Washington State Department of Health

June 2020 (rev. July 2020)
Publication 821-104

COVID-19 Behavioral Health Group Impact Reference Guide

Purpose

This document provides information on the predicted behavioral health impacts related to the COVID-19 pandemic for a variety of groups within Washington. The groups included in this document are based on occupation and social role. The overview, tools, and examples are provided to inform messaging, training, and interventions that are likely to be the most effective for a given group at a specific phase in the course of the pandemic.

This guide is intended for incident response organizations and planners, organizations that support or employ these groups, and organizations responding to or helping to mitigate the behavioral health impacts of the COVID-19 pandemic. Supplemental, public-facing behavioral health resources and messaging can be accessed on the Washington State Coronavirus (COVID-19) Response website under Partner Toolkit and Mental and Emotional Well-being as they are developed and become available. Additional behavioral health resources for response planning can be found on the DOH Behavioral Health Resources & Recommendations webpage.

Contents

Using this Guide

Using interventions informed by this timeline and group-specific strategy can result in more efficient and effective delivery of support for each group in Washington.

For a general overview of behavioral health impacts, disaster psychology, and risk factors, go to the **Behavioral Health Impact Overview** section on page 3.

For group-specific information, go to the group sections as identified in the **Contents** section on page 1. For each group, the following information is provided:

- Unique behavioral health considerations
- Risk factors
- Timeline of behavioral health priorities
- Recommended support strategies

The timeline relates to the following five specific points in the pandemic response, and the related psychosocial, emotional, and behavioral impacts for each group, at each point:

- Month of outbreak
- Three months post-outbreak
- Six months post-outbreak
- Nine months post-outbreak
- Twelve months post-outbreak

The following groups, organized by occupation and social role, are included in this guide:

- Groups by occupation (professional and personal considerations are provided for these groups):
    1) Healthcare workers
    2) Law enforcement officers and military personnel
    3) Behavioral health providers
    4) Outreach teams and shelter workers
    5) Businesses and workers
    6) Educators
- Groups by social role:
    7) Families and children
    8) Individuals post-critical care hospitalization

Behavioral Health Impact Overview

This section introduces key disaster psychology concepts and provides an overview of response priorities for managing behavioral health impacts. It also highlights broad behavioral health impacts of disasters and the associated symptoms and risk factors that apply to **all** groups. The COVID-19 pandemic is considered a natural disaster and, as such, this document is heavily informed by research on disaster recovery and response.

KEY THINGS TO KNOW

Behavioral Health Impacts of Disasters and Critical Incidents

1) Approximately 650,000 Washingtonians were receiving treatment for behavioral health needs prior to the COVID-19 outbreak.[1]
2) Approximately 700,000 Washingtonians have mental health concerns, but were **not** receiving behavioral health services prior to the outbreak.[1]
3) Approximately 10% to 33% of individuals experience symptoms of acute stress within one month of a disaster or critical incident.[2,3,4] These symptoms could include negative thoughts, sadness, intrusive dreams or memories, avoidance, insomnia or hypersomnia, headaches, and stomachaches.
4) While only 4% to 6% of people typically develop symptoms of post-traumatic stress disorder (PTSD) following a disaster, this number can vary significantly depending on the type of disaster. This percentage is often higher among first responders and medical personnel when the disaster is more chronic or widespread, children are hurt or injured, and burnout is likely.[2,3,4]

   Rates of PTSD have been much higher (10-35%) in some places more directly impacted by a critical incident.[5] Although rates of PTSD may not reach such critical levels in Washington, it is anticipated that rates of depression are likely to be much higher (potentially 30-60% of the general population) than is typical after a natural disaster occurring at a single point in time. This is due to the chronic and ongoing disruption in people's lives as a result of the COVID-19 pandemic.
5) In Washington, the highest risk of suicide is most likely to occur between October and December 2020. This estimate is based on known cycles of disaster response patterns. Seasonal affective disorder (SAD) exacerbates mental health challenges at that time of year due to increased hours of darkness and inclement weather. Winter holidays can also worsen mental health challenges for many people, as they are often an emotionally and financially difficult time of year. See Appendix B: Additional Information on Suicide for further details on suicide.
6) Suicide rates are highly influenced by unemployment rates.[6,7,8] For every 1% increase in the unemployment rate, there is a corresponding 1.6% increase in suicide rates.[9] In Washington, approximately 1,283 people die from suicide annually. If the unemployment rate increases by 5% (rates similar to the Great Recession in the late 2000s), it is estimated that approximately 103 additional people could die by suicide annually.[8] If unemployment

increases by 20% (rates similar to the Great Depression in the 1930s), approximately 412 additional people in Washington could die by suicide annually.

7) Approximately half of the individuals who experience a behavioral health diagnosis develop a substance-related disorder, and vice versa.[10] As a result, substance-related symptoms and disorders are expected to increase as behavioral health symptoms and disorders increase.

8) A surge in behavioral health symptoms will present differently based on the phase of the pandemic (Figure 1, p. 5), the effectiveness of the overall response effort, and the impacted populations. A second or third pandemic wave could dramatically influence the amount of surge.

   There are three potential scenarios for Washington based on known behavioral health responses to phases of disaster and resource availability. These are outlined in the monthly forecasts (May Update and beyond) on DOH's Behavioral Health Resources and Recommendations webpage.

Responding to Behavioral Health Impacts

1) Behavioral health systems, providers, and public messaging teams should be mindful of the following strategies to maximize the impact of their efforts:
   a. Primary efforts for the next six to nine months should be focused on:
      i. Activating community supports to increase social connections and reduce behavioral health symptoms.
      ii. Encouraging the development of active coping skills among the general public to reduce symptoms of depression.
   b. There should be an educational emphasis on the disaster response cycle to inform individuals about what short-term behavioral responses they may experience. Education and messaging should also highlight that these short-term responses are normal in an abnormal situation, and they do not indicate having a mental illness.

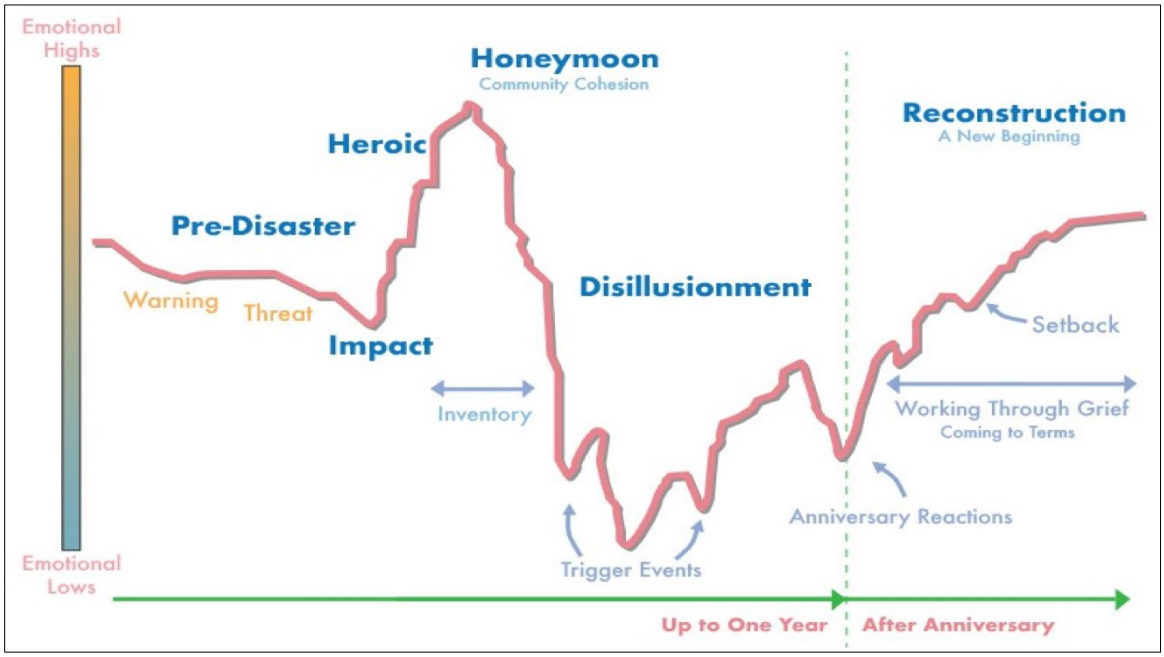
2) The typical long-term outcome to disaster is **resilience**, rather than disorder.[9,11] Resilience is something that can be intentionally taught, practiced, and developed for people across all age groups. Resiliency can be increased by:
   a. Focusing on developing social **connections**, big or small,
   b. Reorienting and developing a sense of **purpose**,
   c. Becoming adaptive and psychologically **flexible**, and
   d. Focusing on **hope**.[12]

3) Outreach and support strategies should be tailored based on the current phase of the incident and the specific population.

4) Community support groups, lay volunteers, and social organizations and clubs are resources that can be amplified to help reduce behavioral health symptoms for the general population, and should be leveraged to take pressure off depleted or unavailable professional medical and therapeutic resources throughout 2020.

Reactions and Behavioral Symptoms in Disasters

Figure 1: Reactions and Behavioral Symptoms in Disasters



Adapted from the Substance Abuse and Mental Health Services Administration (SAMHSA) [13]

The following phases of disasters and the associated reactions and behavioral symptoms are illustrated in Figure 1 above:

1) **Pre-Disaster:** In the pre-disaster timeline, many people may experience some anxiety as they see a disaster begin to unfold. Others may be in denial that there is anything to worry about.
2) **Impact Phase:** At impact, people may be in shock, experience panic, or be in disbelief. Primary concerns are for safety and basic needs for shelter, food, medical care, and reunification if they've been separated.
3) **Heroic and Honeymoon Phases:** During these phases, communities often come together to help each other. Outside resources and help may also come in. There is a sense of cohesion and relief, along with hope that things will shortly be back to normal.
4) **Disillusionment Phase:** The disillusionment phase is marked by fatigue and a realization that recovery is likely to take some time. It is during this phase that behavioral health issues begin to emerge and peak. Commonly, the incidence of depression and rates of suicide rise along with increasing rates of alcohol and drug use.
5) **Reconstruction Phase:** The reconstruction phase marks a time of increased risks to behavioral health disorders. There can be a rise in symptoms related to the anniversary of the event. Grief related to loss of home, family members, jobs, and opportunities need to be addressed as people settle into the new normal.

SYMPTOMS & CONCERNS

This section describes the expected responses that individuals may have to disasters and critical incidents. For more detail, see Appendix A: Symptom Descriptions and Examples.

The human responses to acute stress (Table 1 below) are expected responses during disasters and are seen in the general population. These should be considered normal responses to an abnormal situation. Most individuals will experience some or all of these symptoms following a disaster. For many individuals, these symptoms of acute stress will dissipate over time, leading to additional resilience and recovery.[14,15] Certain individuals who experience losses, such as deaths of loved ones, illness from COVID-19, or job loss and serious economic stress, may go on to develop longer-term mental health diagnoses (e.g., chronic depression, anxiety, and PTSD).[16,17]

Table 1: Responses to Acute Stress (adapted from Russell, M.C. & Brickell, M. (2014)) [18]

Physical	Cognitive/Mental	Emotional	Behavioral
• Chills • Difficulty breathing • Dizziness • Elevated blood pressure • Fainting • Fatigue • Grinding teeth • Headaches • Muscle tremors • Nausea • Pain • Profuse sweating • Rapid heart rate • Twitches • Weakness	• Blaming someone • Change in alertness • Confusion • Hyper-vigilance • Increased or decreased awareness of surroundings • Intrusive images • Memory problems • Nightmares • Poor abstract thinking • Poor attention • Poor concentration • Poor decision making • Poor problem solving	• Agitation • Anxiety • Apprehension • Denial • Depression • Emotional shock • Fear • Feeling overwhelmed • Grief • Guilt • Inappropriate emotional response • Irritability • Loss of emotional control	• Increased alcohol consumption • Antisocial acts • Change in activity • Change in communication • Change in sexual functioning • Change in speech pattern • Emotional outbursts • Inability to rest • Change in appetite • Pacing • Startle reflex intensified • Suspiciousness • Social withdrawal

ADDITIONAL RISK FACTORS

This section highlights additional risk factors that could magnify the behavioral health impact for certain individuals.

Compassion Stress Injury (CSI)

Some people are at increased risk for CSI due to professional and personal obligations which magnify the impact. CSI is estimated to impact 40% to 80% of resident physicians.[19] In addition, CSI is also seen across a wide array of helping populations, such as self-identified trauma therapists,[20] police officers,[21] humanitarian aid workers,[22] early childhood special education teachers,[23] military psychologists,[24] military chaplains,[25] civilian clergy,[26] child welfare workers,[27] emergency department nurses,[28] pediatric intensive care providers,[29] Veterans Affairs counselors,[30] hospice care professionals,[31] children of war veterans,[32] and family caregivers.[33]

Sleep

Meta-analyses and systematic reviews of sleep disturbance and stress-related injuries like PTSD concluded that these behaviors can be both a primary symptom and a primary cause of behavioral health disorders.[34] As a result, we should expect dysregulated sleep to be a vital early marker, as well as a potential catalyst, of mental health degradation.

Intergenerational Transmission

Research on secondary traumatic stress has found that previously non-traumatized children can acquire characteristic trauma-like responses from a parent or caregiver.[35]

Group 1: Healthcare Workers

This group includes, but is not limited to, doctors, nurses, providers, healthcare aides, and first responders such as emergency medical services (EMS) personnel. This section outlines the unique behavioral health considerations, timeline of behavioral health priorities, and strategies for supporting healthcare workers.

UNIQUE BEHAVIORAL HEALTH CONSIDERATIONS

Bottom Line Up Front

This group may:

- Be at extreme risk for job stress, compassion fatigue, and burnout due to infection risk and public-facing interactions.
- Strongly benefit from clear training, communication, and information with regard to their work duties, expectations, and personal protective equipment (PPE) policies and practices.
- Experience isolation from colleagues and family members who would previously be able to offer support, but are no longer able due to the new infection control measures being taken in their professional and personal lives.
- Be at risk of moral injury* due to making decisions about care for patients in scarce or limited resource environments where they feel their morals or ethics are compromised.

Healthcare workers experience extreme professional stress due to the COVID-19 pandemic. Those in coronavirus hot spots endure long shifts, high volume and complexity of patients, high numbers of patients with severe illness and death, having to care for colleagues who've been infected, higher risk of infection themselves, potentially infecting family members, stigmatization, and, on some occasions, violence directed at them due to their jobs.[36] Those in helping professions are also at risk of compassion fatigue, a form of burnout that "affects people in caregiving professions."[37]

Healthcare providers and first responders are at exceptionally high risk of suffering from moral injury during the COVID-19 pandemic. Moral injury occurs when individuals are required to take actions that violate their values, training, or standard of behavior. A fragile healthcare system, in combination with the need to move from conventional care to resource-limited situations that require a different approach, creates tremendous anxiety and often a feeling of helplessness.[38] Life and death decisions have to be made which would not be made in conventional care. Extremely difficult conversations around end of life, many deaths, inability to provide intensive treatment, and triaging some patients into lower tiers of care due to scarce resources add to the massive burden of clinical overload. These challenging circumstances may lead to moral injury.[39] Some EMS workers are at increased risk to infection due to lack of PPE. They may be asked to perform resuscitation on patients without appropriate PPE.

* *Moral injury* is the distressing psychological, behavioral, and social aftermath of exposure to events that contradict an individual's moral beliefs and values, training, or standard of behavior.

In coronavirus hot spots, some EMS staff are asked not to respond to cardiac calls, not to perform CPR, and not to bring some patients to the Emergency Department.[40] These are examples of EMS workers operating outside their normal standard of care, which increases their risks to moral injury.

TRACKING AND MONITORING MORAL AND PSYCHOLOGICAL DISTRESS

Tracking and monitoring worker responses may be a proactive way of mitigating some behavioral health impacts. Early monitoring of short-term stress symptoms may not predict outcomes in the long term. However, uncovering and tracking exposure to certain events within the disaster may predict development of more prolonged psychological distress.[9] Thus, tracking exposures to psychological stressors may identify those individuals at risk, allowing them to proactively engage in support services.[16,41]

Like other essential workers, healthcare workers who are also parents have to manage these changes while also navigating additional changes, such as working from home, caring for young children, and homeschooling older children and teens.

TIMELINE OF BEHAVIORAL HEALTH PRIORITIES

The following tables show the potential psychological impacts and when they may appear in patients who healthcare workers care for (professional considerations) and in healthcare workers themselves (personal considerations). These tables may help guide timing of psychological and other types of support offered.

Table 2: Professional Considerations for Healthcare Workers (Group 1)

	Month of Outbreak	**3 Months Post-Outbreak**	**6 Months Post-Outbreak**	**9 Months Post-Outbreak**	**12 Months Post-Outbreak**
Emotional (responses of patients)	Fear Anger Grief	Fear Anger Grief	Depression Anxiety	Depression Anxiety	Depression, if second pandemic wave occurs Improved mood and functioning, if pandemic subsides

	Month of Outbreak	3 Months Post-Outbreak	6 Months Post-Outbreak	9 Months Post-Outbreak	12 Months Post-Outbreak
Cognitive (responses of patients)	Confusion	Reckless or inappropriate behaviors	Impaired judgment (e.g., diminished sense of consequences)	Negative or distorted thinking	Negative or distorted thinking, if second pandemic wave occurs Hopefulness, if pandemic subsides
Behavioral (responses of patients)	Aggression	Aggression Lethargy	Aggression Lethargy Increased substance use	Increased suicide risk	Withdrawal, isolation, if second pandemic wave occurs Increased socialization, if pandemic subsides

Table 3: Personal Consideration for Healthcare Workers (Group 1)

	Month of Outbreak	3 Months Post-Outbreak	6 Months Post-Outbreak	9 Months Post-Outbreak	12 Months Post-Outbreak
Emotional (of self)	Overwhelmed Sadness Despair Anxiety	Exhaustion Anxiety Grief	Heightened arousal (feeling on edge)	Depression Anxiety	Emotional disorder, if second pandemic wave occurs Resilience, if pandemic subsides
Cognitive (of self)	Confusion Forgetfulness	Distraction Memory problems	Negative or distorted thinking	Negative or distorted thinking	Goal and identity re-orientation

	Month of Outbreak	3 Months Post-Outbreak	6 Months Post-Outbreak	9 Months Post-Outbreak	12 Months Post-Outbreak
Behavioral (of self)	Absenteeism Leaving healthcare profession	Withdrawal Burnout Hyperactive (unable to calm down) Anxiety	Decreased self-care Withdrawal Burnout Increased substance use	Increased suicide risk	Decreased physical health and self-care, if second pandemic wave occurs Improvement in self-care, if pandemic subsides

SUPPORT STRATEGIES

This section provides best practices for increasing resilience in healthcare workers, including those for both their professional and personal lives. These are presented as tips that employers or organizations serving the group can share with individuals within the group. Consider integrating these practices and considerations into your organization's strategy for supporting staff and clients.

Professionally

Tips for organizations that employ healthcare workers:

- Provide regular, clear, and honest situational communication to all staff.
- Create strict and measured work rotations between high stress and low stress work functions.
- If you are in a supervisory or managerial role:
    - Try to lead by example with mandatory and systematic work breaks (on a reasonable schedule). Offer verbal support for colleagues.
    - Uphold boundaries by not calling on staff when they are off duty or taking breaks.
    - Develop and share awareness and training around the cycle of disaster responses (with particular focus on the disillusionment phase 6-9 months post-outbreak when depression and suicide increase).
    - Provide comfortable sleeping arrangements for staff who must remain in the healthcare setting. Provide a space for staff to shower and change clothing prior to leaving after their shift.

Tips to share with healthcare workers for help managing their professional life:

- Maintain on-duty boundaries for work time. Include breaks on work schedule.

- Take time to highlight the impact your work is having on others, and when possible, celebrate victories (even little ones).
- Cultivate a group of coworkers that are supportive, and maintain these relationships.
- Avoid professional isolation by engaging with colleagues while maintaining social distancing (e.g., virtual get-togethers, online consult and affinity groups, and online huddle-style meetings to share information and lessons learned).
- Consider short huddle-style meetings at shift change to allow staff to talk about what went well and what needs to be changed, and to provide a way for everyone to check in on how they're doing.
- If your organization has an Employee Assistance Program (EAP), take advantage of the resources offered for personal support and therapy.

Personally

Tips to share with healthcare workers for help managing their personal life:

- Create a coping plan for yourself. This might include photos of loved ones or special places, breathing tools, or a quick walk away from the stressful situation.
- Identify your markers for stress (e.g., somatic symptoms of a clenched jaw or knotted stomach). Notice when they happen and use your coping strategies.
- Self-monitor for exposure to events that may heighten your chances of developing longer-term psychological issues.
- Try to eat regular, nourishing meals.
- Maintain a regular sleep schedule to the best of your ability. When possible, have the same wake up and bedtime each day. Avoid screens for an hour prior to sleep.
- Exercise when you are able.
- Spend time outdoors when possible.
- Structure your time as much as possible so that on and off duty schedules are very clear.
- Develop off-duty boundaries around taking calls and availability when not on duty. Boundaries are important.
- Create a schedule and try to add one thing each day you enjoy doing.
- Engage with any spiritual practices that you enjoy and find helpful.
- If possible, find a creative outlet to engage in during downtime.
- List things you can do during time off that are completely unrelated to work (e.g., rewatch your favorite show, teach yourself a new hobby using online resources, get lost in a book).
- Avoid unhealthy coping practices, such as drinking too much alcohol.
- Stay in touch with friends and family members who are supportive.
- Develop a daily family check-in where each member can share suggestions for making things better. End the check-in with what is currently going well.
- If in a relationship, set aside a few minutes daily to check in with your partner.

Group 2: Law Enforcement Officers and Military Personnel

This section outlines the unique behavioral health considerations, timeline of behavioral health priorities, and strategies for supporting law enforcement officers and military personnel.

UNIQUE BEHAVIORAL HEALTH CONSIDERATIONS

Bottom Line Up Front

This group may:

- Be at higher risk of job burnout due to public-facing roles and management of public discord.
- Be less inclined to seek services for behavioral health.
- Have a strong internal peer support network that can be leveraged for behavioral health needs.
- Need to focus on strict boundaries with regard to time spent off duty and on duty.

Law enforcement officers (LEOs) and emergency responders are directly exposed to devastating, life-threatening, stressful, draining, and traumatizing situations. In disaster situations, this exposure increases significantly due to increased rates of response calls for child physical abuse, child sexual assault, rape and sexual assault, domestic violence, suicide, threats of suicide, and self-harm. Constant direct exposure, poor access to mental health resources, shame, and fear of stigma related to depression, PTSD, and anxiety have led to a snowballing mental health crisis in police officers.[42]

Approximately 18% of male police officers and 16% of female police officers experience adverse consequences from alcohol use. Nearly 8% meet diagnostic criteria for alcohol abuse or dependence.[43] There is a significant correlation between exposure to a traumatic event and increased alcohol consumption and PTSD.[44] Police officers that report significant stress also report increased suicidal ideation, depression, and anger.[45] Post-disaster response, law enforcement officers tend to experience significantly higher rates of PTSD, depression, burnout, anxiety, and secondary trauma.

Officers that report experiencing burnout at work are 117 times more likely to experience suicidal ideation, and the lifetime prevalence of suicidal ideation in police officers is between 23% and 25%. Police are significantly more likely to die by suicide than in the line of duty.[46]

Despite the prevalence of PTSD, depression, anxiety, and substance abuse in law enforcement, there is a significant gap in access to behavioral health resources and a lack of dialogue regarding mental health symptoms.[42] Police officers continue to feel shame and guilt about their mental health experiences. They are consistently fearful of seeking services due to fear of being placed on administrative leave or being forced to leave their job. Many also worry that their colleagues will perceive them as weak, less skilled, or as a risk or liability to the rest of the department. Confidentiality is also a significant concern for officers seeking in-house support, such as through a Peer Support Program or Employee Assistance Program (EAP).[44] Research

indicates that while many law enforcement agencies are working to provide services that promote officer wellness, the majority lack specific services to prevent suicide.[47]

RISK FACTORS

The following risk factors are associated with higher rates of depression, PTSD, anxiety, and burnout in LEOs:

- Long hours and assignments
- Working in unfamiliar or demanding circumstances
- Not having enough job-related information
- Supervising too many people
- Too many, conflicting, or unfamiliar job duties
- Excessive exposure to graphic sights/sounds and environmental hazards
- Not taking at least one day off each week

PROTECTIVE FACTORS

Factors that help minimize behavioral health impacts:

- Social and organizational support
- Positive relationships with coworkers
- Supportive relationship with supervisors
- Perception that supervisors are approachable
- Clear lines of communication
- Rotation of assignments
- Conflict resolution support if conflict arises among the team
- Informal peer support
- Mental health support and resilience training
- Promotion of behavioral health resources and services

TIMELINE OF BEHAVIORAL HEALTH PRIORITIES

The following tables show the potential psychological impacts and when they may appear in individuals. Under professional considerations in Table 4, LEOs could expect to see the following emotional, cognitive, and behavioral symptoms in individuals they encounter in the line of duty. These tables may help guide timing of psychological and other types of support offered.

Table 4: Professional Considerations for Law Enforcement Officers and Military Personnel (Group 2)

	Month of Outbreak	3 Months Post-Outbreak	6 Months Post-Outbreak	9 Months Post-Outbreak	12 Months Post-Outbreak
Emotional (of encounters)	Fear	Fear Anger	Depression Anger	Depression Anger	Depression Anger
Cognitive (of encounters)	Catastrophic thinking Confusion	Catastrophic thinking	Impaired judgement (sense of consequence)	Negative or distorted thinking Entitlement	Negative or distorted thinking Entitlement
Behavioral (of encounters)	Hoarding Argumentative Aggression	Increased encounters for domestic violence and child abuse (physical and sexual)	Increased encounters for physical assault and sexual assault	Increased encounters for suicide or suicide risk	Continued behavioral trends

Table 5: Personal Considerations for Law Enforcement Officers and Military Personnel (Group 2)

	Month of Outbreak	3 Months Post-Outbreak	6 Months Post-Outbreak	9 Months Post-Outbreak	12 Months Post-Outbreak
Emotional (of self)	Overwhelmed Frustrated	Burnout	Burnout Depression	Depression Anger	Depression Anger
Cognitive (of self)	Confusion Distraction	Confusion Distraction	Frustration	Frustration	Hopelessness Helplessness
Behavioral (of self)	Increased raised voice (yelling)	Increased raised voice (yelling) Increased substance use	Increased risk of professional reprimands	Increased suicide risk	Increased risk of professional reprimands

SUPPORT STRATEGIES

This section provides best practices for increasing resilience in law enforcement officers and military personnel, including those for both their professional and personal lives. These are presented as tips that employers or organizations serving the group can share with individuals within the group. Consider integrating these practices and considerations into your organization's strategy for supporting staff and clients.

Professionally

Tips to share with LEOs and military personnel for help managing their professional life:

- If you are in a supervisory or managerial role:
    - Try to lead by example with mandatory and systematic work breaks (on a reasonable schedule). Offer verbal support for colleagues.
    - Develop and share awareness and training around the cycle of disaster responses (with particular focus on the disillusionment phase 6-9 months post-outbreak when depression and suicide increase).
    - Create strict and measured work rotations between higher and lower stress work functions.
    - Promote the Peer Support Program within your organization, use of EAP, and local behavioral health resources.
- Maintain on-duty boundaries for work time. Include breaks on work schedule.
- If possible, avoid professional isolation.
- Cultivate a group of coworkers that are supportive, and maintain these relationships.

Personally

Tips to share with LEOs and military personnel for help managing their personal life:

- Try to eat regular, nourishing meals.
- Maintain a regular sleep schedule to the best of your ability. Work to cultivate a healthy sleep routine.
- Structure your time as much as possible so on-duty and off-duty schedules are very clear.
- Develop off-duty boundaries around taking calls and availability when off duty. Boundaries are important.
- Develop a plan for what works for you as an individual when it comes to self-care. Try to create a schedule where you pick at least one thing each day you enjoy doing.
- Try to find a physical activity that you enjoy, such as walking, running, cycling, yoga, etc.
- If possible, find a creative outlet to engage in during your downtime.
- List things you can do during time off that are completely unrelated to work (e.g., rewatch your favorite show, teach yourself a new hobby from online resources, get lost in a book).
- Avoid unhealthy coping practices, such as drinking too much alcohol.
- Stay in touch with friends and family that are supportive.
- Reach out to your Peer Support Program, EAP, or local behavioral health resources (e.g., a local therapist).

Group 3: Behavioral Health Providers

This group includes mental and behavioral health providers and the associated organizations and agencies. This section outlines the unique behavioral health considerations, timeline of behavioral health priorities, and strategies for supporting behavioral health providers.

UNIQUE BEHAVIORAL HEALTH CONSIDERATIONS

Bottom Line Up Front

This group may be:

- At risk for job stress and compassion fatigue.
- Adjust to a very different approach to therapy and evaluation.
- Quickly learning new technology and best practices to support teletherapy.
- Experiencing isolation from colleagues who can't be present in person.

Behavioral health workers have similar risks to healthcare workers. They are at risk for compassion fatigue due to their role as a caregiver, exposure to patient trauma by listening to difficult stories, and feeling empathy for their patients.[48,49]

Providers who work in organizations that have large numbers of vulnerable patients, limited access to behavioral health resources, and low-income patients can suffer due to inability to provide enough care for their number of patients. Providers with limited experience are particularly vulnerable. Low salary rates for behavioral health employees, along with the intense demands of practice, can often lead to high provider turnover in community agencies, increasing stress levels on remaining providers.

Providers who are part of solo or group private practices may also be vulnerable given their own personal risk factors. In solo practice, professional isolation can be difficult. Additionally, private practitioners have job stress related to their businesses, such as needing to manage access to practice space and supplies, general overhead, state and federal guidelines and regulation, continuing education and training costs, planning for health insurance and absences where there will be no income generated, and tax and employee documentation. Income for these providers is dependent on maintaining a large enough patient volume to cover overhead.

For all types of behavioral health providers, the COVID-19 pandemic created sudden, massive changes to their regular practices. Social isolation protocols meant a rapid shift to teletherapy. Initially, there were issues with reimbursement and paperwork associated with patient care. Providers had to establish methods and means to provide care through secure videoconferencing. Many providers were completely new to teletherapy, and thus weren't aware of the need for understanding the specific types of consent for care related to teletherapy, evaluating patients for suitability with online services, planning for emergency response (e.g., responding to suicide), determining HIPAA regulations for the switch to teletherapy, and navigating the new way of providing therapy effectively. The specific stressors related to this switch were common to behavioral health providers across settings and across patient demographics. Like other essential workers, behavioral health providers who are also

parents have to manage these changes while also navigating additional changes, such as working from home, caring for young children, and homeschooling older children and teens.

TIMELINE OF BEHAVIORAL HEALTH PRIORITIES

The following tables show the potential psychological impacts and when they may appear in individuals. These tables may help guide timing of psychological and other types of support offered.

Table 6: Professional Considerations for Behavioral Health Providers (Group 3)

	Month of Outbreak	**3 Months Post-Outbreak**	**6 Months Post-Outbreak**	**9 Months Post-Outbreak**	**12 Months Post-Outbreak**
Emotional (of patients)	Fear Grief Anger	Fear Anger Grief Increased clinical symptoms	Sadness Grief Increased clinical symptoms	Depression Anxiety PTSD	Depression Anxiety PTSD Grief
Cognitive (of patients)	Confusion	Catastrophic thinking Clinical decompen-sation[†] in patients	Hopelessness or false optimism (e.g., thinking everything will get back to the way it was)	Hopelessness Helplessness	Increased anxiety, if second pandemic wave occurs Recovery & hopefulness, if pandemic subsides
Behavioral (of patients)	Surge of patients Aggression Isolation Substance use Relationship issues	Surge of patients Substance use Interpersonal violence Isolation Relationship issues	Surge of patients Substance use Interpersonal violence Isolation Relationship issues	Increased suicide risk	Increased suicide risk

[†] *Decompensation* is an increase in symptoms and a loss in ability to function in a healthy way.

Table 7: Personal Considerations for Behavioral Health Providers (Group 3)

	Month of Outbreak	3 Months Post-Outbreak	6 Months Post-Outbreak	9 Months Post-Outbreak	12 Months Post-Outbreak
Emotional (of self)	Feeling overwhelmed	Burnout Anxiety	Burnout Depression	Depression Grief	Grief
Cognitive (of self)	Confusion Distraction Frustration	Confusion Distraction Frustration	Frustration	Frustration	Hopelessness Helplessness
Behavioral (of self)	Absenteeism Consideration of leaving profession	Withdrawal Change in approach to practice	Decreased self-care Withdrawal Increased substance use Relationship problems	Increased suicide risk	Change in practice, if second pandemic wave occurs Adjustment to the new normal, if pandemic subsides

SUPPORT STRATEGIES

This section provides best practices for increasing resilience in behavioral health providers, including those for both their professional and personal lives. These are presented as tips that employers or organizations serving the group can share with individuals within the group. Consider integrating these practices and considerations into your organization's strategy for supporting staff and clients.

Professionally

Tips to share with behavioral health providers for help managing their professional life:

- If you are in a supervisory or managerial role:
    - Lead by example with mandatory and systematic work breaks (on a reasonable schedule). Offer verbal support for colleagues.
    - Uphold boundaries by not calling on staff when they are off duty or taking breaks.
    - Create strict and measured work rotations between higher and lower stress work functions.
    - Develop and share awareness and training around the cycle of disaster responses (with particular focus on the disillusionment phase 6-9 months post-outbreak when depression and suicide increase).

- Maintain on-duty boundaries for work time. Include breaks on work schedule.
- Develop off-duty boundaries around taking calls and availability when not on duty. Boundaries are important.
- Take time to highlight the impact your work is having on others. Celebrate victories when possible (even little ones).
- Cultivate a group of coworkers that are supportive, and maintain these relationships.
- Avoid professional isolation by engaging with colleagues while maintaining social distancing (e.g., virtual get-togethers, online consult and affinity groups, and online huddle-style meetings to share information and lessons learned).
- If your organization has an Employee Assistance Program (EAP), take advantage of the resources offered for personal support and therapy.

Personally

Tips to share with behavioral health providers for help managing their personal life:

- Try to eat regular, nourishing meals.
- Maintain a regular sleep schedule to the best of your ability. When possible, have the same wake up and bedtime each day. Avoid screens for an hour prior to sleep.
- Exercise when you are able.
- Structure your time as much as possible so that on and off duty schedules are very clear.
- Develop and practice clear boundaries. Practice ways to say "no" when necessary (e.g., "I don't have time," "I don't work with this issue," "It is my practice to refrain from responding to emails on rest days," etc.).
- Develop a plan for what works for you as an individual when it comes to self-care. Create a schedule and try to add one thing each day you enjoy doing.
- Mindfulness practices (e.g., meditation and breathing practices) can be helpful.
- Engage with any spiritual practices you enjoy and find helpful.
- If possible, find a creative outlet to engage in during downtime.
- List things you can do during time off that are completely unrelated to work (e.g., rewatch your favorite show, teach yourself a new hobby using online resources, get lost in a book).
- If you have a personal history of trauma, consider professional care services to help process your own history of trauma.
- Avoid unhealthy coping practices, such as drinking too much alcohol.
- Stay in touch with supportive friends and family members.
- Develop a daily ten-minute family check-in where each member can share suggestions for making things better. End the check-in with what is currently going well.
- If in a relationship, set aside a few minutes daily to check in with your partner.

Group 4: Outreach Teams and Shelter Workers

This group includes outreach teams, shelter workers, and others who work with people experiencing homelessness. For both workers and people experiencing homelessness, this section outlines the unique behavioral health considerations and timeline of behavioral health priorities. Additionally, strategies for supporting outreach teams and shelter workers are included.

UNIQUE BEHAVIORAL HEALTH CONSIDERATIONS

Bottom Line Up Front

Outreach teams and shelter workers may:

- Be at high risk of burnout, compassion fatigue, and stress.
- Need additional systemic support from employers and colleagues who can check in regularly about how things are going.
- Need clear information and training about how to protect themselves in an exposure situation, how to use personal protective equipment (PPE), and what procedures to follow.

An estimated 22,000 people are experiencing homelessness in Washington, a number that increased dramatically in recent years. This number includes 1,700 homeless families, 1,600 homeless Veterans, nearly 5,000 experiencing chronic homelessness, and 2,000 homeless youth.[50,51] For older adults, physical and mental deterioration increases rapidly. Homeless adults in their 50s experience impairments equivalent to homed adults in their mid-70s.[52]

Unsheltered individuals, such as those living in encampments, exhibit much higher rates of co-occurring conditions compared to individuals in shelters. This includes rates of physical impairments (84%), mental health impairments (78%), substance use disorders (75%), and all three impairments (50%).[52,53] Those working with people experiencing homelessness have risks associated with compassion fatigue and burnout due to the complex and chronic problems involved with homelessness.[54,55]

Personal Factors

Factors that affect people experiencing homelessness include:

- Resource scarcity, such as food and financial insecurity due to a decrease in active volunteer groups.
- Loss of personal possessions.
- Lack of access to sanitization materials (e.g., personal hygiene, sterilization of needles, clean clothes, etc.).
- Lack of access to proper nutrition.
- Lack of access to safe, dry, clean housing.
- Lack of access to weather-appropriate clothing and shoes.
- Lack of routine.

- Fear of infection.
- Lack of access to healthcare.
- Lack of access to medications and support for mental illnesses.
- Dangers associated with alcohol withdrawal.
- Dangers associated with drug overdose.
- Lack of access to office supplies (e.g., computer, internet, cell phone) to complete paperwork online for government assistance, medical care, participation in telehealth, etc.

Factors that affect outreach teams and shelter workers include:

- Fear of infection or of bringing infection to their household members.
- Changes in work routines due to COVID-19 infection within encampments or shelters.
- Decreased support and increased responsibilities due to community volunteers and organizations not being able to help.
- Responsibility to support individuals who have co-occurring disorders (e.g., substance use and underlying mental health diagnoses).
- Uncertainty of best practices during community wide outbreaks.

TIMELINE OF BEHAVIORAL HEALTH PRIORITIES

The following tables show the potential psychological impacts and when they may appear in individuals. These tables may help guide timing of psychological and other types of support offered.

Table 8: Professional Considerations for Outreach Teams and Shelter Workers (Group 4)

	Month of Outbreak	**3 Months Post-Outbreak**	**6 Months Post-Outbreak**	**9 Months Post-Outbreak**	**12 Months Post-Outbreak**
Emotional **(of people experiencing homelessness)**	Fear Uncertainty	Fear Uncertainty Depression	Anxiety Depression PTSD	Anxiety Depression PTSD	Anxiety Depression PTSD
Cognitive **(of people experiencing homelessness)**	Confusion	Confusion Decreased cognitive skills	Cognitive decompen-sation	Cognitive decompen-sation	Cognitive decompen-sation

	Month of Outbreak	3 Months Post-Outbreak	6 Months Post-Outbreak	9 Months Post-Outbreak	12 Months Post-Outbreak
Behavioral (of people experiencing homelessness)	Acting out Withdrawal Unhealthy isolation Increased used of substances	Acting out Withdrawal Unhealthy isolation Increased use of substances Difficulty managing ADL[‡]	Increased severe mental health symptoms (e.g. psychotic symptoms) Difficulty managing ADL	Increased severe mental health symptoms (e.g., psychotic symptoms) Difficulty managing ADL	Increased severe mental health symptoms (e.g., psychotic symptoms) Difficulty managing ADL

Table 9: Personal Considerations for Outreach Teams and Shelter Workers (Group 4)

	Month of Outbreak	3 Months Post-Outbreak	6 Months Post-Outbreak	9 Months Post-Outbreak	12 Months Post-Outbreak
Emotional (of self)	Fear Uncertainty Exhaustion	Fear Uncertainty Depression Grief Irritable	Fear Uncertainty Depression Grief Irritable	Anxiety Depression PTSD	Emotional disorder, if second pandemic wave occurs Resilience, if pandemic subsides
Cognitive (of self)	Confusion	Memory impacts Decision-making difficulties	Memory impacts Decision-making difficulties	Distraction Negative thinking	Distraction and negative thinking, if second pandemic wave occurs Goal setting, if pandemic subsides

[‡] *ADL*: Activities of daily living

	Month of Outbreak	3 Months Post-Outbreak	6 Months Post-Outbreak	9 Months Post-Outbreak	12 Months Post-Outbreak
Behavioral (of self)	Increased stress responses Absenteeism	Withdrawal Burnout Hyperactive anxious Leaving job	Withdrawal Burnout Hyperactive anxious Leaving job	Increased suicide risk	Decreased self-care, if second pandemic wave occurs Increased self-care, if pandemic subsides

SUPPORT STRATEGIES FOR PEOPLE EXPERIENCING HOMELESSNESS

To increase resilience in people experiencing homelessness:

- Monitor public health guidance updates from the local health department, Washington State Department of Health, and Centers for Disease Control and Prevention (CDC) for best practices in continuing to serve and support people experiencing homelessness.
- Encourage shelter residents to access mental health and substance use disorder assistance.
- Approach substance use disorders from a harm reduction model, which emphasizes safety over abstinence in the short term.
- Encourage shelter residents to maintain a regular schedule.
- Encourage shelter residents to engage in social activities while following social distancing guidelines.

SUPPORT STRATEGIES FOR OUTREACH TEAMS AND SHELTER WORKERS

This section provides best practices for increasing resilience in outreach teams and shelter workers, including those for both their professional and personal lives. These are presented as tips that employers or organizations serving the group can share with individuals within the group.

Professionally

Tips to share with outreach teams and shelter workers for help managing their professional life:

- Create strict and measured work rotations between higher and lower stress work functions.
- If you are in a supervisory or managerial role:
    - Lead by example with mandatory and systematic work breaks (on a reasonable schedule), and offer verbal support for colleagues.
    - Uphold boundaries by not calling on staff when they are off duty or taking breaks.

    - Develop and share awareness and training around the cycle of disaster responses (with particular focus on the disillusionment phase 6-9 months post-outbreak when depression and suicide increase).
- Maintain on-duty boundaries for work time. Include breaks on work schedule.
- Develop off-duty boundaries around taking calls and availability when off duty. Boundaries are important.
- Take time to highlight the impact your work is having on others. Celebrate victories when possible (even little ones).
- Cultivate a group of coworkers that are supportive, and maintain these relationships.
- Avoid professional isolation by engaging with colleagues while maintaining social distancing (e.g., virtual get-togethers, online consult and affinity groups, and online huddle-style meetings to share information and lessons learned).
- If your organization has an Employee Assistance Program (EAP), take advantage of the resources offered for personal support and therapy.

Personally

Tips to share with outreach teams and shelter workers for help managing their personal life:

- Try to eat regular, nourishing meals.
- Maintain a regular sleep schedule to the best of your ability. When possible, have the same wake up and bedtime each day. Avoid screens for an hour prior to sleep.
- Exercise when you are able.
- Structure time as much as possible so that on and off duty schedules are very clear.
- Develop and practice clear boundaries. Practice ways to say "no" when necessary (e.g., "I don't have time," "I don't work with this issue," "It is my practice to refrain from responding to emails on rest days," etc.).
- Develop a plan that works for you as an individual when it comes to self-care. Create a schedule and try to add one thing each day you enjoy doing.
- Mindfulness practices (e.g., meditation and breathing practices) can be helpful.
- Engage with any spiritual practices you enjoy and find helpful.
- If possible, find a creative outlet to engage in during downtime.
- List things to do during time off that are completely unrelated to work (e.g., rewatch your favorite show, teach yourself a new hobby using online resources, get lost in a book).
- If you have a personal history of trauma, consider professional care services to help process your own history of trauma.
- Avoid unhealthy coping practices, such as drinking too much alcohol.
- Stay in touch with supportive friends and family members.
- Develop a daily family check-in, where each member can share suggestions for making things better. End the check-in with what is currently going well.
- If in a relationship, set aside a few minutes daily to check in with your partner.

Group 5: Businesses and Workers

This group includes the many businesses and workers in Washington. This section outlines the unique behavioral health considerations, timeline of behavioral health priorities, and strategies for supporting businesses and workers.

UNIQUE BEHAVIORAL HEALTH CONSIDERATIONS

Bottom Line Up Front

Employers and workers may be:

- At risk for job stress due to changes in roles and business practices.
- Experiencing financial risk associated with company closures due to COVID-19.
- Managing their role as employer, while balancing care for employees with realities of business changes and closures.
- Experiencing isolation from colleagues who can't be present in person.

Job stress is a risk factor for this group.[35] Professional isolation experienced by members of this group due to the pandemic further increases risk.[56] Businesses and workers have stressors associated with potential illness with COVID-19. However, the resulting economic and job effects add additional stress, and sometimes more stress than the pandemic itself. Workers and businesses are dealing with a situation that is less predictable and more devastating than the most recent financial crisis in 2008. The sudden closures of entire industries for undetermined times, teleworking while also having children home, and financial pressures due to ongoing expenses while businesses are unable to generate income are just a few of the factors which can create significant behavioral health impacts. The rates of "death by despair" (suicides and overdoses related specifically to unemployment rates) have risen sharply since 2010.[57] Those deaths primarily manifest in white, middle-aged to senior males.

An additional consideration is the likelihood of a second or third pandemic wave presenting around the same time businesses could be recovering. Some companies will shut and never re-open. Older workers may discover they will not be re-hired. Entry-level workers, including students who have just completed college or trade schools, may find more barriers to entering the workforce.

Modeling of the economic impact due to COVID-19 and the governmental response predicts a record decline of gross domestic product (GDP) in the second quarter of 2020 (30.1% drop) with economic "pain" in the first half of 2020.[57] We might expect an increase in mental health impacts to follow those lines, with an increase in depression, anxiety, suicidality, and substance misuse through early fall 2020. There is already a substantial increase in drug usage and suicide among middle-aged men, which is likely to increase.[57]

If a second pandemic wave presents prior to the development of a vaccine, it is predicted there will be a similar shutdown of businesses and schools as occurred in spring of 2020. This may push many individuals and families beyond their capability to adapt. Behavioral health impacts in the late months of 2020 may be focused on recovery. However, if an additional pandemic

wave occurs and there are subsequent economic and social consequences for most of the population, the focus may shift to a "disaster cascade" where secondary effects have a greater impact than the pandemic itself.

Personal Factors

Factors that affect both workers and employers:

- Loss or change of identity and status
- Lack of routine
- Financial instability and fear

TIMELINE OF BEHAVIORAL HEALTH PRIORITIES

The following table shows the potential psychological impacts and when they may appear in individuals. This table may help guide timing of psychological and other types of support offered.

Table 10: Personal Considerations for Businesses and Workers (Group 5)

	Month of Outbreak	**3 Months Post-Outbreak**	**6 Months Post-Outbreak**	**9 Months Post-Outbreak**	**12 Months Post-Outbreak**
Emotional	Fear Anger	Anxiety Grief Depression	Anxiety Grief Depression	Anxiety Depression Anger Suicidal thoughts or actions	Anxiety, grief, depression, if second pandemic wave occurs Adjustment to the new normal, if pandemic subsides

	Month of Outbreak	3 Months Post-Outbreak	6 Months Post-Outbreak	9 Months Post-Outbreak	12 Months Post-Outbreak
Cognitive	Confusion	Catastrophic thinking	Apathy	Unable to envision future Catastrophic thinking	Unable to envision future, catastrophic thinking, if second pandemic wave occurs Initiating planning for future, if pandemic subsides
Behavioral	Absenteeism Aggression	Withdrawal Unhealthy coping (e.g., drinking too much) Relationship problems	Withdrawal Unhealthy coping (e.g., drinking too much) Relationship problems	Withdrawal Unhealthy coping (e.g., drinking too much)	Withdrawal, unhealthy coping, if second pandemic wave occurs Establishment of new routines, if pandemic subsides

SUPPORT STRATEGIES

This section provides best practices for increasing resilience in businesses and workers, including those for both their professional and personal lives. These are presented as tips that employers or organizations serving the group can share with individuals within the group. Consider integrating these practices and considerations into your organization's strategy for supporting staff and clients.

Professionally

Tips to share with workers for help managing their professional life:

- Plan for your professional future. Consider options in case the business or employer is unable to rehire or reopen.

- Avoid professional isolation by engaging with colleagues while maintaining social distancing (e.g., virtual get-togethers, online consult and affinity groups, and online huddle-style meetings to share information and lessons learned).
- Update professional resume and professional networking profile.
- Reach out to work contacts to explore employment options.
- Consider additional options during downtime, such as classes or certifications.

Personally

Tips to share with employers and workers for help managing their personal life:

- Try to eat regular, nourishing meals.
- Maintain a regular sleep schedule to the best of your ability. When possible, have the same wake up and bedtime each day. Avoid screens for an hour prior to sleep.
- Exercise when you are able.
- If possible, find a creative outlet to engage in during downtime like practicing hobbies.
- Engage with any spiritual practices that you enjoy and find helpful.
- Consider online support groups if struggling with economic or work-related impacts of COVID-19.
- Avoid unhealthy coping practices, such as drinking too much alcohol.
- If in a relationship, set aside a few minutes daily to check in with your partner.
- Look for ways to volunteer and support your community during business closures.

Group 6: Educators

This group includes teachers, paraeducators, principals, and administrative staff. This section outlines the unique behavioral health considerations, timeline of behavioral health priorities, and strategies for supporting educators.

UNIQUE BEHAVIORAL HEALTH CONSIDERATIONS

Bottom Line Up Front

Educators may be:

- At risk for job stress due to changes in roles and teaching practices.
- Required to modify curriculum almost entirely to accommodate virtual learning.
- Managing their role as educator while also having children at home.
- Experiencing isolation from colleagues who can't be present in person.
- Experiencing uncertainty about how schools will be functioning in the future.

Job stress is typically a risk factor for this group.[58,59] Educators revised entire curricula due to the demands of schools closing and the switch to online learning. In addition, many have to learn entirely new technology, some with little input and instruction on the technical side.

Teachers are adapting to extensive changes in the ways they are used to teaching, often while answering many emails from parents struggling with how to support their children's education at home. Special education teachers have additional complexities trying to meet the educational needs of students who often require increased personal attention and federally-mandated services. Administrators and parents may have the expectation that distance learning will mimic standard classroom learning, which is unlikely to be feasible. With ongoing changes to plans for re-opening the state, it is difficult for schools to do intensive planning for the upcoming school year, leading to increased uncertainty.

In disaster situations, increased reports of domestic violence and abuse is typical. School settings are one of the primary settings where potential child abuse or other familial issues are observed and presented. When students are not present in schools, the chance of noticing and intervening decreases dramatically. Teachers may want to be particularly vigilant to student appearance and demeanor on video chats, extensive absences from schoolwork or online meetings, and other indicators that may suggest a child is at risk.

While virtually teaching a classroom of students from home, some teachers also have to balance this with the demands of having their own children at home, which creates an even higher professional and personal stress level. Isolation from colleagues and students may additionally increase risks for emotional impact.

Personal factors could include:

Factors that impact educators:

- Loss or change of job roles and expectations
- Lack of routine
- Isolation from colleagues and students
- Increased risk of professional burnout

TIMELINE OF BEHAVIORAL HEALTH PRIORITIES

The following table shows the potential psychological impacts and when they may appear in individuals. This table may help guide timing of psychological and other types of support offered.

Table 11: Personal Considerations for Educators (Group 6)

	Month of Outbreak	3 Months Post-Outbreak	6 Months Post-Outbreak	9 Months Post-Outbreak	12 Months Post-Outbreak
Emotional	Fear Uncertainty	Anxiety Frustration Depression	Anxiety Frustration Depression Exhaustion	Anxiety Depression Anger	Anxiety, anger, depression, if second pandemic wave occurs Adjustment to the new normal, if pandemic subsides

	Month of Outbreak	3 Months Post-Outbreak	6 Months Post-Outbreak	9 Months Post-Outbreak	12 Months Post-Outbreak
Cognitive	Confusion Information overload	Difficulty with multitasking and focus	Decreased motivation	Unable to envision future Catastrophic thinking	Unable to envision future, catastrophic thinking, if second pandemic wave occurs Initiating planning for future, if pandemic subsides
Behavioral	Overworking	Withdrawal Unhealthy coping Lack of exercise Job burnout	Withdrawal Unhealthy coping Questioning career change	Withdrawal Unhealthy coping Decreased motivation	Withdrawal, unhealthy coping, if second pandemic wave occurs Establishment of new routines, if pandemic subsides

SUPPORT STRATEGIES

This section provides best practices for increasing resilience in educators, including those for both their professional and personal lives. These are presented as tips that employers or organizations serving the group can share with individuals within the group. Consider integrating these practices and considerations into your organization's strategy for supporting staff and clients.

Professionally

Tips to share with educators for help managing their professional life:

- Explore and share resources for effective and equitable teaching that follows social distancing guidelines.

- Avoid professional isolation by engaging with colleagues while maintaining social distancing (e.g., virtual get-togethers, online consult and affinity groups, and online huddle-style meetings to share information and lessons learned).
- Encourage development of effective team building between teachers and administrators.
- If in a supervisory position, model and encourage boundaries around time and duties. Convey these boundaries and expectations to parents.
- Reach out to parent-teacher organizations and other schools to facilitate discussions on emerging best practices for distance learning.

Personally

Tips to share with educators for help managing their personal life:

- Try to eat regular, nourishing meals.
- Maintain a regular sleep schedule to the best of your ability. When possible, have the same wake up and bedtime each day. Avoid screens for an hour prior to sleep.
- Exercise when you are able.
- Engage with any spiritual practices you enjoy and find helpful.
- Maintain firm boundaries between work and leisure time.
- If possible, find a creative outlet to engage in during downtime, like practicing hobbies.
- Avoid unhealthy coping practices, such as drinking too much alcohol.
- If in a relationship, set aside a few minutes daily to check in with your partner.
- Look for ways to decrease isolation, such as virtual get-togethers with friends and online book clubs.

Group 7: Families and Children

This group includes families, parents, guardians, caregivers, and children (infant through adolescent). This section outlines the unique behavioral health considerations, timeline of behavioral health priorities, and strategies for supporting families and children.

UNIQUE BEHAVIORAL HEALTH CONSIDERATIONS

Bottom Line Up Front

Individuals in this group may experience:

- Social isolation from family, friends, and other social supports.
- Lack of consistent routines.
- Lack of peer engagement (especially for teens).
- Educational impacts.
- Inability to access specialized services for children with disabilities or other neurodevelopmental challenges.
- Lack of exercise.

The experience of children, adolescents, and families during the COVID-19 pandemic is complicated and fraught with challenges. Parents and children may become ill. Some families will experience job loss and financial worries about housing and basic expenses, such as food and insurance. Parents, children, and teens may lose contact with friends and family due to social isolation. They may worry about older adults or other family members who are at increased risk of serious illness and death from COVID-19. Teens may wonder about how the impacts on their future since they are missing important education in high school and milestone events like graduation. Divorced parents must co-parent in the times that require social distancing and restricted travel. Families may have members with mental health or substance use disorders, which may get worse due to the stress of COVID-19.[60]

TIMELINE OF BEHAVIORAL HEALTH PRIORITIES

The following table shows the potential psychological impacts and when they may appear in individuals. This table may help guide timing of psychological and other types of support offered.

Table 12: Families and Children (Group 7)

	Month of Outbreak	3 Months Post-Outbreak	6 Months Post-Outbreak	9 Months Post-Outbreak	12 Months Post-Outbreak
Emotional	Anxiety Grief	Anxiety Depression	Anxiety Depression Increased risk of suicide	Anxiety Depression Increased risk of suicide	Heightened anxiety and depression, if second pandemic wave occurs Coping and recovery, if pandemic subsides
Cognitive	Confusion	Confusion Problems with attention, concentration, and memory	Apathy Decreased interest and involvement in learning Difficulty in job tasks	Apathy Decreased interest and involvement in learning Difficulty in job tasks	Skills deficits, academic failures, employment challenges, if second pandemic wave occurs Increased future planning and competency, if pandemic subsides
Behavioral	Acting out Withdrawal	Developmen-tal regression Increased substance use disorders Increased domestic violence and child abuse	Acting out Withdrawal Increased substance use disorders Increased domestic violence and child abuse	Hopelessness Lack of planning for future Frustration due to economic stress Suicide	Hopelessness, lack of planning for future, if second pandemic wave occurs Development of coping, if pandemic subsides

SUPPORT STRATEGIES

This section provides best practices for increasing resilience in families and children, including those for families, parents, caregivers, and children (infant through adolescent).

For Families

- Develop a flexible but consistent daily schedule. This helps things feel less out of control and can be reassuring to the whole family.
- Find creative ways to stay connected with your family (e.g., video chat, board games, and puzzles).
- Try to provide reassurance to family members through kind words and closeness.
- Don't worry about "spoiling" a sick child or teen.
- Organize predictable and consistent check-ins with children and teens.
- Set time aside to spend with each child individually (even just 20 minutes).
- When possible, give your children choices.
- Praise your child when they are behaving well.
- Encourage social interactions while following social distancing guidelines. This could include video chats, online multiplayer video games, neighborhood scavenger hunts (e.g., placing objects or chalk drawings to find), etc.

For Parents and Caregivers

- Try to eat regular, nourishing meals.
- Maintain a regular sleep schedule to the best of your ability. When possible, have the same wake up and bedtime each day. Avoid screens for an hour prior to sleep.
- Exercise when you are able.
- If possible, find a creative outlet to engage in during downtime.
- Engage with spiritual practices that you enjoy and find helpful.
- Stay in touch with supportive friends and family members.
- Develop a daily, ten-minute family check-in where each member can share suggestions for making things better. End the check-in with what is currently going well.
- If in a relationship, set aside a few minutes daily to check in with your partner.

For Infants, Toddlers, and Preschoolers

- Provide regular, nourishing meals.
- When possible, have the same wake up and bedtime each day. Avoid screens for an hour prior to sleep.
- Provide reassurance through physical closeness and comforting movements, such as rocking or swaying while holding.
- If possible, find a creative outlet to engage in, such as baking, "painting" the house with a paintbrush and bucket of water, and sensory play with a bin filled with rice.

- Provide verbal reassurance (for children who understand language).
- If possible, video chat with friends and family.

For School-age Children

- Provide regular, nourishing meals.
- Maintain a regular sleep schedule to the best of your ability. When possible, have the same wake up and bedtime each day. Avoid screens for an hour prior to sleep.
- Provide opportunities for exercise. Spend time outside when possible.
- If possible, find a creative outlet to engage in, such as writing and illustrating a book about pandemic experiences from a kid's perspective, drawing sidewalk chalk messages for neighbors, cooking, and baking.
- Provide verbal reassurance, but avoid unnecessary exposure to adult conversations and stressors.
- Engage children in spiritual practices you've found helpful for children.
- Set gentle but firm limits.
- If possible, video chat with friends and family.

For Adolescents

- Provide regular, nourishing meals.
- Maintain a regular sleep schedule to the best of your ability. When possible, have the same wake up and bedtime each day. Avoid screens for an hour prior to sleep.
- Provide opportunities for exercise. Spend time outside when possible.
- If possible, find a creative outlet to engage in during downtime, such as creating a video diary, and writing songs, stories, or poems.
- Engage children in spiritual practices that you've found helpful for adolescents.
- Provide verbal reassurance, but avoid unnecessary exposure to adult conversations and stressors.
- Stay in touch with supportive friends and family members.
- If possible, video chat with friends and family.
- Help children find ways of helping with family responsibilities and assisting neighbors and the community while following social distancing guidelines.
- Have children create a list of "When the pandemic is over, I will…".

Group 8: Individuals Post-Critical Care Hospitalization

This section outlines the unique behavioral health considerations, timeline of behavioral health priorities, and strategies for individuals recovering after critical care hospitalization.

UNIQUE BEHAVIORAL HEALTH CONSIDERATIONS

Bottom Line Up Front

Individuals recovering after critical care hospitalization may be at risk for:

- Complex medical needs, such as occupational therapy, physical therapy, psychiatry, and speech therapy for up to 12 months after discharge.
- Inability to return to pre-critical care levels of functioning, including inability to return to work within 12 months.
- New challenges with activities of daily living (ADL).
- High risk of PTSD upon discharge from critical care.
- High risk of depression.

Post-traumatic stress disorder (PTSD) is a common psychological response for individuals that received critical care.[61] A significant number of COVID-19 positive individuals require critical care, a trend consistent across China (7-26% of cases), Italy (5-12%), and the United States (5-12%). Another challenge that individuals face after discharging from critical care is post-intensive care syndrome (PICS). PICS is diagnosed when an individual presents with a range of health problems during and after a critical illness, such as:

- Prolonged muscle weakness, known as intensive care unit (ICU)-acquired weakness.
- Cognitive dysfunction (e.g., problems with attention, concentration, thinking, memory, problem-solving, judgement, planning, and organization).
- Problems with mood management.
- Other mental health challenges.

TIMELINE OF BEHAVIORAL HEALTH PRIORITIES

The following table shows the potential psychological impacts and when they may appear in individuals. This table may help guide timing of psychological and other types of support offered.

Table 13: Individuals Post-Critical Care Hospitalization (Group 8)

	Month of Outbreak	3 Months Post-Outbreak	6 Months Post-Outbreak	9 Months Post-Outbreak	12 Months Post-Outbreak
Emotional	Fearful Numb	Depression PTSD	Depression PTSD Anger	Depression PTSD Anger Hopelessness	Depression PTSD Anger Hopelessness
Cognitive	Confusion Disorientation	Problems with planning and organization	Difficulty with executive functioning	Difficulty with executive functioning	Difficulty with executive functioning
Behavioral	Difficulty with ADL[§]	Difficulty with ADL	Difficulty with ADL Avoidance and isolating behavior	Difficulty with ADL Increased risk of suicide Avoidance and isolating behavior	Difficulty with ADL Increased risk of suicide Avoidance and isolating behavior

SUPPORT STRATEGIES

This section provides best practices for increasing resilience in individuals recovering from critical care or mechanical ventilation, including strategies to apply prior to hospital discharge and those for their personal lives. Personal support strategies are presented as tips that organizations serving the group can share with individuals within the group.

Prior to Hospital Discharge

Recommended steps for discharge planners to consider:

- Create a comprehensive treatment team that includes all providers and specialties needed to assist the individual with returning to baseline functioning. This will likely include culturally-congruent care[**] through occupational therapy, speech therapy, physical therapy, psychiatry, social work (for care coordination), and psychology.

[§] *ADL*: Activities of daily living

[**] Culturally-congruent care: Patients often understand and address their behavioral health and medical needs through the lens of their cultural beliefs, values, and frame of reference. Culturally-congruent care respects and addresses the unique desires and needs of the patient and family by engaging providers who speak the patient's language and are responsive to their cultural values, norms, and traditions. Adapted from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3074191/

- Develop a clear treatment plan with measurable goals to track progress and contact information for each department represented in the treatment plan.
- Create a resource list for behavioral health needs, such as contact information for the social worker, referrals to clinicians, etc.
- Create a comprehensive behavioral health treatment plan that provides:
    - Psychoeducation regarding common experiences in individuals after critical care or mechanical ventilation (e.g., depression, PTSD, anger, helplessness, and hopelessness).
    - Effective, culturally-congruent coping skills and evidence-based interventions to reduce symptoms of trauma and depression, such as Cognitive Processing Therapy (CPT) and Trauma-focused Cognitive Behavioral Therapy (CBT).

Personally

Tips to share with individuals after critical care hospitalization for help managing their personal life:

- Try to eat regular, nourishing meals.
- Maintain a regular sleep schedule to the best of your ability. When possible, have the same wake up and bedtime each day. Avoid screens for an hour prior to sleep.
- If possible, find a creative outlet to engage in during downtime.
- Engage with any spiritual practices you enjoy and find helpful.
- Avoid isolation by reaching out to others and joining virtual groups.
- Stay in touch with supportive friends and family members.
- Utilize resources, such as a speech therapist, occupational therapist, physical therapist, and psychologist or psychiatrist to help you with the following:
    - Gain more understanding of your current level of functioning.
    - Develop coping skills.
    - Create a treatment plan to help you achieve your goals for independent living and returning to work.

More COVID-19 Information and Resources

Stay up-to-date on the current COVID-19 situation in Washington, Governor Inslee's proclamations, symptoms, how it spreads, and how and when people should get tested. See our Frequently Asked Questions for more information.

A person's race/ethnicity or nationality does not, itself, put them at greater risk of COVID-19. However, data are revealing that communities of color are being disproportionately impacted by COVID-19 – this is due to the effects of racism, and in particular, structural racism, that leaves some groups with fewer opportunities to protect themselves and their communities. Stigma will not help to fight the illness. Share accurate information with others to keep rumors and misinformation from spreading.

- WA State Department of Health 2019 Novel Coronavirus Outbreak (COVID-19)
- WA State Coronavirus Response (COVID-19)
- Find Your Local Health Department or District
- CDC Coronavirus (COVID-19)
- Stigma Reduction Resources

Have more questions about COVID-19? Call our hotline: **1-800-525-0127,** Monday – Friday, 6 a.m. to 10 p.m., Weekends: 8 a.m. to 6 p.m. For interpretative services, **press #** when they answer and **say your language.** For questions about your own health, COVID-19 testing, or testing results, please contact a health care provider.

Acknowledgements

This document was developed by the Washington State Department of Health's Behavioral Health Strike Team for the COVID-19 response. The strike team is a group of clinical psychologists, psychiatrists, and therapists who are professionals in disaster relief and behavioral health. Contributing authors include Tona McGuire, Ph.D., Matt Brickell, Psy.D., Kira Mauseth, Ph.D., and Stacy Cecchet, Ph.D., ABPP.

Appendix A: Symptom Descriptions and Examples

Examples (Alphabetical)	Emotional	Cognitive	Behavioral
Anxiety/Panic	Fear Significant worry Anger Overwhelming sense that something bad will happen (i.e., impending doom) Feeling disorganized or "out of sorts"	Worry about things that remind the person of the event, such as locations, smells, weather patterns, anniversary of events Brain seems like it is "stuck" on worrisome thoughts Difficulty concentrating Catastrophic thinking Difficulty with retrieving information and words Trouble remembering	Physical symptoms such as: ● Rapid heart rate ● Trouble breathing ● Headaches ● Stomach aches ● Nausea ● Restlessness ● Dizziness Difficulty sleeping Feeling as if they may be having a heart attack Going out of their way to avoid people, places, or things that are associated with the event
Depression	Low mood Excessive sadness Anger/Irritability Guilt Grief Hopelessness	Trouble concentrating Word finding problems, trouble remembering	Withdrawal from social activities and friends — they don't seem to want to do any of the things that they used to enjoy Frequent tearfulness Yelling Sleeping too much or too little Eating too much or too little Increased alcohol and drug use May seem blank or numb

Examples (Alphabetical)	Emotional	Cognitive	Behavioral
Grief (loss) for Adults	Bereavement Sadness Anger Guilt Depression Shock Denial Disbelief	Obsessing over memories	Frequent tearfulness May seem blank or numb
Grief (loss) for Kids	Sadness and depression Anxiety Anger	Trouble concentrating and paying attention Forgetfulness Difficulty learning new things Loss of developmental milestones, regressing to a younger stage of development (e.g., bedwetting, inability to dress independently)	Acting out: • Tantrums • Aggression • Risk taking • Noncompliance Or Acting in: ● Withdrawing ● Quiet ● Tearful ● Clingy Physical symptoms such as: ● Stomach aches ● Headaches ● Nausea Trouble sleeping, bad dreams

Examples (Alphabetical)	Emotional	Cognitive	Behavioral
Hopelessness	Low mood Feelings of powerlessness Feelings of abandonment and isolation	Lack of hope for the future, lack of optimism No expectation of positive changes, improvements, or success	Helplessness, unable/unwilling to help self with problem solving Numb, no longer experience a range of emotions, such as happiness, or even sadness Loss of interest in previously enjoyed activities and people
Substance Use	Depression Anxiety Anger Irritability	Using drugs or drinking is continued even though they know and recognize that their use is causing problems in their life They can't control their use of the drug or alcohol; they can't quit using it, even if they want to	Increased tolerance (i.e., they seem to need more and more drugs or alcohol over time in order to feel "high" or drunk) and/or Withdrawal symptoms (i.e., they physically feel sick when not able to use drugs or drink alcohol; they use more drugs or more alcohol than they intend to) They spend a lot of time or energy trying to find, buy, pay for, use, or recover from the drug or alcohol They have trouble at work, at home, in personal relationships with friends, or activities because of their use of drugs or alcohol

Examples (Alphabetical)	Emotional	Cognitive	Behavioral
Suicide *See Appendix B for additional information	Feelings of helplessness or hopelessness	Negative view of themselves, their future, and the world Wishing they could disappear or no longer exist Thinking their family or friends would be better off without them	A sudden, unexplained recovery from a severe depression Putting affairs in order, such as writing a will, or giving away possessions Writing a suicide note Decline in hygiene and self-care behaviors
Trauma (general)	Extremely fearful of things that remind them about the event Feeling numb Anxiety, constant worry Depression Panic Anger	Trouble concentrating Trouble remembering Confusion Feeling disorganized Feeling overwhelmed Problems with initiating and completing tasks Being unable to remember big pieces of the event- large chunks of time are missing from their memory of the event	Images, dreams, and/or memories of a traumatic event that cause the person to re-experience the event long after it has happened Believing, from day-to-day, that the event is happening again, and that they are reliving it Nightmares and trouble sleeping Avoiding, or trying to avoid, anything associated with the events, such as feelings, people, places, activities, etc. Withdrawal from social activities and friends – they don't seem to want to do any of the things that they used to enjoy Hyper alert and jumpy

Appendix B: Additional Information on Suicide

SUICIDE

National suicide rates are highest among adolescents, young adults, and the elderly.[3] Individuals over the age of 65 have the highest rate of suicide.[3] Although women are more likely to attempt suicide, men are more likely to complete suicide.[3] Additional at-risk individuals are listed below.

Warning signs

- Excessive sadness or moodiness
- Sudden calmness
- Suddenly improved mood
- Sudden withdrawal or isolation
- Recent trauma or life crisis
- Notable changes in behavior or appearance
- Giving away belongings or giving gifts to others
- Dangerous self-harm behavior
- Explicit threats to complete suicide
- A plan for how they might complete suicide
- A means for how they would complete suicide, especially one that fits their plan and is feasible
- A timeframe for when they would complete suicide
- Access to highly lethal methods, such as a firearm, other weapons, or poison

At-risk Individuals

- People with a personal history of previous suicide attempts
- People with a family history of suicide, or a relative, close friend, or coworker who has completed suicide
- Older individuals who have lost a spouse recently (e.g., lost due to death or divorce)
- People with a history of sexual, physical, or emotional abuse
- People who are unmarried
- People who are unemployed
- People with substance use problems
- People with long-term pain, disability, or terminal illness
- People recently released from psychiatric hospitalization
- People who are at risk to witness death or loss on the job (e.g., law enforcement or healthcare workers working with terminally ill patients)

Washington

Within the United States, Washington has a higher rate of suicide than the national average.[62] National and Washington suicide rates have been increasing since 2005.[63] Additional suicide statistics of note:

- Annual suicide rates are approximately 17 per 100,000 deaths.[62]
- Suicide is the second leading cause of death for 10-24 year olds.
- American Indians and Alaska Natives die by suicide at a higher rate than every other ethnic and racial group.[64,65,66]
- From 2012–2015, 77% of suicide deaths were males.[64]

References

1. Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Washington, Volume 5: Indicators as measured through the 2017 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA-19-Baro-17-WA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019.

2. Bonanno, G. A. (2004). Loss, Trauma, and Human Resilience: Have We Underestimated the Human Capacity to Thrive After Extremely Aversive Events? *American Psychologist, 59(*1), 20–28. https://doi.org/10.1037/0003-066X.59.1.20

3. Norris F. R., Friedman, M.J., & Watson, P. J. (2002). 60,000 Disaster Victims Speak: Part II. Summary and Implications of the Disaster Mental Health Research, *Psychiatry, 65*(3), 240-260, DOI: 10.1521/psyc.65.3.240.20169

4. Makwana, N. (2019). Disaster and its impact on mental health: A narrative review. *Journal of family medicine and primary care, 8*(10), 3090–3095. https://doi.org/10.4103/jfmpc.jfmpc_893_19

5. Bonnanno, G. A., Galea, S., Bucciarielli, A., & Vlahov, D. (2006). Psychological Resilience after disaster: New York City in the aftermath of the September 11th terrorist attack. *Psychological Science*, *17*(3): 181-6.

6. Pew Research Center, April 2020, "About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19."

7. Phillips, Julie A. "Suicide and the Great Recession of 2007–2009: The Role of Economic Factors in the 50 U.S. States." Social Science & Medicine. 116 (2014): 22-31.

8. Meadows Mental Health Policy Institute (2020). COVID-19 Response Briefing: Mental Health and Substance Use Disorder Impacts of a COVID-19 Economic Recession. Retrieved from https://www.texasstateofmind.org/uploads/whitepapers/COVID-MHSUDImpacts.pdf

9. Substance Abuse and Mental Health Services Administration. (2015, August). Supplemental research bulletin - Issue 5: Traumatic stress and suicide after disasters. SAMHSA. https://www.samhsa.gov/sites/default/files/dtac/srb_sept2015.pdf

10. Kelly T.M, Daley D.C. Integrated Treatment of Substance Use and Psychiatric Disorders. *Soc Work Public Health.* 2013; 28(0): 388-406. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3753025/

11. Bonanno, G. A. (2004). Loss, Trauma, and Human Resilience: Have We Underestimated the Human Capacity to Thrive After Extremely Aversive Events? American Psychologist, 59(1), 20–28. https://doi.org/10.1037/0003-066X.59.1.20

12. Hobfoll, S. E., Watson, P. J., Bell, C. C., Bryant, R., Brymer, M. J., Friedman, M. J., Ursano, R. J. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. Psychiatry Interpersonal & Biological Processes, 70(4), 283-315.

13. Substance Abuse and Mental Health Services Administration. (2020, April 17). *Phases of Disaster.* https://www.samhsa.gov/dtac/recovering-disasters/phases-disaster

14. Sylwanowicz, L., Schreiber, M., Anderson, C., Gundran, C. P. D., Santamaria, E., Lopez, J. C. F., Lam, H., & Tuazon, A. C. (2018). Rapid Triage of Mental Health Risk in Emergency Medical Workers: Findings from Typhoon Haiyan. DOI: https://doi.org/10.1017/dmp.2017.37

15. Bonanno, G. A., Brewin, C. R., Kaniasty, K., & La Greca, A. M. (2010). Weighing the costs of disaster: Consequences, risks, and resilience in individuals, families, and communities. *Psychological Science in the Public Interest, 11,* 1-49. doi:10.1177/1529100610387086

16. Schreiber, M., Cates, D.S., Formanski, S. and King, M. (2019). Maximizing the Resilience of Healthcare Workers in Multi-hazard Events: Lessons from the 2014-2015 Ebola Response in Africa. *Military Medicine, 184*(1) 114-120. https://doi.org/10.1093/milmed/usy400

17. King, M., Schreiber, M., Formanski, S. Fleming, S., Bayleyegn, T.M., & Lemusu, S. S. (2012). A Brief Report of Surveillance of Traumatic Experiences and Exposures After the Earthquake-Tsunami in American Samoa, 2009. *Disaster medicine and public health preparedness*, *7*.

18. Russell, M. C. & Brickell, M. (2014). The "Double-Edge" Sword of Human Empathy: A Unifying Neurobehavioral Theory of Compassion Stress Injury. *Social Sciences 4*(4), 1087-1117. https://doi.org/10.3390/socsci4041087

19. McCray, L. Cronholm, P. F., Bogner, H.L., Gallo, J. J., & Neill, R. A. (2008). Resident physician burnout: Is there hope? *Family Medicine*, *40,* 626–32.

20. Wee, D., & Myers, D. (2002). Response of mental health workers following disaster: The Oklahoma City bombing. In *Treating Compassion Fatigue*. Edited by Charles R. Figley. New York: Brunner/Routledge.

21. Battle, L. (2012). Compassion fatigue, compassion satisfaction, and burnout among police officers who have experienced previous perceived traumas. *Dissertation Abstracts International Section A: Humanities and Social Sciences 73*:6-A.

22. Shah, S. Garland, G. Katz, C. (2007). Secondary traumatic stress: Prevalence in humanitarian aid workers in India. *Traumatology, 13*, 59-70.

23. Naig, L. (2010). *Professional Burnout and Compassion Fatigue among Early Childhood Special Education Teachers.* Ames: Iowa State University.

24. Linnerooth, P. J., Moore, B., & Mrdjenovich, A. (2011). Professional burnout in clinical military psychologists: Recommendations before, during, and after deployment. *Professional Psychology: Research and Practice, 42*, 87-93.

25. Levy, H. Conoscenti, L., Tillery, J., Dickstein, B. D., & Litz, B. T. (2011). Deployment stressors and outcomes among Air Force chaplains. *Journal of Traumatic Stress, 24*, 342-46.

26. Flannelly, J., Roberts, S. & Weaver, A. J. (2005). Correlates of compassion fatigue and burnout in chaplains and other clergy who responded to the September 11th attacks in New York City. *The Journal of Pastoral Care & Counseling, 59*, 213-24.

27. Bride, B., Jones, J., & MacMaster, S. (2007). Correlates of secondary traumatic stress in children protective services workers. *Journal of Evidence-Based Social Work, 4*, 69-80.

28. Gomez, E. and Rutledge, D. (2009). Prevalence of secondary traumatic stress among nurses. *Journal of Emergency Nursing, 35*, 199-204.

29. Meadors, P., Lamson, A., Swanson, M., White, M., & Sira, N. (2010). Secondary traumatization in pediatric healthcare providers: Compassion fatigue, burnout, and secondary traumatic stress. *Omega: Journal of Death and Dying, 60*, 103-28.

30. Tyson, J. (2007). Compassion fatigue in the treatment of combat-related trauma during wartime. *Clinical Social Work Journal, 35*, 183-92.

31. Alkema, K., Linton, J., & Davies, R. (2008). A study of the relationship between self-care, compassion satisfaction, compassion fatigue, and burnout among hospice professionals. *Journal of Social Work in End-of-Life & Palliative Care, 4*, 101-19.

32. Rosenheck, R., and Nathan, P. (1985). Secondary traumatization in children of Vietnam veterans. *Hospital & Community Psychiatry, 36*, 538-49.

33. Lynch, S. & Lobo, M. (2012). Compassion fatigue in family caregivers: A Wilsonian concept analysis. *Journal of Advanced Nursing, 68*, 2125-34.

34. Babson, K., & Feldner, M. (2010). Temporal relations between sleep problems and both traumatic event exposure and PTSD: A critical review of the empirical literature. *Journal of Anxiety Disorders, 24,* 1-15.

35. Figley, C. (1983). Catastrophes: An overview of family reactions. *In Stress and the Family, Vol. II: Coping with Catastrophe.* Edited by Charles R. Figley and Hamilton I. McCubbin. New York: Brunner/Mazel, pp. 3-20.

36. Chen, Q, Liang, M., Li, Y., Gao, J., Fei, D., Wang, L., He, L., Sheng, C., Cai, Y., Li, X., Wang, J., 7 Zhang, Z. (2020). (correspondence) www.thelancet.com/psychiatry. Published online February 18, 2020, https://doi.org/10.1016/S2215-0366(20)30078-X

37. Joinson, C. (1992). Coping with compassion fatigue. *Nursing, 22*, 116-21.

38. Back, A. L. Rushton, C. H., Kaszniak, A. W., & Halifax, J. S. (2015) "Why Are We Doing This?" Clinician Helplessness in the Face of Suffering. *Journal of Palliative Medicin*e*, 18*(1). 2015 doi:10.1089/jpm.2014.0115.

39. Rozario, D. (2019). Moral Injury: How the Wicked Problems of Healthcare Defy Solutions, Yet Require Innovative Strategies in the Modern Era. *Discussion in Surgery*. DOI:10.1503/cjs.002819

40. Edelman, S. and Fitz-Gibbon, J. New York Post. (2020, April 2). *EMTs have stopped taking people in cardiac arrest to coronavirus-strained hospitals*.

41. Schreiber, M. (2005). Learning from 9/11: Toward a national model for children and families in mass casualty terrorism. On the Ground after September 11: Mental Health Responses and Practical Knowledge Gained. 605-09.

42. Heyman, M., Dill, J., & Douglas, R. (2018). The Ruderman white paper on mental health and suicide of first responders. Retrieved from https://rudermanfoundation.org/white_papers/police-officers-and-firefighters-are-more-likely-to-die-by-suicide-than-in-line-of-duty/

43. Ballenger, J. F., Best, S. R., Metzler, T. J., Wasserman, D. A., Mohr, D. C., Liberman, A., Delucchi, K., Weiss, D. S., Fagan, J. A., Waldrop, A. E., & Marmar, C. R. (2011). Patterns and predictors of alcohol use in male and female urban police officers. *American Journal On Addictions, 20*(1), 21–29. doi: 10.1111/j.1521-0391.2010.00092.x

44. Fleischmann, M., Strode, P., Broussard, B., & Compton, M.T. (2018). Law enforcement officers' perceptions of and responses to traumatic events: a survey of officers completing Crisis Intervention Team training. *Policing and Society, 28*(2), 149-156, doi: 10.1080/10439463.2016.1234469

45. Bishopp, S. A., & Boots, D. P. (2014). General strain theory, exposure to violence, and suicide ideation among police officers: A gendered approach. *Journal of Criminal Justice, 42*(6), 538–548. doi: 10.1016/j. jcrimjus.2014.09.007

46. Blue Help. (2019). Statistics. Retrieved from https://bluehelp.org/service/statistics/

47. Ramchand, R., Saunders, J., Osilla, K.C., Ebener, P. A., Kotzias, V., Thornton, E., Strang, L., & Cahill, M. (2019). Suicide prevention in U.S. law enforcement agencies: a national survey of

current practices. *Journal of Police and Criminal Psychology, 34*, 55-66. doi:10.1007/s11896-018-9269-x

48. Ghahramanlou, M., & Brodbeck, C. (2000) Predictors of secondary trauma in sexual assault trauma counselors. *International Journal of Emergency Mental Health, 2*, 229-40.

49. Creamer, T., & Liddle, B. (2005) Secondary traumatic stress among disaster mental health workers responding to the September 11 attacks. *Journal of Traumatic Stress, 18* 89-96.

50. United States Interagency Council on Homelessness. (2019, January). *Washington Homelessness Statistics.* https://www.usich.gov/homelessness-statistics/wa

51. National Health Care for the Homeless Council. *Responding to COVID-19 Among People Experiencing Unsheltered Homelessness.* https://nhchc.org/wp-content/uploads/2020/04/NHCHC_Unsheltered-Homelessness_Final.pdf

52. Brown, R.T., Hemati, K., Riley, E.D., Lee, C. T., Ponath, C., Tieu, L., Guzman, D., & Kushel, M. B. (2017). Geriatric Conditions in a Population-Based Sample of Older Homeless Adults. *The Gerontologist, 57*(4), 757-66.

53. National Alliance to End Homelessness. *Population at Risk: Homelessness and the COVID-19 Crisis.* https://endhomelessness.org/wp-content/uploads/2020/03/Covid-Fact-Sheet-3.25.2020-2.pdf

54. McLean, S., Wade, T., & Encel, J. (2003). The contribution of therapist beliefs to psychological distress in therapists: An investigation of vicarious traumatization, burnout, and symptoms of avoidance and intrusion. *Behavioural and Cognitive Psychotherapy, 31*, 417–28.

55. Quevillon, R. P., Gray, B. L., Erickson, S. E., Gonzalez, E. D., & Jacobs, G. A. (2016). Helping the helpers: Assisting staff and volunteer workers before, during, and after disaster relief operations. *Journal of Clinical Psychology, 72*(12), 1348–63. doi: 10.1002/jclp.22336

56. Sverke, M., Hellgren, J., & Näswall, K. (2002). No security: A meta-analysis and review of job insecurity and its consequences. *Journal of Occupational Health Psychology, 7,* 242-264. doi: 10.1037/1076-8998.7.3.242

57. United States Congress Joint Economic Committee. (2019, September 5). *Long-Term Trends in Deaths of Despair.* https://www.jec.senate.gov/public/index.cfm/republicans/2019/9/long-term-trends-in-deaths-of-despair

58. Herman, K.C. Brewett, S.L. Eddy, C.L, et al (2020) Profiles of middle school teacher stress and coping: Concurrent and prospective correlates. J. School Psychology. Vol 78, Feb.2020, 54-68.

59. Gewertz, Catherine. (2020, April 16). *Exhausted and Grieving: Teaching During the Coronavirus Crisis*. https://www.edweek.org/ew/articles/2020/04/16/exhausted-and-grieving-teaching-during-the-coronavirus.html

60. Battle, C. E., James, K., Bromfield, T., & Temblett, P. (2017). Predictors of post-traumatic stress disorder following critical illness: A mixed methods study. *Journal of the Intensive Care Society*, *18*(4), 289–293. doi: 10.1177/1751143717713853

61. Anesi, G.L. & Manaker, S. (2020) Coronavirus disease 2019 (COVID-19): Critical care issues. Retrieved from https://www.uptodate.com/contents/coronavirus-disease-2019-covid-19-critical-care-issues?source=related_line

62. Center for Disease Control and Prevention. National Center for Health Statistics, Stats of the State of Washington. Retrieved from https://www.cdc.gov/nchs/pressroom/states/washington/washington.htm

63. Rossen, L. M., Hedegaard, H., Khan, D., & Warner, M. (2018). County-level trends in suicide rates in the US, 2005–2015. American Journal of Preventive Medicine, 55(1), 72–79. https://doi-org.proxy.seattleu.edu/10.1016/j.amepre.2018.03.020

64. American Foundation for Suicide Prevention. (2020, March 1). *Suicide Statistics.* Retrieved from https://afsp.org/suicide-statistics/

65. Pacific Northwest Suicide Prevention Resource Center. (2020). *Suicide Statistics.* Retrieved from http://depts.washington.edu/hiprc/suicide/stats/

66. Washington State Department of Health, Center for Health Statistics. (2019, October). Death Certificate Data, 2000-2018, Community Health Assessment Tool (CHAT). Retrieved from https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/MortalityDashboards/ACHInjuryDeathsDashboards