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Supplementary appendix

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Supplement to: Dotson S, Ciarocco S, Koh KA. Disaster psychiatry and homelessness: creating a mental health COVID-19 response. *Lancet Psychiatry* 2020; published online Aug 4. http://dx.doi.org/10.1016/S2215-0366(20)30343-6.

Appendix: Implementation of a Mental Health COVID-19 Disaster Response

We specifically drew upon the eight factor model of PFA as articulated in the Field Operations Guide for Psychological First Aid published by the National Center for PTSD in collaboration with the National Center for Child Traumatic Stress Network.[1] These eight factors, familiar to readers already acquainted with the common factors of psychotherapy, are: Contact and Engagement, Safety and Comfort, Stabilization, Information Gathering, Practical Assistance, Connection with Social Supports, Coping Information, and Linkage with Collaborative Services (see panel in main text). A description of the implementation of services based on each of these principles follows.

Contact and Engagement: Upon entry to the facility, staff greeted patients and provided each person with a standardized welcome packet that included toiletries and a list of services offered at the field hospital. Patients were screened at registration for substance use, use of medication-assisted treatment, and existing mental health providers. The treatment team was then immediately introduced. This team screened for high-risk behaviors using the Broset violence checklist which assesses confusion, irritability, boisterousness, verbal threats, physical threats, and attacks on objects.

Safety and Comfort: Each patient was given a private room with locked cabinets for their belongings. Female-only areas were established. National Guard and police personnel were present for security, and their presence in this setting was carefully explained given the potential for confusion and concern among immigrant patients fearing deportation. We employed a culturally diverse workforce that was addiction-informed and trauma-informed. The use of a diverse workforce was especially important in our region given the disparities in COVID-19 prevalence and mortality among ethnic and racial minorities in the United States.

Stabilization: We performed individual consults for acute mental health needs to help promote stabilization, with follow-up visits as needed. We provided sleep hygiene materials given the bi-directional nature of sleep and psychiatric symptoms. We offered an outside space for fresh air breaks. We also utilized expressive therapy groups extensively as these required minimum staffing, and allowed patients to produce artwork with messages of hope and gratitude that were prominently displayed to encourage future guests.

Information Gathering: In designing this mental health response, we collected information from expert consultants on how to maximize the safety of the milieu. We also sought patient input on quality improvement and had peer specialists gather feedback during education groups. Finally, we learned about systems-level and individual patient needs through interviews with all members of the medical teams.

Practical Assistance: We helped patients with limited access to reliable information by providing access to landlines and donated cell phones, creating an internet cafe, and providing tablet access. We also created a patient library with newspapers and books. Case management services were available for connecting patients with housing and clothing resources.

Connection with Social Supports: We encouraged the development of a therapeutic milieu that enhanced the community's sense of self-efficacy by using recovery groups, walking and dance

groups, games (e.g. bingo), and social activities (e.g. movies and karaoke). We gave positive reinforcement for group attendance. We also connected interested patients with their pre-existing therapist or psychiatrist using telehealth.

Coping Information: We offered coping skills groups, as well as groups addressing specific forms of coping including meditation, yoga, mindfulness, aromatherapy, and expressive therapy. We also offered stress balls. Finally, we offered interfaith and spirituality resources, including religious texts in multiple languages and a designated chapel area.

Linkage with Collaborative Services: Telehealth resources were particularly important in this response as they extended our provider workforce, reduced exposure to the virus, and reinforced existing therapeutic relationships. We also were able to link patients with new community providers through telehealth. Special attention was also paid to substance use disorders as management of overdose and withdrawal addresses many of the core elements of PFA (Engagement, Safety, Stabilization, Practical Assistance, Connection with Social Supports, and Linkage with Collaborative Services). Our efforts in this area included limiting drug trade by securing the perimeter, using standardized alcohol and withdrawal management protocols (CIWA and COWS), encouraging attendance at recovery groups, prominently posting naloxone kits throughout the site, using reverse motion detectors in bathrooms to detect overdoses, and connecting patients with sober homes and long-term office based addiction treatment. Finally, we offered connection with long-term services including government agencies, shelter services, and local non-profit organizations.

APPENDIX REFERENCES

1. Uhernik JA, Husson MA. Psychological first aid: An evidence informed approach for acute disaster behavioral health response. *Compelling counseling interventions: VISTAS* 2009;**200:**271–80.