouting match.
  - Acknowledging the person's point of view.
  - Disengaging from the person if you are being insulted or threatened.
  - Contacting law enforcement personnel if you feel that you are in danger.

For more information about Emergency Preparedness and Psychological First Aid, refer to *www.ready.gov* and *www.ncptsd.org*.



Andrea Booher/FEMA Photo

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Commissioner

New York State Department of Health
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Commissioner

UNIVERSITY OF ROCHESTER MEDICAL CENTER

Psychological First Aid

Healthcare Professionals

When Disaster Strikes

Influenza is reaching epidemic proportions throughout your county. The local public health director has declared a health emergency, placing all hospitals, clinics, and medical providers on high alert. With the national concern and publicity about influenza, you know that your healthcare facility will be overwhelmed with people, some with actual flu symptoms and many who are worried that they have been exposed to the flu.

Individuals who are sick will be encouraged to stay home from work and social activities. Parents will stay home to care for their children or older family members who are sick. Many doctors, nurses, and healthcare staff will be exposed to the sick and dying and may get sick themselves. Staffing levels will be reduced; resources will be stretched; stress levels will be high. You know that it will take more than medical expertise to maintain an effective and organized environment and to perform essential job tasks.

Psychological First Aid in Healthcare Settings

Your background and training tell you that in times of crisis it is imperative to keep people calm and to provide support to co-workers, patients, and family members who are experiencing high levels of stress and uncertainty.

People may find themselves overwhelmed by the magnitude and complexity of issues and problems they must face in trying to work, care for family members, understand the treatment options available to them, and get effective medical services, all within a healthcare system that is overwhelmed by the demand placed upon it by the influenza epidemic.

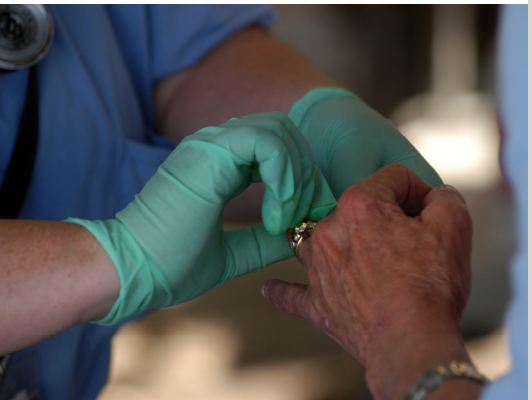
Petty Officer Second Class Paul Roszkowski/U.S. Coast Guard Photo

PFA in Practice

Psychological First Aid (PFA) can play an important role in helping people cope with stressful situations. PFA is a way to give emotional support and help to people of any age, ethnic and cultural heritage, and social and economic background in the immediate aftermath of disaster or in the midst of a public health emergency. Since situations like this make no discriminations among victims, you can expect people from all ages and life circumstances to experience stress responses that will test your patience and fortitude.

You can use PFA to meet the basic needs of people in stressful situations, no matter what the differences are among them. PFA will provide you with basic strategies to help people cope with their pressing concerns and needs in the days and weeks after the disaster and throughout the public health emergency.

Mark Wolfe/FEMA Photo



Reach out to those who need help and provide comfort care.

- Let individuals know you are concerned about them and describe how you may be able to help.
- Make eye contact and determine the person's comfort level with you as a helper. Be aware that some people are not comfortable asking for help.
- Speak slowly and clearly, and allow the person to speak without interruption.
- Protect the person's privacy by keeping your conversation from being overheard.
- Avoid making promises you will not be able to keep.
- Make certain that you, your co-workers, and patients understand and practice the facility's hygiene and infection control procedures.
- Offer immediate assistance to distressed individuals by looking for ways to keep them comfortable (e.g., providing blankets and water or directing them to a place to sit).
- Provide an interpreter or translator when necessary and be sensitive to cultural and ethnic needs.

Recognize basic needs and support problem-solving.

- Determine and coordinate activities that will keep co-workers engaged and helpful to each other.
- Be tolerant and patient. You may need to explain things more than once.
- Help your co-workers contact their family members and childcare providers.
- Assist them in finding resources to care for their pets.
- Help individuals get transportation to and from the hospital.
- Facilitate information sharing between healthcare providers and families of patients.
- Identify what an individual's specific needs are and help him or her develop a plan of action.
- Be specific and concrete, and focus on one task at a time.

Validate feelings and thoughts.

- Listen and hear what individuals have to say about the current situation by being fully present and attentive.
- Allow them to talk as little or as much as they care to. Try not to push too hard to get them to talk about what happened or how they are feeling.
- Avoid the temptation to judge the rightness or wrongness of their reactions.

Provide accurate and timely information.

- Provide accurate information in response to questions as soon as you can.
- Treat all questions seriously and offer truthful answers.
- Avoid the temptation to ignore questions that seem unimportant to you.
- Connect individuals with the resources that can provide the answers to their questions.

Connect individuals with support systems.

- Encourage co-workers to stay connected with their family members.
- Help families to provide support and care for loved ones who are hospitalized.
- Facilitate spiritual practices by connecting patients, co-workers and their family members with spiritual leaders and practitioners.
- Seek help from mental health professionals, especially if individuals exhibit risky or dangerous behaviors or request to see a counselor.

Provide education about stress responses.

- Help patients, co-workers, and their family members to understand the stress they may be experiencing in response to the situation will lessen with time.
- Encourage individuals to seek help from a family physician or mental health professional.
- Exercise caution that you don't minimize a person's reactions.

Reinforce strengths and positive coping strategies.

- Encourage patients, co-workers, and their family members to get back to routine activities as soon as practical.
- Suggest that individuals choose healthy foods and minimize the amount of junk food they eat.

COVID-19 HAVE YOU FEELING:

SCARED? SAD? FRUSTRATED? WORRIED? UNCERTAIN? AFRAID TO COME TO WORK OR TO GO HOME? CONCERNED FOR YOUR OWN FAMILY?

HELP IS A PHONE CALL AWAY!

IT'S FREE, IT'S CONFIDENTIAL!

Call our toll free number 888-522-7228 where you can talk to a member of the Kentucky Community Crisis Response Team.

#TeamKentucky #WeAreInThisTogether

KCCRB

Kentucky Community Crisis Response Board

Behavioral Health Providers & Emergency Resources

Kentucky Community Crisis Response Board (KCCRB): 1-888-522-7228

National Suicide Lifelines: 1-800-273-8255 or 1-800-784-2433

National Domestic Violence Hotline: 1-800-799-SAFE
Kentucky Coalition Against Domestic Violence: https://kcadv.org/

National Sexual Assault Helpline: 1-800-656-HOPE
Kentucky Association of Sexual Assault Programs: https://www.kasap.org/

Kentucky Child/ Adult Abuse Hotline: 1-877-597-2331

Kentucky's Regional Community Mental Health Centers:
http://dbhdid.ky.gov/cmhc/default.aspx

For more information and resources visit **Kentucky's COVID 19 webpage** at:
https://govstatus.egov.com/kycovid19